Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 25 June 2026** at **9.30am** via MS Teams

AGENDA

Time	No		Lead	Paper
9.30	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.33	**2**	**DECLARATIONS OF INTEREST**	Chair	*Appendix-2026-37*
9.34	**3**	**MINUTES OF PREVIOUS MEETING** 02.04.26	Chair	*Attached*
9.36	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.40	**5**	**CHIEF EXECUTIVE'S REPORT**	Chief Executive	*Appendix-2026-38*
9.45	**6**	**FINANCE AND RISK ASSURANCE**		
9.45	6.1	External Annual Audit Report *(Not available to the public until laid before the Scottish Parliament)*	Audit Scotland	*Appendix-2026-39 Circulated separately*
10.00	6.2	Audit & Risk Committee Assurance Report *(Not available to the public until laid before the Scottish Parliament)*	Chair A&RC	*Appendix-2026-40 Circulated separately*
10.05	6.3	NHS Borders Annual Report & Accounts *(Not available to the public until laid before the Scottish Parliament)*	Director of Finance	*Appendix-2026-41 Circulated separately*
10.20	6.4	NHS Borders Endowment Annual Accounts *(Not available to the public until laid before the Scottish Parliament)*	Director of Finance	*Appendix-2026-42 Circulated separately*
10.25	6.5	NHS Borders Private Patients Funds Annual Accounts *(Not available to the public until laid before the Scottish Parliament)*	Director of Finance	*Appendix-2026-43 Circulated separately*
10.30	6.6	Finance Report	Director of Finance	*Appendix-2026-44*
10.35	6.7	Medium Term Financial Plan	Director of Finance	*Appendix-2026-45*

10.45	**7**	**STRATEGY**		
10.45	7.1	Delivering Our Strategies: 2026/27 Implementation Plan	Director of Planning & Performance	*Appendix-2026-46*
11.35	7.2	Director of Public Health Annual Report 2025	Director of Public Health	*Appendix-2026-47*
11.45	**8**	**QUALITY AND SAFETY ASSURANCE**		
11.45	8.1	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	*Appendix-2026-48*
11.55	**9**	**ENGAGEMENT**		
11.55	9.1	Whistleblowing Annual Report 2025/26	Director of People & Culture	*Appendix-2026-49*
12.00	**10**	**PERFORMANCE ASSURANCE**		
12.00	10.1	NHS Borders Performance Scorecard • Performance Improvement & Oversight Report	Director of Planning & Performance, Director of Acute Services, Director of Urgent Care, Community Services & Mental Health	*Appendix-2026-50*
12.25	**11**	**GOVERNANCE**		
	11.1	Board Committee Appointments	Chair	*Appendix-2026-51*
	11.2	Implementation of sub-national planning: co-operation and planning directions 2025	Chief Executive	*Appendix-2026-52*
	11.3	Consultant Appointments	Director of People & Culture	*Appendix-2026-53*
	11.4	Resources & Performance Committee by-exception Report	Chair R&PC	*Appendix-2026-54*
	11.5	Clinical Governance Committee by-exception Report	Chair CGC	*Appendix-2026-55*
	11.6	Staff Governance Committee by-exception Report	Chair SGC	*Appendix-2026-56*
	11.7	Audit & Risk Committee minutes: 23.03.26	Chair A&RC	*Appendix-2026-57*
	11.8	Staff Governance Committee minutes: 30.01.26	Chair SGC	*Appendix-2026-58*
	11.9	Area Clinical Forum minutes: 12.03.26	Chair ACF	*Appendix-2026-59*
	11.10	Scottish Borders Health & Social Care Integration Joint Board minutes: 18.03.26	Board Secretary	*Appendix-2026-60*
	11.11	Health Charity Board of Trustees minutes: 06.10.25, 02.02.26, 11.05.26	Chair Health Charity	*Appendix-2026-61*
12.28	**12**	**ANY OTHER BUSINESS**		
12.30	**13**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 6 August 2026 at 10.00am via MS Teams	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**F Sandford, Chair**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

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

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Regulatory requirement.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to **note** the inclusion of the Declaration of Interests for B Brewis, Director of Strategic Projects in the NHS Borders Register of Interests.

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Register of Interests for B Brewis, Director of Strategic Projects.

Borders NHS Board

Register of Interests of Board Members

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

Board Member: BEN BREWIS ..... *(please insert your full name in capital letters)*

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

Signed..... Date 16/6/26

Borders NHS Board

Minutes of the Borders NHS Board meeting held on Thursday, 2 April 2026 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams (Hybrid).

Present:
F Sandford, Interim Chair
J Ayling, Non Executive
L O'Leary, Non Executive
J Pepper, Non Executive
D Parker, Non Executive
P Williams, Non Executive
P Moore, Chief Executive
A Bone, Director of Finance
L McCallum, Medical Director
S Bhatti, Director of Public Health

In Attendance:
I Bishop, Board Secretary
J Smyth, Director of Planning & Performance
A Keen, Director of People & Culture
G Clinkscale, Director of Acute Services
L Jones, Director of Quality & Improvement
S Whiting, Infection Control Manager
C Oliver, Head of Communications & Engagement
L Henderson, Communications Officer
M O'Reilly, Chief Nurse for C&PD
C Wilson, General Manager Primary Community Services
E Dickson, Associate Nurse Director
C Barlow, Fundraising Manager

1. Apologies and Announcements

1.1 Apologies had been received from J McLaren, Non Executive, L Livesey, Non Executive, S Horan, Director of Nursing, Midwifery & AHPs and O Bennett, Interim Director of Acute Services

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

1.3 The Chair welcomed A Keen, Director of People & Culture to her first meeting of the Board.

1.4 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

The **BOARD** approved the 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 previous meeting of Borders NHS Board held on 5 February 2026 were approved.

4. Matters Arising

4.1 **Action 2025-6:** S Bhatti confirmed that an appointment had been made and a further appointment to a permanent consultant was in train with interviews taking place in April. The work relating to waiting well was being piloted and all processes were in place. The Board agreed to close the item on the action tracker.

4.2 **Action 2025-7:** A Bone confirmed that cost avoidance reporting would be included in the next financial year and the Quarter 1 Report. He was on track to make it effective from 1 April. The Board agreed to close the item on the action tracker.

The **BOARD** agreed to close Actions 2025-6 and 2025-7.

The **BOARD** noted the Action Tracker.

5. Chief Executive's Report

5.1 P Moore provided an overview of the content of the report and referred to the clinical strategy, metrics and process to turn the vision into operational reality, what community hubs might look like, and the appointment of a Chief Officer to the IJB.

5.2 S Bhatti commented that he had previously highlighted that clinical colleagues often emphasised the importance of sharing information and providing patient leaflets to support well-being. However, evidence suggested those materials alone may not be effective and could be outdated with the latest developments. His team had consistently clarified that the focus should be on facilitating behaviour change, rather than simply disseminating information.

5.3 G Clinkscale commented that R Devine, Public Health consultant had manned a preventative station at the workshop and facilitated productive exchanges between public health professionals and clinicians and would provide additional recommendations for that area prior to implementation.

5.4 P Moore commented that the being well was everyone's role across all interactions across all services and communities.

The **BOARD** noted the report.

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

6. NHS Borders Deliverables Update

6.1 J Smyth provided an overview of the content of the report and highlighted: the work taken forward over the past 12 months on the organisational strategy and implementation moving forward; 10 deliverables of initial key priorities; 5 were complete; 5 remained in progress and were either close to completion or would sit under the enabling strategies and their plans.

6.2 Discussion focused on: extensive range of public engagement and staff involvement; the need for demographic information; application of the net zero agenda on future work; challenging delivery; challenging outwith the financial envelope; logistical issues; volume of work involved; credibility for the organisation will be in the delivery; as broad a voice as possible had been captured during the engagement process; embedding quality improvement in the organisation; and the importance of setting objectives and measuring against them.

The **BOARD** noted the report.

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

7. Anti Racism Plan

7.1 A Keen introduced the anti racism plan in its final stage and commented that the Scottish Government had instructed Boards to produce anti racism plans over 2024/25. C Wilson had been the lead in taking the anti racism plan forward and had co-produced it with the minority ethnic staff network. P Moore had put in place reverse mentoring for protected characteristics and A Keen was responsible for the race characteristic.

7.2 C Wilson provided a presentation on the Anti Racism Plan that focused on: it being a collective responsibility; mission statement; vision and guiding principles; key improvements; delivery objectives; gaps against Scottish Government guidelines; and recommendations.

7.3 D Parker commented that A Carter had started the work on the anti racism plan in 2025 and had presented to the Staff Governance Committee his expectations on what could be achieved. He suggested the plan actually exceeded those expectations and he commended the staff involved and the power of work that has been undertaken to produce such a meaningful plan.

7.4 Discussion focused on: expanding the plan to include children and feed into the work of the Children and Young People Partnership; recognition of the diversity of workforce with international colleagues; anti racism is everybody's business; potential to link to the IJB and care sector; important to link in the Gypsie traveller communities and make that link quite transparent; be a part of a broader people committee to bring all the work around workforce together; the role of compassionate leadership and challenging inappropriate behaviours; equality impact assessment; and the behavioural framework and values to treat each other with dignity and respect.

7.5 The Chair commented that it would be good to have a route map to all protected characteristics.

The **BOARD** approved the Anti-Racism Plan in principle, noting its substantial alignment with national guidance.

The **BOARD** supported the commitment of resources to progress the action plan.

The **BOARD** confirmed that it had received moderate assurance from the report because the Anti-Racism Plan was substantially aligned with national guidance and underpinned by strong engagement, enabling it to be published. However, some key elements required for full assurance remained in development, as the Plan itself set out further actions for the organisation.

8. Resources & Performance Committee minutes: 15.01.26, 05.03.26

No items were escalated to the Board.

The **BOARD** noted the minutes.

9. Audit & Risk Committee minutes: 15.12.25

No items were escalated to the Board.

The **BOARD** noted the minutes.

10. Finance Report

10.1 A Bone provided an overview of the content of the report and highlighted that: the position continued to improve and the final figures at month 11 showed a trajectory of under £10m; savings delivery was not in line with trajectory and although progress was made a proportion of the savings were non recurring; £7.5m recurring savings were expected to be achieved against a previous forecast of £6m; and there were increased agency costs and cost pressures.

10.2 J Ayling commented on the positive position.

10.3 P Moore enquired what the expected deficit or planned deficit had bene. A Bone commented that there had be an original £12.8m deficit, the delivery of assumptions to reach £12.8m had been challenging however there was real confidence that £10m or more would be achieved.

The **BOARD** noted the contents of the report including the following:

YTD Performance	£8.79m overspend
Outturn Forecast at current run rate	£9.59m overspend
Projected Variance against Financial Plan (current run rate)	£3.21m improvement
Actual Savings Delivery (current year effect)	£8.73m (actioned)
Projected gap to Forecast	Best Case £9.59m (Trend) Worst Case £10.0m (Forecast)

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

The **BOARD** confirmed that it has received significant assurance from the report in terms of in year financial performance.

11. Risk Appetite Policy

11.1 L Jones highlighted 2 key elements to the Board: within the policy the governance work had been strengthened on revising decision making groups and the delivery group structure would take responsibility and oversight of strategic risks; O Bennett and G Clinkscale had strengthened the Hospital Management Board and Community Hospital Management Board and had oversight of operational risk; and a minor change of wording had also been agreed with the Audit & Risk Committee.

The **BOARD** approved the updated Risk Appetite Policy.

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

12. Clinical Governance Committee minutes: 14.01.26

No items were escalated to the Board.

The **BOARD** noted the minutes.

13. Quality & Clinical Governance Report

13.1 L Jones provided an overview of the report and highlighted several key points which included: the Coming Home programme and ensuring those repatriated back to the Scottish Borders received the best care; the fragility of the workforce in health and social care and within independent providers as well as pressures on the nursing workforce; increased demand for school nursing given the complexity of some children in the Scottish Borders; and medicine safety and the recurring theme of the absence of HEPMA in NHS Borders.

13.2 Discussion focused on: workforce assurance; work undertaken on new initiatives to develop the clinical workforce and get staff on to undergraduate programmes and collaboration with Borders College and Queen Margaret and Napier Universities; vulnerabilities in the medical workforce space; and the provision of HEPMA.

13.3 A Bone commented that in regard to HEPMA he would take a report on capital prioritisation overall to the next Resources & Performance Committee and make reference to HEPMA, capital priorities and the balance of risk against the wider portfolio of issues.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report based on the mixed assurance levels taken at the Board Clinical Governance Committee.

14. Infection Prevention & Control Report

14.1 S Whiting drew the attention of the Board to page 7, section 3.3 of the report and advised that all of the internal audit management actions for the infection control audit

of 2024 had been completed. He then advised that hand hygiene compliance had improved in some areas and there would be a focus on leadership culture and accountability through a 100 day improvement programme due to commence in July.

14.2 J Ayling recorded his thanks to S Whiting for the completion of all of the internal audit points.

The **BOARD** noted the report.

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

15. Health & Care (Staffing) (Scotland) Act 2019 - Annual Report

15.1 E Dickson provided an overview of the content of the report and highlighted several key elements which included: an assessment of how the Board had performed over the previous year; reasonable assurance against the Health & Care Staffing assurance matrix; across 10 duties within the legislation, 9 had been assessed and provided reasonable assurance and 1 provided limited assurance which related to adequate time to provide to clinical leaders; staffing tools had been strengthened; support with the roll out of optimum safe care; staffing pressures; clear escalation routes; and the recording of risk; and workforce modelling.

15.2 Discussion focused on: quantification and totality of risk; compliance of clinical services; workforce gaps; multi disciplinary teams as opposed to professions working in isolation; recruitment issues within specific professional groups; vulnerable services; and single points of failure.

The **BOARD** noted the report.

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

16. Staff Governance Committee minutes: 17.07.25, 16.12.25

16.1 No items were escalated to the Board.

The **BOARD** noted the minutes.

17. Area Clinical Forum Minutes: 11.12.25

17.1 P Williams commented that the last meeting had focused on risk and workforce escalations.

The **BOARD** noted the minutes.

18. Whistleblowing Quarter 4 Report

18.1 I Bishop provide an overview of the content of the report.

18.2 P Moore commented that he had met with Independent National Whistleblowing Officer (INWO) along with J Smyth and I Bishop in regard to the learning from a case from 2024/25 and recommendations advised by INWO. The discussion with INWO had been very supportive and all of the recommendations had been completed. He

recognised that the organisation needed to ensure it had the right infrastructure in place for whistleblowing and it had been challenging to support the function in terms of capacity over the previous year. He expressed his thanks to I Bishop for supporting the organisation through that very disruptive period.

18.3 I Bishop expressed her thanks to A Keen for her support as the Executive Lead for whistleblowing since coming into post in February 2026.

18.4 The Chair commented that the low level of cases might suggest conversations were taking place and being resolved proactively at the line manager level, however, it remained important to ensure staff were comfortable raising issues and knowing the correct channels to go through to raise any concerns.

The **BOARD** noted the Whistleblowing Quarter 4 report.

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

19. Workforce Report

19.1 A Keen advised that she intended to bring a regular workforce report to the Board and sought input from the Board on what they would be most keen for it to contain. She confirmed that in February the organisation had 3540 employees with 2810 whole time equivalents (wte). Sickness absence levels for 24/25 were at 4.8% and for 25/26 were at 5.7% which showed a significant increase and a deep dive to interrogate that data would be progressed. The implementation of erostering was at 50% for substantive staff being live on that system and there were 52 live vacancies being worked on at different stages.

The **BOARD** noted the update.

20. NHS Borders Performance Scorecard

20.1 J Smyth provided an overview of the content of the report and highlighted that the new style of performance reporting would be introduced from June 2026 as it would contain April data.

20.2 G Clinkscale commented that the Emergency Access Standard performance at the end of March was 0.1% off of the 70% target. There had been significant focus through the Borders General Hospital over the last few weeks on 4 hour performance. He also updated the Board in regard to the expansion of the Hospital at Home service into the Teviot locality, progress with delayed discharges, the home first service, child and adolescent mental health services and psychology waiting times.

20.3 The Chair welcomed the progress that had been made in the performance of the Emergency Access Standard and the functioning of the Frailty unit.

The **BOARD** noted the report.

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

21. Director of Public Health Annual Report

21.1 S Bhatti through a presentation provided an independent professional assessment to the Board to inform and challenge decision-making across the Scottish Borders. He drew the attention of the Board to the report and the requirement of the Board to take whatever action it deemed from the recommendations. The focus of the report was the health and wellbeing of children and young people in the Scottish Borders, with an emphasis on prevention across the life-course. He highlighted the surface key challenges, inequalities and opportunities and set out clear, actionable recommendations to improve outcomes.

21.2 Discussion focused on the presentation and the alignment to the clinical strategy.

21.3 It was noted that the actual report had not been shared with the Board in advance of the meeting and that it required updating following feedback received from childrens' services.

21.4 J Pepper asked that in terms of bringing the report back to the Board, that further information be provided to the Board on what had been achieved over the previous 12 months around childrens' services planning across the Health Board and the Local Authority and other community planning partnerships.

The **BOARD** agreed to defer the item to the next meeting.

22. Scottish Borders Health & Social Care Integration Joint Board minutes: 21.01.26

22.1 No items were escalated to the Board.

The **BOARD** noted the minutes.

23. Code of Corporate Governance Sectional Refresh

23.1 I Bishop provided an overview of the changes made within the sectional refresh.

The **BOARD** formally approved the sectional refresh of the Code of Corporate Governance.

The **BOARD** confirmed it had received significant assurance that the refreshed section of the Code of Corporate Governance was in line with appropriate legislative requirements and directions as issued by the Scottish Government.

24. Consultant Appointments

24.1 A Keen provided an overview of the content of the report and recorded her thanks to V Roy in her team for pulling the report together.

The **BOARD** noted the report.

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

25. Any Other Business

The **BOARD** noted there was no further business identified.

26. Date and Time of next meeting

26.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 25 June 2026 at 10.00am in Scottish Borders Council and via MS Teams.

Borders NHS Board Action Point Tracker

Meeting held on 4 December 2025

Agenda Item: Health Inequality Progress Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-6	8	The **BOARD** agreed to add an overview of what was currently done in regard to Health Inequalities and Social Prescribing to the Action Tracker.	**S Bhatti**	**On going**	**Update 05.02.26:** S Bhatti confirmed that progress had been made. A locum consultant had been appointed to lead the joint strategic needs assessment and undertake the option appraisal. Recruitment was also progressing to an epidemiology intelligence function and progress was being made liaising with Live Borders on the waiting well initiative and social prescribing service. **Update 02.04.26:** S Bhatti confirmed that an appointment had been made and a further appointment to a permanent consultant was in train with interviews taking place in April. The work relating to waiting well was being piloted and all processes were in place. The Board agreed to close the item on the action tracker. **Complete**	G

Agenda Item: Finance Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2025-7	11	The **BOARD** agreed to include progress in regard to "cost avoidance" for the following financial year on the action tracker.	**A Bone**	**June 2026**	**In Progress:** This will be implemented within the Finance Report from Month 1. **Update 05.02.26:** A Bone confirmed that cost avoidance reporting would be included in the next financial year and the Quarter 1 Report. **Update 02.04.26:** A Bone confirmed that cost avoidance reporting would be included in the next financial year and the Quarter 1 Report. He was on track to make it effective from 1 April. The Board agreed to close the item on the action tracker. **Complete**	G

Meeting held on 5 February 2026

Agenda Item: Chief Executive's Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2026-1	5	The **BOARD** agreed to receive a paper on Nursing Workforce and future delivery of services at the June Board meeting.	**S Horan** **A Keen**	~~**June 2026**~~ **August 2026**	**In Progress:** This item has been rescheduled to the 6 August Board meeting due to the large amount of business already scheduled on the June Board meeting agenda.	A

Meeting held on 2 April 2026

Agenda Item: Director of Public Health Annual Report

Action No	Minute Ref	Action	Lead	Timescale	Status	RAG Status
2026-3	21	The **BOARD** agreed to defer the item to the next meeting.	**S Bhatti**	**June 2026**	**In Progress:** Item rescheduled to 24 June 2026 Board meeting.	

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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Chief Executive's Report**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
Report Author:	**L Shillinglaw, EA to Chief Executive**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Delivery Plan
- Government policy/directive
- Local policy
- 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 will provide a progress update on the Clinical Strategy and performance, alongside key national and organisational developments, including system-wide planning, quality improvement and strengthened partnership working.

I would also like to take this opportunity to formally welcome Gill Main to her role as Chief Officer of the Integration Joint Board. This appointment represents an important step in strengthening joint leadership and partnership working with Scottish Borders Council, supporting our shared ambition to deliver high quality, integrated services for the people of the Borders.

2.2 Background

Since Board approval of the Organisational and Clinical Strategies, work has progressed to support implementation planning and the alignment of performance improvement priorities with strategic delivery, ensuring a coordinated approach to improving outcomes and service sustainability.

This report has been further developed following additional executive input to reflect recent developments, including national and sub-national planning, quality improvement activity, strengthened partnership working and overall organisational progress.

2.3 Assessment

Performance Report – Update

The Board continues to receive regular performance reporting through established governance routes, with a focus on key national and local indicators including unscheduled care, elective performance, and workforce sustainability.

Current performance continues to reflect the wider national context, with sustained pressure across urgent and unscheduled care pathways and ongoing challenges relating to workforce capacity and service demand.

Work is ongoing to ensure that performance improvement priorities are fully aligned to the Clinical Strategy implementation plan, with a particular focus on strengthening community-based models of care, improving patient flow, and reducing avoidable delay. This alignment will support delivery of sustainable improvement over time, rather than short-term solutions.

Clinical Strategy – Implementation Update

Significant work has been undertaken across services, clinical teams and corporate functions to translate strategic intent into a deliverable implementation plan. This has focused on identifying and prioritising Year 2 (2026/27) deliverables as the first phase of stepped change towards the 2030 vision.

Engagement workshops and structured discussions with Clinical Management Teams and corporate leads have supported agreement on priority actions, sequencing and dependencies. This has ensured that deliverables are clinically owned, outcome-focused and aligned to the needs of the population.

This work has been undertaken alongside the refinement of enabling strategies and the establishment of a consistent Delivery and Improvement Approach. This brings together programme management, quality improvement and evidence-based decision-making within a single organisation-wide framework.

This approach ensures that strategic priorities, operational delivery and financial planning are aligned within one integrated plan, supported by clear governance, defined accountabilities and a shared methodology for implementation. As a result, NHS Borders is transitioning from strategy development into a coordinated phase of delivery, with a clear line of sight from strategic ambition through to measurable actions and outcomes.

Sub National Planning Update

Work is also progressing in relation to sub-national planning across the East of Scotland. As previously reported a joint plan for West and East was submitted to Scottish Government on 31st March 2026. This was during the pre-election period and as yet there has been - understandably - been no formal feedback from the Scottish Government. It should be noted that the plan did not include plans for the delivery of a 'digital front door' which has a separate deadline of 30th June 2026.

On 18th May the Deputy Chief Executive of NHS Scotland wrote to the lead CEOs for the East and West SPDCs noting the improvement in elective waiting times performance and citing the close working between Boards as part of the reason for that improvement. The Deputy Chief Executive asked that the SPDCs build on the work undertaken in Orthopaedics to agree a broad ask for all elective specialties and that this be shared with the Scottish Government by mid-June. The approach being taken in the East is to bring together the work already undertaken to develop individual Board plans.

Elections Update

The Scottish Parliament Election of 7th May led to the appointment of John Swinney as First Minister and appointments to the Cabinet were made on 22nd May. These included Jenny Gilruth, MSP, as Deputy First Minister and Cabinet Secretary for Finance, Angela Constance MSP as Cabinet Secretary for Health and Care, and Ivan McKee MSP as Cabinet Secretary for Public Service Reform.

Quality Improvement QI Programme

The QI programme continues to gain traction across the organisation, supporting a culture shift towards continuous improvement. The QI Champions programme aims to build the technical skills in QI and is open to all staff working in NHS Borders who would like to practice QI in their day-to-day work and support other colleagues to practice QI. Cohort 5 of the QI champions programme is currently running with around 110 graduates of the programme across the 5 cohorts. Graduates are asked to complete a workplace QI project on completion of the course supported by group mentorship and networking sessions to share learning and support each other through the project stage. Cohort 1 of the QI practitioners programme will run in August 2026 aimed at building skills in managerial and leadership teams around coaching for improvement. The annual NHS Borders Quality Improvement symposium is being held on the 22 June giving an opportunity for colleagues to network, share the learning from QI work underway across the organisation, celebrate achievements and explore innovations to enhance the quality of our services.

Delivery Board – one year Anniversary

As the organisation approaches the first anniversary of the Delivery Board, significant progress has been made alongside improvements in key performance areas as undernoted:

Urgent & Unscheduled Care Update

Over the past year, the Urgent and Unscheduled Care programme has delivered tangible improvements across access, flow and performance. Key successes include strengthened whole-system governance and delivery grip, clearer prioritisation of improvement actions, and closer integration between acute, community, primary care and SAS partners. The programme led the launch of a new Acute Frailty Unit in December 2025 coinciding with an expanded Home First service and new Integrated Discharge Team. Record numbers of older people are now being supported home following their hospital stay. Hospital at Home more than doubled the number of patients that they care for last year. The number of Delayed Discharges halved last year to the lowest level in the previous few years. We are now seeing an impact on Emergency Access Standard performance, reflecting more consistent application of flow principles, expanded use of alternatives to admission, and better coordination of discharge planning and community capacity. The Hawick Walk in Clinic pilot recently launched providing improved local access to urgent care. Collectively, these improvements have supported safer, more timely care for patients while increasing system resilience during periods of sustained demand.

Significant Reduction in Waiting Times

In the last twelve months there has been a significant reduction in waiting times for elective care, cancer treatment and diagnostics. I would like to put on record my sincere thanks to the acute team and others that have delivered this impressive scale of improvement which will have made a significant impact on patients. Below are some of the improvements that I would like to particularly highlight:

- The number of patients waiting over 62 days for cancer treatment halved and we eliminated all very long waits
- 70% of patients on a cancer pathway treated within 62-days in March 2026 compared to 35% at the beginning of the year.
- Most patients (98%) received their MRI, CT or NOUS within 6 weeks by March 2026; the best performance in Scotland.
- We performed 374 more elective operations last year compared to the previous year, and 1,750 more outpatient appointments.
- Reduced the overall elective waiting list by 8.3%
- Eliminated all 2+ year waits for capacity reasons
- Nearly eliminated all 18-month waits
- Most specialties no longer have elective waits exceeding one year
- Reduced one year waits for new outpatient appointments by 80%, compared to the national average of 75%.
- Reduced one year waits for treatment by 93%, compared to the national average of 52%, which put us as the second most improved Health Board in Scotland.
- 4-hour ED performance in March was 70% compared to 62% at the beginning of the year & 1 of only 3 Boards in Scotland to show an improvement in March 2026.
- Delayed discharges from hospital reduced by 32%.

Chief Officer Appointment

Gill Main will commence in early August as Chief Officer for the Borders Integration Joint Board (IJB) and Health and Social Care Partnership (HSCP). This post represents an important step in strengthening joint leadership and partnership working with Scottish

Borders Council, supporting our shared ambition to deliver high quality, integrated services for the people of the Borders.

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

The Board is asked to note the report.

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

3 List of appendices

None

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25th June 2026**
Title:	**Finance Report – May 2026**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Andrew Bone, Director of Finance**

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 NHS Scotland 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 report will be discussed at the meeting of the Borders Delivery Group to be held on 24th June 2026.

2.4 Recommendation

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

The Board is 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 – Finance Report for the period to the end May 2026

FINANCE REPORT FOR THE PERIOD TO THE END OF MAY 2026

1 Purpose of Report

1.1 The purpose of the report is to provide Board members with an update in respect of the board's financial performance (revenue) for the period to end of May 2026.

2 Recommendations

2.1 Board Members are asked to:

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

- The financial position after two months is £1.478m overspent.
- Forecast outturn remains £10.0m deficit in line with financial plan.
- Recurring savings delivery after two months is £0.45m against £10.0m target.

2.1.2 **Note** the assumptions made in relation to Scottish Government allocations and other resources.

3 Summary Financial Performance

3.1 The board's financial performance as at 31st May 2026 is an overspend of £1.478m. This position is summarised in Table 1, below.

Table 1 [1]– Financial Performance for two months to end May 2026

Revenue Resource Summary (RRL)	Year to Date			2026-27 Forecast Year End Position		
	Actual £000s	Resource Budget £000s	Variance £000s	Forecast Outturn £000s	Annual Resource Budget £000s	Variance £000s
NHS Board Services	34,525	33,397	(1,128)	208,445	201,231	(7,214)
Scottish Borders Health & Social Care Partnership	35,968	35,618	(350)	154,567	151,781	(2,786)
RRL Expenditure	**70,493**	**69,015**	**(1,478)**	**363,012**	**353,012**	**(10,000)**
Total Non-core RRL Expenditure	1,020	1,020	0	6,119	6,119	0
FHS non discretionary net expenditure	3,392	3,392	0	17,326	17,326	0
Total RRL Outturn	**74,905**	**73,427**	**(1,478)**	**386,457**	**376,457**	**(10,000)**

3.2 Variance is inclusive of unmet savings. Within the year to date position there is £2.0m slippage on savings targets. The net operating variance excluding savings is £0.5m underspent.

3.3 The reported position at M02 includes £3.7m of anticipated funds not yet enacted within operational budgets. This is predominantly in relation to IJB reserves, where funding cannot be released until finalisation of 2025/26 audit. This is expected to be in place in advance of M03 report.

[1] Table 1 is presented in line with refreshed Scottish Government Financial Reporting Template. This requires separate analysis of non-delegated and delegated budgets. Non-core RRL reflects depreciation on fixed assets; FHS non-discretionary expenditure is aligned with income recovered through independent contractors (i.e. dental payments, etc.).

3.4 At this stage no detailed forecast has been prepared and therefore forecast outturn is reported in line with financial plan.

3.5 HSCP variances exclude Set Aside for large hospital functions, which is reported within NHS Board Services.

3.6 **Core Operational Performance**

3.6.1 Table 2 summarises business unit performance after two months.

Table 2[2] – YTD Performance by Business Unit

	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	Variance exc. Savings £m	Unmet Savings £m	YTD Variance £m
Acute Services	124.6	21.0	22.3	(0.7)	(0.6)	(1.3)
Mental Health & Learning Disabilities	25.1	4.6	4.9	(0.3)	(0.1)	(0.4)
Primary & Community Services	114.6	29.5	29.4	0.3	(0.3)	0.0
Clinical Support Services	7.1	1.2	1.1	0.1	(0.0)	0.1
Corporate Services	26.7	4.8	4.9	0.2	(0.3)	(0.1)
Estates & Facilities	25.1	4.2	4.4	0.0	(0.2)	(0.2)
Commissioned Healthcare	44.5	7.4	8.5	(0.7)	(0.4)	(1.1)
Board Administered	26.6	2.2	0.6	1.5	(0.0)	1.5
Other Operating Income	(12.2)	(1.4)	(1.4)	(0.0)	0.0	(0.0)
	382.1	**73.4**	**74.9**	**0.5**	**(2.0)**	**(1.5)**

3.6.2 Acute services is reporting a £0.7m overspend on core budget excluding savings. At month 2 the main drivers of adverse variance are Medical staffing (£0.5m, including agency locums), Nursing costs associated with surge capacity (£0.4m, estimated) and non-pays (£0.3m). These costs are offset by vacancies across other staffing (£0.2m) and slippage on prescribing budgets (£0.3m).

3.6.3 Mental Health & Learning Disabilities is reporting a £0.3m overspend before savings. This is mainly attributable to ongoing use of medical agency locums.

3.6.4 Primary & Community Services are reporting an underspend of £0.3m before savings, largely in relation to vacancies on core establishment. This includes ongoing impact of reduced community hospital capacity due to closure of Knoll Hospital.

3.6.5 Clinical support services (Pharmacy) and Corporate services are reporting slight underspends (excluding savings) due to ongoing vacancies. Estates & Facilities are breakeven, excluding slippage on savings targets.

3.6.6 There is a £0.7m core overspend against Commissioned Healthcare budgets. This is driven by two main areas: tertiary outflow activity to other Health Boards (predominantly NHS Lothian); continuation of high cost out of area placements for a small number of individuals with complex mental health or learning disabilities requirements.

[2] Difference in annual budget against table 1 is due to treatment of non-core RRL funding. This has no impact on overall variance. Non-core expenditure is reported within Board Administered funds in table 2.

3.6.7 Board Administered funds includes funds held in reserve not yet distributed to operational budgets. As noted in para 3.3, £3.7m of funds are anticipated within business unit position pending release. A benefit of £1.5m is recognised against Board administered funds in line with flexibility identified within the financial plan. This includes phased impact of £3.3m additional Scottish Government support ('sustainability funds').

3.7 Planned Savings

3.7.1 As noted in Table 2, the overall financial performance at Month is £1.5m overspent, of which £2.0m represents unmet savings.

3.7.2 Table 3, below, summarises current plans as reported within the Board's Financial Improvement Programme.

Table 3 – FIP dashboard 2026/27: Schemes identified

Business Unit	26/27 Target	Savings Delivery FYE	Savings Delivery PYE	Savings Delivery FYE (% of target)	Savings Delivery PYE (% of target)
Acute	£4,235K	£1,584K	£1,572K	37%	37%
Commissioning	£2,386K	£313K	£313K	13%	13%
Corporate	£1,887K	£1,050K	£1,050K	56%	56%
Estates	£414K	£0K	£0K	0%	0%
Facilities	£1,018K	£233K	£233K	23%	23%
IJB - MH/LD	£632K	£676K	£676K	107%	107%
IJB - PACS	£1,665K	£1,879K	£1,879K	113%	113%
Organisation Wide	£0K	£150K	£150K		
Primary Care Prescribing	£766K	£832K	£832K	109%	109%
Total	**£13,003K**	**£6,717K**	**£6,705K**	**52%**	**52%**

3.7.3 It should be noted that the target reported in table above represent residual balance of three year target set at April 2024. The expected savings delivery in 2026/27 as set in the Board's financial plan is £10m recurring (c.80% of target).

3.7.4 Plans identified above demonstrate £6.7m FYE, approximately 52% of the overall target and £3.3m below the level required to meet the financial plan.

3.7.5 Phasing of PYE delivery is likely to fall below the level described in Table 3, with actual delivery timescales for majority of plans pending review at Gateway 2. Table 4 below describes the status of overall plans by Gateway.

Table 4 – FIP Schemes by Gateway

	FYE £000s	PYE £000s
Gateway 1	5,105	5,105
Gateway 2	1,010	1,000
Gateway 3	150	150
Gateway 3 Blue	453	451
	6,718	6,706

3.8 Actual Savings Delivery

3.8.1 Table 5 summarises delivery of savings reported within Business Unit performance as at May 2026 (M02).

Table 5 – Current year savings achieved as at May 2026

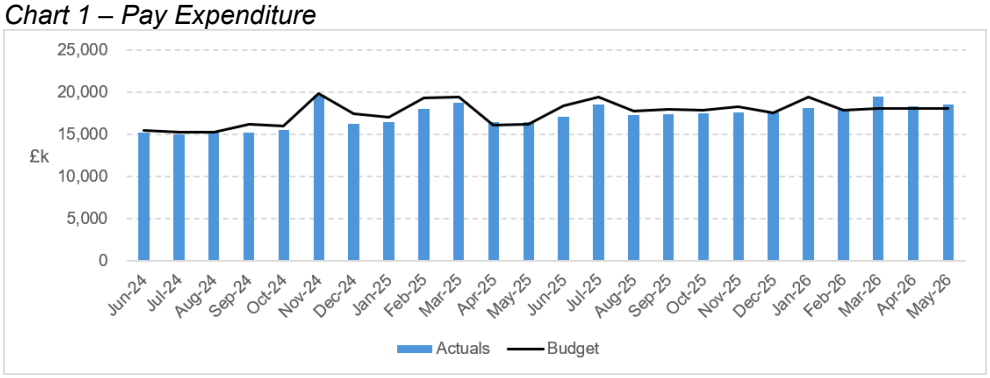
	Savings Target £m	Recurring Savings Achieved £m	Non Recurring Savings Achieved £m	Total Achieved £m	Unmet Savings (current year) £m
Acute Services	4.2	0.4	-	0.4	3.9
Mental Health & Learning Disabilities	0.6	0.0	-	0.0	0.6
Primary & Community Services	1.7	0.0	-	0.0	1.7
Corporate Services	1.8	0.1	-	0.1	1.8
Estates & Facilities	1.4	0.0	-	0.0	1.4
Commissioned Healthcare	2.4	0.0	-	0.0	2.4
Other	0.1	0.0	-	0.0	0.1
Total	**12.2**	**0.5**	**-**	**0.5**	**11.8**

3.9 Expenditure Trends

3.9.1 The following section is intended to provide context to broader trends in expenditure. This will be developed further in future reports.

3.9.2 Chart 1 illustrates the overall position on pay expenditure over the past 24 months. This position includes substantive, bank and agency staffing and will reflect changes in recruitment as well as pay awards and other changes to cost base.

Chart 1 – Pay Expenditure



3.9.3 Within this position, agency expenditure remains high.

3.9.4 At end May 2026, total agency spend is £0.7m of which the majority relates to Medical locum cover. Trend usage across Medical and Nursing is described below.

Chart 2 – Medical Agency Costs

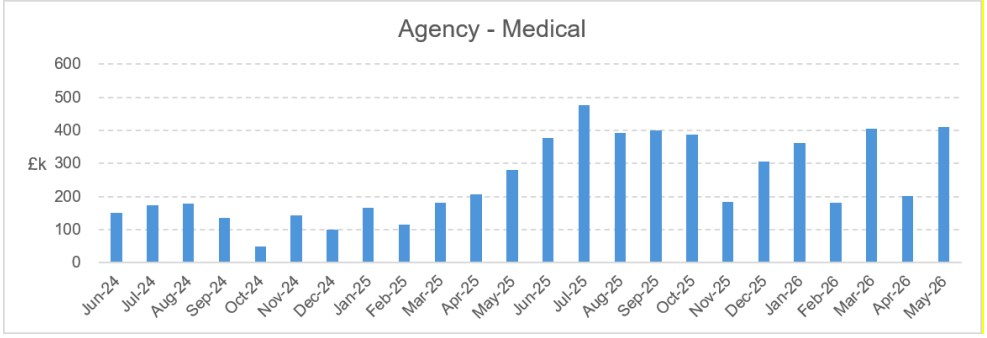
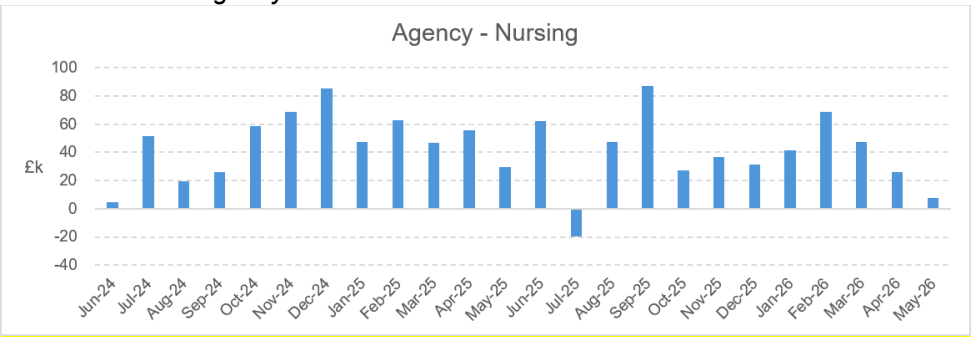


Chart 3 – Nurse Agency Costs



3.9.5 Variation between individual months is in part attributable to timing of invoices, however it is clear that agency use remains significant. Medical agency is driven largely by vacancies and service risk within specialist roles; Nursing agency continues to be mainly driven by surge capacity within Borders General Hospital.

3.9.6 It should be noted that expenditure is partly offset by vacancies on core establishment.

3.9.7 As at May 2026 there is no significant pressure reported against medicines expenditure however growth forecasts within the financial plan suggest that this position is likely to deteriorate during 2026/27. The following charts illustrate current trend across Hospital and Community (HCH) and Primary Care Prescribing.

Chart 4 – Hospital & Community Prescribing Costs

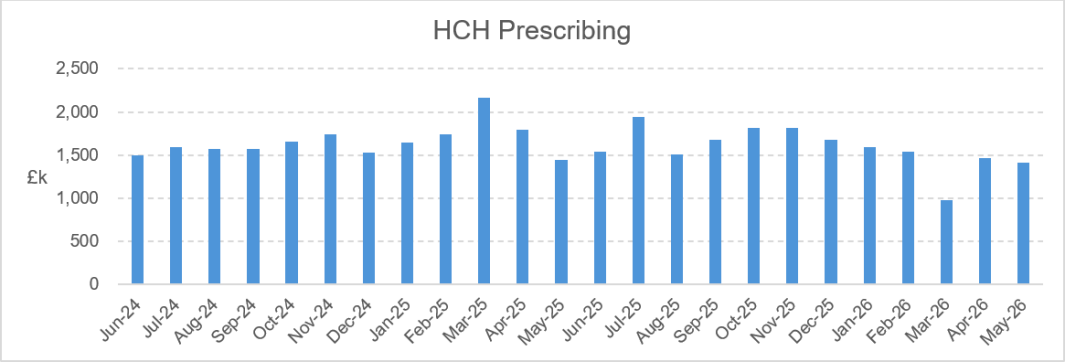
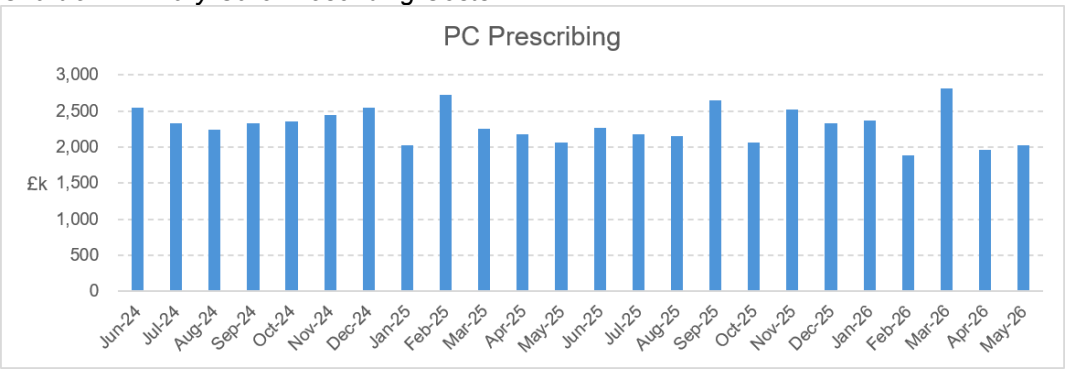


Chart 5 – Primary Care Prescribing Costs



3.9.8 Further information on trends against key costs will be included in future reports.

4 Scottish Government Oversight

4.1 The Board's medium term financial plan has been approved by Scottish Government with expectation that outturn deficit is within the control limit set for current financial year (£10m).

4.2 The Health Board remains at Stage 3 of the Scottish Government's Support and Intervention Framework. Recent dialogue with SG colleagues has included detail on specific criteria required to achieve de-escalation to Stage 2 of the Government's Support & Intervention Framework. An assessment of this criteria will be presented to the Resources & Performance Committee at its next meeting.

4.3 Although the brokerage mechanism for financial support has been discontinued it is important to note that NHS Borders continues to hold £48.33m brokerage liability under the arrangements in place to March 2025. Timelines for repayment remain subject to future discussion with SG at point when NHS Borders is able to demonstrate return to financial balance.

5 Key Risks

5.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 547). This is presently being updated and a revised assessment will be reported to the Resources & Performance Committee in due course.

Appendices

- There are no appendices to the report

Author(s)

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25th June 2026**
Title:	**Medium Term Financial Plan**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance**

1 Purpose

This is presented to the Board for:

- Decision

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 Board is required to approve its Financial Plan for the period 2026/27 to 2028/29.

A revised financial plan was submitted to Scottish Government on 26 March 2026 and formal approval was confirmed on 30 March 2026, following engagement to address concerns regarding the previous draft position.

The approved plan demonstrates delivery of the Scottish Government deficit control limit of £10 million in 2026/27, representing the required level of financial performance for the Board.

This represents a material change from earlier iterations of the plan presented to the Resources & Performance Committee, where a gap remained against the required position and further actions were required to secure approval.

The purpose of this paper is therefore to present the final approved plan to the Board and seek formal approval of the financial trajectory and associated governance framework required to deliver it.

There are no changes to position reported to the Resources & Performance Committee at its meeting held on 7th May 2026.

2.2 Background

The draft financial plan was reviewed by an extraordinary meeting of the Resources & Performance Committee on 19th March 2026. Following feedback from Scottish Government on the draft plan, further changes were made to the plan and a final iteration submitted to Scottish Government on 26th March 2026.

The updated plan was discussed at the meeting of the Resources & Performance Committee held on Thursday 7th May 2026. At this meeting, the committee were advised that Scottish Government had approved the final submission of the plan and had confirmed additional deficit support available to NHS Borders to meet the financial gap as set out in the plan.

2.2.1 National Financial Planning Context

Scottish Government required Boards to submit detailed three-year financial plans demonstrating:

- Delivery of 3% recurring savings in 2026/27
- Improvement in financial position across the planning period
- A credible and deliverable trajectory supported by clear governance and accountability arrangements

The Government also confirmed that Boards must operate within deficit support limits, with NHS Borders required to deliver a maximum deficit of £10m in 2026/27, and no brokerage support available.

2.2.2 Financial Plan Development (2026/27)

The development of the plan progressed through the following stages:

- Initial draft plan presented with a £16m deficit position, reflecting incomplete savings identification and significant underlying pressures
- Revised submission reflecting improved outturn and savings adjustments
- Further revision following Scottish Government feedback indicating the plan would not be approved in its draft form
- Final submission on 26 March 2026, incorporating additional flexibility and revised assumptions, resulting in a £10m deficit position aligned to control limit

Scottish Government approval was subsequently confirmed, with recognition of the risks associated with delivery and requirement for ongoing oversight and engagement.

2.3 Assessment

The financial plan for 2026-27 outlines brought forward pressures of £30.8 million; pay policy costs of £10.1 million; non pay growth of £6.6 million; national commitments of £0.7 million; and additional funding of £16.4 million. The outturn forecast at March 2027 is £10 million deficit, after delivery of £10 million recurrent savings with a requirement for a further £4.7 million additional non-recurrent actions including release of corporate flexibility.

Figure 1 describes the projected deficit before savings and how this is expected to reduce through impact of recurrent and in year savings and offsetting flexibility (including vacancies).

Figure 1: financial outlook before/after savings

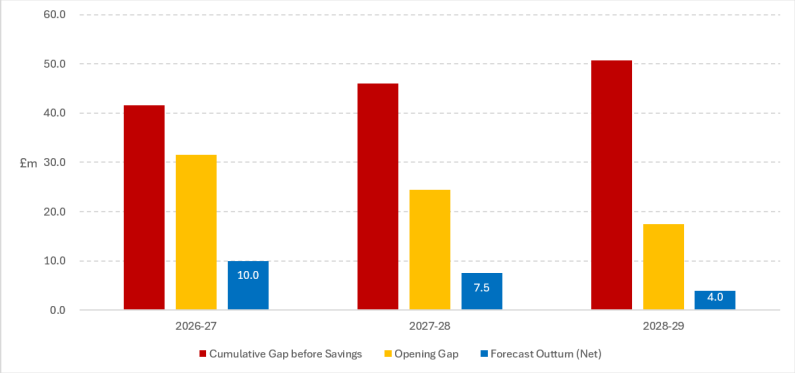

Table 1, below, provides overview of the financial forecast for each year, as set out in the draft plan. This position is predicated on delivery of recurrent savings within each year and therefore a reduction to the cumulative gap described in figure 1.

The table also provides comparison against target level performance (i.e. deficit support).

Table 4: Medium Term Financial Plan (summary)

	2026-27			2027-28			2028-29		
	R	NR	Total	R	NR	Total	R	NR	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Financial Gap before Savings	(41.6)	16.9	(24.7)	(36.0)	11.2	(24.8)	(29.2)	8.1	(21.1)
Savings Target	10.0	4.7	14.7	11.5	5.8	17.3	11.7	5.4	17.1
Projected Outturn	***(31.6)***	***21.6***	***(10.0)***	***(24.5)***	***17.0***	***(7.5)***	***(17.5)***	***13.5***	***(4.0)***

The plan has been constructed on a tightly constrained and explicit set of assumptions, reflecting national guidance and local risk assessment. These assumptions are summarised below:

- 2% uplift to baseline funding
- full funding of national pay awards, with the expectation that pay policy impacts above baseline assumptions would continue to be underwritten by the Scottish Government
- Costs of implementing Agenda for Change Reduced Working Week assumed to be contained within the £3.3 million funding allocation

- Medicines growth modelled at 10% in 2026/27, reducing to 8% per annum thereafter, reflective of delay to full implementation of weight loss drugs approved in current year
- Non-pay inflation modelled at 2% in 2026/27, rising to 2.2% in subsequent years (and noting risk attendant on this given current CPI level exceeds 3%)
- No increase in energy costs in 2026/27, with modest increases assumed thereafter (assumptions based on national price modelling prior to recent price disruption arising from situation in middle east)

The financial plan demonstrates:

- Delivery of £10m planned deficit in 2026/27, aligned to national expectations
- Continued improvement in years 2 and 3 of the planning period (consistent with earlier plan assumptions)
- A trajectory dependent on delivery of recurring savings and in-year management actions

However, the plan retains a significant underlying recurring deficit, requiring further action beyond the current planning period to achieve full financial sustainability.

It should be noted that the plan presents a risk of increased volatility in financial performance due to the release of contingency previously held in reserve across the planning period. This will require close management attention to variation from plan and early intervention to identify corrective actions where required.

This reinforces the requirement for strong governance, monitoring and escalation arrangements.

Appendix 1 sets out the updated financial plan as submitted to Scottish Government. Delivery of the plan is dependent on a strengthened financial recovery framework, including:

- Refresh of Financial Improvement Programme (FIP) governance
- Establishment of a Strategic Budget Review Group
- Introduction of a Support & Intervention framework to manage delivery risk
- Enhanced vacancy controls and expenditure management processes

Additional leadership capacity has been introduced through appointment of a Director of Strategic Projects to support delivery of financial recovery and transformation.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

The development of financial recovery plans over the term of the plan will include areas where difficult decisions are required impacting on how services and care is delivered in future, including potential restrictions to access and/or availability of services.

The implications of the financial position are that the Board will need to consider how it balances financial and non-financial risks and that decisions will be required which – without mitigation - may impact adversely on quality/patient care, workforce, performance and safety. It is expected that the full impact of these choices will be assessed, and appropriate engagement undertaken where required, prior to any implementation.

2.3.4 Risk Assessment/Management

Financial sustainability remains a very high strategic risk to the Board.

Key risks associated with the plan include:

- Non-delivery of savings targets
- Reliance on non-recurring measures
- Workforce and pay cost pressures
- Uncertainty in allocation funding (OIP / PCPIP)
- Continued growth in underlying recurring deficit

Mitigation will be delivered through:

- Strengthened FIP governance and escalation
- Enhanced Board and Committee oversight
- Continued engagement with Scottish Government
- Development of longer-term financial strategy

The plan remains exposed to several key risks:

- OIP funding – potential residual gap requiring mitigation through slippage and reserve utilisation
- PCPIP funding shortfall – significant structural gap requiring service redesign
- Reliance on IJB reserves and non-recurring support
- Exposure to inflation, demand growth and commissioning pressures

These risks were explicitly recognised in correspondence with Scottish Government and remain subject to ongoing engagement.

2.3.5 Equality and Diversity, including health inequalities

At this stage no impact assessment has been undertaken. Impact assessments are expected to be undertaken in relation to individual components of the plan.

2.3.6 Climate Change

No impacts identified.

2.3.7 Other impacts

No impacts identified.

2.3.8 Communication, involvement, engagement and consultation

The draft financial plan was presented to the Resources & Performance Committee at its meetings in March 2026 and to the Borders Delivery Group in April 2026. Briefing to the Public Involvement Partnership Group was provided earlier in June 2026.

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.

- Resources & Performance Committee, 5th March 2026
- EO Resources & Performance Committee, 19th March 2026
- NHS Board Development Session, 2nd April 2026
- Resources & Performance Committee, 7th May 2026

2.4 Recommendation

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

The Board is requested to:

- **Approve** the Financial Plan for 2026/27 to 2028/29
- **Note** that the plan delivers the required £10m deficit control limit in 2026/27, in line with Scottish Government approval
- **Acknowledge** the significant risks associated with delivery of the plan
- **Endorse** the strengthened governance and financial recovery arrangements required to support delivery

Assurance

Area	Proposed Assurance Level	Rationale
Systems / Processes	Moderate	Strengthened governance and delivery arrangements now in place
Outcomes	Limited	Delivery dependent on further savings, allocation clarity and transformation actions

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Medium Term Financial Plan

Appendix 1 – Financial Plan 2026/27

Summary of Revenue Outturn

	2026-27			2027-28			2028-29		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Gross Expenditure - Clinical & Non-clinical	400,106	23,688	423,794	395,575	27,168	422,743	395,401	29,533	424,934
Less: Gross Income	14,798	5,468	20,266	14,798	5,468	20,266	14,798	5,468	20,266
Total Expenditure	**385,308**	**18,220**	**403,528**	**380,777**	**21,700**	**402,477**	**380,603**	**24,065**	**404,668**
Less: Total Non-Core RRL Expenditure	0	7,199	7,199	0	7,199	7,199	0	7,199	7,199
Less: FHS Non Discretionary Net Expenditure	16,722	0	16,722	16,722	0	16,722	16,722	0	16,722
Core Revenue Resource Outturn	**368,586**	**11,021**	**379,607**	**364,055**	**14,501**	**378,556**	**363,881**	**16,866**	**380,747**
Baseline Allocation	332,897		332,897	339,555		339,555	346,346		346,346
Anticipated Allocations: Rec/ Non-rec/ Earmarked	4,109	32,601	36,709	0	31,501	31,501	0	30,401	30,401
Core Revenue Resource Limit (RRL)	**337,006**	**32,601**	**369,606**	**339,555**	**31,501**	**371,056**	**346,346**	**30,401**	**376,747**
Forecast Variance against Core RRL	**(31,580)**	**21,580**	**(10,000)**	**(24,500)**	**17,000**	**(7,500)**	**(17,535)**	**13,535**	**(4,000)**
Forecast Variance (% of Core RRL)			**-2.7%**			**-2.0%**			**-1.1%**

	2026-27			2027-28			2028-29		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Financial Gap before Savings	**(41,567)**	**16,900**	**(24,667)**	**(35,986)**	**11,200**	**(24,786)**	**(29,226)**	**8,100**	**(21,126)**
Savings Target	9,987	4,680	14,667	11,487	5,800	17,287	11,690	5,435	17,125
Forecast Variance against Core RRL	**(31,580)**	**21,580**	**(10,000)**	**(24,499)**	**17,000**	**(7,499)**	**(17,535)**	**13,535**	**(4,000)**

Forecast Outturn Detail

	2026-27			2027-28			2028-29		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Additional Funding									
Uplift on baseline	6,400		6,400	6,658		6,658	6,791		6,791
NRAC Adjustment	0		0	0		0	0		0
New Medicines Funding		5,500	5,500		5,500	5,500		5,500	5,500
Other new allocations	6,574	3,300	9,874		2,200	2,200		1,100	1,100
Additional income			0			0			0
Additional Funding for AfC staff to 3.75%	87		87			0			0
Total Additional Funding	**13,061**	**8,800**	**21,861**	**6,658**	**7,700**	**14,358**	**6,791**	**6,600**	**13,391**
Brought Forward Pressures									
Unachieved Savings (from prior year)	12,966		12,966	21,796		21,796	14,630		14,630
Other Brought Forward Pressures	24,164	-8,100	16,064	9,784	-3,500	6,284	9,870	-1,500	8,370
Total Brought Forward Pressures	**37,130**	**-8,100**	**29,030**	**31,580**	**-3,500**	**28,080**	**24,500**	**-1,500**	**23,000**
Pressures									
Pay									
Uplifts									
Pay Uplift - AfC	5,839		5,839	3,355		3,355	3,423		3,423
Pay Uplift - Medical & Dental	903		903	947		947	966		966
Pay Uplift - Other	56		56	57		57	58		58
Total Uplift Pressures	**6,798**	**0**	**6,798**	**4,360**	**0**	**4,360**	**4,447**	**0**	**4,447**
Workforce									
Nursing			0			0			0
Medical			0			0			0
Other Staffing [AFC Reform]	3,300		3,300			0			0
Total Workforce Pressures	**3,300**	**0**	**3,300**	**0**	**0**	**0**	**0**	**0**	**0**
Non Pay									
Prescribing									
Acute Prescribing	1,937		1,937	1,705		1,705	1,841		1,841
Primary Prescribing	2,590		2,590	2,279		2,279	2,461		2,461
Total Prescribing Pressures	**4,527**	**0**	**4,527**	**3,984**	**0**	**3,984**	**4,302**	**0**	**4,302**
Estates and Infrastructure									
Energy Costs	0		0	93		93	95		95
Other Estate Level Costs	120		120	40		40	41		41
Total Estate and Infrastructure Pressures	**120**	**0**	**120**	**134**	**0**	**134**	**136**	**0**	**136**
Digital									
National Programmes	84		84			0			0
Local Programmes			0			0			0
Business Systems Transformation			0	tbc		0	tbc		0
Total Digital Pressures	**84**	**0**	**84**	**0**	**0**	**0**	**0**	**0**	**0**
Service Level Agreements	1,439		**1,439**	1,482		**1,482**	1,527		**1,527**
Sub-National Planning	0	0	**0**			**0**			**0**
National & Policy Decisions									
NSSC Risk Share	191		191			0			0
Estimated other national Commitments	500		500	500		500	500		500
Other National & Policy Decision			0			0			0
Total National & Policy Decisions	**691**	**0**	**691**	**500**	**0**	**500**	**500**	**0**	**500**
Other Board Specific Non Pay									
Other Non Pay	539		539	605		605	605		605
Other Board Specific Non Pay	**539**	**0**	**539**	**605**	**0**	**605**	**605**	**0**	**605**
Total Non Pay Pressures	**7,400**	**0**	**7,400**	**6,704**	**0**	**6,704**	**7,070**	**0**	**7,070**

	2026-27			2027-28			2028-29		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Brought Forward Pressures	37,130	-8,100	29,030	31,580	-3,500	28,080	24,500	-1,500	23,000
Pay Pressures	10,098	0	10,098	4,360	0	4,360	4,447	0	4,447
Non-Pay Pressures	7,400	0	7,400	6,704	0	6,704	7,070	0	7,070
Additional Funding	-13,061	-8,800	-21,861	-6,658	-7,700	-14,358	-6,791	-6,600	-13,391
Financial Gap Before Savings	**41,567**	**-16,900**	**24,667**	**35,986**	**-11,200**	**24,786**	**29,226**	**-8,100**	**21,126**

Savings Summary

	2026-27			2027-28			2028-29		
	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s	R £000s	NR £000s	Total £000s
Financial Gap before Savings	**(41,567)**	**16,900**	**(24,667)**	**(35,986)**	**11,200**	**(24,786)**	**(29,226)**	**8,100**	**(21,126)**
Planned Savings	6,608	3,800	10,408	2,925	1,300	4,225	2,001	1,800	3,801
Schemes in Development	3,379	880	4,259	8,562	4,500	13,062	9,689	3,635	13,324
Total Savings	**9,987**	**4,680**	**14,667**	**11,487**	**5,800**	**17,287**	**11,690**	**5,435**	**17,125**
Total Savings Target	**9,987**	**4,680**	**14,667**	**11,487**	**5,800**	**17,287**	11,690	5,435	**17,125**
3% Target Analysis									
3% Baseline Recurring Savings Target	**9,987**			**10,187**			**10,390**		
Planned Recurring Savings as % of Baseline	2.0%			0.9%			0.6%		
Recurring Schemes in Development as % of Baseline	1.0%			2.5%			2.8%		
Board Recurring Savings Target as % of Baseline	3.0%			3.4%			3.4%		
Forecast Variance against Core RRL	**(31,580)**	**21,580**	**(10,000)**	**(24,499)**	**17,000**	**(7,499)**	**(17,535)**	**13,535**	**(4,000)**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Delivering Our Strategies: 2026/27 Implementation Plan**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning and Performance**
Report Author:	**Katy George, Planning and Performance Manager**

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

Since the approval of the NHS Borders Clinical Strategy 2025–2030 in December 2025, significant work has been undertaken with clinical teams, services and corporate functions to begin translating the strategy into delivery. The focus of this work has been to identify and prioritise the Year 2 (2026/27) deliverables that will form the basis of the implementation plan for the coming year and represent the first stepped change towards our 2030 vision.

This work is aligned to our ambition to enable our communities to keep themselves well, reduce long-term health inequalities, and ensure that when our communities need us, NHS Borders is easily accessible and delivers compassionate, efficient, high-quality, person-centred care at the right time and in the right place.

Further engagement workshops have been held with services and teams to agree what needs to be done, and in what order, to begin moving in the right direction. In parallel, further refinement of the enabling strategies has taken place to ensure they clearly support delivery, are aligned to the implementation priorities, and provide a coherent framework for action across the organisation.

This approach is ensuring that the 2026/27 financial plan aligning strategic priorities, delivery plans and financial decisions within one integrated plan, focused on delivering the planned stepped change and maximising value through the best use of available resources. This is what will be referred to as the Delivery Plan for 2026/27 for NHS Borders.

2.2 Background

The Board considered and endorsed the overall direction set out in the NHS Borders Organisational Strategy 2025–2030, which established a clear vision, purpose and long-term outcomes for the organisation. The Organisational Strategy set out NHS Borders' ambition to improve population health, reduce inequalities and deliver high-quality, person-centred care in a way that is sustainable, affordable and aligned to national policy direction.

Building on this, the NHS Borders Clinical Strategy 2025–2030 was developed and approved by the Board in December. The Clinical Strategy describes how services will contribute to the organisational ambition, with a clear focus on prevention, strengthening primary and community services, improving the efficiency and effectiveness of secondary care, and ensuring equitable access to tertiary services.

The strategies were shaped through extensive engagement with clinical teams, staff, and communities, ensuring it reflected both local need and professional insight. This commenced in January 2025 with our Organisational Strategy Roadshow, and then output of this initial phase then shaped the sessions that were held between July – September, and further workshops that were then held in November to shape the final version of the Clinical Strategy ahead of it being approved at the Board in December 2025.

Since approval of the Clinical Strategy, the organisation has moved into the next phase of work: translating strategy into delivery. Continued engagement has taken place with services and corporate teams to identify and prioritise the Year 2 (2026/27) deliverables, recognising that delivery of the strategy requires planned, phased change over time. A series of workshops has been held to agree what needs to be delivered, and in what sequence, to start making tangible progress towards the 2030 vision.

In parallel, this work has been undertaken within the context of sub-national and regional planning arrangements, ensuring alignment with national priorities and regional programmes of work. The emerging plan brings together national NHS Scotland priorities at the time of producing these and the informational available, regional and sub-national commitments, and local Clinical and Organisational Strategy deliverables, so that activity at service level contributes coherently to wider system objectives as well as local outcomes for the Borders population. An overview of the agreed priority areas is outlined below:

Supporting People to Keep Themselves Well	**Ensuring that Primary & Community Services can support as many people back to good health as possible**	**Making Secondary Care fast, efficient & effective**	**Ensuring Equity of Access for our patients who require access to Tertiary Services**
Embed prevention in every pathway	Transform Community Services including Community Hubs	Optimise Clinical Productivity	Develop a strong, collaborative approach with system and East Regional partners to develop new clinical models targeting fragile services and opportunities to develop longer-term more sustainable delivery models.
Supporting self management	Enhance the unscheduled care pathway to improve system wide flow and access to urgent and emergency care	Transform the existing Outpatient delivery model	
Implementing Learning Disability Annual Health Checks	PCIP Option Appraisal	Optimise orthopaedic service model in line with East Region target operating model	
Women's Health Hub	Integrate, transform and improve access to Children's and Young Persons services	HEPMA	
Diversion away from Statutory Services	New clinical model to support more people to die in their place of choice		
Healthy Weight	Enable people with learning disabilities to live within Scottish Borders in line with Coming Home Report		

Further details of the 2026/27 deliverables and associated delivery plans can be found within **Appendix 1.** This also outlines the Programme Governance Structure for this work.

The Organisational and Clinical Strategies are being implemented in close alignment with the NHS Borders Financial Plan, ensuring that strategic ambition, delivery priorities and financial decisions are brought together within one integrated plan. This approach supports a clear focus on value and sustainability, ensuring that resources are directed towards activity that delivers the greatest impact for patients, communities and staff,

while remaining affordable over the medium term. By aligning strategy, delivery and finance, NHS Borders is moving away from separate planning processes and towards a coherent, value-based approach that supports long-term system sustainability and delivery of the 2030 vision.

Alongside this, further refinement of the enabling strategies which can be found as **Appendix 2**, and Social Compact which can be found as **Appendix 3,** has taken place to ensure they collectively support delivery of the Clinical and Organisational Strategies and align to the agreed priorities. Taken together, this work is moving the organisation towards one integrated plan, aligning national, regional and local priorities with delivery activity, performance management and the 2026/27 financial plan, with a clear focus on value, sustainability and impact.

2.3 Assessment

As NHS Borders moves from strategy development into delivery, this phase of work also includes a reset and clarification of the NHS Borders Delivery and Improvement Approach. This sets out a consistent, organisation-wide way of working that brings together programme and change management, quality improvement, involvement of staff, patients and communities, and core decision-making processes such as options appraisals and business case development.

This approach is intended to provide a clear and consistent way of doing business across the organisation, ensuring that change is well-designed, evidence-based, value-focused and aligned to strategic priorities. It supports proportionate oversight and assurance, while enabling services and teams to deliver improvement in a structured, coordinated and sustainable way.

By applying this Delivery and Improvement Approach to the implementation of the Clinical and Organisational Strategies, NHS Borders is aligning how we plan, decide, improve and deliver. This ensures that national, regional and local priorities are translated into action through a single, integrated plan, supported by consistent governance, clear accountability and a shared improvement methodology.

The proposed Governance Structure for oversight of the Clinical Strategy delivery and the Enabling Strategies delivery can be found within **Appendix 4**.

2.3.1 Quality/ Patient Care

The implementation of our Strategy will contribute to a more supportive and collaborative environment. This will enhance the quality of patient care and lead to better health outcomes and higher patient satisfaction.

2.3.2 Workforce

Delivering the strategic ambitions for 2025–2030 will require a sustainable, skilled, and adaptable workforce. Workforce planning is central to achieving the priorities outlined in the Organisational and Clinical Strategy. Key considerations include:

- **Capacity and Capability**: Addressing current workforce shortages and ensuring the right skill mix to meet future service demands

- **Recruitment and Retention**: Implementing strategies to attract and retain staff in a competitive labour market, with a focus on clinical and specialist roles

- **Workforce Wellbeing**: Supporting staff health and wellbeing to maintain resilience and reduce turnover

- **Education and Development**: Investing in training, leadership development, and digital skills to enable innovation and service transformation

- **Integration and Flexibility**: Promoting multidisciplinary working and flexible deployment across care settings to improve efficiency and patient outcomes

The enabling People Strategy, which is within Appendix 2, will provide detailed actions and timelines to support these priorities.

2.3.3 Financial

The delivery of the Organisational and Clinical Strategies for 2025–2030 will require significant financial planning and disciplined resource management. Key considerations include:

- **Current Position**: NHS Borders continues to operate within a challenging financial environment, with pressures from rising demand, workforce costs, and inflationary impacts

- **Investment Requirements**: Implementation of strategic priorities will require targeted investment in workforce, digital infrastructure, estates, and service redesign

- **Efficiency and Sustainability**: Achieving financial balance will depend on delivering efficiency savings, optimising resource utilisation, and reducing unwarranted variation in care

- **Risk and Mitigation**: Financial risks include uncertainty in national funding allocations, cost escalation, and the pace of transformation. Mitigation will involve robust financial governance, phased implementation, and prioritisation of high-impact initiatives

The Financial Strategy, included within Appendix 2 will set out detailed plans to support delivery of the strategic framework.

2.3.4 Risk Assessment/Management

As the strategy is implemented a full risk assessment will need to be considered against the delivery and operational implementation plan.

2.3.5 Equality and Diversity, including health inequalities

The proposed strategic framework for 2025–2030 has been developed to support the Public Sector Equality Duty, the Fairer Scotland Duty, and the Board's Equalities Outcomes by:

- Advancing equality of opportunity through inclusive service design and workforce planning
- Eliminating discrimination by embedding equality principles in organisational and clinical priorities
- Reducing health inequalities by targeting interventions to address the needs of vulnerable and marginalised groups
- Promoting fairness in resource allocation and access to care across all communities

The strategies recognise the importance of tackling health inequalities as a core component of improving population health and ensuring equitable outcomes.

An Equality Impact Assessment will be completed as part of the implementation plan to ensure that actions taken under these strategies fully comply with equality and fairness duties.

2.3.6 Climate Change

Once the strategy is implemented this will require an assessment however should have a positive impact on climate change.

2.3.7 Other impacts

These will be assessed throughout the implementation of the Clinical Strategy deliverables.

2.3.8 Communication, involvement, engagement and consultation

The development of the Organisational and Clinical Strategies has been underpinned by extensive engagement with staff, partners, and the wider community. This process included:

- Large-scale staff and community conversations: A series of workshops, focus groups, and surveys were conducted to capture views from across NHS Borders and local communities, ensuring that the strategic priorities reflect the needs and aspirations of those we serve

- Clinical Staff Engagement: Particular emphasis was placed on engaging clinical teams through targeted sessions, specialty forums, multiple workshops and leadership discussions. This ensured that the Clinical Strategy is grounded in frontline experience and informed by clinical expertise.

Draft strategies were shared widely for feedback, and communication channels were maintained throughout the process to encourage participation and build trust.

This inclusive approach has strengthened the strategic framework and will continue during implementation to ensure ongoing involvement and co-production.

An initial version of the Year 2 Delivery Plan was presented to the Borders Delivery Group on the 27th of May for review and discussion.

2.3.9 Route to the Meeting

The development of NHS Borders Strategy and approach has been discussed across a range of groups and committees:

- NHS Borders Board
- Board Executive Team
- Borders Delivery Group
- Area Clinical Forum
- Area Partnership Forum
- Senior Medical Staff Committee
- GP Committee Sub committee

2.4 Recommendation

NHS Borders Board are asked to:

Approve the Year 2 Delivery Plan for the Clinical Strategy for 2026/27.

Approve the Enabling Strategies

Approve the Social Compact

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

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

The following assurance levels are suggested for the Boards consideration:

- **Systems and Processes –** Significant Assurance
- **Outcomes –** Moderate Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders 2026/27 Delivery Plan
- Appendix 2, NHS Borders Enabling Strategies
- Appendix 3, NHS Borders Social Compact
- Appendix 4, Governance Structure

Delivering our Strategies 2026/27 Deliverables

Our True North Statement

Our mission 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.

Supporting People to Keep Themselves Well

A3 Plan and Report for Project: Embed Prevention in Every Pathway

Date Plan Agreed:

Senior Responsible Officer:

Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

NHS Borders faces increasing demand from long-term conditions, preventable illness and health inequalities, which continues to place pressure on acute, community and mental health services. Embedding prevention systematically within clinical pathways is a core enabler of the Clinical Strategy ambition to support people to stay well and reduce avoidable demand.

Assessment (Current and Future State)

Current pathways do not consistently and systematically incorporate preventative interventions, leading to missed opportunities to reduce future demand and avoid escalation. Targeted opportunities have been identified for 2026/27, including opt-out referral to smoking cessation using the ScotCURE model, the introduction of a Wellbeing Advisor in the Emergency Department and increasing the capability of the clinical workforce through training in Level 1 & 2 psychological care and behaviour change skills. These actions address unwarranted variation, reduce follow-up and routine appointments and improve equity of access to preventative support.

Aim Statement (Goal)

We will embed prevention within everyday clinical practice by integrating evidence-based preventative interventions into priority pathways, strengthening workforce skills and improving connections to community and self management resources. The aim is to increase the proportion of patients supported through self-management pathways, reduce unnecessary clinical contacts and follow-up and improve patient confidence in managing their own health.

Recommendations (Delivery Approach inc. Performance Measures)

- Optout referral to smoking cessation for patients seen under Respiratory, Cardiology and Vascular consultants. (ScotCURE model)
- Wellbeing Advisor in ED to operate as a care navigator connecting high risk individuals with available community services.
- Train clinical staff in Level 1 and 2 psychological care in two areas (eg **cancer & diabetes**) and practice including MAP (motivation, action & prompt) behaviour change skills to normalise supportive conversations with patients so they can best self-manage their long-term conditions
- Implement standardised prevention-focussed discharge prompts eg, smoking cessation, medication optimisation, physical activity
- deliver the agreed milestones in the Oral Health Strategy
- develop plan to achieve shared care agreement with Primary Care (or alternative model) for physical health monitoring of those on Lithium, antipsyhotics and ADHD medication AND Reduced crisis escalation from Carers

Alignment to Organisational Strategy

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phasing of Projects to be carried out										
Establish PB										
Scoping										
Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Supporting self-management

Date Plan Agreed:

Senior Responsible Officer:

Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Supporting people to manage their own health and wellbeing is central to preventing avoidable deterioration, reducing health inequalities and ensuing services remain sustainable. While a wide range of self-management and community-based support exists, this deliverable seeks to strengthen sign-posting to self-management resources as a routine part of care, ensuring people are supported earlier and more consistently to stay well.

Assessment (Current and Future State)

Awareness and use of self-management support is currently inconsistent across pathways, with access often reliant on individual clinician knowledge. Key 2026/27 actions focus on addressing this gap by mapping community groups that support self-management and developing a clear, accessible directory in partnership with Scottish Borders Council, Borders Community Action and the Community Planning Partnership. Further development of digital self-management resources will support more provision

Aim Statement (Goal)

We will strengthen and normalise signposting to high-quality self-management support across clinical pathways by improving visibility of available resources and making access easier for patients and staff. The aim is to increase uptake and active use of self-help and digital resources, improve patient confidence in self-management, and reduce reliance on follow-up appointments. This will contribute to better health and wellbeing outcomes, reduce demand on services and a shift toward more preventative, person centred care.

Recommendations (Delivery Approach inc. Performance Measures)

- Further development of MSK Phio app
- National Diabetes remission programme
- Development of MHOAS digital resource pack
- CAMHS Neurodevelopmental social media and website resources for parents
- Collaboration with the British Heart Foundation
- Development of online Psychology to support self-management
- Map community groups which support self-management and create a directory
- Link and develop the LAC/Social Prescribing system being developed with SBC
- Expand the number of services using 'request for assistance' referral models including school nursing.

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phasing of Projects to be carried out										
Establish PB										
Scoping										
Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Implement Learning Disability Annual Health Checks

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

People with learning disabilities experience poorer health outcomes and significantly reduced life expectancy compared to the general population, often due to preventable conditions that are not identified early enough. Annual Health Checks are a key preventative intervention, enabling earlier detection of health needs and more proactive management of long-term conditions.

Assessment (Current and Future State)

Uptake of Learning Disability Annual Health Checks remains variable, meaning opportunities for early identification and preventative intervention are being missed. The 2026/27 focus is on implementing a consistent approach to ensure all adults with a learning disability are offered an Annual Health Check, with a clear delivery plan and expanded access points, including additional venues where checks can be undertaken. This work supports improved early detection of preventable health conditions and strengthens co-ordination between primary care, community services and learning disability teams.

Aim Statement (Goal)

During 2026/27 we will continue to increase the number of patients receiving Learning Disability Annual Health Checks with a target of **400 checks completed by March 2027.** The aim is to improve earlier identification of physical and mental health conditions, enhance overall wellbeing and contribute to improved life expectancy for people with learning disabilities.

Recommendations (Delivery Approach inc. Performance Measures)

- Provide all adults who have a Learning Disability with an Annual Health Check
- Achieve 400 health checks by March 2027.

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Date Plan Agreed: Women's Health Hub	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

Background & Problem (What / Where / When / Why / Who?)

Women experience specific health needs across the life course, including menstrual health, fertility, pregnancy, menopause and gynaecological conditions, yet care is often fragmented across multiple services and settings. The Women's Health Hub deliverable supports the Clinical Strategy ambition to improve equity, access and experience by providing more coordinated, community based women's health support aligned to the national Women's Health Plan.

Assessment (Current and Future State)

Current pathways are not consistently joined up, with women often navigating multiple services to meet related health needs. The 2026/27 focus is on establishing a Women's Health Hub within the community to support the delivery of the Women's Health Plan more equitably, supported by closer collaborating between maternity, gynaecology, primary care, community services and third-sector partners. Key actions include strengthening partnership working, improving access to education and preventative support and ensuring pathways are clearer and more consistent across the Borders.

Aim Statement (Goal)

We will develop and implement a Women's Health Hub within the community to provide more accessible, co-ordinated and preventative women's health care. The aim is to improve equity of access, reduce fragmentation across services, support earlier intervention and self-management and enhance outcomes and experience for women across the life course.

Recommendations (Delivery Approach inc. Performance Measures)

- Undertake a structure scoping and design phase to define the most appropriate Women's Health Hub model for NHS Borders informed by service mapping, inequalities analysis and co-design with women with lived experience.

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Diversion Away from Statutory Services
Date Plan Agreed:

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

This priority is focused on making referral to social prescribing and the emerging LAC system in Scottish Borders Council a routine and embedded part of General Practice, rather than an ad hoc option. The intention is to direct people earlier toward non-clinical support such as income maximisation, fuel poverty and housing support, loneliness services, third sector services, and carer support, with proper feedback loops and a dashboard to show whether referrals are working and whether they are reducing inequalities.

Assessment (Current and Future State)

It is a strong prevention approach that could reduce avoidable demand on medication, diagnostics and wider health services, but it depends on good referral pathways, feedback to clinicians, and reliable social care data sharing.

Aim Statement (Goal)

Our aim is to embed social prescribing and LAC referrals as a normal, default part of care so people get the right support earlier, inequalities are not widened, and pressure on statutory services is reduced.

Recommendations (Delivery Approach inc. Performance Measures)

- Develop process for social prescribing being embedded into General Practice
- Build a data collection and reporting dashboard

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Healthy Weight Date Plan Agreed:	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

Background & Problem (What / Where / When / Why / Who?)

Unhealthy weight is a significant contributor to poor health outcomes, increased long-term conditions and widening health inequalities across the Scottish Borders. Addressing healthy weight is central to preventing avoidable illness, improving quality of life and reducing demand on health and care services. This Year 2 deliverable supports the Clinical Strategy ambition to help people stay well by embedding prevention and early intervention approaches.

Assessment (Current and Future State)

Current approach to healthy weight support are fragmented, with variation in access to preventative intervention and self-management resources. The focus is on strengthening co-ordinated, prevention led approached to obesity, aligned to wider self-management and community support initiatives. This includes improving access to weight management support, linking individuals to appropriate community and digital resources, and ensuring healthy weight is consistently addressed as part of routine care and preventative conversations.

Aim Statement (Goal)

We will strengthen a system-wide approach to healthy weight, supporting earlier intervention, prevention and self management. The aim is to improve population health and wellbeing, reduce the impact of obesity-related conditions and support more sustainable use of health and care services. This work will contribute to reduced demand on clinical pathways, improved patient confidence in managing their health and better long term outcomes for individuals and communities across the Borders.

Recommendations (Delivery Approach inc. Performance Measures)

- Establish a whole system, regional approach to obesity prevention and management explicitly embedded within the national Population Health Framework.
- Produce a Board approved framework for Obesity Prevention and Management that defines shared system accountability across clinical services, primary care, public health and third sector partners.

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

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To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

Ensuring that Primary & Community Services can support as many people back to good health as possible

A3 Plan and Report for Project: Transform Community Services including Community Hubs

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Demand for community services is increasing due to an ageing population, rising long-term conditions and pressures on urgent and unscheduled care. Current models are fragmented across teams and locations. A review is required to define a future community services model that improves flow across the whole system, with Community Hubs offering an opportunity to bring MDT services together to simplify access.

Assessment (Current and Future State)

This deliverable will consider the current community services models, including capacity, demand, pathways and workforce to identify opportunities to improve access, quality and patient flow. This will include pathway mapping for stroke, frailty and orthopaedics, benchmarking against evidence informed models (including Early Supported Discharge and community rehabilitation) and analysis of performance data. The assessment will also include mapping the blueprint of Community Hubs and include co-location, Single Point of Access and integrated MDT working

Aim Statement (Goal)

To design and agree a future community services model, including Community Hubs that improves access, patient experience and system flow by strengthening community nursing, rehabilitation and reablement, enabling earlier discharge and implementing more integrated multidisciplinary working.

Recommendations (Delivery Approach inc. Performance Measures)

- Assess the case for Early Supported Discharge model for Stroke, Orthopaedics and Frailty
- Create a clear definition and blueprint for a Community Hub, with clear criteria for referral and use; identify the outcomes it is expected to deliver and the potential location for the first hub; undertake patient pathway work alongside this; and test one hub in 2026/27 as a 'What Matters Hub' including social care, mental health and the third sector.
- Test single point of access in one locality
- Introduce single holistic assessment to reduce patient story repetition.
- Design MH services alignment or support for model, include social care and third sector and consider how the new hub will interface with the 'What Matters' Hubs
- Further developed MDT and cross-specialty working.
- Implement and evaluate the full Hawick walk-in service by Autumn 2026
- Start Development of PACS, MH, LD space and infrastructure plan
- Deliver new Community Nursing model
- Review the current care pathway for those with Eating Disorders including physical healthcare

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible.

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Boards Reset

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Enhance the unscheduled care pathway to improve system-wide flow and access to urgent and emergency care

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Unscheduled care demand continues to place sustained pressure on emergency and inpatient services, contributing to delays, longer lengths of stay and challenges in meeting the Emergency Access Standard. The actions within this deliverable will support smoother patient flow across the whole system.

Assessment (Current and Future State)

This deliverable will consider the current work underway within Urgent and Unscheduled Care to support and enhance patient flow. It will also support patients being seen in the right place, at the right time. The actions within this deliverable will maximise the efficiency of services.

Aim Statement (Goal)

To improve system wide flow across unscheduled care by strengthening multidisciplinary working, optimising inpatient and discharge processes and ensuring patients are assessed and treated in the right place at the right rime. This will result in faster access to urgent and emergency care and fewer avoidable delays, including achieving **75%** compliance with the Emergency Access Standards and keeping 12-hour waits **under 7%** of attendances. To design and agree a future community services model, including Community Hubs that improves access, patient experience and system flow by strengthening community rehabilitation and reablement, enabling earlier discharge and implementing more integrated multidisciplinary working.

Recommendations (Delivery Approach inc. Performance Measures)

- Strengthen MDT working and use of Planned Date of Discharge (PDD) across all inpatient areas
- Test an increase in reablement capacity collaborating with Third Sector and SBC.
- Enhance ED / acute pathways and processes, including AAU, MAU & Frailty Unit.
- Expand Hospital @ Home service to 50 beds enabled by Remote monitoring.
- Continue to develop the Integrated Discharge Team and expand their remit to cover the Community
- Explore enhanced care planning for frequent Emergency Department attenders attending with Mental Health related condition

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible.

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To be developed as Programme Board Resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Primary Care Improvement Plan Review
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

The nationally agreed General Medical Services contract 2018, and the Memorandum of Understanding (2), set out the need to refocus the role of GPs as expert medical generalists.
NHS Borders Primary Care Improvement Plan (PCIP) set out six key workstreams which will enable the Health Board to deliver the GMS contact with the aim of transforming general practice services, releasing capacity of General Practitioners to allow them to undertake their role as Expert Medical Generalists.

Assessment (Current and Future State)

A review of the future sustainability of PCIP services, following confirmation that national PCIP demonstrator site funding has now ended is required. The agreed approach is to undertake an option assessment encompassing all PCIP services to establish an safe, equitable and affordable range of PCIP services that support primary care.

Aim Statement (Goal)

- Work with GPs and the IJB to complete an options appraisal, enabling agreement on the preferred delivery model for PCIP services using the following principles
- Sustaining a core PCIP offer while adapting delivery to available resources
- Optimise MDT working and communication, and consider opportunities to contribute to a Community Hub approach
- Equity of access Any redesigned service models must ensure fair and equitable access for patients and practices across NHS Borders, avoiding unintended geographical or population-based inequalities. Current provision of services, or lack of, should be rebalanced as part of any redesign
- Affordability, efficiency and sustainability Services must be delivered within the reduced financial envelope, but must also balance patient safety, efficiency, value-based care and long-term sustainability.

Recommendations (Delivery Approach inc. Performance Measures)

- Undertake Option Appraisal for PCIP future model

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible.

High Level Schedule 2026/27

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To be developed as Programme Board Resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Integrate, transform and improve access to Children & Young Persons Services

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Children and Young Person (C&YP) services are experiencing growing demand, increasing complexity and pressures on timely access across. Current pathways can be fragmented, with variation in referral routes, assessment processes and interfaces between hospital based and community based care. This can lead to avoidable delays, inconsistent patient experience and inefficiencies in how care is co-ordinated.

Assessment (Current and Future State)

This deliverable focuses on developing an integrated operating model for Children & Young Persons services across BGH and community teams, aligning young peoples care and maternity within Community Hub planning. It includes exploring a single point of access, redesigning ambulatory care and strengthening partnership working. Delivery will also prioritise access to key C&YP services including testing the CAMHS School Neurodevelopmental pathway.

Aim Statement (Goal)

To design and implement an integrated Children & Young Persons operating model across BGH and Community Services, improving access and co-ordination of care. This will shift appropriate care to ambulatory / say day & home-based models, improving flow and reducing avoidable admissions and length of stay.

Recommendations (Delivery Approach inc. Performance Measures)

- Develop a new operating model that builds on the integration of children's services at the BGH with Community Health Services. Consider the Community Hubs as part of this.
- Explore single point of access for Children & Young Persons population.
- Strengthen partnership working between NHS Borders and partner agencies.
- Redesign and implement a new ambulatory / same day care clinical model
- Improve access to key Children & Young Persons services, including SLT, School Nursing, Perinatal Mental Health & CAMHS Neurodevelopmental service
- Test CAMHS Schools ND pathway in 20% of school-age population
- Provide improved expert CAMHS clinical support within the Borders both in the community and inpatient services (Huntlyburn and Paediatric inpatients) recognising the reduction in specialist resources.
- Reduction in paediatric dental general anaesthetic waiting times

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

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To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project:
Date Plan Agreed: New Clinical Model to support more people to die in their place of choice

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Many people would prefer to die in their place of choice, but inconsistent access to co-ordinated palliative and community support can make this difficult. This includes strengthening community nursing and palliative cate capacity, improving co-ordination across services and ensuring rapid access to the right support in the final days / weeks of life.

Assessment (Current and Future State)

This deliverable focuses on developing models of care that enhance and support people to die in their place of choice. The Marie Curie District Nursing service model will enhance the current District Nursing provision and offer a service 7 days a week from 8pm – 8am. Alongside this, enhancing the inpatient and community palliative care model will provide better patient experience and also decrease the length of stay in the hospital.

Aim Statement (Goal)

The aim of this deliverable is to increase the number of people who are able to die in their place of choice by strengthening end of life care across community and hospital settings through both the test of change for Marie Curie District Nursing service model, and also to enhance the inpatient and community palliative care model.

Recommendations (Delivery Approach inc. Performance Measures)

- Test Marie Curie District Nursing service model.
- Enhance the inpatient and community palliative care model through improved (early) identification of those dying and improved anticipatory care planning.
- Improve discharge process for people who are dying and want to die at home.

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible.

High Level Schedule 2026/27

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Specific Actions Next 8 Weeks

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To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Coming Home Project
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Some people with learning disabilities from the Scottish Borders are currently living in out of area placements, often far from families, communities and local services. The Coming Home Report sets out a national commitment to support people to live within their home communities wherever possible. This deliverable supporting the Clinical Strategy ambition to improve quality of life, promote inclusion and deliver person-centered care closer to home.

Assessment (Current and Future State)

Out-of-area placements can increase distress for individuals and families and create challenges for continuity of care and workforce sustainability. The 2026/27 focus is on progressively supporting people with learning disabilities, particularly those in the highest-risk (DSR red category), to return to the Borders with appropriate accommodation, workforce and person-centred support arrangements in place.

Aim Statement (Goal)

During 2026/27, NHS Borders will enable more people with learning disabilities to live within the Scottish Borders by implementing the Coming Home approach. The aim is to improve quality of life, reduce reliance on out-of-area placements and strengthen sustainable, local models of support through the development of appropriate accommodation and skilled workforce capacity.

Recommendations (Delivery Approach inc. Performance Measures)

- People with learning disabilities who are placed out of area, including in hospital settings are progressively supported to return to their home communities in the Scottish Borders
- Ensure all patients on the DSR (red category) have a patient centred plan

Alignment to Organisational Strategy

Ensuring that Primary & Community Services can support as many people back to good health as possible.

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To be developed as Programme Board Resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

Making Secondary Care fast, efficient and effective

A3 Plan and Report for Project: Optimise Clinical Productivity
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Clinical services across NHS Borders are experiencing sustained demand pressures alongside workforce and financial constraints. This deliverable focuses on maximising the use of existing capacity across theatres, outpatients, diagnostics and community activity to increase clinical activity, reduce waiting times and improve patient outcomes.

Assessment (Current and Future State)

Current productivity is constrained by variation in theatre utilisation, outpatient delivery models and diagnostic capacity, alongside other inefficiencies such as cancelled operations and manual processes within pathways. There is opportunity to optimse the use of lists, improve average cases per list and support the expansion of outpatient and endoscopy activity. Without co-ordination action across theatres, outpatient services, diagnostics and community activity, opportunities for increased activity, cost avoidance and improved flow will not be fully realised.

Aim Statement (Goal)

NHS Borders will optimise clinical productivity by increasing planned clinical activity and making better use of existing capacity across theatres, outpatients, diagnostics and community services. Collectively the actions within this deliverable aim to deliver increased clinical activity, reduced waiting times, improved patient outcomes and reduced reliance on premium and out of hours activity within existing resource.

Recommendations (Delivery Approach inc. Performance Measures)

- Enhanced theatre productivity focusing on average cases per list, optimisation of lists and cancelled operations.
- Enhanced Colonoscopy capacity
- Enhanced outpatient activity through effective job planning for consultants and specialist nurses.
- Optimise diagnostic capacity and capability including Radiology. Develop business case for second CT scanner.
- Treat more patients on a cancer pathway, ensure at least 85% of patients are treated within 62-days of referral, and deliver a high performing prostate pathway.
- Optimised community activity through use of new activity dashboards and enhanced oversight.
- Transition low vision services from specialist care to community optometrists (dependent on national agreements)
- Support improved access of routine NHS dental care; maintain emergency dental services in and out of hours to meet needs

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To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Transform Existing Outpatient Delivery Model
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

The existing outpatient delivery model across NHS Borders has developed over time and has a variation in clinic templates, processes and administrative approaches which can impact on capacity, efficiency and patient experience. Rising demand for outpatient care, alongside workforce and financial pressure require a more consistent, standardised and modern approach to outpatient delivery. This deliverable will support increased clinical activity, improve access for patients and reduce unnecessary variation by introducing standardised ways of working.

Assessment (Current and Future State)

Outpatient services are constrained by non-standard clinic templates, inconsistent processes and a high administrative burden which limits the ability to safely increase activity. There is dependence on legacy systems and manual processes, alongside variation in referral quality and clinic utilisation. Planned growth in outpatient activity will place additional pressure on clinical teams, administrative staff and supporting systems unless the delivery model is redesigned.

Aim Statement (Goal)

We will transform the existing outpatient delivery model by standardising clinic templates, processes and operating procedures to enable increased outpatient activity and improved patient access. This will be achieved through implementation of consistent clinic models, improved referral management and triage using RefHelp and looking at the longer term TrakCare enhancements. The transformed model will support increased clinical activity, reduced costs and a more efficient, person centred outpatient service which is sustainable within available workforce and digital capacity.

Recommendations (Delivery Approach inc. Performance Measures)

- Standardised clinic templates, processes and standard operating procedures.
- Referral management guidelines based on good clinical practice and evidence (REFHELP).
- Establish face to face MDT secondary and primary care interface collaboration to optimise best-value specialist referral.
- Standardised triage process at specialty level.
- Digitise administrative processes to reduce the burden of admin processes on staff and to reprioritise capacity on more value adding tasks.
- Upgrade TRAK and shift to a paper-light medical record model across all acute services.
- Procedures with limited clinical value and outcomes.
- Undertake test of change to look at the redesign adult ADHD annual review pathway by March 2027

High Level Schedule 2026/27

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To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Optimise Orthopaedic service model in line with East Region

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Orthopaedic services face ongoing pressure from sustained demand, long waiting times and the need to deliver equitable access across the east region. As part of the Year 2 priorities, NHS Borders aims to optimise the orthopaedic service model in line with the agreed East Region target operating model. This focuses on improving productivity and outcomes by making best use of existing infrastructure, resources, increasing clinical activity and supporting regional collaboration.

Assessment (Current and Future State)

Current orthopaedic service delivery is constrained by capacity limitations, variation in utilisation of resources and differences in access across the East Region. There is scope to increase clinical activity by improving use of existing infrastructure, enhancing capacity within Diagnostics and Day Procedure Units and align flow of patients across the region to support equity and reduce unwanted variation. Delivering this optimisation will require careful consideration of workforce capacity and cost, alongside data sharing and regional collaboration.

Aim Statement (Goal)

We will optimise the orthopaedic service model in line with East Region target operating model by improving utilisation of existing infrastructure and resources, increasing clinical activity by up to 10%, and enhancing capacity. This will be supported by collaboration across the East Region to improve patient flow, reduce variation in access, and deliver improved waiting times and outcomes.

Recommendations (Delivery Approach inc. Performance Measures)

- Optimisation within existing infrastructure and resource
- Enhance capacity through additional resource and better utilisation of DPU in line with the GIRFT target operating model
- Different flow of patients from across the East Region to reduce variation in access and health inequalities

Alignment to Organisational Strategy

Making Secondary Care fast, efficient and effective.

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To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: HEPMA
Date Plan Agreed:

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

HEPMA (Hospital Electronic Prescribing and Medicines Administration) is a key digital enabler to improve medication safety, efficiency, and staff experience across NHS Borders. The Year 2 priority is to develop a full business case, recognising that this is a **major clinical transformation** requiring significant clinical, technical, and organisational input, including integration with existing systems such as TrakCare and supporting infrastructure (e.g. Wi-Fi and digital foundations)

Assessment (Current and Future State)

Current prescribing processes are partly manual and fragmented, with significant complexity and dependencies (e.g. TrakCare integration, Wi-Fi infrastructure, and workforce capacity). Delivery requires substantial resource, clear requirements, and alignment with wider digital programmes.

Aim Statement (Goal)

Develop and secure approval of a deliverable HEPMA business case in 2026/27 that sets out the model, costs, and requirements to improve medication safety, efficiency, and staff experience.

Recommendations (Delivery Approach inc. Performance Measures)

- Develop HEPMA Business Case
- Develop a timeline to begin activities for this deliverable

Alignment to Organisational Strategy

Making Secondary Care fast, efficient and effective.

High Level Schedule 2026/27

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Not Aligned to a Programme Board Currently

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

Ensuring Equity of Access for Patients who Require Access to Tertiary Services

A3 Plan and Report for Project: Develop a strong, collaborative approach with East Region
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Some clinical services within NHS Borders are increasingly fragile, with sustainability challenges driven by workforce availability, scale, and rising demand. Addressing these challenges requires a shift from localised solutions towards stronger system and East Regional collaboration. This Year 2 deliverable supports the Clinical Strategy ambition to develop more resilient, high-quality clinical services by working collectively with regional partners to redesign care models and improve long-term sustainability.

Assessment (Current and Future State)

Current maternity service arrangements are under increasing pressure from workforce constraints, variation in activity and the need to maintain safe, sustainable access to care. The 2026/27 focus is on working with East Region partners to better understand regional flows of activity into maternity units across the East of Scotland and to explore opportunities for a more coordinated approach. This will support planning for future maternity models that improve resilience, make best use of available capacity and help ensure equitable access to high-quality care for women, babies and families.

Aim Statement (Goal)

We will work with East Region partners to design and test new collaborative clinical models that improve sustainability, quality and patient outcomes in fragile services. The aim is to reduce service risk, improve resilience through shared approaches, and support financial efficiency while ensuring equitable access to specialist care for the Borders population. This work will lay the foundations for longer-term, sustainable delivery models aligned to regional and national direction.

Recommendations (Delivery Approach inc. Performance Measures)

- Explore with partners regional flowers of activity into maternity units across the East of Scotland

Alignment to Organisational Strategy

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phasing of Projects to be carried out										
Reset PB										
Scoping										
Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Develop a strong, collaborative approach with East Region – Acute

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Some clinical services within NHS Borders are increasingly fragile, with sustainability challenges driven by workforce availability, scale, and rising demand. Addressing these challenges requires a shift from localised solutions towards stronger system and East Regional collaboration. This Year 2 deliverable supports the Clinical Strategy ambition to develop more resilient, high-quality clinical services by working collectively with regional partners to redesign care models and improve long-term sustainability.

Assessment (Current and Future State)

Current clinical models in fragile services are constrained by limited capacity, variation in access and duplication across the system. The 2026/27 focus is on developing a more coordinated approach with East Regional and system partners to explore shared clinical models, regional flows of activity and opportunities to improve efficiency, resilience and equity of access. This includes collaborative design of future service models in areas such as cardiology and other fragile specialties, recognising the need for shared infrastructure, data sharing agreements and aligned governance to enable effective regional working.

Aim Statement (Goal)

We will work with East Region partners to design and test new collaborative clinical models that improve sustainability, quality and patient outcomes in fragile services. The aim is to reduce service risk, improve resilience through shared approaches, and support financial efficiency while ensuring equitable access to specialist care for the Borders population. This work will lay the foundations for longer-term, sustainable delivery models aligned to regional and national direction.

Recommendations (Delivery Approach inc. Performance Measures)

- Design a new clinical and delivery model for cardiology based on best clinical practice
- Explore the opportunity to integrate clinical labs to benefit from scale to improve efficiency and long term resilience
- Develop future clinical model for haematology services
- Develop future clinical model for neurology services

Alignment to Organisational Strategy

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phasing of Projects to be carried out										
Reset PB										
Scoping										
Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Develop a strong, collaborative approach with East Region – Mental Health / LD
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

Background & Problem (What / Where / When / Why / Who?)

Some clinical services within NHS Borders are increasingly fragile, with sustainability challenges driven by workforce availability, scale, and rising demand. Addressing these challenges requires a shift from localised solutions towards stronger system and East Regional collaboration. This Year 2 deliverable supports the Clinical Strategy ambition to develop more resilient, high-quality clinical services by working collectively with regional partners to redesign care models and improve long-term sustainability.

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Recommendations (Delivery Approach inc. Performance Measures)

- Develop LD hub and spoke model
- Test & evaluate regional perinatal mental health improvement programme by March 2027
- Explore regional shared LD inpatient capacity to support Coming Home Programme
- Explore provision of Forensic Psychiatry expertise via new Forensic Mental Health Board

Alignment to Organisational Strategy

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phasing of Projects to be carried out										
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Scoping										
Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

Programme Management Approach

Delivering Our Strategy – Programme Structure for 2026/27 Deliverables

Clinical Transformation

Supporting People to Keep Themselves Well

Ensuring that Primary & Community Services can support as many people back to good health as possible

Making Secondary Care Fast, Efficient and Effective

Ensuring equity of access for our patients who require access to tertiary services

Population Health Programme Board

Urgent & Unscheduled Care Programme Board

Planned Care Programme Board

Mental Health & Learning Disabilities Programme Board

Women & Children Services Programme Board

Business Transformation: Enabling Strategies

QMS: Leadership Pillar

- Quality
- Risk
- Research & Innovation

QMS: Business Process Pillar

- Digital*
- Property & Sustainability
- Finance

QMS: Partnerships Pillar

- Partnerships

QMS: Staff Pillar

- People

Financial Recovery & Sustainability

- Foundational Governance
- Core workstreams
- Clinical productivity
- Local service plans
- Strategic budget review group

Business Systems

- Workstreams TBC

**Programme Board will oversee the operational delivery and transformation activity within scope of the digital programme. Where change requires underpinning business processes development or redesigned, the Board will utilise the Business Processes Pillar to develop the necessary process*

Programme Boards Aims & Executive Leads

Programme Board	Aim	Executive Lead
Clinical Transformation		
Population Health Programme Board	To increase the number of people supported through preventative and self-management approaches, including completion of 400 Learning Disability Annual Health Checks by March 2027, reducing avoidable clinical activity (demand), lower population weight distributions, reducing inequalities in outcomes, strengthening patient confidence and improving long-term health and wellbeing.	Sohail Bhatti
Urgent & Unscheduled Care Programme Board	To strengthen system-wide flow and coordination of care through integrated community, acute and specialist models — improving access, reducing avoidable delays and admissions, supporting earlier discharge, and enabling more people, including children, young people and those at end of life, to receive high-quality care in the most appropriate setting.	Gareth Clinkscale
Planned Care Programme Board	To make secondary care faster, more efficient and sustainable by optimising clinical productivity and service models across outpatients, orthopaedics, diagnostics and theatres, maximising use of existing capacity, standardising ways of working, increasing planned clinical activity, reducing waiting times and improving patient outcomes	Oliver Bennet
Mental Health Programme Board	Improve access, quality and outcomes in mental health and learning disability services, reducing inequalities and supporting more people to live well in their communities	Gareth Clinkscale
Women and Children's Services Programme Board	To design and implement an integrated Children & Young Persons operating model across BGH and Community Services, improving access and co-ordination of care. This will shift appropriate care to ambulatory / same day & home-based models, improving flow and reducing avoidable admissions and length of stay.	Oliver Bennet

Programme Boards Aims & Executive Leads

Programme Board	Aim	Executive Lead
Business Transformation		
Digital Portfolio Programme Board	Enable NHS Borders to deliver safe, effective and person-centred care through robust, future-proof digital infrastructure and services	June Smyth
Capital Programme Board	Prioritisation of capital investment to deliver safe, sustainable and high-value infrastructure aligned to clinical priorities.	Andrew Bone
QMS: Leadership Pillar	Leadership that works compassionately to support and empower staff to deliver care	Lynn McCallum Laura Jones
QMS: Business Process Pillar	Business Processes that support the delivery of quality (safe, effective, person centred, timely, equitable and efficient care)	Laura Jones Andrew Bone
QMS: Staff Engagement Pillar	A competent and motivated workforce which feels valued for its contribution	Avril Keen Sarah Horan
QMS: Partnerships Pillar	Partnerships that deliver person centred decision making by working with people who have experienced our services, the wider public and partners	June Smyth Sohail Bhatti

NHS Borders Enabling Strategies 2025 - 2030

Contents Page

Enabling Strategies

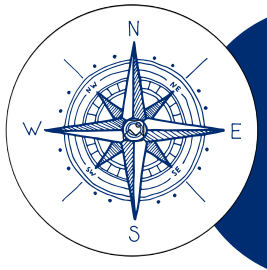
Our Clinical Strategy sets out how we will transform care across life stages, improve outcomes, and deliver services closer to home. Achieving this vision requires more than clinical redesign—it depends on the foundations that enable change. These are our Enabling Strategies, which provide the tools, capabilities, and culture to make our ambitions real.

Our enabling strategies remain under development as we continue to assess the priorities set out in the Clinical Strategy to ensure full alignment. While some enablers are incorporated within the current strategic framework, the final and complete set of enabling strategies will be brought forward for Board consideration in April 2026. This phased approach ensures that supporting strategies are robust, integrated, and responsive to the organisation's long-term objectives.

NHS Borders
Partnerships Enabling Strategy

Purpose

Partnership working is when two or more organisations or groups collaborate to achieve a common goal more effectively than they could alone. It involves sharing resources, responsibilities, and expertise, often creating new structures or processes to achieve mutually beneficial outcomes for both the partners and the communities they serve.



Our True North Statement

Our mission 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.

This strategy has been developed to enable NHS Borders Organisational and Clinical Strategies, and sits as one of a suite of enabling strategies to deliver our mission, as defined in NHS Borders True North Statement.

At the most simple level, care is delivered in partnership. Our approach is rooted in listening, understanding, and valuing the perspectives of others, ensuring that collaboration is built on mutual respect and shared insight. The breadth of Partners that we work with became apparent when engaging with colleagues and Partners to write this strategy. For the purposes of our strategy the terms 'Partner' and 'Partnerships' include, but are not limited to; NHS Boards, Scottish Borders Council, Scottish Borders Integrated Joint Board, universities, colleges, third sector organisations, Police Scotland, independent care providers (residential care, home care and specialist support), local communities and service users, healthcare staff and professional bodies.

Partnerships span strategic, operational, educational and improvement spaces.

NHS Borders Partnerships Strategy sets our intention to;

- Foster a collaborative and inclusive culture across all partner organisations
- Maximise the impact of shared resources through coordinated planning and transparent governance
- Ensure work with partners effectively addresses key priorities for our population
- Strengthen integrated locality working through structured collaboration and system alignment

Context and Background

Anchor Institution

As a major employer and Anchor Institution in the Scottish Borders, NHS Borders takes our responsibilities seriously. We aim to be a great employer, support the local economy and offer services that are efficient and convenient for patients. NHS Borders also plays a key role in helping staff, partners and the public achieve better health outcomes, while promoting inclusion and raising aspirations in our region.

Local Context

Effective engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people. In January 2025 NHS Borders undertook an extensive engagement exercise with our staff and communities to inform our Organisational Strategy 2025-2030. What we heard informed the development of our True North Statement and our Partner Organisations Strategic Goal, to which this Partnerships Strategy is aligned. Local context is also set out in our NHS Borders 2024 - 2030 health inequalities strategy.

Strategic Context

The Partnerships Strategy is one of nine enabling strategies to support the implementation of our Organisational and Clinical Strategies. It explains how NHS Borders will work with others to deliver high-quality care. Partnerships are part of everyday work for staff, and this strategy shows why they matter: helping improve services, strengthen community impact and support financial sustainability. It also encourages shared working, resources and ideas to achieve common goals.

National Context

NHS Borders Partnerships Strategy is written within the context of the Scottish Government's **Public Service Reform Strategy**.

The aim is to work together more effectively, focus resources on frontline services, and make services more efficient, joined up and preventative.

Informing Our Strategy

Partners and staff agree that strong relationships and shared goals are the foundation of effective partnership working; valuing trust, respect and regular communication.

Key Priorities and Strengths

- Address service gaps and improve communication
- Deliver more community-based care
- Maintain strong partnerships and staff development
- Build on trust, shared goals, and flexible engagement

Areas for Improvement

- Break down organisational silos and align strategies
- Improve clarity and consistency in communication
- Formalise structures and governance
- Create more opportunities for joint sessions and cross-partner training
- Strengthen links with community, third sector, and neighbouring health boards

Opportunities and Actions

- Unified communications and clear points of contact
- Secondments and shared resources
- Formal agreements and funding alignment
- Greater inclusion
- Better measurement of success and celebration of achievements

Desired Outcomes

- Reduce health inequalities
- Achieve population-level improvements
- Improve workforce recruitment and retention
- Make better use of resources through shared services and coordination

Strategic Objectives

Objective 1: Culture and Ways of Working

Foster a collaborative and inclusive culture across all partner organisations.

What we will do:	How we will do it:	How success and impact will be measured:
Promote trust, respect, and shared goals through regular joint sessions and co-productive initiatives across our range of partners Encourage flexible engagement formats and digital platforms to support diverse participation and joint service delivery Create development opportunities for staff to train together and expand networks Recognise and celebrate partnership successes to boost morale and reinforce positive behaviours Enhance relationships with academic partners to support workforce sustainability	Engage Partners on our Values and Behaviours Framework and agree ways of working Explore best practice in engagement formats and methods and agree a standard process of engagement across Partnerships Expand our emerging 'celebrating success' approach across Partnerships Audit current joint development and training opportunities and identify gaps to pursue	Issue quarterly updates on Partnerships successes Number of new joint development and training opportunities identified

Strategic Objectives

Objective 2: Involving Patients and Public

Deliver person-centred decision making and care by working with and embedding the voices of people who have experienced our services, the wider public and partners.

What we will do:	How we will do it:	How success and impact will be measured:
Reintroduce a robust volunteering programme within NHS Borders and maximise their potential in supporting public involvement Widen the network of equality-focused groups and strengthen relationships to ensure inclusive service design Use shared data and feedback to continuously improve patient outcomes and experience Undertake a review of the public involvement resource model Ensure that local involvement activity is aligned with the new 'Scottish Approach to Change' and 'Getting it right for everyone' (GIRFE) principles Plan for the upcoming review of the 'Involving People Framework' ensuring relevant stakeholders (internal and external) are involved	Undertake two-way conversations with our staff, communities and partners on an ongoing basis as per the organisational priority Maximise volunteer / public member involvement Work with the Scottish Borders Integration Joint Board to support public engagement in the setting of directions	Ensure that outputs from two way conversations are shared with staff, communities and partners, and acted on as required Enhance the feedback and evaluation section of the Involving People Framework in the 2026 update

Strategic Objectives

Objective 3: Resources and Value

Maximise the impact of shared resources through coordinated planning and transparent governance.

What we will do:	How we will do it:	How success and impact will be measured:
Develop shared service models and joint funding strategies to reduce duplication and increase resilience Create and maintain resource directory to improve visibility and access Formalise relationships with Service Level Agreements and shared metrics to track value and outcomes, including commissioned services Seek out new relationships with business partners to identify shared priorities and joint development opportunities	Identify key opportunities for shared service models and develop shared plans to delivery Increase Board oversight of work to develop shared service models and delivery Agree and issue staff guidance on Service Level Agreements Develop a resource directory	Number of shared service models and joint funding strategies in place Reduction in cost base of shared services Data on resource directory usage

Strategic Objectives

Objective 4: Population Based Planning

Develop explicit partnership approaches and strategies to address shared 'wicked issues'

What we will do:	How we will do it:	How success and impact will be measured:
Using the 'life stage' approach, work with partners to identify shared wicked issues and develop joint delivery plans (e.g. obesity and poverty) Develop a single truth understanding of population need through a shared data approach with key partners Improve organisational oversight and support for shared governance arrangements Engage with equality-focused groups to ensure inclusive service design Use shared data and feedback to continuously improve patient outcomes and experience	Develop joint delivery plans with partners, with clear agreed goals, across each of the life stages Develop shared datasets and needs assessments with Partners that describe delivery across life stages Assign an executive lead for Children and Young Person's strategy and partnership working	Improvement in performance metrics aligned to key wicked issues (for example health inequalities or patient flow) Delivery plans developed in partnership across each of the life stages

Strategic Objectives

Objective 5: Locality Based Care

Strengthen integrated locality working through structured collaboration and system alignment.

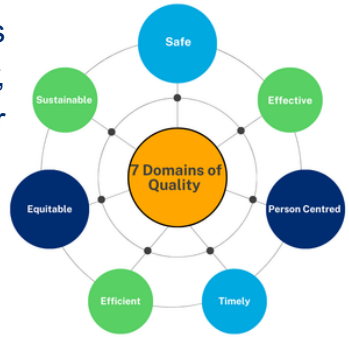
What we will do:	How we will do it:	How success and impact will be measured:
Strengthen community-based care through partnerships with local organisations Develop co-terminus environments and shared working spaces for cross-organisational teams working with the same populations Improve engagement with delivery partners Establish service-level named contacts and joint operational plans to support seamless service delivery	Develop locality working and engagement into locality huddles Increase Home First and Hospital @ Home engagement at a locality level Engage with locality staff and partners to identify priority areas for shared working and match them with available space Create spaces for secondary care clinicians in the community to support joint working Re-establish the integrated workforce planning group (People Strategy co-dependency) Work with the Scottish Borders Integration Joint Board to support commissioning of integrated services	Admissions avoided Increase in number of shared working environments Satisfaction survey of staff working in shared working environments

NHS Borders
Quality Enabling Strategy

Introduction

Purpose

The purpose of the Quality Strategy is to support our staff and teams to do the very best for their patients and colleagues everyday. To do this we need to create an environment where improvement is part of day to day practice, fostering autonomy, accountability, and confidence within teams. By aligning improvement efforts with organisational priorities, we will strengthen our ability to meet the needs of our communities efficiently and effectively across the seven dimensions of quality.



Context and Background

The organisation operates in a complex and evolving healthcare environment, facing increasing challenges, rising costs and growing demands on services. To respond effectively, we must embrace improvement as a core part of our organisational culture and focus on:

- Designing reliable systems and processes to support delivery of care across the seven domains of quality.
- Enhancing capability through the development of leadership skills as well as the technical skills of quality improvement.
- Establishing governance and delivery structures to review progress, maintain consistency and bring openness and transparency to our improvement work.
- Understanding human behaviour to reduce waste and variation creating safe, efficient and sustainable practices.

Our staff are our greatest asset, and we are committed to creating conditions where they can excel and maintain high standards. Through our Social Compact, we acknowledge the need for improvement and commit to creating space and capability for staff to innovate and act on opportunities for better care.

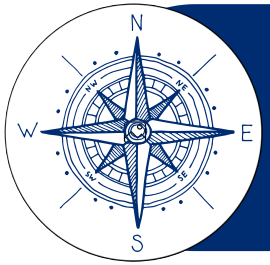
Our Improvement Approach

Our improvement approach, set out in the NHS Borders Organisational Strategy, is designed to create the conditions for every member of staff to deliver the best possible outcomes for patients and experience fulfilment in their work. It is underpinned by a clear understanding of human behaviour and built on three essential elements; everyone at NHS Borders should know what's expected of them, receive feedback on their performance and importantly know how to access the tools to improve the gap. We will use a structured framework under the NHS Borders Quality Management System (QMS) to bring together the processes, standards, and behaviours needed to ensure that the organisation consistently delivers high-quality services and outcomes. This will provide a systematic approach to planning, implementing, monitoring, and improving quality across all areas.

Strategic Principles

Strategic Principles

A True North statement defines our core purpose and provides a consistent direction for all decision-making. They serve as enduring principles that align stakeholders with our organisational goals and guide us toward achieving our strategic ambitions. **Our overarching statement guides us to what we want to deliver over the lifespan of the strategy** and is underpinned by seven statements spanning the dimensions of quality. These statements form the foundation from which we will develop an annual action plan focused on continuous improvement.



Our True North Statement

We will consistently deliver safe, effective, person-centred, timely, efficient, equitable and sustainable care by creating the conditions for every member of staff to understand, measure and continually improve the quality of the care they provide, using data, learning and collaboration to inform decision-making and achieve the best possible outcomes for our population.

Safe	Our priority is the safety of our patients and staff, we are committed to delivering care that is consistently safe and free from harm. When harm does occur, we will respond openly, learn from it, and take action to improve.
Effective	We will deliver treatment and care that is grounded in the best available evidence, ensuring it leads to the highest possible outcomes for our patients.
Person Centred	We will work in partnership with our patients, through shared decision-making and collaborative care planning across teams. We will actively listen to patient feedback and use it to shape and improve the way our services are developed and delivered.
Timely	Our patients time is precious, we will reduce unnecessary waits and harmful delays in care, recognising the impact they have on both those receiving care and those delivering it.
Efficient	We will use our resources wisely to deliver best value and maximise benefit for our population. This includes avoiding waste; whether of equipment, supplies, ideas or energy and ensuring every action contributes meaningfully to high-quality care.
Equitable	We will provide care that is consistently high in quality, and does not vary due to personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status. We are committed to equity in access, experience, and outcomes for all.
Sustainable	We will develop our services with a focus on safeguarding resources for future generations, taking responsible decisions on the allocation of resources, our impact on the environment and the role we play in our local community as an anchor institution.

To bring our Quality Strategy to life, we have identified five key objectives that translate our vision into practical actions. Each objective reflects a core element of our commitment to delivering our true north principles across the seven dimensions of quality.

Strategic Objectives

Objective 1 - Agency

Empower and equip everyone working for NHS Borders to make small changes which improve the work environment and the care delivered to patients, building ownership and participation. This will be enabled by ensuring there are effective systems and processes in place to support the delivery of care across the seven domains of quality, underpinned by effective clinical education and professional development with a focus on human factors

To achieve this objective we will:

- Design a strategy deployment approach as part of quality planning which connects strategy to frontline Quality Improvement (QI) plans.
- Establish a QI Academy offering a range of technical skills training to all staff.
- Test approaches to protecting time in people's roles to deliver QI.
- Build an approach to visible leadership which seeks to enquire, understand and enable frontline improvement.
- Establish an innovation and improvement project pipeline and fund to enable the design, testing, assessment and spread.
- Provide quality coaching to consolidate technical skills training and embed QI practice.
- Provide a consistent suite of documentation and tools for staff to use in day-to-day QI and quality planning.
- Embed a data standard and provide support to access, understand and use data to drive improvement.
- Design and test a consistent visual management approach and way of working to support its use.
- Refresh the NHS Borders Quality Management System to provide a systematic approach to planning, implementing, monitoring, and improving quality across all areas.
- Embed the Scottish Approach to Service Change in our improvement and transformation work.
- Refocus the governance structure for key programmes of work ensuring alignment with the quality management approach.
- Enhance clinical and non-clinical leadership to each workstream of key programmes ensuring effective systems and processes are in place with professional and technical advice and oversight.
- Continue to strengthen the range of clinical and non-clinical education offered across NHS Borders.
- Build a human factors approach across the organisation ensuring that systems, processes, and environments are designed with a deep understanding of how people interact with them and recognition of human error.

Strategic Objectives

Objective 2 - Curiosity

Using our intelligence effectively build a culture of enquiry which seeks to understand how care is being delivered, celebrate success and identify areas for continual improvement.

To achieve this objective we will:

- Embed a robust care assurance process through implementation of NHS Borders Care Assurance and Delivery Programme within inpatient wards, emergency department, theatres, outpatient and day case procedure areas.
- Design care assurance systems appropriate to community teams and for medical devices beginning with a review of standards, development of a continual data collection approach and systems and processes to monitor and assess quality.
- Maintain a strong focus on how we practice Infection Prevention and Control and Health and Safety and consider the healthcare built environment.
- Scope out an accreditation and recognition system.
- Introduce a system for sharing learning and celebrating success where peers can come together to provide mutual support and encouragement, enabling lessons learned and success to be shared across the organisation.
- Embed the care assurance system as a core element of professional roles, ensuring a strong voice patients and staff which is integrated into the clinical governance system.
- Ensure all areas have access to quality data to support them in delivering effective care and continual improvement.
- Build digital dashboards with real-time data feeds for key quality indicators, accessible to teams and Board committees.
- Ensure data is effectively embedded in operational, decision making and assurance groups.
- Provide training on interpreting data and using SPC (Statistical Process Control) for continual improvement, decision-making and assurance.
- Embed robust demand, capacity, activity and queue data to facilitate effective use of resources.
- Bring a focus to understanding inequalities through our data.

Strategic Objectives

Objective 3 - Insight

Protect time to learn and reflect, engaging colleagues, patients, families and carers to gain a deeper understanding of patient safety and care experience, informing the ongoing delivery of care and treatment.

To achieve this objective we will:

- When care does not go as planned, we will ensure that patients, families and carers are compassionately supported through timely, honest communication, access to appropriate emotional and practical support, and opportunities for involvement in learning and improvement. This approach reflects our commitment to transparency, trust, and healing placing people at the heart of our response. We will use Duty of Candour Scotland Regulations 2018 to guide our work in this area.
- ·When care does not go as intended, we will ensure staff are immediately supported through the staff support pathway for traumatic events, which includes structured debriefing and timely access to appropriate emotional, psychological, and professional support. This approach reinforces a culture of compassion, learning, and resilience, enabling teams to recover, reflect, and improve together.
- When care does not go as intended, we will apply a human factors approach to the review of Significant Adverse Events. This will ensure a balanced understanding of both how work is normally carried out and the contextual factors that may influence individual and team performance. By focusing on everyday practice and system conditions, we aim to generate meaningful learning and drive improvements that are both practical and sustainable.
- Strengthen learning and improvement from Adverse Event Review (including reviews covering Child Death, Drug Death and Suicide), Mortality and Morbidity Review and for Patient Feedback by introducing more effective ways to share information and by embedding thematic learning in core educational programmes and our proactive Quality and Safety programme.
- Introduce a Team Based Quality Review approach to the review of Mortality and Morbidity by clinical teams bringing a human factors approach to reflect on the delivery of patient care and treatment.
- We will strengthen our care experience feedback mechanisms by ensuring that all feedback is systematically triaged, acted upon promptly, and that learning from complaints is embedded into service improvement processes. This approach will support a responsive, person-centred culture that values the voices of patients, families, and carers as key drivers of quality improvement. We will use the Patients Rights Act 2011 to guide our work in this area.

Strategic Objectives

Objective 4 - Safeguard

Those who are the most vulnerable or in the greatest need by ensuring their voice is heard and used to influence the design and delivery of services, bringing a focus to making the best use of resources for future generations.

To achieve this objective we will:

- Collaborate across agencies to ensure effective information sharing, learning and review of cases where there is a concern relating to a child or adult. Our work in this area will be guided by the Adult Support and Protection Act 2007 and National Guidance for Child Protection in Scotland 2021.
- Act in the best interests of adults and children who are at risk of harm, guided by the Adults with Incapacity (Scotland) Act 2000 and National Guidance for Child Protection in Scotland 2021 ensuring any review focuses on the rights, needs and wellbeing of individuals.
- Strengthen multiagency working across the Scottish Borders Health and Care Partnership by embedding a coordinated partnership arrangement to support prevention and improve access for underrepresented groups, particularly children and young people.
- Use population health data to identify priority areas and mitigate health inequalities that disproportionately affect vulnerable children, adults and families.
- Provide assurance that there are embedded ways of working to ensure that the Involving People Framework and the Scottish Approach to Change are reflected in NHS Borders Partnership Strategy.
- ·Embed Equality Impact Assessments (EQIA) and equity into the development of services guided by the Equality Act 2010.
- ·Collaborate across partners to deliver our responsibilities around the provision of health and social care support under the Scottish Government Getting It Right for Every Child (GIRFEC) and Getting It Right for Everyone (GIRFE) approach.
- ·Provide assurance that actions under the programme of work relating to Environmental Sustainability are delivered to protect future resources and safeguard the planet for generations to come.

Strategic Objectives

Objective 5 - Compassion

Encourage a culture of compassion and shared decision making between healthcare professionals, patients, carers and families building a person-centred, trauma informed approach.

To achieve this objective we will:

- Encourage the development of a compassionate approach in our work with each other and a culture of supporting wellbeing in our work.
- Embed routine shared decision-making (SDM) and “What matters to you?” prompts into all relevant care pathways.
- Through our work on Treatment Escalation and Care Planning build an inclusive approach to involving patients, carers and families in care planning and decision-making.
- Deliver a compassionate leadership programme based on the principles of attending, understanding, empathising, and helping, aiming to support staff working across the organisation to understand themself as a leader, how they lead in a team and within our system.
- Provide targeted leadership development for clinical leaders.
- Bring a focus to team health and wellbeing testing approaches to working with teams to build psychological safety and a culture of learning and improvement.
- Working with leaders to develop a quality coaching approach supporting our objective to give agency to all staff to make continual improvements.

NHS Borders
Risk Management
Enabling Strategy

Introduction

Purpose

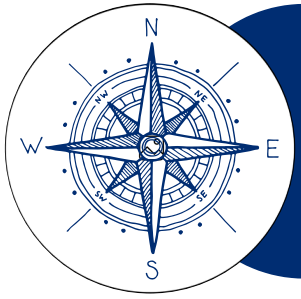
The risk strategy sets out how risk becomes a key part of our operating model across all parts of NHS Borders. Good risk management is critical to the successful running of a healthcare organisation because it preserves patient and staff safety, ensures continuity of care, and supports informed decision-making.

Context and Background

In a complex and high-pressure environment like healthcare, unmanaged risks can lead to clinical errors, financial losses, reputational damage, and regulatory breaches. By embedding risk management into everyone's daily practice, we move from a reactive approach to a proactive culture where risks are identified early, mitigated effectively, and opportunities for improvement are embraced. Effective risk management is an integral part of the NHS Borders Improvement Approach detailed in our Quality Strategy.

Strategic Principles

A True North statement defines our core purpose and provides a consistent direction for all decision-making. It serves as a principle that aligns stakeholders with our organisational goals and guides us towards achieving our strategic ambitions. Our approach to managing risk at NHS Borders is set out in this statement.



Our True North Statement

NHS Borders will lead a proactive, integrated and collaborative approach to risk, continuously improving how risks are identified, understood and managed—so that high-quality intelligence informs effective decision-making at every level and harm is prevented, delivering safe, reliable care for every patient.

To bring our Risk Strategy to life, we have identified four key strategic objectives that translate our vision into practical actions. Each objective reflects a core element of our commitment to delivering our true north principles.

Strategic Objectives

Objective 1 - Lead

Lead by example bringing a strong focus and commitment to risk management throughout the organisation

Effective leadership and a strong commitment to risk management throughout NHS Borders can be achieved through the board's oversight and guidance. The board plays a crucial role in setting the tone and culture for risk management, ensuring it's integrated into strategic decision-making and daily operations.

To achieve this objective we will:

- Set the tone at Board level to enhance the risk management culture through an annual review of the organisational risk appetite.
- Ensure effective risk management practices are in place by providing risk oversight and governance, ensuring that significant risks are identified and managed effectively.
- Promote a positive risk culture by encouraging open communication about risks, fostering a culture where employees feel comfortable raising concerns.
- Ensure mindful leadership to ensure risk is considered in all decision making through using lessons learned from both successes and failures in risk management are shared and incorporated into future practices.

Objective 2 - Integrate

Integrate risk into the way we work having a clear understanding of our risk culture and what we need to do to continually improve and mature

A strong risk culture is crucial for the success of NHS Borders because it shapes how individuals perceive and respond to risk, influencing decision-making and ultimately impacting the ability to achieve objectives. It's more than just policies and procedures; it's the shared values, beliefs and behaviours related to risk awareness, management and communication by all staff.

To achieve this objective we will:

- Explore use of a digital tool to monitor risk culture maturity in NHS Borders to identify outcome-based suggestions for improvement.
- Regularly monitor the risk culture and feed results into NHS Borders governance structures, using insights gained to identify areas for improvement.
- Clearly define NHS Borders risk appetite, identifying key risks that could hinder strategic goals, and establishing robust controls and assurance processes ensuring staff are educated in this process.
- Create, implement and embed a Board Assurance process and link into associated governance structures that aligns risks, strategic objectives and strategic planning and performance.

Strategic Objectives

Objective 3 - Collaborate

Collaborate to ensure the proactive identification of risks enabling effective planning, decision making and action within NHS Borders and across the Scottish Borders Health and Social Care Partnership

Proactive risk identification by all staff is crucial for building organisational resilience within NHS Borders. This approach involves systematically identifying potential hazards, threats and vulnerabilities and developing improvement strategies to minimise the impact of disruptions and ensure the continued delivery of services.

To achieve this objective we will:

- Ensure risks are logged in the risk register before they escalate by training and empowering staff to dynamically assess risks and stop unsafe practices without fear of blame.
- Proactive risk management supports the NHS Scotland Adverse Event Framework and helps prevent adverse events by identifying residual risks from lessons learned and feeding them back into the risk management process.
- Adopt a joined-up approach to identify emerging threats early, in line with the Civil Contingencies Act; ensuring NHS Borders is prepared for emergencies ranging from localised incidents to major disruptions.
- Build organisational resilience through proactive risk management and lessons from reactive responses to reduce risks, protect patients and staff, and improve overall care quality.
- Maintain, review and improve the Integrated Risk Management Strategy and Policy in partnership with Scottish Borders Council.

Objective 4 - Improve

Integrate risk into the way we work having a clear understanding of our risk culture and what we need to do to continually improve and mature

To ensure a Risk Management Framework remains effective, it needs to be updated to reflect new legislation, regulations and organisational changes. This includes adapting strategies, policies and processes to address emerging risks and opportunities.

To achieve this objective we will:

- Regularly monitor for new legislation, regulations and industry standards that affect NHS Borders, using topic specialists where appropriate and regular networking both internally and externally, at local and national levels.
- Evaluate how these changes affect existing risk profiles and identify new risks or opportunities, ensuring any changes that cause additional threats or opportunities are captured through existing risks or entered as new risks into the organisational risk register.
- Modify risk management strategy, policy and framework to incorporate necessary changes, ensuring compliance with best practices.
- Communicate changes to staff where applicable.

NHS Borders Research and Innovation Enabling Strategy

Introduction

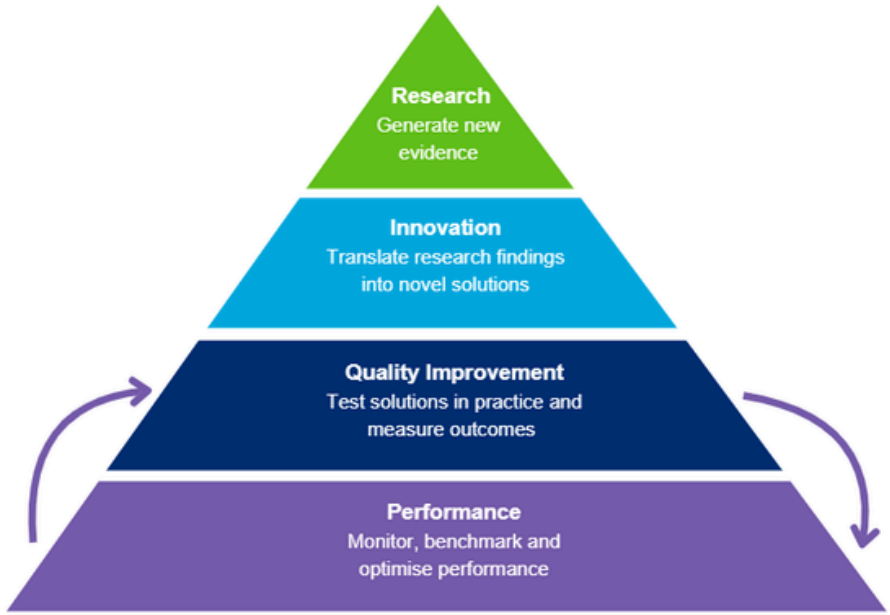
Purpose

The strategy plays an important role in underpinning the NHS Borders Organisational and Clinical Strategies setting out our strategic principles and objectives for research and innovation in the next 5 years. The Research and Innovation Strategy focuses on creating the knowledge for the NHS to continue to advance in the long term, looking at best value solutions to the challenges faced in the delivery of health and care. By expanding our research and innovation portfolio, we aim to deliver on the ambitions outlined in the People and Partnership strategies, positioning NHS Borders as an attractive place to work and a thriving hub for collaboration.

Context and Background

We aim to make research practical and useful for improving care and how we work. Research and innovation should build on our quality improvement approach to help healthcare evolve. Our vision is to create a strong research and innovation culture within NHS Borders, with a broad portfolio that gives patients and staff opportunities to take part in studies across all life stages in our Clinical Strategy. We will work with partners to explore how healthcare can be environmentally, economically and socially sustainable, and how digital, technology and artificial intelligence can shape future services.

We will enable staff to explore new ideas and innovative solutions to overcome challenges in delivering day-to-day services, creating opportunities to systematically test, validate and refine concepts that enhance patient care and treatment, ensuring improvements are evidence-based and sustainable.



The strategy will seek to maximise our unique characteristics as a remote and rural NHS Board to understand how we can evolve and develop local services to meet population need in the long term. Our collaborations with the public, academia, industry and partners operating within the Scottish Borders Health and Social Care partnership will be critical in delivering our strategy enabling the Scottish Borders to actively participate and inform the research and innovation agenda across Scotland, the United Kingdom and internationally.

Introduction

NHS Borders is part of NHS Research Scotland and the Health Innovation South East Scotland Hub forming part of the strategic partnership between the NHS Boards and the Chief Scientist Office to deliver clinical research and innovation projects. Patient and Public engagement is vital in designing research and innovation projects and identifying key priorities for improving service delivery. Feedback has been gathered from our patients and staff in the Scottish Borders as to why research and innovation matters to us:

> It gives opportunity for staff to expand their clinical skills/embed evidence based practice into their role

> We can build an NHS fit for the future

> Offering people promising advances in their personal patient care

> It makes the possible safe

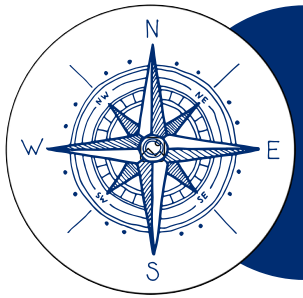
> Imperative for service development

> Clinical research has made treatments I thought would be 'science fiction' a reality for our patients

> Helps people live life in a health and productive way

Strategic Principles

A True North statement defines our core purpose and provides a consistent direction for all decision-making. It serves as an enduring principle that align stakeholders with our organisational goals and it guides us towards achieving our strategic ambitions: The following statement forms the foundation from which we will develop our research and innovation approach.



Our True North Statement

To embed a culture of research and innovation at the heart of NHS Borders, attracting and enabling staff and partners to co-create and deliver evidence-based solutions that improve outcomes, sustain services, and position the Borders as a leading rural centre for collaboration, learning and innovation.

To bring our Research and Innovation Strategy to life, we have identified four key objectives that translate our vision into practical actions. Each objective reflects a core element of our commitment to delivering our true north principles.

Strategic Objectives

Objective 1 - Inform

Inform the future delivery of healthcare by becoming an organisation that actively contributes to research and innovation.

To achieve this objective we will:

- Undertake a scoping survey to establish baseline and identify gaps in skills and training.
- Embed Research and Innovation into organisational culture providing protected time for research and innovation to inform evidence-based practice.
- Deliver more training opportunities including bite size talks on key topics identified in scoping survey.
- Build a research infrastructure to support clinical staff to ensure recruitment can be delivered to time and target.

Objective 2 - Collaborate

Collaborate to strengthen our reach and capability in research and innovation.

To achieve this objective we will:

- Co-design with Academic, Industry, public and patient partners to build a pipeline of local research and innovation projects that add value to service provision and meet local strategic health priorities.
- Work closely NHS Lothian and NHS Fife as part of Health Innovation South East Scotland (HISES) innovation hub to increase the number of innovation projects supported in the region.
- Support the Scottish Economy by collaborating with Small and Medium-sized enterprises to test new health care solutions that meet the priorities of the NHS.
- Strengthen links with the Accelerated National Innovation Adoption (ANIA) pathway to ensure values cases are fit for purpose in a remote and rural NHS Board and to ensure that local adoption can be managed effectively.

Strategic Objectives

Objective 3 - Advocate

Advocate to ensure equity of access to clinical trials for people of the Scottish Borders.

To achieve this objective we will:

- Work with the Chief Scientist Office and our nodal partners NHS Lothian to increase access to research in response to Lord O'Shaughnessy's report on commercial clinical trial delivery.
- Work with NHS Lothian to establish a hub and spoke model to increase clinical trial delivery.
- Identify areas of priority such as cancer services where our clinical pathways are delivered jointly to enable research to be carried out closer to home where possible.

Objective 4 - Enable

Enable innovation and research by proactively pursuing external opportunities for funding, recognising the need for additionality to do this successfully alongside core service delivery.

To achieve this objective we will:

- Scope out the potential avenues for external collaboration and funding.
- Proactively seek opportunities for external funding to pump prime research and innovation initiatives to enable involvement of core services.
- Work with NHS Borders Health Charity to explore a process for funding small pilot projects which can demonstrate impact.
- Build a robust benefits analysis approach into innovation projects to assess impact, cost and value informing long term decision making.

NHS Borders
Digital Enabling Strategy

Purpose

Why Digital Enablement Matters

NHS Borders stands at a crossroads. Our investment in digital has not kept pace with the increasing dependency on modern digital infrastructure and systems to deliver efficient and value-based healthcare, and to allow us to adopt advancements in healthcare technology that would enable us to transform our services.

As clinical priorities evolve and models of care change, digital must be the enabler—making it possible to deliver safer, effective and person-centred services for our population.

Our purpose is to enable NHS Borders to deliver its clinical and organisational ambitions through robust, future proofed, and fit-for-purpose digital infrastructure and services.
This strategy sets out a clear case for urgent investment to strengthen our digital foundations to be able to support transformation that underpins the clinical strategy and ensure NHS Borders, complies with regulatory requirements and remains aligned with national policy and strategy.

Delivery Context

- **Technology advancements**: We will remain sighted on advancements in technology and adopt an agile approach to ensure we can adapt as models of care change, ensuring digital infrastructure, systems and skills keep pace within constraints of existing contracts and system dependencies.
- **National Strategy:** We will align with national digital health and care and data strategic deliverables.
- **National Policy:** We will adopt the ‘Once for Scotland’ by default approach to digital.
- **Delivery Partners:** We aim to work collaboratively with other health boards and agencies, recognising historic challenges in gaining traction but committed to shared solutions for resilience and sustainability.
- **Regulatory Compliance:** We must meet regulatory requirements for data protection, cybersecurity, and medical device safety.
- **Evolving national delivery landscape**: We will seek clarity on the role of NHS Delivery in local digital delivery and flexibility to make our own choices.

Digital Enabling

Enabling Clinical Transformation

Digital will enable the delivery of our Clinical Strategy by:

- Supporting care closer to home through remote consultations and remote monitoring technologies.
- Facilitating seamless clinical information sharing and care planning across teams, settings, and health boards.
- Standardising workflows and pathways to reduce unwarranted variation in care.
- Reducing prescribing errors to improve patient safety.
- Prompting people to follow evidence based guidelines.
- Reducing time spent on administrative tasks, freeing up time to care.
- Empowering patients to digitally transact with healthcare services and use digital tools for self-management.

Strategic Objectives

Objective 1 - Strengthen

We will build safe and resilient digital foundations by:

- Modernising networks, data centres, and hardware for resilience and performance.
- Implementing strong cyber security controls.
- Enhancing governance processes to ensure value-based investment, effective change control and delivery of projects aligned with best practice standards.
- Strengthening supplier, contract and asset management.
- Consolidating legacy systems.
- Providing robust, tested business continuity plans.
- Complying with regulatory requirements for information governance and medical devices and national standards for clinical safety.
- Implementing national data and interoperability standards.
- Providing training and clear career pathways for all digital staff to ensure there is a sustainable digital service.
- Establishing a multidisciplinary clinical digital leadership team and upskilling with the necessary competences.
- Using digital business facilitators to engage with service teams.

Objective 2 - Connect

We will enable multidisciplinary teams to connect, share information and interact with each other across care settings and health boards by:

- Using M365 collaboration tools.
- Facilitating access to standardised referral guidelines.
- Delivering a person-centred digital health and care record, include tools for creating and sharing care plans and end-of-life preferences.
- Exploring digital pathway platforms which support triage, monitoring and optimised care at every stage of a patient journey, complementing existing electronic patient records.

Strategic Objectives

Objective 3 - Digitise

We will ensure ongoing and rapid adoption of digital technologies to improve patient care and operational efficiency, by:

- Digitising paper records to reduce administrative burden and costs.
- Delivering the Vision electronic health record into all GP practices by 2027 and upgrading the Docman electronic document management system by 2028.
- Evaluate the current Community and Mental Health system to ensure it continues to meet organisational needs effectively and delivers value for money.
- Enhancing the capabilities offered in TrakCare to develop digital patient records and support data capture on mobile devices.
- Optimising management of Ophthalmology patient pathways through use of the Open Eyes clinical system.
- Procuring and implementing a Hospital Electronic Prescribing and Medicines Administration system to enhance patient safety.
- Implementing the national My Care app to enable patients to digitally transact with healthcare services and access their health and care record.
- Standardising and improving the quality of data captured in clinical systems.

Objective 4 - Transform

We will support equitable care closer to home and facilitate new models of care by:

- Standardising digital workflows and pathways to reduce unwarranted variation.
- Expanding virtual consultations.
- Deploying remote monitoring and wearable technologies to facilitate virtual care and re-design of some diagnostic pathways.
- Using automation and artificial intelligence to reduce administrative burden, enhance diagnostics and free up clinical time to care.
- Enabling data-driven insights.

Strategic Objectives

Objective 5 - Empower

We will encourage a 'digital first' culture within the organisation, by:

- Establishing a digital champion clinical network and encouraging clinical representation in digital projects.
- Training and upskilling staff so they can use digital systems effectively.
- Co-designing digital services with staff and patients.
- Empowering digital experts to identify and implement innovations that will support transformation.
- Implementing digital tools that support patients to self-manage.
- Addressing barriers to digital inclusion within the local population so they can use new digital systems to interact with healthcare services.

Objective 6 - Collaborate

We will work collaboratively with others who can support us to achieve our ambitions by:

- Exploring options for shared digital services and system deployments with other health boards to support local resilience, sustainability and optimise use of local digital resources.
- Maximising use of resources and expertise available within national boards to address specialist gaps.
- Working with Scottish Borders Council and third sector organisations to improve digital literacy for our population and promote use of self-management tools.
- Fostering collaboration with academic and commercial partners to enhance research and innovation opportunities and secure inward investment.

Next Steps

The Case for Enabling Investment

NHS Borders requires urgent and sustained investment in digital enablement - not just to keep pace, but to leapfrog into a position where we can deliver safe, efficient, and transformative care. Our unique challenges and history of underinvestment in healthcare technology advancements make us a special case for Board and Scottish Government support.
Investment will enable:

- Safe, resilient systems to support patient care
- Transformation of care delivery
- Empowerment of staff and patients
- Delivery of regional and national ambitions

Next Steps

Prioritise deliverables for each strategic objective

Develop detailed delivery plans and business cases for investment

Engage with Board, Scottish Government and regional partners to secure investment and support

NHS Borders
People Enabling Strategy

Introduction

Purpose

Our greatest asset at NHS Borders is our workforce. We value them and we want to be sure they see this on a daily basis in how we listen, and in our values, decisions and actions. Without great people, we cannot support our communities when they need us. It is that simple.

We are completely committed to supporting our workforce to be the best that they can be as often as possible, and in doing this we want NHS Borders to be a great place to work. This means making sure NHS Borders is or becomes a place where every member of staff feels valued, supported, and empowered to deliver safe, effective, and person-centred care.

Our people strategy is designed to enable our workforce to thrive, ensuring sustainability, reducing waste, and maximising value-added time with patients.

It is built around our Social Compact and sits as part of our suite of integrated strategies specifically our Clinical, Quality and Research and Innovation strategies. Through this we aim to foster a culture of compassion, learning, and continuous improvement.

Social Compact

Our Social Compact is a unique agreement developed with our Partnership Forum and staff groups that calls on all staff to recognise where we can improve for the benefit of our patients and our staff. Then to commit to continuous improvement, which is fundamental to our ethos and the agency we promote. By fostering a culture of excellence, we aim to achieve better outcomes for patients and a more fulfilling work environment.

Social Compact

Social Compact

There are four elements to the social compact:

Firstly, a recognition of the need to improve, reducing the time it takes to meet our communities needs and working more effectively and efficiently.

Secondly, to support this performance improvement we are investing in the improvement capability of our workforce. The people who see the issues and opportunities on a day to day basis are those best placed to make improvements, so we will train our workforce in improvement methodology.

Thirdly, we recognise that this takes time, and we commit to embedding space for improvement to ensure this work is not an added burden but a core part of how we function.

Finally, we heard about the challenges our workforce face with rising costs and living expenditure. To support this we aim to maximise the benefits available to our staff by enhancing the visibility of existing benefits and exploring new options, staff benefit schemes, such as salary sacrifice schemes for purchasing cars and household goods, which offer savings on tax, National Insurance, and pension contributions.

Underpinning Principles

Underpinning this Social Compact are a set of key principles;

- **Great Place to Work:** Foster a culture of respect, inclusion and celebration.
- **Quality at the Core:** Embed the seven domains of quality - Safe, Effective, Person-Centred, Timely, Efficient, Equitable, Sustainable - in all people practices.
- **Sustainable Workforce: Plan** and develop our workforce to meet current and future needs.
- **Value-Added Care:** Reduce waste and free up staff time for direct patient care.
- **Staff Celebration:** Recognise and celebrate achievements and contributions.

Strategic Objectives

Objective 1 - Attract

Making NHS Borders a great place to work

We will:

- Promote NHS Borders as a great place to work, highlighting our commitment to staff wellbeing, development, and diversity.
- Executive reverse mentoring programme for all protected characteristics.
- Embed Equality Impact assessments are in all of our decision making processes.
- Create a psychologically safe workplace where diversity is celebrated.
- Provide access to health and wellbeing resources, including peer support, mindfulness, and occupational health services.
- Build resilience through coaching, peer support, and leadership development.
- Maximise employability opportunities through apprenticeships, placements, and partnerships with local education providers.
- Ensure our workforce reflects the diversity of our communities and provides opportunities for all.

Objective 2 - Improve

Support our People to Drive Improvement

We will:

- Embed the dimensions of Quality in our workforce; Safe, Effective, Person Centred, Timely, Efficient, Effective and Sustainable.
- Foster a caring and learning culture, embedding psychological safety and reflective practice.
- Engage staff in decision-making, ensuring their voices shape service reform and quality improvement.

Strategic Objectives

Objective 3 - Sustain

Growing Skills and Potential

We will:

- Ensure all staff have regular Personal Development Reviews (PDR) to identify learning and development needs.
- Develop modern, values-based recruitment processes that ensure every candidate has a positive experience.
- Strengthen workforce planning to ensure we recruit the right people with the right skills for evolving models of care.
- Support longer, healthier working lives through innovative job design and wellbeing initiatives.
- Implement work-life balance policies and flexible working arrangements.
- Provide high-quality training, leadership development, and mentorship opportunities.
- Support succession planning and talent management to build future leaders.
- Encourage continuous learning and reflective practice to maximise staff potential.
- Promote digital literacy and new ways of working to support service transformation and quality improvement.

Objective 4 - Value

Waste Reduction and Free Up Time to Care

We will:

- Streamline processes and reduce administrative burden, freeing up staff for direct care.
- Harness digital tools and automation to improve efficiency and reduce waste.
- Redesign roles and workflows to ensure staff operate at the top of their licence.
- Involve staff in identifying and implementing improvements that enhance patient care.
- Monitor and report on time spent in value-added activities, using feedback to drive further improvement.

Strategic Objectives & Conclusion

Objective 5 - Success

Wellbeing, Inclusion and Partnership

We will:

- Celebrate staff achievements through recognition programmes and regular feedback.
- Recognise and celebrate achievements at individual, team, and organisational levels.
- Share success stories and good practice across NHS Borders.
- Promote a culture of appreciation, where staff feel valued for their contributions.
- Use staff feedback to continuously improve our recognition programmes.
- Work in partnership with staff, trade unions, and local organisations to deliver on our commitments.

Conclusion

Our Call to Action

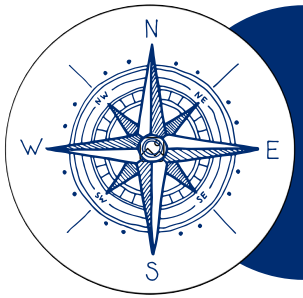
NHS Borders is committed to enabling our people to deliver the best possible care. By making NHS Borders a great place to work, investing in our workforce, reducing waste, and celebrating our staff, we will build a sustainable, resilient, and high-performing organisation. Together, we will deliver value-added care for our patients and communities, fully aligned to our quality ambitions.

NHS Borders
Nursing, Midwifery, and Allied Health Professions (NMAHP) Enabling Strategy

Introduction

Purpose

This enabling strategy exists to support the delivery of NHS Borders' organisational and clinical strategies focussed on our Nursing, Midwifery, and Allied Health Professions (NMAHP) workforce. Employing over 1700 staff, the NMAHP workforce is the single largest clinical workforce employed by NHS Borders. Working across all aspects of the Health Board and Health and Social Care Partnership, NMAHP staff are critical to the delivery of safe and effective care and are often at the forefront of holistic and preventative care supporting our Borders population to live healthy and fulfilling lives.



Our True North Statement

NHS Borders will lead a proactive, integrated and collaborative approach to risk, continuously improving how risks are identified, understood and managed—so that high-quality intelligence informs effective decision-making at every level and harm is prevented, delivering safe, reliable care for every patient.

This NMAHP strategy seeks to support the wellbeing and development of our NMAHP staff, will give direction to the development of our services and pathways, and will outline the ways in which our NMAHP workforce can provide the solutions to many of our whole system challenges.

Introduction

Context & Background

National Context

Numerous national policy documents and professional body guidance have shaped the development of this strategy.

- Scottish Government's (2025) Scotland's Population Health Framework - gov.scot and Health and Social Care Service Renewal Framework - gov.scot provide the national direction of travel focussed on prevention, holistic and integrated care, and making best use of our clinical workforce
- Nursing 2030 vision - gov.scot
- Health and Care (Staffing) (Scotland) Act 2019: overview - gov.scot
- Allied Health Professions - education and workforce policy review: recommendations - gov.scot
- Scottish allied health professions public health strategic framework implementation plan: 2022 to 2027 - gov.scot

Local Context

- NHS Borders Organisational Strategy 2025-2030 sets out the direction of travel as an organisation
- NHS Borders Clinical Strategy provides a framework based on the principles of patient focused, effective care, flexible workforce, community focussed, equitable access, collaborative working, evidence based, innovative.
- The development of this NMAHP strategy has been developed through an equality and human rights impact assessment lens with direct engagement with over 220 NMAHP staff through a variety of forums. Borders NMAHP strategy staff engagement

Strategic Objectives

Objective 1 -

NMAHP Staff Who Feel They Belong

NMAHP staff in NHS Borders will feel valued by the organisation, will feel part of a team, and will be supported to bring their unique contribution to their role.

Objective 2 -

NMAHP Staff Who Demonstrate Leadership

In line with Nursing and Midwifery Council and Healthcare Professions Council standards, NMAHP staff have a responsibility to lead the professional and clinical delivery of services. As set out in NES career framework, elements of leadership should exist in every job role and every level of the career framework.

Objective 3 -

NMAHP Staff Who Are Supported To Develop

NHS Borders commits to the development of all NMAHP staff regardless of their job role. The ongoing development across all 4 pillars of practice are relevant regardless of job title, banding or professional background.

Objective 4 -

NMAHP Staff Who Drive Meaningful Change

NMAHP approaches provide solutions to many of the 'wicked issues' that currently exist in our system. The holistic, pathway approach taken by NMAHP practitioners and services provide a blueprint for whole system change locally, regionally and sub-nationally.

Strategic Objectives

Objective 1 -

NMAHP Staff Who Feel They Belong

NMAHP staff in NHS Borders will feel valued by the organisation, will feel part of a team, and will be supported to bring their unique contribution to their role.

What we will do:

- Ensure staff feel valued within their job role and team
- Ensure staff feel competent and safe to deliver on their role
- Ensure staff have the time for essential learning, support, supervision, and ongoing professional development

How we will do it:

- Embed supervision in every team and every clinical setting
- Deliver on Protected Learning Time (PLT) through job planning and rostering
- Support staff to participate in NHS Borders Compassionate Leadership Programme

How success and impact will be measured:

- Care Assurance visits as part of a broader Care Assurance Framework
- Safe Staffing legislation compliance
- Imatter feedback

Strategic Objectives

Objective 2 -

NMAHP Staff Who Demonstrate Leadership

In line with Nursing and Midwifery Council (NMC) and Healthcare Professions Council (HCPC) standards, NMAHP staff have a responsibility to lead the professional and clinical delivery of services. As set out in NES career framework elements of leadership should exist in every job role and every level of the career framework.

What we will do:

- Support the development of leaders throughout the career framework
- Provide professional, clinical, and managerial leadership opportunities for NMAHP staff
- Ensure NMAHP leadership exists at Board and Executive level to lead, influence, and direct clinical services
- Provide a proactive and positive professional leadership voice across NHS Borders, the region, and 'Scotland East'.

How we will do it:

- Leadership development is embedded within Newly Qualified Practitioner (NQP) programme
- Team Leaders/ Senior Charge Nurse and Midwifes are equipped through internal and external development opportunities
- Aspiring leaders are given exposure to senior roles and forums and given opportunities to develop their skills
- Professional leadership requirements are seen as essential to any service or structure redesign
- Commission AHP Professional Forum and the Professional Nursing and Midwifery Leadership Council (PNMLC) to lead and deliver on specific pieces of work to support the development of NMAHP staff and services

How success and impact will be measured:

- Recruitment, retention, and succession planning within NMAHP leadership roles
- Imatter feedback
- Care Assurance visits
- NMAHP staff completing NHSB Compassionate Leadership Programme

Strategic Objectives

Objective 3 -

NMAHP Staff Who Are Supported To Develop

NHS Borders commits to the development of all NMAHP staff regardless of their job role. The ongoing development across all 4 pillars of practice are relevant regardless of job title, banding or professional background.

What we will do:

- Support education and development for staff regardless of profession or job role
- Ensure staff possess the expertise and confidence needed to excel in their roles and deliver safe, high-quality care
- Expand the HCSW career framework across all job families and continue to grow, the development of 'earn as you learn' opportunities and modern apprenticeships
- Embed the Advanced Practice Framework fully and consistently, ensuring alignment with all national standards and professional guidance
- Promote Clinical Academic Homes to foster career development opportunities, enhance collaboration and develop capacity and capability in the four pillars of practice

How we will do it:

- All staff will have an annual Professional Development Plan (PDP) with specific development objectives as part of TURAS appraisal process
- Support the embedding of Protected Learning Time (PLT) to facilitate education and development
- Collaborate with our HEI partners to provide bespoke learning opportunities and tailored courses

How success and impact will be measured:

- Equitable skills, knowledge and experience across job families at all points in career framework
- Staff functioning at the highest level of their professional scope delivering high quality care

Strategic Objectives

Objective 4 -

NMAHP Staff Who Drive Meaningful Change

NMAHP approaches provide solutions to many of the 'wicked issues' that currently exist in our system. The holistic, pathway-based approach taken by NMAHP practitioners and services provide a blueprint for whole system change locally, regionally and sub-nationally.

What we will do:

- Celebrate success and share best practice from across NMAHP staff and services
- Ensure NMAHP staff are strategically placed to support and influence whole system thinking
- Support a biopsychosocial model of service delivery which makes best use of NMAHP workforce and skillset
- Evidence the benefit of holistic and preventive care by NMAHP, especially in a community setting
- NHS Borders NMAHP leaders will be at the forefront of 'Scotland East' planning relating to clinical pathway design and delivery

How we will do it:

- Ensure NMAHP voices are heard and valued at service, clinical management team, Clinical Board and organisational level
- Equip NMAHP staff through local QI programme
- Ensure NMAHP staffing establishments and workforce planning are fit for purpose to deliver high quality care
- Support the autonomy of NMAHP staff to make positive changes in the workplace to improve care for our patients

How success and impact will be measured:

- Use of QI approach to evaluate and celebrate quality care and improvement
- Use of AHP Professional Forum and PNMLC to share and spread best practice
- Develop performance dashboards related to clinical outcomes and prevention

Strategic Milestones (2025-2031)

Strategic Objective		Year 1	Year 2	Year 3	Year 4	Year 5
NMAHP staff in NHS Borders will feel valued by the organisation, will feel part of a team, and will be supported to bring their whole selves to their role.	Supervision embedded across services	■				
	At least one member of each team will have completed compassionate leadership programme	■	■	■	■	■
	5 point increase in iMatter scores	■	■			
In line with Nursing and Midwifery Council (NMC) and Healthcare Professions Council (HCPC) standards, NMAHP staff have a responsibility to lead the professional and clinical delivery of services. As set out in NES career framework (link) elements of leadership should exist in every job role and every level of the career framework.	Leadership component to be embedded in NQP programme	■				
	Development of Team Lead/ SCN leadership programme	■	■			
	Identification of aspiring leaders	■	■	■		
NHS Borders commits to the development of all NMAHP staff regardless of their job role. The ongoing development across all 4 pillars of practice (link) are relevant regardless of job title, banding or professional background.	Job planning and PLT embedded in all NMAHP teams		■	■		
	Competency frameworks in place for all relevant roles	■	■	■		
NMAHP approaches provide solutions to many of the 'wicked issues' that currently exist in our system. The holistic, pathway approach taken by many NMAHP practitioners and services provide a blueprint for whole system change locally, regionally and sub-nationally.	QI development delivered to 50% NMAHP workforce	■	■	■	■	■
	Development of performance and quality dashboards across NMAHP services		■	■	■	
	Review of workforce establishments and future workforce planning	■	■	■		

NHS Borders
Finance Enabling Strategy

Introduction

Purpose

This purpose of this document is to set out a framework for the actions we will need to take to support delivery of our Clinical Strategy and to become financially sustainable. Being financially sustainable will allow us to make the decisions necessary to achieve our objectives, delivering improved health outcomes for the population of Scottish Borders.

The framework identifies the governance and decision-making structures that will be required to ensure that resources are managed effectively and risks mitigated, whilst creating the conditions for improvement and transformational change. It also outlines the information requirements underpinning this approach, and how these will be met.

Within this framework there is a fundamental shift in how we will plan and develop our services in future, using activity-based commissioning to redirect resources and support restructuring of how health and care are delivered in future within the Scottish Borders.

To successfully make these changes, we will need to consider how this can be achieved within the current economic environment, with increasing pressure on public sector budgets and a corresponding need to deliver increasing value for every public pound.

Where there is a requirement for capital investment to enable transformation, we will develop robust business cases and engage with Scottish Government to make the case for change.

The opportunities presented by digital technologies and new models of care offer a route to improved clinical outcomes and our commissioning approach will support this change through clear measurement of impact and with strong performance management at each stage.

Introduction

Context

Our most recent financial plan identified a projected underlying deficit of £30m before taking actions to address this position. Although we have achieved improvement to our financial position, inflationary pressures and increasing demand continue to drive costs upward. NHS Borders' financial sustainability remains at risk and we continue to balance the challenges of expectation and need, safety, quality and workforce sustainability in a difficult economic climate.

We aim to achieve financial balance within five years. This will only be possible if we work collaboratively with our partners, both locally and regionally, to explore all opportunities for improvement and change.

Over the past 12 months, the Scottish Government has set out a strategic approach to service renewal and reform, both within the NHS and across the wider public sector. This approach recognises the need for the health service to address the requirements of an ageing population, and to reduce the length of waits for urgent and planned care. It is clear however that this demand will need to be made within an increasingly challenging economic environment.

The introduction of sub-national planning frameworks is a key step towards a population health-based planning approach which will drive shifts in how and where specialist and tertiary treatment is delivered and offers opportunities to share common infrastructure to best effect.

Our local approach set out in our organisational and clinical strategies identifies the changes necessary to deliver improved value, increased efficiency, and greater sustainability within the services we provide to the population of Scottish Borders. Our Financial Strategy will seek to support this vision by identifying the actions required to maximise the benefits we deliver for each £pound we spend.

Every day we spend around £1,000,000 (£1m) to deliver healthcare across the Scottish Borders. By creating the conditions by which we can rewire our organisation we will seek to reshape how this resource is deployed to improve outcomes whilst achieving financial sustainability.

Strategic Principles

- We will introduce a new commissioning approach which will support the implementation of strategic shifts in how and where care is delivered across primary, community, secondary and tertiary services.
- We will develop a new prioritisation framework which seeks to promote prevention and early intervention and reduces ‘failure demand’.
- We will improve how we identify, plan and measure the impact of changes in clinical productivity.
- We will continue to maximise efficiency and reduce waste across our cost base through our ongoing financial improvement programme.
- We will develop the case for investment in new technologies and digital transformation.
- We will identify new ways to improve value of our services by working with clinicians to align financial and non-financial information and support delivery of improved outcomes.

Strategic Objectives

Objective 1 - Commissioning Framework

- Our Clinical Strategy sets the direction of travel for changes which will impact on how and where our clinical services are delivered in future.
- Changes in workforce, technology and clinical models offer opportunities to deliver care differently from traditional ways of working.
- By shifting towards a population-health based approach which prioritises prevention and early intervention we will aim to rebalance our system, providing care locally wherever possible whilst ensuring that hospital care is focussed on specialist interventions where this is necessary to deliver the right balance of efficiency and quality.
- In order to manage the changes necessary and to develop a resource plan which supports this shift we are introducing a new commissioning framework. This framework will set out the expected levels of demand and capacity across each of our services and map out the impact of changes in our plan.
- By setting out the plan for both activity and resources this framework will change how we manage and report our performance, focussing on the metrics necessary to drive improvement and deliver our strategy.
- This commissioning approach will be integral to how we make the shift towards new ways of working, managing how we allocate resources and measure the effectiveness of our services.

ACTION: We will develop and implement a new framework for Activity-Based Commissioning for implementation by December 2026.

Strategic Objectives

Objective 2 - Prioritisation Framework

- Making best use of our resources is an essential requirement for how we deliver the outcomes we need to achieve through our Clinical Strategy and, alongside this, improve our financial sustainability.
- Given the pressures on our financial position, it is increasingly important that we understand the relative benefits and risks of every choice which impacts on how we spend our money.
- Our Clinical Strategy sets out the reasons why a shift towards prevention and earlier intervention will support more effective delivery of healthcare. Alongside this we need to ensure that the case for change is supported by clear metrics for how this will increase value and support improvement.
- For every area where we increase our spend, we will need to identify the areas which will release the resources to finance this investment.
- We will introduce a new planning and prioritisation framework which provides a robust mechanism for identifying the potential benefits of each individual proposal. This will be supported by a commissioning approach to business case development.
- Alongside this, our framework will provide a mechanism for relative prioritisation, recognising the competing demands for limited resources and the need to ensure that these resources are directed to the areas where they will deliver the greatest impact.

ACTION: We will introduce a new prioritisation framework in advance of October 2026 and embed this in our annual planning cycle over the next twelve months.

Strategic Objectives

Objective 3 - Improving Productivity

- We know that too many people already wait too long to access our services.
- As our population ages, we anticipate this will further increase demand for our services.
- Our capacity is limited not only by financial constraints but also through availability of workforce.
- We need to maximise the productivity of our clinical services by removing waste from our processes, freeing our clinical teams to concentrate on the interventions which will deliver greatest benefit.
- We will continue to benchmark our services, implementing opportunities identified through national and local workstreams.
- This will include identifying how we can manage increased demand within existing capacity wherever possible.
- We will ensure that the resources are available to support continuous quality improvement across our services, and to measure the impact of this work.
- We will develop a clear plan for how clinical productivity will be measured, identifying opportunities for improvement, and setting goals for how this will be achieved.

ACTION: We will develop an improvement plan which sets out the expected impact of changes in our clinical productivity over the next five years.

Strategic Objectives

Objective 4 - Reducing Waste

- Our financial improvement programme (FIP) has delivered significant savings over the past few years; however, we continue to face increases to costs which exceed growth in our resources.
- As we seek to improve the value of all our services, we will also focus on how we can ensure our expenditure is as efficient as possible through a relentless drive to eliminate unwarranted variation and waste.
- This approach will be underpinned by embedding a Quality Improvement methodology across our services and management teams.
- We will develop a sustainable plan for our workforce which will focus on supporting our staff to deliver high quality care, promoting attendance at work, improving recruitment and retention, and rebalancing workload across clinical professions and services, reducing our reliance on premium rate staffing solutions.
- We will mitigate growth in the costs of our medicines and clinical supplies by ensuring that we implement national and local contracts and price changes which reduce variation in product selection, maximise economies of scale, and ensure effective use of high-cost equipment and supplies.
- We will support clinical services to explore service redesign which will maintain the quality and capacity of services whilst reducing costs by minimising variation, eliminating waste and making structural changes which release resources to direct clinical care.
- We will review our back office and support services to identify where we can improve resilience and reduce overhead costs through introduction of digital processes and by exploring the potential for collaborative working with local and regional partners.

ACTION: We will refresh our financial improvement programme and set out the actions necessary to deliver 3% annual savings over the next five years.

Strategic Objectives

Objective 5 - Digital Transformation

- Constraints on both capital and revenue resources have limited the pace at which we adopt new technologies; this in turn means that we continue to operate services on the basis of a '20th century model'.
- New medical devices and technologies offer opportunity to transform how care is delivered, improving productivity by releasing clinician's time to focus on the interventions where their expertise can deliver greatest impact.
- Developments such as the Digital 'Front Door', will support improvement in how our services are accessed and organised.
- Our current patient administration and business systems are often a barrier to delivering the changes we need to make to improve the quality and productivity of our services.
- Digital health records are a prerequisite for the future of healthcare delivery, supporting effective information flows across clinical pathways and ensuring that citizens and health and care staff can access the information required to deliver effective and timely care.
- We will develop the case for change to support a significant shift in our use of digital technologies, seeking investment from Scottish Government where necessary to achieve the changes set out in our clinical strategy.

ACTION: We will work with clinicians and digital services to develop a business case for digital investment and engage with Scottish Government to seek funding to address this requirement.

Strategic Objectives

Objective 6 - Improving Value

- We know that a significant proportion of healthcare interventions are unnecessary or can be delivered more effectively through a shift in how and where care is delivered.
- Our approach to Value Based Health & Care (VBHC) will help us identify the treatments and interventions which provide greatest benefit to our patients.We will look to eliminate waste in clinical practice by reducing those treatments and interventions which offer limited value.
- Our clinicians have asked us to empower them to make changes to maximise the value of the services we deliver.
- To do this we need to provide information which demonstrates how clinical outcomes are impacted by the choices made throughout the care pathway.
- We also need to model different scenarios so that we can demonstrate the incremental benefit of these choices and to identify the steps we need to take to make these changes by shifting resources across the whole patient journey.
- We will develop our use of patient-level costing and information in order to support clinical decision makers to understand and influence the cost and benefits of their services.

ACTION: We will work with clinicians to improve financial information supporting clinical decision-making and to develop our patient level costing and information system.

NHS Borders
Property Enabling Strategy

Introduction

Purpose

This document sets out our vision for how our estate can become an enabler to safe, sustainable and person-centred care and support delivery of our Clinical Strategy and wider organisational objectives.

We aim to recognise the priorities set by our clinicians, and to make decisions regarding our estate and equipment within the context of whole-system planning, supporting the delivery of effective, high-quality services while maintaining compliance with statutory and regulatory requirements.

Our strategy recognises that available resources will not support large-scale estate replacement or expansion. As a result, the primary focus will be on making best use of existing assets - through improved utilisation, active management of space, repurposing of facilities and targeted investment - ensuring that the estate supports service delivery in the most efficient and sustainable way possible.

The strategy will support the transition of our estate towards integrated community-based hubs, maintaining the role of local facilities as anchors for population health, wellbeing and partnership working. We will also seek to support our clinicians to improve productivity, access and quality of care through the refresh of our medical devices, diagnostic and digital equipment.

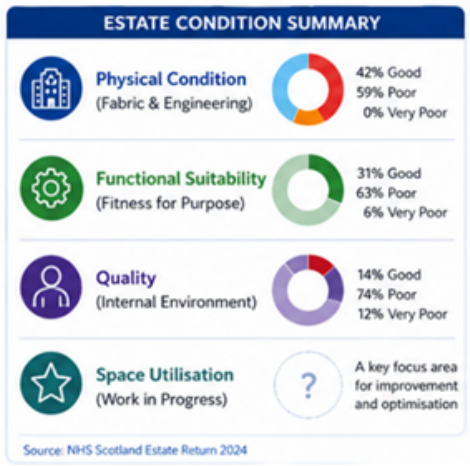
The strategy will also support the transition to more sustainable models of healthcare delivery. This includes reducing the environmental impact of our buildings, ensuring that our estate does not contribute to poor health through greenhouse gas emissions, and placing greater focus on delivering services locally where appropriate, reducing the need for travel for our communities.

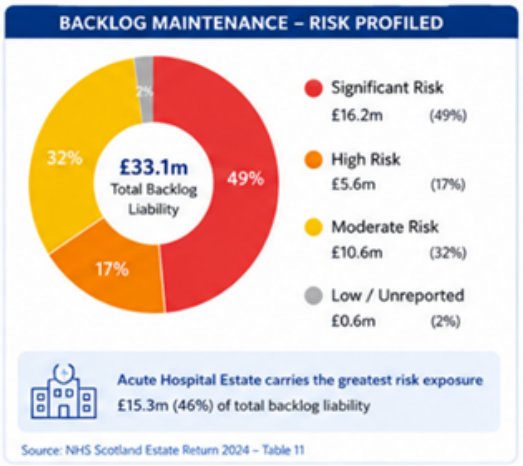
At the outset, the organisation must prioritise the use of limited resources towards maintaining a safe and compliant estate and addressing the highest risk infrastructure issues. Within these constraints, the strategy will provide a clear framework for incremental improvement, transformation and alignment of the estate to the future model of care.

Introduction

Context

Although currently well maintained, our estate is ageing and many of our buildings require significant investment to support their intended life cycle, with other buildings operating beyond their original expected life. Constraints on capital resources have led to an increasing maintenance backlog which continues to grow year on year.





Over the past five years we have undertaken a comprehensive survey of our estate, evaluating the condition and functional suitability of all our properties.

These reviews collectively confirm that, while the estate remains operational, its current configuration and condition do not fully support emerging service models and require a more strategic and prioritised approach to infrastructure planning.

This strategic shift is set out within the clinical strategy, which describes a shift towards prevention, community-based care and reduced reliance on bed-based facilities. This means that we will need to develop our estate to be more flexible, better utilised and able to support new service models across both hospital and community settings. It also requires that we support clinicians through the introduction of the new technologies, equipment and digital infrastructure required to support innovation in diagnostics, treatment and service delivery.

Both through national policy and local strategy, there is expectation that the healthcare estate contributes to improved population health not only through service delivery, but also through reduced environmental impact. This requires a focus on decarbonisation, energy efficiency and sustainable design, alongside supporting models of care that reduce unnecessary travel and environmental burden.

Beyond this, there is a growing requirement for integration across health, social care and third sector partners, with implications for co-location, shared use of assets and place-based service delivery. We will need to work closer with other public sector partners to achieve this vision.

Introduction

Context

NHS Scotland operates within a constrained capital funding environment, and NHS Borders has a heavy reliance on nationally prioritised funding routes. Available funding is insufficient to address the full scale of backlog maintenance and asset lifecycle requirements, resulting in a focus on business continuity and statutory compliance over strategic transformation. This creates a continued tension between sustaining a safe, compliant estate and investing in modern, flexible infrastructure required for future models of care.

The strategy must be grounded in this reality. Transformation will therefore be incremental and prioritised, focusing on maximising the value and effectiveness of the existing estate while creating the conditions for longer-term service modernisation.

OUR ESTATE

75,274 m²	34	£100.2m	£33.1m	69%	98%	96,402 MWh	19,865 t
Total Gross Internal Area (GIA)	Sites	Total Estate Value (Land + Net Book Value)	Total Backlog Liability (Risk Profiled)	of estate between 30–50 years old	Owned Estate (2% Leased)	Energy Consumption (2024/25)	Tonnes CO_2 (2024/25)

Strategic Principles

- We will **maintain a safe environment** for patients, visitors and staff that meets all relevant healthcare standards and legal requirements
- We will **strengthen estate resilience** to ensure continuity of infrastructure and services
- We will **maximise the use of our existing assets**, and their productivity
- We will align new investment with clinical priorities and the **transformation** set out in our clinical strategy
- We will **reduce the environmental impact** of our estate and improve its sustainability
- We will make effective decisions that **deliver best value from our property** assets and that meet the needs of our population

Strategic Objectives

Objective 1 - Safety & Compliance

We will maintain a safe environment for patients, visitors and staff that meets all relevant healthcare standards and legal requirements

We will:

- Using asset information systems and processes, including condition surveys and targeted infrastructure appraisals, to strengthen understanding of estate condition, performance, compliance and assurance levels
- Applying risk-based lifecycle and maintenance planning across critical infrastructure (e.g. medical gases, ventilation, water and essential plant)
- Embedding risk management reporting and escalation through effective governance structures
- Maintaining compliance across our estate with relevant legislation and healthcare guidance (e.g. health & safety)
- Ensuring environments remain clinically suitable and support infection prevention and control (IPC)
- Strengthening governance, assurance and inspection arrangements, including internal reporting, external audit and regulatory readiness

Objective 2 - Resilience

We will strengthen estate resilience to ensure continuity of infrastructure and services

We will:

- Improving our understanding of the condition of the estate and its impact on how services are delivered
- Improving the balance between planned and reactive maintenance to make more effective use of available resources
- Strengthening the reliability of critical infrastructure (power, water, ventilation, digital systems and plant)
- Working closely with services to ensure there is a clear understanding of estate capability, constraints and risks
- Maintain flexibility to support service changes, increased demand or temporary relocation of services
- Support resilience across a dispersed and rural estate, working with partners to enable coordinated response and mutual support
- Effective business continuity and major incident planning

ACTIONS:

- We will ensure that there is a systematic assessment of operational and strategic risk within the healthcare environment and that actions are in place to manage these risks
- We will develop a medium-term business continuity plan (BCP) for our estate which sets out the actions necessary to achieve statutory compliance, manage backlog, and reduce risk within our property assets

Strategic Objectives

Objective 3 - Efficiency

We will maximise the use and productivity of our existing assets

We will:

- Improving our understanding of how our buildings are currently used by gathering information on occupancy and benchmarking analysis
- Establish clear processes for managing and planning for changes in the use of space, linked to service need and organisational priorities
- Begin to better align estate use with service activity and demand, recognising current constraints across the estate
- Identify opportunities to reduce underused or inefficient space by improved scheduling and room booking
- Explore opportunities to reduce demand for physical space through digital solutions and new ways of working
- Support shared use and co-location of services where appropriate, working with internal teams and partners

Objective 4 - Transformation

We will align new investment with clinical priorities and the changes set out in our clinical strategy

We will:

- Working with clinicians to understand their requirements and explore options for how this can be supported
- Identifying practical opportunities to reconfigure and improve use of existing space wherever possible
- Supporting changes in how our community estate is used to reflect new models of care
- Identifying actions to support the implementation of new technologies and medical devices within both our digital and physical estate
- Ensuring that when investment is required it is targeted at solutions which both enhance service delivery and reduce risks within our estate
- Working with public and third sector partners to support integration, population and place-based planning

ACTIONS:

- Undertake a review of how space is managed across our estate and implement processes to improve utilisation and to align how space is used with the aims of our clinical strategy
- Re-establish a pipeline for minor works requests which supports our services to deliver the changes they need to improve patient experience and outcomes
- Develop our Whole System Infrastructure Plan (WSIP) and undertake Strategic Assessments (SA) which support the case for capital investment and long term infrastructural renewal

Strategic Objectives

Objective 5 - Sustainability

We will reduce the environmental impact of our estate and improve its sustainability

We will:

- Promoting more sustainable use of buildings and resources, reducing waste and improving overall efficiency, including opportunities to reduce travel through more localised and community-based service delivery
- Improved understanding of energy performance, carbon impact and sustainability performance across the estate using national tools and systems
- Embedding sustainability within all of our estate planning and capital investment decisions
- Strengthening organisational capability and focus on Net Zero and carbon reduction, supported by a clear decarbonisation plan and ongoing monitoring of progress
- Maximising opportunities for external funding, grants and partnership investment to support delivery of sustainability initiatives
- Work with partners through local sustainability and climate groups to support coordinated planning, shared learning and delivery

Objective 6 - Value

We will make effective decisions that deliver best value from our property assets and that meet the needs of our population

We will:

- Ensuring that decisions are taken within a wider organisational governance structure which supports effective decision making
- Maximising value from existing assets through effective use of space, resources and infrastructure before pursuing new build or large-scale expansion
- Applying clear and consistent prioritisation, balancing risk, service need, benefit and affordability
- Ensuring investment delivers measurable outcomes (including quality, access, sustainability, resilience and workforce benefit), and monitor how value is realised over time
- Seeking opportunities to leverage external funding, partnerships and shared investment opportunities to maximise value within limited resources
- Making the case for investment to Scottish Government, setting out how our strategy will deliver outcomes for our population

ACTIONS:

- We will refresh our climate adaptation and decarbonisation plans, setting out the actions we are taking to contribute to the reduction of greenhouse gas emissions
- We will refresh our capital governance and implement a prioritisation framework which balances the need the delivery of strategic outcomes with the need to manage operational risk

NHS Borders

NHS BORDERS
SOCIAL COMPACT

WHAT TO EXPECT IN OUR SOCIAL COMPACT

- Social Compact Overview
- Owning our need to improve
- Creating space for improvement
- Developing our improvement capability
- Maximising NHS Borders Employee Benefits

SOCIAL COMPACT OVERVIEW

Creating the conditions that help everyone deliver safe, compassionate and excellent care.

NHS Borders Commits to:	Our Staff Commit to:
Clear direction and vision guided by our True North Statement	**Working towards** one shared goal and vision across the organisation
Building improvement skills for all	**Continuous** improvement Mindset
Creating protected time for development and improvement	**Using** protected time purposefully
Embedding our Values and Behaviours in our culture	**Living** our shared values and behaviours everyday
Create a culture where everyone feels safe to speak up & raise concerns.	**Creating** a psychologically safe workplace for everyone
Staff benefits and wellbeing that are accessible and meaningful	**Actively** support their wellbeing

OWNING OUR NEED TO IMPROVE

Our True North Statement

Our mission 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.

> We commit to putting staff, patients and communities first, guided by our True North statement.

At NHS Borders, we recognise that improvement begins with acknowledging where change is needed. **Our True North Statement** gives us a clear direction to achieve together, and anchors us in shared values of **Compassion**, **Kindness**, **Integrity**, **Teamwork** and **Excellence**. We work openly recognising the pressures on our services and the gap between our current performance and our aspirations, working together collaboratively to improve services for the patients and communities we serve.

Improvement is a **shared** responsibility. Through our Social Compact, we commit to:

- Working collaboratively to learn continuously
- Ensure every role contributes meaningfully to better outcomes.
- Creating the right conditions to work and learn in through our behavioural framework

Our Values

Compassion

Integrity

Excellence

Kindness

Teamwork

Our Behavioural Framework

NHS Borders

Compassion

Behaviours we will promote

- Listening actively to staff, patients, and families, showing empathy and understanding
- Treating people as individuals, not just as roles or numbers
- Supporting colleagues during difficult times, both personally and professionally
- Being non-judgemental, especially in emotionally charged situations
- Recognising the impact of decisions on staff wellbeing and showing genuine concern

Behaviours we will not accept

- Dismissive attitudes toward staff concerns or ideas
- Judging or making assumptions about others without understanding their context
- Ignoring emotional wellbeing, especially during times of stress or personal difficulty
- Disrespectful language or tone, including shouting or berating
- Failure to recognise individual needs, treating people as tasks rather than humans

Integrity

Behaviours we will promote

- Doing the right thing even when no one is watching
- Being honest and transparent in communication and decision-making
- Taking accountability for actions and owning mistakes
- Treating people fairly, regardless of role or background
- Following through on commitments and promises made

Behaviours we will not accept

- Dishonesty or withholding information, especially in decision-making
- Taking credit for others' work or manipulating achievements
- Passive-aggressive or threatening behaviour in communication
- Inconsistency in applying policies, leading to unfair treatment
- Lack of accountability, including avoiding responsibility or blaming others

Excellence

Behaviours we will promote

- Striving to do the best possible job, not settling for "good enough"
- Seeking feedback and using it to improve performance
- Ensuring staff have the right skills and training to perform at their best
- Driving continuous improvement and embracing change
- Maintaining high standards in care, communication, and professionalism

Behaviours we will not accept

- Settling for mediocrity, doing the bare minimum or cutting corners
- Resistance to feedback or change, especially when improvement is needed
- Failure to provide training or development opportunities, limiting staff potential
- Tolerance of poor performance, especially when it affects patient care
- Undermining professional standards, such as ignoring uniform policies or best practices

Kindness

Behaviours we will promote

- Checking in on colleagues, especially after difficult meetings or personal challenges
- Being pleasant and tolerant, even in stressful situations
- Expressing gratitude and appreciation regularly.
- Choosing kindness in interactions, even when giving constructive feedback
- Avoiding gossip and exclusion, promoting inclusivity and respect

Behaviours we will not accept

- Bullying, intimidation, or patronising behaviour, especially toward junior staff
- Exclusion or cliques, creating division within teams.
- Insensitive feedback, lacking empathy or constructive intent
- Disrespecting personal circumstances, such as health or caring responsibilities
- Manipulative or selfish actions, prioritising personal agendas over team wellbeing

Teamwork

Behaviours we will promote

- Collaborating across departments, not working in silos
- Respecting everyone's role and contribution to the team
- Supporting each other during busy or challenging shifts
- Creating psychologically safe environments for open discussion
- Sharing learning and celebrating success together

Behaviours we will not accept

- Not pulling your weight, leaving others to carry the workload
- Poor communication, including changing plans without notice or failing to listen
- Siloed working, refusing to collaborate across teams or departments
- Sabotaging others' efforts, including jealousy or favouritism
- Blame culture, avoiding shared responsibility and undermining trust

CREATING SPACE FOR IMPROVEMENT

To support meaningful and sustainable improvement, we recognise that everyone needs space, time and the right environment to reflect, problem-solve and test new ideas. Through the Social Compact, the organisation commits to embedding **space for improvement** to ensure this work is not an added burden but a core part of how we function. This investment reflects our belief that those closest to the work are best placed to identify opportunities for change, and that improvement must be woven into everyday practice, not squeezed in around it.

Time to improve, time to reflect, time to innovate

Having the opportunity to problem solve, review processes or try small tests of change

What does this mean for me?

You, as the people closest to the work shaping the future

Being part of a safe environment to reflect, share and try new ideas

DEVELOPING OUR IMPROVEMENT CAPABILITY

Building strong improvement capability is essential to delivering our **True North Statement**. NHS Borders is committed to equipping all staff with the skills, tools and confidence needed to improve care. Through our Quality Enabling Strategy, we are embedding consistent QI methods, better use of data, human factors principles and supportive systems that make problem solving part of everyday work.

Quality Improvement Academy

Our QI Academy is central to this effort. It consists of a four-tier training model; **Foundation, Champion, Practitioner** and **Advanced** to ensure that you can access the right level of improvement learning suited to you. The Academy's faculty provides the skills to support real-world improvement aligned with our ambition that **all staff are equipped and empowered to drive continual quality improvement.**

Together, the QI Academy and our organisation-wide improvement approach aims to create the conditions where everyone has the skills they need to resolve the issues they encounter, understand how they are doing and what they can do to improve as part of a continuous cycle of improvement.

Our Vision

We all have the ability to improve how we do things in NHS Borders which collectively will make a big difference. This all contributes to ensuring that improvement becomes a natural, routine part of how we all work collaboratively within NHS Borders.

MAXIMISING NHS BORDERS EMPLOYMENT & WELLBEING BENEFITS

We are committed to ensuring that our staff can access the full range of benefits available to them, enhancing both financial wellbeing and overall quality of working life. As part of our Social Compact, we are increasing the visibility of our existing benefits and staff wellbeing options, alongside expanding the range of options on offer to you. This includes exploring new salary sacrifice schemes for items such as cars and household goods, enabling staff to potentially save on tax, and benefits received through National Insurance and pension schemes.

Exisiting Benefits

- Blue Light Card Discount
- Cycle to Work Scheme
- Money Worries App
- Library Services
- Gym Memberships
- Continued Development
- Staff Wellbeing
- Progressive Workforce Policies

To view the full range of both staff benefits and staff wellbeing opportunities that are available to you, please **click here** to be taken to the resources on the Intranet.

Delivering Our Strategy – Programme Structure for 2026/27 Deliverables

Clinical Transformation

Supporting People to Keep Themselves Well

Ensuring that Primary & Community Services can support as many people back to good health as possible

Making Secondary Care Fast, Efficient and Effective

Ensuring equity of access for our patients who require access to tertiary services

Population Health Programme Board

Urgent & Unscheduled Care Programme Board

Planned Care Programme Board

Mental Health & Learning Disabilities Programme Board

Women & Children Services Programme Board

Business Transformation: Enabling Strategies

QMS: Leadership Pillar

- Quality
- Risk
- Research & Innovation

QMS: Business Process Pillar

- Digital*
- Property & Sustainability
- Finance

QMS: Partnerships Pillar

- Partnerships

QMS: Staff Pillar

- People

Financial Recovery & Sustainability

- Foundational Governance
- Core workstreams
- Clinical productivity
- Local service plans
- Strategic budget review group

Business Systems

- Workstreams TBC

**Programme Board will oversee the operational delivery and transformation activity within scope of the digital programme. Where change requires underpinning business processes development or redesigned, the Board will utilise the Business Processes Pillar to develop the necessary process*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Director of Public Health Annual Report**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti, Director of Public Health**
Report Author:	**Dr Sohail Bhatti supported by Kirsty Kiln, Consultant in Public Health**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging issue

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

- Person Centred

2 Report summary

2.1 Situation

This is an independent professional assessment intended to inform strategic decision-making across NHS Borders and partner organisations. It sets out an overview of the health and wellbeing of children and young people in the Scottish Borders, highlighting the most pressing issues affecting outcomes across early years and adolescence and making recommendations. The Board is asked to comment on the recommendations and note the plan for publication of the report.

2.2 Background

An ageing population increasingly shapes strategic focus and service planning in NHS Borders. While this attention is necessary, it has meant that the needs of children and young people have, at times, received comparatively less system-wide oversight. The report highlights that, although older adults have rightly been a major priority, it is essential that the needs of children are not overshadowed within a region where their proportion of the population is smaller than the national average.

2.3 Assessment

Health inequalities take root long before a child reaches school age, and our own NHS Borders data show that these disparities are evident from birth. Local analysis demonstrates that maternal health, pre-conception wellbeing and early pregnancy behaviours strongly shape outcomes and can set diverging life-course trajectories from the very start.

Childhood is being reshaped by a set of rapidly emerging risks that intersect with, and often deepen, existing inequalities. Rising screen time and exposure to online harms are increasingly affecting sleep, attention, physical activity and mental wellbeing. At the same time, the normalisation of ultra-processed foods, reinforced by local high-street environments dominated by cheap, calorie-dense options, present significant threats to healthy growth, metabolic health and long-term weight outcomes, particularly for families facing financial constraint. The landscape of need is also shifting, with practitioners consistently reporting a rise in autism and wider neurodevelopmental concerns, alongside growing pressure within CAMHS and related pathways. These challenges demand whole-system responses.

2.3.1 Quality/ Patient Care

Not directly applicable

2.3.2 Workforce

Not directly applicable

2.3.3 Financial

The report sets out the challenges identified and sets recommendations for further exploratory work; there are currently no financial implications. That said, investing in prevention and early intervention is cost-saving to the system at large.

2.3.4 Risk Assessment/Management

Not directly applicable

2.3.5 Equality and Diversity, including health inequalities

At this stage, there is no need for an impact assessment. As plans are developed to take forward any recommendations, detailed impact assessments will be required.

2.3.6 Climate Change

Not directly applicable

2.3.7 Other impacts

Need to strengthen partnership approaches to ensure that whole-system change around children’s services and preventative activities is taken.

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.

- Discussions with health visitors and school nursing representatives – Jan 2026;
- Discussions with colleagues in Education in SBC – Dec 2024 to date;
- Discussions with other children's services, including dietetics, Childsmile, Vaccination and Immunisation – Dec 2024 to date.

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.

- Not applicable – independent report

2.4 Recommendation

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

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

- **Significant Assurance**

3 List of appendices

The following appendices are included with this report:

Appendix No 1, Powerpoint overview of the report and its recommendations
Appendix No 2, Director of Public Health Annual Report 2025

NHS Borders

Our Future Selves

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

The Director of Public Health Annual Report

2025

Dr Sohail Bhatti | Director of Public Health

Purpose & Scope

- Provide an independent professional assessment to inform & challenge decision-making across the Scottish Borders. The Board has to receive the Report and take whatever action it deems from the recommendations. It is TO the Board, not the Board's report to itself.

- Focus on the health and wellbeing of children and young people in the Scottish Borders, with an emphasis on prevention across the life-course.

- Surface key challenges, inequalities and opportunities.

- Set out clear, actionable recommendations to improve outcomes.

The Population of Children & Young People

- 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). With an ageing population, it is easy to give less attention to the relatively smaller proportion of children and young people but each has a family too….

- The Scottish Borders continues to experience a notably low birth rate, now well below the Scottish average. The area faces ongoing natural population decline, driven by sustained low fertility and an ageing population structure.

Concerted Action

My report sets out recommendations to strengthen how we meet the health and wellbeing needs of children and young people in the Scottish Borders.

- It starts with the need for clear governance and effective oversight, so responsibilities are defined and progress can be monitored.
- It calls for targeted action to reduce health inequalities.
- It emphasises shaping environments that enable healthy choices and promote healthy starts.

Health Inequalities

Health inequalities start before birth, are already evident by the time children begin school, and can persist throughout life. In the Scottish Borders:

- Health visitors report that **42% of children are growing up with a parent who has a mental health condition**, with higher rates in more deprived areas.
- Maternal smoking is highly influenced by socio-economic status. **30% of mothers in the most-deprived group are smokers** and only 1% in the least deprived group.
- **Maternal obesity affects 10% more mothers in the most deprived group**.
- There is also a **23.3 percentage-point gap between the most and least deprived areas in the proportion of children with a healthy weight.**
- For oral health, **57.4% of children in the most deprived group have no tooth decay**, compared with 84.9% in the least deprived group.
- Uptake of the HPV vaccine among S1 pupils is around **25% lower in the most deprived communities** than in the least deprived.

What people have told us…

Frontline professionals in the NHS, Education and Children's Services more widely have spoken with us. Consistent themes have emerged:

- Intervening early is vital, but services face rising complexity and demand
- Care-experienced children require consistent, trauma-informed and coordinated support, with clearer corporate parenting responsibilities across services.
- Emotional health and wellbeing needs are increasing among pre-adolescents and adolescents, contributing to anxiety, low mood, school avoidance. Parents of older children often lack accessible parenting support, despite increasing behavioural, emotional and developmental challenges during this time.
- System gaps, including fragmented community planning, limited neurodevelopmental pathways (especially 0–5), **and** significant workforce constraints, hinder coordinated responses to poverty of opportunity, unmet need and early identification.

Recommendations

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 Integration Joint Board (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

Recommendations

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

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.

Recommendations

6. Embed ACEs Informed Practice and Strengthen Prevention

- The Borders should adopt a consistent, trauma-informed approach to the collection and use of Adverse Childhood Experiences (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.

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.

Recommendations

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 care management capability within parents/guardians waiting for CAMHS assessment for their children

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.

Recommendations

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. This should include providing clear, evidence-based guidance on recommended screen time limits for different ages, and tailored support for those facing additional pressures such as parental stress, financial strain or limited access to alternative activities.

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

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

CONTENTS

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

INTRODUCTION

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.

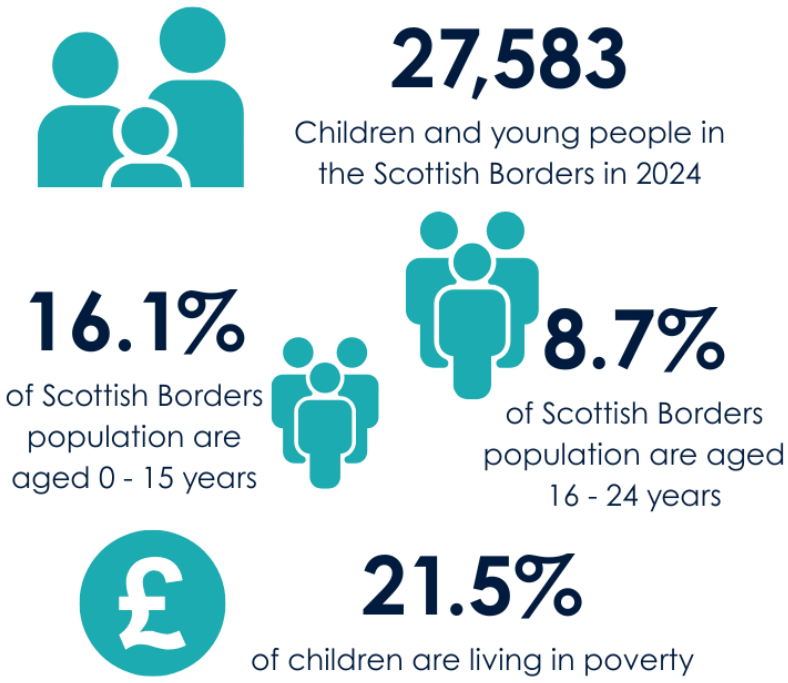
By bringing together evidence, lived experience and the perspectives of partners across sectors, this report invites us to recommit to a shared ambition: that every child in the Scottish Borders grows up with strong foundations for lifelong health and wellbeing.

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.



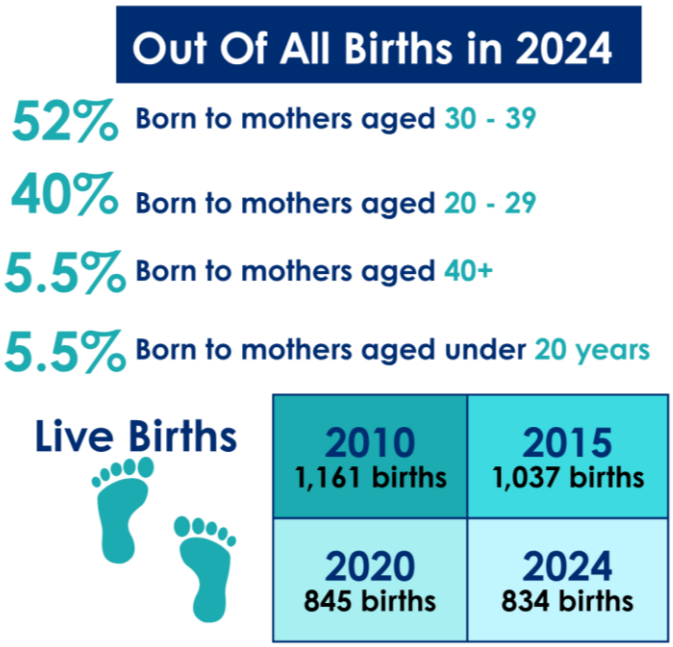
CHAPTER 1
THE DEMOGRAPHICS OF THE BORDERS

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.

CHAPTER 2
OVERARCHING ISSUES

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

CHAPTER 2
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.

CHAPTER 3
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:

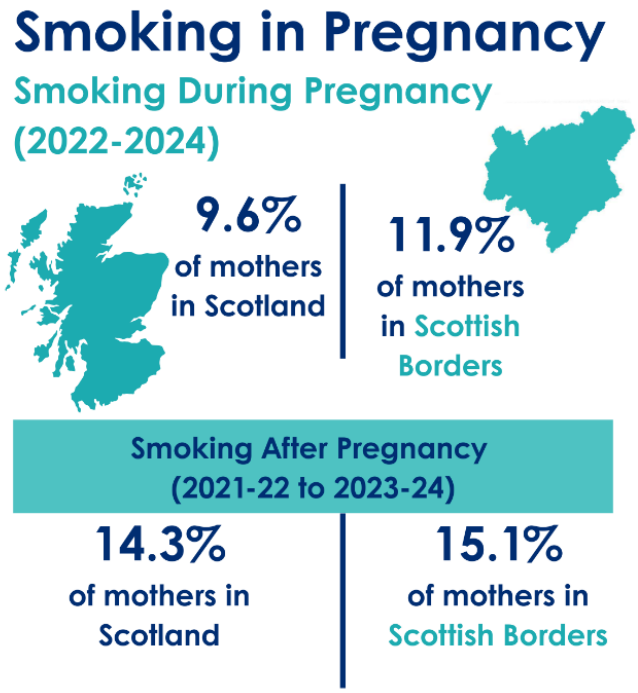
- nutrition,
- mental wellbeing,
- smoking,
- alcohol use, and
- long-term conditions before pregnancy.

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.

CHAPTER 4

SUPPORTING CHILDREN TO HAVE THE BEST START

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.

CHAPTER 4

SUPPORTING CHILDREN TO HAVE THE BEST START

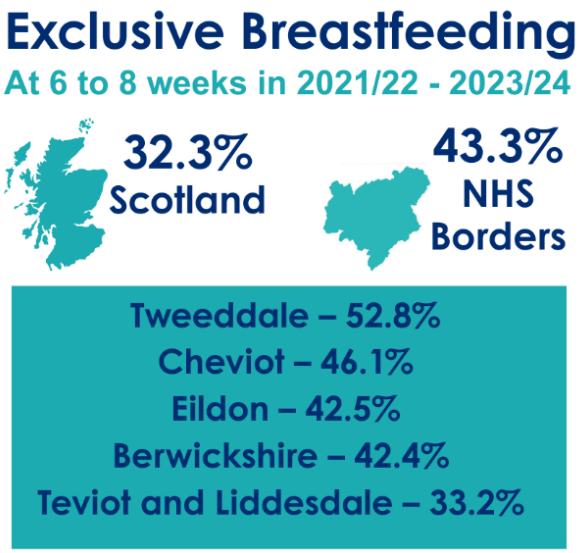
Focus has been placed on:

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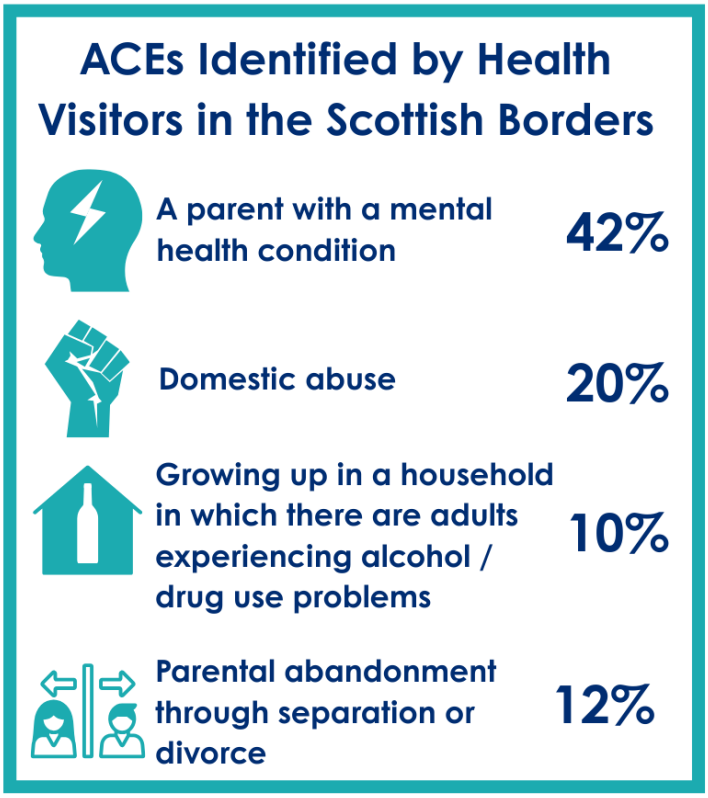
We want to better understand how we can reduce issues in data collection and also consider how we can use the data to understand where there is greatest need for early intervention and support is.

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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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

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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.

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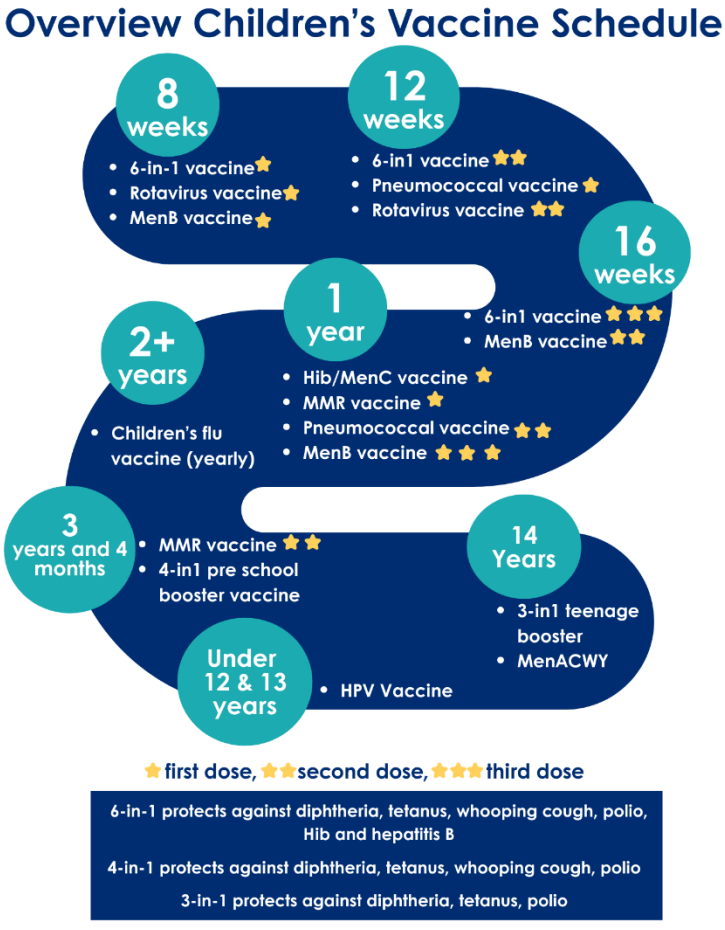
Vaccination

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.

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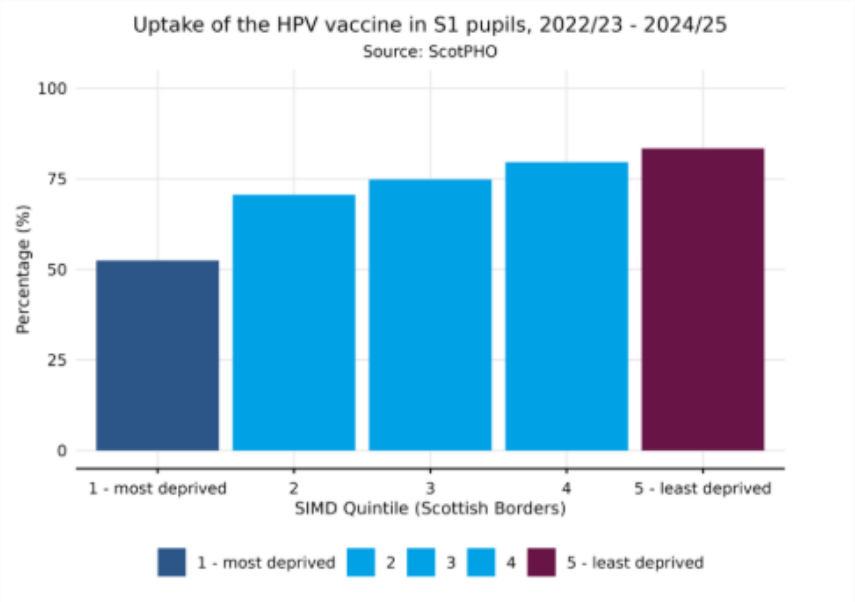
The HPV vaccine is transforming the landscape of cervical cancer prevention by targeting the virus responsible for most cervical cancer cases. Routine HPV immunisation, now offered from S1 onwards, protects against the high-risk HPV types that cause cervical, anogenital, and head and neck cancers, with 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.

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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.

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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.

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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.

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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

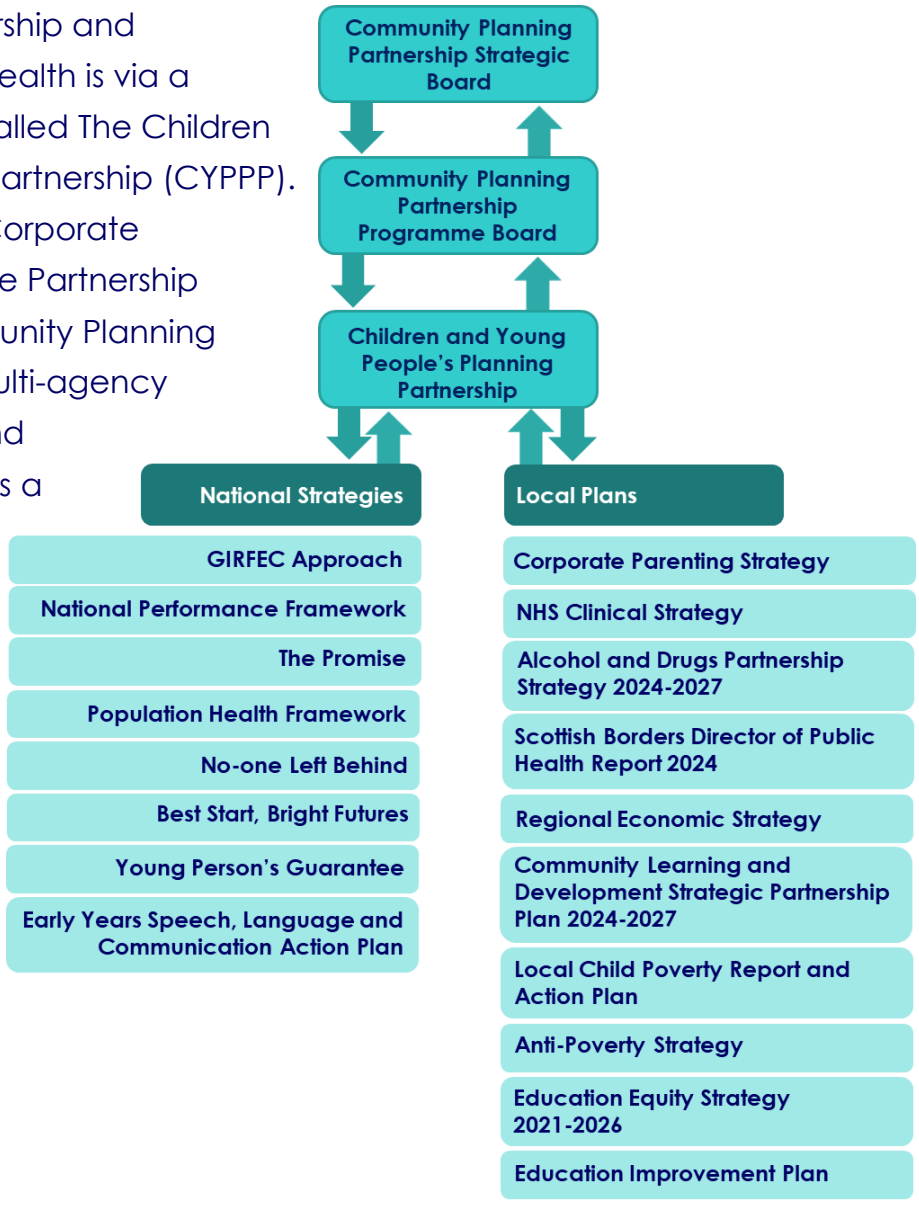
safer and more supportive. In practice, this means designing and investing in welcoming, accessible places and programmes that are affordable and inclusive for people of different ages and abilities.

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.

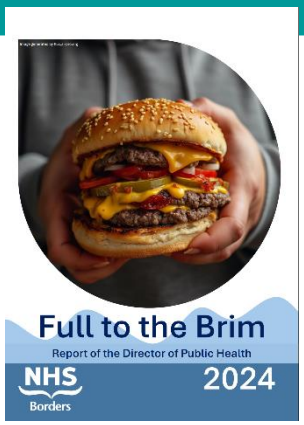
11 Reducing Screen-Time and Promoting Healthy Routines

- 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.

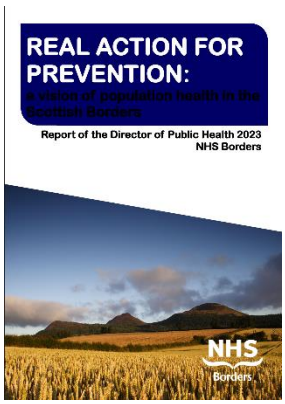
ANNEX 1
REVIEW OF PREVIOUS DPH REPORTS



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

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Infection Prevention and Control**
Responsible Executive/Non-Executive:	**S Horan, Director of Nursing, Midwifery & AHPs**
Report Author:	**S Whiting, Infection Control Manager**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

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

- Safe

2 Report summary

2.1 Situation

This report provides an overview for NHS Borders Board of infection prevention and control with particular reference to the incidence of Healthcare Associated Infections (HAI) against Scottish Government targets.

2.2 Background

The Scottish Government requires reports on infection surveillance and monitoring of key topic areas impacting on the prevention and control of infection to be discussed as part of bi - monthly Board meetings and published on NHS Board websites.

2.3 Assessment

Contents

1.0 Executive Summary

1.1 This report provides the NHS Borders Board with an update on Infection Prevention and Control (IPC) performance for April 2026, with a particular focus on healthcare associated infections (HAI), system controls, outbreak management, and progress with priority quality improvement programmes.

1.2 Surveillance data demonstrate no statistically significant change in healthcare associated ***Clostridioides difficile*** **infection (CDI)** or ***Escherichia coli*** **bacteraemia (ECB)** since the previous reporting period, and NHS Borders achieved the 2025/26 Scottish Government HAI standards for both infections. In contrast, ***Staphylococcus aureus*** **bacteraemia (SAB)** performance did not meet the national standard for 2025/26, although case numbers remain stable. Recent SAB cases have been primarily associated with peripheral venous catheters (PVCs), skin and soft tissue infections.

1.3 Process measures provide generally positive assurance, with cleaning standards consistently meeting national requirements, robust audit arrangements in place, and admission screening for MRSA and CPE performing well compared to national benchmarks. Mandatory IPC training compliance has increased by 3% from last month.

1.4 Quality improvement activity continues across key risk areas, including CAUTI prevention, PVC safety, hand hygiene, and standardised cleaning documentation, with several initiatives progressing through testing and implementation phases. Overall, the report provides moderate assurance that IPC arrangements remain effective, with clearly defined improvement actions in place to address identified areas for continued focus.

1.5 All graphs and tables referenced in the report are provided in Appendix A.

2.0 Outcome Measures - Infection Surveillance

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

- There has not been any statistically significant change in healthcare associated (HAI) CDI cases since the last report (**Figure 1**)
- NHS Borders achieved the Scottish Government HAI CDI standard for 2025/26 (**Figure 2**)
- Learning from recent HAI CDI case: poor documentation of patient symptoms
  - Action taken: implementation of sticker in patient notes to prompt appropriate response
- 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, C**

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

- There has not been any statistically significant change in the number of HAI ECB cases since the last report (**Figure 3**)
- NHS Borders achieved the Scottish Government HAI ECB standard for 2025/26 (**Figure 4**)
- A review of 3 recent HAI ECB cases identified no care failings. The review highlighted the importance of recognising increased infection risk and diagnostic complexity following healthcare abroad, surveillance limitations with some cases having no identifiable source despite investigation, and the need for early multidisciplinary input when infection occurs in patients with significant co-morbidities.
- Urinary catheters and Lower Urinary Tract Infection (UTI) are the primary cause of ECB infections (**Figure 5**)
- Measures to reduce the risk of ECB:
  - Avoid using urinary catheters when possible, maintain urinary catheters in accordance with NHS Borders Policy, remove urinary catheters at the earliest opportunity (**Section 5.1**)
  - Cases of UTI associated ECB are being reviewed to identify any learning for improvement. No specific learning outcomes have been identified to date

Background information and explanation is provided in **Appendix A, B and C**

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

- There has not been any statistically significant change in the number of HAI SAB cases since the last report (**Figure 6**)
- NHS Borders did not achieve the Scottish Government HAI SAB standard in 2025/26 (**Figure 7**)
- The main known recent causes of HAI SAB cases were skin / soft tissue and Peripheral Venous Catheters (PVC) (**Figure 8**)
- Learning from recent HAI SAB case: incomplete PVC documentation
  - Action taken: Quality Improvement project focussed on PVC management and documentation
- Measures to reduce the risk of SAB:
  - Avoid using urinary catheters when possible, insert and maintain in accordance with NHS Borders Policy, remove at the earliest opportunity (**Section 5.1**)
  - Avoid using PVCs when possible, insert and maintain in accordance with NHS Borders guidance, remove at the earliest opportunity (**Section 5.2**)
  - Adult inpatients (excluding Mental Health and Maternity) should be screened for Methicillin-resistant *Staphylococcus aureus* (MRSA) (**Section 3.5**)

Background information and explanation is provided in **Appendix A, B and C**

2.4 Surgical Site Infection (SSI) Surveillance

- The Scottish Government paused the requirement for mandatory surgical site infection (SSI) surveillance on the 25th of March 2020. There has been no indication of a potential date for re-starting national SSI surveillance. NHS Borders continues to conduct local SSI surveillance
- There has not been any statistically significant change in the SSI rate for C-Sections or following hip / knee replacement surgery (**Figure 9 and 10**)
- A review of hip and knee SSI cases in 2025 has been completed. Of the 9 confirmed SSIs cases reviewed, the majority (78%) were classified as superficial incisional infections. The following key learning points were identified:
  - SSIs arise from combined (not single) factors. Patient vulnerability, particularly obesity and poor skin integrity materially increases risk
  - Delayed orthopaedic assessment despite evolving wound concerns with multiple community reviews without escalation
- A recently constituted SSI Forum is progressing actions to reduce delays in escalating orthopaedic assessment following surgery

2.5 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 11** shows the number of deaths per month where *C.difficile, E.coli* or *S. aureus* (including MRSA) was noted on the death certificate and the person's primary place of residence at time of death was within the Scottish Borders. This data is based on specific codes in the data to indicate these infections. The graph should be interpreted with caution due to variation in the recording of infection on death certificates by doctors and the potential for human error in subsequent coding attributed to the narrative on the certificate.

3.0 Process Measures

3.1 Hand Hygiene – Key Messages

- An update on hand hygiene is included in the Quality Improvement update (**Section 5.3)**

3.2 Cleaning – Key Messages

- Cleanliness is monitored in accordance with national standards
- There is a national target to maintain overall compliance with standards above 90%
- **Figure 12** shows that of the areas audited, all audited areas scored above the standard 90% in March except for one area that achieved 78%. Any area that does not reach this standard should have the issues rectified and the area re-audited within 21 days. When this area was re-audited, the cleanliness score was 93%
- In **Figure 12** '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
- NHS Borders compliance is comparable with NHS Scotland (**Figure 13**)

3.3 Audit – Key Messages

- All management actions in response to the 2024 infection control internal audit report have been completed (**Figure 14**)
- Between February & March 9 full audits were completed with all audited areas achieving a 'Green' status
- Between February & March, 16 spot checks were completed resulting in 2 areas achieving an 'Amber' status. The remaining areas achieved 'Green' status with a score of 90% or higher
- Recurring themes from the audits and spot checks:

Recurring themes of good practice

- Good PPE practice
- Hand gel dispensers clean and working
- Waste managed correctly

Recurring themes of poor practice

- Single patient use items in communal items
- Dirty commodes
- Temporary closures on sharps bins not in use

- 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
- New cleaning documentation has been implemented in BGH. Spread to other areas will progress in 2026
- Themes from spot checks and audits are used to inform content of staff education delivered by the Infection Prevention and Control Team
- An established audit and spot check follow-up process is used to determine the timescale for follow-up based on the outcome of each visit

3.4 Care Home visits

- The Infection Prevention and Control Team provide support to care homes in the Scottish Borders. A care home audit tool is used to ensure consistency in approach and to support an objective assessment with a 'Red', 'Amber' or 'Green' (RAG) status to inform further action.

- In February and March - 9 care homes were visited with 7 scoring 'Green' and 2 scoring 'Amber'

3.5 HAI Risk – Inpatient Admission Screening

- MRSA screening of adult inpatients (excluding Maternity and Mental Health services) is mandatory in Scotland (DL 2019 23)
- MRSA admission screening compliance is monitored monthly for the main admitting wards within BGH (**Figure 15**)
- Carbapenemase-producing enterobacteriaceae (CPE) inpatient screening is mandatory in Scotland (DL 2019 23)
- CPE admission screening compliance is monitored monthly for the main admitting wards within BGH (**Figure 16**)
- In Quarter 3 2025, NHS Borders had a higher level of compliance with MRSA and CPE screening than NHS Scotland (**Figure 17**)
- Monthly compliance reports are fed back to the Senior Charge Nurse and Clinical Nurse Manager for the relevant wards

3.6 Mandatory Training

- On 1st April 2026, NHS Borders overall staff training compliance was:
  - Infection Control – Core Mandatory E-Learning Module (all substantive staff) 85%. This is an increase of 3% from last month
  - NES Hand Hygiene – Role Mandatory E-Learning Module (all relevant substantive staff) 39%. This is an increase of 2.6% since 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 18**) and the risk to patients (**Figure 19**) to determine the class of precautions to be implemented (**Figure 20**).
- 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
BGH Bus stop	Type 3	Highest	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
Aseptic suite, BGH	Type 3	High	Class III / IV
BMC - water system	Type 4	High	Class III / IV
Lift refurbisment / replacment (BGH)	Type 2	Highest	Class III / IV
Flooring replacement (Radiology)	Type 2	High	Class II
Hawick GP walk-in service	Type 3	High	Class III / IV
Surgical wing roof overlay	Type 3	High	Class III / IV
Moss removal Hawick Community Hospital	TBC	Low	
Mamography - water system	TBC		
Remedial works in ED	TBC		
BGH public changing space	TBC		

4.0 Adverse Events / Outbreaks / 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
- During March 2026, there were 2 minor incidents reported

4.2 Outbreaks – Key Messages

- Since the last update, there have been 16 closures in NHS Borders. Detail of each closure is reported under **Figure 21**.

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. A catheter process map has been completed for district nurses and CTAC services. Separate catheter process mapping sessions are being arranged for nursing homes. Subsequent sessions will be organised for community hospitals and BGH.
- The CAUTI Task and Finish Group continues to progress with their specific remit:
    - Develop new urinary catheter documentation to replace the existing Catheter Passport used by staff in the acute setting
    - Develop or recommend a patient information leaflet to support safe catheter use and self-care
    - Review and update NHS Borders Urinary Catheterisation Policy to ensure alignment with current best practice
- The Task and Finish Group has developed a catheter insertion and change sticker, daily maintenance bundle and a discharge checklist to support continuity of care.
- Testing of the new documentation began on a ward in BGH December 2025. Initial engagement was slow due to staffing and site pressures. Engagement has since improved along with testing in a further inpatient ward in BGH and two community hospitals. The "Study" phase of this pilot is continuing. Staff are currently using the documentation during catheter insertion and maintenance.
- A staff survey will be conducted in May 2026 seeking feedback on the national urinary catheter passport which is a patient-held-record. Feedback will be key to informing development of improved resources for conveying key messages to patients and improving documentation and communication between professionals.
- The Task & Finish Group is also exploring utilisation of Trakcare to see if content regarding catheters can auto populate onto discharge letters.

5.2 Peripheral Venous Catheter (PVC)

- The improvement project aims to improve the safety and quality of peripheral vascular catheter (PVC) use across acute inpatient areas by:
    - Standardising documentation and improving access
    - Improving staff knowledge
    - Strengthening audit processes
- Current Excellence in Care (EiC) audits show variable completion of PVC insertion and maintenance records. This increases patient risk of phlebitis, avoidable cannulation attempts, and healthcare-associated infections (HAI).

- IPC will provide regular progress updates through the EiC governance structure to ensure oversight.

5.3 Hand Hygiene

- The table below shows the most recent hand hygiene audit results completed in April 2026 by staff group

Hand Hygiene Audit Compliance byStaff Group

April 2026	Overall Compliance by Staff Group
General Services/Other	
Opportunities observed	20
Opportunities taken	15
Compliance	**75%**
Nursing	
Opportunities observed	163
Opportunities taken	108
Compliance	**66%**
Medical	
Opportunities observed	43
Opportunities taken	25
Compliance	**58%**
Allied Health Professionals	
Opportunities observed	20
Opportunities taken	11
Compliance	**55%**

- There has been significant support to improve hand hygiene compliance including:
  - Ensuring adequate infrastructure and accessibility to hand gel
  - Visible prompts and reminders
  - Policies, protocol and guidance to support compliance
  - IPC developed and promoted short videos about hand hygiene

- IPC delivered proactive back-to-basics education
- IPC deliver reactive education when poor practice is observed
- IPC conduct regular audits with feedback including compliance by staff group and WHO hand hygiene 'moment' in a poster format
- IPC offer targeted Quality Improvement (QI) support following each round of audits

- Further work to improve hand hygiene will require more focus on local leadership, culture and accountability in clinical areas.
- The Associate Director of Nursing Acute Hospital is commencing an improvement programme with SCNs and CNMs. From July 2026, a 100-day improvement programme will include a focus on hand hygiene compliance. During this period, there will be increased performance monitoring with a clear expectation of action and ownership by local leaders in each clinical area
- The IPCT are considering options to engage with patients and visitors to support a shift in hand hygiene culture in clinical areas
- Hand hygiene re-audit timescales are now informed by previous audit scores in line with other audit and spot-checking processes
- Following this audit, the Associate Director of AHPs has commissioned work to review staff compliance with mandatory hand hygiene training. The Associated Medical Director for Acute will be discussing the hand hygiene audit results and further actions with the Clinical Directors

6.0 Horizon Scanning

- No national alerts published since the last update report

7.0 National Guidance/Learning

7.1 Policy/guidance updates

- Archiving of IPC within Neonatal Settings (NNU) Addendum
- Update to Respiratory and Cough hygiene literature review and associated NIPCM and CHIPCM content
- Updated Headwear literature review and associated NIPCM content
- Water Safety Guidance (SHTM 04-01) Draft for Public Consultation | National Services Scotland
- Update to Patient and Resident Placement for Isolation and Cohorting literature review

7.2 Healthcare Improvement Scotland (HIS) Report Findings for noting

- Unannounced Inspection Report Maternity Services Safe Delivery of Care Inspection

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

- **Moderate Assurance (recommended)**

3 List of appendices

The following appendices are included with this report:

- Appendix A, Graphs and Tables
- Appendix B, Background Explanation
- Appendix C, Graphs and Data Explanation

Figure 1

NHS Borders, days between healthcare associated CDI cases (G Chart). May 2023 - March 2026

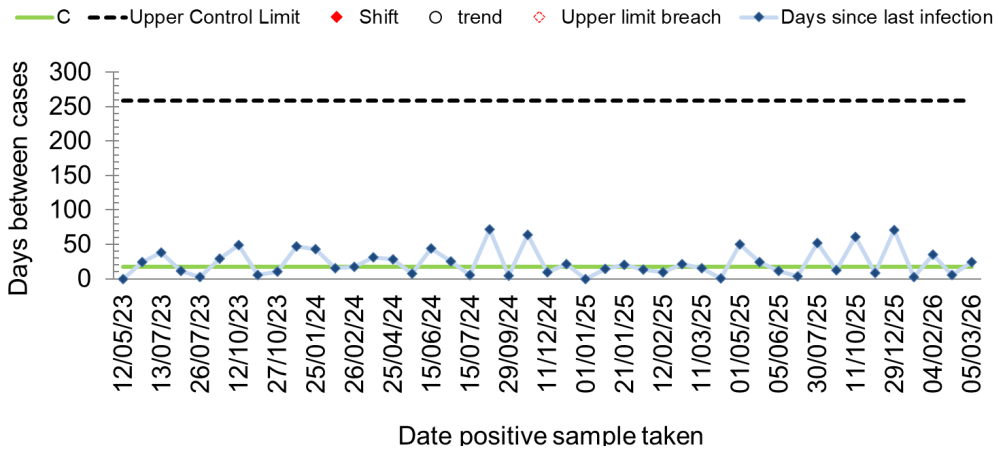


Figure 2

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

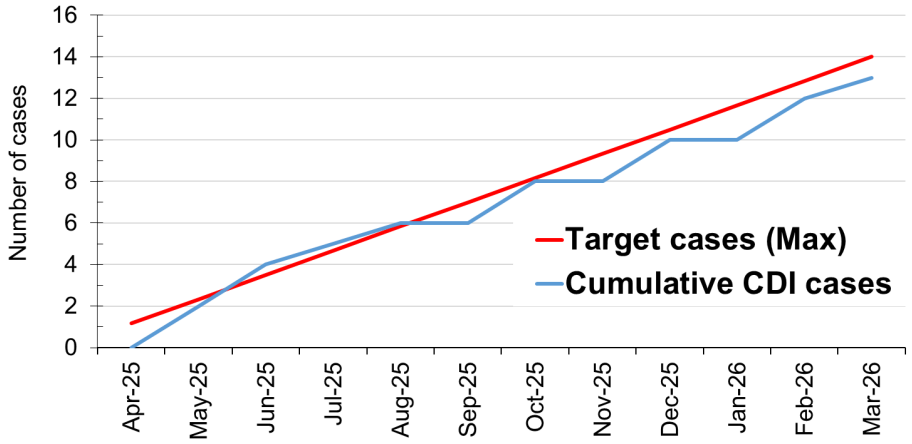


Figure 3

NHS Borders healthcare associated ECB cases per month (C Chart). January 2023 - March 2026

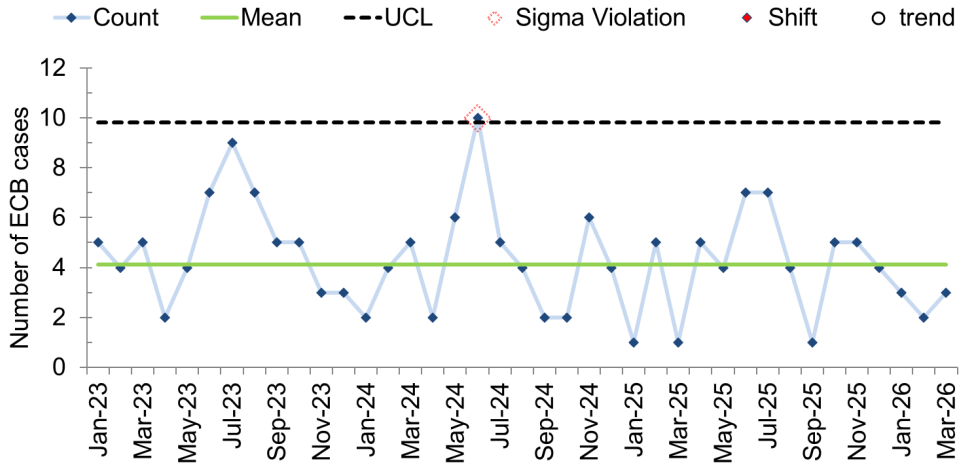


Figure 4

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

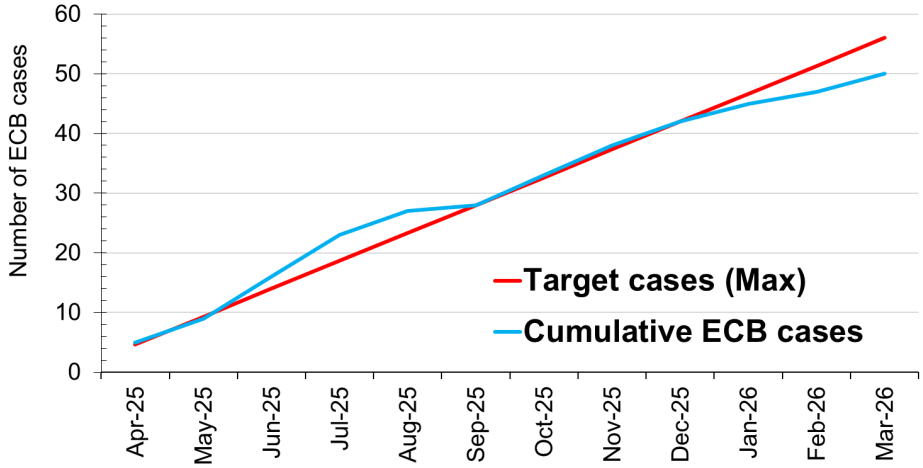


Figure 5

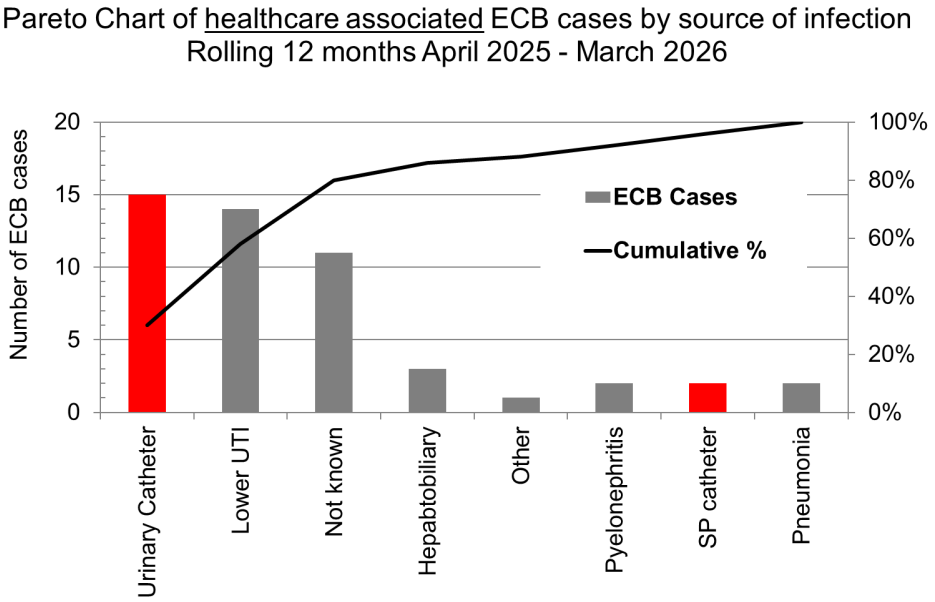


Figure 6

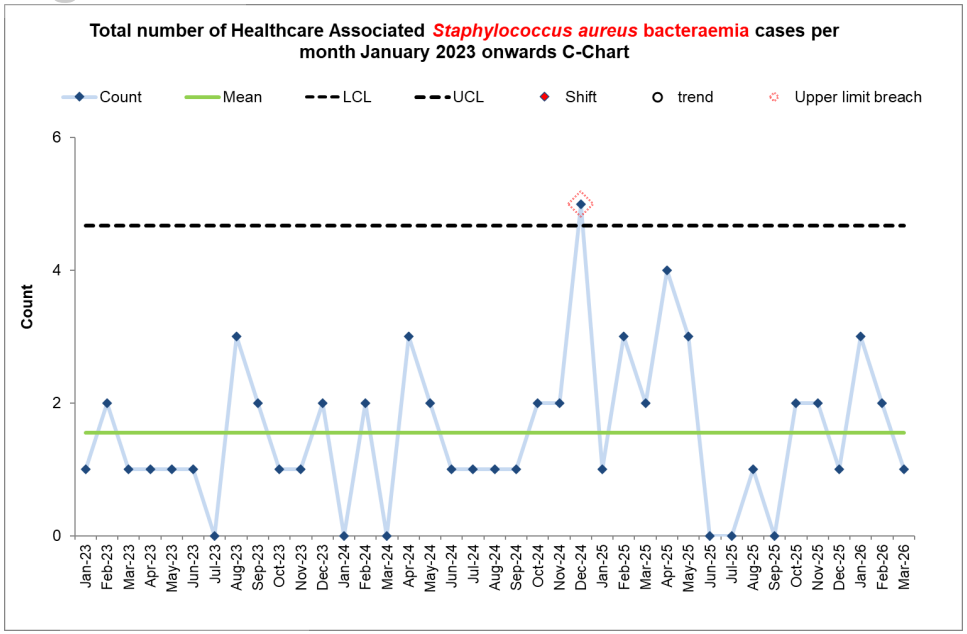


Figure 7

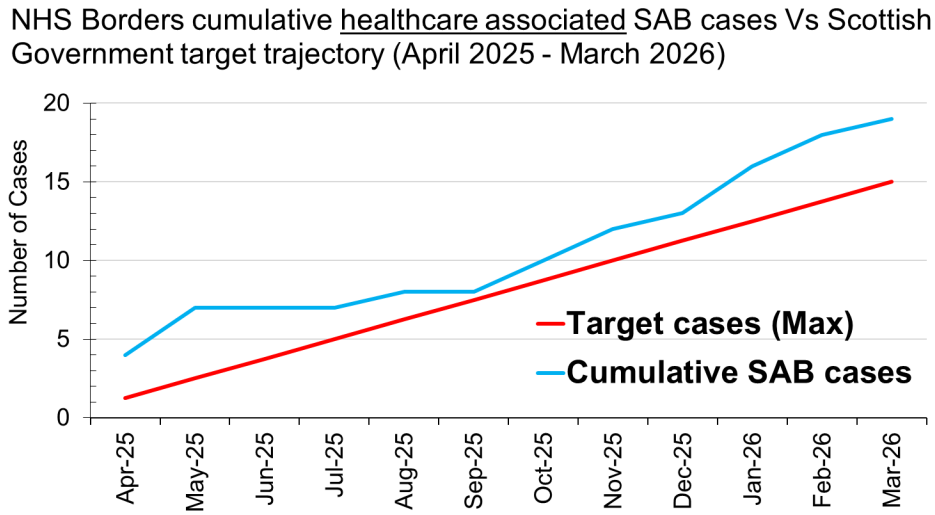


Figure 8

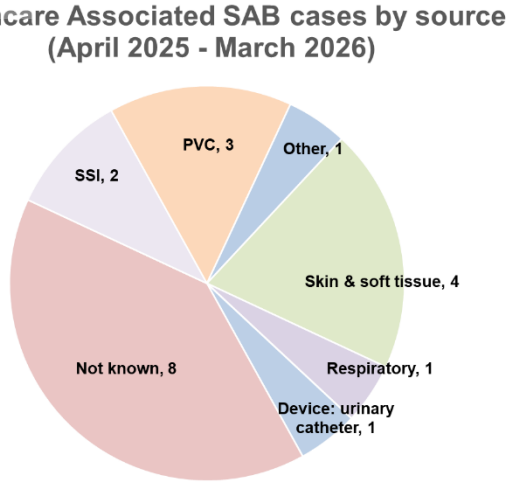


Figure 9

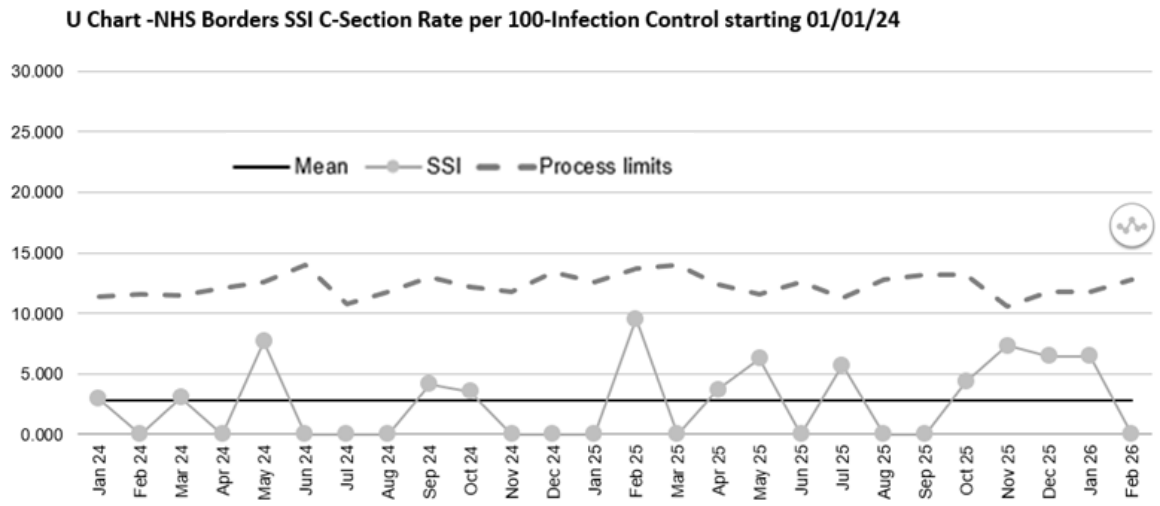


Figure 10

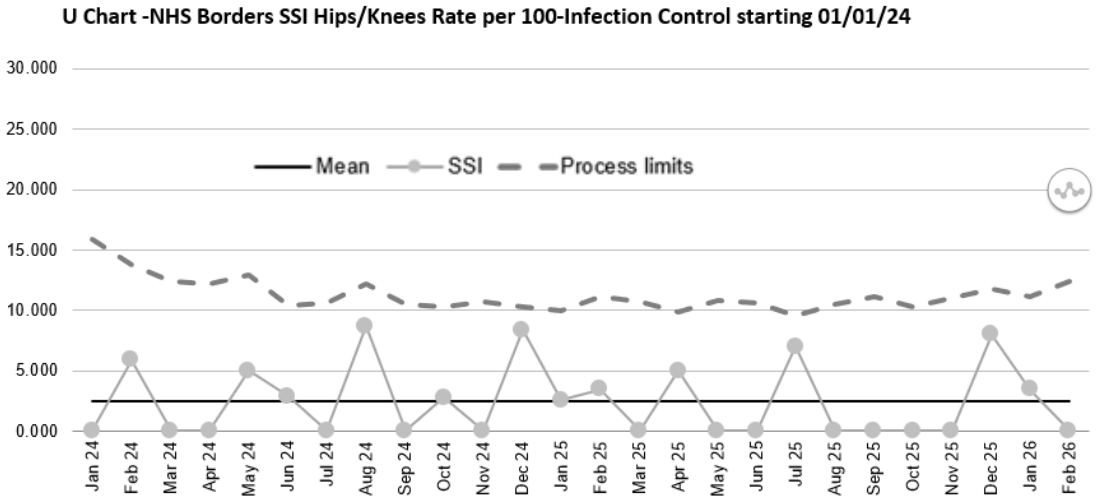


Figure 11

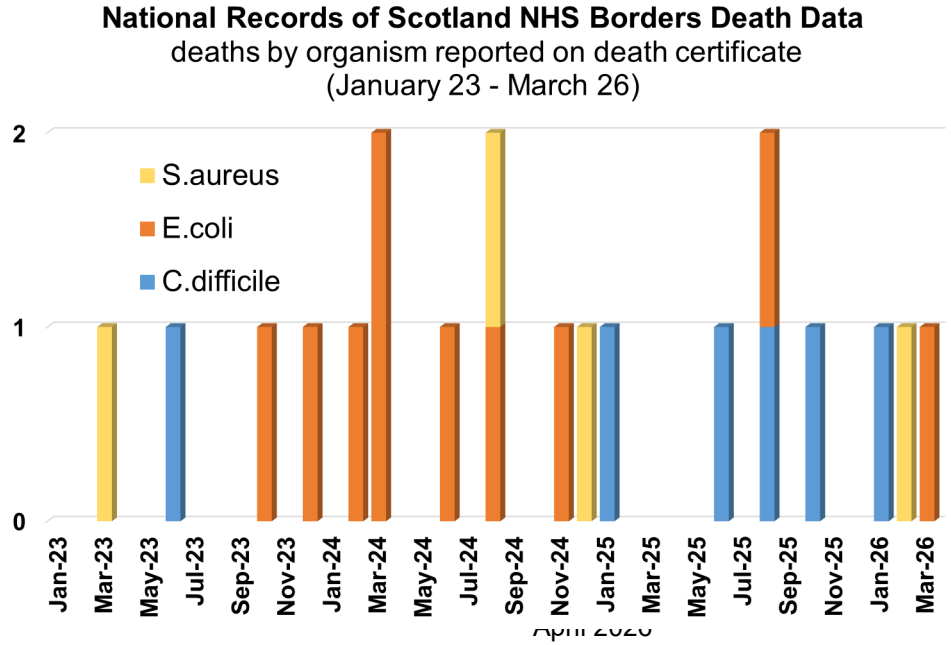


Figure 12

Ward	2026					
	Jan		Feb		March	
	Domestic	Estates	Domestic	Estates	Domestic	Estates
Ward 4	92.9	99.1	92.4	95.8		
Ward 5	94.2	97.3	95.5	93.9	96.4	95.6
Medical Assessment Unit	93.5	98.8	95.6	97.7		
DME14	95.3	92.3				
Emergency Department	90.9	96.5			94.8	97.3
MKU	94.9	91.4	96.1	96.0	90.1	99.4
BSU	97.3	96.8	96.7	97.6		
Renal Dialysis	98.7	100.0	93.5	99.2	98.5	100.0
Ward 7	90.7	98.8	92.4	95.4		
Ward 9	95.7	100.0	94.6	100.0	96.5	100.0
ITU	97.3	98.7	97.5	97.6	94.3	96.0
DPU	94.3	92.2	96.1	97.6	97.0	95.7
Ward 17	92.6	100.0				
Borders Macmillan Centre	97.4	97.8			97.7	97.3
Theatre					96.6	100.0
Endoscopy	95.0	95.7	92.3	97.2	93.6	96.0
Ward 15	97.8	97.4	98.8	96.4	95.2	98.5
Ward 16	92.2	98.8				
Labour/SCBU	94.6	100.0	95.7	100.0	96.6	100.0
Frailty Unit			89.7	98.5	92.2	94.3
	Domestic	Estates	Domestic	Estates	Domestic	Estates
Haylodge Hospital (Ward 1)					78.38	97.9
Hawick Hospital (Ground Floor Ward Area)					96.2	100.0
Kelso Hospital (Ward 2)	94.4	99.1			95.5	100.0
Knoll Hospital (Ward Area)						
East Brig (Galavale)	98.7	100.0			97.5	99.5
Huntlyburn Ground Floor Ward	96.9	94.7			96.9	94.7
Borders Specialist Care Dementia Unit						
Cauldshiels	95.9	98.8			96.7	100.0
	Domestic	Estates	Domestic	Estates	Domestic	Estates
New OPD					94.8	100.0
BUCC					97.7	94.1
OPD First Floor						
Eye Centre					96.8	100.0
Coldstream Dental Unit					98.1	100.0
Hawick Dental Unit					96.1	100.0

Figure 13

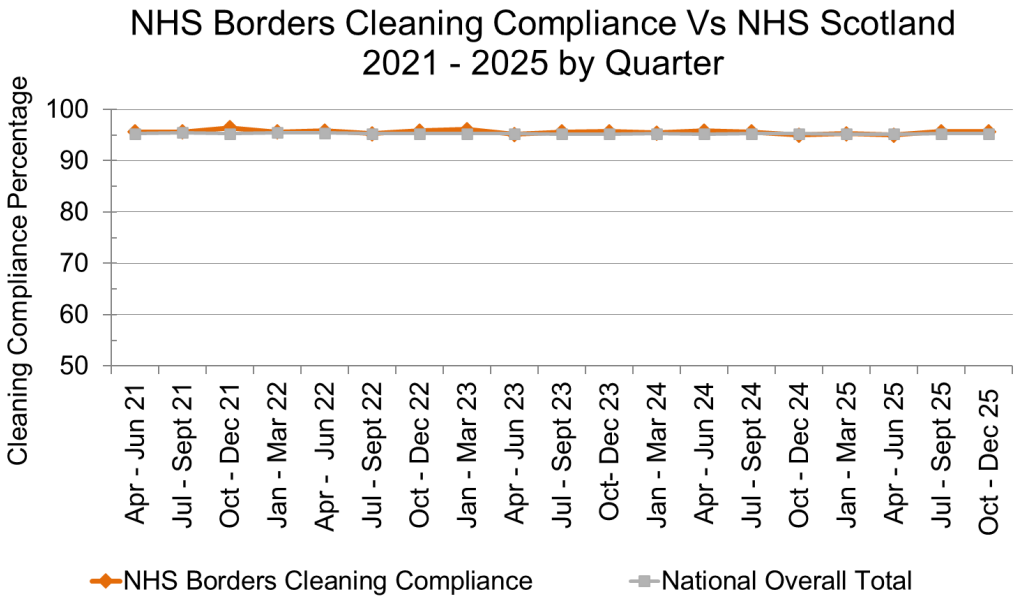


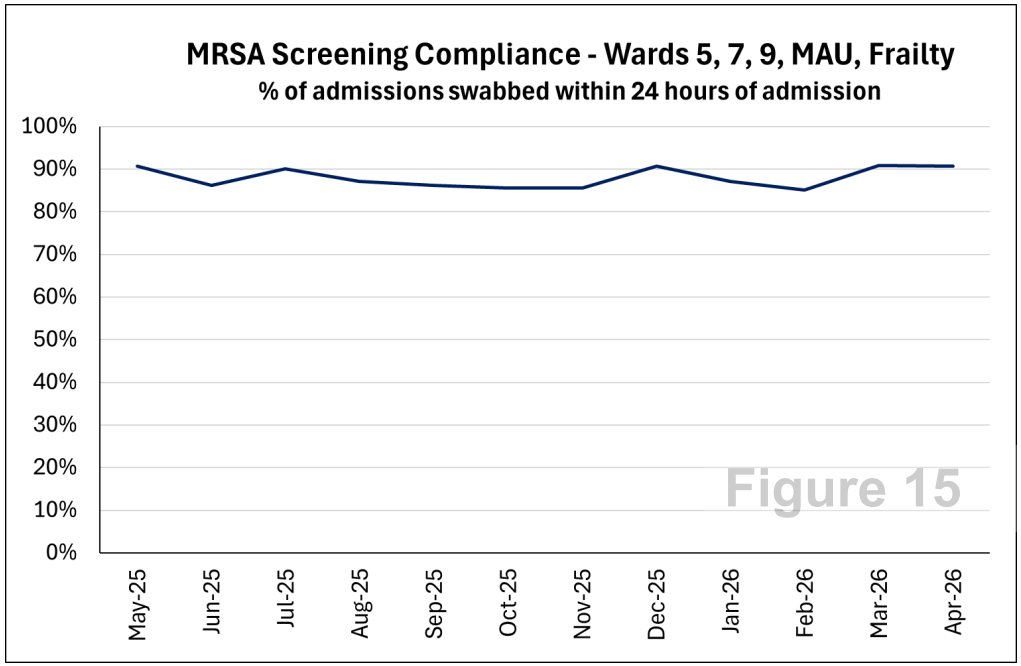
Figure 14

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**

2024 Internal Audit - Infection Prevention &Control Action

Progress as at 02/04/2026

		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	Complete
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



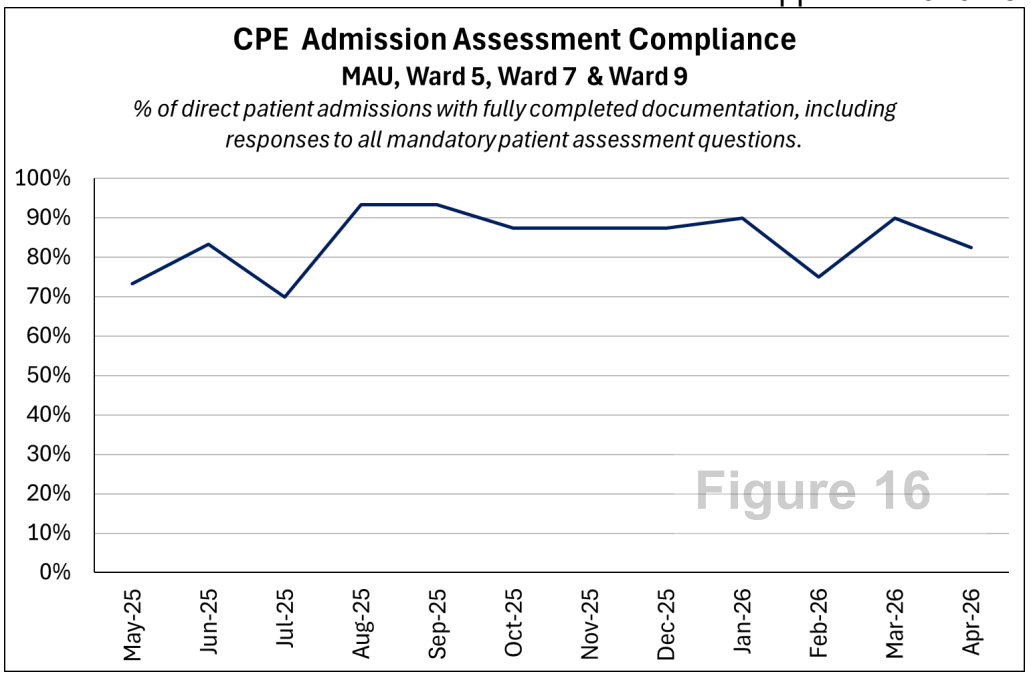


Figure 17

MRSA Uptake	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Borders	90.0%	95.0%	95.0%	95.0%
Scotland	81.4%	81.3%	83.0%	84.8%

CPE Uptake	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Borders	100.0%	95.0%	100.0%	100.0%
Scotland	83.3%	84.4%	85.4%	87.2%

Figure 18

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 20

	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 19

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).

Figure 21

NHS Borders - Closures for Infection Control Reasons (27/02/2026 - 26/04/2026)

Outbreak start date	Outbreak end date	Outbreak location(s)	Ward Closure Status	Organism	Positive patient cases	Patient deaths	Suspected staff cases	Blocked empty bed days
23/03/26	24/03/26	BGH, DME 14	2 Bays	RSV	2	0	1	0
23/03/26	24/03/26	BGH, BSU	1 Bay	RSV	2	0	0	1
27/03/26	09/04/26	BGH, DME 14	2 Bays	RSV	4	0	2	0
30/03/26	31/03/26	BGH, BSU	2 Bays	RSV	3	0	0	3
07/04/26	07/04/26	BGH, Ward 9	1 Bay	RSV	1	0	0	3
22/04/26	22/04/26	BGH, Ward 7	1 Bay	Parainfluenza	1	0	0	2
21/04/26	21/04/26	BGH, BSU	1 Bay	RSV	1	0	0	0
					14	**0**	**3**	**9**

Organisms and Infections

In March 2025, the Scottish Government wrote to all Boards with new Healthcare Associated Infection (HAI) standards. The expectation is that there should be no increase in the incidence (number of cases) of *Clostridioides difficile* infection (CDI), *Escherichia coli* bacteraemia (ECB), and *Staphylococcus aureus* bacteraemia (SAB) by March 2026 from the 2023/24 baseline

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 C

Graphs and Data

This report routinely includes Statistical Process Control (SPC) charts to analyse data. All systems including healthcare operate with a level of variation. The graphs generally display an Upper Control Limits (UCL) and / or Lower Control Limits (LCL). When the plotted line is within these limits, it is an indication that a system is stable. The graphs help us by highlighting where the amount of variation is exceptional and outside the normal predicted limits which is indicative that something in the system has changed.

2.1 Funnel plots

A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days (TOBDs). Any plot that is within the blue funnel is not a statistical outlier.

2.2 C Charts

A control chart that monitors the total number of nonconformities (defects) per unit or subgroup. For example, used to analyse the number of infections per month within NHS Borders.

2.3 G Charts

A control chart used to monitor the frequency of rare events over time. For example, the number of days between infections when there are low numbers of cases each month.

Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system.

It is important to remember that as these graphs plot the number of days between infections, we are trying to achieve performance above the green average line.

2.4 U Charts

A control chart used to monitor the average number of nonconformities per unit, or defects per unit, when sample sizes can vary. For example, used to analyse infection rates across all Boards in Scotland.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Whistleblowing Annual Report 2025/26**
Responsible Executive/Non-Executive:	**L Livesey, Non-Executive**
Report Author:	**A Keen, Director of People & Culture & Executive Lead Whistleblowing** **I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The National Whistleblowing Standards (the Standards) have been in place now since 1 April 2021. The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS Boards to manage, record and report whistleblowing concerns.

Where the employee remains dissatisfied, the concern can be escalated for external review to the Independent National Whistleblowing Officer .

NHS Borders supports and encourages an environment where employees, students, contractors and volunteers can raise concerns about patient safety, malpractice and any perceived wrongdoing.

2.2 Background

The National Whistleblowing Standards are underpinned by legislation and constitute formal guidance to the NHS in Scotland; guidance which has been implemented locally as *"Raising whistleblowing concerns : a guide for staff at NHS Borders"*. The Scottish Public Services Ombudsman (SPSO) and stakeholders, including NHSScotland employers and trades unions, co-produced the Standards, which were also subject to public consultation.

NHS Borders has a designated Whistleblowing Champion – Lynne Livesey, Non Executive, an Executive Lead – Avril Keen, Director of People & Culture and an INWO Liaison Officer – Iris Bishop, Board Secretary.

A range of staff from different backgrounds across the organisation act as Confidential Contacts; publicised points of contact available to staff & students to work out if their issue is indeed in the public interest and covered by the whistleblowing construct.

2.3 Assessment

The NHS Borders approach to handling whistleblowing allegations under the Independent National Whistleblowing Officer (INWO) Standards continues to evolve in line with evolving guidance from INWO.

The Standards are applicable across all NHS services**.** They must be accessible to anyone working to deliver an NHS service, whether that is through an employment, educational or commissioning arrangement. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

The format of the Whistleblowing Annual Report 2025/26 is in line with the June 2023 guidance received from the Independent National Whistleblowing Officer regarding what areas must be covered.

2.3.1 Quality/ Patient Care

The Whistleblowing initiative assists the organisation by creating an environment where staff who have concerns about patient safety issues and other harms will be carefully listened to and offered impartial advice, encouragement, support and protection against victimisation.

2.3.2 Workforce

The monitoring of whistleblowing concerns ensures colleagues are afforded the highest standards of governance as set out in the NHS Scotland Staff Governance hand book and a culture which supports the appropriate raising and handling of concerns.

The standards support our ambition for an open and honest organisational culture where staff have the confidence to speak up and all voices are heard. This is focused

through our organisational Values of Care and Compassion, Dignity and Respect, Openness, Honesty and Transparency and Quality and Teamwork.

These standards support our commitment to making a positive contribution to organisational change. In order to maintain a healthy work environment, we believe that staff need to be empowered to speak up without fear, confident in the knowledge that their voices will be heard and taken into consideration. Our organisational values of openness, honesty and transparency are used to achieve this goal.

Whistleblowing can be stressful for the whistleblower, those who allegations are brought against and the Confidential Contact.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Risks can relate to a wrongdoing, patient safety or malpractice which the organisation oversees or is responsible or accountable for. In a health setting, these concerns could include, for example:

- patient-safety/care issues
- poor professional practice
- unsafe working conditions
- fraud (theft, corruption, bribery or embezzlement)
- changing or falsifying information about performance
- breaking any legal obligation
- abusing authority
- deliberately trying to cover up any of the above.

2.3.5 Equality and Diversity, including Health Inequalities

The Standards are underpinned by legislation and form the National Whistleblowing Policy for NHSScotland. The Scottish Public Services Ombudsman and stakeholders, including NHSScotland employers and trade unions, co-produced the Standards, which were also subject to public consultation.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Under the Whistleblowing Standards, NHS Borders must ensure that all staff have access to a ‘Confidential Contact’ whose role is to provide a safe space to discuss concerns and provide options for staff to take forward their issue.

NHS Borders Confidential Contacts are listed on the Whistleblowing page of the NHS Borders website.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development.

- Whistleblowing Governance Group on 24 April 2026.

2.4 Recommendation

- **Awareness** – For Members' information only and publication on NHS Borders external webpages.

3 List of appendices

The following appendices are included with this report:

- Appendix No1, Whistleblowing Annual Report 2025/26

Whistleblowing Annual Report 2025/2026

1. INTRODUCTION

1.1 This is the fifth Annual Whistleblowing Report which is presented to the NHS Borders Board for consideration.

1.2 During the year 2025/26 our Executive Lead for Whistleblowing, the Director of HR, OD & OH&S retired. We appointed a new Director of People & Culture in February 2026 who took on the role of Executive Lead for Whistleblowing.

1.3 An Internal Audit on Fraud Risk Management and Whistleblowing was also undertaken during this period.

1.4 The whistleblowing element of the InPhase risk system has also been developed with the aim of roll out in 2026/27.

1.5 An annual communications plan has been developed, aiming to distribute quarterly updates throughout the organisation to foster a progressive "speak up" culture.

2. KEY PERFORMANCE INDICATORS (KPIs)

Key Performance Indicator	Requirement	Local Update
1	**Statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns**	There were 2 whistleblowing cases raised for the year 2025/26. Case 1 was resolved at Stage 1. Case 2 is a complex case. The first notification was 13.11.24. The case had been held in abeyance following INWO advice to allow HR processes to conclude, so there have been significant delays.

		There have been 347 working days since 13.11.24. Difficulties were being encountered in being able to identify a willing external investigator in order to commission the investigation.
2	**Statement to report the experiences of all those involved in the whistleblowing procedure**	There have been 2 whistleblowing cases raised for the year 2025/26. Case 1 – Resolved at Stage 1 as it was an HR issue. Case 2 – Held in abeyance until all HR processes had concluded. As we are a small Health Board due to confidentiality we are unable to provide commentary on the experiences of those involved in these cases. During 2025/26 at the whistleblower's request, INWO reviewed Case 4 (2024/25 Annual Report) and recommended that the Board issue a further apology, update investigation guidance, information governance guidance and improve confidentiality procedures. All guidance was updated as a package for investigators and covered information governance and confidentiality. All actions were completed to INWO's satisfaction during 2025/26.
3	**Statement to report on levels of staff perceptions, awareness and training**	Staff Awareness – From 29 September to 3 October 2025, NHS Borders engaged in Speak Up week. The theme was "Listen Act, Build Trust" and aligned well with our work co-producing a new organisational strategy, the engagement exercises that took place across the summer on the clinical strategy and our focus on formulating a social compact. Staff Training – During 2025/26 the following Whistleblowing training via Learnpro has been completed:

		Number of staff (Head count): 3142 Number of Managers (Head count): 396 Total No of Staff who have completed 'Whistleblowing for staff' training: 123 % of total staff who completed training: 3.92% Total No of Staff who have completed 'Whistleblowing for line managers' training: 43 Total No of Staff who have completed 'Whistleblowing for senior managers' training: 28 No of managers who completed training: 71 % of managers who completed training: 17.93% During 2025/26 the following Whistleblowing training via eLearning has been completed: *Whistleblowing for senior managers –7 learners* *Whistleblowing for line managers – 26 learners* *Whistleblowing for staff – 81 learners* Board Awareness – The annual iMatter survey outcomes are reviewed by the Board to seek assurance that our staff have the awareness and ability to speak up should they have any concerns. The NHS Borders website was regularly updated in the period 2025/26 and includes the whistleblowing quarterly and annual reports as well a flowchart for staff and contractors to understand how whistleblowing concerns are taken forward.
4	**Total number of concerns received**	From 01 April 2025 to 31 March 2026, NHS Borders received 2 whistleblowing concerns.

		During 2025/26 2 concerns were received and investigated to see if they passed the definition for whistleblowing. NHS Borders did not think that 1 case (Case 1) met the criteria and referred it to the organisations internal HR process. The other concern involved Case 2 which progressed to the commissioning of an external investigation following lengthy delays due to the concluding of HR processes as agreed with INWO.
5	**Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed**	During 2025-26 1 Whistleblowing Case was concluded at Stage 1 (Case 1). During 2025/26 1 Whistleblowing Case was progressed to the commissioning of an external investigation following a lengthy delay to allow HR processes to conclude (Case 2).
6	**Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage**	During 2025-26 1 Whistleblowing Case was concluded at Stage 1 – Not Upheld (Case 1).
7	**Average time in working days for a full response to concerns at each stage of the whistleblowing procedure**	For Whistleblowing Case raised in 2025/26 under Stage 1 the total time taken from notification to resolution was 2 days (Case 1). Case 2 is a complex case. The case had been held in abeyance following INWO advice to allow HR processes to conclude, so there have been significant delays. There have been 347 working days since the case was raised.
8	**Number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working day**	For Whistleblowing Case raised in 2025/26 the total time taken from notification to resolution was 2 days (Case1).

9	**Number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1**	No cases handled under Stage 1 required an extension.
10	**Number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2**	Case 2 has had lengthy delays and systems are now in place to record extensions at 20 working day intervals. These were inconsistent in 2025 and have been applied consistently in 2026.

3. CONCLUSIONS

3.1 The NHS Borders approach to handling whistleblowing allegations under the INWO Standards continues to evolve in line with evolving guidance from INWO.

3.2 NHS Borders appreciates that the decision to pursue whistleblowing allegations is not taken lightly and wishes to express its thanks to those parties who took the time and effort to do so during 2025-2026, and also to staff who were involved in responding to concerns, including our network of Confidential Contacts.

3.3 In terms of improving our learning from whistleblowing cases, we have developed an improvement plan that remains live and is discussed at our regular Whistleblowing Governance Group to ensure progress is being made.

LYNNE LIVESEY
Whistleblowing Champion

AVRIL KEEN
Executive Lead for Whistleblowing

IRIS BISHOP
INWO Whistleblowing Liaison

YEAR END REPORTING - INWO

Reporting Year: 2025-26

KPI	Category (link to Guidance)	Description	Total	Percentage
3	Staff perceptions, awareness and training	No of staff (headcount)	3142	
3		No of staff who completed training	123	
3		% of total staff who completed training	3.92%	3.92%
3		Manager headcount	396	
3		No of managers who completed training	71	
3		% of managers who completed training	17.93%	17.93%
4	Received	Total number of concerns received	2	
5	Closed	Total number of concerns closed	1	
5	Stage 1	Number of concerns closed at Stage 1	1	100%
5	Stage 2	Number of concerns closed at Stage 2	0	0%
6	Stage 1 Outcomes	Number of concerns upheld at Stage 1	0	0%
6	Stage 1 Outcomes	Number of concerns partially upheld at Stage 1	0	
6	Stage 1 Outcomes	Number of concerns not upheld at Stage 1	1	100%
6	Stage 2 Outcomes	Number of concerns upheld at Stage 2	0	0%
6	Stage 2 Outcomes	Number of concerns partially upheld at Stage 2	0	
6	Stage 2 Outcomes	Number of concerns not upheld at Stage 2	0	0%
7	Stage 1 Avg Working Days	Average working days for concerns at Stage 1	2	
7	Stage 2 Ave Working Days	Average working days for concerns at Stage 2	347	
8	Stage 1 Timescales	Number of concerns at Stage 1 closed within 5 working days	1	100%
8	Stage 2 Timescales	Number of concerns at Stage 2 closed within 20 working days	0	0%
9	Stage 1 Extensions	Number of concerns at Stage 1 with authorised extension	0	0%
10	Stage 2 Extensions	Number of concerns at Stage 2 with authorised extension	1	100%

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**NHS Borders Integrated Performance Report (IPR) – April 2026**
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

As highlighted previously to the Board we are introducing a refreshed Integration Performance Report (IPR) and performance framework for 2026/27. This means that in addition to the IPR, where performance falls below agreed levels, a detailed exception report setting out the underlying causes of variance, the actions being taken to address gaps, and how and when improvement or recovery will be achieved.

2.2 Background

As in previous years, routine performance reports will continue to be presented to provide an overview of delivery against agreed standards. However, for 2026/27 a revised performance framework is being introduced to strengthen focus and support

more effective discussion. The framework will prioritise areas where performance is outwith agreed levels, with no additional narrative provided for indicators meeting or exceeding agreed performance levels (Green). For areas beyond this threshold, within 10% (Amber) and outwith 10% (Red), a more detailed exception report will be included, clearly setting out the drivers of performance, the actions being taken to address the gap, and the anticipated impact of these actions. This approach will enable more targeted scrutiny and informed decision-making on areas requiring improvement, while also recognising and maintaining oversight of areas where performance remains on track.

While we develop and embed the new reporting framework, we will adopt a phased approach—starting with a core set of priority measures to establish a consistent baseline, and then progressively introducing additional measures and refinements throughout the year. This will allow the framework to evolve in line with data availability, organisational priorities, and learning from early implementation, ensuring it remains practical, meaningful, and aligned to our overall performance and improvement ambitions.

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

2.3 Assessment

This report is presented in the revised style outlining the April 2026 position. From this month and moving forward the following documents are presented:

Integrated Performance Report (IPR) (Appendix 1): The IPR provides a structured overview of organisational performance against local and national performance priorities. It includes a summary dashboard of performance across key service areas, supported by trend data and assurance measures to enable interpretation of performance direction and variation. The report covers core domains across Urgent & Unscheduled Care, Planned Care and Mental Health for now, and as noted above, as we develop and embed the new reporting framework, we will adopt a phased approach—starting with a core set of priority measures to establish a consistent baseline, and then progressively introducing additional measures and refinements throughout the year.

Please note that the Waiting Times trajectories have been set on the planning assumption that funding to achieve this level of performance will be allocated from the Scottish Government. If this funding is not allocated or a reduced allocation is received these trajectories will require to be reassessed.

Quality & Performance Improvement Oversight Report (Appendix 2): This report provides further detail and information on the areas where performance delivery is outwith agreed levels (Amber and Red), this exception report includes further information on, the drivers of performance, the actions being taken to address the gap, and the anticipated impact of these actions. The April 2026 position highlights 4 areas where performance has fallen short of agreed levels as per the table below.

Aim Statement	April 2026 Performance /RAG Status	Lead Exec
Urgent & Unscheduled Care		
Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.	65.9%	Director of Mental Health, Primary & Community Services & Urgent Care
Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.	33.13	Director of Mental Health, Primary & Community Services & Urgent Care
Planned Care		
Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.	88%	Director of Acute Services
Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027.	94.1%	Director of Acute Services

Lead Directors are accountable for reviewing and formally approving the measures and supporting narrative within their portfolios prior to submission, and they will present this information during the meeting.

2.3.1 Quality/ Patient Care

The milestones and priorities set out within the Operational Improvement Plan and our local delivery plans are key monitoring tools 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

For measures falling short of agreed performance levels 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 agreed performance levels.

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 is developed with the Clinical Boards and services.

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. Suggested assurance levels for consideration are outlined below:

- **Systems and Processes** – Moderate Assurance
- **Outcomes** – Limited Assurance

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** NHS Borders Integrated Performance Report April 2026
- **Appendix 2:** NHSB Quality & Performance Improvement Oversight Report April 2026

NHS Borders

Integrated Performance Dashboard

April 2026

Last Refresh Date: 04/06/2026

Integrated Performance Dashboard - Information

The Integrated Performance Report contains a page per performance measure where Statistical Process Control charts are used to show whether each measure is under control, or whether there are variations in the data that show performance requires exploring. The charts also show targets for achievement, and this is another consideration when viewing the data (red lines). Is the target being achieved or performance improving towards target or deteriorating. Table 1 below shows the rules that are highlighted in the charts to highlight whether further investigation is required or not.

Confidence Levels – Upper Control Limit (UCL) & Lower Confidence Limit (LCL)

The Confidence Limits are shown in the charts with a dotted line either side of the green mean line. The wider the Upper Confidence Limit and Lower Confidence Limit the more varied the data is, the closer the Limits are together the more stable it is.

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Table 1 - Special Cause Variations

Astronomical Points – Sigma Violation

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

Imp. Ast. Point - Improving Astronomical Point

Det. Ast. Point - Deteriorating Astronomical Point

Shifts

This where there are 6 or more data points in a row above or below the average:

Imp. Shift - Improving Shift

Det. Shift - Deteriorating Shift

Trend

This is where there are 6 or more points heading upwards or downwards:

Imp. Trend - Improving Trend

Det. Trend - Deteriorating Trend

Measure Name	Aim Statements	April Position	RAG	Assurance Status	Variation Status
Emergency Access Standard	Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.	65.9%			
12 Hour Breaches	Reduce 12-hour waits to <9% by July 2026 and <7% by March 2027.	10.1%			
Length of Stay	Reduce average non-elective length of stay by 1 day by March 2027, Excludes paeds/obstetrics & ITU.	9.9			
Bed Occupancy	Average number of Acute occupied beds 85%.	82.18%			L
Delayed Discharges	Sustain delayed discharges at <40.	40			L
Ambulance Handover Time	Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.	31.38		F	L
AAU Admissions	Increase the number of patients admitted to AAU by 10%.	446			H
Outpatient Waiting List	Deliver sustained compliance with outpatient waiting times by achieving zero 52-week waits from April 2027 maintaining zero tolerance for 78+ week waits.	173			L
Inpatient Waiting List	Deliver sustained compliance with inpatient waiting time standards by achieving zero 52-week waits from April 2026 and maintaining zero tolerance for 78+ week waits across all specialties, including TTG.	80			L
Theatre Utilisation	Maximise elective theatre productivity by achieving at least 85% utilisation by July 2026.	71.9%			
Diagnostics Over 6 Weeks	Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.	88%			H

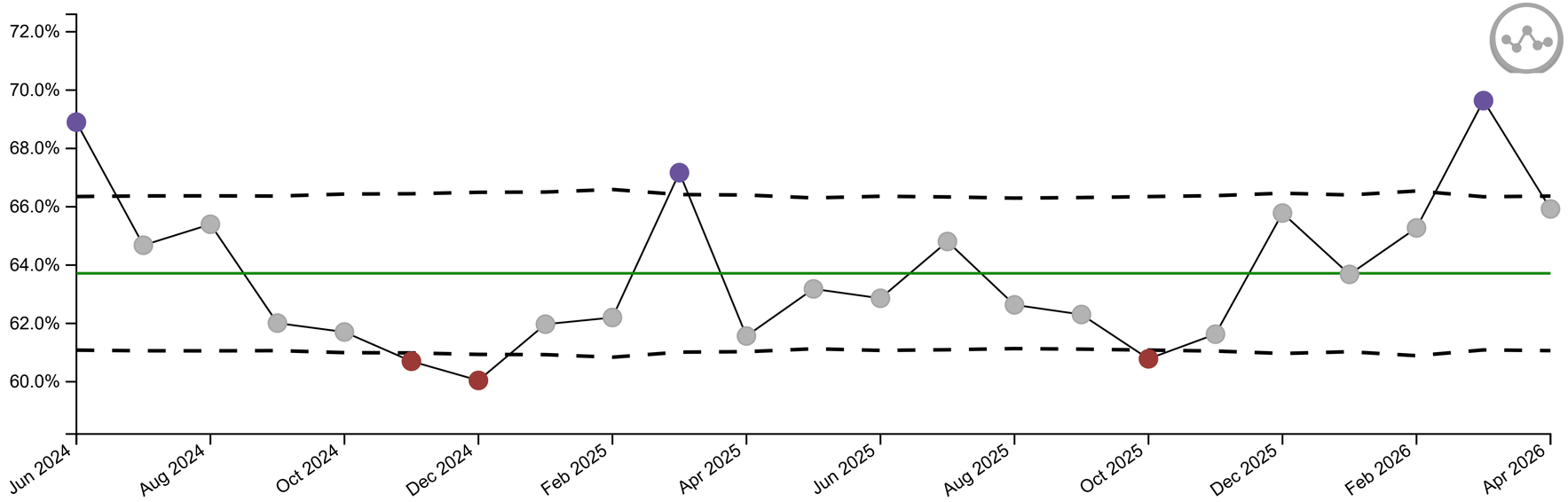
Measure Name	Aim Statement	April Position	RAG	Assurance Status	Variation Status
Cancer 62 Days	Improve timely access to cancer treatment by achieving 85% of patients treated within 62 days of urgent referral by March 2027.	76.5%		F	
Cancer 31 Days	Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027, ensuring at least 95% of eligible patients start treatment within 31 days of decision to treat.	94.1%		P	L
CAMHS RTT	90% of patients received CAMHS treatment within 18 weeks of referral.	100.0%		?	H
Psychological Therapy	90% of patients received PT treatments within 18 weeks of referral.	84.2%		?	
BAS 3 Week Target	90% of patients received BAS treatments within 3 weeks of referral.	99.0%		P	

Integrated Performance Dashboard - Urgent & Unscheduled Care

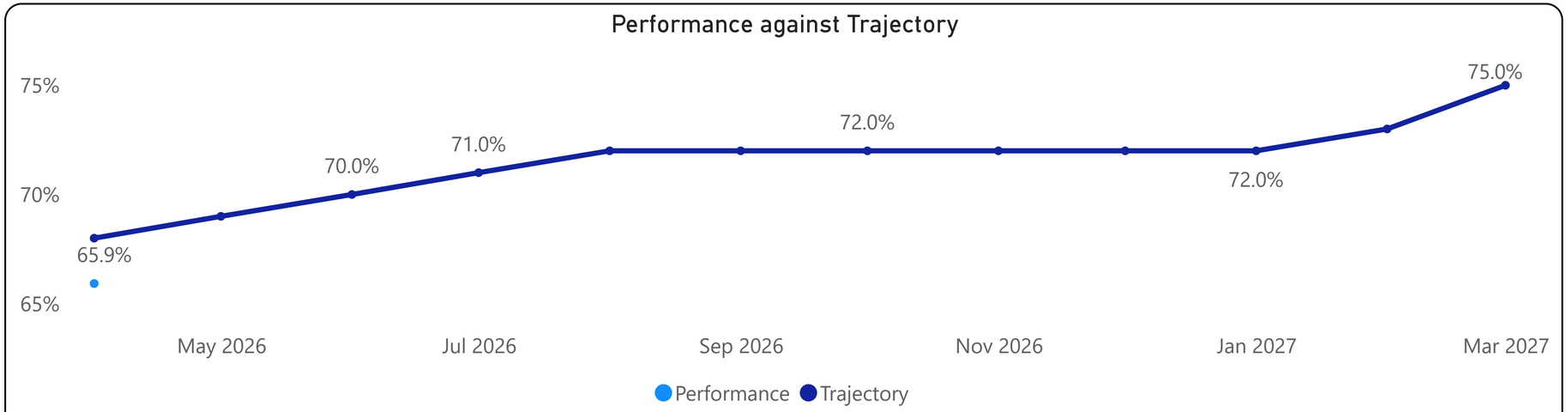
Lead Director: Gareth Clinkscale

Emergency Access Standard

p-Chart: Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within 10% of tolerance levels, for further detail please see the performance improvement and oversight report.

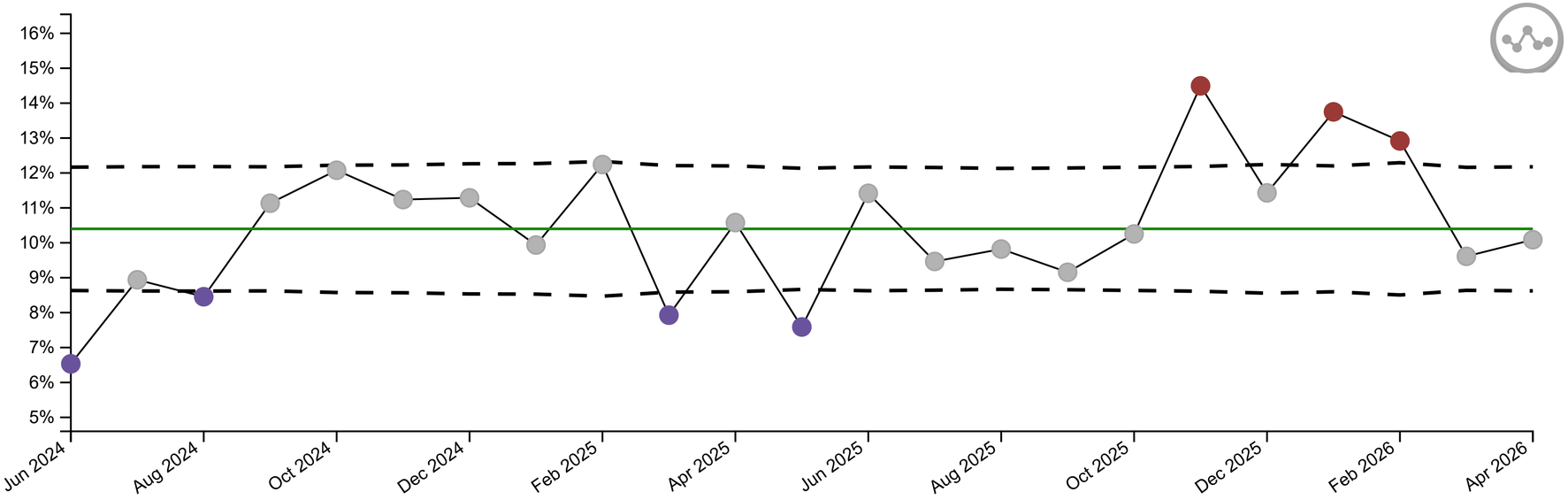
MonthEndDate	Attendances	Breaches	EAS
30/04/2026	2964	1954	65.9%
31/03/2026	3017	2101	69.6%
28/02/2026	2609	1703	65.3%
31/01/2026	2880	1834	63.7%
31/12/2025	2756	1813	65.8%
30/11/2025	2932	1807	61.6%
31/10/2025	3004	1826	60.8%
30/09/2025	3080	1919	62.3%
31/08/2025	3126	1958	62.6%
31/07/2025	3032	1965	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%
28/02/2025	2516	1565	62.2%
31/01/2025	2677	1659	62.0%
31/12/2024	2693	1617	60.0%
30/11/2024	2794	1696	60.7%
31/10/2024	2815	1737	61.7%
30/09/2024	2964	1838	62.0%
31/08/2024	2945	1926	65.4%

Integrated Performance Dashboard - Urgent & Unscheduled Care

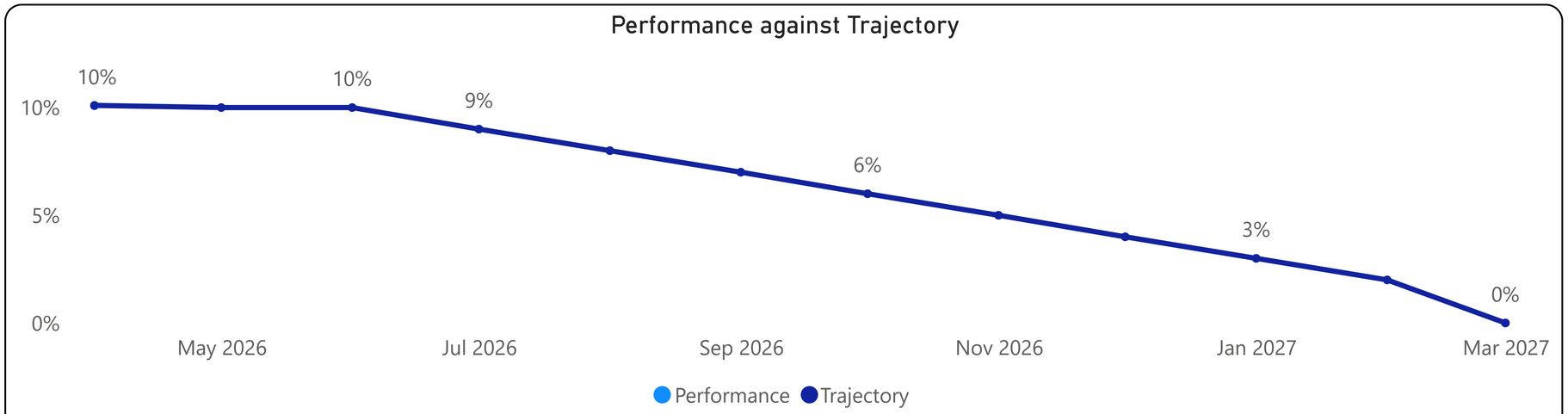
Lead Director: Gareth Clinkscale

12 Hour Delays

u-Chart: Reduce 12-hour waits to <9% by July 2026 and <7% by March 2027.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within normal tolerance levels.

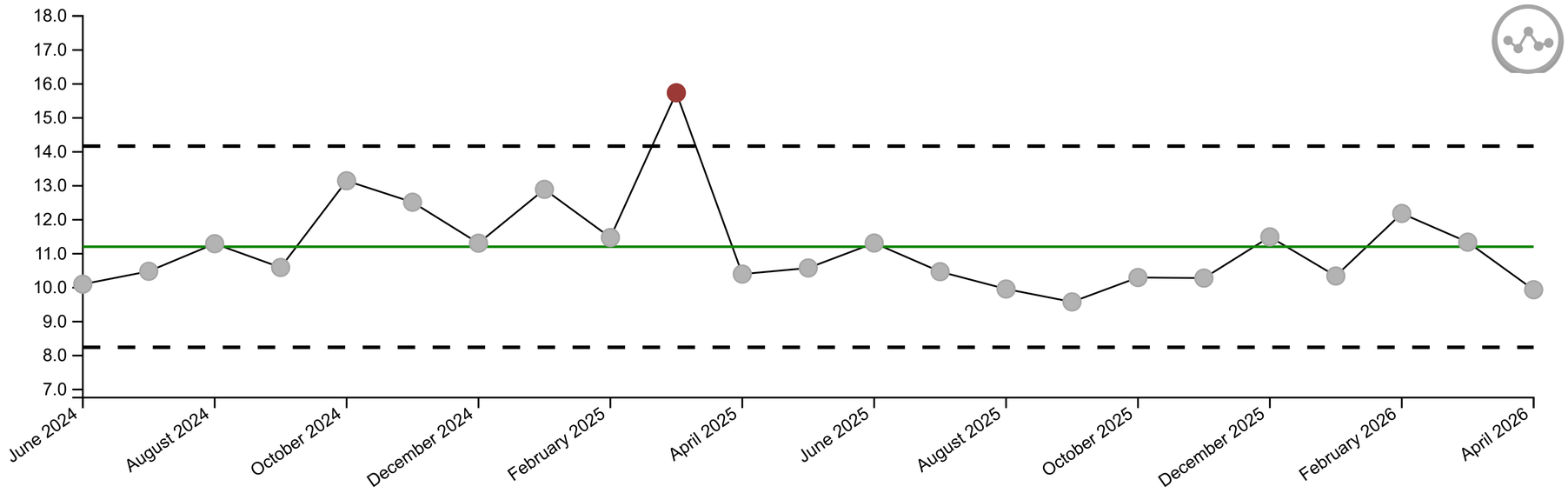
MonthEndDate	Attendances	12 Hour Delays
30/04/2026	2964	299
31/03/2026	3017	290
28/02/2026	2609	337
31/01/2026	2880	396
31/12/2025	2756	315
30/11/2025	2932	425
31/10/2025	3004	308
30/09/2025	3080	282
31/08/2025	3126	307
31/07/2025	3032	287
30/06/2025	2978	340
31/05/2025	3110	236
30/04/2025	2883	305
31/03/2025	2851	226
28/02/2025	2516	308
31/01/2025	2677	266
31/12/2024	2693	304
30/11/2024	2794	314
31/10/2024	2815	340
30/09/2024	2964	330
31/08/2024	2945	249

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

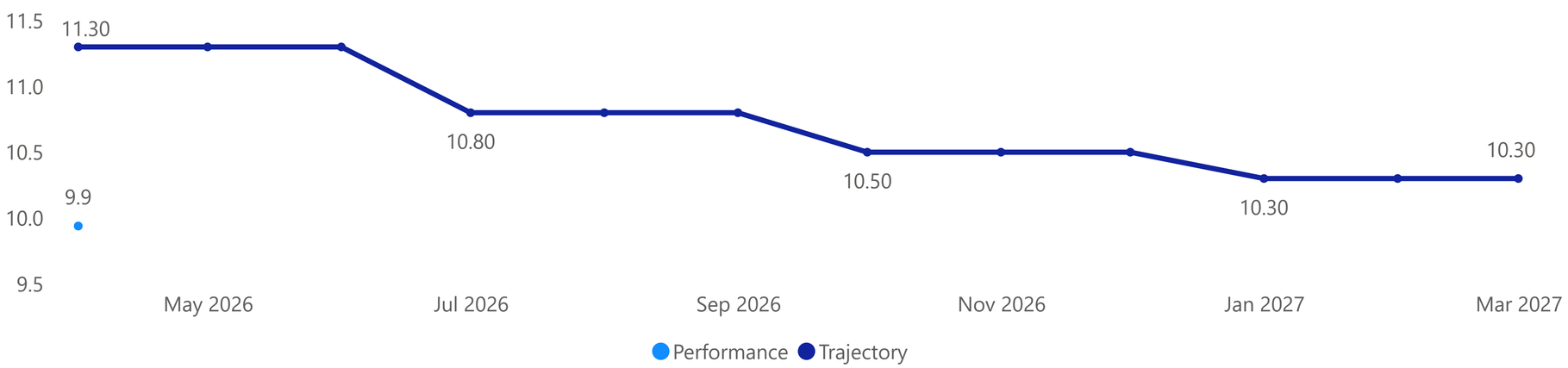
Length of Stay

i-Chart: Reduce average non-elective length of stay by 1 day by March 2027, Excludes paeds/obstetrics & ITU.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Performance against Trajectory



Current performance is within normal tolerance levels.

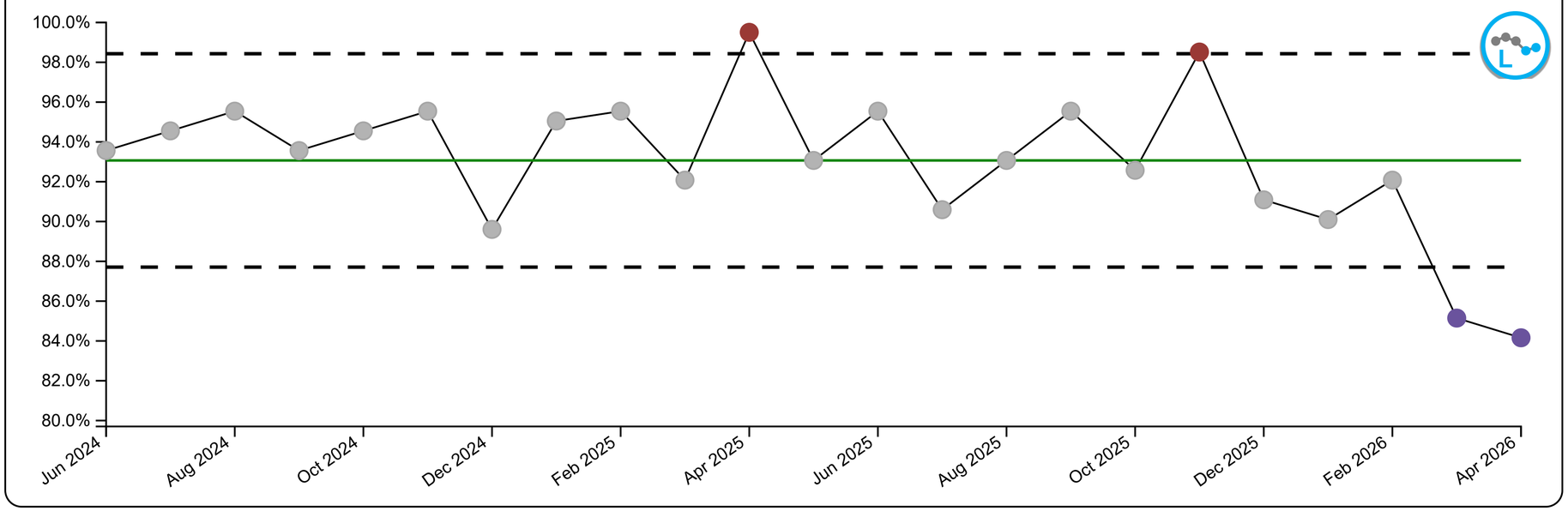
MonthEndDate	Average Length of Stay
April 2026	9.9
March 2026	11.3
February 2026	12.2
January 2026	10.3
December 2025	11.5
November 2025	10.3
October 2025	10.3
September 2025	9.6
August 2025	10.0
July 2025	10.5
June 2025	11.3
May 2025	10.6
April 2025	10.4
March 2025	15.7
February 2025	11.5
January 2025	12.9
December 2024	11.3
November 2024	12.5
October 2024	13.1
September 2024	10.6
August 2024	11.3

Integrated Performance Dashboard - Urgent & Unscheduled Care

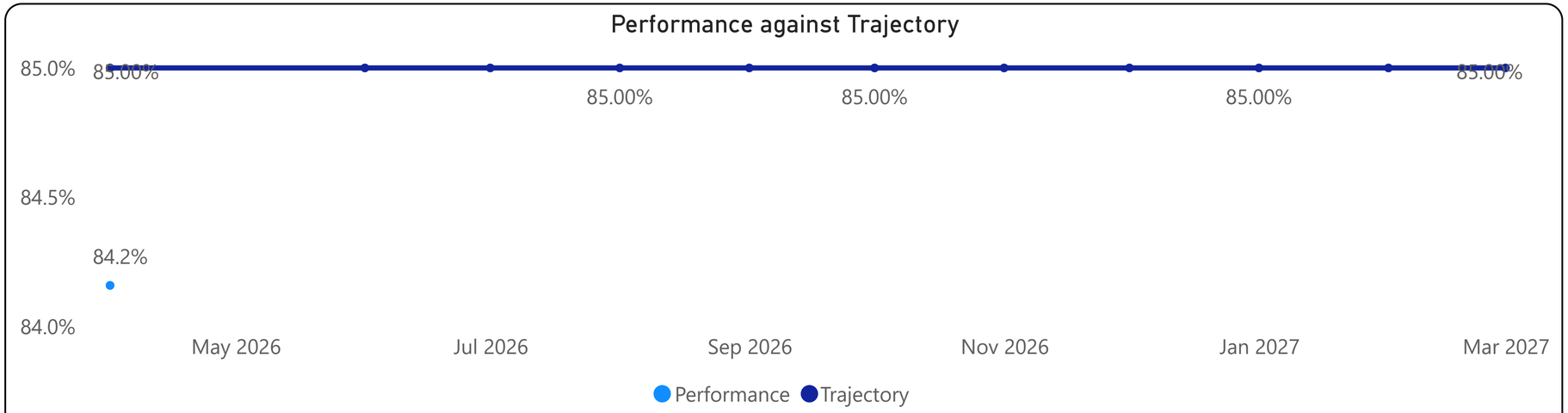
Lead Director: Gareth Clinkscale

Average Acute Occupancy

p-Chart: Average number of Acute occupied beds 85%.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within normal tolerance levels.

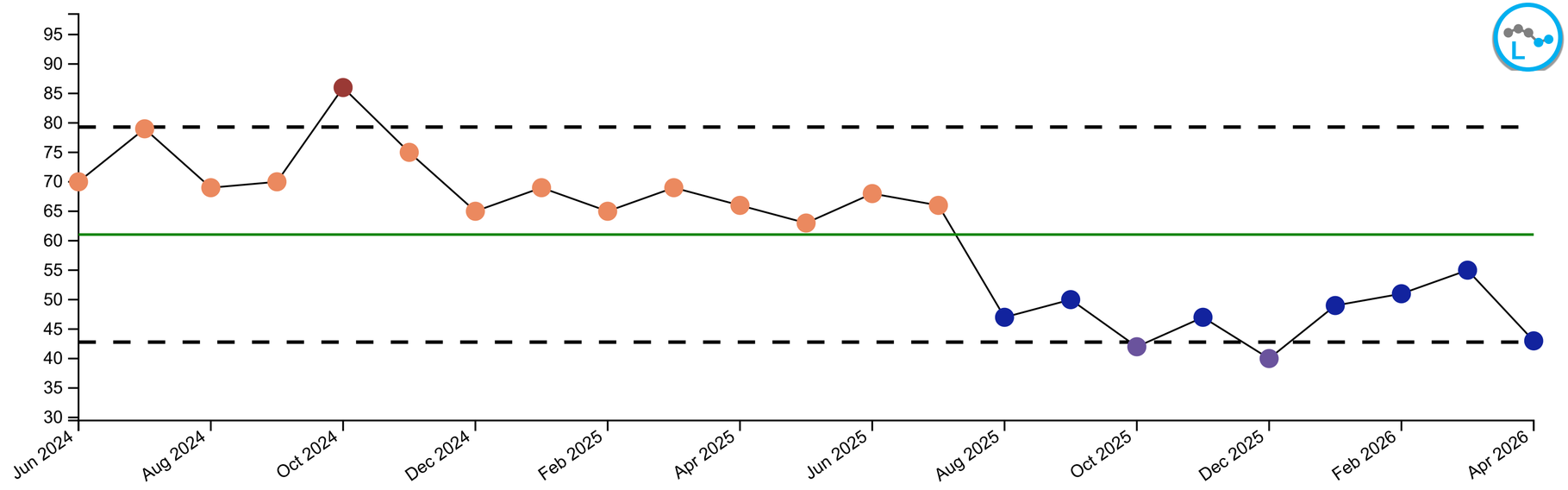
EndOfMonth	Occupied Beds	%
30/04/2026	170	84.2%
31/03/2026	172	85.1%
28/02/2026	186	92.1%
31/01/2026	182	90.1%
31/12/2025	184	91.1%
30/11/2025	199	98.5%
31/10/2025	187	92.6%
30/09/2025	193	95.5%
31/08/2025	188	93.1%
31/07/2025	183	90.6%
30/06/2025	193	95.5%
31/05/2025	188	93.1%
30/04/2025	201	99.5%
31/03/2025	186	92.1%
28/02/2025	193	95.5%
31/01/2025	192	95.0%
31/12/2024	181	89.6%
30/11/2024	193	95.5%
31/10/2024	191	94.6%
30/09/2024	189	93.6%
31/08/2024	193	95.5%

Integrated Performance Dashboard - Urgent & Unscheduled Care

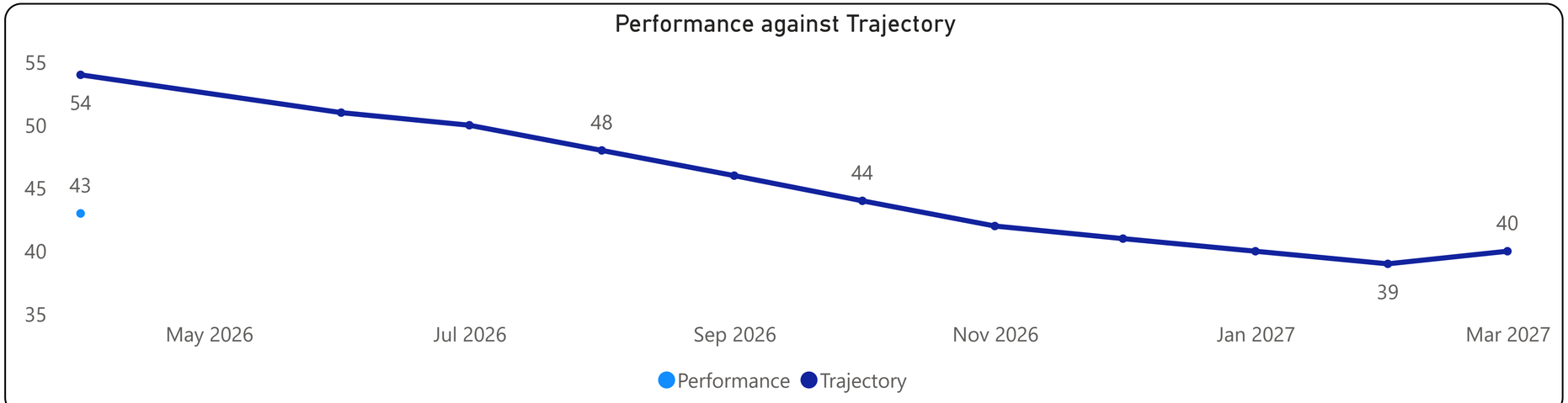
Lead Director: Gareth Clinkscale

Delayed Discharges

i-Chart: Sustain delayed discharges at <40.



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift



Current performance is within normal tolerance levels.

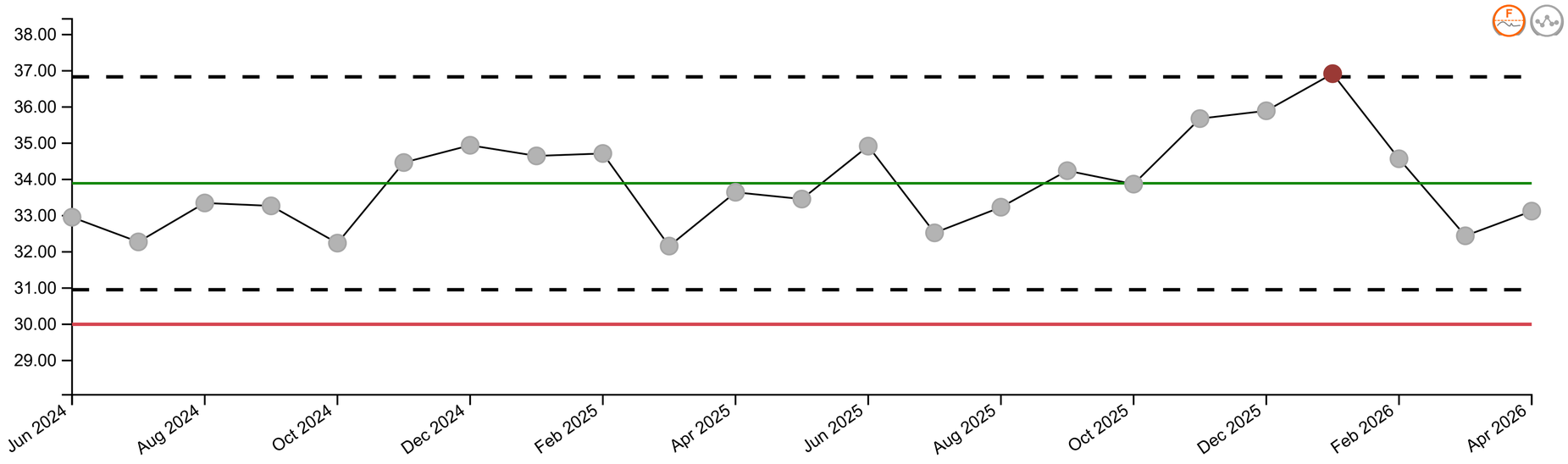
EndOfMonth	Delayed Discharges
30/04/2026	43
31/03/2026	55
28/02/2026	51
31/01/2026	49
31/12/2025	40
30/11/2025	47
31/10/2025	42
30/09/2025	50
31/08/2025	47
31/07/2025	66
30/06/2025	68
31/05/2025	63
30/04/2025	66
31/03/2025	69
28/02/2025	65
31/01/2025	69
31/12/2024	65
30/11/2024	75
31/10/2024	86
30/09/2024	70
31/08/2024	69

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

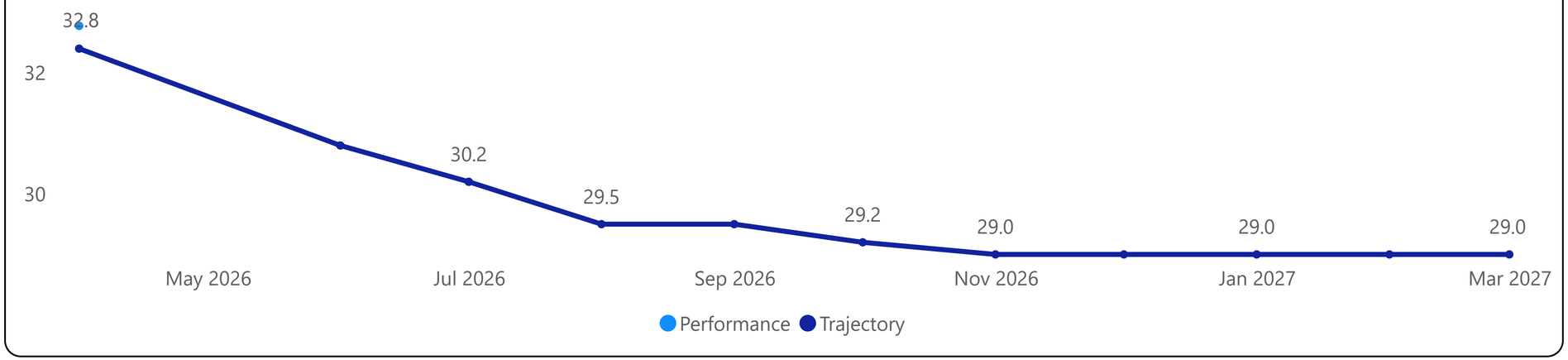
Ambulance Handover Time

i-Chart: Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift

Performance against Trajectory



Current performance is within 10% of tolerance levels, for further detail please see the performance improvement and oversight report.

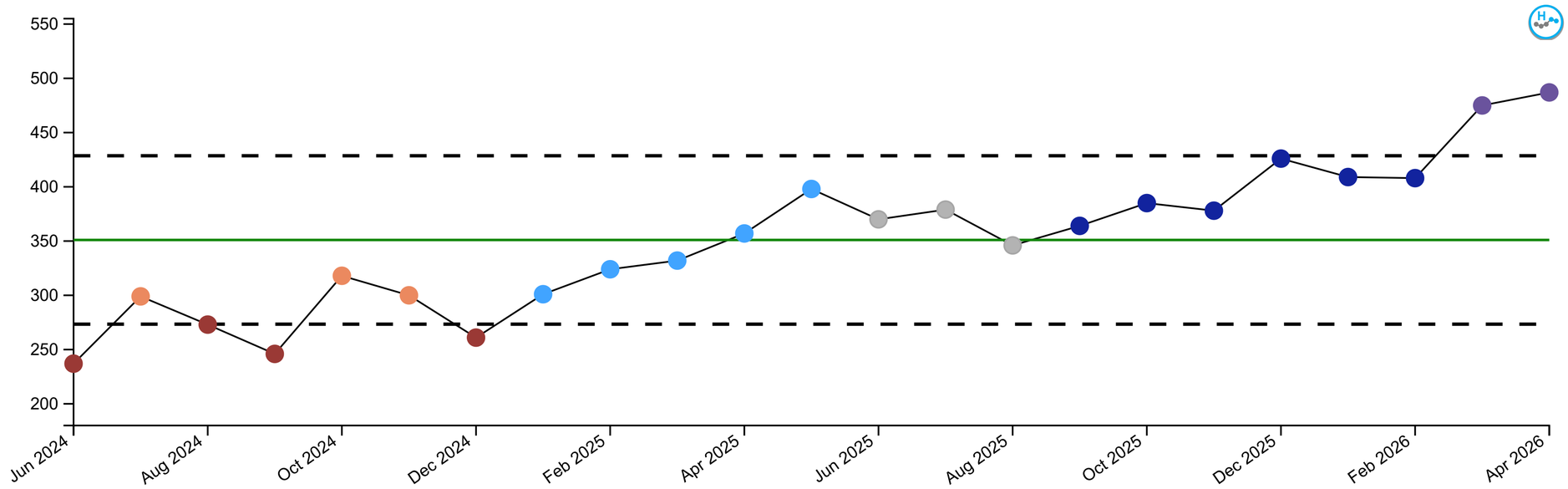
EndOfMonth	Handover Times (Minutes)
30/04/2026	33.1
31/03/2026	32.4
28/02/2026	34.6
31/01/2026	36.9
31/12/2025	35.9
30/11/2025	35.7
31/10/2025	33.9
30/09/2025	34.2
31/08/2025	33.2
31/07/2025	32.5
30/06/2025	34.9
31/05/2025	33.5
30/04/2025	33.6
31/03/2025	32.2
28/02/2025	34.7
31/01/2025	34.7
31/12/2024	34.9
30/11/2024	34.5
31/10/2024	32.2
30/09/2024	33.3

Integrated Performance Dashboard - Urgent & Unscheduled Care

Lead Director: Gareth Clinkscale

AAU Admissions

i-Chart: Increase the number of patients admitted to AAU by 10%.

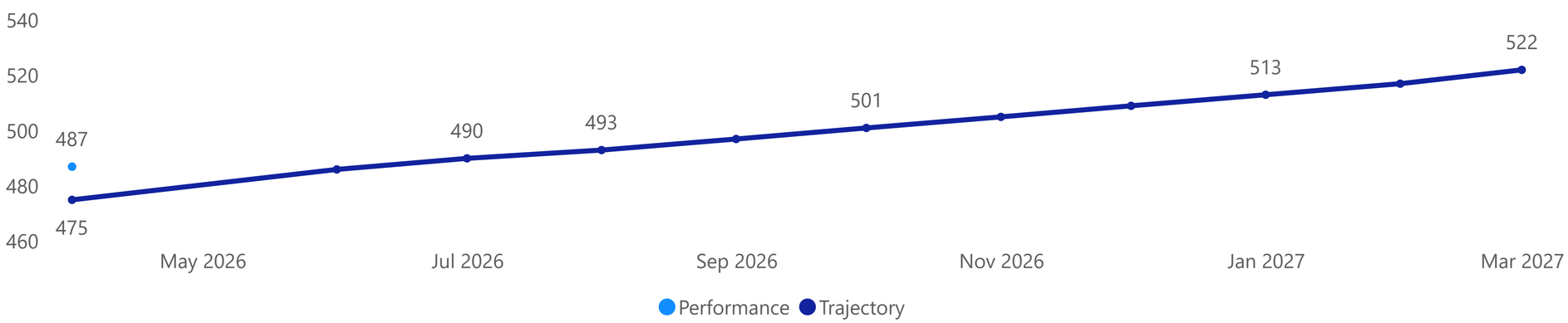


Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Current performance is within normal tolerance levels.

MonthEndDate	Admissions
30/04/2026	487
31/03/2026	475
28/02/2026	408
31/01/2026	409
31/12/2025	426
30/11/2025	378
31/10/2025	385
30/09/2025	364
31/08/2025	346
31/07/2025	379
30/06/2025	370
31/05/2025	398
30/04/2025	357
31/03/2025	332
28/02/2025	324
31/01/2025	301
31/12/2024	261
30/11/2024	300
31/10/2024	318
30/09/2024	246

Performance against Trajectory

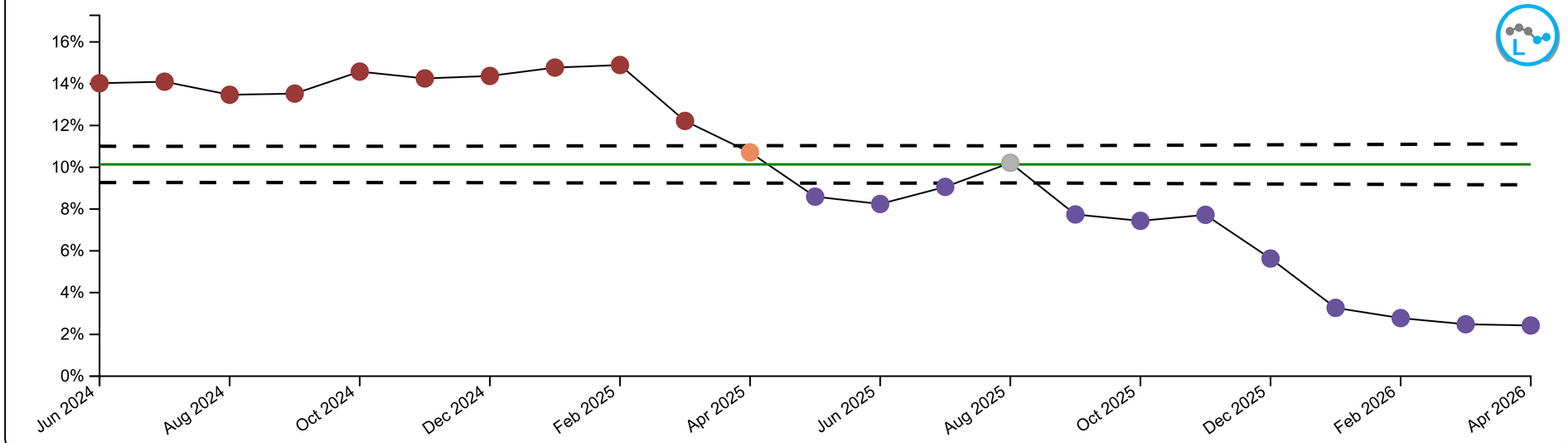


Integrated Performance Dashboard - Planned Care

Lead Director: Oliver Bennett

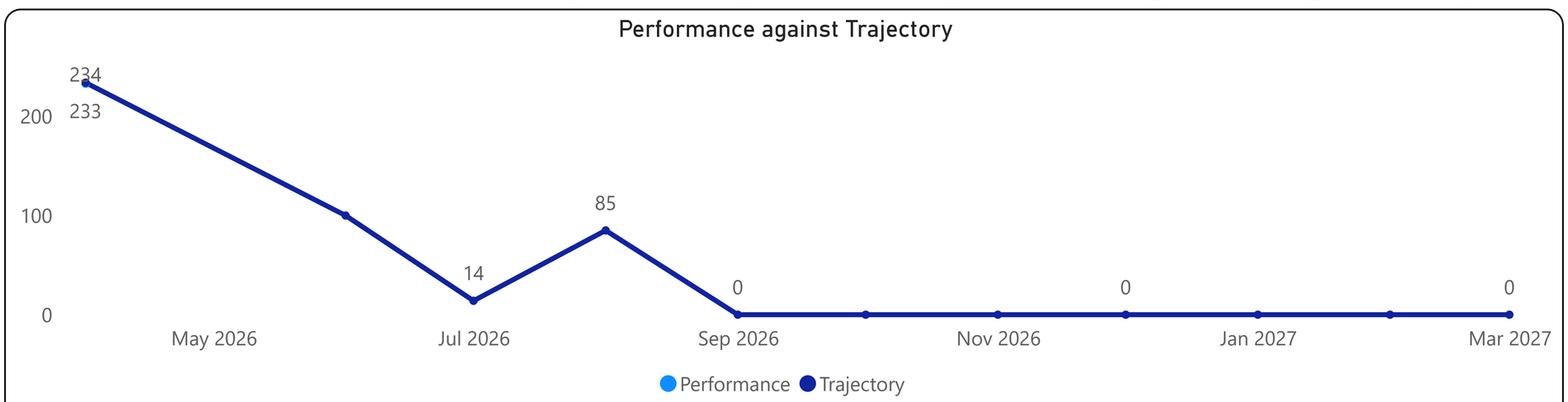
NOP - Over 52 Weeks

u-Chart: Deliver sustained compliance with outpatient waiting times by achieving zero 52-week waits from April 2027 maintaining zero tolerance for 78+ week waits.



Current performance is within normal tolerance levels.

These trajectories have been set on the planning assumption that funding to achieve this level of performance will be allocated from the Scottish Government. If this funding is not allocated or a reduced allocation these trajectories will require to be reassessed.



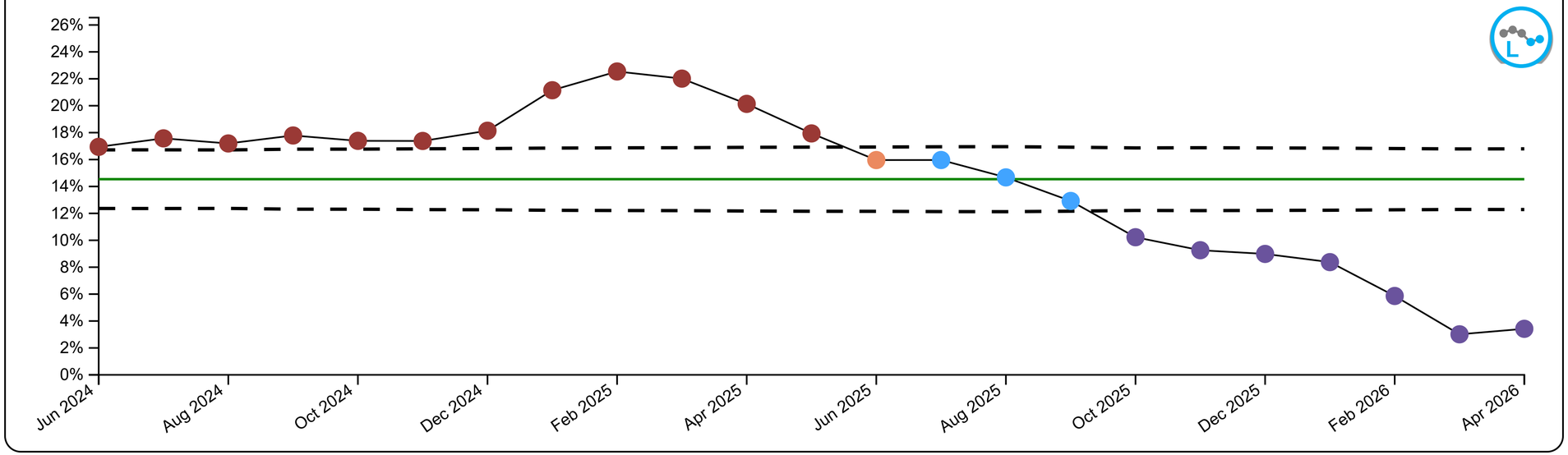
EndOfMonth	Waiting Over 52 Weeks
30/04/2026	233
31/03/2026	240
28/02/2026	275
31/01/2026	332
31/12/2025	583
30/11/2025	831
31/10/2025	808
30/09/2025	877
31/08/2025	1185
31/07/2025	1034
30/06/2025	930
31/05/2025	972
30/04/2025	1216
31/03/2025	1405

Integrated Performance Dashboard - Planned Care

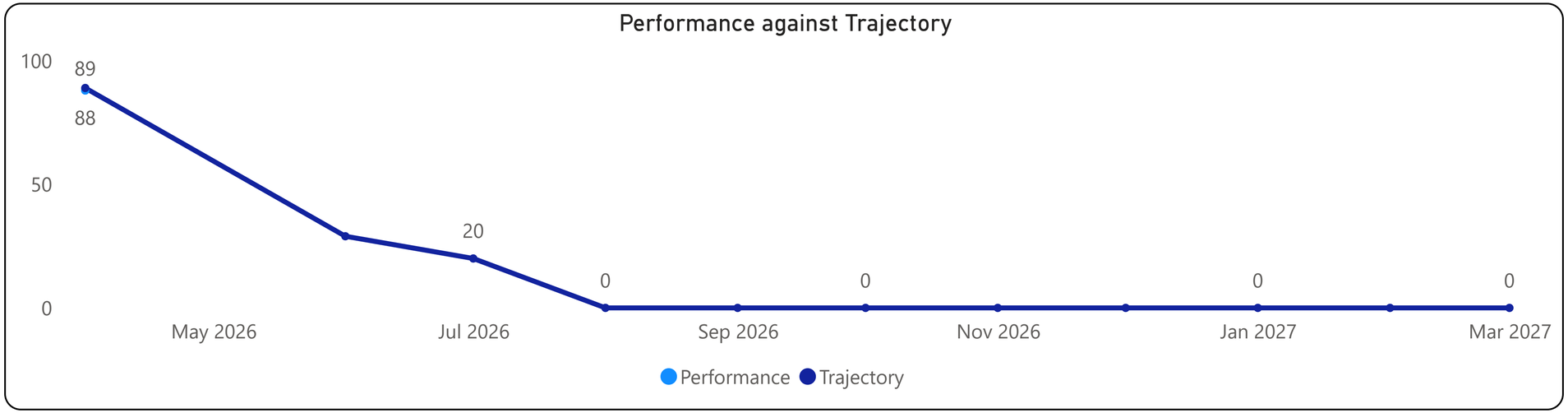
Lead Director: Oliver Bennett

TTG - Over 52 Weeks

u-Chart: Deliver sustained compliance with inpatient waiting time standards by achieving zero 52-week waits from April 2026 and maintaining zero tolerance for 78+ week waits across all specialties, including TTG.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within normal tolerance levels.

These trajectories have been set on the planning assumption that funding to achieve this level of performance will be allocated from the Scottish Government. If this funding is not allocated or a reduced allocation these trajectories will require to be reassessed.

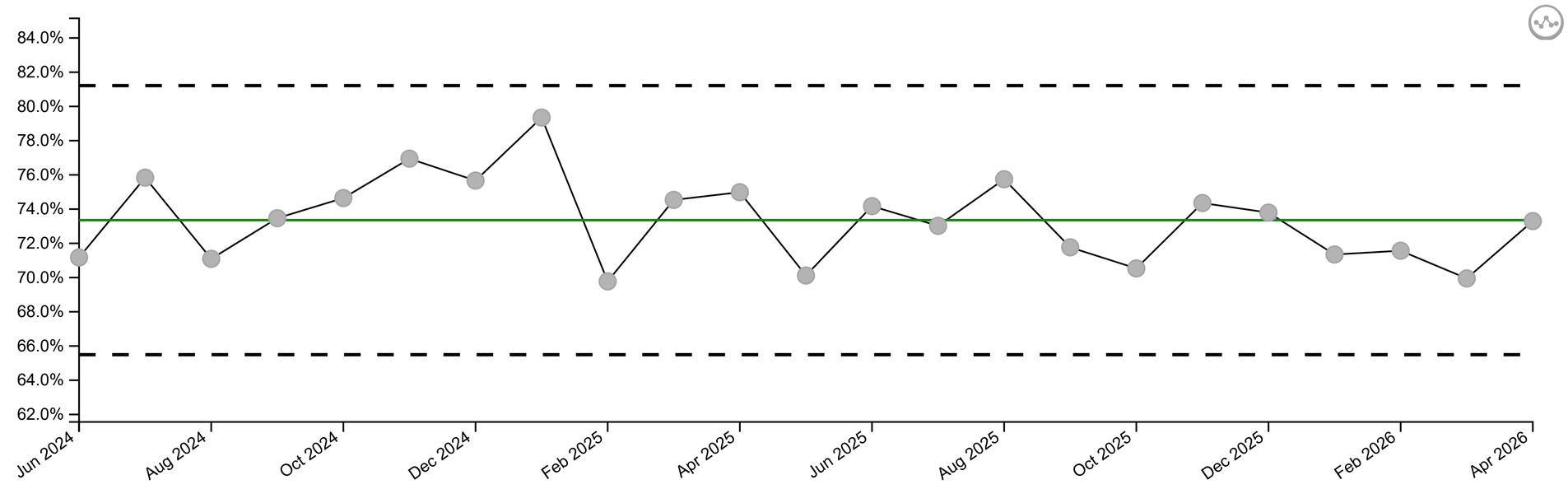
EndOfMonth	Waiting Over 52 Weeks
30/04/2026	88
31/03/2026	78
28/02/2026	148
31/01/2026	206
31/12/2025	218
30/11/2025	222
31/10/2025	248
30/09/2025	299
31/08/2025	329
31/07/2025	360
30/06/2025	366
31/05/2025	413
30/04/2025	471

Integrated Performance Dashboard - Planned Care

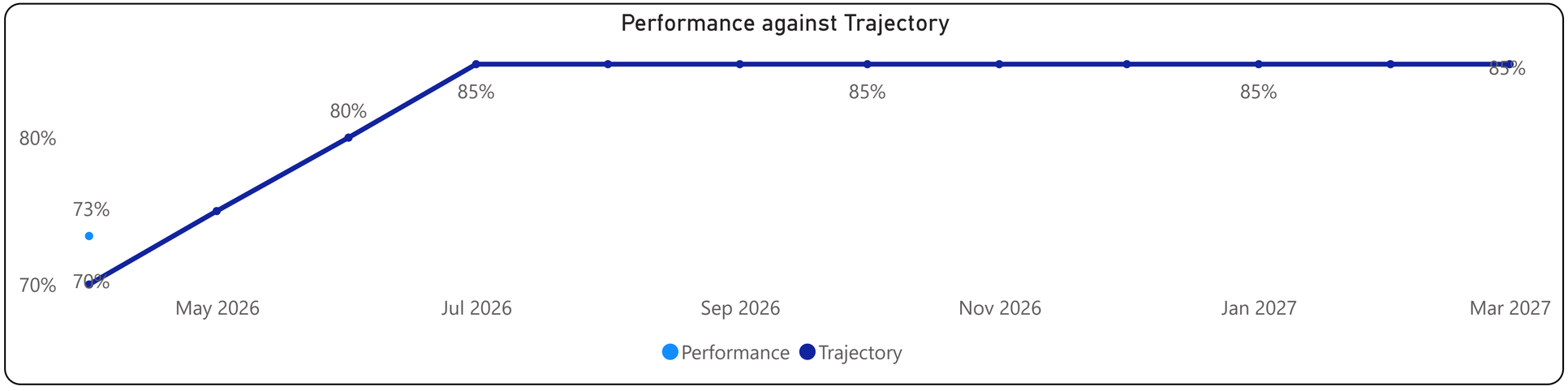
Lead Director: Oliver Bennett

Theatre Utilisation

i-Chart: Maximise elective theatre productivity by achieving at least 85% utilisation by July 2026.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within normal tolerance levels.

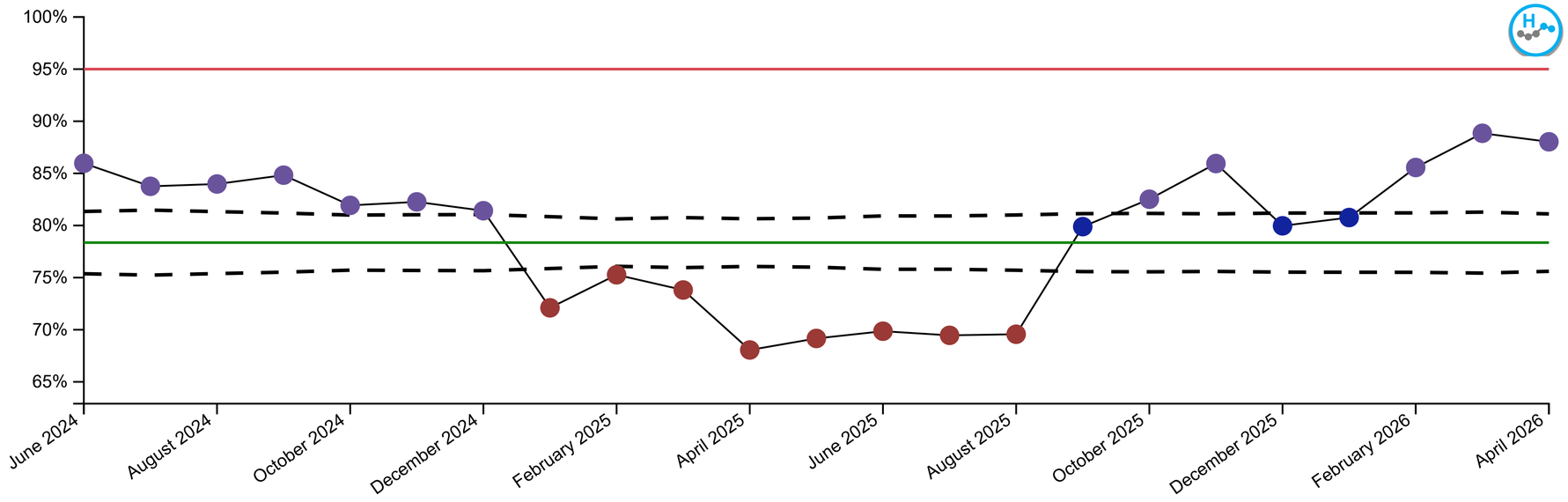
MonthEnding	Utilisation %
30/04/2026	73.3%
31/03/2026	69.9%
28/02/2026	71.6%
31/01/2026	71.3%
31/12/2025	73.8%
30/11/2025	74.4%
31/10/2025	70.5%
30/09/2025	71.8%
31/08/2025	75.7%
31/07/2025	73.0%
30/06/2025	74.2%
31/05/2025	70.1%
30/04/2025	75.0%
31/03/2025	74.5%
28/02/2025	69.8%
31/01/2025	79.3%
31/12/2024	75.7%
30/11/2024	76.9%
31/10/2024	74.6%
30/09/2024	73.5%
31/08/2024	71.1%

Integrated Performance Dashboard - Planned Care

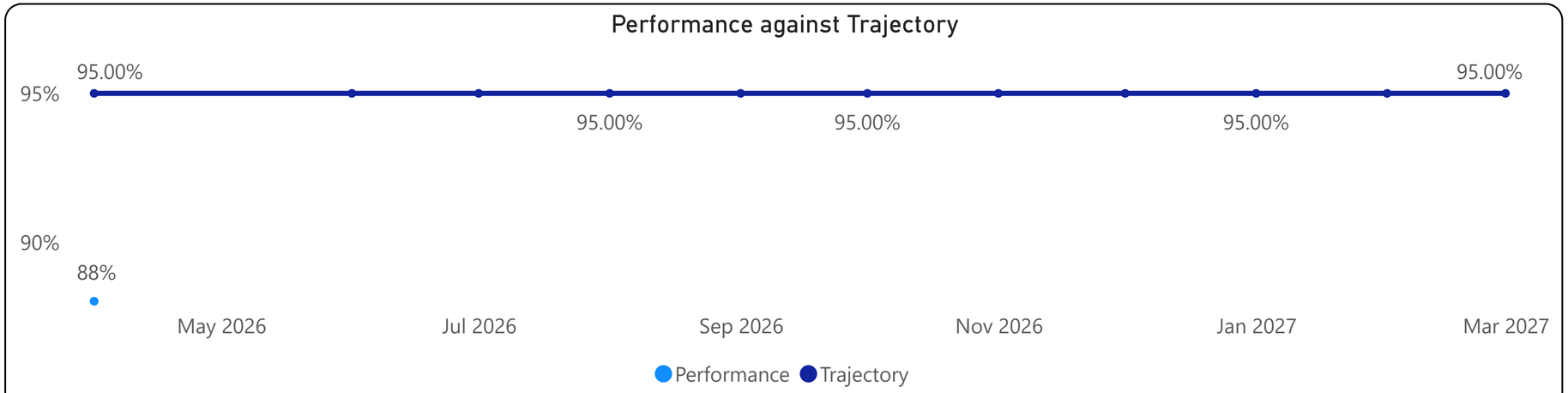
Lead Director: Oliver Bennett

Diagnostic Patients Seen within 6 Weeks

i-Chart: Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within 10% of tolerance levels, for further detail please see the performance improvement and oversight report.

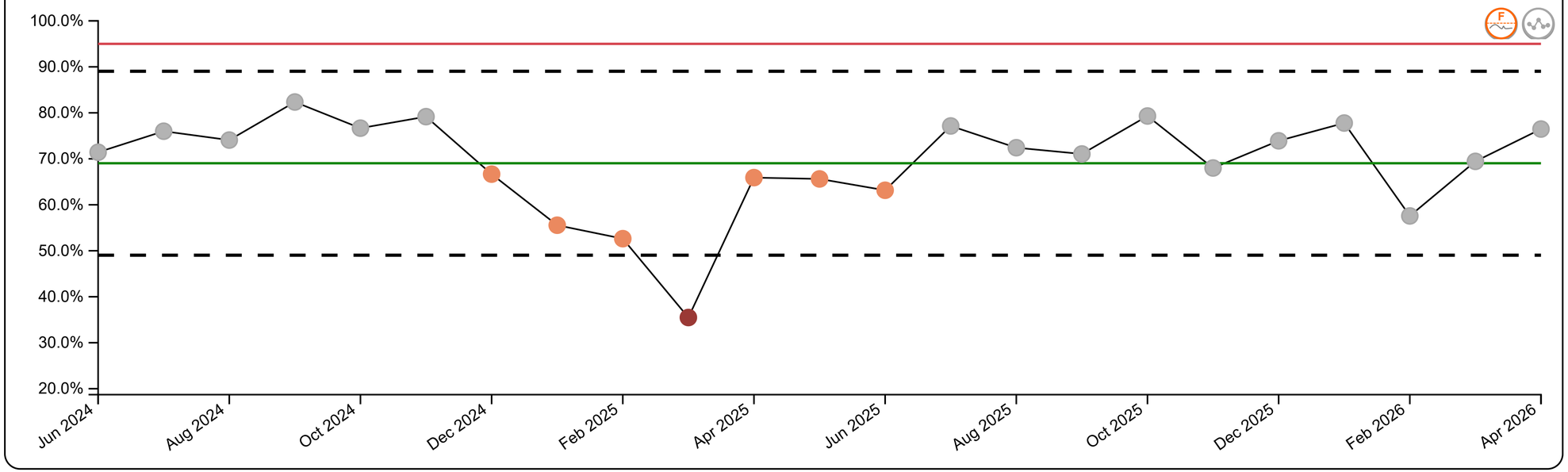
Month/Year	Seen within 6 Weeks	%
April 2026	1772	88%
March 2026	1585	89%
February 2026	1606	86%
January 2026	1524	81%
December 2025	1521	80%
November 2025	1718	86%
October 2025	1605	83%
September 2025	1577	80%
August 2025	1511	70%
July 2025	1624	69%
June 2025	1627	70%
May 2025	1902	69%
April 2025	1990	68%
March 2025	1956	74%
February 2025	2222	75%
January 2025	1778	72%
December 2024	1713	81%
November 2024	1758	82%
October 2024	1791	82%
September 2024	1610	85%

Integrated Performance Dashboard - Cancer Care

Lead Director: Oliver Bennett

Cancer - Treated within 62 Days

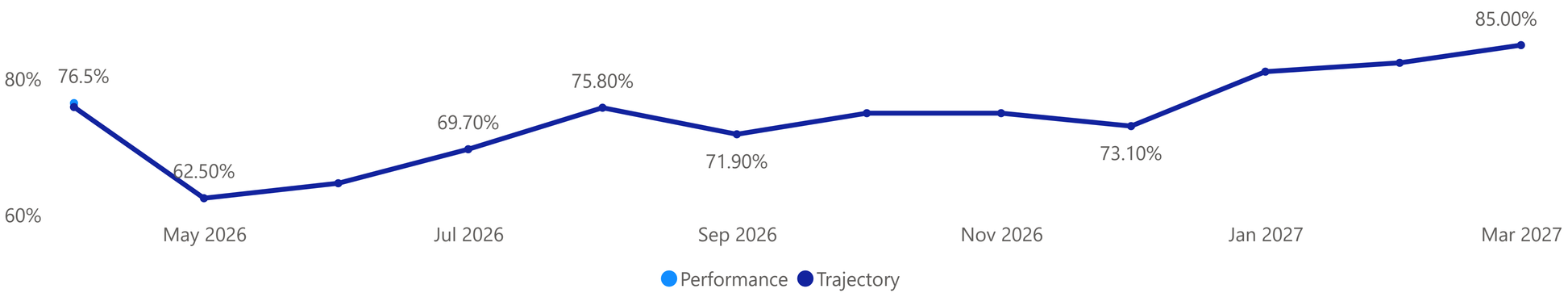
i-Chart: Improve timely access to cancer treatment by achieving 85% of patients treated within 62 days of urgent referral by March 2027.



Current performance is within normal tolerance levels.

Treat Month	62Day%
April 2026	76.5%
March 2026	69.4%
February 2026	57.6%
January 2026	77.8%
December 2025	73.9%
November 2025	68.0%
October 2025	79.3%
September 2025	71.1%
August 2025	72.4%
July 2025	77.1%
June 2025	63.2%
May 2025	65.6%
April 2025	65.9%
March 2025	35.5%
February 2025	52.6%
January 2025	55.6%
December 2024	66.7%
November 2024	79.2%
October 2024	76.7%

Performance against Trajectory



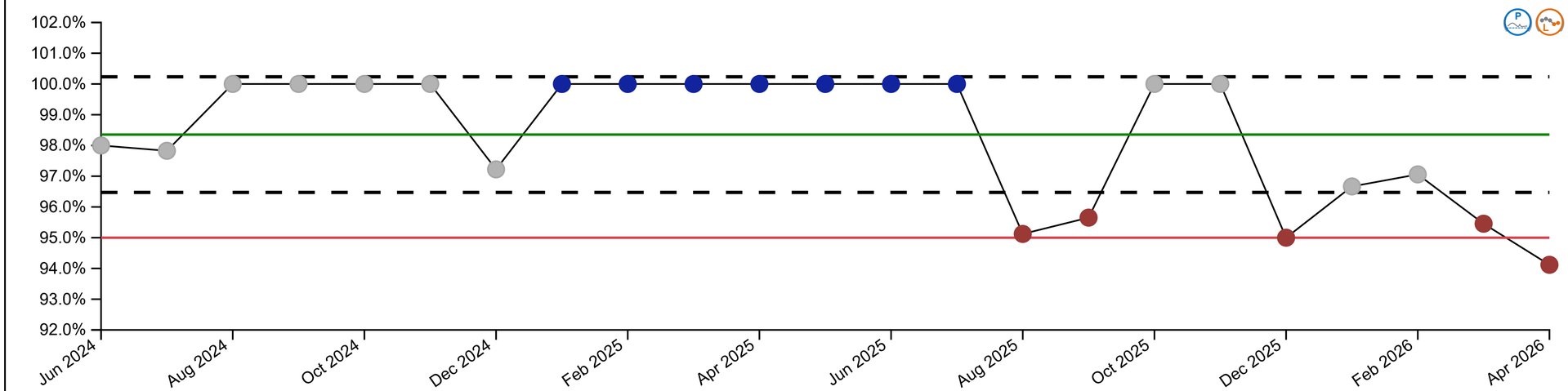
95% Target | Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift

Integrated Performance Dashboard - Cancer Care

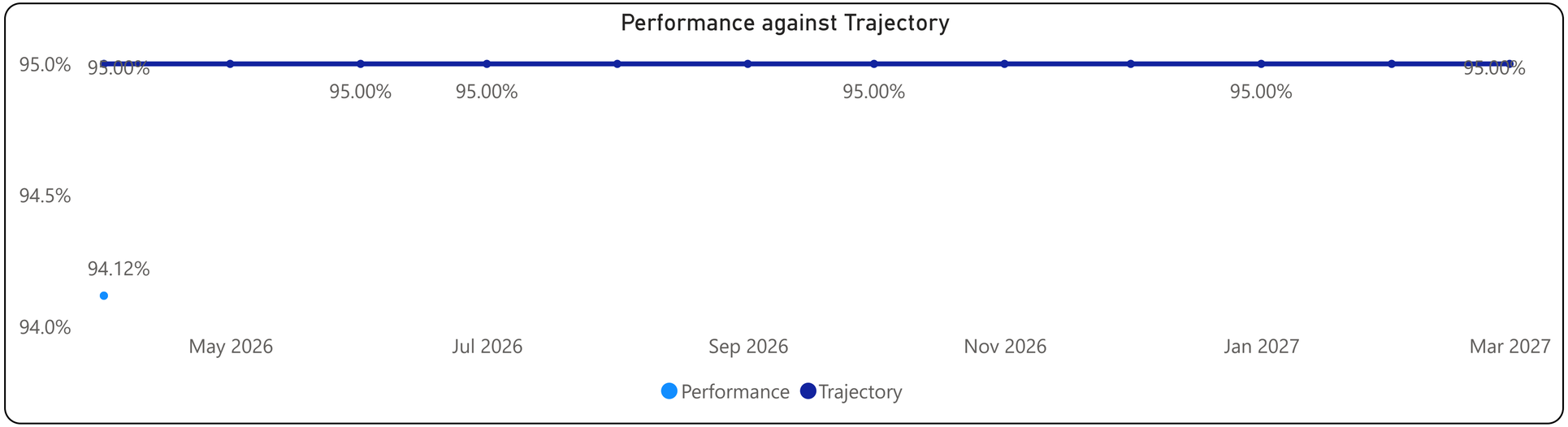
Lead Director: Oliver Bennett

Cancer - Treated within 31 Days

i-Chart: Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027, ensuring at least 95% of eligible patients start treatment within 31 days of decision to treat.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within 10% of tolerance levels, for further detail please see the performance improvement and oversight report.

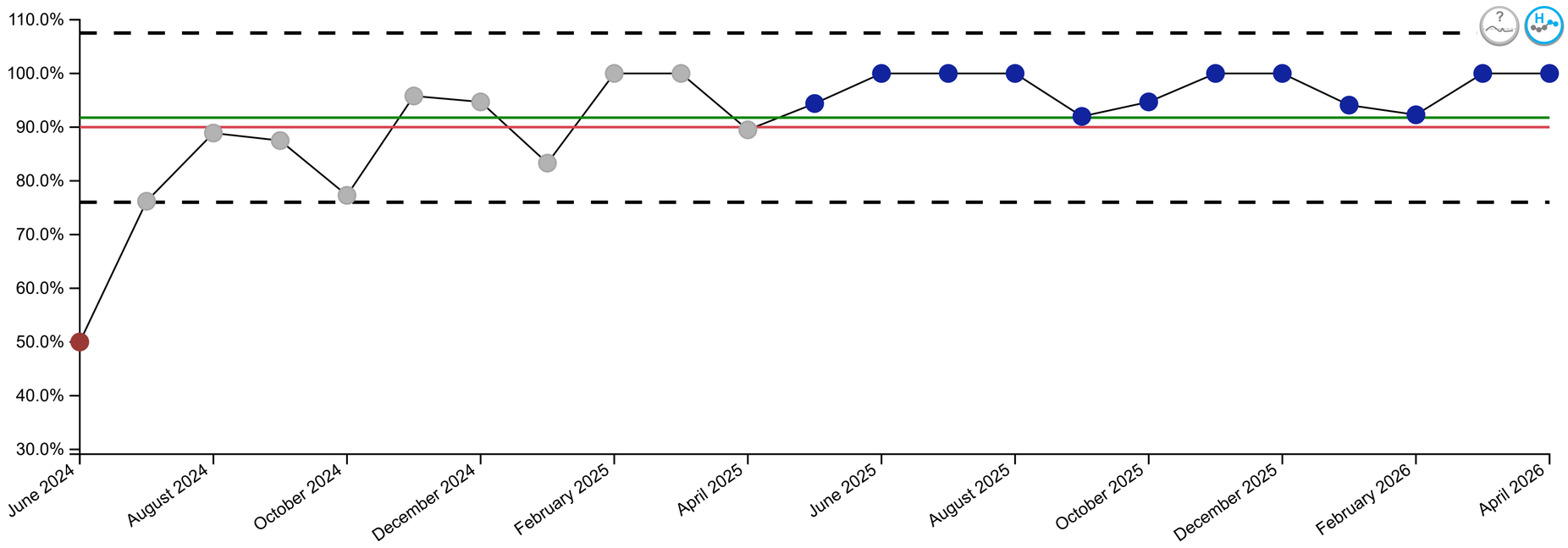
Treat Month	31Day%
April 2026	94.1%
March 2026	95.5%
February 2026	97.1%
January 2026	96.7%
December 2025	95.0%
November 2025	100.0%
October 2025	100.0%
September 2025	95.7%
August 2025	95.1%
July 2025	100.0%
June 2025	100.0%
May 2025	100.0%
April 2025	100.0%
March 2025	100.0%
February 2025	100.0%
January 2025	100.0%
December 2024	97.2%
November 2024	100.0%
October 2024	100.0%
September 2024	100.0%

Integrated Performance Dashboard - Mental Health

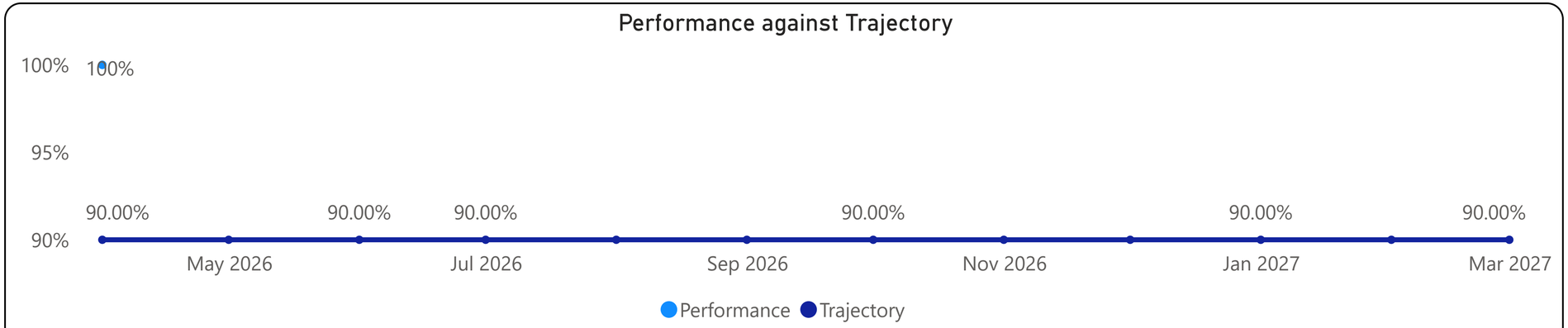
Lead Director: Gareth Clinkscale

CAMHS RTT

i-Chart: 90% of patients received CAMHS treatment within 18 weeks of referral.



Mean Line — 99% Limits - - - - - - Imp. Trend Det. Trend Imp. Ast. Point Det. Ast. Point Imp. Shift Det. Shift



Current performance is within normal tolerance levels.

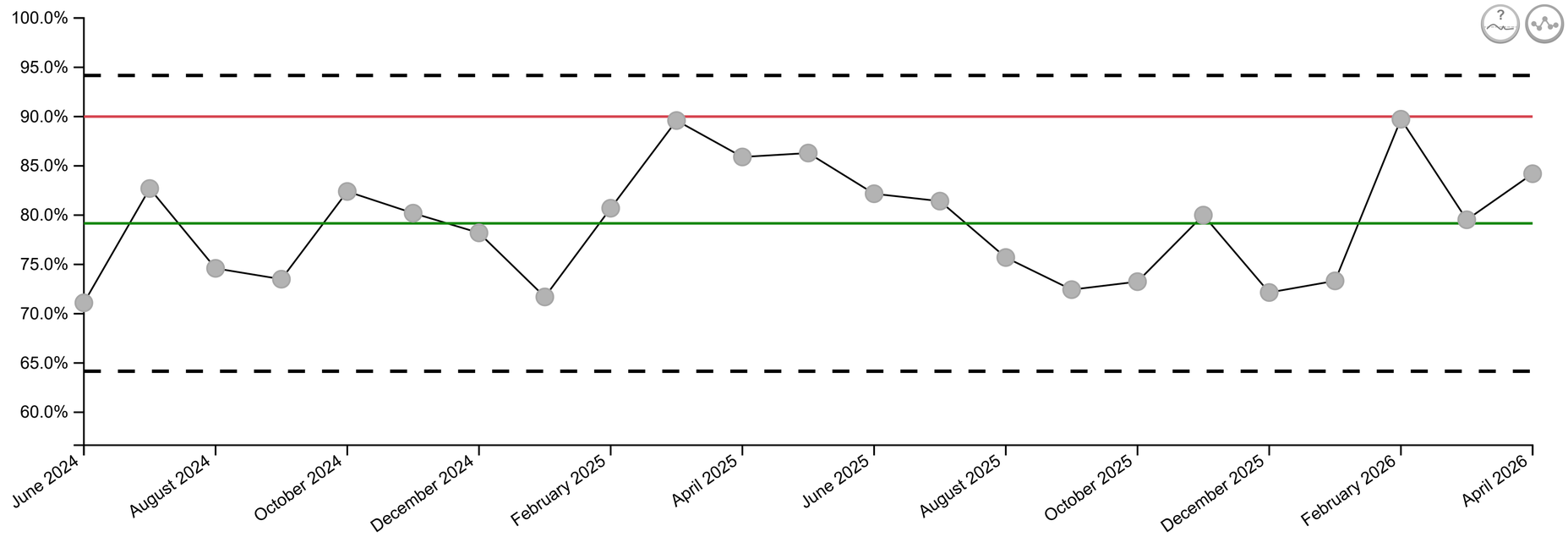
Month	Treatment %
April 2026	100.00%
March 2026	100.00%
February 2026	92.30%
January 2026	94.10%
December 2025	100.00%
November 2025	100.00%
October 2025	94.70%
September 2025	92.00%
August 2025	100.00%
July 2025	100.00%
June 2025	100.00%
May 2025	94.40%
April 2025	89.50%
March 2025	100.00%
February 2025	100.00%
January 2025	83.30%
December 2024	94.70%
November 2024	95.80%
October 2024	77.30%
September 2024	87.50%
August 2024	88.90%

Integrated Performance Dashboard - Mental Health

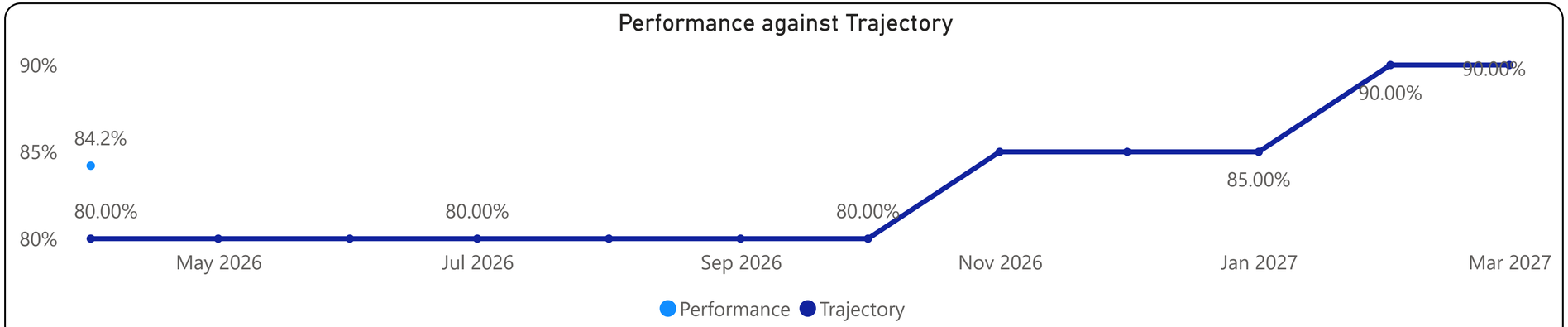
Lead Director: Gareth Clinkscale

Psychological Therapy

i-Chart: 90% of patients received PT treatments within 18 weeks of referral.



Mean Line | 99% Limits | Imp. Trend | Det. Trend | Imp. Ast. Point | Det. Ast. Point | Imp. Shift | Det. Shift



Current performance is within normal tolerance levels.

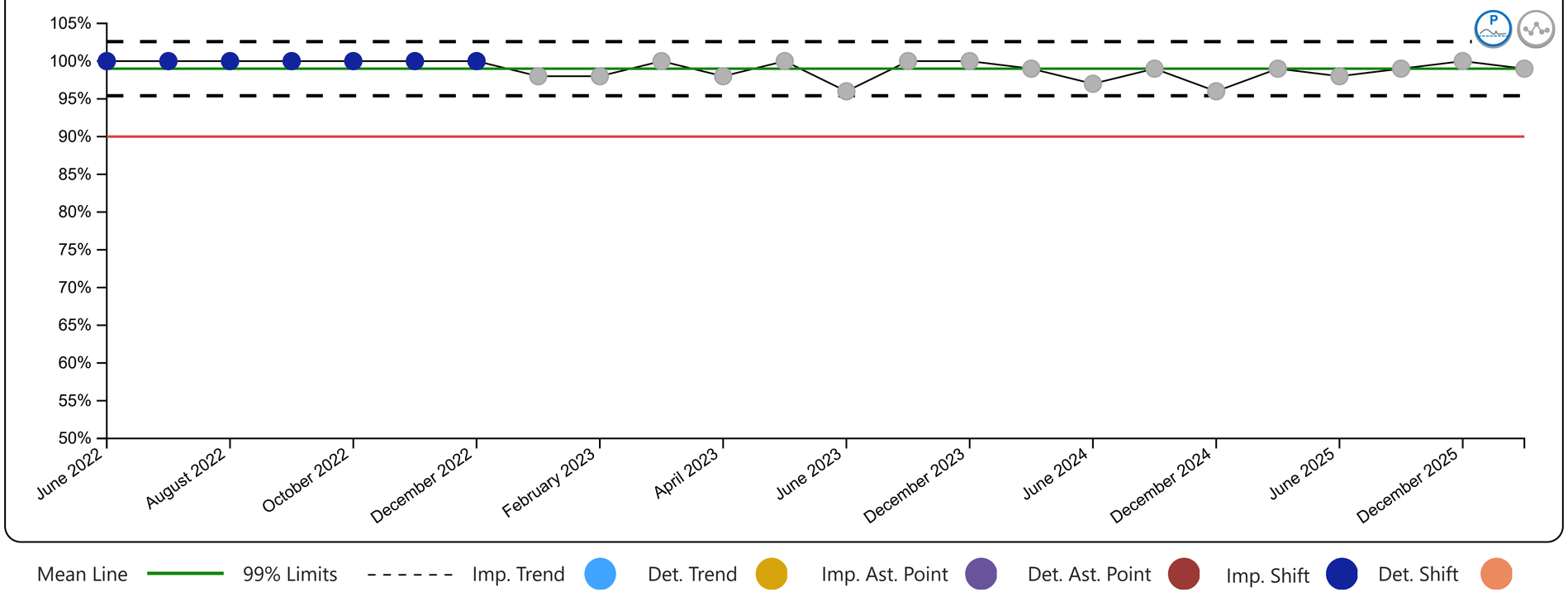
Month	Treatment %
April 2026	84.2%
March 2026	79.5%
February 2026	89.7%
January 2026	73.3%
December 2025	72.2%
November 2025	80.0%
October 2025	73.3%
September 2025	72.4%
August 2025	75.7%
July 2025	81.4%
June 2025	82.2%
May 2025	86.3%
April 2025	85.9%
March 2025	89.6%
February 2025	80.7%
January 2025	71.7%
December 2024	78.2%
November 2024	80.2%
October 2024	82.4%
September 2024	73.5%
August 2024	74.6%

Integrated Performance Dashboard - Mental Health

Lead Director: Gareth Clinkscale

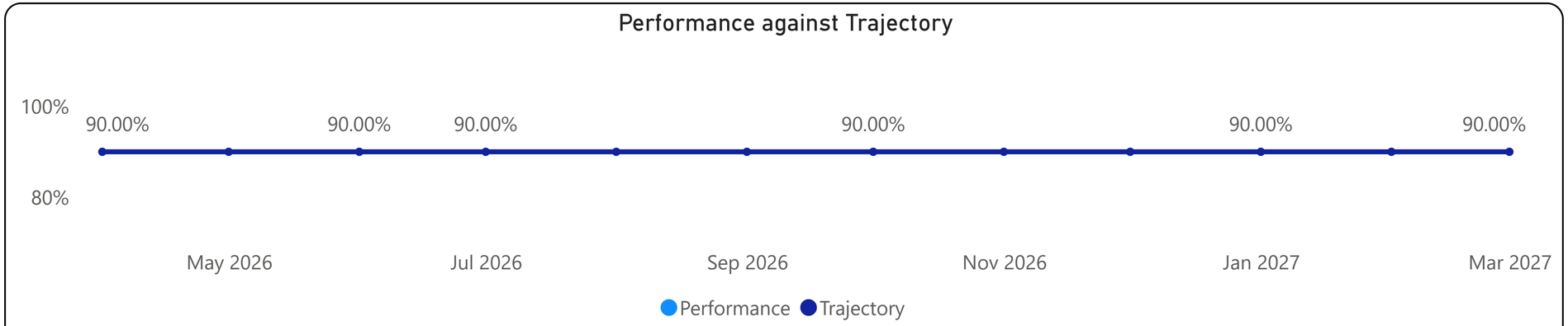
BAS 3 Week Target

i-Chart: 90% of patients received BAS treatments within 3 weeks of referral.



Current performance is within normal tolerance levels.

Date	Treatment %
March 2026	99%
December 2025	100%
September 2025	99%
June 2025	98%
March 2025	99%
December 2024	96%
September 2024	99%
June 2024	97%
March 2024	99%
December 2023	100%
September 2023	100%
June 2023	96%
May 2023	100%
April 2023	98%
March 2023	100%
February 2023	98%
January 2023	98%
December 2022	100%
November 2022	100%
October 2022	100%
September 2022	100%



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

Quality & Performance Improvement Oversight Report

June 2026

(April Performance)

Performance Gap Recovery Template

When an agreed performance measure falls outside the tolerated range of the agreed performance trajectory, this template will be completed by Service Leads and approved by the Executive Lead, detailing the cause of the performance gap, the key recovery actions required to return to the agreed performance level, how each action will support recovery, the owner responsible for delivery, and the expected delivery timeline.

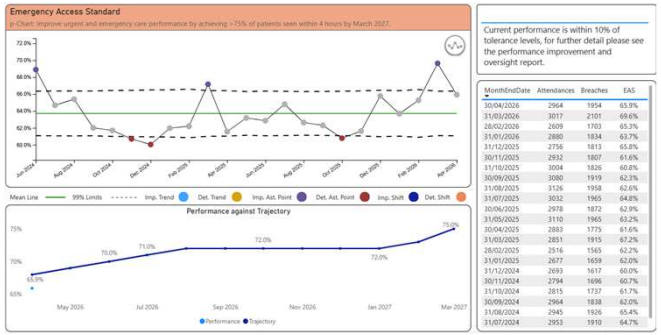
	Performance is within trajectory – no action required
	Performance gap is within 10% of the agreed trajectory – ½ page per indicator
	Performance gap is outwith 10% of the agreed trajectory – 1 page per indicator

Quality & Performance Indicators: UUC

Strategy Alignment	Aim Statement	Monitoring and Assurance Route	April Performance/RAG
Ensure that Primary & community services can support as many people back to good health as possible/Making secondary care fast, efficient and effective	Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**65.9%**
Ensure that Primary & community services can support as many people back to good health as possible	Reduce 12-hour waits to <9% by July 2026 and <7% by March 2027.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**10%**
Making secondary care fast, efficient and effective	Reduce average non-elective length of stay by 1 day by March 2027, Excludes paeds/obstetrics & ITU.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**9.9**
Making secondary care fast, efficient and effective	Average number of Acute occupied beds 85%.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**84.2%**
Ensure that Primary & community services can support as many people back to good health as possible	Sustain delayed discharges at <40.	UUC Programme Board - PCS Clinical Board - BDG - RPC	**43**
Making secondary care fast, efficient and effective	Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**33.13**
Ensure that Primary & community services can support as many people back to good health as possible	Increase the number of patients admitted to AAU by 10%.	UUC Programme Board -Acute Clinical Board - BDG - RPC	**489**

Amber = Off trajectory (Performance Gap within 10% tolerance) – Urgent & Unscheduled Care

Aim Statement: Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.
April Performance: 65.9%



What is driving this performance gap: Attendances significantly higher than previous year and environmental and infection control issues have affected bed capacity and flow. This has in turn resulted in an overcrowded Emergency Department, and 'exit block' has meant patients have waited longer in the dept. Delivering sufficient discharges to meet demand at the right time has prevented optimal flow and caused unnecessary delays.

What key actions are we taking to close the performance gap:

Action	Impact
Early supported discharge & community rehabilitation project.	TBC
Integrated community hub and access design with person-centred assessment project.	TBC
Community access and prevention services project.	TBC
Inpatient flow and discharge optimisation project	TBC
Reablement capacity project	TBC
Acute pathway design – front door and downstream project	TBC
Alternatives to admission (virtual capacity) project	TBC
Nursing home transformation project	TBC

Strategic Objective:

Risk No: N/A

Risk Grading:

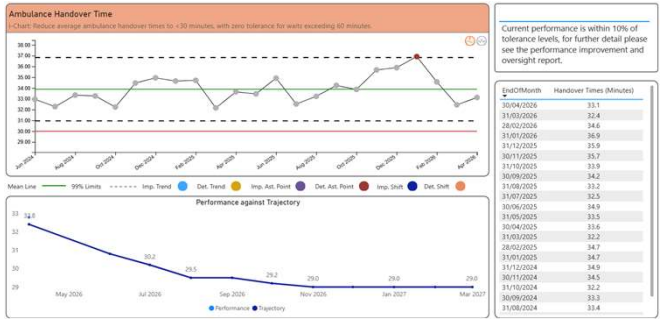
Risk Appetite:

Risk Approach:

Target Risk Level:

Executive Lead: Gareth Clinkscale

Aim Statement: Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.
April Performance: 33.13 minutes



What is driving this performance gap: April performance was 33 minutes against the required trajectory of <30 minutes, which is the best performance in Scotland. An overcrowded Emergency Department with 'exit block' results in ambulance handover delays. The pattern of ambulance conveyances during the day also impacts on handover and this is being monitored.

What key actions are we taking to close the performance gap:

Action	Impact
Fully deliver and embed HALO project	2 mins
Delivery of the unscheduled care improvement plan priorties (described above) will support flow and decongest the Emergency Dept improving handover	2-5 mins

Strategic Objective:

Risk No: N/A

Risk Grading:

Risk Appetite:

Risk Approach:

Target Risk Level:

Exec Lead: Gareth Clinkscale

Quality & Performance Indicators: Planned Care

Strategy Alignment	Aim Statement	Monitoring and Assurance Route	April Performance/RAG
Making Secondary Care fast, efficient and effective	Deliver sustained compliance with outpatient waiting times by achieving zero 52-week waits from April 2027 maintaining zero tolerance for 78+ week waits.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**233**
Making Secondary Care fast, efficient and effective	Deliver sustained compliance with inpatient waiting time standards by achieving zero 52-week waits from April 2026 and maintaining zero tolerance for 78+ week waits across all specialties, including TTG.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**89**
Making Secondary Care fast, efficient and effective	Maximise elective theatre productivity by achieving at least 85% utilisation by July 2026.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**73.3%**
Making Secondary Care fast, efficient and effective	Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**88%**
Making Secondary Care fast, efficient and effective	Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**94.1%**
Making Secondary Care fast, efficient and effective	Improve timely access to cancer treatment by achieving 85% of patients treated within 62 days of urgent referral by March 2027.	Planned Care Programme Board -Acute Clinical Board - BDG - RPC	**76.1%**

Amber = Off trajectory (Performance Gap within 10% tolerance) – Planned Care

Aim Statement: Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.
April Performance: 88%

What is driving this performance gap:
Radiology is achieving the 95% performance standard consistently; the performance challenge is in scope waiting times and is still consistent capacity sufficient to meet variable demand. NHS Borders performed 97.17% against the 6-week target for OGD in 25-26 and were the best performing board in Scotland. Colonoscopy was 69.84% against the 6-week target in 25-26. Scotland's overall performance was 62.88%.

What key actions are we taking to close the performance gap:

Action	Impact
Continue to book weekend colonoscopy clinics to support capacity.	Reduce waiting times for USOC and Urgent scopes
Relocate Truss Biopsies from the endoscopy department by end August 2026.	1 extra list per week
Optimise productivity and existing capacity	Increase capacity (amount TBC)
Develop capacity and demand plan for endoscopy	

Strategic Objective: Making Secondary Care fast, efficient and effective

Risk No:

Risk Grading:

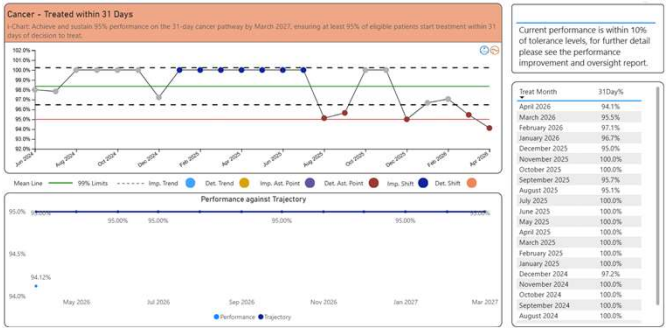
Risk Appetite:

Risk Approach:

Target Risk Level:

Exec Lead: Oliver Bennett

Aim Statement: Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027, ensuring at least 95% of eligible patients start treatment within 31 days of decision to treat.
April Performance: 94.1%



What is driving this performance gap:
Performance against this standard is consistently above the national standard of 95%. However, in April 2026, 2 patients breached the standard. Both had surgery as their first treatment; one patient was delayed due to unforeseen consultant availability, and the other had their surgery rescheduled due to ITU bed availability.

What key actions are we taking to close the performance gap:

Action	Impact
A new Trak report has been developed for Central Booking to highlight patients who are potentially reportable against this standard	This will enable earlier identification of patients who need to be appointed within 28-days, and support improved planning of theatre lists and capacity
Cancer Trackers will continue to highlight patients to Central Booking and Service Managers with an escalation process up to executive level.	Support escalation of patients who are booked outwith required timescales / standards

Strategic Objective: Making Secondary Care fast, efficient and effective

Risk No: N/a

Risk Grading: Low

Risk Appetite: Low

Risk Approach: Tolerate

Target Risk Level: Low

Exec Lead: Oliver Bennett

Quality & Performance Indicators: P&CS, MH/LD

Strategy Alignment	Aim Statement	Monitoring and Assurance Route	April Performance/RAG
Ensure that Primary & Community Services can support as many people back to good health as possible	90% of patients received CAMHS treatment within 18 weeks of referral.	MH Clinical Board - BDG - RPC	**100%**
Ensure that Primary & Community Services can support as many people back to good health as possible	90% of patients received PT treatments within 18 weeks of referral.	MH Clinical Board - BDG - RPC	**84.17%**
Supporting People to Keep Themselves Well	% of patients received treatments within 3 weeks of referral.	MH Clinical Board - BDG - RPC	**99%**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Board Committee Appointments**
Responsible Executive/Non-Executive:	**F Sandford, Chair**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Chair Appointment
F Sandford has been formally appointed by the Cabinet Secretary as Chair of NHS Borders Board with effect from 01.04.26 to 31.03.2030.

A recruitment campaign is now underway to appoint a further Non Executive Director to fill the vacancy created by the appointment of F Sandford to the Chair role.

Non Executive Committee Memberships
It is good practice for Non Executives to be exposed to the full range of Committees that service the Board and as part of the annual Appraisal process for Non Executives, the Chair discusses with them the range of Committees they service.

This report provides an update to the changes in Board memberships since those agreed by the Board on 5 February 2026.

- J Pepper will join the Integration Joint Board Audit Committee.
- L O'Leary will join the Remuneration Committee.

Further discussions will take place on the appointment of a new Non Executive to the Board in regard to membership of the following Committees:-

- Audit & Risk Committee (requires 4 Non Executives)
- Staff Governance Committee (requires 4 Non Executives)
- Remuneration Committee (requires 5 Non Executives)

On the appointment of a new Non Executive the role of Sustainability Champion will also be discussed.

2.2 Background

In line with the Code of Corporate Governance the Board must approve the Non Executive membership, including the appointment of Chairs and Vice Chairs as appropriate, of its Committees.

2.3 Assessment

This report provides an update to the changes in Board memberships since those agreed by the Board on 5 February 2026.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Committees are created as required by statute, guidance, regulation and Ministerial direction and to ensure efficient and effective governance of the Boards' business.

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 report has been prepared directly for the Board.

2.4 Recommendation

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

The Board is asked to **note** the changes in Non Executive memberships of its Committees as above and as set out in the NHS Borders Non Executives Committee Chart (Appendix 1).

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Board Committee Memberships

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2026 – 17.06.26

Name/Cttee	**Vacant** (Hold for savings)	**John McLaren** (APF)	**Fiona Sandford** (Chair)	**Jacquie Pepper**	**Paul Williams** (ACF)	**Lucy O'Leary** (Digital Champion) (Vice Chair)	**Cllr David Parker** (LA)	**Lynne Livesey** (Whistle-blowing Champion)	**Vacant** (Sustain-ability Champion)	**James Ayling**	**Exec Lead & Secretariat**
Borders NHS Board (All NEDs) (Quoracy 1/3 all members)	**X**	**X**	**C**	**X**	**X**	**VC**	**X**	**X**	**X**	**X**	CEO BS
GOVERNANCE											
Resources & Performance Committee (All NEDs) (Quoracy 2 NEDs)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**C**	CEO BS
Audit & Risk Committee (4 NEDs) (Quoracy 2 NEDs)						**X**	**X**	**C**	**X**		DoF DoF PA
Clinical Governance Committee (4 NEDs) (Quoracy 2 NEDs)				**X**	**X**	**C**		**X**			DoQI CG&Q PA
Staff Governance Committee (4 NEDs) (Quoracy 2 NEDs)		**X**					**C**	**X**	**X**		DHR DHR PA
Remuneration Committee (5 NEDs) (Quoracy 3 NEDs)		**X**	**X**			**X**			**X**	**C**	DHR BS
Area Clinical Forum (Chair ACF) (Quoracy 1/3 all members)					**C**			**A**			ACF Chair ACF PA
PARTNERSHIP											
Area Partnership Forum (Chair APF) Quoracy 5 x Management, 5 x Staff Side)		**C**									ED ED PA
Community Planning Partnership Strategic Board (Chair & Vice Chair)			**X**			**X**					SBC
CYPPP Board (1 NED)										**X**	SBC
Police, Fire & Rescue & Safer Communities Board (1 NED)										**X**	SBC

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2026 – 17.06.26

Name/Cttee	Vacant (Hold for savings)	John McLaren (APF)	Fiona Sandford (Chair)	Jacquie Pepper	Paul Williams (ACF)	Lucy O'Leary (Digital Champion) (Vice Chair)	Cllr David Parker (LA)	Lynne Livesey (Whistle-blowing Champion)	Vacant (Sustain-ability Champion)	James Ayling	Exec Lead & Secretariat
OTHERS											
Health Charity Trustees (All NEDs)	**X**	**X**	**C**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	DoF DoF PA
Expert Advisory Group to Health Charity (4 NEDs)	**X**	**C**		**X**	**X**						DoP&P DoP&P PA
Car Park Appeals Panel (1 NED)		**C**									GSM GSM
Values Based Healthcare					**X**					**X**	MD PA
Health & Care Staffing Board								**X**			DoNM DoNM PA
Whistleblowing Champion								**X**			Scot Gov't
Sustainability Champion									**X**		Scot Gov't
Digital Champion						**X**					Scot Gov't
OCCASIONAL/AS AND WHEN NECESSARY											
Discretionary Points Committee (Annual)				**C**							DHR DDHR
Pharmacy Practices Committee	**X**										MD DoP PA
Dental Appeals Panel (1 NED required at the final escalation stage only)											MD MD PA
ECR Panels (1 NED required at the final escalation stage only)											MD DPH PA
Dismissal Appeal Hearings (1 NED required on all dismissal appeal hearings as per NHSS Formal Hearing Guide)											DHR DDHR
LINKAGES											
Mental Health Partnership Board										**A**	GM MH&LD PA
Learning Disability						**A**					GM MH&LD

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2026 – 17.06.26

Name/Cttee	Vacant (Hold for savings)	John McLaren (APF)	Fiona Sandford (Chair)	Jacquie Pepper	Paul Williams (ACF)	Lucy O'Leary (Digital Champion) (Vice Chair)	Cllr David Parker (LA)	Lynne Livesey (Whistle-blowing Champion)	Vacant (Sustain-ability Champion)	James Ayling	Exec Lead & Secretariat
Partnership Board											PA
Organ Donation Committee (Chaired by Harriet Campbell, as a member of the public)											Hospital Management
TOTAL	**4**	**8**	**5**	**6**	**7**	**8**	**5**	**9**	**7**	**8**	

Changes highlighted in pink

KEY

C	Chair	DDHR	Deputy Director of HR
VC	Vice Chair	GSM	General Services Manager
X	Member	GM	General Manager
A	Attendee	DoME	Director of Medical Education
CEO	Chief Executive	SBC	Scottish Borders Council
DoF	Director of Finance	ED	Employee Director
DoNMA	Director of Nursing, Midwifery & AHPs	PA	Personal Assistant
DPH	Director of Public Health	CO H&SCI	Chief Officer Health & Social Care Integration
MD	Medical Director	DHR	Director of HR, OD & OH&S
DoQI	Director of Quality & Improvement	CG&Q	Clinical Governance & Quality
DoP&P	Director of Planning & Performance	DoP	Director of Pharmacy
BS	Board Secretary		

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AND ASSOCIATED COMMITTEES

Name/Cttee	Vacant	John McLaren (APF)	Fiona Sandford (Chair)	Jacquie Pepper	Paul Williams (ACF)	Lucy O'Leary (Digital Champion) **(IJB Vice Chair April 2025-28)**	Cllr David Parker (LA) **(IJB Chair April 2025-28)**	Lynne Livesey (Whistle-blowing Champion)	Vacant (Sustain-ability Champion)	James Ayling	Exec Lead & Secretariat
Scottish Borders Health & Social Care Integration Joint Board (H&SC IJB) (5 NEDs Required)		**XV**	**XV**	**XV**		**VC-XV**	**C** (Appointed in capacity as a Cllr)			**XV**	**IJB CO BS**
H&SC IJB Audit Committee (2 NEDs Required)				**XV**		**XV**					**IJB CFO BS**
H&SC IJB Strategic Planning Group **(Vice Chair of IJB, Chairs the SPG)**						**C**					**IJB CO PA**
TOTAL	**0**	**1**	**1**	**2**	**0**	**3**	**1**	**0**	**0**	**2**	

Changes highlighted in pink

KEY

C	Chair
VC	Vice Chair
XV	Member (Voting)
XNV	Member (Non Voting)
BS	Board Secretary
IJB CO	Integration Joint Board Chief Officer
IJB CFO	Integration Joint Board Chief Financial Officer
PA	Personal Assistant

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Implementation of sub-national planning: co-operation and planning directions 2025**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
Report Author:	**C Briggs, Lead Director of Strategic Planning, SPDC East**

1 Purpose

To provide the Board with an update on progress with the implementation of DL (2025) 25.

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Annual Delivery Plan
- Government policy/directive
- Legal requirement
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

DL(2025)25 was published on 14th November 2025. It includes a Ministerial Direction to Health Boards to collaborate on the development of joint plans on key priorities including orthopaedic waiting times and emergency healthcare services.

2.2 Background

Board members will recall that NHS Scotland has a long history of collaboration between Boards to jointly plan, commission, and deliver services, and that the powers to do so are laid out in Section 12 of the 1978 NHS Act (Scotland).

In November 2024, the Scottish Government issued DL(2024)31, with a focus on more planning at the population level. In January 2025 the First Minister launched the Service Renewal Framework, which was published alongside the Population Health Framework and Public Sector Reform Strategy in June 2025. All three emphasised the need for closer collaborative working between Scotland's large number of public sector bodies and focussing on a smaller number of priorities in so doing.

DL(2025) established two new Subnational Planning and Delivery Committees (SPDC), East and West. DL(2025)25 is clear that there is no change to accountabilities for each board for clinical, staff, or financial governance.

A joint plan with SPDC West was submitted on 31st March 2026. This was during the pre-election period and as yet there has – understandably – been no formal feedback from the Scottish Government.

It should be noted that this plan did not include plans for the delivery of a "digital front door", where the deadline set in DL (2025) 25 was 30th June 2026.

SPDC East undertook to revise its sections of the joint plan by the end of June 2026 when feedback from the Scottish Government was provided.

The Scottish Parliament Election of 7th May led to the appointment of John Swinney as First Minister and appointments to the Cabinet were made on 22nd May. These included Jenny Gilruth, MSP, as Deputy First Minister and Cabinet Secretary for Finance, Angela Constance MSP as Cabinet Secretary for Health and Care, and Ivan McKee MSP as Cabinet Secretary for Public Service Reform.

On 18th May the Deputy Chief Executive of NHS Scotland wrote to the lead CEOs for the East and West SPDCs noting the improvement in elective waiting times performance and citing the close working between Boards as part of the reason for that improvement. The Deputy Chief Executive asked that the SPDCs build on the work undertaken in Orthopaedics to agree a broad ask for all elective specialties and that this be shared with the Scottish Government by mid-June. The approach being taken in the East is to bring together the work already undertaken to develop individual Board plans, in response to the Deputy Chief Executive of NHS Scotland's letter of 24th February.

2.3 Assessment

As noted, work undertaken to date is in the process of being revised.

The implications of policy announcements from the new Government will be updated on verbally at the Board meeting, as these are emergent. However, there is a very clear focus on Public Sector Reform for the new government, and in reducing the cost of the public service. The letter of 18th May can be seen as an example of how Boards will be increasingly expected to work more closely together.

2.3.1 Quality/ Patient Care

The intent of this work is expressly to improve the quality of patient care.

2.3.2 Workforce

The work mandated in DL(2025)25 is intended to improve the sustainability of NHS Scotland's services.

2.3.3 Financial

The estimate from SPDC East included in its plan of 31st March is that it carries a recurrent deficit of £330m into the 2026/7 financial year.

2.3.4 Risk Assessment/Management

There are no implications for the Board's corporate risk register.

2.3.5 Equality and Diversity, including health inequalities

At this stage no ECRIA has been undertaken, but all proposals made in line with DL(2025)25 will require a process of assessment.

2.3.6 Climate Change

None noted.

2.3.7 Other impacts

None noted.

2.3.8 Communication, involvement, engagement and consultation

The Board is responding here to Scottish Government policy.

2.3.9 Route to the Meeting

This report has been formulated for all Boards in the East SPDC.

2.4 Recommendation

The Board is recommended to **discuss** and **note** the implications of the report.

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No1, Deputy CEO NHS Scotland letter to CEOs NHS Lothian and NHS Greater Glasgow and Clyde

Chief Operating Officer & Deputy Chief Executive,
NHS Scotland

T: 07725 070649
E: christine.mclaughlin@gov.scot

Scottish Government
Riaghaltas na h-Alba

To: Caroline Hiscox, Chief Executive, NHS Lothian and Jann Gardner, Chief Executive, NHS Greater Glasgow and Clyde

Copy to:
NHS Chairs
NHS Chief Executives

18 May 2026

Dear Caroline and Jann

As you are aware there has been significant progress delivered over the last year in order to reduce both the overall list size of those awaiting planned care treatment, but in particular those waiting over 52 weeks. As discussed with Ministers, it is evident that the NHS and its wider partners have mobilised at pace and scale to deliver and maintain a very high run rate of activity which in turn has delivered demonstrable and significant reductions in waits over 52 weeks, supported in part by the provision of over £200m. This has resulted in a reduction in long waits of 74.6% for New Outpaitents (NOP) and 52.4% for Inpatient and Daycases (IP/DC).

I note that whilst of itself this is incredibly impressive, it is particularly worthy of noting that as well as embedding a very high level of grip and assurance, alternative delivery models have been developed and tested that extend beyond territorial board boundaries and supported by our National Boards.

On that basis, we would ask that you use the sub national structures to build on this learning and approach in order to develop a clear and deliverable plan to eradicate all long weeks over 52 weeks as soon as possible, with the ambition of doing so within this calendar year, recognising that current modelling suggests this may take longer. This should include the prioritisation of those who have been waiting over 78 and 108 weeks. We recognise that there may be specific capacity issues for some specialities, but we would encourage the sub national structures to explore all possible opportunities to develop a plan that makes best use of capacity available within Scotland, including through patient movement and sharing of resources.

We would also encourage you to consider opportunities to improve productivity and reduce warranted variation, drawing on learning from the last year as well as exploring the value in pooling or centralising activity such as list validation. To that end, we would expect the national boards to provide direct support to the sub national structures to facilitate this.

The immediate focus on reducing long waits should be progressed alongside the requirements set out in DL 2025 (25), including the development of sustainable speciality plans such as orthopaedics.

We recognise that delivery will depend on the continued commitment of our workforce, and that any proposed changes to ways of working will require appropriate local engagement with staff-side representatives and careful consideration of workforce sustainability. We also recognise the importance of ongoing national engagement with staff-side representatives in shaping this work.

Given what we know about lead in times to mobilise and deliver at the run rate achieved last year, it would be helpful to have your proposition by mid-June, recognising that this can be iterated as plans develop.

In the meantime, I have taken the liberty of copying this correspondence to all CEOs and Chairs of NHS Boards so they are clear on my ask of you as the chairs of the Sub National Boards and to ensure collective visibility and support for this work.

Yours sincerely

Christine McLaughlin
Chief Operating Officer & Deputy Chief Executive, NHS Scotland

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
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.

2.2 Background

Board members were briefed in December 2017 on revisions to the guidance on medical consultant appointments.

2.3 Assessment

Since the last report to the Board, 1 new consultant has been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date

Dr Peter Connick	Consultant Neurologist	August 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.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Resources & Performance Committee by exception report**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Delivery Plan
- Government policy/directive
- Local policy
- 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

To support a clear and transparent route for escalation from Board Sub-Committees to the Board, the Chair has requested the introduction of a concise, one-page exception report. This should be used to highlight both positive matters and areas of concern requiring escalation from the Committee. The report will focus on the levels of assurance received by the Committee where levels of limited or moderate with caveats were expressed at its most recent meeting.

2.2 Background

The Resources & Performance Committee met on 5 May 2026.

2.3 Assessment

Integrated Performance Report: The Committee considered the end-of-year Integrated Performance Report, noting that it was the final report in the current format before introduction of a revised framework aligned to the emerging clinical strategy and organisational priorities. Members heard that urgent and unscheduled care performance had improved over the year, including 4-hour A&E performance rising to 69.6%, although 8-hour and 12-hour delays and delayed discharges remained areas of concern. Strong progress was also reported in planned care, cancer pathways, diagnostics and theatre productivity, with substantial reductions in long waits and exceptionally strong diagnostic performance. Members welcomed the improvements and commended staff, while also seeking more balanced future reporting on patient flow, delayed discharge causes, Home First pressures and the interaction between AAU and ED performance. Discussion also highlighted the importance of focusing on patient safety, outcomes and value, as well as the need to sustain gains in the context of continued demand, uncertainty over non-recurrent waiting-times funding and the Board's wider financial pressures.

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

LIMS Update G Clinkscale provided a verbal update on the Laboratory Information Management System (LIMS) programme, noting that following go-live in June 2025 a number of post-implementation issues had required sustained management attention, but that the principal outstanding matters relating to the transmission and display of results, including sexual health reporting, had now been resolved and formally signed off by relevant clinical leads. He advised that a clinical safety case, including external expert review of the system, standard operating procedures and governance arrangements, had been completed and had generated recommendations for ongoing management, and confirmed that the programme had now formally closed with responsibility for remaining business as usual matters transferring to O Bennett. During discussion, the Committee welcomed the use of a clinical safety case and agreed that this should become standard practice for future major digital and clinical system change, while also seeking assurance that contractual and financial risks remained under active management; G Clinkscale confirmed that a decision would be required by December 2026 on whether to continue under the relevant national contractual arrangements and that IM&T and Finance colleagues were actively managing the position.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance from the update subject to continued implementation of actions arising from the clinical safety case and the ongoing management of contractual issues.

Financial Recovery Update: The Committee considered an update on financial recovery planning for 2026/27, noting early identification of savings and cost avoidance measures, the appointment of a Director of Strategic Projects, and establishment of a Strategic Budget Review Group. Members emphasised the need for genuine transformation rather than further erosion of support services, highlighted the importance of evaluating short-term funded initiatives before recurring adoption, and

discussed whether more difficult decisions should be taken now or aligned with wider strategic planning.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance for systems and processes and limited assurance for outcomes form the report.

Capital Plan Update: A Bone presented an update on the 2025/26 capital outturn and 2026/27 forward position within the Whole System Infrastructure Planning framework, highlighting a highly constrained capital environment, £9.95m expenditure against a revised £12.33m budget, an anticipated £1.94m carry-forward, a significant estates backlog of around £32m, and a wider unfunded pipeline of approximately 70 projects. He emphasised the tension between maintaining a safe and compliant estate and progressing infrastructure modernisation to support the emerging clinical strategy, noting that while national policy and funding routes constrained many major decisions, local prioritisation remained necessary for business continuity planning and for up to three Strategic Assessments to be submitted by March 2027. Potential priorities included Borders General Hospital refresh, digital infrastructure and HEPMA, mental health estate consolidation and primary care estate priorities, with detailed prioritisation proposed through the Delivery Board and strategic scrutiny through the Resources & Performance Committee. In discussion, members acknowledged the complexity of prioritisation, stressed the need for decisions and residual risks to be clearly reflected in the risk register, and noted the additional short-term pressure arising from the resignation of the Head of Capital Planning.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance for systems and processes and limited assurance for outcomes from the report.

2.3.1 Quality/ Patient Care

As described with in the relevant minutes of the meeting.

2.3.2 Workforce

As described with in the relevant minutes of the meeting.

2.3.3 Financial

As described with in the relevant minutes of the meeting.

2.3.4 Risk Assessment/Management

As described with in the relevant minutes of the meeting.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

As described with in the relevant minutes of the meeting.

2.3.7 Other impacts

As described with in the relevant minutes of the meeting.

2.3.8 Communication, involvement, engagement and consultation

Not required.

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.

- Board Executive Team: 22.06.26

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

3 List of appendices

None.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Clinical Governance Committee by exception Report**
Responsible Executive/Non-Executive:	**Sarah Horan Executive Director of Nursing Midwifery and AHPs (NMAHPs) / Lucy O Leary Non-Executive - Chair of Clinical Governance Committee**
Report Author:	**Sarah Horan Executive Director of NMAHPs Heather Stirling PA to Executive Director of NMAHPs**

1 Purpose

This is presented to the Board for:

- Awareness
- Discussion

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

This exception report provides a focused escalation of principal **clinical governance risks** impacting on the delivery of safe, effective, and person-centred care across NHS Borders. It identifies areas where **risk exposure exceeds current control effectiveness**, requiring ongoing Board oversight and targeted mitigation.

The Board is asked to note this report, recognising that detailed scrutiny of risk, assurance and mitigating actions is undertaken through the Clinical Governance Committee. Supporting evidence is provided within the appended Committee minutes.

2.2 Background

NHS Borders continues to operate within a **high-risk system environment**, characterised by sustained demand, constrained capacity, and system-wide workforce fragility. Workforce risk remains the **primary strategic risk driver**, directly affecting service sustainability, patient flow, and the organisation's ability to consistently deliver safe and effective care.

Whilst **clinical governance frameworks and controls remain established**, there is increasing evidence that **control effectiveness is being constrained by operational pressures**. This results in variable assurance across services and a widening gap between **risk exposure and mitigation capacity**.

This reflects a position where risks are **actively managed but not consistently reduced**, requiring continued Board focus on risk prioritisation, investment decisions, and system-wide mitigation.

2.3 Assessment

Within the Primary and Community Clinical Board, workforce fragility represents a **high-impact, high-likelihood risk** to service sustainability and the delivery of the Primary Care Improvement Plan (PCIP). Capacity constraints are limiting implementation of transformation objectives, creating a risk to both access and quality of care. While controls are in place, they are only partially effective, and the residual risk remains elevated.

Assurance is **Moderate for delivery**, but **Limited for workforce sustainability**, indicating a **material risk gap**.

Across the Acute Clinical Board, patient flow and capacity pressures present a **significant system-level risk with direct implications for patient safety and experience**. Workforce fragility across all job families further reduces resilience. Emerging indicators, including increased pressure damage and rising complaint volumes, suggest **early deterioration in quality under sustained pressure**. Current controls are mitigating impact but not reducing underlying risk.

Assurance is **Moderate for service delivery**, but **Limited for flow and workforce**, with a **deteriorating risk trajectory**.

Within the Mental Health and Learning Disabilities Clinical Board, workforce constraints and health inequalities remain the **dominant risk drivers**. The "Coming Home" programme introduces additional **system and transformation risk**, requiring capacity and cross-partner coordination. While services remain stable, delivery is increasingly dependent on fragile workforce models, increasing the likelihood of delay or variance.

Assurance is **Moderate for care delivery**, but **Limited for workforce and system resilience**, with a **risk of delivery slippage without additional mitigation**.

Within Primary Care Pharmacy, demand has exceeded available capacity, creating a **capacity-risk imbalance**. Financial and workforce constraints are limiting responsiveness, increasing the risk of delays and reduced effectiveness. Current controls are maintaining delivery but with minimal resilience.

Assurance remains **Moderate**, with **escalation risk if demand continues to increase**.

General Practice sustainability continues to present a **multi-factorial risk**, driven by workforce shortages, estate limitations, and increasing service demand. In addition, limited availability of clinical quality data restricts the ability to provide **robust assurance**, creating both a **delivery risk and an assurance gap**.

Assurance is **Moderate for planning**, but **Limited for clinical quality oversight**, with **reduced visibility of emerging risks**.

The Value Based Care programme continues to deliver positive progress, including implementation of Treatment Escalation Plans. However, delivery is constrained by programme capacity and variation in practice. There is a risk that benefits realisation will be **partial and inconsistent without further investment in multidisciplinary transformation capacity**.

Assurance is **Moderate**, with **transformation delivery risk identified**.

The Hospital Standardised Mortality Ratio (HSMR) has been affected by a change in methodology, presenting a potential **special cause variation**. There is no evidence of deterioration in care quality; however, this represents a **quality and reputational risk requiring continued scrutiny**.

Assurance is **Moderate**, with **enhanced monitoring in place**.

2.3.1 Quality/Patient Care

In relation to Quality and Governance, reduced audit capacity is impacting on the effectiveness of **assurance and early risk detection mechanisms**. Although data and reporting improvements are evident, reduced audit coverage presents a **control weakness**, limiting the ability to identify emerging risks proactively.

Assurance is **Moderate**, with **gaps in assurance robustness**.

Patient experience data reflects increasing system pressure, with rising complaints aligning to wider capacity and workforce constraints. This represents a **lagging indicator of system stress** and highlights a risk of further deterioration in patient experience if pressures are not mitigated.

Assurance is **Moderate**, with a **risk of worsening outcomes**.

2.3.2 Workforce

At an organisational level, workforce sustainability represents a **critical, cross-cutting strategic risk**, impacting all clinical services. Recruitment challenges, reliance on temporary staffing, and limited workforce pipeline sustainability mean that **current**

service delivery is not maintainable in the medium term without intervention. Existing controls are insufficient to reduce risk exposure.

Assurance is therefore **None at organisational level**, representing a **high-priority risk requiring sustained Board focus**.

2.3.3 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 Borders.

2.3.4 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. NHS Borders risk profile has increased because of the extreme pressures across Health and Social Care services.

2.3.5 Equality and Diversity, including Health Inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.6 Climate Change

No additional points to note.

2.3.7 Other Impacts

No additional points to note.

2.3.8 Communication, Involvement, Engagement, and Consultation

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

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 Boards Clinical Governance Groups
- Clinical Governance Committee

2.4 Recommendation

The Board is asked to **Note** the report.

Taking all areas into account, the overall position reflects **elevated, interdependent risks driven predominantly by workforce constraints and system capacity pressures**. While mitigating actions are in place, these are not consistently sufficient to reduce overall risk exposure.

The Clinical Governance Committee therefore reports an overall position of **Moderate assurance**, within a context of **persistent high and extreme risks in key domains**, requiring **continued Board oversight, alignment to risk appetite, and targeted strategic intervention**.

The Board is asked to confirm the level of assurance it has received from this report.

3 List of Appendices

None

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Staff Governance Committee by exception Report**
Responsible Executive/Non-Executive:	**A Keen, Director of People & Culture**
Report Author:	**A Keen, Director of People & Culture**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Delivery Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To support a clear and transparent route for escalation from Board Sub-Committees to the Board, the Chair has requested the introduction of a concise, one-page exception report. This should be used to highlight both positive matters and areas of concern requiring escalation from the Committee. The report will focus on the levels of assurance received by the Committee where levels of limited or moderate with caveats were expressed at its most recent meeting.

2.2 Background

The Staff Governance Committee met on 30 April 2026.

2.3 Assessment

Strong Overall Staff Governance Framework

The Committee received consistent and positive assurance that NHS Borders maintains a strong and well-established staff governance framework. Corporate services demonstrated clear alignment with Staff Governance Standards, with evidence of embedded leadership behaviours, partnership working, and staff engagement across a wide range of services.

There is a clear culture of continuous improvement, with services actively using governance processes to support workforce planning, staff experience, and service delivery. The Committee recognised that governance systems, including reporting structures and oversight mechanisms, are mature and functioning effectively.

Committee discussion confirmed confidence in the overall governance position, with members formally agreeing that the evidence presented supports a high level of assurance.

While some operational pressures exist, these are not due to weaknesses in governance but rather external service demand and workforce capacity challenges. The underlying governance model therefore remains robust.

Summary:

- **GOOD:** Strong governance systems, embedded culture, and leadership
- **IMPACT:** Provides a solid foundation for workforce and organisational delivery
- **ASSURANCE: SIGNIFICANT ASSURANCE**

Staff Engagement and iMatter Approach

Staff engagement across NHS Borders continues to be a key strength, particularly through the use of the iMatter framework. The Committee heard that iMatter is now well embedded across teams, with clear evidence of staff participation and structured action planning taking place at local level.

Importantly, there is a strong link between staff feedback and improvement activity, demonstrating that engagement is being used meaningfully to drive change. Where participation levels are lower, services are implementing targeted actions to improve engagement and feedback loops, reflecting a mature and responsive approach.
However, the Committee acknowledged that while engagement processes are strong, there is currently limited visibility of how local improvements translate into measurable organisational outcomes. Discussion highlighted an opportunity to strengthen reporting mechanisms to better demonstrate impact at Board level.

Despite this, the overall position remains positive, with engagement clearly embedded into organisational processes and culture.

Summary:

- **GOOD:** High levels of engagement and meaningful use of iMatter
- **IMPACT:** Supports staff involvement and continuous improvement
- **ASSURANCE: SIGNIFICANT ASSURANCE**

Progress in Training Compliance (Core Modules)

The Committee noted positive progress in statutory and mandatory training compliance, particularly in relation to core training modules. Performance is described as high, stable, and continuing to improve, reflecting effective governance and oversight arrangements.

Systems such as LearnPro and performance dashboards provide strong management oversight, enabling services to monitor compliance and take corrective action where required. The introduction of mandatory line manager engagement with these systems has further strengthened data quality and accountability.

This demonstrates a clear improvement trajectory and reflects a well-managed system of training compliance for core requirements. However, it is important to note that this positive position does not extend consistently to role-specific training, where further challenges remain (outlined below).

Overall, the Committee recognised that the direction of travel is positive, with governance arrangements supporting sustained improvement.

Summary:
- **GOOD:** Improving compliance and strong oversight systems
- **IMPACT:** Supports safe and effective practice
- **ASSURANCE: MODERATE TO SIGNIFICANT (IMPROVING POSITION)**

Workforce Data and Dashboard Development

The development and embedding of the workforce dashboard represent a significant improvement in organisational oversight and data transparency. The dashboard now provides a comprehensive, user-friendly view of key workforce metrics, with monthly updates available to service leads and Board members.

This has modernised the way workforce information is presented and used, including the ability to view trends over time and identify areas of concern such as absence hotspots. The addition of trend dashboards covering a two-year period further strengthens analytical capability and supports more informed decision-making.

Committee discussion focused on how this information should be used going forward, including frequency of reporting and alignment with Staff Governance requirements. This demonstrates a proactive approach to ensuring that data supports meaningful assurance rather than simply information sharing.

While there are some technical and resource limitations (discussed below), the overall governance approach to workforce data is strong and continues to evolve.

Summary:
- **GOOD:** Modernised data reporting and improved visibility
- **IMPACT:** Enhances organisational oversight and decision-making

- **ASSURANCE: SIGNIFICANT ASSURANCE**

Protected Learning Time Not Embedded

A significant concern identified by the Committee relates to the inability to consistently provide protected learning time for staff. This is primarily driven by operational pressures, staffing shortages, and service demand, which result in staff being unable to attend scheduled training or being pulled back into clinical areas.

The current staffing model includes a 2% uplift for training; however, analysis indicates that this is insufficient to meet training requirements, particularly for nursing and midwifery staff, where even basic mandatory training consumes this allocation.

This presents a risk to both compliance and staff development, with wider implications for patient safety and organisational assurance.

Plan:
- Detailed analysis of actual training time requirements (including part-time workforce impact)
- Development of a realistic protected learning time model
- Establishment of a short-life working group to review implementation across all staff groups

Summary:
- **ISSUE:** Learning time not consistently protected
- **IMPACT:** Risk to training compliance and workforce development
- **ASSURANCE: MODERATE ASSURANCE**

Role-Specific Training Compliance Gaps

Despite improvements in core training, the Committee highlighted ongoing concerns regarding role-specific mandatory training. Compliance levels remain significantly lower in areas such as manual handling and PMAV, with some services reporting completion rates around 50%.

These gaps present a clear risk to staff safety, patient safety, and compliance with statutory requirements. The issue is not attributed solely to training delivery but is strongly linked to workforce capacity constraints and limited protected learning time.

There were also indications that, in some instances, training sessions are cancelled, or staff are unable to attend due to operational pressures, further exacerbating the issue.

Plan:
- Improved monitoring through enhanced dashboards and reporting
- Mandatory line manager use of LearnPro to strengthen accountability
- Targeted review of bank staff compliance
- Ongoing governance through Training and Education forums

Summary:
- **ISSUE:** Low compliance in key role-specific training
- **IMPACT:** Risk to safety and regulatory compliance
- **ASSURANCE: MODERATE ASSURANCE**

Workforce Capacity Pressures

Sustained workforce capacity pressures were identified as a cross-cutting issue impacting multiple areas of staff governance. Factors such as long-term absence, high service demand, and staffing shortages are affecting the ability of services to consistently deliver training, appraisals, and engagement activity.

These pressures directly contribute to other areas of concern, particularly training compliance and the ability to provide protected learning time. The Committee recognised that these challenges are not due to a lack of commitment but rather structural and capacity-related constraints.

Plan:
- Use of workforce dashboards to identify hotspots and prioritise action
- Development of targeted improvement plans for affected services
- Continued oversight through corporate governance structures

Summary:
- **ISSUE:** Capacity constraints across services
- **IMPACT:** Affects consistency of delivery and compliance
- **ASSURANCE:** MODERATE ASSURANCE

Data and System Limitations

While workforce data has improved significantly, the Committee noted ongoing limitations in underlying systems and processes. Current dashboard production relies on manual data collation and is dependent on a small number of key staff, creating a sustainability risk.

In addition, system incompatibilities mean that data cannot be automatically integrated, increasing workload and the potential for inconsistency.

Plan:
- Development of improved system integration through future business systems
- Cross-training and shared ownership to reduce single point of failure
- Continued refinement of dashboards and reporting mechanisms

Summary:
- **ISSUE:** Manual processes and system limitations
- **IMPACT:** Risk to data reliability and sustainability
- **ASSURANCE: MODERATE ASSURANCE WITH CAVEATS**

2.3.1 Quality/ Patient Care

As described within the relevant minutes of the meeting.

2.3.2 Workforce

As described within the relevant minutes of the meeting.

2.3.3 Financial

As described within the relevant minutes of the meeting.

2.3.4 Risk Assessment/Management

As described within the relevant minutes of the meeting.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

As described within the relevant minutes of the meeting.

2.3.7 Other impacts

As described within the relevant minutes of the meeting.

2.3.8 Communication, involvement, engagement and consultation

Not required.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. Their feedback has informed the development of the content presented in this report.

- Staff Governance Committee

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

3 List of appendices

None.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 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.

- Audit & Risk Committee 25 May 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit & Risk Committee minutes 23.03.26

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 23rd March 2026 @ 10 a.m. via MS Teams.

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

In Attendance: O Bennett, Director of Acute Services (Interim) (Item 6.2)
I Bishop, Board Secretary (Item 8.3)
A Bone, Director of Finance
J Boyd, Director, Audit Scotland (Joined meeting at 10.35 a.m.)
S Cadden, Risk Advisory Manager (BDO) (Item 6.4)
G Clinkscale, Director of Urgent Care, Community Services and Mental Health (Joined meeting at 10.20 a.m.)
B Everitt, Personal Assistant to Director of Finance (Minutes)
S Harold, Senior Audit Manager, Audit Scotland
L Jones, Director of Quality Improvement
G MacLeod, Risk Advisory Services Manager, BDO
P Moore, Chief Executive
K Rodgers, Deputy Director of Finance
F Sandford, Interim Chair
J Smyth, Director of Planning & Performance (Items 4, 6.3 and 11.1)

1. Introduction, Apologies and Welcome

James Ayling welcomed those present to the meeting.

Apologies were received from D Parker, Non Executive Director.

James confirmed that today's meeting was quorate.

2. Declaration of Interest

There were no declarations of interest.

3. Minutes of Previous Meetings – 15th December 2025

The minutes were approved as an accurate record.

4. Matters Arising

Action Tracker
It was noted that an update for the contracts management action relating to the communication to be issued across the organisation would be provided at item 6.4.

Peter Moore commented on the way action trackers were presented across all Governance Committee and noted that he would be picking this up with the Board Secretary as he would like to see them having deadlines included for completing actions.

The Committee noted the action tracker.

Medicines Governance & Prescribing Internal Audit Report – Update from Clinical Governance Committee
Laura Jones advised that the report had gone to the January meeting of the Clinical Governance Committee for review and discussion. It was noted that the Director of Pharmacy would be providing the Committee with regular updates on actions. In regard to HEPMA, which would be a solution for a number of the recommendations arising from the audit, it was noted that a business case would be presented to the Board in due course for approval.

Fiona Sandford provided an update on the change to the Chair and Executive Lead of the Clinical Governance Committee where it was noted that Lucy O'Leary would be taking over as Chair and Sarah Horan would now be the Executive Lead.

The Committee noted the update.

Digital & Information Services Aged Actions Update
June Smyth spoke to this item which provided an update on the 2 outstanding actions that had not been completed by the intended deadline of 31st March 2026.

In regard to the first outstanding action (2.2 Recovery and Resilience), it was noted that 15 business continuity plans remained outstanding and with exception of the Knoll Hospital the 31st May was estimated for completion of these.

June went on to provide an update on the second outstanding action (2.3 IT Recovery Resilience) where she concluded that given the interdependency with the overall Business Continuity planning process and the development of exercise plans for 2026, for which digital would be included, proposed that this action now be closed.

Following discussion and recommendation from Internal Audit it was agreed that 2.2 remain open and 2.3 be closed as it had been sufficiently progressed.

The Committee confirmed it had received a moderate level of assurance for systems and processes and limited assurance for outcomes.

The Committee noted the update.

5. **Risk Management**

5.1 *Review of Risk Appetite*
Laura Jones spoke to this item and advised that the Risk Appetite Policy was being brought to the Committee today for an opportunity to comment and to recommend that it go forward to the Board for approval at the April meeting.

It was noted that the policy is refreshed on an annual basis and that the governance arrangements within sections 7 and 8 had been strengthened which

Laura provided an update on. Laura explained that all strategic risks will now be reported to the NHS Borders Delivery Group.

Laura referred to the Risk Appetite Statements and confirmed that following discussion at the Board Development Session the compliance category had been split into 2 statements.

Lynne Livesey raised a concern relating to the proposed wording of the second compliance statement. Lynne suggested the wording needed to be strengthened to be clear it extended to all groups of people and not just patients and staff and also that where fraud was evident we would not accept a cautious approach. Laura Jones agreed to refine the wording to reflect this comment and link in with Lynne for review of the wording ahead of submission to the Board.

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

The Committee approved the revision to the Risk Appetite Policy including the proposed revision to the risk appetite statements for the category of compliance subject to a revised form of wording to be approved prior to it going forward to the April Board meeting.

6. **Internal Audit 2025/26**

6.1 *Internal Audit Plan Update Report*
Gemma MacLeod spoke to this report which provided a summary on the delivery of the 2025/26 Internal Audit plan. Gemma confirmed that she was comfortable with the progress and the 2 remaining audits to be completed were both on track to come forward to the next meeting.

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

The Committee noted the report.

6.2 *Internal Audit Report – Productivity (Theatre Management)*
Gemma MacLeod introduced this report which had an overall rating of moderate assurance for design and moderate assurance for effectiveness. The finding ratings were noted as 3 medium and 2 low.

Gemma went on to highlight that there were effective controls in place including a comprehensive set of standard operating procedures along with interactive training programmes to help staff use the Infix system to generate procedure lists. Oversight groups were in place to monitor the performance of theatres and implement changes to improve the overall productivity. Scheduling principles were also in place and set out plans to ensure that cancellations were minimised and theatres prepared for scheduled procedures.

The findings identified related to the budget setting procedures whereby budgets had not been updated since 2019 and there was a misalignment between reported and operational budgets. In addition to this it was noted that action trackers maintained by oversight groups did not all have due dates and owners. There were also inaccuracies in the data collected for session times and

sequence of operations and an opportunity to enhance the use of benchmarks for KPIs.

Gemma confirmed that management have accepted all recommendations and will be taking these forward.

Oliver Bennett confirmed that actions would be addressed and taken forward at pace and assured that none of the findings had come as a surprise. Oliver advised that the processes for finance and budgeting were being strengthened with some action already being taken forward in advance of receiving the report.

Andrew Bone added that there was an action plan being taken forward within the Finance Department to improve the budget setting process and he was confident that this would be completed by the deadline.

Fiona Sandford highlighted that there seemed to be comparatively low theatre utilisation when measured against the benchmark (85% in England). Fiona was surprised to see that dentistry was partly attributable to this as she was aware of issues being raised around the shortage of theatre slots for dentistry.

Lynne Livesey noted concern that the budget issues and theatre utilisation had not been picked up prior to the audit given the previous focus on these areas.

Oliver advised that for theatre utilisation they had not previously adopted the national definition, however the system has since been changed to reflect this and he hoped to see the benefit within reporting in the next 1 to 2 months. In regard to dentistry, he agreed that there was a data quality issue which would require to be picked up.

Peter Moore referred to discussion at the recent Resources & Performance Committee and highlighted that the organisation is learning how to develop the infrastructure around areas such as these and noted that this would be a core part of the Transformation Plan which would play a part in the financial challenges faced by the organisation making it as efficient as possible.

James Ayling asked for clarification around one of the observations which noted there were no start times within the theatres. Andrew Bone confirmed that there were start times for sessions but not for every individual procedure.

The Committee confirmed it had received a moderate level of assurance for systems and processes and moderate assurance for outcomes.

The Committee noted the report which would have oversight by the Resources & Performance Committee.

6.3 *Internal Audit Report – Management of Change*

Gemma MacLeod introduced this report which had an overall rating of moderate assurance for design and moderate assurance for effectiveness. The finding ratings were noted as 1 medium and 3 low.

Gemma advised that whilst no significant gaps had been found in the approaches taken for the projects reviewed, it had been noted that projects did not all follow the established NHS Borders' framework or use consistent project artefacts. Gemma went on to provide examples of these.

Gemma confirmed that management have accepted all recommendations and will be taking these forward.

Lynne Livesey noted that there was a difference between the number of findings within the table compared to the number within the executive summary and assumed that this was an error. Gemma confirmed that it was and that she would amend and reissue the report.

Lynne noted the comment about streamlining attendance at meetings and felt that this would be very beneficial in ensuring that meetings are as effective as possible as well as releasing staff time. Lucy O'Leary echoed these comments.

June Smyth noted that this was a fair report and agreed with the findings. June confirmed that whilst implementing the actions this would pick up the issue raised around streamlining attendance at meetings.

The Committee confirmed it had received a moderate level of assurance for systems and processes and moderate assurance for outcomes.

The Committee noted the report which would have oversight by the Resources & Performance Committee.

6.4 *Contract Management Update*

Sophie Cadden provided an overview on the work undertaken to date in supporting the recommendations arising from the contract management audit. It was noted that good progress had been made in the last quarter and Sophie highlighted this within the presentation. It was also noted that the first meeting of the Contract Management Steering Group had taken place where the Terms of Reference had been agreed. These meetings would take place monthly and include representatives from the relevant departments across the organisation. Sophie also highlighted that in addition to Agility, other options for a contract management system were being explored.

Sophie referred to the recommendation for NHS Borders to recruit to a full-time Contract Manager to establish and maintain a consistent and effective contract management framework across the organisation, to which formal approval was being requested to take this forward.

James Ayling was aware there would be considerable focus on contracting so was extremely pleased to see this work being taken forward.

Andrew Bone noted his support to recruit a full-time Contract Manager and advised that it was the expectation that this would be presented to the NHS Borders Delivery Group for approval alongside other proposals of this nature.

Karlin Rodgers referred to the outstanding action on the action tracker in relation to the timeline for a comms being issued to the organisation on the process being

undertaken and advised that this was due to be issued within the next week which would conclude the action.

The Committee confirmed it had received a significant level of assurance for systems and processes.

The Committee noted the update and supported the proposal to recruit a full-time Contract Manager, whilst noting the financial constraints of the organisation.

6.5 *Draft Internal Audit Plan 2026/27*

Gemma Macleod presented to the Committee the draft Internal Audit Plan for 2026/27 and reminded that as part of their audit needs assessment undertaken the previous year a baseline 3 year plan had been produced. Gemma advised that she had met with the Director of Finance prior to circulation of year 2 of the plan to ensure that it was still appropriate. Gemma advised that the comments received to date were mainly in relation to the scoping.

Gemma confirmed that the number of audits remained the same for 2026/27 and the plan provided the proposed scheduling for these.

Andrew Bone confirmed that he had circulated the draft plan to the Board Executive Team and Chairs/Executive Leads of the Governance Committees for comment. It was noted that the comments received had been primarily around scoping.

Lynne Livesey noted her concern that the organisation faces significant issues around its workforce management in terms of appraisals, training uptake and development and the monitoring of this and felt this warranted a review.

Andrew Bone highlighted that the workforce audit within next year's plan focussed on medical workforce but that this could be revised if there was a view that a different area should be prioritised and offered to discuss with the Board Executive Team around changing the focus of this. This was agreed. Andrew also suggested that workforce could be audited over several years covering different areas as he suspected that it would not be possible to cover everything in one audit. This approach was agreed as a sensible way forward.

James Ayling asked Committee members and Executive Directors if they felt there were sufficient audits undertaken throughout the year. Peter Moore felt that these were sufficient to provide a good level of assurance to the organisation. Andrew reminded that there is always an opportunity to commission an extra audit should the need arise or rebalance the plan depending on priorities.

The Committee confirmed it had received a significant level of assurance for systems and processes.

The Committee approved the Audit Plan for 2026/27 subject to exploring a cycle of workforce audits to be put in place over the coming years.

7. **Annual Accounts 2025/26**

7.1 *External Audit Annual Audit Plan & Annual Accounts Timetable 2025/26*
John Boyd spoke to this item and advised that the plan was similar to previous years and referred to the overview describing what the audit would cover.

John referred to exhibit 1 which detailed the materiality levels and highlighted that materiality had been set at 1.5% of the benchmark which was comparable to other Boards of a similar size to NHS Borders.

John went on to highlight exhibit 2 about significant risks of material misstatement to the financial statements where an outline of these risks were detailed. It was further noted that a reporting threshold of £300k had been set and any figure which arose above this during the audit or any misstatement, either adjusted or unadjusted, would be reported in the annual audit report to the Committee.

It was noted that exhibit 3 detailed the outcome of the risk assessment procedures on the group audit which included NHS Borders, Borders Health Board Endowment Fund (NHS Borders Health Charity) and Scottish Borders Integration Joint Board.

John highlighted exhibit 4 which detailed wider scope risks and it was noted that this covered financial management and financial sustainability

John advised that the proposed audit fee would be retained at the baseline fee and added that there had not been any specific matters identified to cause an uplift to this.

In regard to audit independence within the audit team John confirmed that no matters had been identified and confirmation of this would be incorporated within the annual audit report.

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

The Committee noted the External Audit Annual Audit Plan and the Annual Accounts timetable for 2025/26.

8. **Governance & Assurance**

8.1 *Audit Follow Up Report*
Gemma MacLeod spoke to this item and advised that although the number of actions fully implemented was still low there had been an improvement from the last quarter. Gemma highlighted that 6 recommendations had been noted as superseded and asked the 202Committee to pay particular attention to these as well as those being recommended for closure.

Andrew Bone confirmed that there is continued focus on this by the Board Executive Team and the outstanding recommendations are shared with colleagues. Andrew anticipated seeing an improvement in actions being closed in the next report received by the Committee.

James Ayling noted that the Director of Finance was against one of the health inequalities findings and assumed this was an error. Gemma confirmed that it was and would ensure this was updated.

James referred to page 64 of the report in relation to inconsistency in the staffing uplifts which he thought had been resolved between the Director of Finance and Director of Nursing. Andrew confirmed that he had discussed with the Director of Nursing, however the position arrived at was it was not going to be possible to directly amend every budget across the organisation with the resources available. It was noted that the process agreed was for the Health & Care Staffing Act Working Group to review individual establishments and make recommendations for each service area. As these come forward for review the decisions made would inform future budgeted establishments.

The Committee confirmed it had received a moderate level of assurance for systems and processes in place and limited assurance around the outcomes achieved.

The Committee noted the report.

8.2 *Aged Debt Write Off Report*

Karlin Rodgers spoke to this item which was a routine report received by the Committee. Karlin advised that the report provided an update on aged debt provision following a lengthy review undertaken and went on to provide a comprehensive overview which culminated in requesting the Committee, due to the value, to approve £834k be written off. It was noted that credit control processes are being refreshed within the Finance Department and the Committee will continue to receive an update at each meeting.

James Ayling asked for confirmation that the debts could still be recovered even after being approved for write off. Andrew confirmed that this was correct. Andrew also advised that he expected another request to come forward to the Committee at the next meeting in relation to legacy debt.

James recalled from the last meeting the Committee's request to continue to try and recover the outstanding debt from NHS England. Karlin advised that this was not included within today's report but was being actively pursued.

Peter Moore enquired around the debt with Scottish Borders Council as he was surprised to see this. Karlin explained that these invoices related to queries which were currently being investigated and she did not anticipate any issues with payment of these. Andrew advised that write off would only be proposed where the Health Board was unable to validate the basis of original invoiced amounts and that this may be the case for long standing debt.

Andrew Bone went on to provide the Committee with an update on a pay write off in relation to a payment to an individual which had arisen following a failure in payroll controls. This issue had arisen after the previous payroll audit and therefore was not noted in that report. It was noted that revised controls had been implemented and that the Deputy Director of Finance would be picking this up with Internal Audit to undertake testing to ensure that the additional controls are sufficient to address the risk of reoccurrence. Andrew advised that, should a write

off of overpayment be required, he would bring this forward to a future meeting of the committee.

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

The Committee noted the report and agreed to the proposed write-offs of irrecoverable debt and reiterated its request that the NHS England debt continue to be pursued.

8.3 *Code of Corporate Governance Sectional Update*
Iris Bishop spoke to this item and explained that a full refresh is undertaken every 3 years with the next one due in 2027. It was noted that a sectional update was being presented today and included a change in title from the Director of HR, OD & OHS to Director of People & Culture and a revised Terms of Reference for 3 Committees. In addition to these, Iris advised that a further change was required as the Resources & Performance Committee would now be chaired by a Non Executive Director rather than the Board Chair.

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

The Committee recommended the sectional refresh of the Code of Corporate Governance go forward to the Board for formal approval.

8.4 *Audit & Risk Committee Annual Self-Assessment*
Andrew Bone spoke to this item which was an exercise undertaken on an annual basis. Andrew advised that the report provided an overview of the self-assessment findings and that as Executive Lead he would be picking up the key recommendations with the incoming Chair of the Committee.

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

The Committee reviewed the report and noted the proposed action plan would be discussed between the Committee Chair and Director of Finance.

9. **External Audit**

9.1 *Audit Scotland Reports*
It was noted that the report provided a list of where relevant Audit Scotland reports are distributed across the organisation.

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

The Committee noted the report.

9.2 *Audit Scotland Report : NHS in 2025*
Andrew Bone spoke to this item and highlighted that the actions contained within the report were for NHS Scotland, with 2 of these being business as usual actions for NHS Borders so there would be no additional impact.

The Committee confirmed it had received a significant level of assurance for systems and processes and a moderate level of assurance for outcomes from the report.

The Committee noted the report.

10. **Fraud & Payment Verification**

10.1 *Counter Fraud Update*

Karlin Rodgers spoke to this report which provided an update on counter fraud activities and went on to highlight key areas which were of interest to the Committee.

Karlin referred to the Fraud Annual Action Plan for 2025/26 which CFS expected would take time to embed into organisations. It was noted that the outstanding actions for this financial year would be carried forward into 2026/27 and progressed through the Countering Fraud Operational Group.

Karlin advised that the NFI exercise was now concluded with no fraud identified. Karlin highlighted there had been 6 duplicate payments made and recovery of these was ongoing with 88% having been recovered to date. It was noted that this was a bi-annual exercise with the next one commencing in October 2026.

Karlin also referred to the Economic Crime & Corporate Transparency Act (ECCTA) which came into force on 1st September 2025 and placed greater responsibility on organisations, not just individuals, to prevent fraud. Karlin advised that she would be working with Counter Fraud Services and Internal Audit to ensure that the Board has robust measures in place.

Lynne Livesey noted that there were only 2 people within the organisation who had completed the fraud training modules which she felt was a high risk and would like to see focus on this as a matter of urgency. Karlin explained that this was a new mandatory eLearning module for the organisation so would expect to see a rise in the completion numbers by the next report. Andrew Bone added that he suspected failing to publicise this internally to staff would also have contributed to the low number reported.

Lucy O'Leary enquired if, regardless of any mandatory training modules, there was any specific fraud training particularly for the Finance Department. Karlin advised that there were specific modules around procurement and bribery and these were presently being worked through with the team. Finance specific training was also being looked into with CFS colleagues. Karlin highlighted that members on the Countering Fraud Operational Group also had areas which would be deemed as higher risk to the potential of fraud so this would be an area of focus for them also.

James referred to the ECCTA which he felt highlighted the need to get training in place as by doing this would appear to constitute a reasonable fraud prevention measure.

James suggested that this paper also be shared with the Board Executive Team, particularly in respect of the ECCTA. Andrew confirmed that he would take it to a future meeting.

Andrew also reminded the Committee a representative from CFS attends the Board Development Session on a regular basis.

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

The Committee noted the update.

11. **Integration Joint Board**

The Committee noted the link to the IJB Audit Committee agenda and minutes.

11.1 *IJB Directions Tracker*
June Smyth spoke to this report which was a standing item and provided updates on existing and any new directions. It was noted that in the absence of a Chief Officer there had been no new directions issued to date from the IJB this financial year. June highlighted the appendices which provided updates on those issued the previous financial year and the most recent H&SCP Performance and Delivery report for information.

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

The Committee noted the IJB Directions Tracker.

12. **For Noting**

12.1 *Information Governance Committee Minutes: 10th December 2025*
The Committed reviewed the minutes from the Information Governance Committee meeting held on 10th December 2025.

Lynne Livesey noted that once again the Committee had not been quorate and asked for confirmation that the reports presented to this meeting had been circulated for review/approval as per the minutes. James suggested that as the June meeting had also not been quorate that this should be checked for that meeting also.

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

The Committee noted the minutes of the Information Governance Committee.

13. **Any Other Competent Business**

Fiona Sandford noted that this was James Ayling's last meeting as Chair and thanked him for his meticulous chairing of the important work undertaken by the Committee over the past few years. Fiona also thanked Lynne Livesy for agreeing to take over as Chair of the Committee.

14. **Date of Next Meeting**

Monday, 25th May 2026 @ 10 a.m. via MS Teams.

BE
02.04.26

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Staff Governance Committee Minutes**
Responsible Executive/Non-Executive:	**D Parker, Chair Staff Governance Committee**
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 Staff Governance Committee with the Board.

2.2 Background

The minutes are presented to the Board as per the Staff 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 Staff 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.

- Staff Governance Committee 30 April 2026

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, Staff Governance Committee minutes 30.01.26

Staff Governance Committee
Minutes

A meeting of the **Staff Governance Committee** was held on **Thursday 30th January 2026** at 10am via MS Teams

Present:
Lucy O'Leary, Non-Executive Director (Acting Chair)
Lynne Livesey, Non-Executive Director / Whistleblowing Champion
John McLaren, Employee Director
Claire Smith, Head of Workforce Systems, Planning and Analysis
Elaine Dickson, Associate Nurse Director
Edwina Cameron, Head of Organisational Development
Oliver Bennett, Director of Acute Services
Sohail Bhatti, Director of Public Health
Ailsa Paterson, Deputy Director of HR
Lisa Clark, Service Manager MH
Kirsteen Guthrie, Associate Director of Midwifery for Women & Children's Services
Cathy Wilson, General Manager, Primary & Community Services
Kirsty McLachlan, Head of Occupational Health
Kirk Lakie, Acute General Manager
Vikki Mann, Partnership Lead
Tammy Chapman, PA to Director of People & Culture (minutes)

1. ANNOUNCEMENTS & APOLOGIES

1.1 Peter Moore, Lynne Boyle, Michelle O'Riley,

1.2 The Chair welcomed members to the meeting and noted apologies as recorded above. Due to the delayed availability of the substantive Chair, Lucy O'Leary agreed to act as Chair for the meeting. The Committee confirmed that the meeting was quorate and that the agenda could be progressed in full. Members were advised that the meeting was being recorded to support accurate minute-taking and governance assurance.

1.3 The Chair reminded members of the Committee's role within the wider NHS Borders governance framework, particularly its responsibility to provide assurance to the Board on workforce, staff wellbeing, culture and compliance with the Staff Governance Standard.

2. DECLARATIONS OF INTEREST

2.1 The Chair invited members to declare any interests relevant to items on the agenda. No declarations of interest were made.

2.2 The Committee noted that standing declarations remained unchanged and that no conflicts of interest were identified which would require mitigation or affect decision-making for items under consideration.

Assurance Level: Reasonable
The Committee was satisfied that appropriate governance procedures were followed.
Actions / Next Steps:
None.

The **STAFF GOVERNANCE COMMITTEE** noted there were no verbal declarations.

3. MINUTES OF PREVIOUS MEETING

3.1 The Committee reviewed the minutes of the previous meeting held on 16 December 2025. Members confirmed that the minutes accurately reflected the discussion, challenge and decisions taken.

3.2 The Chair noted that actions arising from the previous meeting would be addressed under the Matters Arising and Action Tracker agenda items.

Assurance Level: Reasonable
The Committee confirmed the accuracy of the formal record.

Actions / Next Steps:
None.

4. MATTERS ARISING

4.1 The Committee reviewed matters arising from the previous meeting, focusing on ongoing governance themes rather than individual actions. Attention was given to whistleblowing governance arrangements and the People & Wellbeing Strategy.

4.2 In relation to whistleblowing, the Committee reiterated concerns previously raised regarding clarity of Executive leadership, continuity of oversight and stability of administrative arrangements. Members acknowledged that whistleblowing governance structures are established; however, changes in senior leadership and inconsistent follow-through have limited confidence in effectiveness and staff assurance. The Committee emphasised that whistleblowing is a core element of the Staff Governance Standard and a key indicator of organisational culture and psychological safety. Unresolved leadership clarity was identified as a potential reputational and cultural risk, particularly in the context of forthcoming audit activity and staff confidence in speaking up.

4.3 The Committee also revisited the People & Wellbeing Strategy and clarified the respective roles of the Staff Governance Committee and the NHS Borders Board. Members acknowledged that previous ambiguity around whether papers were presented for discussion, assurance or approval had weakened governance effectiveness and created confusion. The Committee agreed that future papers must explicitly state their purpose, expected assurance and escalation route to ensure robust oversight and avoid duplication or gaps in Board assurance.

Assurance Level: Limited
Assurance is constrained by unresolved leadership clarity in whistleblowing governance and historic ambiguity in governance routes for strategic workforce programmes.

Actions / Next Steps:

- Head of Organisational Development to confirm Executive leadership arrangements for whistleblowing governance
- Committee Secretariat to ensure future papers clearly state whether items are for discussion, assurance or Board approval

ACTION TRACKER:

4.4 The Committee reviewed the Action Tracker to assess the accuracy, relevance, and governance of outstanding actions. Concerns were raised over prolonged use of Amber RAG ratings for overdue actions, which should be escalated to Red when delays are long-term. Inaccurate ratings risk giving false assurance and weaken the Committee's oversight.

4.5 A specific issue was the action on whistleblowing confidential contacts: meetings had lapsed with unclear ownership, making the action unrealistic. The Committee decided to close and re-scope this action through the Whistleblowing Governance Group with clearer accountability and achievable timelines.

4.6 The Action Tracker will be treated as a live tool, applying stricter standards to ensure actions remain current and accurately rated.

Assurance Level: Limited – Ongoing issues with slippage and RAG rating consistency limit assurance, but corrective actions have been set.

Actions / Next Steps:

- Correct and re-rate all overdue actions using proper RAG definitions.
- Close and re-scope the whistleblowing confidential contacts action via the Whistleblowing Governance Group.

5. MENTAL HEALTH STAFF GOVERNANCE REPORTING

5.1 The Committee received the Mental Health Staff Governance update covering mandatory/statutory training, appraisals, staff wellbeing and governance. Members welcomed transparent reporting and noted improvements in serious incident management, including clearer debriefing, better identification of affected staff, and improved access to Occupational Health and Psychology support.

5.2 The Committee noted continuing variation in training compliance across teams and low appraisal completion (around 50%). While incident responses are improving, members highlighted the cumulative impact of repeated traumatic events as an ongoing risk to wellbeing, morale and sickness absence.

5.3 Members emphasised the need for sustained improvement (not short-term mitigations), including leadership focus, protected time for appraisals/training and clear local accountability. Governance was described as strengthening, but the pace and consistency of improvement in key workforce metrics remains a concern.

Assurance Level: Limited
Governance is strengthening, but inconsistent outcomes and sustained workforce pressures limit confidence that risks are fully controlled.

Actions / Next Steps:

- Continue targeted improvement on appraisal and training compliance.
- Monitor wellbeing and serious incident support arrangements, report back to the Committee.
- Future updates to evidence sustained improvement across teams.

6. ACUTE STAFF GOVERNANCE REPORTING

6.1 The Committee reviewed staff governance arrangements within Acute Services and noted encouraging evidence of positive cultural change. Members welcomed increased clinical engagement, devolved decision-making, and improvements in iMatter staff engagement indicators. These were viewed as early signs of progress in leadership behaviours, staff involvement and local ownership.

6.2 Despite these positive indicators, appraisal completion was described by management as **unacceptable**, a view strongly endorsed by the Committee. Members emphasised that appraisals are a fundamental mechanism for staff engagement, development, and early identification of concerns, and that persistent under-performance in this area represents a significant governance weakness.

6.3 The Committee discussed the link between appraisal completion, staff voice, and psychological safety, noting that without effective appraisal processes, opportunities for early resolution of issues and development planning are lost. While recognising operational pressures within Acute Services, the Committee was clear that appraisal delivery must remain a leadership priority.

6.4 Members welcomed proposals to reset the appraisal approach during 2026/27 and to identify a small number of cross-cutting iMatter themes to drive a single Acute-wide action plan. The Committee emphasised that these proposals must result in measurable improvement and not remain aspirational.

Assurance Level: Limited
While the direction of travel is positive, core workforce controls remain weak, limiting overall assurance.

Actions / Next Steps:
- Acute leadership to implement and monitor the revised appraisal approach
- Acute Services to develop a consolidated iMatter action plan and report progress to the Committee
- Future reports to demonstrate measurable improvement in appraisal completion

7. HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – QUARTER 1 AND QUARTER 2 REPORT

7.1 The Committee reviewed compliance with the Health & Care Staffing (Scotland) Act and challenged a previously reported Moderate Assurance position. Members noted ongoing workforce capacity pressures, particularly within nursing, and limitations in e-rostering and real-time staffing data which constrain the ability to provide robust assurance.

7.2 The Committee acknowledged that professional judgement overrides are sometimes necessary to maintain safe service delivery, particularly in the context of workforce shortages. However, members emphasised the importance of robust

audit trails, consistent application and system maturity to ensure transparency and accountability. Concerns were raised that current system limitations reduce confidence in real-time compliance monitoring.

7.3 Members agreed that while statutory processes are in place, system and capacity constraints mean that a Moderate Assurance position cannot currently be justified. The Committee agreed that external reporting should accurately reflect the level of assurance that can be provided.

Assurance Level: Limited
Processes are in place, but workforce and system constraints limit assurance.

Actions / Next Steps:
- Executive Director of Nursing to correct external assurance reporting
- Continued development of workforce systems to support Act compliance

8. INTERNAL AUDIT WORKFORCE MANAGEMENT (NURSING)

8.1 The Committee considered the Internal Audit report on workforce management, which identified weaknesses in workforce planning systems, reliance on manual data extraction, and low staff engagement with audit surveys. Members agreed that these issues significantly limit confidence in long-term workforce sustainability and predictive planning.

8.2 Planned improvements, including enhanced dashboards and analytics, were welcomed; however, members noted that these are not yet sufficiently embedded to improve assurance. The Committee emphasised the importance of improving data quality, analytical capability and staff engagement to support more robust workforce planning and informed decision-making.

8.3 The Committee discussed the importance of triangulating workforce data with qualitative intelligence, including exit interviews and staff feedback, to strengthen assurance and identify emerging risks.

Assurance Level: Limited
System weaknesses materially limit confidence in workforce planning outcomes.

Actions / Next Steps:
- Workforce team to progress implementation of improved analytics and dashboards
- Exit interview analysis and reporting to be strengthened and presented to the Committee

9. STAFF GOVERNANCE FOR NURSING, MIDWIFERY AND ADVANCED PRACTICE WITHIN WOMEN & CHILDREN SERVICES

9.1 **Kirsteen Guthrie**, Associate Director of Midwifery for Women & Children's Services, presented the report and provided a verbal overview of key workforce challenges and associated risks within Women & Children's Services.

9.2 The Committee was advised that **community midwifery staffing is currently significantly reduced**, due to a combination of long-term sickness absence, vacancies and maternity leave, with small teams operating across a wide

geographical area. As a result of these pressures, and following governance review, the **home birth service has been temporarily suspended for three months** on patient safety grounds. Members were advised that this affects approximately **two to three women per month**, and that women impacted have been contacted directly and offered alternative birth options.

9.3 The Committee noted that **acute midwifery staffing resilience remains fragile**, with frequent prioritisation of emergency activity required. Members acknowledged the mitigations in place but expressed concern regarding ongoing risk, particularly in the context of increased clinical complexity and national scrutiny of maternity services. It was confirmed that these risks are recorded on the **service risk register** and are monitored through **local and corporate governance structures**, including Clinical Management Teams and the Clinical Governance Committee.

9.4 The report also highlighted **additional workforce pressures** arising from increased role-mandatory training requirements and service expansion. Work is ongoing to review workforce tools and models, with further alignment expected through the **Health and Care (Staffing) (Scotland) Act** reporting.

Assurance Level: LIMITED
The Committee recognised the actions and mitigations in place but agreed that assurance is limited due to current staffing fragility and service pressures.

Actions / Next Steps:
- Ongoing monitoring of Women & Children's workforce risks through established governance routes
- Continued review of workforce models and sustainability within maternity and neonatal services
- Any material changes or escalation of risk to be reported back to the Committee

10. WORKFORCE DASHBOARD

10.1 The Committee received an update on the People Dashboard, now available to service managers as a single source of workforce data. Members welcomed improved access to consistent information and the move away from fragmented reporting.

10.2 However, the Committee emphasised that visibility alone does not provide assurance unless data is actively used to drive improvement. Persistent low appraisal completion remains evident across services, reinforcing concerns raised elsewhere on the agenda. Members stressed the importance of embedding dashboard use within routine management and governance processes to support early intervention and accountability.

Assurance Level:
- **Process:** Reasonable
- **Outcomes:** Limited

Actions / Next Steps:
- Embed dashboard use within routine management processes
- Continue monitoring appraisal trends through the Committee

11. STATUTORY AND MANDATORY TRAINING

11.1 The Committee received a verbal update highlighting **critically low role-mandatory training compliance** in some areas, presenting a direct patient safety risk. Members expressed serious concern regarding the scale and persistence of non-compliance and noted that the issue has been escalated within the organisation.

11.2 In the absence of a written paper, and given the seriousness of the risk, the Committee agreed it could not provide assurance that controls are effective or that risks are adequately mitigated. Members agreed that role-mandatory training is a fundamental safety control and that failure to achieve compliance undermines safe care delivery.

11.3 The Committee agreed that this issue requires active Board oversight and formal return reporting.

Assurance Level: No Assurance
Insufficient evidence is currently available to assure the Committee or the Board.

Actions / Next Steps:

- Written report on role-mandatory training compliance to be provided
- Issue to be escalated to the Board for active oversight

12. ANTI RACISM PLAN

12.1 The Committee welcomed the Anti-Racism Plan and commended the work undertaken to date. Members expressed confidence in the quality and intent of the plan and its alignment with national expectations and staff engagement.

12.2 However, the Committee noted that executive sponsorship and governance arrangements are not yet fully confirmed. Members emphasised the importance of clear accountability, performance measures and reporting cycles to ensure delivery and meaningful impact.

Assurance Level: Moderate

Actions / Next Steps:

- Executive team to confirm executive sponsorship
- Governance and reporting arrangements to be clarified
- Progress updates to return to the Committee

13. FOR NOTING

STAFF WELLBEING GROUP WORK PLAN

13.1 Edwina Cameron, Head of Organisational Development, provided a verbal update on the Staff Wellbeing Group Work Plan, which was presented for noting in line with the approved agenda.

13.2 The Committee was advised that the Work Plan aligns with the wider People & Wellbeing agenda and supports delivery of the Staff Governance Standard,

particularly in relation to staff experience, wellbeing, and engagement. The update confirmed that the Staff Wellbeing Group's primary function is to provide strategic coordination and governance oversight of wellbeing activity across the organisation, rather than delivering individual wellbeing interventions.

13.3 The Work Plan aims to improve consistency and coherence across wellbeing initiatives, reduce duplication, and strengthen links between wellbeing activity, workforce governance, and organisational priorities. It provides a structured approach to monitoring activity, identifying gaps in provision, and escalating emerging risks through established governance routes where appropriate.

13.4 Members acknowledged that staff wellbeing is a cross-cutting theme across several agenda items, including appraisal completion, sickness absence, the impact of serious incidents, and mandatory training compliance. The Committee recognised the importance of maintaining a clear line of sight between wellbeing activity and measurable workforce outcomes, particularly in high-pressure service areas.

13.5 As the item was presented for noting, no formal paper or assurance was requested at this stage. However, the Committee welcomed the continued focus on wellbeing governance and agreed that future updates would benefit from clearer linkage to outcome measures.

Assurance Level: MODERATE (for noting)

Actions / Next Steps:

- Edwina Cameron to provide a written Staff Wellbeing Group Work Plan to a future meeting
- Future updates to include clearer linkage to workforce metrics (e.g. sickness absence, appraisal completion, staff survey feedback)
- The Committee to continue receiving Staff Wellbeing updates as part of the wider People & Wellbeing governance framework

NURSING WORKFORCE REPORTING

13.6 The Committee noted the Nursing Workforce Reporting paper presented for information by Elaine Dickson, Associate Nurse Director. The item was presented for noting in line with the published agenda.

13.7 No discussion was recorded, and no assurance or actions were requested by the Committee at this stage.

OCCUPATIONAL HEALTH & SAFETY FORUM MINUTES: 15.07.25 & 04.11.25

13.8 The Committee noted the Occupational Health & Safety (OH&S) Forum minutes from meetings held on 15 July 2025 and 4 November 2025, which were presented for information in line with the published agenda.

13.9 Members noted that the OH&S Forum continues to provide oversight of key organisational health and safety risks, including incident reporting, staff safety, workload pressures, and training-related risks. The minutes reflected ongoing monitoring of trends in occupational health and safety incidents, with particular reference to fatigue, training disruption, and the impact of workforce pressures on

staff wellbeing and safety.

13.10 The Committee acknowledged the Forum's role in identifying and escalating emerging risks through established governance routes and welcomed the continued focus on ensuring statutory and mandatory training is undertaken safely and within rostered working hours. Members also noted the Forum's contribution to wider organisational wellbeing activity, including planned wellbeing events and engagement initiatives.

13.11 As the item was presented for noting, no detailed discussion was recorded at the Committee, and no additional assurance was sought beyond confirmation that appropriate governance arrangements remain in place.

Assurance Level: MODERATE (for noting)
The Committee was satisfied that the OH&S Forum is operating effectively and that appropriate systems are in place to identify, monitor and escalate health and safety risks. Assurance is limited by the absence of substantive discussion at this meeting.

Actions / Next Steps:

- No new actions were identified by the Committee
- The Committee will continue to receive OH&S Forum minutes as part of routine governance oversight

TRAINING EDUCATION & DEVELOPMENT BOARD MINUTES: 01.10.25

13.12 The Committee reviewed the TED Board minutes from 1 October 2025, as presented per agenda.

13.13 Members confirmed that the TED Board oversees education, training, and development priorities, including statutory and mandatory training, professional development, and learning infrastructure. The minutes highlighted efforts to strengthen workforce capability, enhance training access, and address operational challenges impacting delivery.

13.14 The Committee recognised the TED Board's role in supporting Staff Governance Standard delivery and noted its relevance to other topics such as appraisal completion, compliance, and wellbeing.

13.15 No detailed discussion or further assurance was requested, with the Committee confident in existing governance arrangements for training and development escalation.

Assurance Level: MODERATE (for noting)
The TED Board is deemed effective with suitable oversight systems, though assurance remains limited due to a lack of substantive discussion at this meeting.

Actions / Next Steps:
No new actions were identified
The Committee will continue to receive TED Board minutes for regular oversight

AREA PARTNERSHIP FORUM MINUTES: 05.12.25

13.16 The Committee reviewed the Area Partnership Forum (APF) minutes from 5 December 2025 as an information item per the agenda.

13.17 Members acknowledged that the APF remains a key forum for management and staff-side representatives to address workforce, employment, and staff governance matters. The minutes covered ongoing workforce issues such as service pressures, sustainability, staff experience, and application of partnership principles.

13.18 The Committee emphasized the APF's role in supporting the Staff Governance Standard, notably in applying employment policies fairly, engaging staff effectively, and identifying workforce concerns early. Relevant discussions also informed other Committee topics like appraisal, wellbeing, and workforce capacity.

13.19 No detailed discussion or further assurance was sought at this meeting, as the item was for noting. The Committee agreed that partnership governance is effective and escalation processes are clear.

Assurance Level: MODERATE (for noting)
The Committee confirmed that partnership structures operate effectively with suitable oversight and escalation of workforce issues. Some assurance is limited by the lack of substantive discussion at this session.

Actions / Next Steps:
No new actions were identified
Area Partnership Forum minutes will continue to be received for routine governance oversight

14. ANY OTHER BUSINESS

14.1 The Committee noted the following matters raised under Any Other Business:

- Members requested that the verbal Staff Wellbeing Group Work Plan referenced earlier in the meeting be circulated in writing to provide clarity and support future assurance. It was confirmed this would be shared outside the meeting.

- The Committee acknowledged recurring themes arising throughout the meeting in relation to iMatter engagement and appraisal completion. Due to time constraints, detailed discussion was deferred, and it was agreed that these matters should return as substantive agenda items at a future meeting, with a focus on communication, engagement, and organisational approach.

- It was noted that responsibility for bringing forward future papers on iMatter communication and appraisal improvement would be confirmed, with the expectation that this would be coordinated through the People & Wellbeing governance arrangements.

14.2 No additional matters were raised.

15. DATE OF NEXT MEETING

15.1 The Committee confirmed the date of the next meeting as Thursday 30 April 2026.

LEVEL OF ASSURANCES

Item No.	Agenda Item	Level of Assurance Agreed
2	Declarations of Interest	Reasonable
3	Minutes of Previous Meeting (16 December 2025)	Reasonable
4	Matters Arising (including Action Tracker)	Limited
5	Mental Health Staff Governance Reporting	Limited
6	Acute Staff Governance Reporting	Limited
7	Health and Care (Staffing) (Scotland) Act 2019 – Quarter 1 & Quarter 2	Limited
8	Internal Audit – Workforce Management (Nursing)	Limited
9	Staff Governance for Nursing, Midwifery & Advanced Practice (Women & Children's Services)	Limited
10	Workforce (People) Dashboard	Process: Reasonable / Outcomes: Limited
11	Statutory and Mandatory Training	No Assurance
12	Anti-Racism Plan	Moderate
13.1	Staff Wellbeing Group Work Plan (For Noting)	Moderate (for noting)
13.3	Occupational Health & Safety Forum Minutes	Moderate (for noting)
13.4	Training, Education & Development Board Minutes	Moderate (for noting)
13.5	Area Partnership Forum Minutes	Moderate (for noting)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**P Williams, Non Executive**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

2.2 Background

The minutes are presented to the Board as per the Area Clinical Forum 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 Area Clinical Forum 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.

- Area Clinical Forum 11 May 2026

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, Area Clinical Forum minutes 12.03.26

Area Clinical Forum
12th March 2026
Microsoft Teams

No	Item
	Welcome and Apologies **Chair**: P Williams **Present**: A Harrison, M Cunnigham, C Proudfoot, K Harvey, L Livesey, R Duncan, P Grieve, T Sporle, M Dwyer, R Devine, G Laker, B Thomson (admin) **Apologies**: I Hayward, L Russell, C Cochrane, M Clubb ***Please note that co-pilot was used to transcribe these minutes as a trial to improve meeting efficiency.***
1	**Previous Meeting Minutes** Previous minutes were approved without further amendment.
2	**Action Tracker** Action tracker amended and updated as appropriate.
3	**Terms of Reference** • No further comments. Group happy to sign these off without any further amendments. • Vice Chair – C Proudfoot volunteered for role and has been accepted into official Vice Chair role.
4	**Feedback from Board** • The board remains in financial deficit, with a £16 million shortfall expected to reduce to £10 million by year-end, requiring significant recurrent savings and potentially impacting clinical service delivery. • The Scottish Government has set ambitious targets for financial recovery by 2026-27, prompting discussions about the feasibility of further savings without compromising safety and quality in clinical services. • NHS Borders is a pilot site for budget tagging to map spending on prevention, acute, and community care, as part of a national initiative led by Public Health Scotland and the Scottish Government. • Ongoing sub-national planning happening, including regional collaboration on orthopaedic and unscheduled care pathways, with the aim of standardising service delivery and potentially attracting investment to NHS Borders.
5	**Clinical Strategy Engagement Sessions** • Was reported that AHPs, public health, psychology, pharmacy, and GP's had limited or delayed involvement in the development of implementation plans, often learning about decisions after the fact. • Several members expressed concern that the tight timeline for implementation had led to a return to siloed planning, with services developing separate plans rather than co-producing integrated solutions.

	• It was emphasised the necessity of digital transervices including EPMR and EPMA, as a prerequisite for meaningful change in clinical services, and advocated for broader leadership involvement in digital initiatives. • It was discussed the need for realistic conversations about shifting resources from hospital to community settings, highlighting the importance of commissioning and the role of the new IJB chief officer in facilitating change. • Next Steps: PW proposed circulating draft implementation plans to forum members for comment and inviting operational directors to future meetings to discuss ongoing and future planning, aiming to improve clinical engagement and oversight.
6	**Reduced Working Week** • It was reported that some requests for clinical backfill had not been responded to, leading to planned reductions in service hours. Across nursing services it has been described a variable approach, with some receiving support and others left uncertain. • It was highlighted that information about the option to apply for backfill and the associated appeal process was not widely communicated, resulting in some teams proceeding without support. ***FOR ACTION:*** *P Williams to formally raise concerns with the Director of Finance and Director of HR regarding the lack of transparency and the clinical risks associated with the reduced working week implementation.*
7	**Advisory Committee Escalations** ***FOR ACTION:*** *B Thomson to gather advisory committee ToR's to ensure consistency across groups.*
8	**Any Other Competent Business** Nothing to note
	Date and Time of Next Meeting: Thursday 9th April 2026, 1230-1330

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**P Moore, Chief Executive**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Integration Joint Board 20 May 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 18.03.26

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 18 March 2026 at 10am** via Microsoft Teams

Present:
(v) D Parker (Chair)
(v) R Tatler
(v) E Thornton-Nicoll
(v) T Weatherston
(v) F Sandford, Non-Executive
(v) J Ayling, Non Executive
(v) J McLaren, Non-Executive
L Turner, Chief Financial Officer
N Hood, Borders Carers Centre
N Istephan, Chief Executive, Eildon Housing Association
S Horan, Director of Nursing, Midwifery & AHPs
L McCallum, Medical Director
J Smith, Borders Care Voice
J Amaral, Chief Executive, Borders Community Action

In Attendance:
I Bishop, Board Secretary
K Steward, Community Nurse Manager, NHS Borders
C Myers, Director of Adult Social Work & Care
M Fleming, Finance Manager, SBC
G Clinkscale, Interim Director of Urgent Care, Community Services & Mental Health, NHS Borders
L Jones, Director of Quality & Improvement, NHS Borders
C Oliver, Head of Communications, NHS Borders
S Burt, Chief Social Work Officer, SBC
J Stacey, Chief Internal Auditor, SBC

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from L O'Leary, Non Executive, N Richards, Elected Member, R Duncan GP, L Jackson, LGBTQ+, D Bell, Staff Side, SBC, P Moore, Chief Executive, NHS Borders, D Robertson, Chief Executive, SBC, A Bone, Director of Finance, NHS Borders, S Bhatti, Director of Public Health, NHS Borders.

1.2 The Chair welcomed attendees and members of the public to the meeting.

1.3 The Chair advised that the recruitment process for the appointment of a Chief Officer had concluded and it was hoped an announcement would be made shortly.

1.4 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting held on 21 January 2026 were approved.

4. MATTERS ARISING

4.1 **Action 2024-7:** L Jones commented that the hospital at home service update was included within the urgent and unscheduled care paper on the agenda and suggested the item be closed.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to close Action 2024-7.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Action Tracker.

5. PERFORMANCE AND DELIVERY REPORT

5.1 The Chair advised that whilst the Chief Officer position remained vacant the Performance & Delivery Report had been formulated as per normal processes in order to ensure the Board maintained an oversight of progress within certain activities.

5.2 Any questions in regard to the content of the report could be emailed to I Bishop who would source answers outwith the meeting.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Performance and Delivery Report.

6. 2026/27 PAYMENT OFFER UPDATE

6.1 L Turner presented the 2026-27 payment offers, followed by an overview of the in-year financial position. Payment offers were essential for setting the IJB budget. Discussions regarding principles had taken place with NHS colleagues, and they continued to work through their budgeting process with the Scottish Government. At present, she could not provide definitive figures from the NHS side, but once available, they would be incorporated into a comprehensive IJB budget for future consideration. Included in the briefing paper was information regarding Scotland's challenging financial situation, drawing on data from the Accounts Commission's IJB Financial Bulletin for 2024-25. Those findings illustrated a deteriorating position across Scotland, with expenditures increasing more rapidly than funding, and 19 boards (60%) had requested additional payments.

6.2 Turning to the payment offer from Scottish Borders Council, following their budget setting on February 19, an offer of £88.7m had been received. Notably, this year the Scottish Government revised its calculations for council funding allocations relating

to older people. Larger councils experienced significant shifts, but for SBC the expected reduction was approximately £7m in funding over time. That impact would be tempered by the application of the 'floor' formula, which aimed to stabilise allocations over about 5 years. Whilst it did not directly translate to reductions in social care budgets, it remained the primary area affected. The current payment offer represented an increase of £5.2m compared to previous years, comprising of 2 main components: a fully funded uplift for the real living wage (£3.8m), ensuring continued compliance for commissioned care services, and a council-funded pay award of 3.5% (£1.5m) for directly employed staff, aligned with national agreements. An assumed savings target of £2m was included, which was expected to be met through adjustments to care-at-home delivery models, increased self-directed support payments, and temporary staff reductions at Deanfield Care Home during renovations.

6.3 Additionally, it was noted that adult social work and social care were projected to overspend by £4.8m. Efforts led by C Myers and senior managers were underway to develop clear spending plans, aligning service delivery with available budgets. Despite the additional funding, balancing the 2026-27 budget in line with service needs was anticipated to remain challenging, particularly given no budget increases for current overspends.

6.4 Regarding the NHS payment offer, discussions with A Bone and his team suggested that the 2025-26 budget would be carried forward with the addition of a 2% inflationary uplift, as applied by the Scottish Government. Any pay awards exceeding 2% would be fully funded by the government and passed on accordingly. Changes to working patterns for 'Agenda for Change' staff, including reducing the working week from 37 to 36 hours, would be managed through 6 months of backfill where necessary, after which a permanent approach would be evaluated. Cost pressures arising in 2026-27 were to be absorbed within existing service budgets, with no new savings targets anticipated beyond the outstanding £3.5m. There were concerns regarding certain anticipated Scottish Government funding streams, such as the new frailty unit and hospital-at-home initiatives, which had not yet been baselined. The absence of confirmed funding could significantly impact service provision, and that risk was being highlighted for board awareness. Once the final NHS payment offer was received, both offers would be consolidated into a detailed budget position and a medium-term plan would be presented to the board.

6.5 F Sandford enquired about the financial challenges and their impact and suggested a future report addressing how that affected community care as well as outlining the changes being made to improve social care efficiency should be commissioned. She was also keen that the board receive an update on delayed discharges and people in unsuitable placements.

6.6 N Istephan highlighted that although regulated care workers now received the uplifted living wage, independent providers were not fully funded for that increase, meaning overall service costs remained unmet. Some services and higher-grade positions were not fully funded, leading to a situation where supervisors in regulated care may earn little more than those they managed. That unintended result of efforts to better compensate social care workers placed added pressure on independent providers.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** accepted the payment offer from Scottish Borders Council.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the principles expected to be included within the payment offer from NHS Borders.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a paper on the financial challenges and how they affected community care combined with the improvements being made in social care efficiency and effectiveness.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive an update on the Delayed Discharges position.

7. IJB 2025/26 QUARTER 3 FINANCIAL MONITORING POSITION

7.1 L Turner commented that the financial position had declined compared to the previous year and the last quarter. Budgets had increased slightly, with £240m allocated for delegated services and £34m for set aside. Currently, there was an £8.9m overspend in delegated services, comprising £4m from the NHS and £4.8m from SBC. The £1.8m increase was primarily on the SBC side, reflecting delayed implementation of anticipated savings and initiatives. According to the Scheme of Integration, the respective partners would be required to fund the deficit. Set aside services were projected to be overspent by £7m, which remained NHS Borders' responsibility and represented an increase over previous years. Unfortunately, the situation was not improving.

7.2 Regarding savings, the table under the savings section showed £1.6m in unmet savings for SBC, which formed part of the £4.8m budgetary pressure and would need permanent resolution next year. Similarly, NHS Borders had £500k in expected savings that were not achieved this year, adding to the £3m already identified for future years. There was a substantial amount of carried forward savings yet to be addressed. Notably, set aside services had delivered more savings than planned but remained in an overspend position.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast financial position of the IJB as at 31st December 2025.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the ongoing risk to the financial sustainability of the IJB due to current funding levels compared to running costs and demand and the anticipated impact of this in 2026/27.

8. URGENT AND UNSCHEDULED CARE PAPER

8.1 G Clinkscale presented an overview of the significant body of work completed over the past six months regarding the frailty model across the partnership. That initiative had been fully aligned with the 2023–26 strategic framework, focusing on early intervention and enhanced access to services. He also shared some management information which highlighted early indicators of impact.

8.2 The 4 hour emergency access standard remains challenging with an average achievement of just above 64%. Patients often face long waits, sometimes over two days in winter, due to overcrowding, revealing wider system flow problems. Process inefficiencies and limited capacity have contributed to those issues. Delayed

discharge figures have improved; as of February 2024, numbers dropped from about 85 at peak to mostly in the 40s, occasionally rising to the 50s. Those gains come from collaborative efforts and expanded home care provision.

8.3 After receiving £3.4 million from the Scottish Government last autumn, investment in the frailty pathway to improve patient outcomes and flow was prioritised and 5 areas were targeted for change:

- Dedicated frailty unit offering seven-day specialist care and early rehabilitation.
- Integrated discharge team to streamline hospital stays.
- Expanded Home First service for increased reablement capacity and earlier discharges.
- Growth in Hospital at Home service, boosting virtual bed capacity.
- Quality improvement teams standardizing processes under the National Discharge Without Delay program.

8.4 The strategy speeds up older patients' discharge and reduces deconditioning. The frailty unit launched with 6 beds (now 12), and in 2 months, 63% of patients returned home directly outperforming other units. Average length of stay is 6 days but aimed at 4. Home First doubled its caseload, supporting smoother transitions and lessening ongoing care needs. Robust reablement services reduce post-rehabilitation home care requirements. Hospital at Home capacity has also doubled, further enhancing virtual care, with L Jones leading recent developments.

8.5 L Jones acknowledged that it was the IJB that had provided initial pump-prime funding during a time of limited resources. Using non-recurring funds, the aim had been for a 20-bed Hospital at Home model, which has been successfully delivered exceeding expectations in its system impact. The service handles 40–50 patients weekly with a 4.8 day average stay and is now the main discharge route from the medical assessment and acute frailty units. Patient feedback has been excellent, especially as the service helps people stay home during difficult times. There is an intention to expand to 25 beds by April with new staff and permanent Government funding, replacing previous temporary funds. Plans include expanding coverage across the Borders, adding hubs in Hawick and Hay Lodge, to ensure the original business case goals are met.

8.6 G Clinkscale commented that the integration of hospital at home services within the frailty unit had improved activity and collaboration. Home First, hospital at home, and the new integrated discharge team were now managed under one clinical team to support patient flow from acute beds to the community. Priorities for 26-27 included expansion of reablement offerings, increasing early supported discharge pathways in areas like orthopaedics and stroke, and growing our integrated discharge team's coverage. The Scottish Government remains committed to hospital at home, and improving inpatient flow is a top priority. Recent partnership efforts had led to significant progress, thanks to shared objectives and strong operational support, especially over the past six months.

8.7 N Istephan enquired if there was any data on how **s**ustainable it is for people to remain at home after returning, both in terms of services and their physical environment? He also offered input to the living environment which was crucial for independence, through adaptations and equipment to help ensure homes were as supportive as possible. G Clinkscale advised that nurse coordinators were joining

locality huddles with the integrated discharge team, enhancing social care collaboration and improving processes as well as working closely with social workers and the social care team, especially regarding the care and repair service. He suggested collaborating with Chris and Nile outwith the meeting.

8.8 Further discussion focused on: benchmarking against other areas may be useful; workforce pressures, especially in nursing, will persist due to past national policy decisions, leading to a potential 10-year deficit in registered nurses; it is important to move beyond professional silos; whilst discharging people home is positive, the ongoing demand for social care and maintaining staff remains a challenge; how do we future proof; encourage personal responsibility for self management of health; the benefits of co-location; NHS Borders clinical strategy messaging to the public; How to support people to live better at home without the expectation that the first port of call is going to be an admission into hospital or an attendance at the emergency department; need to emphasise the self directed support system to make effective changes; and getting it right for everyone.

8.9 The Chair suggested presenting the item to Scottish Borders Council and asked C Myers to arrange.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the significant work underway across unscheduled care including developments in the Frailty pathway.

9. CLINICAL & CARE GOVERNANCE - CSWO ANNUAL REPORT 24/25

9.1 S Burt commented that in adult social work and care, there was movement toward commissioning more services from the third sector, which demonstrated strong adaptability, innovation, and partnership. Most learning disability and mental health support had already been commissioned from the third sector, whose resilience and versatility were key strengths. Self-directed support, though underutilised, could have offered individuals greater choice by enabling them to use their budgets for community-based third-sector services, thereby reducing reliance on traditional care models. For that to succeed, financial flexibility was crucial, and resources needed to shift according to people's actual needs instead of maintaining outdated systems. If implemented well, self-directed support could benefit both individuals and providers, ensuring essential care remained available for those who needed it most.

9.2 C Myers commented that SBC and NHS Borders were reviewing the third sector with the aim to build a resilient sector through partnership and commissioning. He explained that good practices were being explored with Falkirk District Association of Mental Health.

9.3 L Jones commented that in regard to care at home, it was crucial for the delivery of quality services but also faced challenges due to workforce shortages. Smaller providers often struggled to maintain services, leaving other teams to absorb additional hours into core services. She recognised that all providers were competing for the same care workforce, which impacted sustainability. This issue was especially relevant given the population profile and efforts to improve system flow.

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

10. STRATEGIC PLANNING GROUP MINUTES: 18.06.25

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

11. ANY OTHER BUSINESS

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted there was no further business to discuss.

12. DATE AND TIME OF NEXT MEETING

12.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 20 May 2026, from 10am to 12 noon through MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**25 June 2026**
Title:	**Health Charity Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**A Bone, Director of Finance**
Report Author:	**I Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Endowment Fund Board of Trustees with the Board.

2.2 Background

The minutes are presented to the Board as per the Health Charity 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.

- Health Charity Board of Trustees: 02.02.26
- Health Charity Board of Trustees: 11.05.26
- Health Charity Board of Trustees: 15.06.26

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 06.10.25
- Appendix No 2, Health Charity Board of Trustees: 02.02.26
- Appendix No 3, Health Charity Board of Trustees: 11.05.26

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 6th October 2025 @ 10 a.m. via Microsoft Teams.

Present:
J Ayling, Trustee
K Hamilton, Trustee (Chair)
J McLaren, Trustee
P Moore, Trustee
D Parker, Trustee
F Sandford, Trustee

In Attendance:
C Barlow, Charity Development Manager
T Dixon, Charitable Funds Accountant
R Egan, Fundraising Officer
B Everitt, PA to Director of Finance (Minutes)
M McLean, Investment Advisor
S Swan, Deputy Director of Finance (Head of Finance)
K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting and in particular to Tony Dixon who had recently taken up post of Charitable Funds Accountant.

Apologies had been received from A Bone, Trustee, S Bhatti, Trustee, L O'Leary, Trustee, L McCallum, Trustee and J Smyth, Director of Planning & Performance.

2. **Declaration of Interests**

James Ayling referred to the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

James also referred to item 5.3 (Charity & Fundraising Policy) as he felt that this was potentially a conflict of interest due to it also going to Borders NHS Board. Karen Wilson advised that it was being presented today to allow Trustees to have sight and an opportunity to comment prior to it going forward to Borders NHS Board for approval.

3. **Minutes of Previous Meeting : 12th June 2025**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
The action tracker was noted.

Capital Projects Update
Item carried forward to the next meeting.

Adult Changing Facility Update
Karen Hamilton, on behalf of Andrew Bone, reported that upon completion of the MacMillan phase 1 works, anticipated to be November, resources would be diverted to this project with expectation that the tender would be completed this financial year and a target date of summer 2026 for works to be underway.

Fiona Sandford noted her frustration around the length of time this has been ongoing and felt it was crucial for plans to be firmed up timeously.

David Parker added that this was an unsatisfactory situation and was disappointed that there was no report at today's meeting. David proposed that this be escalated to Borders NHS Board for discussion and agreement on a way forward.

James Ayling echoed these comments.

Peter Moore advised that the timeframe outlined could be challenged but reminded of the lack of available resources as discussed at previous meetings. Peter suggested that the Board discussion on this be in private in the first instance. This was agreed.

The Endowment Fund Board of Trustees noted the update.

5. **Strategy & Fundraising**

5.1 *Grants Update*
Colleen Barlow spoke to this item which provided an update on the transition to a Single Point of Access and also gave a position statement on the grants awarded and those in the pipeline. Colleen went over the report bringing any key issues to Trustees' attention.

James Ayling referred to the Volunteer Services Manager as he was pleased to see this role being appointed to. Colleen advised that the person appointed was an internal candidate, giving them a good grounding, and that they took up post today and would report to the Head of Clinical & Professional Development. It was noted that this was a fixed term post and that the Fundraising Team have requested to be kept involved around any future developments.

Colleen also referred to the Fund Manager engagement exercise undertaken, noting a 32% engagement which was the highest to date. Coleen also highlighted the feedback received from this.

The Board of Trustees noted the update.

5.2 *Fundraising Update*
Karen Wilson spoke to this item which provided an update on the workplan where it was noted that the majority of activity over the last period had been on the re-brand exercise. Karen highlighted the table within the report which detailed the costs associated with this and advised that the remaining budget would be used for marketing materials for the Tree of Light campaign.

Karen referred to the development of a Charity Strategy and advised that the timeline had been pushed back to the end of the year to allow for this to follow the same direction as the organisational strategy and the emerging clinical and supporting strategies.

It was noted that progress had been made around updating donation forms etc to remove specific fund options and reflect unrestricted language to encourage donations to be made in this way. Karen highlighted that more work was required around the staff training programme on unrestricted giving and this was ongoing.

Karen advised that progress was being made with the staff lottery which she hoped would be relaunched in the near future with proceeds from this going to the charity.

James Ayling enquired if enough was being done to push the charity following its re-brand. Karen felt that they were getting publicity but agreed more work was required to build on this.

The Board of Trustees noted the update and the progress made.

5.3 *Charity & Fundraising Policy*

Karen Wilson spoke to this item where it was noted that the policy was being presented as draft to allow Trustees to have sight and ask for endorsement to take forward to Borders NHS Board for formal approval.

Karen advised that the policy set out how staff across the organisation can interact with the Fundraising Team as well as setting out a consistent platform for other charities to ensure there is equity.

Karen referred to the Fundraising Framework currently in place which was now extremely outdated and was largely based on supporting appeals. As the organisation had moved away from a phase of supporting one large appeal after another, it was felt that this policy provided all the relevant information and guidance for staff.

It was noted that there would be further consultation with support teams and charities to ensure it was fit for purpose before being presented to the Board for approval.

Karen Hamilton referred to the “requesting funding” section on page 9 as she felt that the third bullet point related to offers of funding rather than requests for funding which was contradictory. Karen W agreed to look at this and make the necessary amendments to avoid any confusion.

For Trustees’ awareness, Karen H advised that there had been meetings with other significant charities to discuss the relationship with them and how to achieve the requests for funding and the activities to which they are fundraising for. This also fed into earlier discussion around resource provision, project management, estates involvement etc. Karen H felt that this section required further discussion with charitable partners across the whole organisation.

James Ayling referred to page 5 of the policy where it stated “every year NHS Borders Health Charity contributes over half a million to NHS Borders services, its staff and the care of its patients”. James felt that this required to be reviewed to provide clarity on the distinction between core and non core funding.

James also referred to the suggested £5k limit to which staff could speak with patients and families in regard to donations and legacies as he felt that this limit was too high.

James also stressed that it was essential that anyone making a donation are completely clear around where they are donating to and what the donation will be used for.

James also felt that clarification was required to ensure that neither the Board of Trustees nor Borders NHS Board were responsible for the actions of any other charity operating on the Board’s estate.

Karen W agreed to take these points on board and amend the policy appropriately. The updated policy would be circulated virtually around Trustee for endorsement.

The Board of Trustees made comments on the draft Charity & Fundraising Policy which would be updated and circulated virtually for endorsement prior to going to Borders NHS Board for approval.

6. **Financial Report**

6.1 *Financial Report and Primary Statements*
Susan Swan spoke to this item which provided an update on the level of spend to 31st August 2025 against the level of income that had been received. Susan advised that the format of this report, along with the legacies and donations report, would be reviewed to provide Trustees with more comprehensive reporting going forward and these would also take into consideration previous comments received.

A cumulative total of £4.99m was reported on the balance sheet, however since the report had been issued this had risen to just over £5m. It was noted that work continues with the Fundraising Team on the review of restricted funds. Susan referred to the Statement of Financial Activities attached to the report which provided the detail of all income and expenditure for the period being reported.

The Board of Trustees noted the report.

6.2 *Register of Legacies and Donations*
Susan Swan spoke to this item which provided Trustees with an update on all legacies and donations received over £5,000 for the period 1st April to 31st August 2025. Susan advised that the Charitable Funds Accountant, along with the Fundraising Team, would be looking at legacies and donations which are due to come forward to allow projects to be planned in anticipation of receipt of these.

James Ayling enquired if contact was being made with local solicitors by way of promoting the charity. Karen Wilson advised that this was planned as part of the rebrand exercise.

The Board of Trustees noted the report and their thanks for the generous donations received.

7. **Funds Management**

7.1 *Investment Advisor Report*

Fiona Sandford referred to the format of the main report and noted that the report pages were incorrectly orientated and therefore were difficult to view especially when consolidated within the pack of papers. Mark agreed to ensure future reports are presented correctly for consolidation.

Mark McLean spoke to this item and highlighted that as at 31st August 2025 the value of the portfolio was just short of £5.1m and as of Friday, 3rd October 2025 it was just short of £5.2m.

Mark advised that in the last quarter the portfolio had increased by +2.2%, net of fees, which was still slightly behind the benchmark of +3.59%.

It was noted that since the last meeting some changes had taken place within the portfolio around the UK and European investments which had been well received. Mark felt that it was now pertinent to review the US exposure within the portfolio, look at income from other asset classes and increase US growth type investments which would hopefully see the portfolio move closer to the benchmark. Mark noted the 10% turnover limit (between meetings) detailed in the Investment Policy and that transactions above this limit would require to be approved by the Trustees should they wish to purse this portfolio change as the asset classes movement would be in the region of £1.5m – £2m.

Looking ahead, Mark advised that UK equities would be dominated by the budget at the end of November. Mark also referred to the situation within the middle east which continues to have an impact.

Karen Hamilton asked for clarification that the proposed asset class movement Mark was proposing would be greater than the agreed 10% and would therefore require Trustees' approval. Mark confirmed that it would as he was looking to take £900k out of the portfolio and add £1m back in which equated to a 40% turnover on a £5m portfolio. Mark agreed to email the Deputy Director of Finance with the proposals for onward circulation to Trustees for approval.

Fiona Sandford asked for clarification that it was the intention to move from US income stocks to US growth stocks. Mark confirmed that in regard to the US equity exposure that was correct.

James Ayling felt that it would be helpful to include any costs involved, i.e. brokerage etc, within the proposal. Mark did not anticipate any brokerage fees on a charity portfolio but would check this and confirm.

James also noted that within the new reporting format there was no longer an income statement included. Mark confirmed that this was correct for this report received by Trustees, however this was still included within the full valuation report which would be in future meeting packs.

James felt that it would be beneficial for the report to also include the benchmark performance as well as the portfolio performance to compare against. Mark agreed to request for this to be added for future reports but couldn't guarantee that it would be.

The Board of Trustees noted the report.

8. **Any Other Business**

8.1 *Investment Advisor Contract Update*
Mark McLean left the meeting
Susan Swan provided Trustees with an update on the contract for the Investment Advisor where it was noted that the Charitable Funds Accountant would be picking up this piece of work and would be in touch with Trustees in due course.

James Ayling noted caution around changing the investment asset class proportions within the portfolio with an impending change of Investment Advisor and felt it may be worthwhile keeping the status quo until a new advisor is appointed. David Parker agreed with this and did not feel that it would be appropriate to make any changes at the present time.

Following discussion it was agreed to review the proposals from the Investment Advisor when received and make a decision at that time.

Peter Moore enquired around the timescales for appointing a new Investment Advisor to weigh up against any potential benefit to the portfolio should changes be made as per proposals discussed at the previous item. Susan explained that she would be looking to expedite this piece of work and would do as much as possible virtually rather than being bound by meeting dates.

James highlighted that Trustees could undertake the exercise to appoint a new Investment Advisor themselves or employ a third party to do this and suggested that he, Susan and the Charitable Funds Accountant look into this further and bring back a proposal for Trustees' agreement. This was agreed.

The Board of Trustees noted the update.

8.2 *Endowment Advisory Group Update*
Colleen Barlow provided Trustees with an update from the recent meeting of the Endowment Advisory Group. It was noted that the group had met on the 1st October 2025 and had reviewed 8 applications, 4 of which had been approved by the group, 2 referred to the Board of Trustees for approval as they were outwith the group's delegated authority level. The remaining 2 had been deferred until organisational and financial assurances were in place.

Colleen went on to explain that the role of the Endowment Advisory Group had also been discussed and a small panel, including the Director of Finance, would be discussing this further prior to the Board of Trustees meeting in February.

The Board of Trustees noted the update.

As this was the last meeting which Karen Hamilton would chair, Karen Wilson wished to note her thanks for all her support over a number of years.

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

Monday, 2nd February 2026 @ 10 a.m.

BE
17.10.25

Minutes of a Meeting of **NHS Borders Health Charity Board of Trustees** held on Monday, 2nd February 2026 @ 10 a.m. via Microsoft Teams.

Present:
J Ayling, Trustee
A Bone, Trustee
S Horan, Trustee
L Livesey, Trustee
J McLaren, Trustee (Joined meeting at 10.25 a.m.)
P Moore, Trustee
L O'Leary, Trustee
D Parker, Trustee (Left meeting at 11.10 a.m.)
F Sandford, Trustee (Chair)
P Williams, Trustee

In Attendance:
C Barlow, Charity Development Manager
T Dixon, Charitable Funds Accountant
R Egan, Fundraising Officer
B Everitt, PA to Director of Finance (Minutes)
M McLean, Investment Advisor (Left meeting at 11.35 a.m.)
K Rodgers, Deputy Director of Finance
K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Apologies had been received from J Smyth, Director of Planning & Performance and L McCallum, Trustee.

2. **Declaration of Interests**

James Ayling referred to the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

3. **Minutes of Previous Meeting : 6th October 2025**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
Andrew Bone provided an update on capital projects where it was noted there was 1 live project which was reaching conclusion and 1 pending project. Andrew went on to provide an update on the live project, namely Macmillan phase 1, where it was noted that although works had concluded earlier in 2025 the unit remained closed pending resolution of water safety issues; this position was actively being managed and would be further reviewed at a meeting to be held on Friday. Sarah Horan advised that from the information she had received she was not confident there would be a resolution at Friday's meeting. Lynne Livesey enquired if the area was being used given the vulnerability of users. Andrew confirmed that it was not being used and had been decanted elsewhere within the hospital.

Regarding the pending project, namely the adult changing facility, Andrew advised that he expected the design to be signed off within the next 2 weeks and following this it was anticipated that a procurement exercise would be undertaken to appoint a contractor. Andrew went on to explain that the estimated cost of this project had increased from previous estimates and was likely to exceed the identified budget. Confirmation of funding would be required prior to proceeding with the project.

The action tracker and update was noted.

Capital Projects Update
This was covered under the previous item.

5. **Strategy & Fundraising**

5.1 *Update on Implementation of Non-Legislative Recommendations from the Review of Governance of NHS Endowment Funds*
Colleen Barlow spoke to this item which provided an update on progress with implementation of the non-legislative recommendations arising from the Review of Governance of NHS Endowment Funds. Colleen highlighted the recommendations which could be taken forward and the action taken to date on these. Colleen explained that there were still actions required to fully implement the recommendations, as well as some areas of improvement, and these would be included within a Governance Action Plan which would be reported to Trustees in due course.

James Ayling asked for an update on the practice which continued of putting unrestricted donations into existing restricted funds, which was against guidance and good practice, and enquired what was being done to resolve the situation. Colleen explained that previously there had only been a limited resource available from Finance, however now that the Charitable Funds Accountant was in post they would be able to provide expert advice in this area. James felt that there should be a timescale noted against this piece of work and suggested by the next meeting. Karen Wilson highlighted that there were deadlines detailed within the paper and this one was noted as June 2026 and provided assurance that this was being treated as a priority.

The Board of Trustees noted the update.

5.2 *Annual Review of Charity Governance Framework*
Colleen Barlow spoke to this item and advised that it had been some time since a comprehensive review had been undertaken, with the last significant change being in 2024 when the Scheme of Delegated Authority had been updated to align with the Grant Making Framework.

Colleen explained that several documents within the existing Framework were now out of date, some only requiring small changes to reflect the new branding for example, whilst others required more significant changes to ensure they were in line with recommendations and best practice. Coleen proposed that the team worked with the relevant Executive Director leads to progress these during 2026/27.

Colleen also noted the use of the term ‘endowments’ as this referred to a very specific type of fund which there were none of at the present time and asked

Trustees for support when in meetings to use the term “NHS Borders Health Charity” to support this messaging going forward.

Fiona Sandford suggested that, in consultation with the Board Secretary, the name of this meeting be changed to the ‘NHS Borders Health Charity Board of Trustees’ to avoid any confusion. This was agreed.

The Board of Trustees noted the proposed review, plan and activities.

5.3 *Fundraising Update*

Karen Wilson spoke to this item which provided an update on the agreed fundraising workplan. Karen highlighted the work undertaken since the last meeting which included the rebrand of the Charity, the Tree of Light Campaign and renewing relationships with Friends of the BGH.

James Ayling referred to the objective to have at least 10% of income received classed as unrestricted by the end of the financial year and asked for feedback on conversations with individuals / groups regarding this. Karen clarified that the timescale for this was the 31st March 2027 to give sufficient time from implementation to see the effect in terms of donors’ behaviours. Karen confirmed that where possible these discussions are taking place and the concept for doing this has been positively received.

Lynne Livesey enquired about the timescale for training on unrestricted giving to ‘gatekeepers’. Karen confirmed that this had been completed for internal gatekeepers and for external gatekeepers, such as solicitors and undertakers, she hoped that this would be complete by the end of the financial year.

Lynne also referred to ‘Wills Week’ which she had raised previously and hoped to see this included as part of the workplan going forward. Karen confirmed it was the intention to build relationships in anticipation of this taking place in the autumn and Trustees would be kept updated on progress.

Sarah Horan referred to a consultant entirely funded by charitable monies and stressed the importance of advertising these types of examples as they are very relatable to the reader.

Lucy O’Leary enquired about the proportion of income received from legacies in comparison to donations. Tony Dixon advised that on average over the last 3 years this equated to 65% for donations and 35% for legacies.

Lynne also enquired if the Charity was included within the Charities Directory. Karen was unaware of this publication but would investigate and ensure it was included going forward.

The Board of Trustees noted the update.

5.4 *2026/27 NHS Charities Together (CT) Membership*

Karen Wilson spoke to this item and highlighted that the Charity would now move into a higher membership bracket with NHS CT. Karen explained that the benefits for the next financial year were less compelling and she felt that the membership offer was vastly different in Scotland when compared to England as there were

more grant opportunities available to English members. Karen recommended not renewing the membership for 2026/27 but to continue monitoring this throughout the year and decide whether to rejoin the following financial year.

The Board of Trustees approved the recommendation not to renew NHS Borders' Health Charity's membership with NHS Charities Together for 2026/27 unless this had an impact on the funds discussed under item 5.5.

5.5 *NHS Charities Together (CT) Grant Underspend*

Karen Wilson spoke to this item which provided background on an underspend from a grant award which she anticipated returning a proportion of to the funder (NHS CT). It was noted that the original grant of £77k was for the installation and expansion of existing staff rest areas through the provision of benches and shelters as well as the creation of a Greenspace campaign in partnership with NatureScot. The scope of the grant was subsequently amended to remove the Greenspace campaign element. Following installation of 12 staff shelters at the BGH and community hospital sites it had been agreed not to roll out the scheme further due to the challenge of finding viable sites. NHS CT had been notified of the anticipated underspend of £30k which they were open to it being used for an alternative project, providing it still related to staff wellbeing, before the 31st March 2026. Despite efforts an alternative project had not been identified to date therefore it was anticipated that the underspend would have to be returned.

Trustees unanimously agreed that returning the underspend should be seen as a last resort and following discussion it was agreed that Karen should meet with John McLaren and Sarah Horan to look at the options for retaining these funds. An update to be provided at the next meeting.

The Board of Trustees noted the efforts to identify alternative uses for the underspend and agreed that further options should be explored prior to it being returned.

6. **Financial Report**

6.1 *Financial Report and Primary Statements*

Tony Dixon spoke to this item and advised that as at 31st December 2025 the balance sheet noted assets of £4.95m which saw an increase of approximately £230k since the last report. Tony also highlighted the statement of financial activities which noted an excess of expenditure over income of £176k. In regard to income from donations and legacies to 31st December 2025 these totalled £336k which was an increase of £182k since the last report. Investment income for the same period amounted to £96k.

Tony advised that expenditure for the 9 month period was £608k with grant funded activity accounting for the largest share of this at £431k.

Tony highlighted that the net gains on investments amounted to £439k which saw an increase of £285k since the last report. The portfolio value was noted as just over £5.09m seeing an increase of £90k since the last update.

Tony went on to provide Trustees with an update on a financial tool he was currently working on which would provide Trustees with more meaningful information. Trustees would be kept updated on this.

The Board of Trustees noted the report.

6.2 *Register of Legacies and Donations*
Tony Dixon spoke to this item which provided Trustees with an update on all legacies and donations received over £5,000 for the period 1st April to 31st December 2025. It was noted that there had been 1 donation received since the last report with no new legacies.

The Board of Trustees noted the report.

6.3 *Forecasting of Palliative, Cancer & Stroke*
Colleen Barlow spoke to this item and advised that the overall purpose of the paper was to provide Trustees with the financial position for these 3 funds, noting that Palliative and Cancer were the largest funds held. Colleen went on to take Trustees through the recommendations within the paper which would help inform grant making over the next 1 – 3 years. Colleen also provided background on each of the funds where she proposed setting an annual spend budget for each of these which could be re-assessed at the end of the calendar year. Coleen also proposed setting up a short-life working group to further develop the charity's direction and to agree communications with staff and the public.

Fiona Sandford referred to the stroke fund where she was keen to see any available funds being spent within this area. Sarah Horan confirmed that there would be opportunities to do this which could perhaps align with the Clinical Strategy. Paul Williams agreed but highlighted the challenge clinical teams have in determining what is classed as a core service to be funded by the Board and what is an enhanced service to be funded by the Charity.

The Board of Trustees noted the report and agreed with the approach as outlined in the assessment.

6.4 *Forecasting of General Unrestricted Fund*
Colleen Barlow spoke to this item and advised that at the beginning of the financial year a paper summarising all outstanding large grant commitments had been presented to the Endowment Advisory Group and then to the Board of Trustees which highlighted the significant pressures on unrestricted funds.

Colleen explained that the paper presented provided a status update on each of the 5 open grants which have been committed against the general unrestricted fund. Colleen highlighted that Trustees were being asked to agree to a review of these commitments to obtain a full understanding and proposed a freeze on any further commitments meantime.

Fiona Sandford referred to the adult changing facility, which was included within the list, and stressed the importance of moving forward with this due to the length of time this has been discussed.

James Ayling suggested that the exercise to review unrestricted income against commitments be undertaken as soon as possible, particularly with a new investment portfolio being in the offing.

Andrew Bone stressed that commitments now exceeded original plans, with some plans having been taken forward and now seeing a deficit. Andrew agreed that there was a need to come back rapidly with options once work has been concluded to inform decision making on commitments previously made but not yet commenced as there were still options to either pause or do something differently before the situation was exacerbated further. Andrew suggested that the outcome of the review be remitted to the Endowment Advisory Group or an extraordinary meeting of the Board of Trustees to agree a way forward.

James Ayling asked for an update on why the overspend situation had arisen with the Volunteer Services Manager and the Admiral Nurse posts. Coleen advised that the salary costs for these posts had been higher than anticipated and explained the course of action which would now be taken to avoid this happening in future. Andrew added that a level of contingency should always be included within plans until there is cost certainty.

The Board of Trustees noted the report and approved a freeze on further commitments against the General Unrestricted Fund.

6.5 *Audit Completion Report – Update on Recommendations*

Tony Dixon spoke to this item which provided Trustees with an update on action taken against the recommendations arising from the 2024/25 Endowment Funds audit undertaken by Thomson Cooper, the External Auditor for the Charity. Tony took Trustees through the recommendations and updates for each of these.

The Board of Trustees noted the report and the update on recommendations.

7. Funds Management

7.1 *Investment Advisor Report*

Mark McLean spoke to this item and highlighted that as at 31st December 2025 the value of the portfolio was just over £5.1m which saw an increase of +3.2%, net of fees, since the report dated 30th September 2025. The comparable gross benchmark was noted as an increase of +3.5%. Mark went on to highlight that the portfolio had produced an income yield of 3% which equated to an annual income of just under £151k. Mark also referred to the performance of the portfolio detailed over 1, 3 and 5 years and noted that for 1 year the portfolio was up by 10% against the benchmark which was up by 14.7%. It was noted that portfolio had slightly outperformed the ARC benchmark of 9.1%.

Mark went on to advise that going into 2026 he anticipated market movement to be dominated by political rather than economical issues. Mark also referred to the global events during 2025 which had impacted on the market and which he expected to continue during 2026.

Mark noted that since January precious metals, such as gold, had increased hugely in price and was being looked at as a short-term investment.

Mark reminded of proposals made at the last meeting to make changes to the portfolio and was aware of the Trustees' decision to retain the 10% turnover restriction between meetings.

The Board of Trustees noted the report.

7.2 *Portfolio ESG Status Annual Report*

Mark McLean spoke to this report which was brought to Trustees on an annual basis. Mark highlighted the conclusion section which indicated that the portfolio was well positioned with the embargoes in place and in general there were very few investments to cause any concern from an environmental, governance or social perspective.

Mark also referred to the Rathbones engagement plan which had been attached for Trustees' information.

The Board of Trustees noted the report.

Mark went on to advise of some routine admin which required to undertaken, such as adding Tony Dixon as an authorised signatory and removing Susan Swan, updating Trustees following the retirement of Karen Hamilton and undertaking money laundering checks for some of the Trustees. All these actions would be picked up in due course with the relevant personnel.

The Board of Trustees noted the update.

8. **<u>Any Other Business</u>**

8.1 *Investment Advisor Contract Update*

Mark McLean left the meeting

Tony Dixon spoke to this item and referred to the SBAR circulated to Trustees in December about the tender process for appointing a new Investment Advisor. It was noted that there had been unanimous agreement to proceed with this process. It had also been proposed to use an Independent Investment Consultant to assist with taking this forward. Tony went on to provide an update on discussions with Broadstone who were prepared to undertake this on behalf of Trustees and that he would seek virtual approval as this developed.

Tony assured that this would be taken forward as quickly as possible and Trustees would be kept updated on progress. It was noted that a short term working group would be set up which would include the Director of Finance and a minimum of a further 2 Trustees to review the proposals which come forward.

James Ayling went on to provide an update on discussions which had taken place to date to achieve the proposed way forward. James also noted that he would be willing to be one of the Trustees on the working group to review proposals.

The Board of Trustees noted the update.

8.2 *Endowment External Audit Contract*

Tony Dixon spoke to this item which provided an update on the status of the contract with Thomson Cooper, the Charity's appointed External Auditor. It was noted that the current contract which had been agreed 5 years ago was for 4 years with the option to extend by 1 year and on 31st March 2026 this would see the conclusion of the 5 year contract. Tony advised Trustees that he was proposing to retrospectively agree a further year with Thomson Cooper and then undertake a retender process which he would keep Trustees updated on once the process commenced.

James Ayling asked for confirmation that the annual accounts for 2024/25 had now been lodged with OSCR. Tony confirmed that they had been lodged prior to the festive break.

The Board of Trustees agreed to retrospectively extend the existing contract by 1 year thereby approving that Thomson Cooper could undertake the audit of the Charity's financial statements for the year ending 31st March 2026.

The Board of Trustees noted that the re-tendering of the External Audit contact was scheduled to be undertaken during the 2026/27 financial year.

8.3 *Assurance Levels*

To keep in line with best practice the Chair requested that all future papers presented to the Board of Trustees include assurance levels.

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

Monday, 11th May 2026 @ 10 a.m.

BE
12.02.26

Minutes of a Meeting of **NHS Borders Health Charity Board of Trustees** held on Monday, 11th May 2026 @ 10 a.m. via Microsoft Teams.

Present:
J Ayling, Trustee
A Bone, Trustee
P Moore, Trustee (Joined Meeting at 10.10 a.m.)
L O'Leary, Trustee
J Pepper, Trustee
F Sandford, Trustee (Chair)
P Williams, Trustee (Left Meeting at 11.05 a.m.)

In Attendance:
C Barlow, Charity Development Manager
T Dixon, Charitable Funds Accountant
R Egan, Fundraising Officer
B Everitt, PA to Director of Finance (Minutes)
M McLean, Investment Advisor
K Rodgers, Deputy Director of Finance
K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Apologies had been received from S Horan, Trustee, L McCallum, Trustee, L Livesey, Trustee, J McLaren, Trustee, D Parker, Trustee, S Bhatti, Trustee and J Smyth, Director of Planning & Performance.

The Chair confirmed that the meeting was quorate.

2. **Declaration of Interests**

James Ayling referred to the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

3. **Minutes of Previous Meeting : 2nd February 2026**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
Rebecca Egan provided Trustees with an update on the action relating to training for external gatekeepers.

The action tracker was noted.

5. **Strategy & Fundraising**

5.1 *Charity Workplan 2025/26 – End of Year Report*
Karen Wilson spoke to this item which provided a summary of the work undertaken throughout the year against the charity workplan for 2025/26. It was noted that major focus during the year had been on delivery of the charity rebrand, including aligning materials and increasing awareness. A number of activities introduced as

part of the rebrand, i.e. publishing stories on the website and initiating the use of QR codes, were now embedded as business as usual. It was also noted that the Staff Ambassador Programme has developed throughout the year, following the appointment of the Director of Planning & Performance as Executive Lead, and further work will continue into 2026/27 alongside the governance review and fund revalidation.

James Ayling asked how successful QR codes had been in raising funds. Karen explained it was currently difficult to attribute income directly to this because QR code users go via the website and although web traffic can be seen the specific route is not always identifiable. Karen went on to advise that the team will be exploring improvements to tracking and will also be looking to put in place an even quicker donation experience, such as 'tap-to-donate'.

James also enquired if QR codes etc were being used within community hospitals. Karen advised that there are opportunities to do this and that a specific piece of work is required to build relationships with community hospitals and understand local processes to tailor donation options appropriately.

The Board of Trustees took moderate assurance from the report.

The Board of Trustees noted the report.

5.2 *Charity Strategy & Plan 2026-28*

Karen Wilson introduced this item which provided the Charity Strategy for 2026 – 2028. It was noted that the strategy reflected completion of the rebrand and the establishment of an effective management team, supported by the Director of Planning & Performance as Executive Lead. Karen highlighted that the strategy formalised the direction of travel, setting out a key shift from a reactive fund structure towards thematic priorities and outcomes, alongside fund revalidation and a governance review to strengthen stewardship and improve impact.

Karen highlighted the communications and partnership challenges associated with implementing the strategy and clarifying grant-making guidelines whilst maintaining a positive message. Lucy O'Leary enquired about the nature of staff concerns. Colleen Barlow advised that some staff groups perceive that access to funds has been removed and that funds have been merged into a single 'pot'. Colleen explained that she has reassured that funds held for specific areas remain held for those purposes and that the change relates to fund manager arrangements and clearer stewardship. Colleen noted the need for strong case studies demonstrating where funding has been unlocked and access widened through a focus on outcomes.

Andrew Bone emphasised that the strategy will strengthen governance processes and reminded that the charity exists for the benefit of patients rather than staff. Andrew also noted the Annual Report and Accounts helped to demonstrate the impact.

Andrew also asked for an update on how the objective for proactive fundraising and increasing unrestricted income, including a target that 10% for unrestricted income, would be achieved. Karen Wilson advised that they intended to shift from passive

fundraising to proactive, charity-led activity to help influence the proportion of funds received that are unrestricted.

James Ayling asked if there was any benchmarking data available on the level of unrestricted income achieved by other NHS endowment/health charities. Karen agreed to undertake a benchmarking exercise and would report findings back to Trustees in due course.

The Board of Trustees took moderate assurance from the report.

The Board of Trustees approved the Charity Strategy 2026 2028 as the guiding framework for the Charity's work over the next two years.

The Board of Trustees endorsed the proposed sequencing, with year 1 focused on governance review, fund revalidation and enabling activity, and year 2 focused on expanded programme delivery.

The Board of Trustees agreed to receive assurance reporting against the strategy to support ongoing oversight of progress, risks and control.

5.3 *General Unrestricted Fund*

Colleen Barlow introduced this item and reminded Trustees of the emerging issues previously reported regarding the gap between available resources within the General Unrestricted Fund and existing commitments. It was noted that clarity from end-of-year reporting has supported actions to address pressures, noting that Trustees had recently approved transfer and apportionment of the outstanding installation costs for the automated drugs cabinets. An inappropriate charge to the charity in relation to a staff cost had also been identified which was another pressure removed. It was noted that a meeting with the relevant Executive Directors was due to take place the following day to review remaining commitments and an update would be brought back to Trustees in due course.

The Board of Trustees noted the update.

6. Financial Report

6.1 *Financial Report and Primary Statements*

Tony Dixon spoke to this item providing the draft financial report for the year to 31st March 2026. Tony went on to provide a presentation highlighting key points which he would share with Trustees for information. Trustees noted that the majority of funds remain restricted, limiting flexibility, and that the unrestricted fund continues to face pressures with committed expenditure exceeding unrestricted income.

Tony advised that he will be preparing a presentation on a monthly basis to share with the charity team and would include the most current version available at future meetings.

The Board of Trustees noted the report.

6.2 *Register of Legacies and Donations*

Tony Dixon spoke to this item which provided Trustees with an update on all legacies and donations received over £5,000 for the period 1st April 2025 to 31st March 2026. Tony highlighted a significant legacy with an expected total value of £750,000, noting that the first instalment £500,000 had been received. This legacy would be for use solely by the Margaret Kerr Unit.

Tony also advised that additional legacies were expected and would be reported in a future report. Tony highlighted that the Belvedere Trust, previously noted as a donation, was in fact a grant and had been reclassified as such.

Colleen Barlow went on to advise that where a narrower purpose donation has been placed within a wider purpose fund, a draft policy/framework is being developed, with professional advice where appropriate, to ensure appropriate stewardship of truly restricted funds whilst avoiding detriment to spending. Colleen proposed circulating the draft policy virtually for approval by Trustees. This was agreed.

The Board of Trustees noted the report.

7. **<u>Annual Report & Accounts 2025/26</u>**

7.1 *Draft Annual Report & Accounts 2025/26*

Tony Dixon spoke to this item which provided Trustees with the draft Annual Report and Accounts for the year ended 31st March 2026. Tony advised that since the first draft had been produced there had been minor amendments to income and expenditure with no material impact on the overall position. It was noted that a draft had been shared with the auditors and an initial review meeting had taken place with supporting information being provided. Tony advised that the audit is progressing to plan and remains on track to meet the June deadline. Tony also offered to circulate a refreshed draft later in the week if Trustees would find this helpful.

James Ayling commended the Annual Report and Accounts as a professional and engaging document with strong use of stories and images and suggested that the automated drugs cabinets story be brought earlier in the narrative. Fiona Sandford echoed the positive feedback and highlighted the document demonstrates the breadth of impact.

Karen Wilson advised that photographs for the automated drugs cabinets story are still awaited and agreed with the point made around re-ordering.

James also suggested consideration be given to producing an abbreviated printed version, focussing on the stories with a QR code/link to the full accounts, for external stakeholders such as funeral directors and solicitors. Trustees noted the need to balance the benefit with cost and Karen agreed to explore options and report back with an indicative proposal and costs.

The Board of Trustees noted the draft Annual Report & Accounts for 2025/26

8. **Funds Management**

8.1 *Investment Advisor Report*

Mark McLean spoke to this item and highlighted that the value of the portfolio as at 31st March 2026 was just over £4.95m, noting a decrease of 2.2%, net of fees, since the report dated 31st December 2025. This compared with a benchmark decrease of 0.7%. Mark noted a timing effect on 31st March whereby a 3% rise in US markets was reflected in the benchmark but not fully reflected in the valuation due to market close timing and that it would be reflected in the next valuation report. In addition, the estimated ARC performance figures had been confirmed and have changed from showing a decrease of 0.7% to a decrease of 1.7%.

Mark highlighted that the portfolio income yield was 3.1% (£154k per annum) noting that underperformance against the internal benchmark has continued as we have experienced previously, the reasons for which have been discussed over the past couple of years.

Mark advised that market volatility continues primarily due to the situation in the middle east and no major changes had been made to the portfolio as they expected a deal to be struck at some point. Mark assured if there was any risk to the portfolio longer term this would be re-assessed and if the middle east situation became a longer term issue then consideration could be given to putting money into more cash like investments.

Mark referred to the recent election which brought further uncertainty within UK politics which was visible through the gilt markets and government bond yield movements.

Mark also referred to trading within the portfolio over the last quarter and provided an update on this.

Fiona Sandford enquired about increasing exposure within UK gilts/bonds. Mark felt that the gilt market was steadier than the corporate bond market and confirmed that this could be done as a short or longer term measure. Fiona clarified that this was only an enquiry and not an instruction to proceed at this time.

James Ayling referred to risks associated with the management and performance of the portfolio and asked what additional measures, beyond diversification and professional management, were in place to provide reassurance to Trustees that enhanced measures were in place to mitigate risk.

Mark advised that all portfolios managed have a risk level from 1 to 6 with the Borders portfolio being rated at risk level 4. Mark did not feel that the current portfolio was taking a huge amount of risk over and above the charity's objectives. Mark went on to explain the different parameters on how money can be invested within risk level 4 without the need to adjust the risk level overall. This could include shifting weightings between asset classes, for example taking money out of equities and moving into Government Bonds or cash during periods of market weakness. Mark confirmed that as things currently stood there were no additional risk levels in place. Mark added that the only thing he would suggest as an additional layer to add to the portfolio would be moving some of the bond exposure into index linked

government stocks to provide an element of inflation protection which could come into effect with increased oil prices in coming months.

Peter Moore enquired about decision thresholds. Mark advised that the investment research team provides top-down guidance on the various risk levels unless specific instructions are received from clients.

Tony Dickson referred to the substantial legacy referred to earlier in the meeting and alerted that it was the intention to transfer approximately £550,000 over to the investment portfolio later in the week.

The Board of Trustees took moderate assurance from the report on the arrangements in place for investment management and oversight.

The Board of Trustees took limited assurance from the report on investment performance outcomes, noting continued underperformance against the benchmark.

The Board of Trustees noted the report.

9. **Any Other Business**

James Ayling asked if at some stage there would be an opportunity to increase the size of the fund by merging with any other charities to allow the charity to grow outwith income and legacies.

Jacquie Pepper also queried if a partnership approach could be developed to maximise opportunities, particularly with third sector organisations.

Karen Wilson, Colleen Barlow and Tony Dixon agreed to consider these suggestions and provide views in due course.

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

Monday, 15th June 2026 @ 10 a.m.

BE
14.05.26