

A meeting of the **Borders NHS Board** will be held on **Wednesday 7 October 2026** at 10.00am at Tweed Horizons (Courtyard Room), Newtown St Boswells

AGENDA

Time	No		Lead	Paper
10.00	1	ANNOUNCEMENTS & APOLOGIES Apologies received from David Parker, Lucy O'Leary Welcome & Introduction to Allister Short, new Non Executive Director	Chair	<i>Verbal</i>
10.01	2	DECLARATIONS OF INTEREST	Chair	<i>Verbal</i>
10.02	3	MINUTES OF PREVIOUS MEETING N/A	Chair	<i>Verbal</i>
10.03	4	MATTERS ARISING Action Tracker	Chair	<i>Verbal</i>
10.05	5	Board Lived Experience Stories Proposal	Director of Quality & Improvement	<i>Appendix-2026-77</i>
10.25	6	CHIEF EXECUTIVE'S REPORT	Chief Executive	<i>Appendix-2026-78</i>
10.30	7	STRATEGY		
	7.1	Population Health Organisation	Director of Public Health	<i>Appendix-2026-79</i>
	7.2	Sustainability and Climate Change Annual Report	Director of Finance	<i>Appendix-2026-80</i>
	7.3	Subnational Planning and Delivery	Director of Planning & Performance	<i>Appendix 2026-81</i>
	7.4	Early Intervention, prevention & social prescribing - Live Borders proposal	Director of Urgent Care, Community Services and Mental Health	<i>Appendix-2026-82</i>

11.00	8	FINANCE AND RISK ASSURANCE		
	8.1	Resources & Performance Committee by-exception Report	Chair R&PC	<i>Verbal</i>
	8.2	Finance Report	Director of Finance	<i>Appendix-2026-83</i>
11.20	9	QUALITY AND SAFETY ASSURANCE		
	9.1	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	<i>Appendix-2026-84</i>
	9.2	Public Protection Annual Assurance Report	Director of Nursing, Midwifery & AHPs	<i>Appendix-2026-85</i>
	9.3	Mental Health – Inpatient bed – Risk	Director of Urgent Care, Community Services and Mental Health	<i>Appendix-2026-86</i>
	9.4	Board Assurance Framework	Director of Quality & Improvement	<i>Appendix-2026-87</i>
11.50	10	ENGAGEMENT		
	10.1	Staff Governance Committee by-exception Report	Chair SGC	<i>Verbal</i>
	10.2	Area Clinical Forum by-exception Report	Chair ACF	<i>Verbal</i>
	10.3	People Metrix Report	Director of People & Culture	<i>Appendix-2026-88</i>
12.05	11	PERFORMANCE ASSURANCE		
	11.1	NHS Borders Performance Scorecard Quality & Performance Improvement Oversight Report	Director of Planning & Performance, Director of Acute Services, Director of Urgent Care, Community Services & Mental Health	<i>Appendix-2026-89</i>
12.20	12	GOVERNANCE		
	12.1	Scottish Borders Health & Social Care Integration Joint Board minutes	Board Secretary	<i>Appendix-2026-90</i>

	12.2	Resources & Performance Committee minutes	Chair R&PC	<i>Appendix-2026-91</i>
	12.3	Audit & Risk Committee minutes	Director of Quality & Improvement	<i>Appendix 2026-92</i>
	12.4	Clinical Governance Minutes/Exception Report and Minutes	Chair CGC	<i>Appendix-2026-93</i>
	12.5	Staff Governance Committee minutes	Chair SGC	<i>Appendix-2026-94</i>
	12.6	Area Clinical Forum Minutes	Chair ACF	<i>Appendix-2026 - 95</i>
	12.7	Consultant Appointments	Director of People & Culture	<i>Appendix-2026-96</i>
	12.8	Appointment of Registered Nurse as Professional Advisor to the Scottish Borders Integration Joint Board	Chief Executive	<i>Appendix-2026-97</i>
12.28	13	ANY OTHER BUSINESS		
12.30	14	DATE AND TIME OF NEXT MEETING		
		Thursday, 3 December 2026 at 10.00am via MS Teams	Chair	<i>Verbal</i>

Meeting:	Borders NHS Board
Meeting date:	<i>Wednesday 7 October 2026</i>
Title:	Board Lived Experience Stories
Responsible Executive/Non-Executive:	Laura Jones, Director of Quality and Improvement
Report Author:	Laura Jones, Director of Quality and Improvement

1 Purpose

The Board is asked to consider the options for introducing a lived experience component to the Board meetings either through Public Board or the Board Resource and Performance Committee. These lived experiences would bring the voices of patients, carers, the public, our staff, volunteers, students and trainees and share aspects of their experiences of receiving or providing healthcare in the Scottish Borders. These stories would aim to bring different perspectives into the Board discussions allowing Board members to examine services delivered by NHS Borders through different lenses. The Board are asked to agree the proposed approach for next twelve months of scheduled Board sessions.

This is presented to the Committee for:

- Discussion

This report relates to a:

- Patient, public and staff experience.

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

- Safe, effective, person centred.

2 Report summary

2.1 Situation

The Board would like to re-introduce a lived experience section within the Board work programme. This was a core component of Board sessions in the past but hasn't been reintroduced following the pandemic.

2.2 Background

Patient, carer and public involvement stories were routinely prepared for the previous Board Strategy and Resources Committee (SRC). This process was supported by the Public Involvement Officer who provided support with the preparation of stories and the support for those attending meetings. Other NHS Boards also suspended Board stories and have been more recently working to reintroduce approaches to this. Some Boards use digital stories and many have diversified beyond patient stories to include a wide range of voices.

2.3 Assessment

It is proposed that a range of lived experience stories are planned into the Board work programme for the coming year to include patients, carers, community engagement and public involvement activities, as well as, from staff including employed staff, volunteers, students and trainees. A proposed programme is detailed below for the following six sessions of the Board:

Meeting	Topic	Lead	Executive Lead
December	Patient Story	Patient Experience Team and Divisional Lead	Laura Jones
February	Volunteer Story	Clinical and Professional Development Team	Lynn Barker
April	Public Involvement/Community Engagement Story	Public Health Team or Communications and Engagement Team	Sohail Bhatti/June Smyth
June	Student/Trainee Story	Medical Education and Clinical and Professional Development Team	Lynn McCallum
August	Carer Story	Supported by commissioned service with Carers Centre	Gill Main
October	Staff or Staff Group Story	Human Resources Team	Avril Keen

Stories will be developed using a variety of approaches to ensure inclusivity enabling a diverse range of voices to be heard by the Board. This will include in person attendance and pre-prepared stories using a range of media.

Stories will be scheduled for the first 30mins of either the Public Board or the Board Resource and Performance Committee meeting. The Board is asked to consider the most inclusive meeting to host this approach for the coming year. A de-brief will be scheduled after the first six sessions to consider how the approach can be refined and developed.

This approach should add to more detailed reports on patient, carer, staff experience and public involvement activities reported directly to sub-committees of the Board; Clinical Governance, Staff Governance and Resource and Performance Committee.

In addition to this programme of lived experience stories a standing item will be introduced at each Public Board or Board Resource and Performance Committee meeting to enable Non-Executive Board members and members of the Executive team to provide formal feedback on any leadership visits which have taken place during the previous two-month period. Leadership visits cover how the team use staff and patient feedback to drive improvements in their services, the challenges faced by services and opportunities teams see to improve. The aim of sharing this with the wider group of Board members is to enable increased visibility of staff experiences and service quality and to allow for triangulation with the range of assurance approaches provided to the Board and its sub-committees. A short proforma contained in Appendix 1 will be used to capture learning from any leadership visits taking place.

2.3.1 Quality/ Patient Care

The report supports quality and patient care by strengthening the voice of patients and carers and staff groups contributing to the provision of NHS Borders services. These voices should be triangulated with other sources of intelligence and assurance in the assessment of quality and safety by the Board.

2.3.2 Workforce

There is no workforce risk associated with the report, a range of media will be used to enable participation.

2.3.3 Financial

There are no direct financial approvals requested through this report. As the public involvement officer role no longer exists the executive team have designed a programme to span a wide range of lived experience distributing the workload to support this programme across several teams aligned to existing portfolios.

2.3.4 Risk Assessment/Management

The proposal aims to give a greater profile to a range of voices at the Board to gain a deeper understanding of perspectives, challenges and opportunities.

2.3.5 Equality and Diversity, including health inequalities

The proposal aims to increase the Boards access to a range of experiences and will include a focus on unheard groups and stories covering the themes of protected characteristics.

2.3.6 Climate Change

There are no direct climate change or carbon impacts identified within this proposal.

2.3.7 Other impacts

Other impacts include strengthened organisational learning and improved transparency of staff patient and carer experience.

2.3.8 Communication, involvement, engagement and consultation

The proposal sets out to increase involvement and engagement.

2.3.9 Route to the Meeting

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

- Board Executive Team

2.4 Recommendation

The Board are asked to consider the:

1. proposed approach to re-introducing lived experience stories into the Board programme
2. approve the programme outlined for the next 6 meetings to include a planned de-brief after the scheduled programme to refine and develop the approach
3. most appropriate forum to deliver the programme to ensure inclusivity at either the start of the Resource and Performance Committee or the Public Board

3 List of appendices

The following appendices are included with this report:

Appendix 1: Leadership Visit Summary - Template

Appendix 1 - Leadership Visit Summary

Site/Department	
Exec Member and others in visiting team	
Themes from conversation	
Observations made (e.g. environment, staffing, patients)	
Discussion points for Board	

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	NHS Borders as a Population Health Organisation: Initial Maturity Assessment and Improvement Plan
Responsible Executive/Non-Executive:	Sohail Bhatti, Director of Public Health
Report Authors:	Rebecca Devine, Consultant in Public Health Medicine; Claire McElroy, Head of Health Improvement; Kirsty Kiln, Public Health Consultant

1 Purpose

This is presented to the Board for:

- Decision
- Discussion

This report relates to:

- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambitions:

- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Borders is required to submit a Population Health Organisation (PHO) maturity assessment and accompanying improvement plan to Public Health Scotland by 11 December 2026. The Board is asked to consider the initial assessment arising from its development session, endorse the proposed improvement priorities, and support their further development through NHS Borders governance and engagement with partners.

2.2 Background

National PHO guidance from Public Health Scotland positions NHS Boards as leaders of a prevention-focused, collaborative system that improves population health, reduces inequalities and supports sustainable, value-based health and care. The maturity matrix is an

improvement and assurance tool structured around six PHO principles, six development areas and four maturity levels.

NHS Borders held a Board Development Session on 25th June 2026. Facilitated discussion and participant scoring identified existing strengths, development needs and potential priorities. The matrix has also been shared with the Community Planning Partnership during the Delivery Group and Strategic Group meetings in August and September 2026. Whilst the matrix is not to be completed by CPPs (as per national direction), we have shared the process and agreed to circulate any outputs for discussion and reflection.

A fuller programme of Executive, Integration Joint Board and Scottish Borders Council engagement was originally planned. To meet the revised timetable for Board consideration, this paper presents an initial assessment based on the evidence and discussion available to date. Further partner input is proposed as part of implementation and review.

2.3 Assessment

The overall assessment is that NHS Borders has strong foundations for becoming a Population Health Organisation. Strengths include:

- partnership working
- growing organisational focus on prevention and inequalities
- Clinical Strategy commitments to prevention and care closer to home.

The consistent development need is to translate knowledge and strategic intent **into routine decision-making, governance, resource allocation and service redesign.**

PHO principle	Headline assessment	Key discussion points used in this assessment
1. Understand population need	Developing foundation	Joint Strategic Needs Assessment and social and health inequalities data are available, but discussion with board members highlighted limited use of future projections and inconsistent translation of intelligence into action.
2. System-focused and collaborative	Relative strength	Strong partnership intent and an important role for the IJB were recognised. Structural barriers and the practical challenge of shifting resource towards prevention remain.
3. Prevention and tackling inequalities	Developing	Clinical Strategy direction is supportive. Prevention activity and investment are not yet comprehensively mapped, and visibility of healthcare inequalities work should improve.
4. Primary and community care	Developing	Participants identified several examples of progress, with a need to embed good practice more systematically across services.
5. Value-based health and care	Priority for development	A transparent, written local prioritisation framework is required to support investment and disinvestment decisions, making prevention, equity, outcomes and sustainability explicit. This is underway.
6. Governance and accountability	Priority for development	Population health outcomes, prevention and inequalities are not yet consistently visible in governance and performance reporting. Accountability and stewardship require further development.

Four improvement priorities emerge:

1. **Complete prevention mapping work** (and combine with previous budget tagging work by Finance department) to establish a clear baseline of current activity and spend.
2. Develop and test a **values-based prioritisation framework** for investment and disinvestment decisions.
3. **Strengthen population health governance**, accountability and performance reporting.
4. **Build shared organisational capability** so population health is understood and owned across NHS Borders, with local partners.

Further Partnership Feedback

The matrix has been shared with CPP as detailed above. Public Health have scheduled calls with senior IJB members to gain further insight and feedback into this maturity assessment and action plan. Once this engagement is completed it will be incorporated into our report back to Public Health Scotland. Given the deadline for submission falls before the next full board meeting it is proposed the Chair signs off the final submission on behalf of the Board.

2.3.1 Quality / Patient Care

A more systematic population health approach should support earlier intervention, equitable access, care closer to home and transparent consideration of prevention and outcomes in service redesign. Benefits will depend **on implementation through clinical and corporate governance** rather than strategy alone.

2.3.2 Workforce

The assessment identifies a need to build shared population health understanding and capability across services. Initial delivery should use existing organisational development and clinical leadership routes.

2.3.3 Financial

No immediate financial decision is requested through this paper.

Prevention mapping and a values-based prioritisation framework are intended to improve the evidence and transparency supporting future investment and disinvestment decisions.

Delivery implications and any resource requirements will need to be considered through the relevant planning and financial governance processes.

2.3.4 Risk Assessment / Management

Key risks are that population health remains insufficiently embedded in routine decisions; preventive activity and investment remain poorly understood; and improvement actions are agreed without clear ownership, resource or monitoring. Mitigations proposed are: (i) named accountability; (ii) measurable milestones; (iii) routine reporting; (iv) partner engagement and (v) a repeat maturity review in 12 months.

The accelerated timetable has limited the extent of Executive and partner sense-checking completed before this draft. Further engagement should refine implementation without delaying consideration of the initial priorities.

2.3.5 Equality and Diversity, including health inequalities

Reducing health inequalities is integral to the PHO approach and is reflected in the proposed actions on prevention mapping, prioritisation and governance. A standalone impact

assessment has not yet been completed because this paper seeks endorsement of an organisational improvement framework rather than approval of a specific service change.

We note Equality and Fairer Scotland considerations should be applied to each substantive action or service decision arising from the plan.

2.3.6 Climate Change

No direct climate impact has been quantified for this paper.

2.3.7 Other impacts

The work aligns with NHS Borders' role as an Anchor institution and with the wider intention to improve population health through partnership, prevention and sustainable use of resources.

Communication, involvement, engagement and consultation

- NHS Borders Board Development Session on 25 June 2026: facilitated maturity discussion and participant scoring.
- Board Executive Team: initial paper received by BET on 20 July 2026.
- Public Health team: assessment findings and proposed approach developed by the nominated leads who authored this paper.
- Community Planning Partnership Delivery group on 12 August 2026
- Community Planning Partnership Strategic group on 3 September 2026.
- Further engagement with the IJB, Scottish Borders Council, Community Planning Partnership and other partners remains proposed as part of refinement.

Route to the Meeting

- Board Development Session, 25 June 2026.
- Board Executive Team, 20 July 2026.
- Public Health Senior Leadership Team, 16 September 2026.
- Board Executive Team, 21 September 2026.

2.4 Recommendation

- **Discussion** – Examine and consider the implications of a matter.

The board is asked to:

- note the findings and limitations of the initial PHO maturity assessment
- endorse the four proposed improvement priorities
- approve the initial improvement plan in Appendix 1 as the basis for delivery
- support engagement with relevant partners during refinement and implementation
- request a refreshed maturity assessment within 12 months, using the same framework and drawing on wider stakeholder evidence to assess progress.

Suggested assurance level:

- Moderate Assurance for systems and processes
- Limited Assurance for demonstrated outcomes

The organisation has strategic foundations, however the current evidence does not yet demonstrate consistent organisation-wide implementation or measurable improvement in population health outcomes.

List of appendices

- Appendix 1: Initial Population Health Organisation Improvement Plan

Appendix 1: Initial PHO Improvement Plan

The leads and delivery dates below are proposed for confirmation through BET.

Priority	Proposed action	Proposed accountable lead	Target	Measure / evidence	Dependencies / notes
Needs Assessment	The NHS and partners will develop a deep understanding of the needs of their population to supplement metrics around service use and demand	Director of Public Health / Population Health Programme Board/IJB	Baseline report and recommendations by 31 March 2027	Agreed scope and dataset; completed map; report received by governance group; prioritised opportunities and gaps recorded. JSNA draft developed. Health Survey initiated	Requires business intelligence, SBC analytics, PHS analytical input. Scope should be realistic and phased.
Prevention mapping	Complete a proportionate baseline map of NHS Borders prevention activity, investment, target populations and current measures; identify duplication, gaps and opportunities for coordination.	Director of Public Health / Population Health Programme Board	Baseline report and recommendations by 31 March 2027	Agreed scope and dataset; completed map; report received by governance group; prioritised opportunities and gaps recorded.	Requires service, finance and analytical input. Scope should be realistic and phased.
Values-based prioritisation	Develop and pilot a written prioritisation framework that makes population need, equity, prevention impact, outcomes, evidence, affordability and sustainability explicit in investment and disinvestment decisions.	Chief Executive / Executive lead for Planning and Performance	Draft criteria by 31 January 2027; pilot and learning report by 30 June 2027	Framework approved for pilot; number of decisions tested; completed decision records; learning and proposed adoption route reported.	Scores should inform, not replace, Board judgement.
Governance and accountability	Map where population health, inequalities and prevention are considered in current governance; agree an oversight route and minimum reporting requirements.	Chief Executive / Director of Public Health	Governance proposal by 31 March 2027	Delivery Group and Board will lead on these approved terms of reference/reporting route; agreed indicator set; PHO progress included in routine reporting.	Align with Population Health Programme Board and avoid creating duplicate governance.
Organisational capability	Define core population health capabilities for Board members, leaders and services; undertake a proportionate baseline review and agree a targeted development offer.	Director of Public Health / Director of Workforce	Baseline and development proposal by 30 June 2027	Capability framework agreed; baseline completed; development offer approved; participation and feedback reported.	Use existing CPD, improvement and leadership infrastructure where practical.
Partnership and shared accountability	Engage IJB, Scottish Borders Council, CPP, third sector and community representatives to test priorities, clarify shared contributions and identify opportunities for joint delivery.	Chief Executive / IJB Chief Officer / Director of Public Health	IJB Leads input through September/October for sense check discussion.	Engagement record; documented feedback; agreed shared actions, owners and reporting route; changes to plan traceable.	Partner sense checking will continue after the paper goes to October board and will be part of final submission.
Learning and assurance cycle	Report progress six-monthly and repeat the maturity assessment using the national framework in 12 months.	Director of Public Health	Progress report by 30 June 2027; refreshed assessment by 30 September 2027	Evidence log maintained; progress report received; repeat assessment completed; changes and unresolved gaps documented.	Retain comparability with the 2026 exercise and include qualitative partner evidence in addition.

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7th October 2026
Title:	Climate Emergency & Sustainability Annual Report 2025/26
Responsible Executive/Non-Executive:	Andrew Bone, Director of Finance
Report Author:	Fi Laidlaw, Head of Soft FM (Facilities) & Sustainability

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan
- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Scotland Policy for Climate Emergency & Sustainability was published in October 2021. This policy requires that all NHS Boards publish an annual report on their progress towards the implementation of net carbon zero emissions targets and sustainable development goals.

The report is expected to be submitted to Scottish Government and published on the Health Board's public facing website following Board approval.

2.2 Background

DL (2021) 38, *A Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development*, requires all NHS Scotland Boards to publish an Annual Climate Emergency and Sustainability Report. The report must be approved by the Board, published on the organisation's public website, and submitted to Scottish Government. It provides assurance on progress towards NHS Scotland's climate emergency, net zero, adaptation and sustainable development objectives using a nationally prescribed reporting framework.

The national NHS Scotland annual report explains that Board reports should cover:

- Greenhouse gas emissions arising from Board operations.
- Actions taken or underway to reduce emissions and environmental impact.
- Actions to adapt to climate change and increase organisational resilience.

In practice, the national template used by Boards generally includes reporting on:

- Governance and leadership
- Emissions performance
- Energy and estate management
- Sustainable healthcare initiatives
- Travel and transport
- Procurement and waste
- Biodiversity and greenspace
- Climate adaptation and resilience
- Future priorities and targets

NHS Boards also have separate statutory reporting duties under:

- Climate Change (Scotland) Act 2009
- Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015
- 2020 Amendment Order

Under these regulations NHS Boards submit an annual Public Bodies Climate Change Duties (PBCCD) return to the Sustainable Scotland Network (SSN). This is distinct from, but complementary to, the NHS Scotland annual Climate Emergency & Sustainability Report. The PBCCD return presents emissions data for consolidation within national reports. Data presented within this return is consistent with the Board's annual report.

NHS Scotland is expected to publish a refreshed Climate Emergency and Sustainability strategy in 2027. In advance of this work has commenced on development of a local strategy aligned to national priorities. This is expected to be considered through the Resources & Performance Committee in due course.

2.3 Assessment

This paper presents the 2025-26 annual report (Appendix 1) for approval prior to publication. Following approval of the report it will be uploaded to the Board's website in line with requirements.

2.3.1 Quality/ Patient Care

Any issues related to this topic are described within the body of the report.

2.3.2 Workforce

Any issues related to this topic are described within the body of the report.

2.3.3 Financial

The report describes activities undertaken during the financial year 2025/26 and as such there are no additional financial commitments identified.

There are no direct resources identified to support implementation of the wider strategy. This issue will be considered separately via the Board's Resources & Performance Committee in context of updates to future strategy and action plans.

2.3.4 Risk Assessment/Management

Climate Emergency is reported on the Board's Strategic Risk Register. In addition, local climate change impact assessments have been undertaken on an East region basis in collaboration with other public sector bodies.

2.3.5 Equality and Diversity, including health inequalities

This report describes activities undertaken during the year 2025/26. The impact on inequalities of Climate Change is described within the report and is subject to separate reporting through the Board's existing structures regarding health inequalities.

2.3.6 Climate Change

This topic is considered within the main body of the report.

2.3.7 Other impacts

There are no other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

N/A

2.3.9 Route to the Meeting

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

- NHS Borders Climate Change & Sustainability Group

2.4 Recommendation

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

The Board are requested to approve publication of the annual report in line with the Scottish Government policy requirement.

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

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

Moderate assurance is recommended on the basis that the report demonstrates progress above the level of target within the reporting period but within the context of a significant delivery challenge to be addressed over the longer term.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Annual Report



**Annual Climate Emergency
and Sustainability Report
2025 - 2026**

DRAFT

September 2026

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1. Foreword

This is our fifth annual climate report, covering the twelve months to March 2026. It shows how our emissions are changing over time, compares performance with our plans, and identifies where actions are in place to support further improvement. It also highlights areas where our plans do not yet match the scale of change required. Alongside reporting on past performance, we are developing a new climate action plan that we hope to publish later this year.

Over the past twelve months, our overall reported emissions, after carbon sequestration, reduced by 18.72% compared with 2024/25, while building-energy emissions reduced by 18.6%.

Whilst a significant element of this improvement has been achieved through ongoing decarbonisation of national grid we have also seen strong progress in delivery against our own action plans.

Medical-gas emissions fell substantially as clinical teams continued to reduce the use of high-carbon anaesthetic gases. Waste-related emissions also reduced by 13%, and we can report that no waste was sent directly to landfill. These achievements reflect practical changes in how we manage our estate, deliver care and use resources.

We also recognise that an element of the reduction demonstrated in 2025/26 is attributable to the temporary closure of Knoll Hospital. We anticipate that this element will revert during 2027 as the hospital reopens for use following extensive improvement works.

Despite the positive progress we can report, there are nonetheless other areas where progress has been slower than intended. Emissions from metered-dose inhalers reduced, but not by the full targeted amount; fleet emissions and the transition to zero-emission vehicles remain behind trajectory, reflecting the challenges of serving a dispersed rural population and the availability and range of suitable vehicles. Water use increased rather than reduced, and our food-waste reduction target has not yet been achieved.

During 2025 we developed a new organisational and clinical strategy, engaging with clinical teams, our staff, partner organisations and communities, and this strategy was launched in December 2025. In the areas we can influence directly, we expect the strategy to contribute positively to climate change mitigation through greater emphasis on prevention, supported self-management, care closer to home, digitally enabled pathways and efficient, evidence-based models of care. If delivered well, these changes should help avoid unnecessary activity, travel, resource use and waste while improving outcomes and maintaining equitable access across our rural communities.

In March 2026, we held our second organisation-wide Climate Change Conference through MS Teams. This increased awareness of our local action plans and progress to date and enabled staff across the organisation to understand how they can support NHS Borders' net zero ambition.

NHS Borders cannot achieve its long-term net zero goal alone. Success depends on sustained national investment to decarbonise and strengthen the resilience of the public estate; further decarbonisation of electricity and heat supplies; access to affordable low-carbon technologies and vehicles; reductions in the carbon intensity of medicines and other products; and effective action through national procurement and the wider supply chain.

The Programme for Government, published on 1 September 2026, signals public sector reform that will bring changes to public bodies in the years ahead. The future organisational, governance and delivery implications are not yet known. We will therefore need to remain flexible as the reforms develop, while maintaining momentum and ensuring that climate and sustainability considerations remain embedded in future decisions.

I want to acknowledge the commitment of colleagues across NHS Borders, particularly those who have led this work and those who have contributed alongside demanding operational responsibilities.

I am also grateful for the contribution of our public and third sector partners across the Scottish Borders, whose commitment to collaborative working is fundamental to achieving long-term change.

The progress described in this report reflects their expertise, persistence and willingness to change practice, and I am grateful for their continuing leadership and support.

Andrew Bone
Director of Finance, Estates & Facilities
Executive Lead: Climate Change & Sustainability

Further information

More information on NHS Borders and its activities can be found at the following website: [**nhsborders.scot.nhs.uk**](https://nhsborders.scot.nhs.uk)

Our contact details are listed below.

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2. Introduction

Welcome to NHS Borders' fifth annual Climate Emergency and Sustainability Report. Our previous report, detailing our activities up to March 2025, was published in November 2025.

In this report, we outline our greenhouse gas emissions for the financial year 2025/26 and provide a comprehensive narrative on the actions we have taken, as well as our future.

NHS Borders serves the healthcare needs of approximately 116,900 residents in the Scottish Borders, supported by a dedicated team of around 3,315 employees. Our region spans 1,827 square miles of largely rural landscape in southeast Scotland. We operate a variety of community and hospital services, including 23 health centres, four community hospitals, a district general hospital, and several specialist community and mental health facilities.

Many of our facilities are older and were built before modern construction methods and energy-efficient designs were standard. To achieve our net zero carbon goals, significant investment is needed to modernise our estate. Additionally, efforts across the public and private sectors are essential to improve energy efficiency and reduce supply chain emissions.

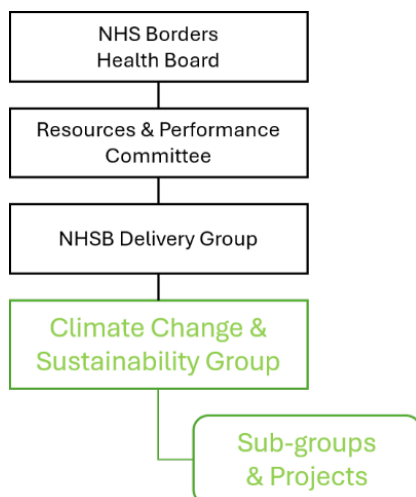
The initiatives detailed in this report align with the NHS Scotland Climate Emergency and Sustainability Strategy 2022-26. You can learn more about this strategy at the following link:

<https://www.gov.scot/publications/nhs-scotland-climate-emergency-sustainability-strategy-2022-2026/>

We are looking forward to publishing the NHS Borders *Environment and Sustainability Enabling Strategy* in the next 12 months.

3. Leadership and governance

Our previous report set out the governance structure and management arrangements the Board has put in place to ensure that we continue to develop and implement our plans to address the impact of climate change. Our Climate Change & Sustainability Group has remained stable over the past 12 months, with some changes to oversight as set out in the figure below.



The Board's Resources & Performance Committee has portfolio responsibility for assurance on risks relating to the healthcare environment, including climate change. Below this, the Delivery Group provides an executive led operational forum for ongoing monitoring and evaluation of progress against the Health Board's organisational strategy and annual delivery plan.

The role of Sustainability Champion has remained vacant throughout the past year due to ongoing turnover in non-executive board membership. Following the appointment of Fiona Sandford as Board Chair early in 2026 recruitment to vacancies in this structure has commenced and it is anticipated that the duties of Sustainability Champion will be assigned following appointment of a new non-executive member in the next few months.

Executive leadership remains under the remit of Andrew Bone, Director of Finance, Estates & Facilities.

The Board's Climate Change & Sustainability Group has responsibility for developing our response to climate change and supporting NHS Borders in becoming environmentally sustainable. The group meets on a bi-monthly basis to ensure progress against its action plan is regularly monitored. Individual workstreams and projects are managed through sub-groups established as and when required.

Despite significant pressures on both time and resources, NHS Borders has dedicated both Board development time and Executive Leadership time to discuss this important agenda. Development and awareness sessions will continue with both the Board and Senior Leaders on a regular basis.

In March 2026 we invited all employees to the national Green Healthcare event as our third all staff virtual Sustainability Conference.

A number of the Executive team lead key projects within their areas or expertise to support the Boards overall Net Zero *ambitions*.

4. Summary of impacts

NHS Borders aims to become a net-zero organisation by 2040 for the sources of greenhouse gas emissions set out in the table below. The table sets out the amount of greenhouse gas produced annually by NHS Borders.

2040 Net-Zero emissions	2020/21	2021/22	2022/23	2023/24	2024/25	2025/2026	Target (2025/26)
Carbon footprint (tCO ₂ e)	10,236.7 tCo ₂ e	10,344.5 tCo ₂ e	9,677.48 tCo ₂ e	10,470.3 tCo ₂ e	10,316.4 tCo ₂ e	8,384.76 tCo ₂ e	9,491 tCo ₂ e

The table above describes limited progress towards reduction in Co₂ emissions over the past six years. The earlier part of this period is impacted by the COVID pandemic, where activity across NHS facilities was significantly below 'normal' levels. As activity has recovered to pre-pandemic levels this has corresponded with an increase in emissions. It is also worth noting that improvements in the capture and monitoring of emissions data may have resulted in changes to how data is reported within individual periods. Nonetheless it is clear that there is a need for greater momentum if the trajectory to net zero at 2040 is to be achieved.

Greenhouse gas emissions 2024/25 & 2025/26, tonnes CO₂ equivalent

Source	2024/25 – emissions	2025/26 – emissions	Percentage change – 2024/25 to 2025/26	2025/26 target emissions reduction	Percentage difference between actual and target emissions – 2025/26
Building energy	7327.6 tCO ₂ e	5964.34 tCO ₂ e	-18.6%	-10%	Exceeded by 8.6%
Non-medical F-gas use	0 ¹ tCo ₂ e	2.21 tCo ₂ e	+100%	No Change	Missed by 100%
Medical gases	602.77 tCo ₂ e	177.95 tCo ₂ e	-70.95%	-5%	Exceeded by 65.95%
Metered dose inhaler propellant	1,695.94 tCo ₂ e	1,646.71 tCo ₂ e	-2.9%	-5%	Missed by 2.1%
NHS fleet use (Fleet & Grey Fleet)	403.3 ² tCo ₂ e	395.37 tCo ₂ e	-1.89%	-10%	Missed by 8.11%
Waste	116.60 tCo ₂ e	100.63 tCo ₂ e	-13%	-10%	Exceeded by 3%
Water	16.69 ³ tCo ₂ e	17.01 tCo ₂ e	+1.91%	-10%	Missed by 8.09%
Business travel	153.50 ⁴ tCo ₂ e	112.24 tCo ₂ e	-26%	-10%	Exceeded by 16%
Total Emissions	10,316.4⁵ tCo₂e	8,416.46 tCo₂e	-18.41%	-8%	Exceeded by 10.41%
Carbon sequestration	-	31.7 tCo ₂ e ⁶		-	Not Available
Greenhouse gas emissions minus carbon sequestration	10,316.4 tCo₂e	8,384.76 tCo₂e	-18.72%	8%	Exceeded by 10.72%

¹ In line with guidance figure calculated on F-Gas top up or removal

² Last year's figure amended due to Business travel & Grey Fleet figures under wrong heading

³ Amended from erroneous report last year

⁴ Last year's figure amended due to Business travel & Grey Fleet figures under wrong heading

⁵ Amended to reflect errors from previous year

⁶ Taken from 1st Natural Capital Accounts – March 2026

Progress against Target

We are pleased to note an overall reduction in our emissions of 18.79%. This is predominantly due to Building energy with a further reduction for including Carbon Sequestration for the first time in 2025/2026.

It should also be noted that throughout the full reporting period, the Knoll Hospital at Duns has not operated due to the ongoing Reinforced Autoclaved Aerated Concrete (RAAC) works.

Data Quality

As in our previous report we have restated historic figures to reflect improvements to the quality of our data and to ensure consistency of reporting. We continue to strive to provide the most accurate information available and as we improve awareness of carbon accounting requirements across our teams and implement changes to our processes this does mean that some information previously provided is reviewed and amended.

Changes in Resources impacting on Emissions

The table below sets out our usage of key resources impacting on greenhouse gas emissions over the last two years and provides further context to the preceding table.

Source	2024/25 Use	2025/26 Use	Percentage change – 2023/24 to 2024/25
Building energy (MWh)	34,875.7 MWh	34,929.1 MWh	+0.15%
Waste (tonnes)	1,046.7 tonnes	918.64 tonnes	-12.2%
Water (cubic metres)	151,137 cubic metres	155,685 cubic metres	+3%
NHS fleet travel (km travelled) Includes Grey Fleet	2,567,693 ⁷ km	2,540,867 km	-1.04%
Business travel (km travelled) Includes Public Transport and Flights)	1,096,569.40 ⁸ km	849,774 km	-22.5%

It should be noted that Building Energy has increased, however a greater proportion of this is now renewable energy. In addition, there is an increase in Water consumption in 2025/2026 this is partly due to NHS Borders changing from the practice of using bottled water for patients and staff to returning to water jugs and tap water.

Within overall building energy, although the overall energy use has increased there is a reduction of 18.6% in emissions (tCO₂e). This is largely due to electricity consumption, where there has been an 8.4% reduction in energy consumption, of which half is attributed to the temporary closure of Knoll hospital, with the balance being due to a range of measures including rollout of LED lighting, and installation of Solar PV. The remainder of the emissions reduction is largely driven by decarbonisation of the grid and corresponding reduction in conversion factors applied to the energy use.

5. Climate change adaptation

⁷ Last years figure amended due to Business travel & Grey Fleet figures under wrong heading

⁸ Last years figure amended due to Business travel & Grey Fleet figures under wrong heading

Scotland's climate is changing faster than expected according to research published by the James Hutton Institute in December 2023. According to this research:

- "Between 1990 to 2019, February and to a lesser extent April have become wetter, particularly in the west, by up to 60%, exceeding the projected change by 2050 of 45-55%."
- "Scotland is on track to exceed "a 2°C increase in temperature by the 2050s, with the months from May to November experiencing up to 4°C of warming over the next three decades (2020-2049)."
- "The number of days of consecutive dry weather – an indicator for drought and wildfire risk – are also expected to increase in drier months, such as September."

Climate change exacerbates existing health risks and introduces new challenges, ranging from the spread of infectious diseases to the intensification of heatwaves and extreme weather events that will impact the health of the population, healthcare assets and services. NHS Scotland plays a pivotal role in safeguarding the life and health of communities by developing climate-resilient health systems capable of responding to these evolving threats.

The changing climate is increasing risks for health and health services. More information on these risks in the UK can be found in the UK Climate Change Committee's Health and Social Care Briefing available here: www.ukclimaterisk.org/independent-assessment-ccra3/briefings/

NHS Borders completed an Adaptation Risk Assessment in 2023. The main risks identified were in relation to changes to population needs (i.e. increased demand for healthcare services) and the adaptability of environmental controls within our estate (e.g. ventilation systems).

This risk assessment is being used to support the Health Board in planning its future estate strategy, ensuring that our land and buildings are adapted to mitigate the risks arising from climate change. This includes both sustaining the fabric of the estate from potential damages as well as ensuring that the healthcare environment does not present and increased risk of harm to our patients, and that it is suitable to meet the future needs of our population.

Population risks impact on healthcare needs includes a potential increase to chronic conditions affected by seasonal temperature variation, for example more patients requiring hospital admission during prolonged hot weather; admissions relating to dehydration, heat stroke, breathing issues and cardiac issues could be anticipated; with further long-term issues relating to potential increase in skin cancers. We also identified wider societal impacts affecting population mental health, with specific concern regarding the isolation of small communities in rural locations.

Risks in relation to environmental controls are in part related to the age and design of our current estate, with integral plant and equipment likely to be insufficient to mitigate increased healthcare acquired infection risks arising from potential changes to temperature and humidity within the operating environment.

The actions to address increased demand will be a collaborative approach between our clinicians, supported by our Public Health and Communications teams, to ensure residents of

the Scottish Borders are engaged in the design of future service models and aware of the actions they can take to ensure that health services are both effective and efficient regarding the impact that these services have on our environment.

In relation to our buildings, we are aware of innovation in building design which offers opportunities to improve natural ventilation and cooling, and we will ensure that these opportunities are considered for both our existing estate and new buildings developed in our long-term property strategy.

During 2025/26 we have continued the work necessary to develop our future property strategy, including commissioning a full review of the design, condition and use of the Borders General Hospital. We expect that the development of this strategy will be informed by the information provided through our climate change risk assessment.

NHS Borders is also working with Climate Ready Southeast, a regional project considering both impact and adaptations that will need to be made.

6. Building energy

We aim to use renewable heat sources for all the buildings owned by NHS Borders by 2038.

NHS Borders has thirty-nine buildings, across 19 sites, such as Borders General Hospital (Acute Hospital), 4 community hospitals, 23 health centres and a range of other facilities.

In 2025/26, NHS Borders used 34,751,986 kWh of energy within its buildings, resulting in 5964.34 of CO2 equivalent, a decrease of 18.6% on previous year emissions (34,841,571kWh and 7,328tCO2e).

Energy consumption is attributed to several factors including the following:

- Due to evolving service delivery models within the community - particularly the transition towards more hub-like environments and extended operational hours at facilities such as health centres - it is anticipated that there will be a corresponding increase in both gas and electricity consumption. These changes reflect a broader commitment to accessibility and integrated care, but they also necessitate greater use of heating, lighting, hot water, and other utilities during periods that were traditionally considered out-of-hours.
- This shift in usage patterns should be factored into future energy management strategies, budget planning, and sustainability assessments to ensure continued operational efficiency and environmental responsibility.
- There has continued to be an increase by additional deployment of mobile diagnostic facilities - including endoscopy, mammography, CT, and MRI units – to further help reduce waiting times. This strategic approach enables continuity of diagnostic services while permanent equipment undergoes upgrades and provides additional capacity to meet rising demand across the region.
- Shift to EV Charging – increase in the number of EV chargers available to support the fleet migration from fossil fuel to renewable energy (electric) – 2025/2026 consumption was circa 84,000 kWh equates to c.1.2% of NHS Borders annual electricity consumption – expected to increase to c.125,000 kWh's in 2026/2027. This effect is offset by a reduction in use of fossil fuels.
- Currently NHS Borders has reduced working on one of our main community hospital and health centre sites, Knoll Hospital, due to ongoing RAAC works – looking at the trend data analysis we estimate this to be as per the below:

	2023/24 (kWh)	2025/26 (kWh)	Change (kWh)	% Change
Gas	366,283	323,833	-42,450	-11.6%
Electricity	231,981	132,660	-99,321	-42.8%
Biomass Pellets	299,310	461,330	+162,020	+54.1%
Total Energy Use	897,575	917,823	+20,248	+2.3%

Note: 2023/24 represents a full year at normal operating capacity. 2025/26 represents a full year at reduced operating capacity. The figures indicate an overall increase in

energy consumption of 20,248 kWh (2.3%) compared to the 2023/24 baseline. This was primarily driven by increased biomass pellet consumption, which was required following gas infrastructure issues that affected the site for a number of weeks, resulting in a greater reliance on biomass heating during this period. Despite this, gas and electricity consumption both reduced compared to the 2023/24 baseline.

Building energy emissions, 2015/16, 2024/25 and 2025/26 – tCO₂e

	2015/16 energy use	2024/2025 energy use	2025/2026 energy use	Percentage change 2015/16 to 2025/2026
Building fossil fuel use	4681.3 tCO ₂ e	5545 tCO ₂ e	4698.9 tCO ₂ e	+0.4%
District heat networks and biomass	129.7 tCO ₂ e	56.7 tCO ₂ e	23.6 tCO ₂ e	-81.8%
Grid electricity	4340.6 tCO ₂ e	1725.9 tCO ₂ e	1,372.4 tCO ₂ e	-68.4%
Totals	9151.6 tCO₂e	7327.6 tCO₂e	6094.9 tCO₂e	-33.4%

Building energy use, 2015/16, 2024/25 and 2025/26 – MWh

	2015/16 energy use	2024/2025 energy use	2025/2026 energy use	Percentage change 2015/16 to 2025/2026
Building fossil fuel use	22368MWh	26019.5MWh	25679.7MWh	+14.8%
District heat networks and biomass	2860.6MWh	1164.4MWh	053.2MWh	-28.2%
Grid electricity	8739.6MWh	7658.7MWh	7018.9MWh	-19.7%
Renewable electricity	2895MWh	33.1MWh	77.3MWh	-93.9% - error in 2015/16
Totals	36863.2 MWh	34875.7 MWh	34929.1 MWh	-5.2%

Over the past year, NHS Borders has implemented a range of measures aimed at reducing emissions associated with building energy use. These actions reflect our commitment to sustainability and operational efficiency across the estate:

- **LED Lighting Upgrade Programme:** A rolling replacement of fluorescent fittings with energy-efficient LED technology is underway across internal and external areas. These installations feature smart lighting systems that incorporate natural light

optimisation, motion sensors, and automated timers to maximise energy efficiency and reduce carbon emissions.

- **Boiler Replacement Programme:** Ongoing replacement of inefficient boiler plant across the estate to improve heating efficiency and reduce fuel consumption.
- **Heating Infrastructure Improvements:** Upgrades to heating pipework insulation and replacement of heating pumps and associated equipment to enhance system performance.
- **Ventilation and Cooling Enhancements:** Lifecycle replacement of inefficient air conditioning units, upgrades to chiller systems, and remedial works to ventilation plant to improve functional efficiency.
- **Building Management System (BMS) Upgrades:** Enhancements to BMS controls to enable better monitoring and optimisation of energy use.
- **Water Efficiency Measures:** Installation of additional condensate recovery units to reduce water and energy waste. Installation of a pilot water systems that allows additional monitoring; temperature, use, efficiency etc.
- **Building Fabric Improvements:** Upgrades to roof coverings and insulation to improve thermal performance and reduce heat loss. A number of solar reduction trials were undertaken in an attempt to offset against the energy required to assist with temporary cooling/thermal comfort.
- **Scottish Green Public Sector Estate Decarbonisation Scheme (GPSEDS):** Delivery of capital projects under this scheme, including fan and pump efficiency upgrades, LED lighting, insulation improvements, solar PV installations, and sub-metering.
 - Estimated Annual Energy Savings: 2398 MWh (electricity and gas combined)
 - Estimated Lifetime Carbon Reduction: Approximately 417 tCO₂e per year

In addition to the grant-funded initiatives, rolling programmes for boiler plant replacement and improvements to pressure systems, condensate units, steam traps, and other core infrastructure continue to be progressed through the Board's capital programme.

Work supporting green theatre initiatives and ventilation plant upgrades - particularly at Borders General Hospital - are also expected to deliver further energy efficiency gains. These were included within the scope of the GPSEDS project, which is now largely complete, pending final commissioning activities.

Forward Plan: Emissions Reduction Measures (2026/27)

Our longer-term strategy for reducing building-related emissions is outlined in the Net Zero Carbon Roadmap developed in 2023. Key initiatives planned for the current financial year include:

- **Ventilation System Upgrades:** Remedial works to critical and general ventilation systems, including extract systems, to improve air quality and energy performance.
- **Hot Water System Improvements:** Further scoping and feasibility on replacement of existing calorifiers with plate heat exchangers, designed to reduce energy use and eliminate the need for hot water storage.
- **Solar PV Expansion:** Installation of a new photovoltaic array at a Community Hospital as part of a RAAC remedial project (structural feasibility underway).
- **BMS Optimisation:** Additions to our BMS system, including upgrades to some of community sites to enable better controls and efficiency

- Feasibility Studies: Development of business cases for future decarbonisation and energy efficiency projects, aligned with the Net Zero Carbon Roadmap and targeting multiple grant and funding streams.
- LED full site replacements: Full Health Centre upgrade to smart lighting technology
- Roof extractions (Ventilation); multiple roof fan replacements as part of a rolling programme – more efficient roof units being installed.

7. Sustainable care

The way we provide care influences our environmental impact and greenhouse gas emissions. NHSScotland has three national priority areas for making care more sustainable – anaesthesia, surgery, and respiratory medicine.

7.1 Anaesthesia and surgery

Greenhouse gases are used as anaesthetics and for pain relief. These gases are nitrous oxide (laughing gas), Entonox (a mixture of oxygen and nitrous oxide) and the ‘volatile gases’ - desflurane, sevoflurane and isoflurane.

Through improvements to anaesthetic technique and the management of medical gas delivery systems, the NHS can reduce emissions from these sources.

NHS Borders total emissions from these gases in 2025/26 were 177.95 tCO₂e, a decrease of 424.82 tCO₂e from the year before. The change is largely attributed to the ordering process as set out in the foot note below

More detail on these emissions is set out in the tables below:

Nitrous oxide and Entonox emissions, 2018/19, 2024/25, 2025/26 – tCO₂e

Source	2018/19 (baseline year)	2024/25	2025/26	Percentage change 2018/19 to 2024/25
Piped nitrous oxide	241 tCO ₂ e	73.91 tCO ₂ e	27.97 tCO ₂ e	-88.4%
Portable nitrous oxide	12 tCO ₂ e	0	0	-100%
Piped Entonox	265 tCO ₂ e	406.38 ⁹ tCO ₂ e	103.85 tCO ₂ e	-60.8%
Portable Entonox	114 tCO ₂ e	110.87 tCO ₂ e	57.46 tCO ₂ e	-49.6%
Total	632 tCO₂e	591.16 tCO₂e	189.28 tCO₂e	-70.1%

⁹ This figure is based on ordering in 2023/2024 ordering in final quarter was reduced. In 2024/2025 a large order was placed in the first quarter and final quarter. It is expected that the figure for 2025/2026 will reduce again.

Volatile medical gas emissions, 2018/19, 2024/25, 2025/26 – tCO₂e

	2018/19 (baseline year)	2023/24	2024/25	Percentage change 2018/19 to 2024/25
Desflurane	33 tCO ₂ e	0	0	-100%
Isoflurane	1.1 ¹⁰ tCO ₂ e	0.2 tCO ₂ e	0	-100%
Sevoflurane	15.3 tCO ₂ e	12.3 tCO ₂ e	9.56 tCO ₂ e	-37.5%
Total	48.6 tCO ₂ e	12.5 tCO ₂ e	9.56 tCO ₂ e	-80.3%

We have moved away from using Desflurane and Isoflurane for volatile anaesthesia. No Desflurane has been purchased by NHS Borders since August 2021 and it is no longer used. Isoflurane has similarly been phased out so now Sevoflurane or total intravenous anaesthesia is our default.

In previous years we moved to GE Aisys anaesthetic machines which have technology that makes giving anaesthetics at lower gas flows more straightforward. This reduces the amount of volatile anaesthetic used as well as piped oxygen and air.

The nitrous oxide manifolds have now been decommissioned resulting in a significant reduction in CO₂e in previous financial years. The timing of orders for replacement cylinders seems to have resulted in an increase in Entonox this year however we would expect that to be compensated by a decrease next year.

A National Green Theatres Programme was officially launched in 2023 to help reduce the carbon footprint of theatres across NHS Scotland and enable more environmentally sustainable care by:

- Working with clinicians and professionals to develop actions that reduce carbon emissions, waste and resource use.
- Supporting Boards to implement, measure and report on these improvements.

We are implementing the green theatre project and have introduced reusable theatre hats for staff, reusable sterile drapes and gowns, embedded waste segregation and oral Paracetamol as the default choice in the peri-operative period. We are working on a process to switch AGS (Anaesthetic Gas Scavenging) and HVAC (Heating Ventilation Air Conditioning) to a background setting out of hours and looking at the business case for alternative surgical suction devices. We have now moved away from in-line fluid warming as default in all theatres resulting in a reduction in consumables and energy use. Rub not scrub has also been firmly embedded and staff are as a result using less water and less energy to heat this.

¹⁰Amended from previous reporting following recalculation Isoflurane previously stated as 0.3 tCo₂e (2018/2019).

7.2. Respiratory medicine

Greenhouse gases are used as a propellant in metered dose inhalers used to treat asthma and COPD. Most of the emissions from inhalers are from the use of reliever inhalers – Short Acting Beta Agonists (SABAs). By helping people to manage their condition more effectively, we can improve patient care and reduce emissions.

NHS Borders clinicians have adopted the approach agreed through national Respiratory pharmacy networks. It is the opinion of the Scottish Respiratory Pharmacist SIG, that the best inhaler is ‘the one the patient can use [most] effectively’. The cost (financially and environmentally) of Dry Powder Inhalers (DPI) is significantly greater than normal use of MDIs (metered dose inhalers). There are two new (environmentally better) propellants coming to market in the next couple of years and it was agreed the greatest immediate gain clinically and environmentally would be to focus on patients’ over-use of SABA inhalers rather than any scheme switching to DPI.

The reduction this year is in part due to uptake of Symbicort AIR. In addition, the severe asthma service is picking up and improving global asthma care for the most severe (and likely then reducing excess inhaler use).

We estimate that emissions from inhalers in NHS Borders were 1,696 tonnes of CO₂equivalent, a reduction 241 tonnes of CO₂equivalent from the previous year.

Inhaler propellant emissions, 2018/19, 2023/24, 2024/25 – tCO₂e

Source	2018/19 (baseline year)	2024/25	2025/26	Percentage change 2018/19 to 2024/25
Primary care	1,751.27 tCO ₂ e	1,662 tCO ₂ e	1,646.71 tCO ₂ e	See below
Secondary care	41.55 tCO ₂ e	33.94 tCO ₂ e		See below
Total	1,792.82 tCO ₂ e	1,695.94 tCO ₂ e	1646.71 tCO ₂ e	-8.14%

In addition, we are involved with Realistic Medicine which will ensure patients are on the most appropriate medicines for the minimum time.

7.3. Other Sustainable Care Action

NHS Borders strives to find ways to deliver sustainable care and actively seek opportunities to deliver exceptional care whilst reducing our carbon footprint.

We are actively seeking opportunities to change practice and are engaged with several Green Health Care programmes.

8. Travel and transport

Domestic transport (not including international aviation and shipping) produced 28.3% of Scotland's greenhouse gas emissions in 2022. Car travel is the type of travel which contributes the most to those emissions.

NHS Scotland is supporting a shift to a healthier and more sustainable transport system where active travel and public transport are prioritised.



Two of NHS Borders EV Fleet

We are reporting a decrease in emissions in relation to both NHS Fleet use and Business Travel. We had anticipated that this would decrease slightly each year and are pleased with this progress against the setting of moving care into the community and increasingly into people's homes in line with NHS Borders Clinical Strategy. To support this work NHS Border will pilot increased electric vehicle access for staff through Enterprise Car Club early April 2026.

We had anticipated an increased mileage in relation to the issue of RAAC at The Knoll with teams increasing frequency of travel to The Knoll and managing logistics and in addition business miles for displaced staff are captured within reporting. The three additional EV cars are to support temporarily redeployed employees at The Knoll.

As last year the inclusion of air, rail, and passenger journeys we supported are now included for completeness. For bus and rail, due to the number of paper expenses claims the mileage was calculated this year as the average km to pence. This will be the process moving forward until we are able to get more accurate data.

The decrease in air travel emissions in part relates to a single long-haul journey the previous year and increased oversight from the Executive Leadership team following last years report. We are also seeing an increase in employees utilising trains instead of planes for journeys as indicated by the increase in public transport emissions.

We continue to work collaboratively with Scottish Borders Council to ensure public transport is effective for NHS Borders staff, patients, and visitors. We are pleased that SBC secured funding to upgrade the bus stop at Borders General Hospital and the work commenced in 2025/2026 and will be concluded late summer 2026.

We continue to enable agile working which enables people to utilise technology such as Microsoft Office Teams to reduce the need to travel to meetings.

NHS Borders recognises that supporting active travel will be a key component of our future travel plans. Our progress to date in this area has been limited however through the

development of our Active Travel plan we expect to increase awareness across staff and visitors and to ensure that our policies and infrastructure is refreshed to support active travel.

NHS Borders continues to work with SEStran and actively participate in the South Regions Strategic Action on Transport to ensure we leverage opportunities for sustainable transport wherever possible.

We remain committed to removing all petrol and diesel fuelled cars from our fleet as soon as possible. Given the rurality this is challenging due to the range issues and in addition funding constraints.

The following table sets out how many renewable powered and fossil fuel vehicles were in NHS Borders fleet at the end of March 2025 and March 2026:

	March 2025		March 2026		
	Total vehicles	Number of % Zero Emissions Vehicles	Total vehicles	Number of % Zero Emissions Vehicles	Difference in % Zero Emissions Vehicles
Cars	40	14	42	20	+6
Light commercial vehicles	36	11	36	12	+1
Heavy vehicles	2	0	2	0	0

	March 2025	March 2026	Percentage change
Bicycles	0	0	0
eBikes	0	0	0

Due to the rurality of the Scottish Borders the relative distances for journeys are significantly higher than in Health Board regions which have a higher population concentration within urban centres.

Following consultation with key stakeholders NHS Borders has decided to undertake further review before progressing any investment in eBikes.

The following table sets out the distance travelled by our cars (Fleet and Grey Fleet), vans and heavy vehicles in 2025/2026

Distance travelled, kms

Source	2024/25	2025/26	Percentage change 2024/25 to 2025/26
Cars	1,982,504 km	2,119,872 km	+6.92%
Light Commercial Vehicles	573,612 km	406,288 km	-29 %
Heavy Vehicles	0	0	-
Total	2,556,116km	2,526,160km	-1.17%

Business travel is staff travelling as part of their work in either their own vehicles or public transport. It covers travel costs which are reimbursable and does not include commuting to and from work. The table below shows our emissions from business travel by transport type. This table includes Fleet, Grey Fleet and business miles claims.

Business travel emissions, tCO₂e

Source	2024/25	2025/26	Percentage change 2024/25 to 2025/26
Cars	446.36 tCO ₂ e	438.38 tCO ₂ e	-1.78%
Public Transport	3.33 tCO ₂ e	3.89 tCO ₂ e	+16%
Flights	10.16 tCO ₂ e	1.47 tCO ₂ e	-85%
Total	459.85 tCO ₂ e	443.74 tCO ₂ e	-3.5%

NHS Borders is investigating how to effectively capture commuter miles for inclusion in future reports.

9. Greenspace and biodiversity

Biodiversity

Biodiversity, or the wide variety of living organisms within an environment, has declined at a rapid rate in the last 50 years. Evidence demonstrates that these trends are attributed to human activities, such as land use change, habitat degradation and fragmentation, pollution, and the impacts of climate change. The State of Nature report published in 2023 has highlighted the decline of nature across Scotland, with 11% of species now classed as threatened with extinction.

Public bodies in Scotland have a duty under the Nature Conservation (Scotland) Act 2004 ([Nature Conservation Scotland Act 2004](#)) to further the conservation of biodiversity, taking care of nature all around us. Furthermore, the Wildlife and Natural Environment (Scotland) Act 2011 ([Wildlife and Natural Environment Scotland Act 2011](#)) requires every public body to summarise their activities to meet this duty, through the production of a publicly available report.

We are fortunate to be in a beautiful and rural part of Scotland and are continuing to work on a long-term strategy to address the identification, protection, and enhancement of biodiversity across our estate. As part of our climate change adaption plans, we will consider how nature-based solutions may align across both the climate and biodiversity emergencies. We recognise this is a complex area and will work with relevant bodies (e.g. Nature Scotland) to ensure that plans are aligned to best practice.

During the reporting period, along with our tree survey AECOM, commissioned by Nature Scot, in Partnership with National Health Services (NHS) Scotland conducted a habitat type report across the organisation. The report highlighted that NHS Borders Board is made up of 48% greenspace and much of this is modified grassland and mixed woodland. NHS Borders Estates team will evaluate the report and consider how some of these areas can be replaced with trees, wildflower meadows and species rich grassland.

Following on from previous years we have maintained our reduced number of cuts of 10 cuts a year at a height of 75mm. We have also further increased the number of areas within all NHS Borders grounds that are planted with new pollen rich planting and wildflowers.

We continue to assess how we can minimise the use of pesticides across our estate and have reduced the times it is used each year, also working alongside Risk, Health & Safety to ensure the correct products are being used.

We are seeking to embed the principles of biodiversity into all our estate planning and management and during the reporting period we transitioned all grounds maintenance activities at community healthcare sites from external contractors to the in-house NHS Borders gardening team. This transition will improve consistency on how our grounds are managed and provide greater flexibility to implement positive green practices into our routines.

Greenspace

The design and management of the NHS Scotland green estate for human and planetary health, offers an opportunity to deliver a range of mutually beneficial outcomes. These include action on climate change (both mitigation and adaptation), biodiversity, health and wellbeing for patients and staff, community resilience building and active travel.

To support this our grounds & gardens team continue to assist in the “Space to Grow” project at Huntlyburn House. The “Space to Grow” area is used for carrying out workshops that assist in the rehabilitation of our mental health patients and is widely accessed by staff and visitors.

We have also continued to develop new outdoor spaces for staff members at all our NHS Borders Hospitals by providing areas in greenspace which promote improved staff wellbeing. These areas are being planted with pollinator plants and shrubs. Healthcare workers often experience high levels of stress, especially in demanding environments like hospitals. Green spaces provide staff with a place to decompress, enhancing job satisfaction and potentially reducing burnout.

10. Sustainable procurement, circular economy, and waste

Procurement has an important role to play in helping NHS Borders reduce its environmental impact. Through sustainable purchasing, supporting circular economy principles and making informed sourcing decisions, we continue to contribute to NHS Scotland's ambition of achieving net zero emissions by 2045.

During 2025/26, we continued to reduce the environmental impact of the goods and services we buy by making use of national contracts and frameworks wherever possible. Most of our purchases are made through NHS National Procurement contracts, helping us achieve better value, reduce duplication and support wider sustainability goals.

A large proportion of our medical consumables are supplied through NHS National Services Scotland's National Distribution Service. This consolidated approach helps reduce the number of deliveries required and, in turn, lowers transport-related emissions. For locally managed purchases, we also look to combine orders across departments where practical, helping to minimise supplier journeys while maintaining an effective and reliable supply chain.

We continue to work closely with colleagues in NHS National Procurement. The Head of Procurement remains actively involved in a number of national groups and forums, including the Sustainable Procurement Steering Group and the National Efficiency Operational Group. This involvement helps ensure NHS Borders both contributes to and benefits from national work on sustainable procurement, circular economy initiatives, commercial efficiency and supply chain decarbonisation.

Delivering wider social value remains an important part of our procurement activity. We continue to use the Community Benefits Gateway and, where appropriate, include community benefits as part of tender evaluations and ongoing contract management.

As a Living Wage Accredited Organisation, NHS Borders continues to support Fair Work First principles through procurement activity and contractual arrangements where relevant. Sustainability training remains mandatory for staff involved in procurement. This includes Scottish Government eLearning modules on Sustainable Public Procurement, Climate Literacy and Circular Procurement and Supply, helping staff build the knowledge and skills needed to support the Board's sustainability and climate objectives.

During 2026/27, NHS Borders will continue to:

- Support NHS Scotland's ambition to achieve net zero emissions by 2045.
- Work collaboratively with NHS National Services Scotland and other NHS Boards to reduce supply chain emissions.
- Apply circular economy principles throughout procurement activities and contract management.
- Promote sustainable procurement practices and wider social value through sourcing activities.
- Support Fair Work First and ethical procurement principles across the supply chain.
- Maintain staff awareness and capability through ongoing sustainability training.
- Look for opportunities to reduce waste, encourage reuse, and increase recycling associated with purchased goods and services.

NHS Borders remains committed to embedding sustainability throughout the procurement lifecycle and ensuring procurement continues to make a positive contribution to the Board's wider climate and sustainability objectives.

We have a commitment to ensuring that waste generated through procurement activities will continue to be reduced and that we will increase how much of this waste is recycled.

The table below sets out information on the waste we produce and its destination for the last three years. Please note the data for 2020/2021 is incomplete.

Type	2022/23 (tonnes)	2024/25 (tonnes)	2025/26 (tonnes)	Percentage change from last year
Waste to landfill	10	0.61	0	-100%
Waste to incineration	63.62	50.36	51.84	+2.85%
Recycled waste	715.9	460.27	101.18	-78.01%
Food waste	15.5	30.36	51.25	+40.76%
Clinical waste	360.9	322.64	300.64	-6.82%

In October 2024 NHS Borders implemented the new waste contract for recycling and general waste. The new contractor is fully compliant with the Environmental Protection Act 1990 duty to provide accurate weighing and tracking of waste. As expected, this has impacted the figures contained within this report. This is the first full year of accurate reporting that NHS Borders has had for all waste streams, and we anticipated that as we moved from estimated collection data to real data the figures would vary considerably.

The significant reduction in Waste to landfill is because of the final treatment of waste provided by the new contractor who can process more waste as recycled or recycled to energy.

The recycled waste reduction figure is, following an investigation, due to the over inflated estimates by the previous contractor regarding the volume of waste uplifted.

We have initiated a programme to increase recycling through the removal of personal bins to encourage the correct segregation. This was successfully piloted by the executive leadership team in the last financial year and we have continued to roll this project out across the organisation.

A key change in during last year is we no longer process food waste through a macerator for disposal into the sewage network, which reduces the risk of blocked drains, changes to microbial communities and production of methane.

This has resulted in an increase to our food waste reported. This food waste is now processed via anaerobic digestion. The catering manager and waste manager are working collaboratively to ensure the food waste is reduced. Again, it should be noted that we expected this rise as we collected the first full year's data.

To reduce the amount of incinerated waste we are reinforcing our education of what should be included in this waste stream and asking for increased vigilance that all recycling packaging is placed in the correct waste stream. In addition, we have worked with infection prevention control to remind clinicians about the correct use of sharps bins.

NHS Borders is pleased to see our continuing reduction in clinical waste and are confident that further improvements can be made.

Across the organisation in 2025/26 we have considered areas that we can reduce waste in our processes for example the removal of couch roll on beds unless operationally required and the return to drinking tap water for staff and patients instead of bottled water.

There are nationally agreed targets setting out reduction to the amount of waste produced across NHS Scotland; the tables below provide information on our performance against those targets. It should be noted that until April 2018 NHS Borders operated an onsite incinerator which was how most of our waste was processed; this means that we do not have segregated data from 2012/2013.

Reduce domestic waste by a minimum of 15%, and greater where possible compared to 2012/2013 – by 2025	
Target – reduce domestic waste by	No 2012/13 baseline data available. Based on 'straight line' methodology, anticipate 1.25% reduction per year. Target = 1.25% x 2021/22 tonnes
Performance – domestic waste reduced by	2023/2024 - 315 tonnes 2024/2025 - 294 tonnes (6.6% Reduction) 2025/2026 – 186.72 tonnes (36% Reduction)
Outcome	Achieved
Further reduction required	3 x 1.25% of 2021/22 less any reduction achieved in 2022/23

**On basis that reduction of 1.25% is expected each year from point where base data is available.*

Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Target – reduce waste sent to landfill by	Target (total landfill at 5% of overall waste)
Performance – waste sent to landfill reduced by	0.0 tonnes (1.3% of all domestic waste based on SBC (Scottish Borders Council) provided data)
Outcome	Achieved
Further reduction required	None

Reduce the food waste produced by 33% compared to 2015/16 – by 2025	
Target – reduce food waste by	3.3% per year based on 33% over 10 years.

	Use 2021/22 as baseline
Performance – food waste reduced by	0 tonnes
Outcome	Not achieved yet
Further reduction required	3.3% x remaining year

Ensure that 70% of all domestic waste is recycled or composted – by 2025	
Target – recycle or compost	100%
Performance – recycled or composted	100%
Outcome	Achieved
Further increase required	None

11. Environmental stewardship

Environmental stewardship means acting as a steward, or caretaker, of the environment and taking responsibility for the actions which affect our shared environmental quality.

This includes any activities which may adversely impact on land, air, and water, either through the unsustainable use of resources or the generation of waste and pollution. Having an Environmental Management System (EMS) in place provides a framework that helps to achieve our environmental goals through consistent review, evaluation, and improvement of our environmental performance.

We continue to work on EMS. This work is ongoing and through our Climate Emergency and Sustainability Group we are aligning EMS to our overall action plan to ensure that as work is undertaken to review and/or introduce our plans, policies, and procedures these will be recorded within our EMS. The work on EMS impacts a wide number of stakeholders and we will work collaboratively to ensure the EMS is robust with organisational wide engagement and teams aware of their responsibilities.

We recognise that resource will impact the EMS work and are frustrated that this will impact the full adaptation of an EMS.

12. Sustainable communities

NHS as an Anchor Organisation

As an anchor organisation, NHS Borders can make a significant contribution to reducing health inequalities and supporting climate action through the way it spends money, employs people, develops its workforce, and uses its buildings, land and other assets. This approach aligns with community wealth building, which seeks to generate, circulate and retain wealth locally so that more of the social, economic and environmental benefits are experienced by local people and communities. In practice, this means using the influence of large public bodies to support a fairer, greener and more resilient local economy, while also improving the wider determinants of health.

NHS Borders established an Anchors Development Group, which meets regularly and includes representation from leads across the anchor pillars – workforce, land and assets, procurement, partnership and communications and sustainability. A key focus of the group is to ensure that Anchors as an approach is embedded across organisational strategies and helps to inform joined-up action across the Board. With the launch of the Community Wealth Building (Scotland) Act 2026, action to support community wealth building will be further strengthened through closer collaboration with other local anchor organisations such as Scottish Borders Council, further and higher education partners, and the third sector. This will support stronger partnership working on shared priorities such as tackling poverty, improving population health, building community resilience and contributing to climate mitigation and adaptation across the Borders.

During the reporting period, NHS Borders continued to support local employability through the Bridge to Healthcare programme, delivered in partnership with the Local Employability Partnership. Two cohorts were funded, with 10 of 14 participants (71%) progressing into employment. This work reflects the NHS anchor role by creating local opportunities, supporting wellbeing, and contributing to more sustainable and resilient communities.

NHS Borders continues to promote the NHS Community Benefits Gateway, creating opportunities to support local initiatives that improve health and wellbeing while also contributing to environmental sustainability and stronger communities.

Communicating the Health Impacts of Climate Change Toolkit

NHS Borders recently published the *Communicating the Health Impacts of Climate Change: A Toolkit for Healthcare Workers* to support staff to talk more confidently and effectively about the links between climate change and health. Developed for use in the Scottish Borders, the toolkit explains why climate and health communication matters, outlines the direct and indirect health impacts of climate change, highlights the health co-benefits of climate action, and provides practical advice on how to tailor messages for different audiences. The toolkit builds climate and health literacy across staff and community groups. It also signposts local initiatives and resources that support environmental sustainability, health improvement and community wellbeing, helping staff to frame climate action in ways that are relevant, hopeful and grounded in local experience. The toolkit was developed by NHS Borders with input from the Scottish Borders Climate Action Network, alongside contributions from Public Health Scotland and sustainability colleagues.

Looking ahead, there are plans to develop a community version of the toolkit to be progressed by Scottish Borders Climate Action Network, helping to extend its reach and support wider public engagement on climate and health.

Green Health Partnership

The Department of Public Health is progressing plans for a Green Health Partnership to support a more joined-up approach to improving health and wellbeing across the Borders. It is envisaged that the partnership will take a collaborative model, working with a range of stakeholders and partners to bring together groups with a shared interest in health and wellbeing, social prescribing, and activities that also support climate action. This approach aims to strengthen connections across sectors, encourage community participation, and promote opportunities that deliver co-benefits for people, places and the environment. The work will also draw on the recently published *Communicating the Health Impacts of Climate Change toolkit* to support consistent messaging and engagement.

Good Food Nation

The Good Food Nation (Scotland) Act 2022 provides the strategic framework for a more joined-up food system in Scotland. Its intent is to improve access to healthy, affordable and sustainably produced food; support better physical and mental health; strengthen local economies and food businesses; and contribute to environmental sustainability, biodiversity and net zero ambitions. In practice, it is about using food policy to deliver wider social, economic and environmental benefits, including reducing inequality and promoting thriving communities.

The final national Good Food Nation Plan was published by the Scottish Government in December 2025, and under the Act local authorities and health boards are required to prepare their own plans when the relevant provisions are commenced, with progress reports expected every two years and plans reviewed at least every five years. Locally, a stakeholder network has already been established to support this work, bringing together Scottish Borders Council, NHS Borders, and third sector partners, amongst others, to help shape a joined-up Borders approach.

Mental Health and Wellbeing

During the reporting period, NHS Borders has focused on recognising the links between climate change, sustainable communities, and mental health and wellbeing. This work takes account of the growing evidence base to inform practical, place-based responses that strengthen community resilience, reduce inequalities and support people most affected by climate-related disruption.

Evidence continues to show that climate-related hazards, including flooding, extreme weather and longer-term environmental change, can affect mental health through direct experiences such as trauma, injury and property loss, as well as indirect impacts on livelihoods, social networks, access to services and feelings of security. NHS Borders is using this evidence to strengthen the case for embedding mental health and wellbeing within local climate adaptation, emergency preparedness and community resilience activity.

Flooding remains a particular concern because of its long-lasting effects on individuals, families and communities, including increased risk of anxiety, depression and post-traumatic stress. NHS Borders Emergency Response and Resilience Team work collaboratively to respond to such events while the Department of Public Health continue to promote a preventative approach that aligns with this, and considers not only physical safety and infrastructure, but also the social and psychological recovery needs of communities following climate events.

It is acknowledged that climate change can compound existing inequalities, with disproportionate mental health impacts on people on lower incomes, those with limited ability to protect their homes or livelihoods, rural and agricultural communities, children and young people, and people already experiencing poor mental health. NHS Borders are therefore considering climate-related mental health risks through an inequality's lens, supporting approaches that are targeted to need while contributing to wider community wellbeing.

The work is supporting a shift from reactive response to proactive planning. Key areas of action moving forward include strengthening partnership working across health, social care, housing, planning, emergency response and community partners; promoting clear and empathetic communication before, during and after climate events; and recognising the protective role of social connection, community assets and local support networks in building sustainable and resilient communities.

Going forward, NHS Borders will continue to embed climate-related mental health and wellbeing considerations within strategic planning, including relevant action linked to suicide prevention, green health, community resilience and sustainability. This will help ensure that action on sustainable communities delivers co-benefits for population health, supports those most at risk, and contributes to a fair and inclusive transition to a more climate-resilient Scottish Borders.

NHS Borders Emergency Planning and Resilience

The NHS Borders *Emergency Planning and Resilience* (EPR) Team continues to strengthen its partnership with Scottish Borders Council (SBC) to support the development of resilient communities across the region. This collaborative approach is increasingly focused on adapting to the growing impact of climate change, particularly the rising frequency and complexity of extreme weather events.

During the reporting period, NHS Borders has contributed practical, health-focused advice to SBC-led community engagement activity, including the Resilient Communities Newsletter. This has provided accessible guidance on the health impacts of climate change, supporting individuals and communities to prepare for heatwaves, storms, and periods of prolonged disruption. Particular emphasis has been placed on protecting vulnerable groups, maintaining access to medication and care, and reducing avoidable pressure on health services.

This preventative work has been complemented by operational response. During *Storm Eowyn*, NHS Borders activated severe weather arrangements in close coordination with SBC partners. While infrastructure impacts were limited, the event disrupted staff movement and increased demand for services. Established resilience plans enabled continued delivery of care and timely support to patients, demonstrating the effectiveness of joint planning and response arrangements.

NHS Borders has also strengthened its contribution to community-led resilience planning. Through ongoing engagement with SBC and local Resilient Communities groups, the EPR team is supporting the integration of health considerations into local plans. This ensures communities are better equipped not only to prepare for hazards such as flooding, snow, and extreme heat, but also to recover quickly while maintaining access to essential health and social care services.

Seasonal health resilience messaging remains a key area of focus. In advance of winter, NHS Borders provides targeted advice covering:

- **Health preparedness:** supporting households to maintain access to medication and care during disruption
- **Cold weather risks:** reducing the impact of cold-related illness and supporting wider public health measures
- **Access to services:** clear information on how to access care during adverse conditions, including NHS 24, Near Me, and community-based alternatives

Formal NHS Borders representation at winter planning sessions ensures that health resilience is embedded within local community plans and decision-making processes.

Maintaining Service Delivery During Severe Weather

NHS Borders continues to enhance its established framework for managing severe weather, including storms, flooding, snow, and extreme heat. Plans are regularly exercised and updated to reflect emerging climate risks and lessons learned from incidents.

Working closely with SBC Emergency Planning and Transport colleagues, joint arrangements are in place to support continuity of care, including:

- Maintaining staff access through priority routes and specialist transport support
- Adapting service delivery through telehealth and alternative models of care
- Real-time monitoring and communication to minimise disruption
- Strengthening supply resilience, including fuel, medicines, and critical equipment

A structured exercise programme continues to test system-wide preparedness, with a growing focus on climate-related scenarios and cross-service coordination.

Flexible Healthcare Delivery and Community-Based Support

Recognising the potential for disruption to traditional healthcare settings, NHS Borders is progressing work to enable more flexible models of care delivery. This includes planning for the use of community-based locations, such as rest centres and mobile facilities, to provide essential services during emergencies.

In partnership with SBC, NHS Borders is contributing to the enhancement of the Care for People framework, ensuring that displaced individuals can access healthcare, medication, and support when required. This work includes:

- Developing health provision within rest centres
- Identifying suitable alternative care locations
- Aligning health response with wider community and social care support
- Ensuring continuity of care for vulnerable and high-risk individuals

Supporting guidance and training are being developed to enable staff to operate safely and effectively in these non-traditional settings.

Looking Ahead

NHS Borders is continuing to embed health resilience within broader community and system-wide planning. By strengthening partnerships, enhancing preparedness, and developing more flexible service models, the organisation is better positioned to respond to the evolving challenges of climate change.

The focus remains on protecting vulnerable populations, maintaining continuity of care, and supporting communities to adapt and recover, ensuring that health services remain accessible, responsive, and resilient in a changing climate.

Green Health and Community Action

Sustainable communities are central to NHS Borders' response to climate change, recognising that the places where people live, work and connect shape health, wellbeing and resilience. Supporting community-led action can help people adapt to the impacts of climate change, including flooding, storms, overheating and wider disruption, while also strengthening local resilience, reducing inequalities and improving the wider determinants of health. A community-centred approach helps ensure that climate action is relevant to local need and delivers practical benefits across the Borders.

There are also opportunities outlined in this report that will support sustainable communities through green health, social prescribing and community-led initiatives that deliver benefits for both people and the environment. Activities such as active travel, community growing, volunteering, reuse and repair, and nature-based opportunities can improve mental and physical wellbeing while also supporting environmental sustainability. By working with partners and local groups, NHS Borders can help strengthen community connections, encourage practical local action, and promote approaches that support both population health and climate resilience.

13. Conclusion

We report an 18.72% reduction in emissions compared with the previous year, from 10,316.4 tCO₂e to 8,384.76 tCO₂e. This reflects actions we have taken directly to reduce our emissions and mitigate their impacts, as well as recognising the reduced emissions from grid-sourced electricity generation.

We also acknowledge that an element of this reduction is attributable to the temporary closure of Knoll Hospital in Duns. Based on current expectations we would anticipate that there will be limited impact during 2026/27 as the hospital reopens on a phased basis towards the end of that year; the full year impact is likely to be realised within the 2027/28 reporting period.

This should not however diminish the underlying progress made in the last year including moving to more sustainable energy usage and the reduction of use in medical gasses.

Reducing carbon emissions across healthcare is inherently challenging because of the complexity of the operating environment and the continued need for products and treatments that currently carry a high carbon footprint. Nevertheless, this report demonstrates the strong commitment of our clinical teams and support services to finding and implementing innovative solutions that reduce emissions without compromising patient care. This commitment is reflected in practical changes to clinical practice, including the substantial reduction in high-carbon anaesthetic gases and wider work to make surgery and respiratory care more sustainable.

However, the scale of change required to achieve net zero is beyond the capacity of individual organisations or local action alone. It will depend on sustained government investment to decarbonise and strengthen the resilience of public infrastructure and the healthcare estate, alongside continued national action to improve energy efficiency and increase the contribution of renewable generation to an increasingly decarbonised electricity grid. It will also require affordable low-carbon technologies and vehicles, lower-carbon medicines and products, and coordinated action through national procurement and the wider supply chain.

The wider public sector reform agenda may also create opportunities for closer collaboration across public bodies in the planning, use and management of the public sector estate, including greater sharing of assets, services and investment where this improves efficiency, resilience and sustainability. Reform of NHS Health Boards will, however, bring both risks and opportunities for delivery over the medium term. Changes to organisational structures, governance, responsibilities and investment priorities could enable more coordinated action and better use of collective resources, but may also create uncertainty, competing demands and disruption to established programmes. These implications will need to be carefully managed to maintain delivery momentum, protect accountability and ensure that climate and sustainability objectives remain embedded throughout the reform process.

Within that national context, NHS Borders will remain focused on the actions available to us locally. We will continue to improve the efficiency and sustainability of our estate, reduce the environmental impact of clinical and wider staff practices, and work with our supply chain to reduce emissions, resource use and waste. Through focused local action, collaboration and sustained changes in practice, we will mitigate the environmental impact of our services wherever possible while maintaining safe, effective and equitable patient care.

Meeting:	Borders NHS Board
Meeting date:	Wednesday 7 October
Title:	Subnational Planning and Delivery
Responsible Executive/Non-Executive:	Peter Moore, Chief Executive
Report Author:	Colin Briggs, Interim Lead Director of Strategic Planning, NHS Scotland East

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Delivery Plan
- Government policy/directive
- 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 13 November 2025 and directed NHS Scotland Territorial Boards to collaborate on the planning and delivery of specific services and programmes through the establishment of joint Strategic Planning and Delivery Committees (SPDCs). NHS Borders is part of SPDC East. This paper updates Board members on activities relating to the SPDCs and invites the Board to discuss its contents.

2.2 Background

DL (2025) 25 was published on 13 November 2025 and, through Ministerial Direction, instructed NHS Scotland Territorial Boards to form two SPDCs. These bodies were to focus on planning of:

- Elective orthopaedic services
- Emergency healthcare services
- Digital Front Door
- A joint approach to financial balance
- A single national approach to business systems

The DL required SPDCs to submit a common plan for these actions by 31 March 2026, except for the Digital Front Door work, which was to be submitted by 30 June 2026. These documents were reviewed in draft form by the Board Executive Team and subsequently presented to the Board for consideration at a Private Board Meeting on 19 March 2026. These plans were submitted during the pre-election period.

The new Scottish Government has indicated a desire to build on this work and over the summer has moved to commission these SPDCs to undertake more work, including;

- Coproducing a national (emergency services) flow plan ([Health and Care Improving Flow Plan 2026 - 2031](#)), which was published by the Scottish Government on 31st August and which SPDCs are now finalising delivery plans for
- Working collectively to maximise capacity across all Boards for elective care. This includes common oversight of performance at an operational management level, and developing plans for increasing capacity in elective orthopaedics in particular
- Taking forward the further implementation of the Digital Front Door, which is a crucial part of both emergency services and elective orthopaedics
- Developing common approaches to prevention and data utilisation
- Providing sponsorship for the national planning team at PSDS
- Building a common approach to financial planning and how constituent Boards can work towards financial balance by the end of this parliamentary term
- Developing a process for commissions being issued to SPDCs by the Scottish Government

On this last point, the Scottish Government has been clear that it expects to issue pan-Board “asks” through SPDCs. The Interim leads for the SPDCs have been providing input and advice to Scottish Government colleagues on how these commissions should be shaped, noting that these are matters of policy and therefore entirely for the Scottish Government to finalise. The intent from the Scottish Government is clear, however, and in line with the approach set out in the *Public Sector Reform Strategy*, with a focus on alignment to a smaller number of common goals clearly articulated at the start of any process.

Commissions to date have include a broad range of work areas, from performance reporting on elective services through to, most recently, neonatology and non-surgical solid tumour oncology. As examples, these latter two require the SPDCs to work together across the 14 territorial boards to implement policy goals expressed through Target Operating Models under development for some time.

SPDCs will receive these commissions formally through Committee meetings.

Most recently, the First Minister laid out the *Programme for Government 2026-31* ([Programme for Government - gov.scot](#)), which sets a clear agenda of performance improvement over the life of this parliament and significant public-sector reform.

2.3 Assessment

Work associated with the original DL commission has now expanded significantly and has developed increasingly positive momentum. It is particularly heartening to see the strong commitment to prevention of ill-health in additional work undertaken by the SPDCs around emergency services and elective orthopaedics.

There remains a significant challenge in providing appropriate capacity to design and deliver this redesign work, and there is an outstanding action mandated by the DL to “align planning resource to support this work”. The Chief Executive of NHS Fife is leading on this piece with input from interim Directors of People and Culture and of Strategic Planning.

Programme for Government seems to redouble the focus on working at a higher population level, with a commitment to reduce the number of mainland health boards from 11 to 2. At the point of drafting of this paper it is understood that detail on next steps for implementation is imminent from SG. There is no doubt that whatever changes come forward will be significant and require a high level of skill to balance the hear and now with the future configuration.

2.3.1 Quality/ Patient Care

The intent of this work is to improve the quality of care for all patients across Scotland.

2.3.2 Workforce

The intent of this work is to improve the sustainability of services across Scotland, which will involve workforce considerations, but at this stage it is too early to comment beyond that headline. There are assumptions regarding workforce in the plan which will need to be tested robustly.

2.3.3 Financial

The programme includes a common approach to financial planning and work towards financial balance by the end of the parliamentary term.

2.3.4 Risk Assessment/Management

As with any plan, there are assumptions within plans which need to be fully tested. The intent is that plans will support Boards in reducing their locally-held risks.

2.3.5 Equality and Diversity, including health inequalities

The author of this report assessed that an Equality Impact Assessment was not required.

2.3.6 Climate Change

No climate change or carbon impact is identified in the source paper.

2.3.7 Other impacts

None noted

2.3.8 Communication, involvement, engagement and consultation

SPDC East has kept Boards updated through Chief Executives and written communications.

A common communications plan is deployed by Directors of Communications.

Staff-side involvement has been challenging during the last ten months but is improving, with the lead Director of People and Culture working with staff-side colleagues to secure appropriate representation in relevant groups and meetings.

2.3.9 Route to the Meeting

The content of this paper has been discussed on an ongoing basis within SPDC substructures, with representation from all geographic parts of SPDC East.

2.4 Recommendation

This update is for awareness, with the Board invited to **note** the contents of this paper.

The Board/Committee will be asked to confirm the level of assurance it has received from this report. It is suggested that the Board takes **moderate assurance** from the update provided.

3 List of appendices

None

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	<i>7 October 2026</i>
Title:	Early Intervention, Prevention & Social Prescribing (Live Borders) Proposal
Responsible Executive/Non-Executive:	Peter Moore, Chief Executive
Report Author:	Gareth Clinkscale, Director of Urgent Care, Community Services and Mental Health

1 Purpose

This paper notes a proposal from Live Borders and Scottish Borders Council to participate in a jointly commissioned Early Intervention, Prevention and Social Prescribing Programme delivered by Live Borders. NHS Borders has fully committed its available resources for 2026/27 to delivery of the NHS Borders Clinical Strategy. However, as the proposal aims to improve community health and wellbeing, Board members are asked to refer this proposal to the Scottish Borders Integration Joint Board (IJB) to consider funding the partner contribution and collaboratively agreeing a delivery and evaluation plan with a joint assessment of impact at six months to inform any future funding decisions.

This is presented to the Board for:

- Noting

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Scottish Borders Council has agreed, subject to matching support from NHS Borders, to jointly commission Live Borders to expand community-based early intervention, prevention and social prescribing provision. The programme would build on the existing Livewell Referral service and establish Livewell Connect, offering structured physical activity, cultural, creative and social opportunities across the five Borders localities.

The proposal aligns with the NHS Borders Clinical Strategy emphasis on prevention, care closer to home and stronger community services. As NHS Borders has fully committed its available resources for 2026/27 to delivery of the Clinical Strategy, the proposal should be considered by the Integration Joint Board for funding.

The proposal identifies a total annual programme cost of £301,042 for the first full programme year, 2027/28, with a proposed NHS Borders share of £150,521. It also identifies a three-month set-up cost in 2026/27 of £125,903, with a proposed NHS Borders share of £62,952. Given that NHS Borders resources for 2026/27 are fully committed, these funding requirements should be considered by the Integration Joint Board through its established financial governance arrangements.

2.2 Background

The proposal responds to increasing pressures associated with an ageing population, long-term conditions, loneliness, social isolation and health inequalities. It is intended to strengthen non-clinical community support and help people maintain wellbeing, independence and connection within their local communities.

The proposed programme has two principal elements:

- Livewell Referral, an expansion of the existing Tier 2 activity referral offer for adults living with long-term conditions or identified risk factors, including specialist physical activity and falls prevention support.
- Livewell Connect, a new Tier 3 community programme for inactive people, people experiencing social isolation or low mood, and people at risk of developing long-term conditions. The offer includes physical, cultural, creative and social activities.

The first full year is planned to provide capacity for approximately 2,700 participants across Livewell Referral, falls prevention, Inside Out, Good Boost/Bump Boost and youth supported gym activity. The programme is intended to operate across the five Scottish Borders localities and to use Live Borders facilities alongside community venues where appropriate.

Should Scottish Borders Integration Joint Board (IJB) agree to fund this proposal, a commitment from both the delegated services and NHS Borders is required to create the capacity to develop clear referral and feedback pathways from both Primary Care and Secondary Care services i.e., General Practice, community services, mental health, MSK physiotherapy, falls, frailty, reablement, hospital discharge and relevant outpatient services. This provision would also provide wellbeing support pathways from NHS Borders Walk-In Clinics and the planned Community Hub.

2.3 Assessment

The proposal is aligned with NHS Borders' Clinical Strategy strategic emphasis on prevention, care closer to home and stronger community services. It would create a more consistent community resource to which NHS services can refer people whose needs include inactivity, reduced confidence, social isolation or support to maintain wellbeing alongside, or following, clinical intervention.

With the development of a joint and integrated delivery plan, potential benefits to NHS Borders include:

- Additional structured wellbeing and community support options for Primary and Secondary Care services.
- A practical onward pathway from Walk-In Clinics and the planned Community Hub for people who would benefit from non-clinical wellbeing support and physical activity.
- Opportunities to support recovery, self-management, mobility, confidence and social connection, including transitions from clinical rehabilitation to community activity.
- Greater consistency in access to physical activity, cultural and social opportunities across localities.
- A jointly governed mechanism for testing whether a coordinated local model improves outcomes and adds value within the Scottish Borders context.

On balance, recognising the strategic alignment of the proposal and the benefits of physical activity and access to social capital, it is recommended that the Board endorses the proposal and asks the Integration Joint Board to consider funding it. A joint assessment of impact should be undertaken at six months by NHS Borders, Live Borders and Scottish Borders Council.

2.3.1 Quality/Patient Care

The programme could increase the range of person-centered support available to people with long-term conditions, inactivity, frailty, social isolation or low mood. However, appropriate referral criteria, clinical governance arrangements, information sharing and escalation routes will be required. Clinical services must remain responsible for clinical assessment and treatment; the programme should complement rather than replace evidence-based healthcare or rehabilitation. A collaboratively agreed delivery and evaluation plan will support the safe and effective delivery of a combination of treatment, care, and support

2.3.2 Workforce

Live Borders proposes additional coordination, coaching and administrative capacity. Delegated services and NHS Borders will be required to identify capacity to design pathways, agree referral criteria, support staff awareness and participate in evaluation. An implementation plan therefore must be jointly agreed and should quantify this NHS staff contribution and ensure that referral processes do not impact on current performance or create disproportionate administrative demand for clinical teams.

2.3.3 Financial

Period	Total programme cost	Contribution requested	Funding recommendation
2026/27 set-up: 3 months	£125,903	£62,952	Integration Joint Board funding consideration requested
2027/28: Year 1	£301,042	£150,521	Integration Joint Board funding consideration requested
Beyond Year 1	Not committed	Not committed	Further Board decision following evaluation

The proposal presented by Scottish Borders Council is a three-year phased programme. NHS Borders has fully committed its available resources for 2026/27 to delivery of the NHS Borders Clinical Strategy and is therefore not in a position to fund the proposal from its existing resources. However, as the proposal aims to improve community health and wellbeing, Board members are asked to refer this proposal to the Scottish Borders Integration Joint Board (IJB) to consider funding the partner contribution and jointly developing a delivery and evaluation plan to inform any future funding decisions. The Integration Joint Board (IJB) is asked to consider the proposed set-up and first full-year funding through its established financial governance route. Any further investment would require a separate decision informed by a six-month assessment of impact, subsequent year-end evidence, affordability and comparison with other priorities.

2.3.4 Risk Assessment/Management

Risk	Potential impact	Mitigation
Programme widens inequalities	Lower uptake by rural, deprived or less mobile groups	Completion of Equality Impact Assessment to identify equality issue and build mitigations into the delivery plan. Monitor uptake and completion by locality and relevant protected characteristics, and adapt delivery locations and access arrangements.
Inappropriate referral or substitution for clinical care	Delay or dilution of necessary clinical intervention	Agree eligibility, exclusion, escalation and feedback arrangements with Primary and Secondary Care services.
Demand increases by identifying unmet need	Additional pressure on clinical services	Monitor onward clinical referrals and unmet need; do not assume demand reduction in financial planning.

Risk	Potential impact	Mitigation
Future affordability	Pressure to continue funding despite wider financial constraints	Make continuation subject to a further Board decision and explicit assessment of opportunity cost.

2.3.5 Equality and Diversity, including health inequalities

The programme has the potential to improve access to wellbeing support. Rurality, transport, cost, digital access and confidence may affect participation. Evaluation should therefore include reach, uptake, completion and outcomes by locality and relevant population groups, with targeted action where inequalities are identified. The proposal states that an Integrated Impact Assessment Stage 1 has been completed by the programme sponsor. As this proposal is a new provision, a full Equality Impact Assessment will be required to meet the Public Sector Equality Duty (PSED) and inform decision making.

2.3.6 Climate Change

The proposal reports no anticipated negative climate effects and intends to deliver within communities to reduce travel distances. Final pathway and delivery design should consider travel requirements for participants and staff and maximise use of accessible local venues.

2.3.7 Other impacts

Information governance, consent, data sharing and reporting arrangements must be agreed before referrals commence. The evaluation dataset will be proportionate, use clearly defined measures and enable partners to distinguish activity, participant outcomes, equity of access and any changes in healthcare use.

Communication, involvement, engagement and consultation

The proposal has been developed by Scottish Borders Council and Live Borders and seeks joint commissioning. Subject to approval, implementation should include engagement with Primary Care, Secondary Care, Allied Health Professionals, Mental Health, Public Health, health and social care partnership services, Walk-In Clinic teams, Community Hub planners and relevant third-sector partners. Patient and participant experience should form part of the six-month assessment.

Route to the Meeting

- Scottish Borders Council, 20th August 2026: proposal approved subject to matching agreement from NHS Borders.
- Borders NHS Board: endorsement and referral to the Integration Joint Board sought.

2.4 Recommendation

The Board is asked to:

1. Note that NHS Borders has fully committed its available resources for 2026/27 to delivery of the NHS Borders Clinical Strategy and cannot fund the proposal from its existing resources.
2. Request that the Integration Joint Board considers funding the proposed partner contribution of £62,952 for the three-month set-up period in 2026/27 and £150,521 for the first full programme year in 2027/28, through its established financial governance route.
3. Require the development of a collaboratively agreed delivery and evaluation plan with a joint assessment of impact at six months jointly between Scottish Borders IJB, NHS Borders Public Health, Live Borders, and Scottish Borders Council to inform any subsequent planning and decision on funding beyond Year 1.

Suggested assurance level:

- Systems and Processes: Moderate Assurance.

List of appendices

- Appendix 1 – Early Intervention, Prevention and Social Prescribing Programme Proposal, Scottish Borders Council, 20th August 2026.



EARLY INTERVENTION, PREVENTION & SOCIAL PRESCRIBING PROGRAMME PROPOSAL

Report by Director of Resilient Communities

SCOTTISH BORDERS COUNCIL

20 August 2026

1 PURPOSE AND SUMMARY

- 1.1 This report proposes the expansion of Early Intervention and Prevention community based activities within the Scottish Borders to support local and national strategies to reduce health inequalities, help to address a growing problem of loneliness and social isolation, improve the overall wellbeing of the local population and thereby reduce the burden on Health and Social Care services. It is proposed that Scottish Borders Council and NHS Borders jointly commission Live Borders to provide a structured programme to help address these challenges and encourage people to live and sustain healthier lifestyles. The impact of the programme will, if approved, be evaluated and reported back to Elected Members for the approval of next steps.**
- 1.2 The Scottish Borders is facing a growing range of health and wellbeing challenges as a result of socio-economic factors, and an ageing population. The Borders has the fifth highest proportion of older adults in Scotland, many of whom are living with at least one long-term health condition.
- 1.3 The consequences of not maintaining a healthy and active lifestyle are significant, with negative consequences for both physical and mental wellbeing. For individuals, this can mean poorer physical and mental health, reduced independence, lower self-esteem, increased risks of chronic health conditions, and reduced quality of life. For communities, the poor health of individuals can contribute to increased social isolation, reduced community cohesion and resilience and widened health inequalities. Such Health inequalities persist within the Borders and a significant proportion of GP appointments are often linked to non-clinical demand. For wider public services, particularly health and social care the consequences can include greater demand for support, increased costs, poor recovery times from surgery, and added pressure on already stretched resources.
- 1.4 The NHS Borders Clinical Strategy (2025-2030) has a focus on prevention and the development of community-based programmes that support

physical and mental wellbeing through the use of social prescribing and targeted early interventions.

- 1.5 [Public Health Scotland's tiered approach to physical activity interventions](#) states that physical activity is an effective treatment in the management and prevention of many long-term conditions, where even small increases in activity can benefit health.
- 1.6 This 'Early Intervention & Prevention' proposal contributes positively to these health strategies and builds on the existing exercise referral programme delivered through Live Borders, broadening opportunities to incorporate cultural, creative, and social activities such as creative writing, arts, crafts, games, and physical activity programmes.
- 1.7 Investment in a coordinated social prescribing programme can deliver:
 - Improved physical health through increased participation in physical activity and healthier lifestyles.
 - Improved mental health and wellbeing through greater social connection, confidence and resilience.
 - Reduced loneliness and social isolation, particularly among older adults, vulnerable groups and those living in rural isolation.
 - Better self-management of long-term conditions, helping people live well for longer.
 - Reduced health inequalities by targeting support towards those facing the greatest barriers to good health.
 - Increased community participation and resilience through stronger connections to local services, groups and activities.
 - Reduced pressure on primary care and wider health and social services by addressing issues earlier, providing non-clinical or service intervention, preventing avoidable deterioration in health and wellbeing.
- 1.8 Investment in social prescribing is an investment in prevention. It creates a bridge between health and social services and community assets, enabling people to access the right support at the right time while improving physical health, mental wellbeing and social connectedness. For the Scottish Borders, social prescribing offers a practical, evidence-based solution that supports national and local priorities, improves outcomes for residents and contributes to a more sustainable health and social care system.
- 1.9 This paper is intended as a starting point for the development of a wider preventative health and wellbeing approach, with a particular focus on physical activity and cultural participation as evidence-based methods of improving health, wellbeing and quality of life outcomes. While the proposed programme concentrates on these areas in the first instance, it is recognised that improving population health requires a broader whole-system approach, including healthy eating, food growing initiatives, the use of parks and greenspaces, and other preventative interventions, all of which have an important role to play in supporting long-term wellbeing.

The proposed model is therefore designed to be incorporated into a wider social prescribing framework as these complementary elements are further developed through partnership working with Live Borders, NHS Borders, Scottish Borders Council and community organisations. Further work will be required to identify and link existing pathways such as clinical dietetic pathways with the programmes. Over time, these partnerships will establish a comprehensive and integrated system of support. Many components of a whole system for social prescribing exist, but this paper addresses one of the biggest gaps, physical activity and creative and cultural activities.

2 RECOMMENDATIONS

2.1 It is recommended that Scottish Borders Council:

- a) Notes the importance of early intervention and prevention in maintaining and improving the health of the Borders population;**
- b) Subject to a matching agreement from NHS Borders, agrees to fund 50% of the total programme costs which for the Council will equate to £650,617 for an initial period of three years from 2027/28 including a set-up phase of three months in 2026/27;**
- c) Agrees that the costs for 2026/27 will be identified through the in-year budget monitoring in the first instance but if not affordable, or there is a shortfall a draw down would be made from the change fund;**
- d) Agrees that regular reporting of this is provided to the External Services/Providers Monitoring Group with a full evaluation report being brought back to Council at the end of the three year programme; and**
- e) Ask officers to refer the paper on to the Board of NHS Borders for their approval of 50% of the total funding required.**

3 BACKGROUND

Early Intervention, Prevention and Social Prescribing – Strategic Context

- 3.1 The Scottish Borders is facing a growing range of health and wellbeing challenges associated with demographic trends, which are placing increasing pressure on health and social care services, whilst healthy life expectancy remains significantly lower than overall life expectancy. Health inequalities continue to persist, particularly in areas experiencing deprivation, where poorer health outcomes, inactivity and social isolation are more prevalent. Research consistently demonstrates that many people present to primary care and social services with wider social, emotional and wellbeing needs that cannot be addressed through clinical interventions alone.
- 3.2 To respond to these challenges, there is a clear need to strengthen prevention and early intervention approaches that empower people to take greater ownership of their health, maintain independence, improve wellbeing and remain connected within their communities.
- 3.3 The proposed Early Intervention, Prevention and Social Prescribing Programme aligns strongly with the NHS Borders Clinical Strategy 2025-2030, which places prevention, care closer to home, reducing health inequalities and supporting wellbeing across the life course at the centre of service transformation. The strategy specifically highlights the importance of community-based approaches, social prescribing and early intervention to improve outcomes and support sustainable healthcare delivery
- 3.4 The proposal also supports the ambitions of Active Scotland, which seeks to enable more people to be active more often, reduce inactivity, improve wellbeing and create resilient communities through a whole-system approach to physical activity. Social prescribing provides an effective route into cultural activity, physical activity, sport, active recreation and community participation, particularly for those who are inactive, isolated or living with long-term conditions.
- 3.5 The programme directly contributes to the priorities within the Scottish Borders Sport and Physical Activity Strategy, particularly Priority 6: Active Health and Social Care, which aims to embed physical activity within routine health and social care pathways. The strategy recognises the role that physical activity plays in improving physical health, mental wellbeing, reducing social isolation, reducing inequalities and supporting healthier communities and connecting communities.
- 3.6 It also supports delivery of the Scottish Borders Community Plan 2023-2033, specifically the Good Health and Wellbeing Theme, which seeks to improve access to services, reduce health inequalities and develop a joined-up system of social prescribing across the Borders. Community Planning Partnership reports have already identified social prescribing as a key mechanism for connecting NHS services, Wellbeing Services, What Matters

Hubs, Local Area Coordinators and third-sector organisations to address the wider determinants of health.

- 3.7 The proposal builds upon the existing Live Borders Activity Referral Programme and adopts a tiered approach consistent with Public Health Scotland best practice. Physical activity is recognised as one of the most effective interventions for preventing and managing many long-term conditions, with even small increases in activity delivering significant health benefits.
- 3.8 Through close partnership working with NHS Borders, Public Health Scotland, Scottish Borders Council and community organisations, the programme will support people to take an active role in managing their own health and wellbeing by using recognised behaviour change approaches.

4 EARLY INTERVENTION & PREVENTION PROGRAMME

Proposed Social Prescribing and Physical Activity Pathway

- 4.1 The programme has been designed to follow Public Health Scotland's Best Practice tiered approach to social prescribing.

Scotland's Tiered Approach to Physical Activity Interventions
Full table at *Appendix 1*.



Link to full paper - <https://publichealthscotland.scot/publications/scotlands-tiered-approach-to-physical-activity-interventions/>

- 4.2 The programme supports people with existing, or at risk of developing, long-term conditions to make meaningful changes to their lifestyle by delivering quality person-centred activities and the use of recognised

behaviour change techniques. The programme will be implemented in a phased approach over 3 years and remains flexible to grow further and reflect the needs of the users. The introduction of Livewell Connect and the expansion of Livewell Referral will also increase the capacity to deliver sessions deeper within our communities.

- 4.3 The table below provides a brief overview of the two programmes being proposed, and who will benefit. The focus of this proposal is adults (age 16+); children and young people are currently engaged by Active Schools, which provides extra-curricular physical activity and wellbeing opportunities. Targeted children and young people's interventions will be incorporated and will be further developed by Live Borders with Active Schools and other key stakeholders. The target is to have a recognised youth and family social prescribing pathway in year two.

	Tier Two - Livewell Referral	Tier Three - Livewell Connect
Age of participants	Adults 16+	Adults 16+ Except youth gym (12-18yrs)
PHS tier (1-5)	Tier 2 intervention Specialised physical activity and health programme.	Tier 3 intervention Community programme
Referral/self-referral	referral	both
Target audience	• Inactive • Living with existing health conditions • Have health risk factors such as overweight, raised blood pressure, anxiety or stress. • Socially isolated	• Inactive • Living with managed/stable health conditions • At risk of developing health conditions due to inactivity • Motivated and ready for change, needing little support
Support	• Delivered by qualified Exercise Referral Instructor • Require one to one behaviour change support to implement lifestyle change • Require support/advice to increase activity and be active independently	• Programme can be delivered by qualified gym instructor, coach or volunteers. • Only require brief behaviour change advice • Requiring low levels of support to be active on their own
Benefits	Manage or reduce symptoms of existing condition(s), improve mobility and flexibility, reduce pain, weight loss, muscle strengthening. Reduce social isolation, increase activity levels, increase connectedness to community, improve	Reduce social isolation, increase activity levels, increase connectedness to community, improve feeling of physical and mental wellbeing, increase confidence and self-esteem, improve mood.

	feeling of physical and mental wellbeing, increase confidence and self-esteem, improve mood.	Reduce risk of developing health conditions.
Example Activities	• Strength and Mobility • Supported Gym • Gentle Movement • Health Yoga • Falls Class	• Board games sessions • Book Groups • Arts/creative sessions • Health Walks • Seated Fitness

4.4 **Tier Two - Livewell Referral**

The scope of this existing programme will be expanded to increase capacity, allowing it to further support people living in our communities with long-term health conditions, with a focus on NHS patients on waiting lists for lower limb arthroplasty and for frailty patients.

This links to **Tier 2** of Scotland's tiered approach to physical activity interventions. Livewell Referral will provide 12 weeks of **free access**, including ongoing support from a Health Instructor, for people referred by a health or social care professional. Livewell Referral focuses on behavioural change and lifestyle planning, giving access to a wide range of specialist classes, swimming and supported gym access.

Livewell Referral		
Programme	What is it?	Who is it for?
Livewell Referral programme	Referral programme for adults with long-term conditions providing 12-weeks of support and behaviour change advice to improve or manage symptoms through increased physical activity.	Adults 16+ living with long term conditions affecting day to day living such as MSK, Mental health, Cardiac, Respiratory, Frailty, Cancer, Weight management
Falls Prevention	Sits within Livewell Referral programme. A tailored 12-week physical activity programme to reduce the risk of falls	Adults (16+) who have had or are at risk of falls

4.5 **Tier Three - Livewell Connect**

Livewell Connect is a completely new programme and will focus on inactive/sedentary people who are at risk of developing long term health conditions. This programme links to **Tier 3** of Scotland's tiered approach to physical activity interventions. Livewell Connect will deliver **12-weeks of free access** to rolling sessions in each locality incorporating elements of physical and cultural activity. This programme will welcome both self-referrals and referrals from health and social care professionals. Individuals will be triaged via a 1:1 consultation prior to first session.

Activities will encourage relationship and confidence building and lifestyle change and include:

Livewell Connect		
Programme	What is it?	Who is it for?
Inside Out	12-week rolling Social Prescribing programme delivering non-medical community-based activities encompassing both physical activity and culture	Adults experiencing social isolation, inactive/sedentary lifestyle, low mood/anxiety. At risk of developing LTC
Bump Boost & Good Boost	12-week water-based programme delivered via waterproof tablets	Bump Boost: Pregnant women experiencing issues with social isolation, diabetes, weight management, musculoskeletal issues
		Good Boost: Adults 16+ experiencing MSK and frailty issues
Youth Supported Gym/class sessions	Gym or studio based sessions for young people aged 12-16	Young people having difficulty engaging in school and/or experiencing issues with socially isolation, weight management, poverty, health inequalities.

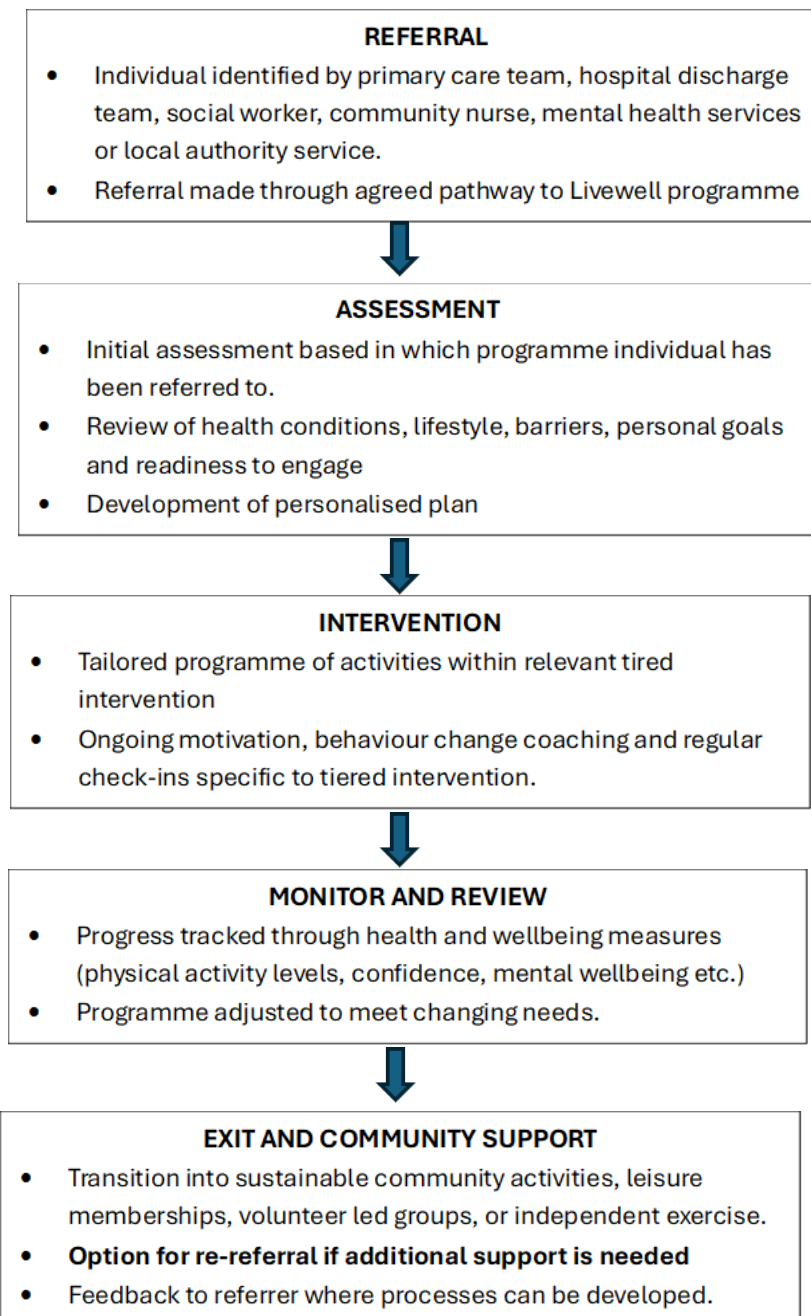
- 4.6 The table below shows the number of available places per year for the current Live Borders Health programme, and the number created for the duration of the funded programme, in line with the phased rollout.

Tier 2 Programme	Current	Year 1 (27/28)	Year 2 (28/29)	Year 3 (29/30)
Livewell Referral	600	900	1,050	1,200
Falls Prevention	100	130	195	260
Tier 3 Programme				
Inside out	0	800	1,200	1,600
Good Boost & Bump Boost	160	720	960	960
Youth Supported Gym	0	150	225	300
TOTAL	860	2,700	3,630	4,320

4.7 Pathway Development

Funding this programme would enable coordinated pathways to be developed between the Live Borders Livewell Programme and health and social care systems in the region. This would allow individuals to receive the right support at the right time, reduce avoidable GP and social care appointments, support hospital discharge, prevent deterioration of long-term conditions, social isolation and help people maintain independence. By integrating clinical and community services, the pathways support prevention, improve outcomes and reduce pressure on services.

Please see the flow chart below, describing a typical pathway.



4.8 Areas identified for pathway development include Falls, Social Services, Reablement, MSK physio and Mental Health Services.

4.9 Live Borders will support wider **Tier 3** opportunities within the organisation such as gentle exercise, book groups and games sessions, to provide sustainable long-term activity options for customers at a low cost.

Live Borders will also support people within **Tiers 4 and 5** through mainstream activity across Leisure and Culture while also signposting alternative community providers such as Walk It, local sports clubs, other cultural activity, and volunteering opportunities, where appropriate.

4.10 Live Borders is committed to ensuring that residents across the Scottish Borders are aware of the wide range of opportunities available to support their health and wellbeing and are empowered to take greater control of

their own health outcomes. Through a coordinated programme of marketing, communications and community engagement, Live Borders will promote both programme activities and wider community-based opportunities, making it easier for individuals to identify support that meets their interests, needs and circumstances. This will include the use of targeted campaigns, digital platforms, local networks, health and community partners, participant testimonials and community champions to raise awareness and encourage participation. Particular emphasis will be placed on promoting self-referral and helping people understand the positive benefits that physical activity, cultural engagement and community participation can have on both physical and mental wellbeing.

Recognising that awareness is often a significant barrier to engagement, Live Borders will work closely with partners to develop clear and accessible information about available services and opportunities. The aim is to create a culture in which residents feel informed, supported and confident to take proactive steps towards improving their health and wellbeing. By showcasing local opportunities, sharing success stories and providing clear pathways into activities and support services, Live Borders will play a key role in connecting people with interventions that can help them live healthier, more active and more independent lives

4.11 Additional Opportunities

There is also the possibility to explore the following options to support the reduction of NHS waiting lists and ease the transitions for patients from clinical based interventions to community-based interventions (Activity referral). This links to **Tier 1** of Scotland's tiered approach to physical activity interventions.

Following clinician led support as detailed below, patients can be referred to tier 2 or 3 activity, or where appropriate can be signposted to tier 4 or 5 activity.

Other		
Programme	What is it?	Who is it for?
Community Appointment Days	Partnership working with NHS and other 3rd sector providers to facilitate mass appointment days for NHS services (e.g.) MSK physio. NHS Lanarkshire Community Appointment Day	Individuals/target groups identified in partnership with NHS
Facilitated clinical rehab	Access to gym and studio spaces within Leisure Centres during quiet periods to allow NHSB physio and OT teams to deliver clinical rehab (supporting the transition from clinical to community intervention)	Patients working towards discharge but still requiring clinician led intervention.

	Space can be offered free of charge for off peak or low volume spaces where supporting strategic pathways.	
Functional Fitness MOT's	Support services providing fitness and mobility checks with appointments available to support lifestyle change and initial uptake of activity	Programme supports wellbeing for staff employed by Scottish Borders Council, NHS Borders and Live Borders by supporting staff to reduce health risks.

4.12 Exit routes and onward pathways from each tier are outlined in the table below. The programme adopts an open-access, person-centred approach, enabling individuals to enter at the tier that best reflects their needs and readiness to engage. Participants are supported throughout their journey by the Live Borders Health Team, who help facilitate progression between tiers and access to appropriate onward pathways.

Programme tier	Onward pathways on completion of programme
Tier 1 – Clinical pathway	Referral to tier 2 or 3 Live Borders programmes where appropriate.
Tier 2 – Physical Activity Referral	- Self-referral to tier 3 activities, - Supported to access tier 4 or 5 programmes (within Live Borders or wider community). - Option to complete 2nd cycle at tier 2 at the discretion of Health Team. - Option to remain in tier 2 programme where appropriate on payg or reduced cost membership options
Tier 3 – Community Activity for Health	- Following completion of 12-week Inside Out programme, clients can move into other Live Borders led tier 3 programmes indefinitely. - Supported access to tier 4 or 5 activities (within LB or wider community) on payg or membership options. - Option to complete 2nd cycle of 12-week programme at the discretion of Health Team
Tier 4 – Signposted activity	- Customers can engage with mainstream activities using payg or membership options - Can seek –referral to tier 2 programme when meeting criteria - Can seek referral or self-refer to tier 3 programme when meeting criteria
Tier 5 – Mainstream activity	- Customers can self-manage physical activity - Can seek –referral to tier 2 programme when meeting criteria - Can seek referral or self-refer to tier 3 programme when meeting criteria

4.13 On completion of the 12-week funded programme, clients will be eligible to maintain access to supportive sessions over the long-term. Live Borders is committing to providing the next 4 weeks free of charge to support continued engagement, before moving clients to low-cost pay-as-you-go or

membership options. This proposal recognises that many clients will require long-term support to maintain or manage their health, while some will move onto mainstream activity.

4.14 Full details of each of the programmes set out in the sections above are included in *Appendix 2*.

5 STAFFING, TRAINING & EQUIPMENT REQUIREMENTS

- 5.1 Having an appropriate level of trained staff in place to deliver the Early Intervention, Prevention & Social Prescribing programmes is critical for success.
- 5.2 In some instances this will require additional hours for existing staff; for others it requires new staff to be employed and trained. There will also be a requirement for additional equipment. The table below outlines the staffing requirement for all of the programmes set out in Section 4 of this report.

Role	Description
Health Interventions Programme Assistant Lead	To support the Health Interventions Programme Lead in the delivery, implementation and evaluation of the project.
Livewell Coordinator x 2	To triage referrals and coordinate the delivery of the Livewell Connect and Livewell Referral programmes.
Lead Health Interventions Coach	To lead and support the Health Interventions Coaching team.
Lead Connect Coach	To lead and support the Livewell Connect Coaching team.
Health Interventions Coach	To deliver specialist exercise classes and support clients throughout the programme.
Connect Coach	To deliver 'Inside Out' and support clients throughout the social prescribing programme.
Youth Gym Instructor	To deliver gym and exercise class sessions to young people.
Youth Gym support staff	To support the instructors and young people accessing the Youth Gym sessions.
Good Boost/Bump Boost Coach	To facilitate the delivery of Good Boost and support participants in the use of the electronic tablets
Admin support	To support the management of referrals, data and evaluation and customer service.

6 IMPLICATIONS

6.1 Financial

The annual costs of the programme are shown in the table below:

Expenditure/Costs	26/27 (3 months)	27/28	28/29	29/30
<u>Staffing</u> Includes staff costs, uniforms and travel	£45,399	£211,922	£351,227	£429,179
<u>IT and Equipment</u> Includes IT equipment, exercise equipment, licences and facility hire.	£45,400	£62,620	£67,663	£62,770
Training	£15,104	£11,500	£10,754	£9,339
Marketing	£20,000	£15,000	£7,500	£7,500
TOTAL	£125,903	£301,042	£437,144	£508,788

50%	£62,952	£150,521	£218,572	£218,572
Tier Two New Places	0	1030	1245	1460
Tier Three New Places	0	1670	2385	2860

Funding Proposal

The proposal is that this is funded jointly by Scottish Borders Council and NHS Borders with 50% of the funding being provided by each of the funding partners.

The Council's share of the set up funding totalling £63k in 2026/27 will be considered as part of the in-year monitoring position as the financial year progresses. Should this additional cost be unaffordable within existing budgets, the shortfall will be drawn down from the Change Fund on the basis that this proposal represents an opportunity for the Council to reprioritise resources through making an upfront investment in early intervention and prevention in order to reduce demand on services in the future. The budget requirement in the following 3 years from 2027/28 (2027/28 - £150k, 2028/29 & 2029/30 - £219k) as shown in the table above will be considered through the Council's 2027/28 financial planning process.

It should be noted that SBC already fund 600 tier two places currently through the Live Borders Management Fee. This proposal is additional to that existing commitment.

Monitoring Impact and Return on Investment

In addition to reporting on activity and outcomes, the programme will place a strong emphasis on evidencing social, health and economic value. This will include monitoring the extent to which participation contributes to reduced demand on health and social care services, supports independent living, improves wellbeing and strengthens community resilience. Establishing a clear evidence base will be essential in demonstrating the return on investment associated with preventative approaches and in supporting future funding and service planning decisions by partners.

To ensure appropriate oversight and accountability, six-monthly performance reports will be presented to partners setting out progress against agreed KPIs, key achievements, emerging challenges and opportunities for further development. These updates will provide an opportunity to review delivery against objectives, assess the effectiveness of interventions and consider any changes required to maximise impact. Reporting will also incorporate outcome data, participant experiences and examples of good practice to provide a comprehensive picture of programme performance.

It is proposed that a Social Prescribing Partnership Group be established to oversee the implementation and development of the programme. The Partnership will bring together representatives from Live Borders, NHS Borders, Public Health Scotland, Scottish Borders Council and relevant voluntary, community and third-sector organisations to monitor delivery,

review performance information and identify opportunities for continuous improvement. A key role of the Partnership will be to ensure that individual interventions are not developed in isolation but are linked together as part of a coordinated whole-system approach to social prescribing.

6.2 Risk and Mitigations

NHS Borders and SBC are facing rising pressures as health inequalities persist, the health gap widens and the increasingly older population needs support. Investment is required in the right places to enable these services to continue to function and relive pressure. The National Academy of Social Prescribing states that social prescribing can deliver an estimated return of £9 for every £1 using life satisfaction as a single measure. Scotlands population is expected to fall by 2043; however, the level of illness is expected to rise by 21% (CHSS) showing the pressures being experienced will only continue over time unless radical change is implemented.

Risk

Funding is not agreed for this programme

Implications

- Programme continues as is, unable to grow to meet the demands
- Existing programme is charged for, reducing equity
- Existing programme is unable to meet required geographic reach to provide equitable access

Risk

Unable to grow programme at proposed rate

Mitigations

- Programme has been phased over 3 years to spread recruitment and training time and manage growth
- Clear plan developed with HR and Marketing teams to ensure timely recruitment and broad reach of advertisement.
- Ensure automated referral management system is in place and embedded early to support management of increased referrals
- Flag concerns early via appropriate mechanisms such as Live Borders Board, senior leadership team and Social Prescribing Partnership Group

Risk

Lack of Buy in from health and social care professionals

Mitigations

- Clear communications plan developed with Live Borders NHS Borders and SBC providing clear information on available services and access routes
- Work with Public Health Scotland to support the continued rollout and embedding of the National Physical Activity Pathway.
- Support Sport and Physical Activity Strategy theme 6
- Build relationships with and ensure visibility with local health and social care providers
- Utilise Social prescribing Partnership Group to address concerns, provide support and information, gather feedback etc.

Risk

Scope of project expanding creating unrealistic expectations

Mitigations

- Develop valid KPI's agreed with partners
- Develop robust reporting metrics maintaining focus of project
- Regular reporting to partners, flagging risks and changing remit early
- Utilise Social Prescribing Partnership Group

6.3 **Integrated Impact Assessment**

An Integrated Impact Assessment (Stage 1) has been completed and can be seen in **Appendix 3**.

6.4 **Sustainable Development Goals**

A United Nations Sustainable Development Goals (UN SDG) checklist has been completed and is included at **Appendix 4**. The proposals are most directly aligned with **Goal 3 – Good Health and Wellbeing**. The expansion of the service provision (as proposed) includes working with partners, it encourages community involvement and encourages health lifestyles.

6.5 **Climate Change**

There are no anticipated negative climate change effects arising from this proposed programme. A Climate Change checklist has been completed and is provided at **Appendix 5**, and climate considerations have been considered.

6.6 **Rural Proofing**

The proposed programme is inclusive especially for those living in rural areas. The aim of the programme is to deliver services within communities to limit travel distances. Delivery of the programme will not be limited to Live Borders facilities, so as not to restrict the range of locations. Live Borders will work in partners and 3rd parties in local areas. This will prevent duplication of provision and allow a wider geographical spread. The programme is also designed to cater for a wide-range of conditions factors to ensure that there can be sufficient numbers of participants from less populated communities. **Appendix 6**

6.7 **Protection Impact Statement**

There are no personal data implications arising from the proposals contained in this report.

6.8 **Changes to Scheme of Administration or Scheme of Delegation**

There are no anticipated changes to the Scheme of Administration or to the Scheme of Delegation.

7 CONSULTATION

- 7.1 The Director (Finance), the Director (Corporate Governance), the Chief Officer Audit and Risk, the Director (People Performance & Change) and

Corporate Communications will be consulted and any comments received will be reported to the meeting.

Approved by

JENNI CRAIG

DIRECTOR – RESILIENT COMMUNITIES

Author(s)

Name	Designation and Contact Number
Jenni Craig	Director – Resilient communities, SBC
Catriona McAllister	Chief Executive Officer, Live Borders
Jennifer Knox	Health Interventions Programme Lead, Live Borders

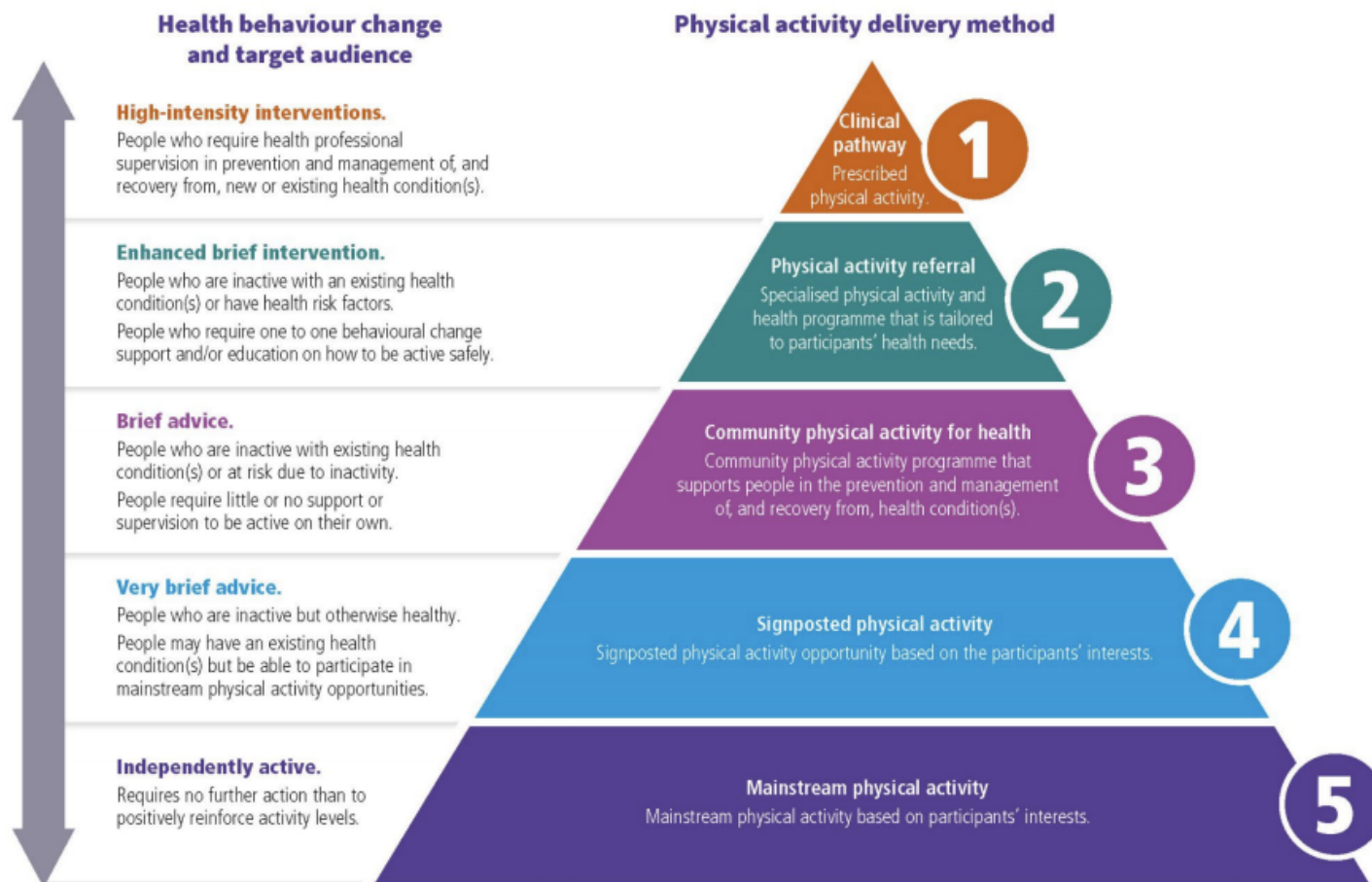
Background Papers: N/A

Previous Minute Reference: N/A

Contact us at Jenni Craig, jcraig@scotborders.gov.uk

Appendix 1: The tiered approach to physical activity interventions

The tiered approach to physical activity interventions



Appendix 2: Livewell – Proposed Activities

Early Intervention & Prevention Activity	NHS Life Stage (Clinical Strategy)	PHS tier	Intervention title	New or Existing	What is it?	Where will it be delivered	Who is it for?	Health Referral/Self-referral	Duration of Intervention	Annual participation number (max capacity)	What do they do next (exit route)
LIVEwell Connect - providing tier 3-4 preventative support to people inactive and at risk of developing LTC's due to inactivity requiring light touch behaviour change intervention	Starting Well	Tier 3	Bump Boost	Existing - requires expansion	Water-based individualised programme delivered via waterproof tablets	Current: Gala Pool; Kelso Pool Expand to: Selkirk Pool, Teviotdale Pool, Eyemouth Pool, Peebles Pool 2 x sessions per week incl 1 in evening or weekend	Pregnant women experiencing issues with social isolation, diabetes, weight management, MSK aches and pains	Both	12 weeks	10 x people per group 8 x groups per year 6 x facilities = 480 participants pa	Access to tablets in Public Swimming sessions as part of existing membership or payg options; Family-based pool activity post birth; Activity Referral; Other mainstream activity
	Living Well Ageing Well	Tier 3	Good Boost	Existing - requires expansion	Water-based individualised programme delivered via waterproof tablets	Current: Gala Pool; Kelso Pool Expand to: Selkirk Pool, Teviotdale Pool, Eyemouth Pool, Peebles Pool 2 x sessions per week incl 1 in evening or weekend	Adults experiencing: MSK issues, frailty issues	Both	12 weeks	10 x people per group 8 x groups per year 6 x facilities = 480pa	Access to tablets in Public Swimming sessions as part of existing membership or payg options. Access other LIVEwell Activity Referral activities using existing reduced cost memberships or payg options
	Growing Well	Tier 3	Youth Supported Gym/class sessions	New	Gym or studio-based sessions for young people aged 12-16	TriFitness; Teviotdale - including trial at Burnfoot.; Selkirk LC; Kelso LC; Eyemouth LC; Gytes LC	Young people having difficulty engaging in school and/or experiencing socially isolation, weight management, poverty	Referral	Sessions ongoing - participants funded for duration	12 x participants per session 52 x sessions annually 6 x facilities = circa 300 participants pa (based on average of 12 weeks attendance)	Maintain attendance. Independently active using mainstream Gyms/classes Youth membership
	Living Well Ageing Well	Tier 3	Inside Out (Social prescribing)	New	Social Prescribing programme connecting individuals with non-medical community-based support encompassing both physical and cultural activities	Berwickshire; Cheviot; Eildon; Teviot and Liddesdale; Tweeddale Coverage will include sessions within identified areas such as Burnfoot, Langlee and Bannerfield	Adults experiencing social isolation, inactive/sedentary lifestyle, low mood/anxiety, at risk of developing LTC	Both	12 weeks	16 x participants per session 12 x sessions to complete 52 x weeks rolling programme 5 x locations 4 x sessions per week =1600 participants pa	Other LIVEwell Connect activities based in physical activity, libraries or museums. Mainstream activity

Early Intervention & Prevention Activity	NHS Life Stage (Clinical Strategy)	PHS tier	Intervention title	New or Existing	What is it?	Where will it be delivered	Who is it for?	Health Referral/Self-referral	Duration of Intervention	Annual participation number (max capacity)	What do they do next (exit route)
LIVEwell Referral - Providing tier 2 early intervention support to people inactive and living with/at risk of developing one or more LTC's, requiring 1:1 behaviour change intervention and support	Living Well	Tier 2	LIVEwell - Activity Referral	Existing - requires expansion	Referral programme for adults with long-term conditions providing support and behaviour change advice to improve or manage symptoms through increased physical activity.	Across the 5 localities within the Borders Region utilising Leisure Centres, Town Halls, Community Centres and other venues Coverage will include sessions within identified areas such as Burnfoot, Langlee and Bannerfield.	Adults 16+ Living with long term conditions affecting day to day living such as: MSK, Mental health, Cardiac, Respiratory, Frailty, Cancer, Weight management	Referral	12 weeks	Based on the assumption capacity is doubled from current circa 600 referral pa =1200 referrals pa	Continue within programme accessing existing reduced cost membership or payg options. Access mainstream activities
	Ageing Well	Tier 2	Falls Prevention Programme	Existing - requires expansion	Class based intervention for people at risk of falling	Eildon; Teviot and Liddesdale; Cheviot; Berwickshire; Tweeddale	Adults (16+) who have had or are at risk of falls	Referral	12 weeks	12 x participants per session 1 x session per week 5 x facilities = 260 participants pa	Can attend Maintenance class or move to Seated Fitness or other Activity Referral or mainstream class where appropriate. Access to reduced cost existing membership or payg options.
Other - Activities supporting NHS clinicians to deliver tier 1 interventions to patients within a community setting	Living Well Ageing Well	Tier 2	Community Appointment Days	New	Partnership working with NHS and other 3rd sector providers to facilitate mass appointment days for NHS services eg. MSK physio	Live Border facilities tbc	Identify target groups in partnership with NHS	referral	1 day	1 x session could support up to 300 patients	Onward referral to LIVEwell programme or other community support

Early Intervention & Prevention Activity	NHS Life Stage (Clinical Strategy)	PHS tier	Intervention title	New or Existing	What is it?	Where will it be delivered	Who is it for?	Health Referral/Self-referral	Duration of Intervention	Annual participation number (max capacity)	What do they do next (exit route)
	Living Well Ageing Well	Tier 1	Facilitated clinical rehab	New	LB to provide access to gym and studio spaces within Leisure Centres during quiet periods to allow NHSB physio and OT teams to deliver clinical rehab - supporting the transition from clinical to community intervention Tweedbank SC; Selkirk LC; Teviotdale LC; Kelso LC; Gytes LC; Eyemouth LC	TBC	Patients working towards discharge who still require clinician led intervention	Referral	12 weeks	6-8 x participants per session 1 x session pw 6 x locations = 2,496 places pa	Patients can then be onward referred to LIVEwell Activity Referral Programme.

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NHS Borders



Meeting:	Borders NHS Board
Meeting date:	Wednesday 7th October 2026
Title:	Finance Report – August 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 BET on 5th October 2026.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Finance Report for the period to the end August 2026

FINANCE REPORT FOR THE PERIOD TO THE END OF AUGUST 2026

1 Purpose of Report

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

2 Recommendations

- 2.1 Members are asked to:

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

- The financial position after five months is £4.4m overspent.
- At current 'run rate' this would result in an outturn overspend of £10.6m.
- Forecast outturn remains £10.0m deficit in line with financial plan.
- Recurring savings delivery after five months is £1.2m (CYE) with an additional £0.8m scheduled for retraction in M06. This still remains significantly below the level required to meet 3% target (£10.0m).
- Achievement of outturn forecast is contingent upon progress towards delivery of savings targets. This remains a high risk to the overall position.

- 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 August 2026 is an overspend of £4.4m. This position is summarised in Table 1, below.

Table 1 ¹ – Financial Performance for five months to end August 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	71,892	69,587	(2,305)	211,526	206,611	(4,915)
Scottish Borders Health & Social Care Partnership	76,387	74,334	(2,053)	174,821	169,736	(5,085)
RRL Expenditure	148,279	143,921	(4,358)	386,347	376,347	(10,000)
Total Non-core RRL Expenditure (Tab 5)	2,445	2,445	0	8,483	8,483	0
FHS non discretionary net expenditure	8,347	8,347	0	20,045	20,045	0
Total RRL Outturn	159,071	154,713	(4,358)	414,875	404,875	(10,000)

- 3.2 Variance is inclusive of unmet savings. Within the year-to-date position there is £3.9m slippage on savings targets. The net operating variance excluding savings is £0.5m overspent.

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.).

- 3.3 HSCP variances exclude Set Aside for large hospital functions, which is reported within NHS Board Services.
- 3.4 The year-to-date variance remains below the level of operational deficit forecast within the financial plan, however this is largely attributable to lower than forecast growth in expenditure on non-pays including prescribing.

4 Core Operational Performance

- 4.1 Table 2 summarises business unit performance after five months.

Table 2² – YTD Performance by Business Unit

Business Unit	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	Variance exc. Savings £m	Unmet Savings £m	YTD Variance £m
Acute Services	129,120	53,491	57,848	(2,906)	(1,451)	(4,357)
Mental Health & Learning Disabilities	26,097	11,171	12,116	(713)	(232)	(945)
Primary & Community Services	128,321	59,965	60,258	199	(492)	(293)
Clinical Support Services	7,770	3,238	2,760	336	142	478
Corporate Services	29,746	12,156	12,371	422	(636)	(215)
Estates & Facilities	25,180	10,473	11,096	(26)	(597)	(623)
Commissioned Healthcare	44,847	18,686	21,412	(1,732)	(994)	(2,726)
Board Non Core Expenditure	5,867	2,445	2,445	(0)	0	(0)
Board Administered	13,989	(12,262)	(16,187)	3,549	375	3,924
Other Operating Income	(12,746)	(4,649)	(5,048)	399	0	399
	398,191	154,713	159,070	(472)	(3,885)	(4,357)

- 4.2 Acute services is reporting a £2.9m overspend on core budget excluding savings. The main drivers of the Acute position (cumulative, August) are Medical staffing (£0.9m overspent, including agency locums), Nursing costs associated with surge capacity (£0.8m, estimated) and non-pays (£1.1m). As detailed last month the costs associated with drugs are moving in an upward trajectory and as at M05 are now showing a £0.1m overspend. There remains a pressure in relation to non-formulary approval for high-cost medicines.
- 4.3 Mental Health & Learning Disabilities continues to report a £0.7m overspend before savings. This is primarily driven by ongoing use of medical agency locums.
- 4.4 Primary & Community Services are reporting an underspend of £0.2m 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.
- 4.5 Clinical support services (Pharmacy) and corporate services are reporting underspends due to ongoing vacancies. Estates & Facilities are reporting a very small overspend. These positions exclude savings, where all areas continue to report shortfall against target.

² Annual budget reported in Table 2 excludes anticipated allocations noted within forecast position in Scottish Government financial performance report (FPR, Table 1).

- 4.6 There is a £1.7m core overspend against Commissioned Healthcare budgets. This is driven by two main areas: tertiary outflow activity to other Health Boards (predominantly NHS Lothian) and continuation of high cost out of area placements for a small number of individuals with complex mental health or learning disabilities requirements.
- 4.7 Board Administered funds includes funds held in reserve not yet distributed to operational budgets. At M05 a benefit of £3.5m 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'). This benefit is non-recurrent.

5 Financial Improvement (Savings)

5.1 Planned Savings

- 5.1.1 As noted in Table 2, the overall financial performance at Month 5 is £4.4m overspent, within which there are £3.9m unmet savings.
- 5.1.2 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 (Recurring)	Savings Plans (Recurring FYE)	% Target With Plans In Place
Acute	£4,235K	£954K	23%
Commissioning	£2,386K	£313K	13%
Corporate	£1,887K	£933K	49%
Estates	£414K	£421K	101%
Facilities	£1,018K	£145K	14%
IJB - MH/LD	£632K	£666K	105%
IJB - PACS	£1,665K	£1,882K	113%
Organisation Wide	£0K	£155K	
Primary Care Prescribing	£766K	£744K	97%
Total	£13,003K	£6,212K	48%

- 5.1.3 Plans identified above demonstrate £6.21m FYE, approximately 48% of the overall target and £3.79m below the level required to meet the financial plan. There has been no significant change from the position reported at M03.
- 5.1.4 As previously reported, the target reported in table 3 represents the residual savings target to be delivered against the three year targets 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).
- 5.1.5 There is a significant risk of further slippage on FYE delivery where the majority of plans remain at Gateways 1 or 2. Table 4 below describes the status of overall plans by Gateway.

Table 4 – FIP Schemes by Gateway

Savings Plans (Recurring FYE), Gateway 1, Gateway 2, Gateway 3, % Of Plans Delivered

BY BUSINESS UNIT

Business Unit	Savings Plans (Recurring FYE)	Gateway 1	Gateway 2	Gateway 3	% Of Plans Delivered
Acute	£954K	£183K	£183K	£588K	61.7%
Commissioning	£313K	£313K			
Corporate	£933K	£774K	£18K	£141K	15.1%
Estates	£421K			£421K	100.0%
Facilities	£145K	£91K	£41K	£14K	9.3%
IJB - MH/LD	£666K	£289K	£75K	£302K	45.4%
IJB - PACS	£1,882K	£1,316K		£565K	30.0%
Organisation Wide	£155K	£155K			
Primary Care Prescribing	£744K	£532K	£125K	£88K	11.8%
Total	£6,212K	£3,653K	£441K	£2,119K	34.1%

5.1.6 Further to the schemes identified above, there are several additional measures identified which are expected to increase savings delivery on a non-recurrent basis in 2026/27, including cost avoidance measures (e.g. agency reduction). A summary of the total plans by business unit is summarised in Table 5.

Table 5 – Total Savings Plans (including non-recurring)

Business Unit	Recurring £000s	Non Recurring £000s	Cost Avoidance £000s	Total £000s
Acute Services	760	879	916	2,555
Mental Health & Learning Disabilities	418	-	1,300	1,718
Primary & Community services	1,873	250	-	2,123
Corporate Services	658	395	-	1,053
Estates & Facilities	521	-	270	791
Commissioned Healthcare	313	-	-	313
Other	155	400	-	555
	4,696	1,924	2,486	9,107

5.2 Actual Savings Delivery

5.2.1 Table 6 summarises delivery of savings reported within Business Unit performance as at August 2026 (M05).

Table 6 – Current year savings achieved as at August 2026

Savings Achieved	Savings Target £000s	Recurring Savings Achieved £000s	Non Recurring Savings Achieved £000s	Total Achieved £000s	Unmet Savings (current year) £000s
Acute Services	4,235	519	242	761	3,474
Mental Health & Learning Disabilities	632	75	-	75	557
Primary & Community Services	2,431	483	-	483	1,948
Corporate Services	1,887	102	228	330	1,557
Estates & Facilities	1,432	-	-	-	1,432
Commissioned Healthcare	2,386	-	-	-	2,386
Other	-	-	396	396	(396)
Total	13,003	1,178	866	2,045	10,958

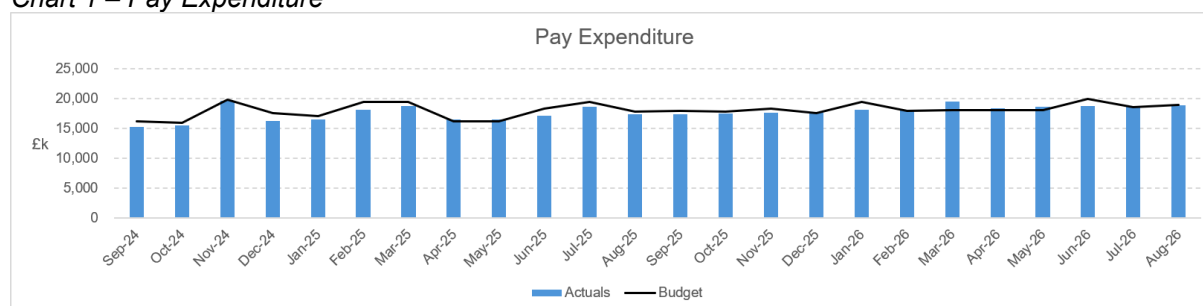
5.2.2 Savings reported above represent the full impact of in year savings (i.e. to March 2027). The year-to-date element of these savings is £1.2m.

- 5.2.3 There are recurring and non-recurring plans sitting at GW3 totalling £1.2m (current Year Effect) which are planned for retraction in M06, and these are not represented in table 6.
- 5.2.4 As noted separately, the financial plan assumes £10.0m savings delivery in 2026/27, in line with SG direction that all Health Boards meet a 3.0% recurring target. On a 'straight-line' basis, this would mean that £4.1m savings should have been achieved by the end of M05. The level of actual savings is well below this and there is therefore a requirement for significant over-delivery through the remainder of 2026/27 in order to meet this requirement.
- 5.2.5 There are several areas of cost avoidance identified within service savings plans which are not reflected within the above table. Work is underway to ensure this element of savings is reported within the overall position. This will include areas where cost pressures highlighted within the financial plan are able to be mitigated and therefore contribution to the net outturn position.

6 Expenditure Trends

- 6.1 The following section is intended to provide context to broader trends in expenditure. This will be developed further in future reports.
- 6.2 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



- 6.3 Within this position, agency expenditure remains high. At end August 2026, total agency spend is £1.6m of which the majority relates to Medical locum cover. Trend usage across Medical and Nursing is described below.

Chart 2 – Medical Agency Costs

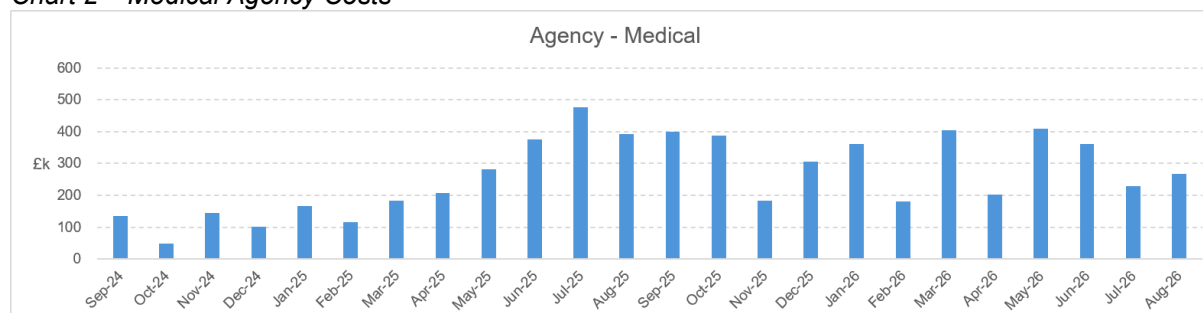
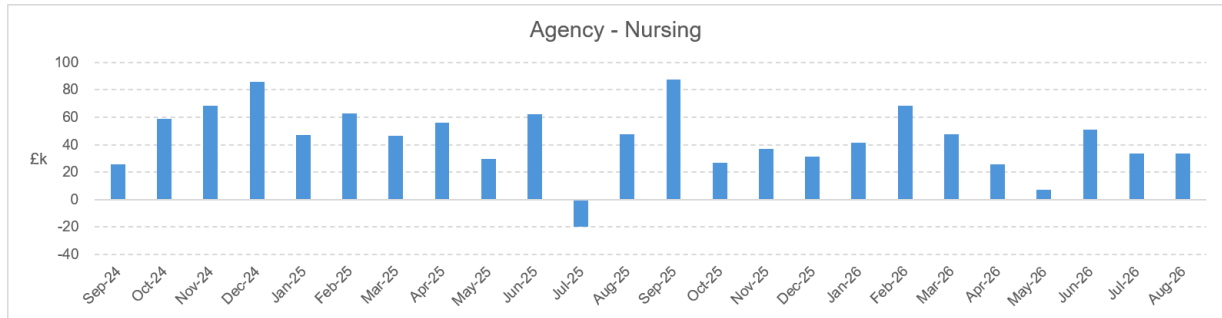


Chart 3 – Nurse Agency Costs



6.4 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.

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

6.6 As at August 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

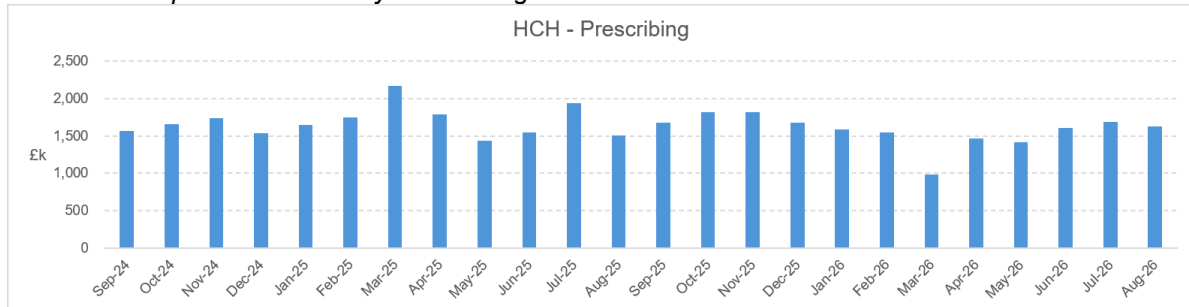
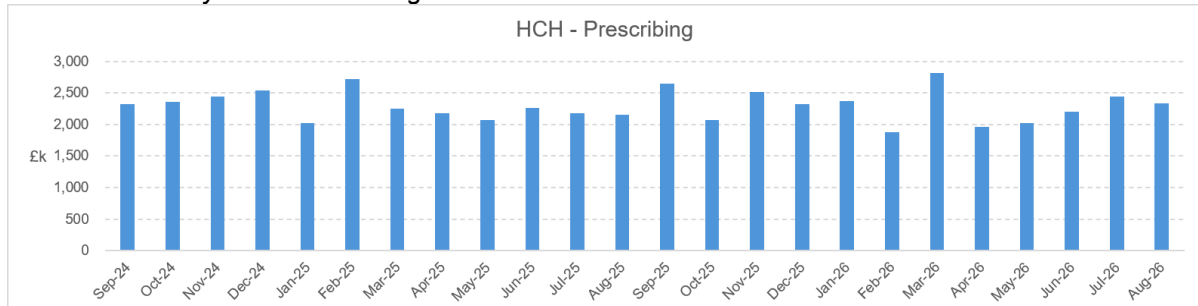


Chart 5 – Primary Care Prescribing Costs



6.7 Within both HCH and PC prescribing there has been an increase in average monthly spend throughout quarter one and into July, then remaining relatively steady into August. A similar increase was exhibited in the same period last year; at this stage it is unclear whether trend will be to sustained growth or mirror the pattern within prior year.

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

7 Scottish Government Oversight

- 7.1 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). This forecast was confirmed at Q1 review and has been discussed with Scottish Government in follow up.
- 7.2 The Health Board remains at Stage 3 of the Scottish Government's Support and Intervention Framework. Conditions required to achieve de-escalation have been set out by Scottish Government and a plan to meet these conditions is being developed. A full update on this plan will be presented at Q2 review.
- 7.3 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.

8 Key Risks

- 8.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 547). This position is actively reviewed on an ongoing basis.

Appendices

- There are no appendices to the report

Author(s)

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Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	Infection Prevention and Control
Responsible Executive/Non-Executive:	Director of Nursing, Midwifery & AHPs
Report Author:	Infection Control Manager

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

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

- Safe

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

Executive Summary

- 2.3.1 At the request of the Clinical Governance Committee, infection prevention and control updates are now presented as exception reports. This report highlights both positive and adverse exceptions.
- 2.3.2 Overall, the report provides moderate assurance that Infection Prevention and Control (IPC) arrangements remain effective. Infection surveillance indicators are stable and NHS Borders infection rates are not significantly higher than the rest of NHS Scotland. The following exceptions are detailed in this report:
- 2.3.4 **Positive exceptions:**
- Healthcare associated *Clostridioides difficile* infection (CDI) and *Escherichia coli* bacteraemia (ECB) remain on trajectory to achieve the interim Scottish Government HAI standards for 2026/27
 - All areas audited for cleaning in July achieved the national standard of over 90%
 - Five of six full IPC audits completed during June and July achieved Green status
 - There have been no outbreak related closures between 1st June and 31st August 2026
- 2.3.5 **Adverse exceptions:**
- Healthcare-associated *Staphylococcus aureus* bacteraemia (SAB) rate is not on trajectory to achieve the interim standard for 2026/27
 - Four of 28 IPC spot checks achieved Red status and one care home achieved Red status.

Infection Prevention & Control Exception Report - August 2026

National Developments

2.3.7 NHS Scotland ten-year Strategy for Infection Prevention and Control

On the 31st July 2026, the Scottish Government published '[An Infection Prevention and Control Strategy for Scotland: Vision and Priority Statements](#)'.

This ten-year strategy sets the following vision along with priority statements for the future of infection prevention and control (IPC) in health and social care settings:

“Ten-year vision: A Scotland where preventable infection is minimised for people accessing, using or providing health and social care”.

The strategy has been developed using a human rights-based approach, recognising that IPC measures should be proportionate, person-led and attentive to the rights, dignity and wellbeing of individuals.

The Strategy sets the following priorities:

- Political commitment, governance, leadership and policies
- Proactive national and local IPC programmes
- IPC integration and coordination
- IPC education, training and IPC career development for health and social care workforce
- Data for action
- Advocacy and communications
- Research, development and innovation
- Collaboration and stakeholders' support

The next phase of the strategy will be the development of the first multi-year action plan covering a three-year implementation period. This will support the realisation of the vision and be led action-planning groups, made up of key stakeholders and representatives from across health and social care.

2.3.8 Transmission Based Precautions

On 10th August 2026, the Scottish Government wrote to Boards ([DL 2026 08](#)) about changes to Transmission Based Precautions (TBPs) within the National Infection Prevention and Control Manual (NIPCM) and Care Home IPC Manual.

The revised guidance will replace the terms 'droplet transmission' and 'airborne transmission' with the single term 'air transmission' and introduce a revised risk assessment process for respiratory infections, including face mask selection.

Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland has issued an implementation bundle and a 6-month bedding-in period has been agreed with Healthcare Improvement Scotland, the Care Inspectorate and the Scottish Government.

The new guidance will be implemented across NHS Borders in September 2026.

Positive Exceptions

2.3.9 Healthcare Associated Infection (HAI) Surveillance

NHS Borders remains on trajectory to achieve the interim 2026/27 Scottish Government HAI standards for healthcare associated *Clostridioides difficile* infection (CDI) and *Escherichia coli* bacteraemia (ECB). Background information is provided in **Appendix A**.

2.3.10 Cleaning Standards

All areas audited during July achieved compliance above the national standard of 90%. NHS Borders cleaning compliance is comparable with NHS Scotland.

2.3.11 IPC Audit - Full Audits

Six full IPC audits were completed during June and July 2026. Five areas achieved Green status and one area achieved Amber status. Recurring good practice included appropriate PPE use, clean and functioning hand gel dispensers, and staff compliance with the dress code.

2.3.12 Infection Outbreaks

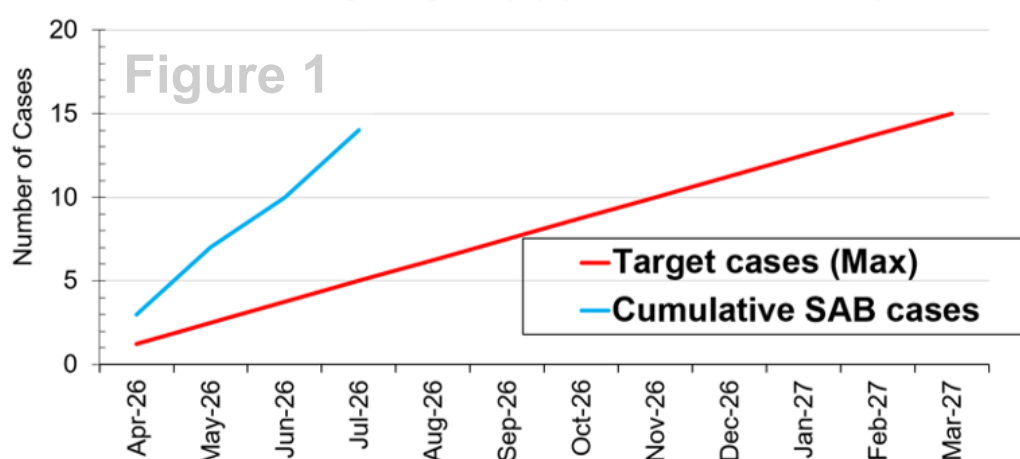
There were no closures due to outbreak in NHS Borders between 1st June 2026 and 31st August 2026.

Adverse Exceptions

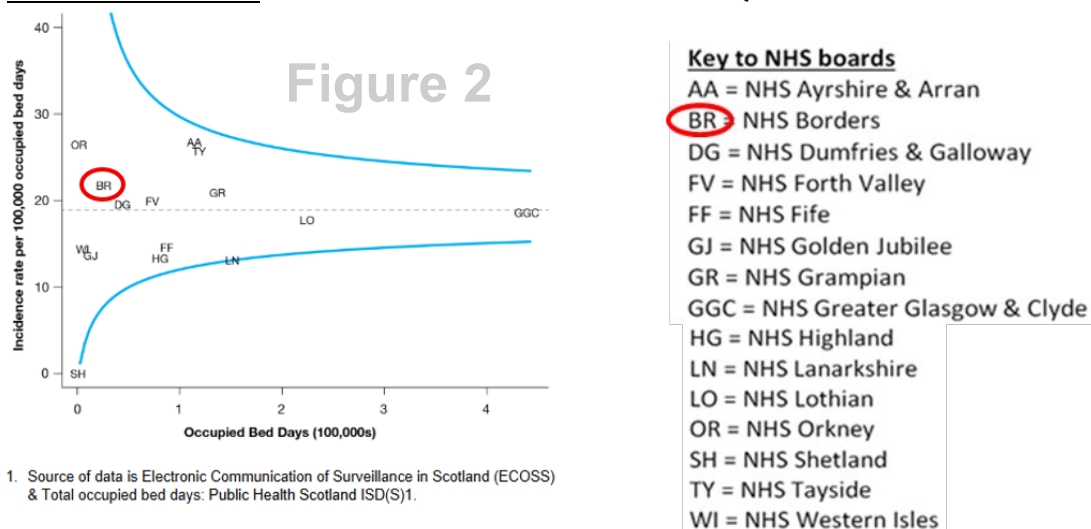
2.3.13 Healthcare Associated *Staphylococcus aureus* Bacteraemia (SAB)

NHS Borders is not currently on trajectory to achieve the interim Scottish Government HAI SAB standard for 2026/27 (**Figure 1**). NHS Borders SAB rates are not significantly higher than the rest of NHS Scotland (**Figure 2** and **Figure 3**), with no statistically significant change in healthcare associated cases since the previous report (**Figure 4**). Background information is provided in **Appendix A** and **Appendix B**.

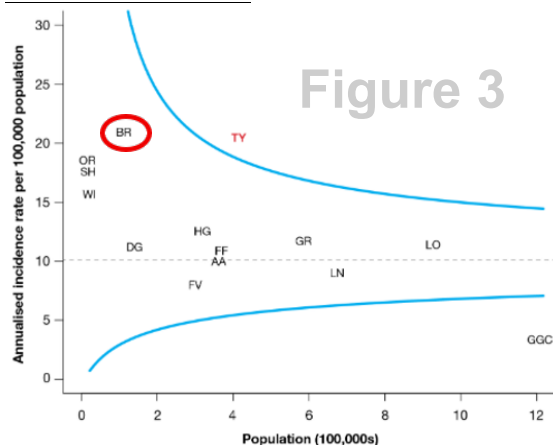
NHS Borders cumulative healthcare associated SAB cases Vs Scottish Government target trajectory (April 2026 - March 2027)

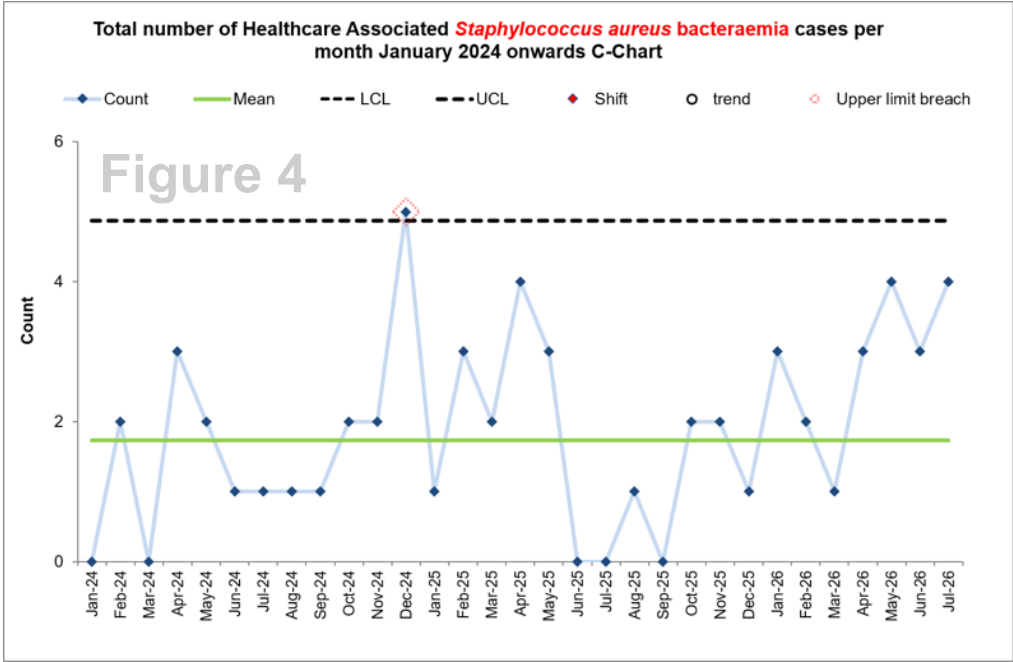


Funnel plot of SAB incidence rates (per 100,000 TOBD) in Healthcare Associated Infection cases for all NHS boards in Scotland in Q1 2026 ¹



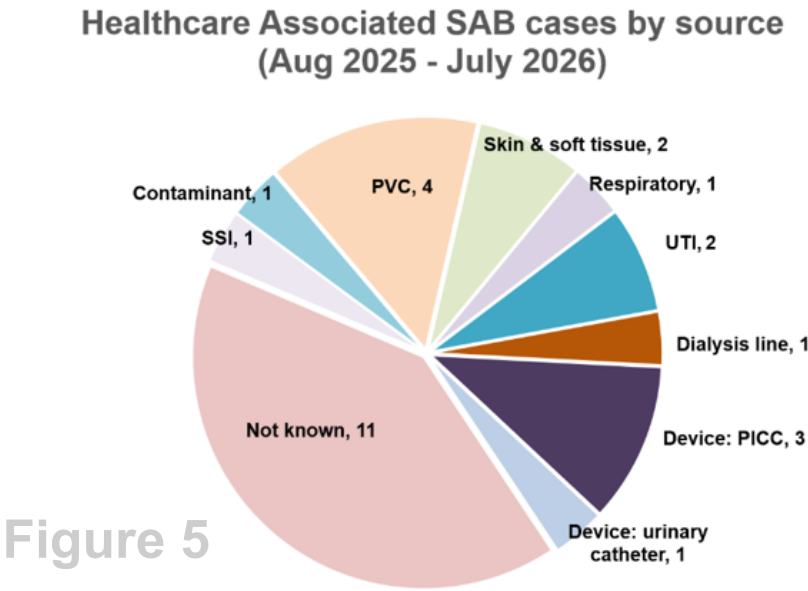
Funnel plot of SAB incidence rates (per 100,000 population) in Community Associated Infection cases for all NHS boards in Scotland in Q1 2026 ^{1,2}





The main known recent causes of healthcare-associated SAB were peripheral venous catheters (PVCs) and peripherally inserted central catheter (PICC) lines (**Figure 5**).

Current Excellence in Care audits show variable completion of PVC insertion and maintenance records. An anonymised patient story of a patient who acquired a PVC associated SAB has been developed for sharing with the Excellence in Care Steering Group and IV Therapy Group.



Following successful recruitment to vacant Infection Prevention and Control Nurse posts, IPC engagement with the IV Therapy Group and associated workstreams will improve. However, it should be noted that the HAI Quality Improvement Facilitator role is now vacant and is currently under review.

The infection surveillance process has been updated to capture identified risk factors for future cases where the cause was '*Not known*'. Given the number of SAB cases with an unknown cause, it is anticipated that this additional information could add extra weight in informing prioritisation of NHS Borders quality improvement activity.

2.3.14 IPC Spot Checks and Care Home Assurance

28 IPC spot checks were completed during June and July 2026:

- 11 areas achieved Green status
- 13 areas achieved Amber status
- 4 areas achieved Red status

Recurring poor practice related to cleaning schedules not being up to date, items stored on the floor in Domestic Services Rooms (DSR) and dirty commodes.

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.

Themes from spot checks and audits are used to inform content of staff education delivered by the Infection Prevention and Control Team.

Two care homes were visited in July. One achieved Amber status and is to be revisited in six months; the other achieved Red status and is due to be revisited in September.

2.3.15 Quality/ Patient Care

Infection prevention and control is central to patient safety.

2.3.16 Workforce

This assessment has not identified any workforce implications.

2.3.17 Financial

This assessment has not identified any resource implications.

2.3.18 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.19 Equality and Diversity, including health inequalities

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

2.3.20 Climate Change

None identified

2.3.21 Other impacts

None identified

2.3.22 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.

2.3.23 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content has been presented to the Clinical Governance Committee.

2.4 Recommendation

Board members are asked to:

- **Discussion** – Examine and consider the implications of a matter.

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

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix A, background explanation (Organisms and Infections)
- Appendix B, background explanation (Graphs and Data)

Appendix A

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 B**Graphs and Data**

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

2.1 Funnel plots

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

2.2 C Charts

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

2.3 G Charts

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

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

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

2.4 U Charts

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

Meeting:	Borders NHS Board
Meeting date:	<i>Wednesday 7 October 2026</i>
Title:	Public Protection
Responsible Executive/Non-Executive:	Executive Nurse Director for Nursing Midwifery and AHPs
Report Author:	Rachel Pulman, Nurse Consultant Public Protection

1 Purpose

- Awareness

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

- 2.1.1 Public Protection remains a fundamental component of safe, effective and person-centred healthcare. NHS Borders is committed to providing leadership, governance and assurance arrangements that support the protection of children, young people and adults at risk of harm. Through ongoing collaboration with partner agencies, workforce development and continuous quality improvement, we seek to strengthen public protection practice and contribute to the shared vision of the Scottish Borders Public Protection Committee (PPC) that *everyone in the Scottish Borders has the right to live free from abuse, harm and neglect*.
- 2.1.2 Public Protection encompasses Adult Support and Protection, Child Protection, Violence Against Women and Girls, Multi-Agency Public Protection Arrangements (MAPPA), and wider safeguarding responsibilities, including the Prevent Duty. These areas require coordinated action across agencies and services to identify risks early, protect individuals and groups at risk of harm and support positive outcomes.

- 2.1.3 Creating and sustaining a culture of prevention, professional curiosity and accountability is a priority for NHS Borders. Public Protection is not the responsibility of a single service or team; it must be embedded within everyday clinical practice and organisational decision-making. This report highlights progress made during the reporting period, partnership activity and ongoing improvement work to ensure that public protection responsibilities are effectively discharged across the organisation.
- 2.1.4 The committee is asked to note the contents of the Public Protection Report and gain assurance that appropriate systems, processes and oversight arrangements are in place to support the protection of individuals at risk of harm. The report demonstrates NHS Borders' commitment to developing a confident and competent workforce, promoting a culture of professional curiosity and ensuring that staff are equipped to recognise concerns, respond appropriately, report effectively and reflect on practice to improve outcomes and reduce the risk of harm.

2.2 Background

- 2.2.1 Public protection in Scotland is underpinned by a comprehensive legislative and policy framework designed to protect children (including unborn babies), young people and adults at risk of harm. NHS Borders has a key role in identifying, responding to and preventing harm through effective partnership working, information sharing and continuous improvement in public protection practice.
- 2.2.2 As a statutory partner, NHS Borders has a duty to cooperate with local authorities, Police Scotland and other agencies in the protection of individuals at risk of harm. All NHS Borders staff have a responsibility to recognise concerns, take appropriate action and contribute to public protection processes when there is a risk of abuse, neglect or harm.
- 2.2.3 Public protection responsibilities are informed by a range of legislation, policy and national guidance, including the Children and Young People (Scotland) Act 2014, the Adult Support and Protection (Scotland) Act 2007, the National Guidance for Child Protection in Scotland (2021, updated 2023) and the Adult Support and Protection Code of Practice (2022). These frameworks support a rights-based, person-centred approach and promote early intervention, prevention and multi-agency cooperation. The NHS Scotland Public Protection Accountability and Assurance Framework(2022) further strengthens governance arrangements by setting out clear lines of accountability and assurance, enabling NHS Boards to evidence compliance with statutory duties and provide oversight of public protection activity.
- 2.2.4 NHS Borders also has statutory responsibilities relating to Violence Against Women and Girls (VAWG), Multi-Agency Public Protection Arrangements (MAPPA) and the Prevent Duty. These duties require effective risk assessment, information sharing, partnership working and support for individuals who may be vulnerable to harm, exploitation or offending behaviour.
- 2.2.5 The Scottish Borders public protection activity is aligned with national priorities including Getting It Right For Every Child (GIRFEC), Equally Safe, trauma-informed practice and Scotland's commitment to protecting and upholding human rights.
- 2.2.6 The Human Rights Act 1998 and the United Nations Convention on the Rights of the Child (Scotland) Act 2024 further highlight NHS Borders' responsibility to ensure that services respect, protect and promote the rights, wellbeing and safety of children, young people and adults.
- 2.2.7 The Scottish Borders Public Protection Committee is committed to delivering a coordinated, person-centred and rights-based approach to public protection. Key strategic priorities include:
- Promoting prevention and early intervention.
 - Strengthening multi-agency collaboration, assessment and information sharing.

- Embedding trauma-informed, person-centred and rights-based practice.
- Supporting staff through effective supervision, training and development.
- Promoting continuous learning and quality improvement.
- Ensuring the voices and experiences of individuals inform service delivery.

2.2.8 The NHS Borders Public Protection Service provides leadership, assurance and support across all areas of public protection through:

- Professional and strategic leadership.
- Expert advice and guidance.
- Workforce learning and development.
- Quality assurance and audit activity.
- Policy development and review.
- Governance and assurance reporting.
- Multi-agency partnership working.
- Promoting learning and continuous improvement.

2.3 Assessment

- Supporting staff to manage complex Child Protection and Adult Support and Protection situations, while recognising the emotional impact associated with protecting individuals at risk of harm.
- Strengthening communication, information sharing, professional challenge and collaborative decision-making across NHS Borders and partner agencies.
- Continuing to embed a culture in which public protection is recognised as everyone's responsibility, supported by leadership, professional accountability and reflective practice.
- Maintaining workforce capability, resilience and compliance with public protection learning requirements amid ongoing service pressures and workforce sustainability challenges.
- Responding to emerging risks, national priorities and inspection activity, including developments relating to child exploitation, harm outside the home, missing children and Bairns' Hoose.
- Reviewing and strengthening public protection policies, procedures and practice guidance to support consistent, effective and evidence-informed practice, including the development and implementation of revised Child's Plan, Chronology and Keeping Children Safe and Well guidance.
- Promoting continuous improvement through partnership working, workforce development and strengthening governance and assurance arrangements across all areas of public protection.

2.3.1 Workforce and Practice Improvement/developments during the reporting period

Successfully secured external funding to commission specialist child protection training delivered by Richard Swan. The programme was attended by practitioners from Health Visiting, School Nursing and the Family Nurse Partnership and was positively evaluated by participants.

The training focused on enhancing critical thinking to support risk assessment and professional curiosity, exploring tools and approaches to strengthen the quality of child protection supervision, and promoting professional resilience when managing complex child protection situations.

Outcome: Feedback from participants demonstrated increased understanding of child protection supervision, analysing and assessing risk, and applying structured approaches to support professional judgement and decision-making. The training has supported practitioners to consider tools to

support more effective risk identification and analysis, improved quality of supervision, greater professional curiosity and a more consistent approach to child protection practice.

'One of the most invaluable training sessions I have attended. Richard, himself, was clearly passionate and had extensive knowledge in the topic which made it very easy to learn from him and engage in reflective conversations. He had the ability to make participants feel psychologically safe and therefore it was easy to ask questions and challenge thinking. I have already used tools he has provided in within my role and signposted others to explore. The training generated a lot of conversation regarding the importance of Child Protection Supervision and the outcomes of children, young people and their families. I plan to continue to share the knowledge from Richard Swan and use the tools and evidence within my daily practice.' Course participant March 2026

Next Steps: Following the training, NHS Borders PP team will continue to review and strengthen its approach to child protection supervision, supported by the updated Child Protection Policy. Work will focus on enhancing assurance and governance arrangements, promoting consistency in supervision practice, and ensuring staff have protected time to pause, reflect and analyse risk. This is particularly important in the context of competing service pressures, as effective supervision supports safe decision-making, staff wellbeing and improved outcomes for children and families.

2.3.2 Adult Support and Protection Practice Improvement

Guidance has been developed to support health professionals and Council Officers undertaking Adult Support and Protection investigations under the Adult Support and Protection (Scotland) Act 2007. The guidance promotes a consistent, proportionate and legally compliant approach to the sharing and review of health information, supporting effective multi-agency decision-making and risk assessment related to Adult Support and Protection referrals specific to harm within a NHS setting.

Outcome: This work strengthens consistency of practice across Adult Support and Protection investigations, clarifies roles and responsibilities, and supports more effective partnership working between health and social work services. The development of a feedback loop between the Public Protection Committee, Patient Safety Team and senior nursing leadership provides enhanced opportunities for organisational learning, governance and assurance, ensuring that themes, learning and improvement actions are identified, communicated and embedded across services.

2.3.3 Adult Support and Protection: Understanding Harm Across the Patient Journey

Learning from Adult Support and Protection (ASP) investigations continues to demonstrate that harm rarely arises from a single event or individual action. Rather, harm is often the result of multiple interconnected factors across the patient journey, including omissions in fundamental care, communication and documentation failures, fragmented transitions of care, organisational pressures, and failures to recognise vulnerability.

A recurring finding is that adults at risk often experience cumulative harm, where a series of omissions or missed opportunities contribute to deterioration in physical health, functional ability, psychological wellbeing, dignity, independence, and safety. Common themes identified through ASP investigations include:

- Failure to recognise and respond to vulnerability, particularly in individuals with frailty, dementia, cognitive impairment, learning disability, or complex care needs.
- Omissions in fundamental care, including nutrition, hydration, personal care and pressure area management.
- Communication and documentation failures affecting risk assessment, escalation and continuity of care.

- Challenges during transitions of care, including discharge planning, information sharing and coordination between services.
- Delayed recognition and response to deterioration, including changes in mobility, cognition, nutritional status and skin integrity.

Investigations also highlight the importance of recognising the potential harms associated with hospital admission, particularly for people living with frailty or complex health conditions. While admission remains clinically necessary for many individuals, evidence from ASP reviews reinforces the need for person-centred decision-making that considers whether care can be safely provided in the most appropriate setting, including community and home-based alternatives.

Key learning emphasises the importance of a whole-system approach to Adult Support and Protection, with shared responsibility across health, social care, care providers, families and carers.

Strengthening early recognition of vulnerability, multidisciplinary working, effective communication and proactive care planning will support NHS Borders' commitment to reducing avoidable harm and delivering safe, effective and person-centred care.

Learning from Adult Support and Protection investigations needs to remain a key focus within Clinical Governance, Patient Safety and Excellence in Care. Ongoing work will continue to strengthen the early recognition of vulnerability, frailty and adults at risk of harm in NHS Borders settings to support timely assessment, mitigate harm and escalation and intervention.

2.3.4 **Person-Centred Learning**

The sharing of Ron's Story across NHS Borders has been a powerful tool in promoting person-centred care and supporting organisational learning. Feedback from staff has demonstrated how hearing the lived experience of an individual and their family has strengthened understanding of the impact that care decisions, communication, and service interactions can have across the patient journey. The story has reinforced the importance of keeping the person at the centre of care. While systems, processes, assessments and performance requirements are essential to delivering safe care, there remains a risk that focus can shift towards managing tasks and processes rather than understanding the individual's experience.

Ron's Story has encouraged reflection on professional curiosity, recognising vulnerability earlier, and considering care through the perspective of the person and their family.

This learning continues to support NHS Borders' commitment to Excellence in Care, patient safety, public protection, and the delivery of compassionate, person-centred care.

2.3.5 **Partnership workshop- building effective communication in child protection practice**

Strengthening Multi-Agency Partnerships

Recognising that effective partnership working is fundamental to keeping children and families safe, NHS Borders facilitated a joint workshop involving managers and team leaders from Children's Community Health Services and Children's and Families Social Work. The workshop focused on strengthening collaborative relationships, improving communication pathways, increasing understanding of respective roles and responsibilities, and exploring the impact of stress, incivility and defensive practice on professional relationships and decision-making in child protection practice.

Outcome: The workshop strengthened shared understanding of assessment processes, promoted constructive professional challenge and reinforced a collective commitment to improving communication and partnership working. A further workshop has been scheduled with operational staff to broaden learning, strengthen relationships across frontline teams and develop a shared

commitment to collaborative practice. This work aims to improve communication, enhance understanding of multi-agency processes and support more coordinated responses to risk, contributing to improved outcomes for children, young people and families.

- 2.3.6 During the reporting period, NHS Borders has contributed to three Multi-Agency Child Protection Learning Reviews, with one Adult Support and Protection Learning review in progress. Learning Reviews require significant organisational commitment and staff resource however provide valuable opportunities to understand practice, embed learning and strengthen public protection systems.
- 2.3.7 Scottish Borders Public Protection Committee participated in Stage 1 of a national review commissioned by the Scottish Government examining responses to Group-Based Child Sexual Exploitation (CSE). This involved the submission of a substantial data set, a detailed position statement, and engagement with inspectors to provide assurance regarding local arrangements, processes and multi-agency responses.

Participation in the review provided an opportunity to reflect on local practice, demonstrate areas of strength and identify opportunities for further development. The review has also supported greater awareness of the risks associated with child sexual exploitation and the importance of coordinated multi-agency responses. Feedback from inspectors and recommendations arising from the review are anticipated in September 2026 and will inform future improvement activity, workforce development and partnership planning.

- 2.3.8 A multi-agency Short Life Working Group has been established to strengthen the strategic and operational response to Harm Outside the Home . The group brings together key partners to review current arrangements, identify gaps and develop a coordinated approach to addressing risks that occur beyond the family home, including child exploitation, group-based harm, peer-on-peer harm and children who go missing.
- 2.3.9 A multi-agency Bairns' Hoose Strategic and Operational Group was established to support local implementation of the Bairns' Hoose Standards and to oversee development of a child-centred, trauma-informed and rights-based approach for children who have experienced abuse, harm or trauma.

This work will help ensure that children and young people receive a more integrated, timely and trauma-informed response, improving their experience of justice, health and protection services while promoting better outcomes.

- 2.3.10 NHS Borders is contributing to national and local work relating to the implementation of the Multi-Agency Public Protection System (MAPPS), including representation on the National Health Implementation Group. The Home Office is progressing the implementation of MAPPS to strengthen information sharing and risk management of high risk offenders.

There remains a lack of clarity regarding the full implications for NHS Boards, particularly in relation to Duty to Co-operate and Restricted Patient responsibilities, workforce requirements, system access and vetting arrangements. These uncertainties have been recorded on NHS Borders Risk Register and National NHS Implementation group. National implementation groups, with representation from workforce, HR, governance and operational leads, are progressing work to clarify requirements and develop consistent implementation approaches across NHS Scotland. Implementation is expected March 2028.

2.3.11 **Emerging Trends and Service Pressures**

- During the reporting period, significant increases in Multi Agency Risk Assessment Conference (MARAC) referrals, Prevent referrals and Child Protection Registration activity,

reflecting both increasing complexity of need and improved recognition of risk across services.

- The rise in children subject to Child Protection Registration appears to be driven more by longer periods of registration and by increased numbers of new registrations. Factors contributing to this include increased case complexity, professional caution regarding de-registration decisions, and the need to strengthen confidence in step-down arrangements and lower-level multi-agency support pathways (level 3).
- Many individuals and families continue to present with multiple and interrelated concerns, including neglect, domestic abuse, parental mental health difficulties, substance use and poverty, often requiring longer-term intervention and oversight.
- This, together with variation in need across localities has placed additional pressure on health professionals involved in public protection activity.
- In response, work is underway with multi-agency partners to strengthen GIRFEC pathways, Child Protection step-down arrangements and multi-agency planning processes.
- Emerging learning highlights the importance of early recognition and response to medical neglect, including effective management of "Was Not Brought" episodes. Missed appointments, non-engagement with services and delayed access to healthcare may be indicators of wider vulnerability or neglect, reinforcing the need for professional curiosity, timely information sharing and early intervention.

3 Quality/ Patient Care

Public protection activity continues to have a positive impact on the quality, safety and effectiveness of care delivered across NHS Borders. Through effective public protection practice, staff identify and respond to concerns relating to abuse, neglect, exploitation and harm, supporting earlier intervention and improved outcomes for children, young people and adults at risk.

Appropriate referrals by NHS staff to Child Protection, Adult Support and Protection and other public protection processes demonstrate awareness of public protection responsibilities across the workforce. In addition, the Public Protection consultation service provides expert advice and support to staff, supporting professional decision-making, risk assessment and confidence in managing complex situations.

Learning from case reviews, audits and consultation activity has highlighted examples where professional curiosity, information sharing and timely escalation of concerns have resulted in earlier identification of risk and more coordinated multi-agency responses.

Continued investment in workforce development, supervision, trauma-informed practice and partnership working is needed to support the delivery of person-centred, rights-based care and contributes to a culture of learning and continuous improvement.

Challenges that continue to impact on the delivery of high-quality public protection practice;

- Learning from reviews and quality assurance activity has identified occasions where earlier recognition of cumulative risk factors, patterns of concern or changes in

presentation may have enabled earlier involvement of public protection services and improved opportunities for preventative intervention.

- Missed opportunities can arise where information is fragmented across services, concerns are viewed in isolation, or uncertainty exists regarding thresholds for intervention.
- Differences in professional judgement, risk perception and thresholds across agencies can also create challenges in achieving a shared understanding of risk and need.
- Effective communication and collaborative partnership working, professional challenge and the use of escalation processes remain critical to ensuring concerns are appropriately considered and that timely protective action is taken where required.

NHS Borders must continue to mitigate these risks through commitment to strengthening opportunities for training, supervision, reflective practice, consultation, workforce development and wellbeing support. Maintaining a skilled, supported and resilient workforce is essential to ensuring the consistent delivery of safe, effective and compassionate care for individuals and families at risk of abuse and neglect.

3.1 Workforce

- The increasing complexity of public protection work, including the impact of trauma, mental health difficulties, substance use, domestic abuse, exploitation, poverty and health inequalities, places additional demands on staff and services across NHS Borders. Public protection activity has increased significantly over recent years, particularly following the adoption of the integrated Public Protection model within Scottish Borders.
- Demand has grown across consultation, strategic and operational activity, training, quality assurance, learning review activity and multi-agency partnership work; however, this has not been accompanied by a corresponding increase in the Public Protection staffing establishment.
- Exposure to distressing and traumatic situations can affect staff wellbeing and resilience, increasing the risk of secondary traumatic stress, vicarious trauma and burnout. Workforce pressures and competing priorities may also impact staff capacity to engage fully in training, supervision and multi-agency processes.
- Despite these challenges, the Public Protection Team continues to demonstrate expertise, commitment and resilience. Recognising the emotional impact of public protection work, the team actively promotes reflective practice, peer support and promoting team wellbeing, and has engaged with Psychology Services to explore additional support mechanisms for staff
- The NHS Borders Public Protection Team is a small specialist service comprising a Nurse Consultant (29.6 hours), the equivalent of 3.0 WTE Band 7 nurses and administrative support. Public protection activity has increased significantly in recent years following the adoption of the integrated Public Protection model in Scottish Borders; however, this growth has not been matched by an increase in staffing establishment. The service is supported by a highly experienced workforce, with two team members currently working under partial retirement arrangements. While this experience is a key strength, it presents a strategic risk in relation to succession planning and the potential loss of specialist expertise, professional networks and organisational memory. This risk is reflected within the Public Protection risk register. The Nurse Consultant for Public Protection is being supported by the Associate Director of Nursing, Corporate Services, to

consider sustainable workforce arrangements that maintain service capacity, expertise and organisational assurance.

- As part of this approach, a member of the Public Protection Team has successfully secured a place on a postgraduate Child Protection Practice programme, which will support service development and help maintain specialist knowledge and skills within the team. NHS Borders has committed funding for the initial module, with applications for funding of subsequent modules to be submitted through the TED process.

3.2 Financial

There are no immediate significant financial implications arising directly from this report. Public Protection functions are delivered within existing resources and staffing establishments.

However, continued growth in public protection activity, increasing case complexity and associated statutory responsibilities place ongoing demands on the Public Protection Service and the wider workforce. Workforce sustainability and succession planning remain key considerations, particularly given the small specialist team and the potential future loss of experienced staff through retirement.

Investment in workforce development is essential to maintaining specialist knowledge and organisational capability.

Failure to maintain sufficient capacity, expertise and workforce resilience may result in increased organisational risk and could impact NHS Borders ability to fulfil its statutory public protection responsibilities and assurance requirements.

3.3 Risk Assessment/Management

Key risks	Mitigations
Increasing demand across Public Protection services, including rising MARAC, Prevent and Child and adult support and Protection activity, places pressure on staff capacity and service sustainability. Impact: • Increased workload and demand on services. • Reduced capacity for early intervention and preventative work. • Potential over-reliance on Child Protection processes where lower-level multi-agency support may be appropriate.	Activity is monitored through Public Protection Committee governance arrangements. Operational prioritisation of workload, escalation through risk management processes/contingency planning and ongoing review of workforce requirements/safe staffing reporting.
Increasing complexity of need, including trauma, mental ill health, domestic abuse, substance use, exploitation, poverty and health inequalities, may result in longer-term involvement with children, families and adults at risk and impact capacity for preventative work.	Continued emphasis on multi-agency planning, early intervention, GIRFEC principles, workforce development and partnership working to support effective risk management and timely intervention.
Variability in thresholds, risk assessment and information sharing across agencies may impact the timeliness and consistency of decision-making.	Multi-agency training, learning reviews, professional challenge and escalation processes, update of Child Protection procedures in progress and updated

	guidance and strengthened partnership working support greater consistency of practice. A programme of Public Protection multi-agency training, Mandatory e-learning once for Scotland Child and Adult Support and Protection modules, learning reviews, professional challenge and escalation mechanisms, together with updated Child Protection Procedures, guidance and enhanced partnership working, promotes a shared understanding of risk and more consistent decision-making. • Multi-agency Public Protection training programme to support consistent understanding and application of thresholds, risk assessment and decision-making. • Completion of Once for Scotland Child Protection and Adult Support and Protection mandatory e-learning modules by staff. • Process of multi-agency learning reviews and dissemination of learning to improve practice. • Established professional challenge and escalation processes to address differences in professional opinion and decision-making. • Ongoing review and implementation of updated Child Protection Procedures and associated guidance. • Protection Committee governance arrangements. • Routine multi-agency case discussions and meetings to support shared risk assessment and coordinated decision-making. • Child Protection supervision and reflective practice opportunities to enhance professional judgement and confidence. • Named Professional for Public Protection support providing expert advice on complex safeguarding and public protection concerns.
learning from reviews, inspections and significant events may not be consistently embedded across services.	Continue to strengthen governance arrangements, dissemination of learning, policy development, audit activity and workforce development programmes support implementation of improvement actions.
Workforce sustainability risk associated with a small specialist Public Protection Team, increasing demand and the potential loss of expertise through retirement. Impact • Reduced specialist Public Protection expertise and leadership capacity. • Increased pressure on remaining team members.	• Risk recorded on the Public Protection Risk Register. • Succession planning and workforce review underway. • Support from Associate Director of Nursing, Corporate Services. • Investment in postgraduate education and professional development.

• Potential reduction in ability to deliver training, consultation, assurance and quality improvement activity. • Risk to organisational resilience and statutory responsibilities.	• Knowledge transfer and mentoring arrangements. • Ongoing recruitment and workforce planning activity.
The use of multiple patient management systems, including both electronic and paper records, can limit the ability to access a complete and timely view of an individual's history, vulnerabilities, needs and involvement with services. This may affect the quality of risk assessment, decision-making and care coordination. Need for Improved digital integration remains a strategic area for development.	• Established information-sharing agreements and multi-agency communication processes to ensure relevant information is exchanged promptly and appropriately. • Standardised recording and documentation practices to improve the quality, accessibility and consistency of information across systems. • Alerts/risk flags and chronologies to support the identification of vulnerabilities, historic concerns and patterns of risk. • Promotion of Professional curiosity and proactive information gathering to ensure assessments are informed by the widest available range of information.
Delays in stepping children down from Child Protection processes where risk has reduced may result in unnecessary oversight and increased system pressures.	Ongoing work with partners to strengthen GIRFEC pathways, Child Protection step-down arrangements and post-deregistration review processes within Child Protection Procedures.
Failure to recognise, respond to or escalate concerns relating to abuse, neglect or harm occurring within healthcare and community settings may lead to missed opportunities to protect vulnerable individuals and prevent further harm. This includes risks associated with medical neglect, "Was Not Brought" episodes, CP/ASP concerns identified during inpatient care and maintaining professional curiosity where concerns are emerging or cumulative. Impact: • Delayed intervention. • Missed opportunities to protect vulnerable children and adults. • Increased risk of harm and poorer outcomes.	Ongoing workforce development focuses on early recognition of harm, escalation pathways, and the consistent application of child and adult support and protection procedures across all care settings and services within NHSB. • Mandatory Public Protection Once for Scotland e-learning in place, Public Protection multi-agency training. • Referral Processes in place. • Clear Child Protection (CP) and Adult Support and Protection (ASP) policies, procedures and escalation pathways, including "Was Not Brought" supported by regular review and updates. • Named and Lead Professionals for Child Protection and Adult Support and Protection providing advice, supervision and support for complex cases. • Regular child protection supervision, reflective practice and professional support to promote professional curiosity and challenge assumptions where concerns are emerging, cumulative or unclear. • Processes for learning reviews and audit programmes to identify gaps in practice, share learning and drive continuous improvement.

	• Multi-agency information sharing arrangements, case discussions and partnership working to ensure concerns are identified, assessed and acted upon promptly. • Established escalation processes where there is disagreement regarding risk, thresholds or required interventions. • Monitoring and follow-up processes for missed appointments and "Was Not Brought" episodes to identify potential neglect, barriers to engagement or escalating risk. • Electronic alerts, documentation standards and recording to support timely identification, communication and management of risk. • Leadership oversight through Scottish Borders Public Protection governance structures, performance monitoring and reporting of key Public Protection indicators.
Implementation of the Multi-Agency Public Protection System (MAPPS) presents potential operational, workforce and governance risks due to ongoing uncertainty regarding Duty to Co-operate responsibilities, Restricted Patient arrangements, staff vetting requirements, system access and administration. • Delays in implementation readiness. • Unclear resource implications for NHS Borders. • Potential governance and information-sharing risks	NHS Borders is represented on national and local implementation groups. The risk is recorded on the Public Protection Risk Register and is monitored through governance structures while national guidance, implementation models and workforce requirements continue to be developed.

3.4 Equality and Diversity, including health inequalities

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

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

Public Protection also supports efforts to reduce health inequalities by:

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

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

3.5 **Climate Change**

N/A to this report

3.6 **Other impacts**

None

3.7 **Communication, involvement, engagement and consultation**

- Report shared with Clinical Governance Committee 16th September 2026

3.8 **Route to the Meeting**

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

- Clinical Governance Committee 16th September 2026

4. **Recommendation**

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

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

- **Moderate Assurance**

5 **List of appendices**

The following appendices are included with this report:

None

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	Risk 00001254 – Access to Appropriate Inpatient CAMHS Beds
Responsible Executive/Non-Executive:	Simon Burt, Joint Manager JLDS and General Manager Mental Health Services
Report Author:	Simon Burt, Joint Manager JLDS and General Manager Mental Health Services

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Emerging issue
- 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

Risk 00001254 is currently rated Very High (20) and remains outside NHS Borders' risk appetite. The risk relates to the inability to consistently access age-appropriate inpatient Child and Adolescent Mental Health Services (CAMHS) beds for young people requiring admission.

NHS Borders does not operate inpatient CAMHS beds and relies on regional provision. Recent reductions in operational bed numbers across Scotland have increased the likelihood that young people requiring admission may be placed in adult mental health settings or alternative environments that are not age appropriate.

The Board is asked to note the current position, recognise that further risk reduction is dependent on regional and national planning decisions, and support continued regional escalation of this issue.

2.2 Background

NHS Borders accesses inpatient CAMHS provision through regional arrangements within the East Region.

Historically, capacity pressures have led to delays in accessing appropriate inpatient care. Whilst local safeguards and procedures are in place, ongoing reductions in available regional beds have significantly increased organisational risk.

Current regional bed availability is:

Unit	Nominal Capacity	Current Operational Capacity
Melville Young People's Mental Health Unit, Edinburgh	12	10
Skye House, Glasgow	24	16
Dudhope Young People's Inpatient Unit, Dundee	12	12
Total	48	38

There is also a potential further reduction at Skye House to 12 operational beds, which would reduce national capacity to 34 beds.

The risk was previously considered by the Operational Planning Group (OPG) on 23 July 2025, when a decision was made to tolerate the risk. Following the reduction in operational capacity and the resulting change in the risk profile, OPG reconsidered the risk on Tuesday 8 September 2026 and approved the Mental Health Service recommendation that the risk should not be tolerated. It was agreed that the risk would be escalated to the NHS Board for awareness and oversight.

Recent correspondence from senior regional mental health leadership has confirmed that future access to the Melville Young People's Mental Health Unit is being considered as part of the ongoing Melville Options Appraisal. This provides an opportunity to consider future inpatient CAMHS capacity and access arrangements within a broader strategic review of regional provision.

In addition, the East Region has secured Scottish Government funding to undertake a scoping exercise of Intensive Home Treatment Services (IHTS) and Tier 4 services. The scope of this work includes consideration of inpatient CAMHS capacity and wider service requirements across the region. This programme provides an opportunity to inform future regional planning and service development, although it is not expected to provide immediate mitigation of the current risk.

2.3 Assessment

NHS Borders has implemented extensive local mitigation measures including:

- CAMHS admissions Standard Operating Procedure.
- Adult at Risk Assessment and Review (ARAF) processes.
- Enhanced observation and safety arrangements.
- Multi-disciplinary oversight and joint care planning.
- Service-wide operating procedures.
- Improved monitoring and data collection.
- Development of a multidisciplinary oversight group.
- Joint planning with Children and Families Social Work, including a Quality Improvement stakeholder workshop to improve pathways, clarify roles, strengthen communication and support coordinated responses for children and young people presenting with high levels of risk and complexity.
- Participation in the North of Scotland Intensive Home Treatment Project.
- Escalation of concerns through regional governance structures.

Despite these measures, the residual risk remains very high because the principal cause of the risk lies outside NHS Borders' direct control.

Further reductions in available inpatient CAMHS beds increase the likelihood of:

- Delayed admission to specialist care.
- Admission of young people to adult mental health environments.
- Increased risk of self-harm and suicide.
- Increased violence and aggression incidents.
- Poor patient and family experience.
- Reputational damage to NHS Borders.

There are emerging regional actions which may support future risk reduction. These include consideration of access to the Melville Young People's Mental Health Unit through the Melville Options Appraisal and the Scottish Government-funded East Region review of IHTS and Tier 4 services. Both programmes provide opportunities to review the future configuration, capacity and sustainability of inpatient CAMHS services across the region.

While the current risk remains outside organisational risk appetite, these developments provide evidence that regional partners are actively considering both immediate and longer-term solutions to address CAMHS inpatient capacity challenges across the East Region. Nevertheless, these programmes remain at an early stage and do not currently reduce the immediate operational risk faced by NHS Borders.

The risk cannot be fully mitigated through local operational action and requires regional and national solutions.

2.3.1 Quality/ Patient Care

The inability to access age-appropriate inpatient CAMHS beds creates significant risks to patient safety, quality of care and patient experience.

Young people may experience delays in accessing specialist treatment and may require admission to adult mental health wards with enhanced safeguards. While mitigations are in place, these arrangements are not equivalent to specialist CAMHS inpatient provision.

Potential consequences include deterioration in mental health, increased distress, increased risk of self-harm or suicide, and poorer patient and family experience.

2.3.2 Workforce

The current position places significant pressure on clinical teams who are required to manage increasingly complex risks locally while awaiting specialist inpatient provision.

Additional workforce demands arise from enhanced observation requirements, multidisciplinary planning, liaison with regional services and management of escalation processes.

2.3.3 Financial

There is no direct funding request associated with this report.

However, the inability to access timely inpatient CAMHS provision may result in increased costs associated with enhanced staffing, alternative placements, prolonged inpatient stays, additional management of clinical risk and associated operational pressures.

2.3.4 Risk Assessment/Management

Risk 00001254 is currently assessed as:

- **Current Risk Rating:** Very High (20)
- **Target Risk Rating:** High (16)

The risk remains outside NHS Borders' risk appetite.

All reasonable local mitigation actions have been implemented. Further reduction in risk is dependent upon restoration and expansion of regional inpatient CAMHS capacity and the development of a sustainable regional plan for specialist inpatient services.

2.3.5 Equality and Diversity, including health inequalities

The risk disproportionately affects children and young people requiring specialist mental health care.

Ensuring equitable access to age-appropriate inpatient services supports NHS Borders' responsibilities under the Equality Act 2010, the Public Sector Equality Duty and wider commitments to reducing health inequalities.

No separate Equality Impact Assessment has been undertaken for this report as it relates to an existing organisational risk and service capacity issue.

2.3.6 Climate Change

No significant climate change implications have been identified within this report.

2.3.7 Other impacts

The issue has implications for regional service planning, public confidence, reputation and inter-board collaboration across Scotland.

Failure to address the reduction in specialist inpatient capacity may increase pressure across the wider mental health system and impact delivery of national ambitions for children and young people's mental health services.

Where timely and appropriate clinical interventions are unavailable or delayed, there is a wider system impact. Children's social work and other partner services may be required to provide additional assessment, care planning, crisis management and safeguarding support for longer periods, potentially diverting capacity from other children and families. Families may also experience increased caring responsibilities, distress and disruption to family life, education and employment, with the potential for escalating need, family breakdown and greater reliance on statutory and emergency services.

Mental Health Services are working closely with Children and Families Social Work to consider how services can more effectively provide coordinated support to children and young people presenting with high levels of risk and complexity. As a specific example of this joint working, a Quality Improvement stakeholder workshop is being planned to bring relevant partners together to identify opportunities for improving pathways, roles, communication and coordinated responses.

2.3.8 Communication, involvement, engagement and consultation

NHS Borders continues to engage through East Region CAMHS governance arrangements, regional mental health planning groups and established escalation routes to ensure the needs of the Borders population are represented within future service development work.

The issue has also been discussed through local and regional governance arrangements, including:

- NHS Borders Operational Planning Group.
- Regional CAMHS governance and planning structures.
- Senior management escalation routes.
- Regional discussions regarding inpatient capacity and future service configuration.

2.3.9 Route to the Meeting

This report has been informed by consideration through:

- NHS Borders Operational Planning Group – initially considered on 23 July 2025 and reconsidered on 8 September 2026, when the Mental Health Service recommendation not to tolerate the risk was approved and escalation to the NHS Board for awareness and oversight was agreed.
- Ongoing East Region CAMHS governance and planning discussions.
- Corporate Risk Management processes.
- Regional discussions relating to the Melville Options Appraisal and future Tier 4 service development.

2.4 Recommendation

The Board is asked to:

- Note that Risk 00001254 remains rated Very High (20) and is outside NHS Borders' risk appetite.
- Note that, on 8 September 2026, the Operational Planning Group approved the Mental Health Service recommendation that this risk should not be tolerated and agreed to escalate it to the NHS Board for awareness and oversight.
- Acknowledge the reduction in available operational inpatient CAMHS beds across Scotland and the resulting increased risk for NHS Borders.
- Note that all reasonable local mitigation actions have been implemented.
- Recognise that the risk cannot be reduced to an acceptable level through local action alone.
- Note that future access to the Melville Young People's Mental Health Unit is being considered through the Melville Options Appraisal and welcome this as an opportunity to strengthen future regional inpatient CAMHS provision.
- Note that Scottish Government funding has been secured by the East Region to scope Intensive Home Treatment Services (IHTS) and Tier 4 services, including consideration of inpatient CAMHS capacity, and support NHS Borders' continued involvement in this work to ensure the needs of the Borders population are reflected in future regional planning.
- Support continued escalation through regional governance arrangements.
- Seek assurance regarding the development of a sustainable regional strategy to address inpatient CAMHS bed capacity across the East Region.

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

- **Limited Assurance**

Suggested Level of Assurance: **Limited Assurance**

Systems and Processes: Moderate Assurance – appropriate local controls, governance arrangements and escalation processes are in place.

Outcomes: Limited Assurance – NHS Borders remains dependent on regional inpatient capacity that is currently insufficient to consistently deliver timely access to age-appropriate inpatient care.

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Risk 00001254 Risk Register Extract
- Appendix 2: Regional CAMHS Inpatient Capacity Summary
- Appendix 3: OPG Risk Paper August 2026

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7th October 2026
Title:	Board Assurance Framework Report
Responsible Executive/Non-Executive:	Laura Jones, Director of Quality and Improvement
Report Author:	Stephanie Errington, Head of Planning and Performance Lettie Pringle, Risk and Effectiveness Manager

1 Purpose

This paper is presented for discussion and assurance.

This is presented to the Committee for:

- Discussion

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework for 2026/27 is presented to provide the Audit and Risk Committee with oversight of NHS Borders' strategic risks and the arrangements in place to manage and assure delivery of the Organisational Strategy, Clinical Strategy and Enabling Strategies. The Committee is asked to discuss the report, consider whether the strategic risks, controls, actions and assurance routes provide a coherent view of delivery risk and confirm the level of assurance received.

2.2 Background

The Board Assurance Framework (BAF) has been developed to align strategic risks to the NHS Borders Organisational Strategy, the Clinical Strategy and enabling strategies.

The framework sets out current and target risk levels, Senior Responsible Officers, action plans, supporting measures and governance routes intended to support Board-level oversight of delivery, escalation and assurance.

2.3 Assessment

The BAF identifies a broad strategic risk profile, with very high risks relating to prevention and avoidable demand, secondary care performance, access to tertiary services, digital enablement, financial sustainability and partnership working. High risks are identified in relation to delivery of the Organisational Strategy, primary and community services, quality improvement, people, and property and sustainability. Medium risks are identified for research and innovation and risk management. Across the framework, common themes include demand and capacity pressure, workforce sustainability, financial constraint, digital and infrastructure dependency, variation in quality and improvement capability, and the need for stronger partnership delivery and governance.

Of the 13 strategic risks, six have green delivery status, six have amber delivery status and one risk has a red delivery status.

2.3.1 Quality/ Patient Care

The BAF supports quality and patient care by strengthening visibility of the risks that may affect safe, effective and person-centred care. It brings together risks linked to prevention, access, patient flow, service sustainability, quality improvement, patient safety, digital infrastructure and estate resilience. Continued variation in delivery, capacity and governance could adversely affect waiting times, outcomes, experience and inequalities if actions are not progressed at pace.

2.3.2 Workforce

Workforce implications are central to the framework. Several risks identify workforce gaps, capacity constraints, temporary staffing reliance, digital capability, improvement capability, leadership and wellbeing as key factors affecting delivery. The BAF provides a route for these issues to be visible, managed and escalated, while recognising that sustained pressure may impact morale, resilience and the organisation's ability to deliver transformation.

2.3.3 Financial

The BAF does not seek approval for new investment through this paper. However, financial sustainability is a strategic risk within the framework and is also a dependency across other strategies. The report highlights the need for clear prioritisation, robust savings delivery, value-based decision-making, productivity improvement and alignment of resources to strategic priorities. Any financial implications arising from individual programmes will continue to be considered through established planning, budgeting and governance routes.

2.3.4 Risk Assessment/Management

The report is itself a key risk management and assurance mechanism. It sets out strategic risks, current and target risk levels, risk owners, action plans, measures and supporting documents. Further development will be required to complete governance and assurance fields consistently, confirm assurance levels through relevant delivery and governance groups, and ensure the BAF remains dynamic, evidence-based and aligned to the strategic risk register.

2.3.5 Equality and Diversity, including health inequalities

The BAF supports delivery of NHS Borders' strategic aim to improve population health and reduce inequalities by making visible the risks that could widen inequality or affect equitable access to care. Several risks explicitly relate to prevention, community-based support, tertiary access, digital inclusion, partnership working and estate sustainability. Individual programmes should continue to complete equality and impact assessments where required through established governance arrangements.

An overarching impact assessment has not been completed for this cover paper because it presents the BAF for discussion and assurance. Equality, diversity and health inequalities impacts should be assessed within the relevant strategy delivery programmes and supporting project documentation.

2.3.6 Climate Change

The BAF includes Property and Sustainability as a strategic risk area, recognising the impact of ageing estate, backlog maintenance, capital constraints, climate adaptation and decarbonisation requirements. The framework supports oversight of actions intended to improve estate resilience, statutory compliance, sustainability and alignment with future models of care.

2.3.7 Other impacts

Other impacts include the need for clear governance, consistent escalation, data quality, performance measures and alignment between delivery groups, governance groups and Board-level assurance. The BAF will require ongoing maintenance to ensure it remains current, proportionate and useful as an assurance tool.

2.3.8 Communication, involvement, engagement and consultation

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

The BAF has been developed with input from the Board Executive Team, Planning & Performance and Risk & Effectiveness teams within the organisation. Ongoing engagement will take place through relevant delivery groups, governance groups and committee routes as risks, controls, actions and assurance levels are reviewed and updated.

2.3.9 Route to the Meeting

The BAF is presented to the Audit and Risk Committee as part of the organisation's developing approach to strategic risk management and Board assurance. It draws together content from the Organisational Strategy, Clinical Strategy and Enabling Strategies, and will continue to be refined through relevant delivery groups, governance groups and Board assurance routes.

2.4 Recommendation

- **Discussion** – Examine and consider the implications of the Board Assurance Framework and the level of assurance provided.

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

- **Moderate Assurance** is suggested at this stage, recognising that a comprehensive framework is in place and aligned to strategic priorities, but

that further work is required to complete governance fields, evidence sources, assurance levels and routine reporting arrangements.

Systems and processes: Moderate assurance is suggested because the BAF structure, risk ownership and action plans are in place, with further work required to evidence consistency of review and escalation.

Outcomes: Moderate assurance is suggested because strategic outcomes are clearly described and linked to measures, but outcome reporting will need to mature as delivery progresses.

3 List of appendices

The following appendix is included with this report:

- Appendix 1 – Board Assurance Framework Report 2026/27

NHS Borders

Board Assurance Framework

2026/27



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.



Board Assurance Framework

Our integrated assurance model bringing together strategy, risk, performance and assurance



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.

OUR STRATEGIC OUTCOMES

We will:



Support people to keep themselves well



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



Making Secondary Care fast, efficient and effective

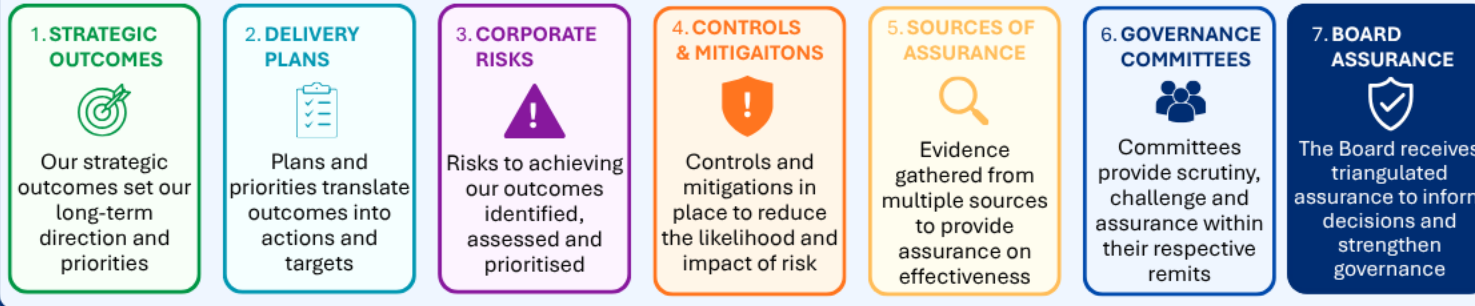


Ensure equity of access for our patients who require access to Tertiary Services



Enable NHS Borders to deliver its Clinical and Organisational Strategies through strong leadership, skilled people, effective partnerships, sustainable resources and continuous improvement.

OUR ASSURANCE FRAMEWORK - FROM STRATEGY TO ASSURANCE



OUR STRATEGIC RISKS



REPORTING TO THE BOARD

Integrated, balanced and triangulated assurance reported to the Board to support informed decision making, challenge, oversight and accountability.

Our Values



Compassion



Integrity



Excellence



Kindness



Teamwork

LEVELS OF ASSURANCE



SIGNIFICANT ASSURANCE

High confidence that risks are well managed and controls are effective and consistently applied



MODERATE ASSURANCE

Satisfactory evidence that risks are managed and controls are generally effective with minor areas for improvement.



LIMITED ASSURANCE

Some evidence that risks are being managed but controls are inconsistent or not fully effective.



NO ASSURANCE

Little or no evidence that risks are being managed or that controls are in place.

ASSURANCE CYCLE & ESCALATION



NHS Borders 2026/27 Strategic Objectives & Risks at a Glance



Source	Strategic Objectives	Strategic Risk	Risk Owner
Organisational Strategy	By March 2027 ensure the year one deliverables are embedded and working effectively.	If NHS Borders does not have sufficient capacity, capability, governance alignment and enabling support to translate strategic intent into delivery, there is a risk that the Organisational Strategy will not be delivered as planned. This could result in continued service pressures, failure to realise strategic benefits, financial imbalance, workforce fatigue and reduced confidence from patients, staff and partners.	Peter Moore
Clinical Strategy	By March 2027, deliver the commitments set out in the year two action plan to support people to keep themselves well.	If NHS Borders is unable to effectively support people to keep themselves well, then NHS Borders will face increasing and unsustainable pressure on acute, community and mental health services, significant strain on the workforce, and reduced ability to shift resources upstream towards prevention resulting in escalating avoidable demand, poorer population health outcomes and widening health inequalities. This would undermine delivery of the Organisational and Clinical Strategies, limit progress towards prevention-focused, person-centred care, and compromise long-term service sustainability and financial balance.	Sohail Bhatti
Clinical Strategy	By March 2027, deliver the commitments set out in the year two action plan ensuring that primary and community services can support as many people back to good health as possible.	If Primary and Community Services are not sufficiently resourced, integrated or effective to support people back to good health, recovery and independence then NHS Borders will experience rising avoidable demand, poorer health outcomes and widening inequalities, alongside increasing and unsustainable pressure on secondary care services and the workforce. Resulting in limiting the organisation's ability to shift care closer to home, constrain system flow, and undermine delivery of the Organisational and Clinical Strategies, resulting in an unsustainable model of care delivery.	Gareth Clinkscale
Clinical Strategy	By March 2027, deliver the commitments set out in the year two action plan ensuring that secondary care is fast, efficient and effective.	If secondary care services are not sufficiently fast, efficient or effective to meet current and future demand then NHS Borders will experience growing waiting times, reduced flow through the system, poorer patient experience and outcomes, and increasing pressure on the workforce. Resulting in inefficient use of capacity and variation in productivity would exacerbate financial pressures, limit the ability to release resources for community-based care, and undermine delivery of the Organisational and Clinical Strategies, resulting in an unsustainable model of care.	Oliver Bennett
Clinical Strategy	By March 2027, deliver the commitments set out in the year two action plan ensuring equity of access for our patients who require access to tertiary services.	If patients who require access to tertiary services do not experience equitable, timely or appropriate access, due to variation in pathways, referral processes, capacity constraints or system coordination beyond NHS Borders then patients may experience delays to diagnosis or treatment, poorer clinical outcomes and unequal access based on geography, condition or system navigation. Resulting in increased pressure on local services, undermine confidence in care pathways, exacerbate health inequalities and compromise NHS Borders' ability to deliver safe, effective and person-centred care in line with its Organisational and Clinical Strategies.	Oliver Bennett
Quality Strategy	By March 2027, implement a consistent Quality Improvement approach across NHS Borders so that 25% of services are actively delivering improvement aligned to the quality dimensions (safe, effective, person-centred, timely, efficient, equitable and sustainable), with routine use of data, QI tools and coaching, resulting in demonstrable improvement across a domain of quality.	If NHS Borders is unable to consistently deliver and sustain high-quality, safe, effective and person-centred care across all services, due to variation in quality improvement capability, assurance, and capacity to embed improvement at pace and scale then NHS Borders may experience unwarranted variation in care quality, increased harm or adverse events, poorer patient and staff experience, and reduced confidence in services. Resulting in undermining delivery of the Quality Strategy, weaken assurance to the Board, and compromise the organisation's ability to improve outcomes while operating within increasing financial and workforce constraints.	Laura Jones
Research & Innovation	By March 2027, NHS Borders will establish the foundations for embedding research and innovation in routine care by establishing a supported pipeline of projects, increasing staff participation, and strengthening partnerships, delivering measurable improvements in patient outcomes and evidence-based care.	If NHS Borders is unable to effectively embed research and innovation as core business, due to limited capacity, capability, infrastructure or integration with service delivery and improvement activity then NHS Borders may miss opportunities to improve patient outcomes, reduce unwarranted variation, increase productivity and attract external funding or partnerships. Resulting in limiting the organisation's ability to adopt evidence-based innovation at pace, reduce resilience and sustainability, and undermine delivery of the Organisational, Clinical and Quality Strategies.	Laura Jones

Source	Strategic Objectives	Strategic Risk	Risk Owner
Risk Strategy	By March 2027, NHS Borders will establish a standardised, integrated risk management and reporting approach across all services, ensuring that 90% of very high risks have clearly articulated controls, current mitigation plans, and are reviewed within agreed timescales, with risk intelligence routinely used to inform decision-making at service, programme and Board level.	If NHS Borders is unable to consistently embed effective risk management as core business across the organisation, where risks are not being identified, assessed, mitigated or escalated in a timely and proportionate way, then NHS Borders may experience increased harm to patients and staff, reduced organisational resilience, poor decision-making, and insufficient assurance to the Board. Resulting in undermining delivery of the Risk Strategy, weaken the Board Assurance Framework, and limit the organisation's ability to anticipate, manage and respond to emerging threats while delivering strategic priorities.	Laura Jones
People Strategy	By March 2027, increase workforce engagement and participation by ensuring at least 80% of teams are actively undertaking regular appraisal and PDP activity, increasing access to development opportunities, and focussing on staff wellbeing.	If NHS Borders is unable to attract, retain, develop and support a workforce with the capacity, capability and wellbeing required to deliver the Organisational and Clinical Strategies then NHS Borders may experience increasing workforce gaps, reduced resilience, lower productivity and morale, and growing reliance on temporary staffing. Resulting in constrained service delivery, slow transformation, impact quality and safety, and undermine financial sustainability, limiting the organisation's ability to deliver person-centred, prevention-focused and sustainable care.	Avril Keen
Digital Strategy	By March 2027, implement priority digital infrastructure and system improvements to enable safe, connected and person-centred care, delivering 80% on digital projects including the rollout of core digital tools that support information sharing, reduce administrative burden, and expand access to remote care, with measurable improvements in workflow efficiency, system reliability, and patient access.	If NHS Borders is unable to effectively deliver and embed digital capability as a core enabler of service delivery, improvement and transformation, due to limitations in digital infrastructure, workforce capacity, data quality, interoperability or adoption at pace and scale then NHS Borders may experience continued reliance on inefficient manual processes, reduced productivity, fragmented information flows and increased risk to safety and quality. Resulting in constraining the organisation's ability to support modern models of care, release clinical and administrative capacity, improve decision-making and deliver financially sustainable services, undermining delivery of the Digital, Organisational and Clinical Strategies.	June Smyth
Finance Strategy	By March 2027, lay the foundations for an activity-based commissioning and prioritisation framework across all services to improve value and resource alignment, deliver at least 3% cost efficiency through waste reduction and productivity improvements, and establish robust patient-level costing and performance data to support evidence-based financial decision-making and progress towards financial balance.	If NHS Borders is unable to achieve and sustain financial balance while delivering the ambitions of the Organisational and Clinical Strategies, due to the scale and pace of cost pressures, rising demand, workforce challenges and limited flexibility within the system then NHS Borders may face continued financial imbalance, increasing reliance on short-term measures, constrained investment in prevention and transformation, and reduced ability to make timely, strategic choices. Resulting in sustained pressure on services and staff, limit the organisation's capacity to modernise care, and undermine long-term service sustainability and value-based decision-making.	Andrew Bone
Partnerships Strategy	By March 2027, establish integrated health and social care arrangements that improve system flow, increase community and third sector capacity, and deliver agreed partnership outcomes through robust governance, shared accountability and regular Board assurance.	If NHS Borders is unable to establish and sustain effective partnership working with key system partners, including Local Authority, HSCP, Third Sector, independent providers and regional partners, to deliver integrated, person-centred and sustainable care then NHS Borders may experience fragmented service delivery, duplication of effort, delayed discharge and poor system flow, widening health inequalities and increased pressure on NHS services and workforce. Resulting in limiting the organisation's ability to shift the balance of care, deliver prevention-focused and community-based models, and achieve the ambitions of the Organisational, Clinical and Partnerships Strategies.	Sohail Bhatti
Property & Sustainability	By March 2027, establish and begin delivery of an approved, risk-based Property and Sustainability Plan that prioritises investment in the estate, reduces the highest-risk backlog maintenance, strengthens statutory compliance and infrastructure resilience, and supports progress towards safe, efficient, sustainable and person-centred models of care.	If NHS Borders is unable to secure and prioritise sufficient investment to maintain, modernise and optimise its ageing estate, address backlog maintenance, and support statutory compliance, resilience and new models of care, then property assets may become increasingly unsuitable, inefficient or unreliable for the delivery of safe, sustainable, community-based and person-centred services, resulting in increased risks to patient, staff and visitor safety, service continuity, statutory compliance, environmental sustainability, financial value and delivery of the Clinical Strategy.	Andrew Bone

Board Assurance Framework: Cross-Cutting Risk Overview

2026/27 • at a glance

13 strategic risks

6 very high

5 high

2 medium

Overall position

The profile is heavily weighted to very high and high risk. Target positions reduce exposure, but no risk is targeted below medium.

Very high and high risk themes

Red = very high • amber = high

DEMAND, CAPACITY AND PATIENT FLOW

Growing and avoidable demand threatens prevention, community services, waiting times and fragile specialist pathways.

FINANCIAL SUSTAINABILITY

Rising costs and demand may continue to outpace resources, restricting investment in prevention and service redesign.

DIGITAL AND DATA RESILIENCE

Legacy infrastructure, cyber exposure, poor interoperability and variable adoption threaten continuity, productivity and information sharing.

EQUITY

Geography, service access, digital exclusion and inconsistent prevention could widen health inequalities.

WORKFORCE RESILIENCE

Recruitment, retention, wellbeing and capability gaps could reduce productivity, increase temporary staffing and slow transformation.

QUALITY AND SAFETY

Variation in improvement practice, learning and assurance creates risks to care quality, patient safety and experience.

PARTNERSHIP AND INTEGRATION

Fragmented governance and insufficient community or social-care capacity could worsen delayed discharge, duplication and system flow.

ESTATE RESILIENCE

Ageing infrastructure, maintenance backlogs and limited capital create safety, compliance and service-continuity risks.

Board focus: manage interdependencies as one portfolio, prioritising workforce, finance, digital and partnership enablers.



NHS Borders Organisational Strategy



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

NHS Borders is operating in an increasingly complex environment characterised by growing demand for services, an ageing population, widening health inequalities, workforce and financial pressures, changing public expectations, and the need to reduce environmental impact. While the organisation has many strengths, including a committed workforce, strong partnerships and high-quality services, current systems, processes and resources are not always aligned to support the scale of transformation required. At the same time, increasing demand is outpacing available capacity, creating pressure on workforce sustainability, financial balance, infrastructure, service performance and the ability to invest in future models of care. Delivering the Clinical Strategy and improving population health outcomes will require a more integrated, preventative and sustainable approach across services, communities and partner organisations. As a result, NHS Borders requires a clear and coordinated Organisational Strategy that aligns resources, workforce, infrastructure, digital capability and partnerships to improve outcomes, reduce inequalities, deliver best value and ensure high-quality, person-centred and sustainable health and care services for the people of the Scottish Borders.

Assessment (Current and Future State)

Current State: Improvement activity is underway, but it is not yet consistently embedded across NHS Borders. Demand, workforce and financial pressures continue to impact sustainability. Future State: NHS Borders is an improvement organisation with a shared culture, empowered staff and sustainable services that improve outcomes and reduce inequalities. Risk of Not Delivering: Failure to deliver the strategy will limit our ability to improve outcomes, reduce inequalities and provide sustainable services.

Aim Statement (Goal)

By March 2027 ensure the year one deliverables are embedded and working effectively

Recommendations (Delivery Approach inc. Performance Measures)

- Improvement capability embedded across all services.
- Delivery milestones achieved for all strategic priorities.
- Improvement in agreed population health and inequality indicators.

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Resource and Performance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Deliver the year 2 2026/27 deliverables as set out across the Clinical & Enabling Strategies	31/03/2027	All Leads
Increase the use of celebrating success by introducing a digital tool, an administrative point of contact in each business unit and resources to support its implementation across departments	31/12/2026	Claire Oliver/Laura Jones
Continue to build capacity and capability by active recruitment to our QI Academy and Compassionate Leadership programmes in order to support delivery of our strategic objectives.	31/03/2027	Laura Jones/Michelle O'Reilly
Strengthen governance by continuing to rewiring the organisation by confirming clear governance, decision-making routes, escalation thresholds and reporting arrangements for delivery of the Organisational Strategy.	31/03/2027	Stephanie Errington/June Smyth
Improve monitoring by implementing routine reporting through programme boards on milestones, risks, dependencies and benefits realisation to support timely intervention, improvement and assurance	31/12/2026	Stephanie Errington/June Smyth
Refresh workforce plan aligned to Organisational and Clinical Strategies, including priority workforce gaps, hard-to-recruit roles, succession risks and capacity needed for transformation	31/03/2027	Avril Keen

Supporting Documents and Measures: Risk Assessment 1591, Individual project plans and scopes within the year 2 deliverables

Delivering our Clinical Strategy



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.



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

NHS Borders faces increasing demand from long-term conditions, preventable illness and health inequalities, placing growing pressure on health and care services. To support people to keep themselves well, there is a need to strengthen prevention, self-management and early intervention across all pathways. While a range of community, digital and voluntary sector support exists, access and signposting are inconsistent, and opportunities for earlier support are often missed. Particular challenges include poorer outcomes for people with learning disabilities, inequalities related to healthy weight, fragmented women's health services, and the need to make social prescribing and community-based support a routine part of care. This programme brings these priorities together to improve wellbeing, reduce inequalities and prevent avoidable demand on services.

Assessment (Current and Future State)

Prevention and self-management are not yet applied consistently across NHS Borders, resulting in variation in access, missed opportunities for early intervention and avoidable demand on services. Priorities for 2026/27 include embedding preventative interventions within routine care, improving access to self-management support, increasing Learning Disability Annual Health Checks, developing a Women's Health Hub, strengthening social prescribing and Local Area Coordination pathways, and taking a more coordinated approach to healthy weight and wellbeing. Without improvement, NHS Borders will face growing pressure on acute, community and mental health services, increasing avoidable demand, widening health inequalities and greater workforce pressures, reducing the organisation's ability to shift resources towards prevention and deliver its strategic ambitions.

Aim Statement (Goal)

By March 2027, deliver the commitments set out in the year two action plan to support people to keep themselves well.

Recommendations (Delivery Approach inc. Performance Measures)

- Embed prevention and early intervention within routine care pathways.
- Expand access to self-management, community support and social prescribing.
- Improve outcomes for priority population groups through targeted programmes, including Learning Disability Annual Health Checks, Women's Health and Healthy Weight.
- Establish the workforce capability, partnerships, governance and data required to sustain a prevention-focused model of care
- Deliver 2026/27 deliverables for each area

SRO: Sohail Bhatti Risk Response: Treat	Current risk level	Target risk level	Delivery status
	Very High (20)	High (16)	

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Resource and Performance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Develop and agree a refreshed prevention and early intervention delivery plan aligned to Board A3 priorities, with clear milestones, owners, performance measures and governance.	31/10/2026	Sohail Bhatti
Identify and approve opportunities through planning and budgeting to shift investment towards prevention, community-based support and earlier intervention in line with strategic priorities and care-closer-to-home ambitions.	30/09/2028	Peter Moore
Define and implement outcome measures and reporting that demonstrate impact on avoidable demand, population health outcomes, inequalities, access and progress against Board A3 deliverables.	31/03/2027	Sohail Bhatti
Agree joint partnership actions focused on priority population groups, community-based support, equitable access and areas of avoidable demand, with shared ownership of delivery.	31/03/2027	Peter Moore
Support services to embed prevention approaches through workforce development, operational leadership and improvement support to sustain community-based delivery and resilience.	31/10/2027	Julieann Brennan

Supporting Documents and Measures: Risk Assessment 1589, Individual project plans and scopes within the year 2 deliverables

A3 Plan and Report: Ensuring that Primary & Community Services can support as many people back to good health as possible



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

NHS Borders is experiencing growing demand across community, primary care, urgent care, children and young people’s services, palliative care and learning disability services. An ageing population, increasing long-term conditions and rising complexity of need are placing pressure on existing services, while current pathways and models of care can be fragmented and inconsistent. These challenges contribute to delays in accessing care, pressures on patient flow, avoidable hospital use and variation in patient experience. National policy and strategic commitments require services to become more integrated, person-centred and delivered closer to home where possible. There is therefore a need to redesign and strengthen community-based services, improve multidisciplinary working and coordination, and ensure people can access the right care, in the right place, at the right time. This will support improved outcomes, greater independence, better patient flow and more sustainable services for the future.

Assessment (Current and Future State)

This programme will review and redesign primary and community services to improve access, quality, patient flow and sustainability. Key areas include Community Hubs, multidisciplinary working, a Single Point of Access, urgent and unscheduled care pathways, future primary care models, integrated Children and Young People’s services, enhanced palliative care and supporting people with learning disabilities to live closer to home. The programme aims to reduce fragmentation, improve coordination across services and support more care to be delivered in the community. This will help ensure people receive the right care, in the right place, at the right time, while improving patient experience and making best use of available resources. There is a significant risk that, without sufficiently resourced and integrated primary and community services, NHS Borders will face rising avoidable demand, poorer outcomes, widening inequalities and increasing pressure on hospital services and the workforce. Delivery of this programme is therefore critical to improving system flow, supporting care closer to home and delivering the Organisational and Clinical Strategies.

Aim Statement (Goal)

By March 2027, deliver the commitments set out in the year two action plan ensuring that primary and community services can support as many people back to good health as possible.

Recommendations (Delivery Approach inc. Performance Measures)

Approve delivery of an integrated Primary and Community Services transformation programme focused on Community Hubs, patient flow, sustainable primary care, integrated children's services, enhanced palliative care, community nursing redesign and the Coming Home programme to improve access, outcomes and care closer to home.

SRO: Gareth Clinkscale Risk Response: Treat	Current risk level	Target risk level	Delivery status
	High (16)	Medium (9)	

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Resource and Performance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Complete the current and future state assessment and agree a future community services model, including a Community Hub blueprint, referral criteria, pathway mapping and a test site for 2026/27.	31/03/2027	Kathy Steward
Strengthen MDT working, planned date of discharge to reduce avoidable delays and improve Emergency Access performance.	31/03/2027	Kirstie Tinkler
Complete the option appraisal for the future PCIP model to define a safe, equitable and affordable service offer that supports primary care and aligns with integrated community models.	31/03/2027	Cathy Wilson
Develop and test integrated pathways and single points of access across priority areas including frailty, stroke, orthopaedics, children and young people, palliative care and mental health interfaces. Invest in early supported discharge model, reablement capacity expansion and increasing Hospital at home capacity to 50 virtual beds.	31/03/2027	Cathy Wilson

Supporting Documents and Measures: Risk Assessment 1575, Individual project plans and scopes within the year 2 deliverables

A3 Plan and Report: Making Secondary Care Fast ,Efficient and Effective		
Background & Problem (What / Where / When / Why / Who?)		
Clinical services across NHS Borders are experiencing sustained demand pressures alongside workforce and financial constraints. Demand continues to grow across outpatient, diagnostic and elective services, while variation in pathways, clinic processes and service models can impact capacity, productivity and patient experience. There is a need to maximise the use of existing resources, standardise ways of working and improve service efficiency to increase clinical activity, reduce waiting times and improve outcomes. This includes modernising outpatient services, optimising orthopaedic services in line with regional models of care, and strengthening digital foundations through the development of HEPMA, a major clinical transformation programme that will improve medication safety, efficiency and staff experience. Together, these changes will support more sustainable clinical services, improved patient access and reduced unwarranted variation across NHS Borders.		
Assessment (Current and Future State)		
Current productivity is constrained by variation in theatre utilisation, outpatient delivery models, diagnostic capacity and manual processes, limiting opportunities to increase activity, reduce waiting times and improve patient flow. Outpatient services are affected by inconsistent clinic processes, high administrative burden and reliance on legacy systems, while orthopaedic services face capacity pressures and variation in access across the East Region. There is significant opportunity to improve efficiency and patient outcomes through better use of existing capacity, standardised pathways and processes, increased regional collaboration, and optimisation of diagnostics, day procedures and outpatient services. In parallel, prescribing processes remain fragmented and manual, with delivery of HEPMA representing a major clinical and digital transformation requiring supporting infrastructure, system integration and workforce readiness. Without coordinated improvement across clinical services and digital infrastructure, NHS Borders will be unable to maximise available capacity, reduce unwarranted variation or realise opportunities for increased activity and cost avoidance. This would result in continued pressure on waiting times, productivity and patient experience, limiting the organisation's ability to deliver sustainable, high-quality services and achieve its strategic objectives.		
Aim Statement (Goal)		
By March 2027, deliver the commitments set out in the year two action plan ensuring that secondary care is fast, efficient and effective.		
Recommendations (Delivery Approach inc. Performance Measures)		
- Optimise clinical productivity across theatres, diagnostics, endoscopy and community services to increase activity, reduce waiting times and improve patient flow. - Standardise outpatient pathways, clinic templates, triage and referral management processes to improve access, consistency and efficiency. - Expand digital ways of working, a paper-light clinical record model to reduce administrative burden. - Improve access and outcomes across key pathways; cancer, mental health, dental and specialist services. - Optimise orthopaedic services in line with the East Region operating model through improved use of capacity, enhanced diagnostics and regional collaboration. - Develop and secure approval of a HEPMA business case, including an agreed delivery plan, infrastructure requirements and implementation timeline.		

SRO: Oliver Bennett Risk Response: Treat	Current risk level	Target risk level	Delivery status
	Very High (20)	High (15)	
Governance & Assurance			
Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:			
Governance Group receiving update: Resource and Performance Committee Assurance level agreed: Date assurance level agreed:			
Action Plan			
Action		When	Lead
Implement theatre improvement actions to optimise lists, increase average cases per list, reduce cancelled operations, and improve patient flow through planned care pathways		31/12/2026	Oliver Bennett
Introduce standard clinic templates, referral management guidance, specialty triage, and streamlined administrative processes to improve capacity and reduce variation.		31/03/2027	Oliver Bennett
Increase diagnostic and endoscopy capacity, strengthen pathway management, and progress the CT scanner business case to improve timely diagnosis and cancer treatment performance.		31/03/2027	Oliver Bennett
Progress the East Region target operating model, improve use of existing infrastructure and DPU capacity, and support regional flow to reduce variation in access and waiting times.		31/03/2027	Oliver Bennett
Develop and secure approval of the HEPMA business case and confirm the enabling requirements for TrakCare integration, infrastructure, and implementation planning.		31/03/2027	Oliver Bennett
Supporting Documents and Measures: Risk Assessment 1958, Individual project plans and scopes within the year 2 deliverables			

A3 Plan and Report: Ensuring Equity of Access for Patients who Require Access to Tertiary Services

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

Some clinical services within NHS Borders are becoming increasingly fragile due to workforce availability, service scale and rising demand. These challenges place pressure on the sustainability of local service models and make it increasingly difficult to maintain resilient, high-quality services across all specialties. Addressing these pressures requires a shift from localised solutions towards greater collaboration across NHS Borders and the East Region. By working collectively with regional partners to redesign care models, share expertise and optimise the use of available resources, NHS Borders can improve service resilience, reduce variation and support more sustainable clinical services for the future. This work supports the Clinical Strategy ambition to develop safe, sustainable and high-quality services that continue to meet the needs of local communities despite increasing workforce and demand pressures.

Assessment (Current and Future State)

Maternity and other fragile clinical services face increasing workforce, capacity and sustainability challenges. Greater collaboration across the East Region offers an opportunity to develop more resilient service models through shared planning, regional clinical pathways and better use of available capacity. Failure to progress this work risks increasing service fragility, workforce pressures, unequal access to specialist care and poorer patient outcomes.

Aim Statement (Goal)

By March 2027, deliver the commitments set out in the year two action plan ensuring equity of access for our patients who require access to tertiary services.

Recommendations (Delivery Approach inc. Performance Measures)

- Develop and test regional clinical service models with East Region partners to improve sustainability, resilience and equitable access across fragile specialties.
- Review regional maternity activity flows and develop options for a more coordinated and sustainable maternity service model.
- Design future service models for cardiology, haematology and neurology through collaborative regional planning and shared clinical approaches.
- Explore opportunities for greater integration of laboratory services to improve efficiency, resilience and long-term sustainability.
- Develop regional models for learning disability services, including a hub-and-spoke approach and shared inpatient capacity to support the Coming Home programme.
- Test and evaluate regional improvements in perinatal mental health services and explore opportunities for shared specialist expertise, including forensic mental health provision.

SRO: Oliver Bennett Risk Response: Treat	Current risk level	Target risk level	Delivery status
	Very High (20)	High (12)	

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Resource and Performance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Work with East Region partners to design a sustainable cardiology clinical and delivery model based on best practice, improving resilience, access and long-term service sustainability.	31/03/2027	Oliver Bennett
Work with East Region partners to explore regional flows of activity for maternity and other fragile services to improve resilience, reduce duplication, and support equity of access.	31/03/2027	Oliver Bennett
Assess opportunities for integrated laboratory and shared enabling infrastructure, including data sharing and governance arrangements, to improve efficiency and long-term resilience.	31/03/2027	Oliver Bennett
Develop future clinical models for fragile specialties including haematology and neurology, with regional partners, to improve sustainability, quality and access.	31/03/2027	Oliver Bennett

Supporting Documents and Measures: Risk Assessment 1599, Individual project plans and scopes within the year 2 deliverables

Delivering our Enabling Strategies



A3 Plan and Report: Quality Strategy



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

NHS Borders has a clear ambition to equip and empower all staff to drive continual quality improvement and embed a culture of learning, assurance and improvement across the organisation. While there is established improvement capability within NHS Borders, approaches to quality improvement, assurance, governance, organisational learning, patient safety, equity and person-centred care remain variable across services. Learning from adverse events, complaints, feedback and reviews is not always consistently shared or translated into improvement, while approaches to multidisciplinary review, safeguarding, involvement, compassionate leadership and staff wellbeing are not yet embedded systematically. This variation limits our ability to consistently improve outcomes across the seven dimensions of quality, reduce unwarranted variation and ensure learning, improvement and assurance are integrated into everyday practice. There is an opportunity to establish a single Care Assurance and Improvement System, aligned to the national Excellence in Care framework, that strengthens learning, assurance, equity, patient safety and continuous improvement across NHS Borders.

Assessment (Current and Future State)

Quality improvement, assurance, governance, learning and use of data are not yet applied consistently across NHS Borders, limiting our ability to reduce variation, improve outcomes and provide robust assurance. The proposed Care Assurance and Improvement System will establish a single Quality Management System aligned to Excellence in Care, bringing together improvement, assurance, insight and learning into one coordinated approach. Failure to deliver this programme risks continued variation in care quality and safety, poorer patient and staff experience, missed learning opportunities and reduced assurance to the Board.

Aim Statement (Goal)

By March 2027, implement a consistent Quality Improvement approach across NHS Borders so that 25% of services are actively delivering improvement aligned to the quality dimensions (safe, effective, person-centred, timely, efficient, equitable and sustainable), with routine use of data, QI tools and coaching, resulting in demonstrable improvement across a domain of quality.

Recommendations (Delivery Approach inc. Performance Measures)

- Deliver the Quality Enabling Strategy through a phased five-year programme focused on Agency, Curiosity, Insight, Safeguard and Compassion, embedding a single Quality Management System (QMS) across NHS Borders and:
- Establish a Quality Improvement Academy and deliver role-based QI training for all staff.
 - Implement a standardised Care Assurance System, including Care Assurance Visits, Quality of Care Reviews and service improvement planning.
 - Strengthen Insight through timely, robust reviews, embedding human factors, systems thinking and Team-Based Quality Reviews (TBQRs) to improve organisational learning and patient safety.
 - Embed Safeguard by strengthening safeguarding, partnership working, equality impact assessment and use of population health data to reduce inequalities and improve outcomes.
 - Embed Compassion by strengthening compassionate leadership, staff wellbeing, psychological safety, shared decision-making and person-centred care.
 - Develop leadership capability through a targeted Band 6/7 Leadership Programme and establish clear governance, reporting and escalation arrangements aligned to the Quality Strategy.

SRO: Laura Jones Risk Response: Treat	Current Risk Level	Target Risk Level	Delivery Status
	High (16)	Medium (6)	

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Clinical Governance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Strengthen leadership and technical quality improvement capability through targeted support, coaching, learning opportunities and use of improvement methods within priority services.	30/11/2026	Julie Campbell
Develop and implement a structured Quality Management System to align standards, processes, behaviours, improvement activity and assurance across services.	31/03/2027	Julie Campbell
Review governance and reporting arrangements to ensure quality risks, improvement priorities, data intelligence, learning and progress against the Quality Strategy are consistently visible and escalated.	31/03/2027	Laura Jones
Establish consistent use of quality intelligence, patient and staff feedback, incident learning, performance data and inequalities information to guide enquiry, prioritisation and improvement decisions.	31/03/2027	Julie Campbell

Supporting Documents and Measures: Risk Assessment 1563, Individual project plans and scopes within the year 2 deliverables, Quality Dashboards

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

Research and innovation are essential to improving outcomes, redesigning services and delivering sustainable healthcare. However, activity across NHS Borders is currently limited and variable, with participation often dependent on individual clinicians rather than being embedded within routine service improvement. Barriers including limited protected time, funding, research capacity and awareness of opportunities restrict staff involvement and the development of a sustainable pipeline of projects. Partnerships, clinical trial activity and access to innovation opportunities remain underdeveloped, creating a risk that people in the Scottish Borders are disadvantaged in accessing emerging treatments, research opportunities and service innovations. A more coordinated approach is required to strengthen capability, collaboration and infrastructure, enabling research and innovation to become a core part of service improvement and organisational development across NHS Borders.

Assessment (Current and Future State)

Research and innovation activity within NHS Borders is limited and variable, with participation often dependent on individual clinicians and concentrated within a small number of services. While partnerships, infrastructure and national opportunities are developing, capacity, awareness, funding and clinical trial activity remain constrained. The proposed programme will strengthen capability, collaboration and research infrastructure, creating a sustainable pipeline of projects aligned to service priorities and increasing access to research, innovation and clinical trials for the population of the Scottish Borders. Failure to deliver this programme risks missed opportunities to improve outcomes, attract external funding, adopt evidence-based innovations and increase research participation. It may also limit access to clinical trials and undermine delivery of the Organisational Strategies.

Aim Statement (Goal)

By March 2027, NHS Borders will establish the foundations for embedding research and innovation in routine care by establishing a supported pipeline of projects, increasing staff participation, and strengthening partnerships, delivering measurable improvements in patient outcomes and evidence-based care.

Recommendations (Delivery Approach inc. Performance Measures)

- Deliver the 2026/27 programme of work, including a staff survey to identify barriers to research and innovation participation.
- Establish a prioritised Research and Innovation Portfolio aligned to organisational and clinical priorities.
- Strengthen collaboration with academic, NHS, industry and public partners to increase funding opportunities, innovation adoption and project delivery.
- Expand access to clinical trials and research opportunities through regional partnerships and hub-and-spoke delivery models.
- Increase staff participation through protected time, targeted support and access to funding.
- Implement performance measures to monitor participation, funding secured, project delivery and impact on service improvement.

SRO: Laura Jones Risk Response: Treat	Current Risk Level	Target Risk Level	Delivery Status
	Medium (9)	Medium (9)	
Governance & Assurance			
Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:			
Governance Group receiving update: Clinical Governance Committee Assurance level agreed: Date assurance level agreed:			
Action Plan			
Action		When	Lead
Develop a systematic process for staff and services to identify, test, evaluate and scale research and innovation ideas, linked to quality improvement, productivity, clinical redesign and strategic priorities.		30/06/2027	Joy Dawson
Map and prioritise external funding, academic, industry, NHS Research Scotland and Health Innovation South East Scotland Hub opportunities to support research and innovation delivery.		31/03/2027	Joy Dawson
Identify and implement a staff development approach to build research, improvement and innovation skills, linked to existing learning, leadership and quality improvement arrangements.		31/12/2026	Joy Dawson
Develop and approve an implementation plan aligned to the Research and Innovation Strategy, Organisational Strategy, Clinical Strategy and Quality Strategy, setting out priorities, milestones, accountability and reporting routes.		31/03/2027	Joy Dawson
Strengthen arrangements for patient and public engagement, equitable access to clinical trials and inclusion of vulnerable and remote/rural communities in research and innovation activity.		20/01/2027	Joy Dawson
Establish a clear governance and reporting framework for research and innovation, including regular progress reporting, escalation of barriers, impact measures and risk review through existing quality and improvement governance routes.		31/03/2027	Joy Dawson
Supporting Documents and Measures: Risk Assessment 1564, Individual project plans and scopes within the year 2 deliverables			

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

Effective risk management is essential to delivering safe, effective and sustainable services and achieving NHS Borders’ strategic objectives. While risk management processes and governance arrangements are established, there is variation in risk maturity, oversight, data quality and the use of risk information across the organisation. As NHS Borders implements a new suite of Organisational, Clinical and Enabling Strategies, there is an opportunity to strengthen risk culture, governance and organisational assurance through a more consistent approach to risk management, improved use of risk intelligence, stronger links between operational and strategic risks, and the implementation of a Board Assurance Framework. This will help ensure risk information is routinely used to support decision-making, performance management, organisational learning and delivery of strategic priorities.

Assessment (Current and Future State)

Risk management arrangements are established across NHS Borders; however, there is variation in risk maturity, risk oversight, assurance processes and the use of risk information to support decision-making. The strategy provides an opportunity to strengthen risk governance through implementation of a Board Assurance Framework, review of risk appetite and policy, improved risk intelligence and closer alignment between operational and strategic risks. Failure to deliver this programme risks inconsistent risk management, weaker organisational assurance, reduced resilience and delayed identification or escalation of emerging risks. This could impact the Board's ability to gain assurance and hinder delivery of strategic objectives and safe, effective services.

Aim Statement (Goal)

By March 2027, NHS Borders will establish a standardised, integrated risk management and reporting approach across all services, ensuring that 90% of very high risks have clearly articulated controls, current mitigation plans, and are reviewed within agreed timescales, with risk intelligence routinely used to inform decision-making at service, programme and Board level.

Recommendations (Delivery Approach inc. Performance Measures)

- Deliver the Year 2 priorities of the Risk Management Enabling Strategy, including –
- Implementation of the Board Assurance Framework (BAF), review of risk governance arrangements and strengthening of risk reporting.
 - Refresh strategic risks, risk appetite and the Risk Management Policy to ensure alignment with organisational priorities and governance requirements
 - Improve risk register quality, compliance and oversight across clinical and corporate services, with stronger integration of risk information into performance and assurance reporting.
 - Strengthen organisational learning and horizon scanning through improved use of risk intelligence, emerging risk processes and re-establishment of the Integrated Risk Forum.
 - Review regulatory requirements, including medical device compliance, and implement improvement actions to ensure the risk management framework remains effective, compliant and aligned to best practice.

SRO: Laura Jones Risk Response: Treat	Current Risk Level	Target Risk Level	Delivery Status
	Medium (8)	Medium (8)	
Governance & Assurance			
Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:			
Governance Group receiving update: Audit and Risk Committee Assurance level agreed: Date assurance level agreed:			
Action Plan			
Action		When	Lead
Agree shared arrangements for identifying, discussing and escalating cross-system risks with partners, including the Health and Social Care Partnership		31/12/2026	Lettie Pringle
Clarify leadership expectations, risk ownership and reporting responsibilities across all levels to support consistent oversight and timely escalation.		31/12/2026	Lettie Pringle .
Establish a baseline assessment of organisational risk management maturity and deliver a targeted improvement plan, including development support and monitoring.		01/06/2027	Lettie Pringle
Create a control framework that monitors effectiveness of controls in place		30/04/2027	Lettie Pringle
Supporting Documents and Measures : Risk Assessment 1565, Individual project plans and scopes within the year 2 deliverables, Risk KPIs			

A3 Plan and Report: People Strategy		NHS Borders		SRO: Avril Keen Risk Response: Treat		Current Risk Level	Target Risk Level	Delivery Status
Background & Problem (What / Where / When / Why / Who?)						High (12)	Medium (9)	
NHS Borders faces increasing workforce pressures, rising demand and changing service requirements, creating challenges in attracting, retaining and developing a sustainable workforce. While staff are recognised as the organisation’s greatest asset, there is variation in workforce experience, improvement capability and opportunities for development, alongside ongoing administrative burden and inefficient processes that reduce time available for direct patient care. At the same time, service pressures can impact wellbeing, engagement, recognition and retention, while limiting the organisation’s ability to fully embed continuous improvement, digital ways of working and new models of care. Without a more coordinated approach to workforce planning, staff experience, leadership, learning and productivity, there is a risk to workforce sustainability, organisational performance and the delivery of safe, effective and person-centred care.								
Assessment (Current and Future State)								
NHS Borders faces growing challenges in attracting, retaining and developing a sustainable workforce. Variability in staff experience, workforce planning, productivity and improvement capability limits our ability to maximise capacity and deliver transformation. This programme will strengthen workforce sustainability through leadership, workforce planning, digital enablement and a positive workplace culture. Failure to deliver it risks workforce gaps, reduced productivity, increased reliance on temporary staffing and reduced ability to deliver the Organisational and Clinical Strategies.								
Aim Statement (Goal)								
By March 2027, increase workforce engagement and participation by ensuring at least 80% of teams are actively undertaking regular appraisal and PDP activity, increasing access to development opportunities, and focussing on staff wellbeing.								
Recommendations (Delivery Approach inc. Performance Measures)								
• Make NHS Borders a great place to work through a strong focus on wellbeing, inclusion, engagement and recognition. • Embed a culture of continuous improvement, ensuring staff are equipped and empowered to lead change and improve quality. • Strengthen workforce planning, recruitment, succession planning and leadership development to build a sustainable workforce. • Ensure all staff have access to regular development, learning and digital capability opportunities. • Streamline processes, reduce waste and increase automation to maximise value-added time for patient care. • Enable staff to work at the top of their licence through role redesign and more effective ways of working. • Foster a psychologically safe, inclusive and supportive culture that values diversity and partnership working. • Celebrate success, recognise staff contributions and use feedback to continuously improve staff experience and retention								
				Governance & Assurance				
				Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:				
				Governance Group receiving update: Staff Governance Committee Assurance level agreed: Date assurance level agreed:				
				Action Plan				
				Action		When	Lead	
				Refresh workforce plan aligned to Organisational and Clinical Strategies, including priority workforce gaps, hard-to-recruit roles, succession risks and capacity needed for transformation.		31/12/2026	Avril Keen	
				Implement targeted retention, attendance, wellbeing and engagement actions for services with sustained vacancies, turnover, sickness absence or temporary staffing reliance.		31/03/2027	Ailsa Paterson	
				Strengthen development, appraisal, leadership and succession arrangements to build capability for current services and future models of care.		31/03/2027	Avril Keen	
				Supporting Documents and Measures: Risk Assessment 1558, Individual project plans and scopes within the year 2 deliverables				

A3 Plan and Report: Digital Strategy				SRO: June Smyth Risk Response: Treat	Current Risk Level	Target Risk Level	Delivery Status
Background & Problem (What / Where / When / Why / Who?)					Very High (20)	High (16)	
Digital is a key enabler of NHS Borders’ Clinical Strategy and future service transformation. However, progress is constrained by legacy systems, fragmented infrastructure, limited interoperability, cyber security risks and variable digital maturity across services. A number of high-priority programmes remain delayed, under-resourced or without confirmed funding, while national and regional digital programmes continue to place significant demands on local capacity and delivery. Digital tools are not yet consistently supporting remote care, automation, information sharing, data-driven decision-making or standardised ways of working. In addition, digital skills, confidence and adoption vary across the workforce, and barriers to digital inclusion limit some patients’ ability to access digital services. A coordinated approach is therefore required to strengthen digital infrastructure, resilience, connectivity, capability and collaboration, ensuring digital technologies can support new models of care, improve productivity and enable care to be delivered closer to home.				Governance & Assurance			
				Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:			
				Governance Group receiving update: Resource and Performance Committee Assurance level agreed: Date assurance level agreed:			
Assessment (Current and Future State)				Action Plan			
				Action		When	Lead
Digital capability is improving across NHS Borders, but progress remains constrained by legacy systems, variable digital maturity, workforce capability gaps and a number of unfunded or high-risk programmes. The Digital Enabling Strategy will strengthen infrastructure, cyber resilience, interoperability and digital skills to support modern models of care and improved productivity. Failure to deliver this programme risks continued inefficiency, fragmented information sharing, reduced resilience and slower progress towards the ambitions of the Digital, Clinical and Organisational Strategies.				Confirm priority infrastructure, network, hardware, cyber and continuity requirements and develop a prioritised delivery plan aligned to Digital Strategy year 2 objectives		31/12/2026	June Smyth
				Develop a clinical digital champion network, targeted training and adoption support for priority systems and workflows, including service-level engagement to reduce variation and manual workarounds.		31/12/2027	June Smyth .
Aim Statement (Goal)				Define priority data quality, reporting and interoperability gaps across key clinical and operational systems and agree actions to improve data capture, standards, sharing and use in decision-making.		31/03/2027	Stephanie Errington
By March 2027, implement priority digital infrastructure and system improvements to enable safe, connected and person-centred care, delivering 80% on digital projects including the rollout of core digital tools that support information sharing, reduce administrative burden, and expand access to remote care, with measurable improvements in workflow efficiency, system reliability, and patient access.				Review critical digital dependencies, update downtime procedures and establish a schedule for testing continuity arrangements for priority clinical and corporate systems.		31/03/2027	Kevin Messer
Recommendations (Delivery Approach inc. Performance Measures)				Ensure digital programmes are prioritised against strategic benefit, safety, quality, financial sustainability, workforce impact and deliverability, with clear escalation of resource and dependency risks.		31/03/2027	June Smyth
Deliver the Digital Enabling Strategy through focused investment in digital foundations, including: • Cyber security, network resilience, infrastructure modernisation and compliance with NIS/CAF requirements. • Complete priority digital programmes, including M365, HealthShare, TrakCare and Digital Front Door, ensuring funding, resources and governance are aligned to delivery priorities. • Improve interoperability, shared care records and information sharing across health and care settings to support integrated, patient-centred care. • Expand the use of digital technologies, including virtual care, remote monitoring, automation and data-driven decision-making, to support service transformation and care closer to home. • Strengthen digital skills, adoption and inclusion for staff and patients, increasing confidence in the use of digital tools and services. • Maximise the use of Once for Scotland, regional partnerships and shared digital services to reduce duplication. improve resilience and accelerate delivery of strategic priorities.				Supporting Documents and Measures: Risk Assessment 1596, Individual project plans and scopes within the year 2 deliverables			

A3 Plan and Report: Finance Strategy		SRO: Andrew Bone Risk Response: Treat		Current Risk Level	Target Risk Level	Delivery Status
Background & Problem (What / Where / When / Why / Who?)				Very High (20)	High (12)	
NHS Borders faces significant financial pressures driven by rising demand, workforce constraints and increasing costs, requiring a fundamental shift in how resources are planned, prioritised and deployed. Current approaches do not consistently align activity, cost and outcomes, limiting visibility of value, productivity and variation across services and reducing the organisation’s ability to direct resources towards the areas of greatest benefit. At the same time, inefficiencies, waste, variation in clinical practice and legacy digital systems create barriers to productivity, service transformation and sustainable service delivery. Without a more systematic approach to resource allocation, prioritisation, productivity improvement, waste reduction, digital transformation and value-based decision-making, there is a risk that demand and costs will continue to outpace capacity and resources, impacting financial sustainability, access to care, outcomes and delivery of the Clinical Strategy.		Governance & Assurance				
		Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:				
		Governance Group receiving update: Resource and Performance Committee Assurance level agreed: Date assurance level agreed:				
Assessment (Current and Future State)		Action Plan				
		Action			When	Lead
NHS Borders faces growing demand, workforce constraints and significant financial pressures, while current approaches to commissioning, prioritisation, productivity, waste reduction, digital enablement and value-based decision-making remain at varying levels of maturity. This limits the organisation’s ability to consistently align resources with demand, outcomes and strategic priorities, maximise productivity, and ensure resources are directed to the areas of greatest value and impact. The opportunity is to implement a more integrated and data-driven approach to planning and decision-making, linking activity, demand, capacity, cost and outcomes to support effective resource allocation, improved productivity, reduced waste, digital transformation and value-based care .Failure to deliver this programme risks demand and costs continuing to outpace available capacity and resources, reducing the organisation’s ability to achieve financial balance, invest in transformation and transition to a population health and value-based model of care. This could impact the quality, safety, accessibility and long-term sustainability of services across NHS Borders.		Develop and maintain a Board-approved financial recovery plan with clear savings targets, delivery milestones, risks, mitigations, escalation triggers.			30/09/2026	Andrew Bone
		Implement a consistent prioritisation approach for investment, disinvestment and service change decisions, linked to clinical strategy, quality impact and value-based decision-making.			31/10/2026	Andrew Bone
		Strengthen oversight of recurring savings schemes, including quantified benefits, quality impact assessment, delivery confidence, slippage reporting and corrective action.			07/01/2027	Andrew Bone
		Cost Pressure Mitigation (including Workforce risk): Review high-cost workforce drivers, temporary staffing, vacancies and service pressures. Establish a clear mechanism for identification and monitoring of cost pressures and mitigating actions where these are material to the Board's financial performance. Ensure that there is a clear escalation framework in place for review of cost pressures which cannot be mitigated without impacting on balancing risk across financial and non-financial domains.			31/01/2031	Andrew Bone
Aim Statement (Goal)						
By March 2027, lay the foundations for an activity-based commissioning and prioritisation framework across all services to improve value and resource alignment, deliver at least 3% cost efficiency through waste reduction and productivity improvements, and establish robust patient-level costing and performance data to support evidence-based financial decision-making and progress towards financial balance.						
Recommendations (Delivery Approach inc. Performance Measures)		Strategic Sustainability Assurance Provide regular (quarterly - tbc) assurance to Board on progress against financial strategy, including: path to balance, finance related risks to delivery of organisational/clinical strategy.			31/03/2030	Andrew Bone
- Implement an Activity-Based Commissioning framework to align demand, capacity, cost, outcomes. - Embed a transparent prioritisation framework to support evidence-based investment and resource allocation decisions. - Deliver a systematic productivity improvement programme focused on reducing variation, waste and non-value-added activity. - Strengthen the Financial Improvement Programme to deliver recurring savings and release resources for transformation. - Invest in digital infrastructure, systems and automation to improve productivity, data flow, service delivery. - Expand the use of data and analytics to support planning, forecasting and performance management. - Develop patient-level costing and value-based decision-making capabilities to improve outcomes and		Identify and scope recurring savings opportunities for 2027/28 aligned to financial plan requirements (minimum 3%). Consider how savings targets will be set, ownership assigned and ensure that there is a robust framework in place to develop detailed plans for implementation in advance of April 2027.			31/12/2026	Andrew Bone
		Develop a strategic assessment which sets out the medium to long term factors impacting on the Board's financial sustainability, and includes scenario modelling impacted by key variables and actions /choices available to mitigate risks in support of the clinical and organisational strategies			31/03/2027	Andrew Bone

A3 Plan and Report: Partnerships Strategy



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

Partnership working is fundamental to NHS Borders and is essential to delivering integrated, person-centred and sustainable health and care services. While strong relationships exist across a wide range of partners, collaboration is not yet consistently embedded, with organisational silos, variable communication, fragmented governance and inconsistent approaches to engagement limiting the full benefits of partnership working. At the same time, patient and public involvement, population-based planning and locality-based service delivery are not yet fully coordinated, with gaps in shared data, joint planning, resource optimisation and feedback mechanisms reducing the ability to deliver seamless, community-focused care and improve outcomes at a system level. As a result, NHS Borders requires a more coordinated and integrated approach to partnership working, engagement, planning and resource utilisation to support prevention, improve population health, maximise the value of shared resources and deliver services closer to home through stronger collaboration with partners, communities and localities.

Assessment (Current and Future State)

NHS Borders has strong relationships with partners, communities and localities, alongside a clear commitment to engagement, integrated working and population-based planning. However, partnership working, patient and public involvement, resource sharing, joint planning and locality-based delivery are not yet consistently embedded, with variation in governance, engagement approaches, use of shared data and collaborative decision-making limiting the full benefits of integrated working. The opportunity is to establish a more coordinated, data-driven and collaborative approach across partners, with consistent engagement, shared planning, integrated locality working and better use of collective resources to improve outcomes for local people and communities. Failure to deliver this programme could result in continued organisational silos, duplication of effort, inefficient use of resources and missed opportunities to improve population health and reduce inequalities. This would limit the ability of NHS Borders and its partners to deliver integrated, person-centred and sustainable services, impacting quality, experience and long-term system resilience.

Aim Statement (Goal)

By March 2027, establish integrated health and social care arrangements that improve system flow, increase community and third sector capacity, and deliver agreed partnership outcomes through robust governance, shared accountability and regular Board assurance.

Recommendations (Delivery Approach inc. Performance Measures)

- Strengthen partnership working through shared governance, joint learning, consistent engagement approaches and collaborative leadership.
- Embed patient, public and partner voices in decision-making, service design and improvement through inclusive and meaningful engagement.
- Maximise the value of shared resources through coordinated planning, shared service models, joint funding opportunities and transparent governance.
- Develop joint plans and partnership approaches to address priority population health challenges and reduce inequalities.
- Improve the use of shared data, intelligence and feedback to support population planning and system-wide improvement.
- Strengthen locality working through joint planning, co-location, integrated delivery models and community partnerships.
- Expand integrated models of care like Home First and Hospital@Home to improve outcomes and care closer to home.
- Monitor and evaluate partnership outcomes to ensure collaboration delivers measurable benefits for people, communities and the wider system.

SRO: Sohail Bhatti Risk Response: Treat	Current Risk Level	Target Risk Level	Delivery Status
	Very High (20)	Medium (9)	

Governance & Assurance			
Date reviewed at Delivery Group: Any decisions/escalations following Delivery Group:			
Governance Group receiving update: Resource and Performance Committee Assurance level agreed: Date assurance level agreed:			
Action Plan			
Action		When	Lead
Develop and monitor a joint system flow plan focused on delayed discharge, admission avoidance, discharge pathways, community capacity and escalation triggers across health and social care partners.		31/10/2026	Gareth Clinkscale
Review and clarify partnership governance arrangements, decision-making routes, escalation processes and shared accountability across NHS Borders, Local Authority, HSCP and wider system partners.		30/11/2026	Peter Moore
Map third sector, independent provider and community assets to identify capacity, gaps and opportunities to support prevention, early intervention and community-based models of care.		31/12/2026	Sohail Bhatti
Provide regular assurance to Board and relevant committees on delivery of partnership strategy priorities, system-wide risks, shared outcomes, inequalities impact and progress in shifting the balance of care.		01/04/2027	Sohail Bhatti
Supporting Documents and Measures: Risk Assessment 1600, Individual project plans and scopes within the year 2 deliverables			

A3 Plan and Report: Property & Sustainability Strategy



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

NHS Borders’ estate is a critical enabler of safe and effective care but is increasingly challenged by ageing infrastructure, a growing maintenance backlog and constrained capital investment. Current estate capacity, utilisation and configuration do not consistently support emerging models of care, service transformation or sustainability ambitions. As a result, the organisation faces increasing pressure to balance safety, compliance, resilience and value for money while ensuring the estate remains fit for purpose. A more strategic, data-driven approach is required to optimise assets, strengthen resilience, improve sustainability and align estate investment with the Clinical Strategy and future service needs.

Assessment (Current and Future State)

NHS Borders maintains a largely compliant and operational estate; however, ageing infrastructure, increasing backlog maintenance, constrained capital investment and legacy estate configurations limit resilience, efficiency, sustainability and the ability to support service transformation. The opportunity is to develop a safe, resilient and sustainable estate that is proactively managed through robust governance, risk-based investment and data-driven decision-making, ensuring assets are optimised and aligned to the Clinical Strategy. Failure to deliver this programme could increase risks to patient, staff and visitor safety, service continuity, statutory compliance and financial sustainability, reducing the estate's ability to support modern models of care and the long-term ambitions of NHS Borders.

Aim Statement (Goal)

By March 2027, establish and begin delivery of an approved, risk-based Property and Sustainability Plan that prioritises investment in the estate, reduces the highest-risk backlog maintenance, strengthens statutory compliance and infrastructure resilience, and supports progress towards safe, efficient, sustainable and person-centred models of care

Recommendations (Delivery Approach inc. Performance Measures)

- Strengthen estate intelligence, governance and compliance assurance.
- Implement risk-based investment, maintenance and lifecycle planning for critical infrastructure.
- Improve estate resilience through enhanced infrastructure reliability and business continuity planning.
- Optimise estate utilisation through data-driven planning and flexible use of space.
- Align estate investment and development with Clinical Strategy priorities and future models of care.
- Deliver a Whole System Infrastructure Plan (WSIP) to inform long-term investment decisions.
- Embed sustainability and Net Zero principles in estate planning and operations.
- Maximise value from estate assets through clear prioritisation, robust governance and evidence-based decision-making.

SRO: Andrew Bone
Risk Response: Treat

Current Risk Level

Target Risk Level

Delivery Status

High (16)

High (12)

Governance & Assurance

Date reviewed at Delivery Group:
Any decisions/escalations following Delivery Group:

Governance Group receiving update: Resource and Performance Committee
Assurance level agreed:
Date assurance level agreed:

Action Plan

Action	When	Lead
Develop a medium-term business continuity plan setting out actions to achieve statutory compliance, manage backlog maintenance and reduce risk across property assets.	31/03/2027	Andrew Bone
Review how space is managed across the estate and implement processes to improve utilisation and align space use with the Clinical Strategy.	31/03/2027	Andrew Bone
Develop the Whole System Infrastructure Plan and supporting strategic assessments to identify long-term infrastructure requirements and support the case for capital investment.	31/03/2027	Andrew Bone
Re-establish a prioritised minor works pipeline to support services to make practical estate changes that improve patient experience, clinical productivity and service resilience.	31/12/2026	Andrew Bone
Refresh capital governance and implement a prioritisation framework that balances strategic outcomes, statutory compliance, service need, affordability and operational risk	30/04/2027	Andrew Bone
Refresh climate adaptation and decarbonisation plans, setting out actions to reduce greenhouse gas emissions and improve estate sustainability	31/03/2027	Andrew Bone

Supporting Documents and Measures: Risk Assessment 1602, Individual project plans and scopes within the year 2 deliverables

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7th October 2026
Title:	Bi-Monthly People Metrics Report
Responsible Executive/Non-Executive:	Avril Keen, Director of People and Culture
Report Author:	Claire Smith, Head of Workforce Planning, Systems and Analytics

1 Purpose

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Over the past year, the Monthly People Dashboards were developed to provide user friendly point in time People Analytics for service leads broken down by Organisational Hierarchy and Job Family. The dashboards include key HR metrics including WTE, Headcount, Absence, Unavailability and Recruitment Time to Hire. Progress towards the Appraisal target, eRostering Implementation, and no of open Employee Relations cases are also included at Business Unit level. This report provides a high-level overview by Business Unit.

2.2 Background

The monthly Power BI dashboard is now fully embedded across NHS Borders and accessed by service leads monthly. This has modernised the collation and presentation of our data, to enable a monthly snapshot of key metrics, improving efficiency and accessibility for service leads, with the ability to drill down to sub-department level. A summary report by business unit is attached.

2.3 Assessment

Over the last year the Staff Governance Committee reviewed the dashboard throughout its development and provided feedback on the content, layout, and usability and the dashboard has been updated to account for these changes, including adding absence hotspots by business unit.

People Monthly Dashboard

A separate People Trends dashboard was more recently made available to Board members capturing the same information at Division/Job Family levels, over a two-year period using Statistical Process Control (SPC) charts and is shown via the link below. This links to the wider organisational Integrated Performance Reports encompassing operational, financial, quality & safety and public health performance.

People Trends Dashboard

As these have now been embedded a report summarising data at business unit level is presented for discussion.

2.3.1 Quality/ Patient Care

Access to consistent key people metrics can support service leads to monitor and address potential challenges. The ability to monitor sickness absence, employee relations disputes, appraisals and vacancy lead in times are likely to positively impact on quality/patient care.

2.3.2 Workforce

Consistent monitoring, and positive progress related to People KPI's could have a positive impact on staff wellbeing. This may include higher levels of engagement, and enhanced patient safety with improved rostering practices, leading to better work life balance for staff with the ability to plan and book annual leave electronically.

2.3.3 Financial

The People Monthly dashboard, and People Trends dashboards will improve efficiency, reduce duplication, and support standardisation of reporting.

2.3.4 Risk Assessment/Management

Person dependency continues to be a risk, due to the current Power BI dashboard being developed and maintained by a mainly self-taught, part-time member of staff, alongside other workforce information responsibilities. Preparation of the data is still

largely manual due to an inability to secure direct connections to key databases, e.g. eESS, SSTS, Jobtrain before they are replaced as part of the business service programme to deliver a new integrated digital system to support HR, finance, payroll, and procurement.

Networking opportunities are developing with BI and Clinical Governance Teams, and capacity/person dependency will be explored as part of any future HR/OD Service Redesign.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the trends dashboard is still in development. This is planned to be progressed within the next quarter.

2.3.6 Climate Change

Improved accessibility to interactive dashboards is likely to lead to a reduction in use of paper reports.

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement and consultation

The dashboard is being promoted/demonstrated at relevant meetings to raise the profile and understanding of the new method of reporting.

2.3.9 Route to the Meeting

- Staff Governance Committee 30th July 2026
- NHS Borders Board Meeting – 6th August 2026

2.4 Recommendation

Board members are asked to discuss the report. An assurance level of moderate assurance is suggested reflecting the improvements to systems and process related to workforce reporting, whilst recognising future developments still in progress.

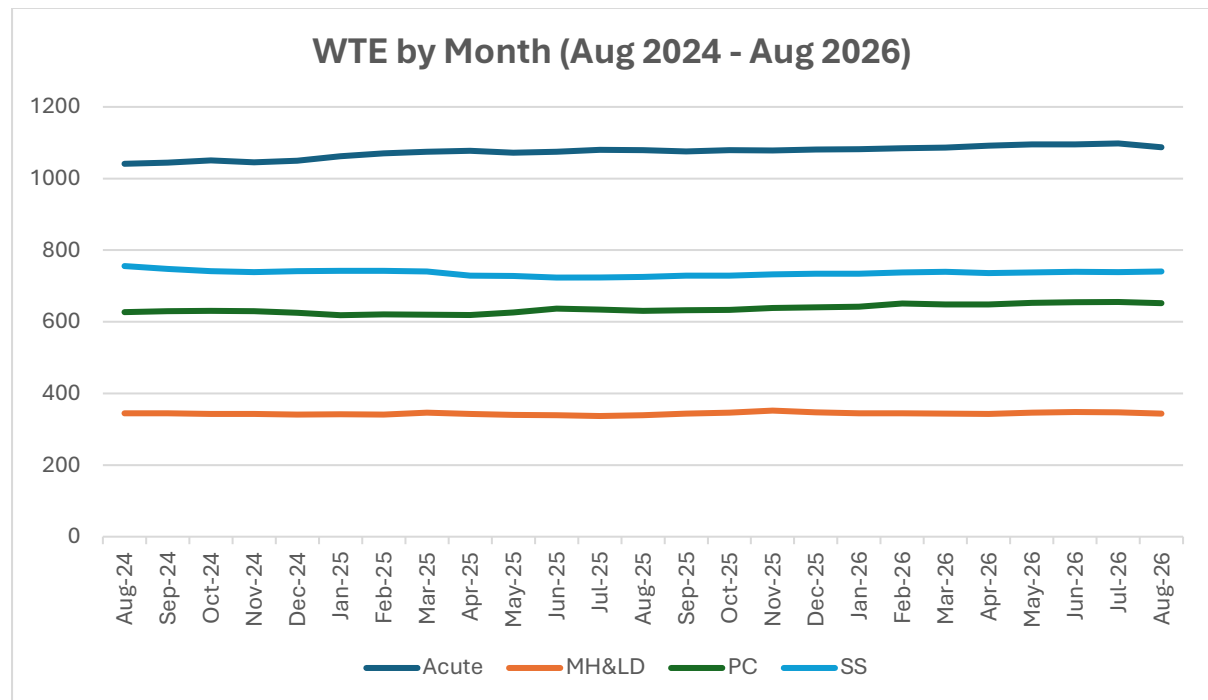
3 List of appendices

The following appendices are included with this report:

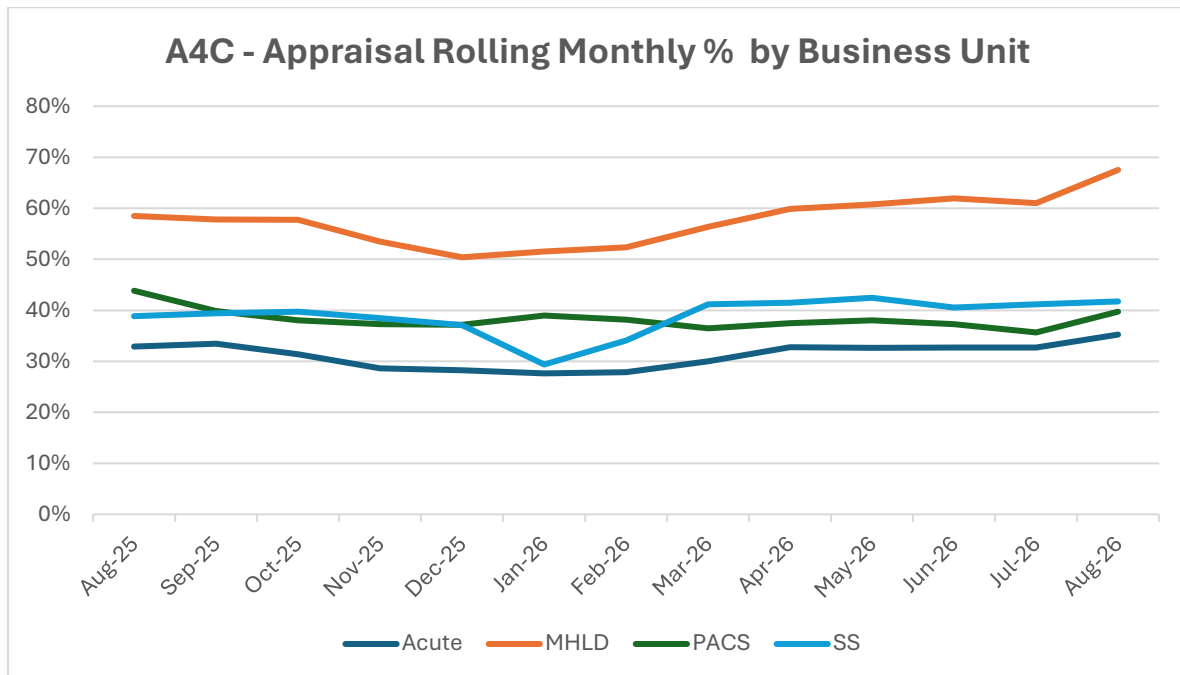
- Appendix No 1: Annual People Metrics report – August 2026

Bi-Monthly People Metrics Report – Sept 2026

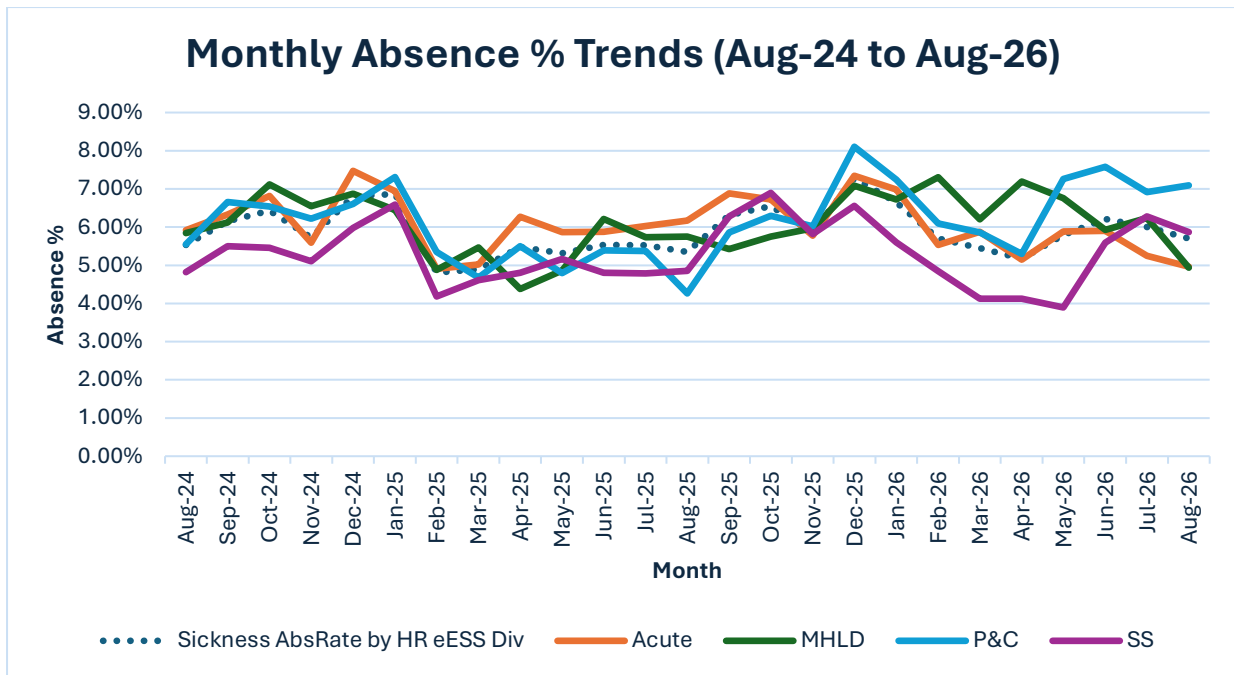
The following information has been primarily sourced from the [People Dashboard](#) and [People Trends Dashboard](#), which have been developed over the past year to modernise and offer an accessible platform for Workforce Reporting within NHS Borders. The dashboards allow data to be analysed by Job Family, Directorate and Department level. This report presents key trends by Business Unit.



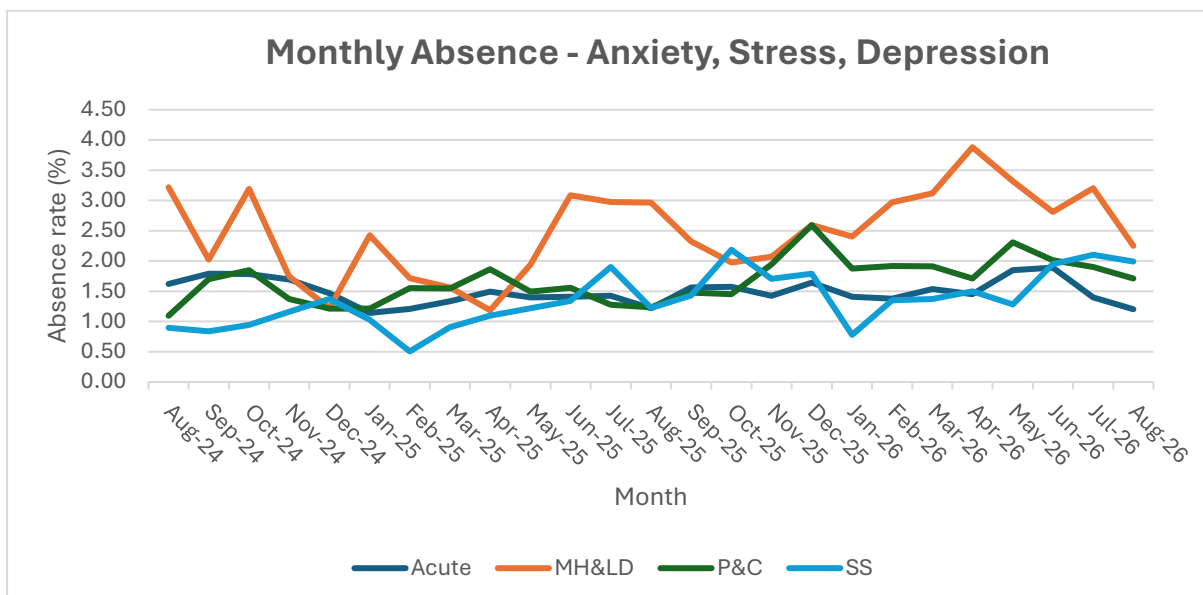
Acute WTE shows a gradual upward trend over the two-year period, which includes investment in key services including Radiology, Margaret Kerr Unit, Emergency Department and Frailty Unit over the last year. Similarly, Primary and Community services show some growth, including recruitment to the recently opened GP walk in clinic, whilst Mental Health & Learning Disabilities remains broadly stable. There has been a slight decline across Acute, PC and MH&LD in recent months, which we expect to stabilise as recently recruited international recruits start in post in September. Support Services, which includes Corporate Services, and Estates and Facilities trends slightly downward overall.



The Mental Health & Learning Disability Service regularly achieves higher rates of completed appraisals than other business units in NHS Borders, whereas Acute records the lowest overall performance. The Staff Governance Committee monitors appraisal rates and have highlighted a requirement for significant improvement in the coming year. All Business Units except for PACS show an improvement on the same point last year, however significant improvement in the coming months is required to reach the target goal of 80-100% (taking account for absence/maternity leave etc) across NHS Borders. Work is currently underway to incorporate Medical and Dental appraisal rates, where compliance rates are much closer to the target.

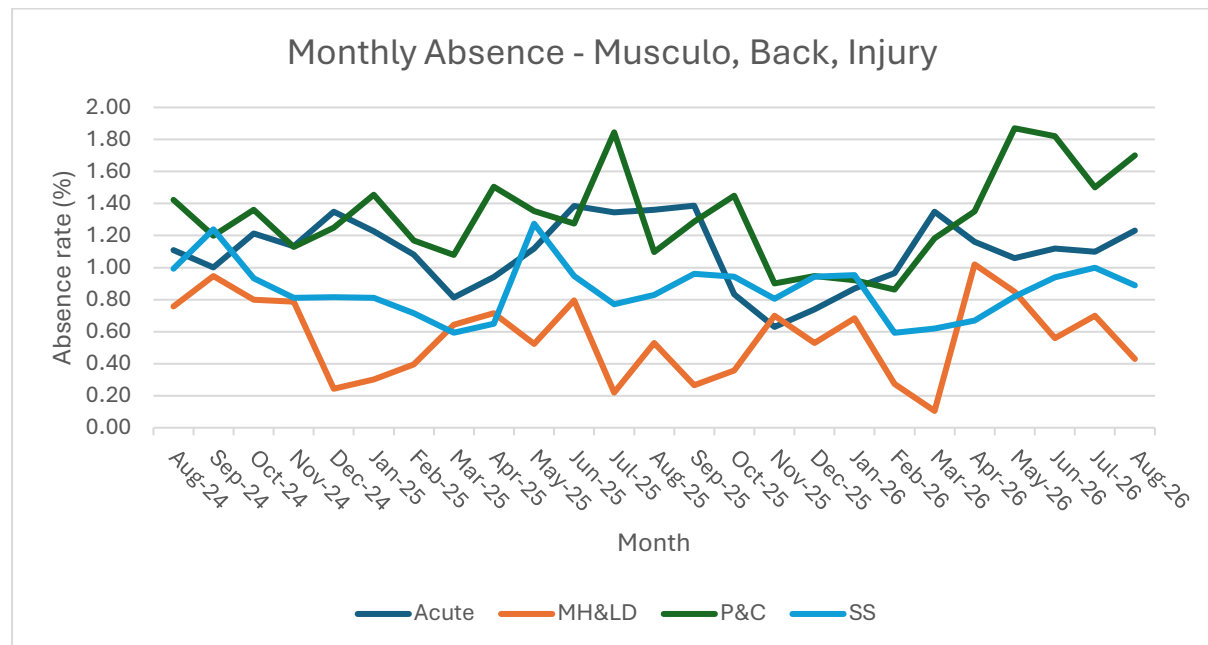


The total % Absence rate shows a clear seasonal pattern, with highest levels in autumn and winter and relative improvement in spring and early summer. Sickness absence rates had increased in May and June across all Business Units except Mental Health which increased pressure on staffing coming into the summer holiday period. Most Business Units saw an overall reduction in absence in the last two months. The average rate of Sickness Absence for the financial year 25-26 was 5.7%, comparing favourably against the NHS Scotland average of 6.39%.

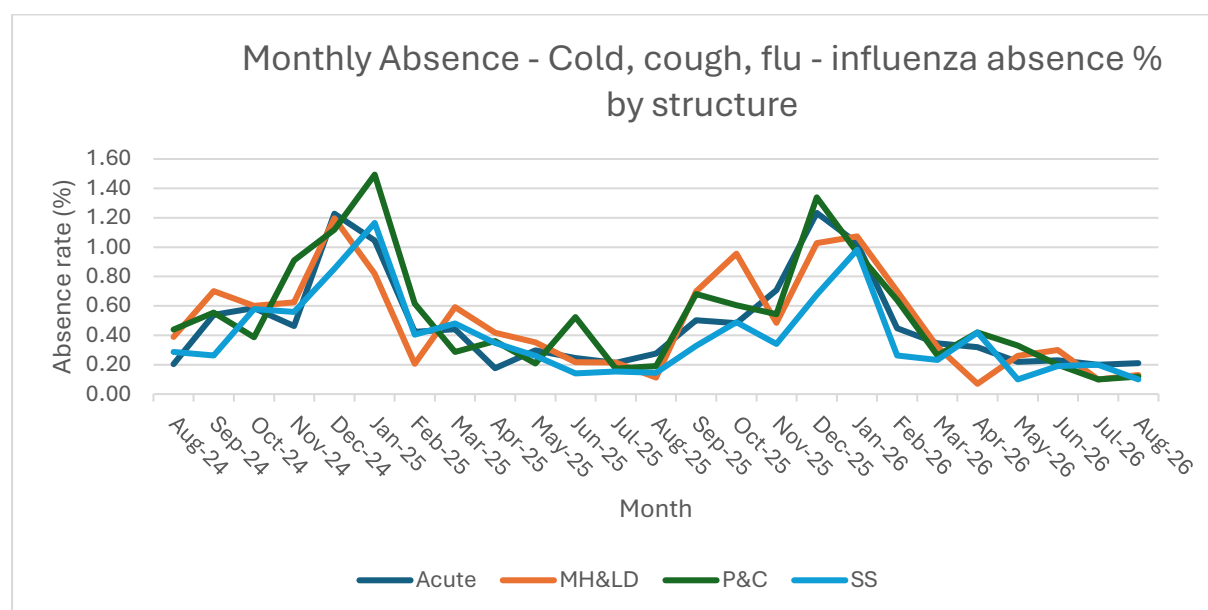


Anxiety, stress, and depression related illness has been the leading causes of sickness absence across all business units over the last two years, with employees in Mental Health & Learning Disabilities consistently experiencing the highest impact. This trend is likely to be linked to

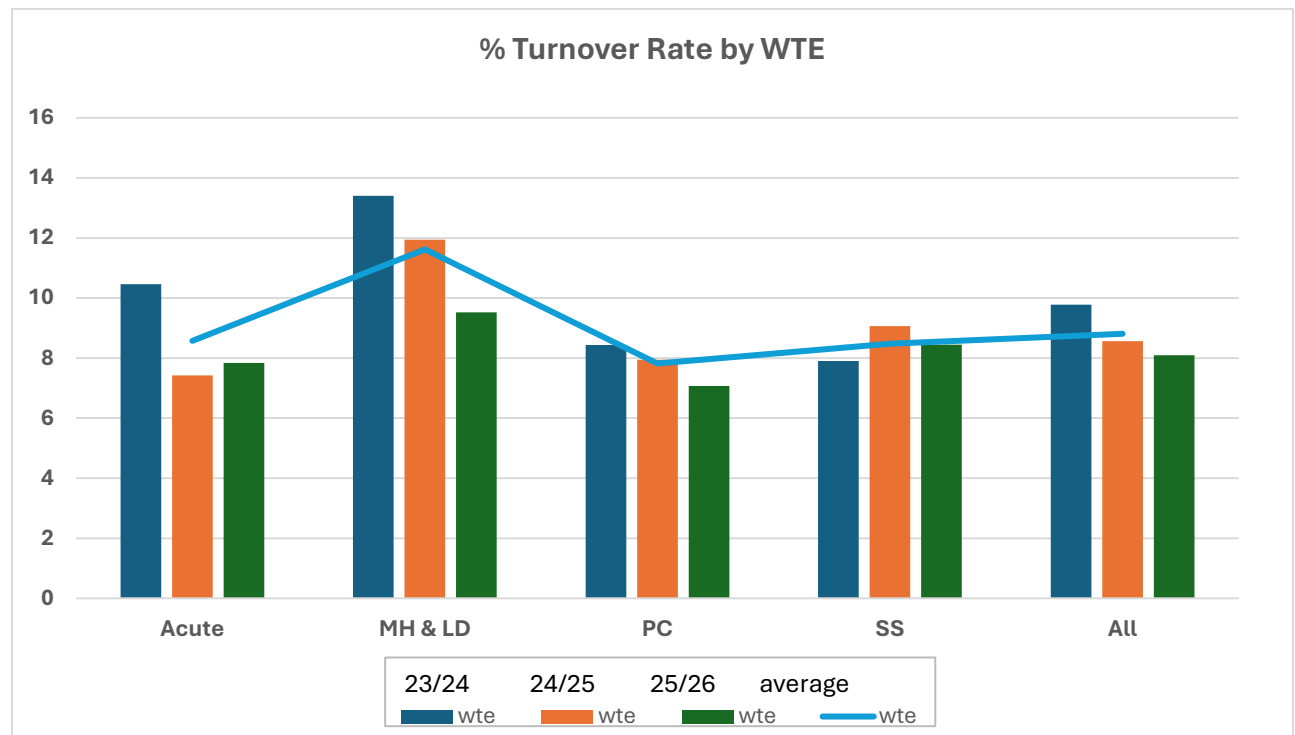
ongoing pressures, and recent events involved in caring for this patient group. Across July and August there has been a reduction across most business units, as staff have been supported back to work. Within Support Services there has been an upward trend over the last few months,



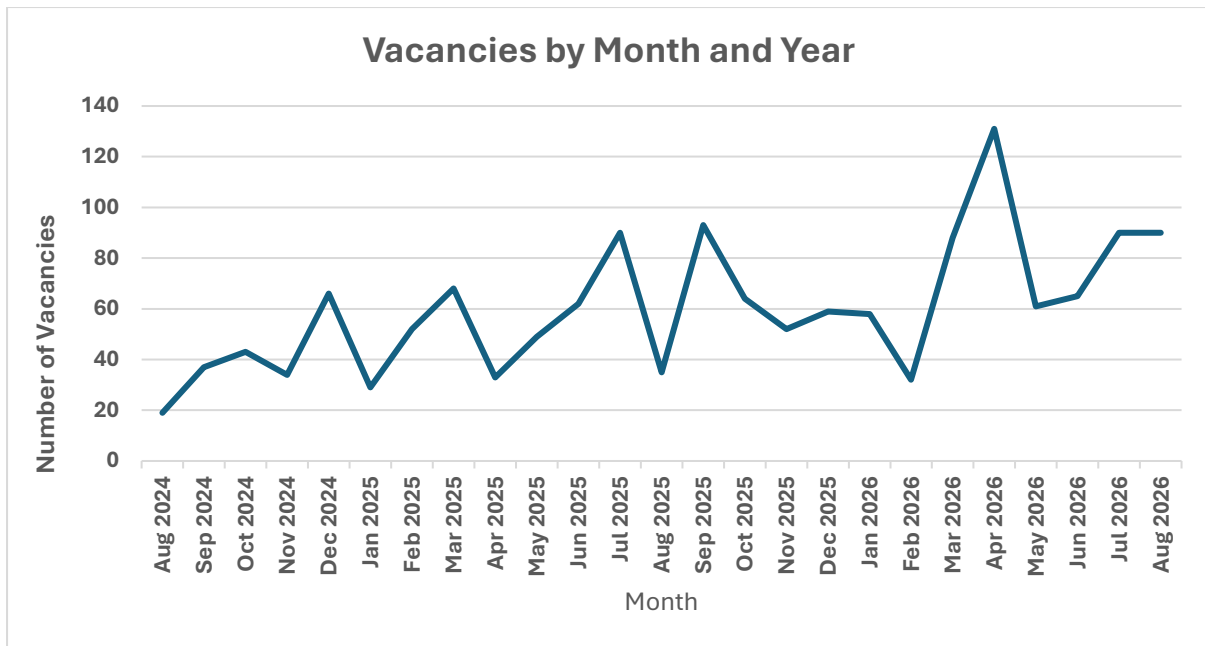
Primary and Community and Acute services exhibit the highest rates of musculoskeletal-related absences, suggesting increased risk exposure for staff working within these business units. A marked increase is evident across Primary and Community Services since April 2026. Acute and P&C have seen increases over the last month, whilst rates have declined across MH&LD and SS.



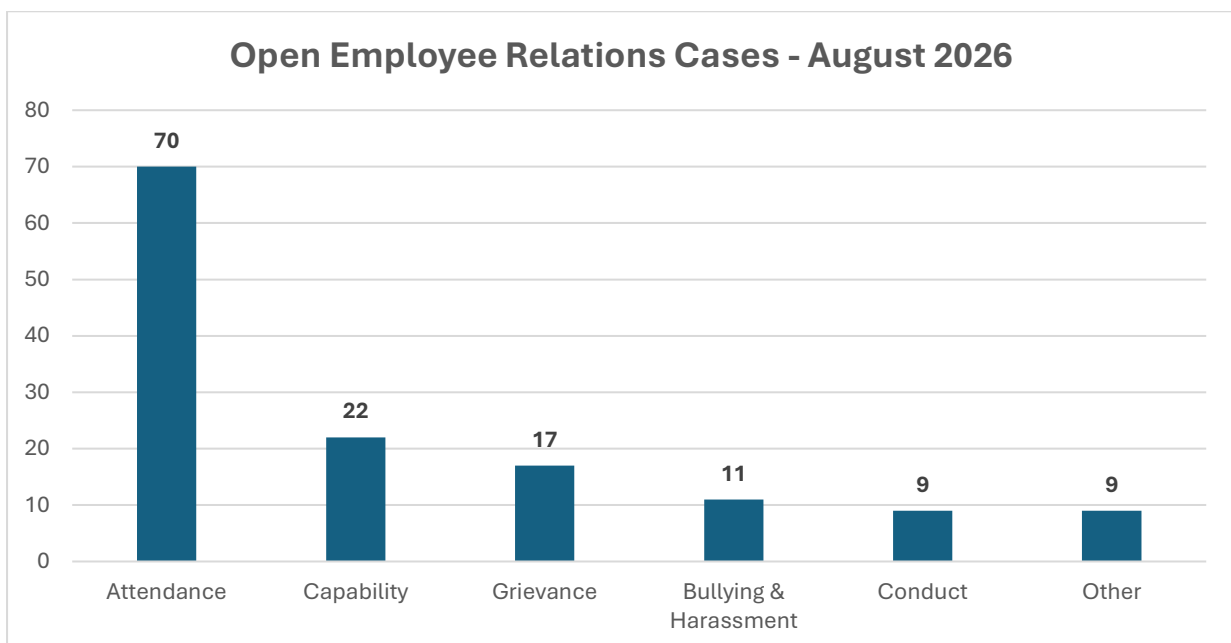
Colds, coughs, and flu have been the third most common reason for employees taking sick leave recently, showing the usual rise during winter across all Business Units. This creates short-term challenges, especially as patient needs and admissions reach their peak. Trend data shows that absences for this reason trend upwards from September each year, highlighting the importance of promoting preventative measures such as Flu Vaccines over the coming weeks.



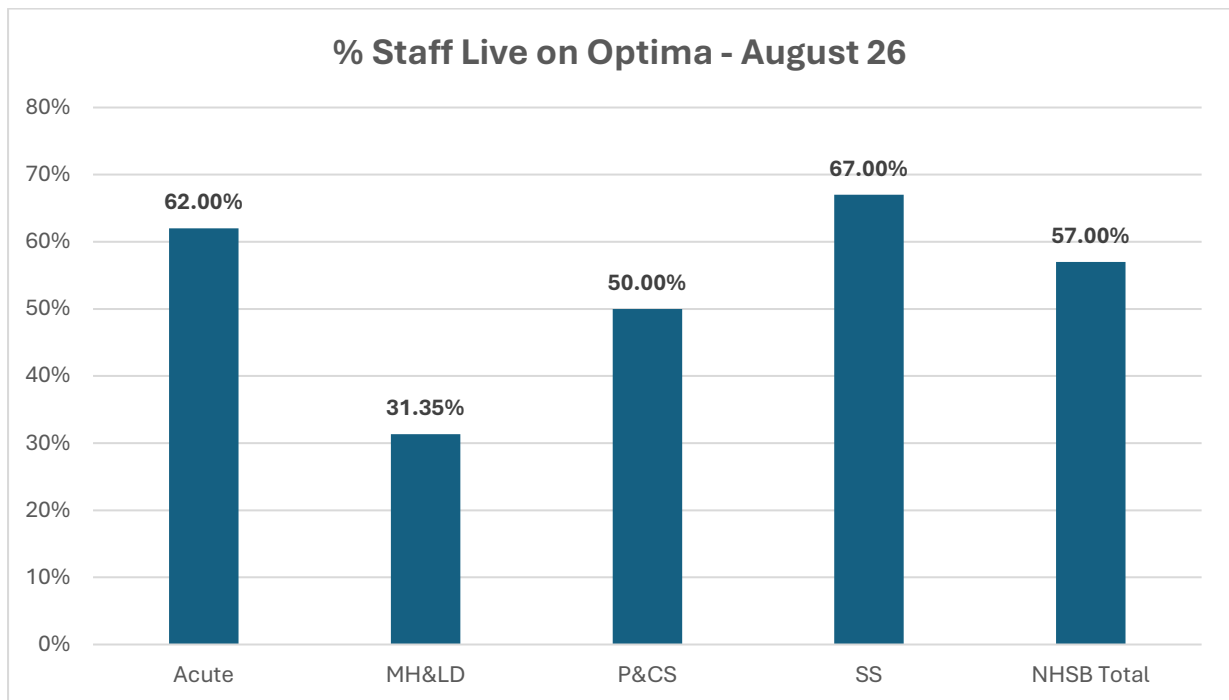
Turnover rates in clinical services have decreased over time, although Acute saw a small rise last year. The Mental Health and Learning Disability business unit has consistently experienced the highest turnover, partly because staff with mental health officer status often retire earlier than those in other groups.



Vacancies recruited through Jobtrain have shown a consistent upward trend, with a significant peak in April 26. During this period, the East Region Recruitment Service (ERRS) experienced staffing challenges, leading to considerable recruitment delays, with posts taking longer than usual to be advertised. As staffing pressures were resolved across March and April, posts that had been delayed in previous months were released, contributing to the peak of vacancies in April. Other factors include two recent International Recruitment campaigns recruiting to 40 vacancies, and clinical and non-clinical posts associated with the GP walk in clinic in Hawick.



Attendance cases are consistently the most common Open ER cases in NHS Borders. Capability and grievance cases have increased in recent months, whilst other types have remained static. This indicates that risks related to employee relations tend to cluster around certain case types. The other category includes formal disputes related to the Job Planning process for Medical Staff.



Acute services are currently furthest ahead with adoption of Optima for online rostering, primarily because Nursing and Midwifery and Medical units have been prioritised for implementation. P&CS have seen the highest increase since the last report, with 50% staff now active on Optima. A project plan is in place, with a required 5% increase each month to guarantee full implementation by the national deadline in March 2028.

NHS Borders



Meeting:	NHS Board meeting
Meeting date:	07 October 2026
Title:	NHS Borders Integrated Performance Report (IPR) – August 2026
Responsible Executive:	June Smyth, Director of Planning & Performance
Report Authors:	Hayley Jacks, 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 / Delivery Plan

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

- Safe
- Effective

2 Report summary

2.1 Situation

As highlighted previously, we are continuing to enhance the Integrated Performance Report (IPR) and Performance Framework for 2026/27 to provide greater insight into performance, the factors influencing results, and the actions being taken to achieve improvement. This month, we have introduced more detailed reporting in two key areas: Inpatient Waiting Times and 12-hour Emergency Department breaches.

These sections provide additional information on the underlying causes of current performance, the impact these factors are having, and the specific improvement actions being implemented to support recovery. As the refreshed reporting approach develops, detailed exception reporting will continue to be introduced for areas performing below

agreed levels, helping to provide greater transparency on performance challenges, improvement plans, and expected timescales for recovery.

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 focus on areas where performance is below agreed levels. No additional narrative will be provided for indicators that meet or exceed agreed performance levels (Green). For indicators within 10% of the agreed level (Amber) or more than 10% below it (Red), a detailed exception report will be included. This will set out the reasons for current performance, the actions being taken to address the gap, and the expected impact of those 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.

As the new reporting framework is developed and embedded, a phased approach will be taken. This will begin with a core set of priority measures to establish a consistent baseline, with additional measures and refinements introduced throughout the year. This approach will enable the framework to evolve in line with data availability, organisational priorities and learning from early implementation, while ensuring it remains practical, meaningful and aligned with our wider 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

Performance against the agreed measures for August 2026 is summarised below and provides an overview of organisational delivery across the key areas of performance, together with the accountable governance groups responsible for oversight and improvement. Overall, 9 measures are achieving target (Green), 3 measures are reporting a moderate variance from target (Amber), and 4 measures are reporting a significant variance from target (Red).

While a number of measures continue to perform in line with expectations, areas rated Amber or Red indicate where performance remains below the agreed standard and

require focused improvement activity. The accountable governance routes for these measures are identified within the report to support clear ownership, oversight and delivery of recovery actions.

The Quality & Performance Improvement Oversight Report (Appendix 1) provides further detail on all Amber and Red measures, including the key factors influencing performance, the actions being taken to secure improvement, and the anticipated trajectory and timescales for recovery where these are known. This ensures that performance reporting not only describes current performance levels but also provides assurance regarding the actions being taken to achieve sustained improvement.

Aim Statement	Executive Lead	Governance and Assurance Route	Previous Position	Latest Position / RAG
Emergency Access Standard Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	67.8%	65.5%
Reduce 12-hour waits to <9% by July 2026 and <0% by January 2027.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	8.6%	7.5%
Reduce average non-elective Length of Stay by 1 day by March 2027, excludes Paediatrics / Obstetrics & ITU.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	11.0 days	10.8 days
Average number of Acute Occupied Beds 85%.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	90.82%	95.35%
Sustain Delayed Discharges at <40.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	49	42
Reduce average Ambulance Handover Times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	34.0 minutes	33.7 minutes
Increase the number of patients admitted to AAU by 10%.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	507	483
Deliver sustained compliance with Outpatient Waiting Times by achieving zero 52-week waits	Oliver Bennett	Acute Performance Oversight Group	67	15

Aim Statement	Executive Lead	Governance and Assurance Route	Previous Position	Latest Position / RAG
from April 2027 maintaining zero tolerance for 78+ week waits.		Hospital Management Board Delivery Group		
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.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	75	64
Maximise elective Theatre Productivity by achieving at least 85% utilisation by July 2026.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	75.3%	76.3%
Sustain 95% of patients having a Diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	88%	84%
Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	100% (Jun 2026)	100% (Jul 2026)
Improve timely access to cancer treatment by achieving 85% of patients treated within 62 days of urgent referral by March 2027.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	78.6% (Jun 2026)	72.2% (Jul 2026)
90% of patients received CAMHS treatment within 18 weeks of referral.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	96.9%	100%
90% of patients received Psychological Therapy treatments within 18 weeks of referral.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	81.9%	80.2%
Borders Addiction Service 90% of patients received treatments within 3 weeks of referral.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	99.0%	100%

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:** NHSB Quality & Performance Improvement Oversight Report August 2026.

Quality & Performance Improvement Oversight Report

September 2026
(August 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

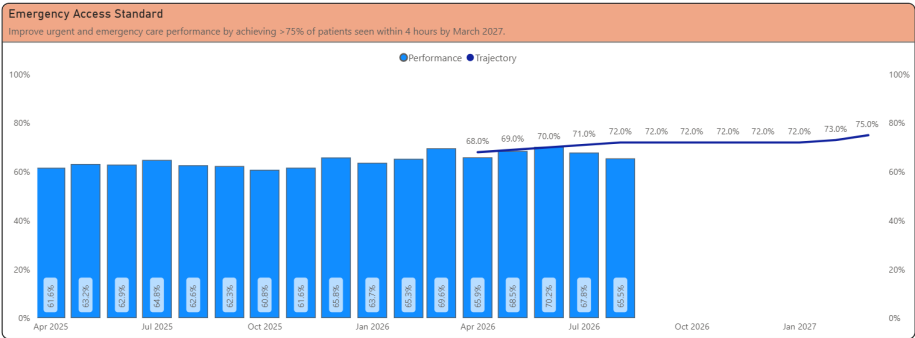


Quality & Performance Indicators: UUC

Strategy Alignment	Aim Statement	Executive Lead	Governance and Assurance Route	Performance/RAG
Ensure that Primary & Community services can support as many people back to good health as possible	Improve urgent and emergency care performance by achieving >75% of patients seen within 4 hours by March 2027.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	65.5%
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 <0% by January 2027.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	7.5%
Making secondary care fast, efficient and effective.	Reduce average non-elective length of stay by 1 day by March 2027, excludes Paediatrics / Obstetrics & ITU.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	10.8 days
Making secondary care fast, efficient and effective.	Average number of Acute occupied beds 85%.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	95.35%
Ensure that Primary & Community services can support as many people back to good health as possible.	Sustain delayed discharges at <40.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	42
Ensure that Primary & Community services can support as many people back to good health as possible.	Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	33.7 minutes
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%.	Gareth Clinkscale	Urgent & Unscheduled Care Programme Board Delivery Group	483

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

August Performance: 65.5%



What is driving this performance gap:
Increased attendances, consistently over 100 per day which is creating additional front door pressure impacting on availability of space to ensure timely triage, 1st assessment, ability to stream patients appropriately and turnaround time. Increase in delayed discharge bed days over previous 3 months.

Improvement Actions	Impact
Refresh Escalation processes and train staff in roles and responsibilities to support real time escalation and actions. This should reduce delays to triage, speciality review, delayed bed allocation and diagnostic delays.	Faster triage of pts, earlier senior decision making and reduction in excessive waits to be seen.
Maximise use of Acute Assessment Unit, Minor Injuries and Frailty pathways.	Appropriate streaming of pts away from ED.
Extend Integrated Discharge Team across all areas. This should provide early assessment and support for discharge, reducing length of stay.	Faster assessment and decision making in AAU. Earlier identification of pts for discharge.

Strategic Objective: Ensure that Primary & community services can support as many people back to good health as possible

Strategic Risk No: 1575

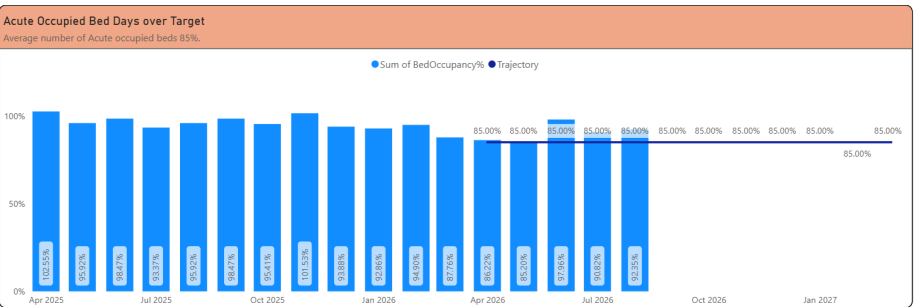
Risk Grading: High

Risk Approach: Treat

Target Risk Level: Medium

Aim Statement: Average number of Acute occupied beds 85%.

August Performance: 89.6%



What is driving this performance gap:
Extended Lengths of stay for patients recorded as reportable delays due to AWI and Residential Care Homes. There are delays in accessing Home First capacity, and from Home First to long term care packages.

Improvement Actions	Impact
Development of case to expand Reablement and Community Rehabilitation provision.	Improved patient flow across the whole system.
Strengthen discharge planning through inpatient flow workstream. Deliver clinical variation Short Life Working Group action plan.	Improved discharge planning.
Implement sub-national General Medicine and < 72 hours best practice principles.	Reduction in length of stay.
Proactive pull of patients from AFU, MAU & ED into H@H and HF. Scope both Care Home Support Team and SAS roles into Care Home admission avoidance. Additional two nurses & SAS will support H@H and IDT by working closely with care home in educating realistic medicine practice to avoid ED admissions. It is anticipated that CHST will also pull care home patients out of hospital to reduce Length of stay.	Reduction in IP demand and reduced LOS for frail / elderly patients.

Strategic Objective: Making secondary care fast, efficient and effective.

Strategic Risk No: 1958

Risk Grading: Very High

Target Risk Level: High

Risk Approach: Treat

Aim Statement: Increase the number of patients attending AAU by 10%.

August Performance: 483



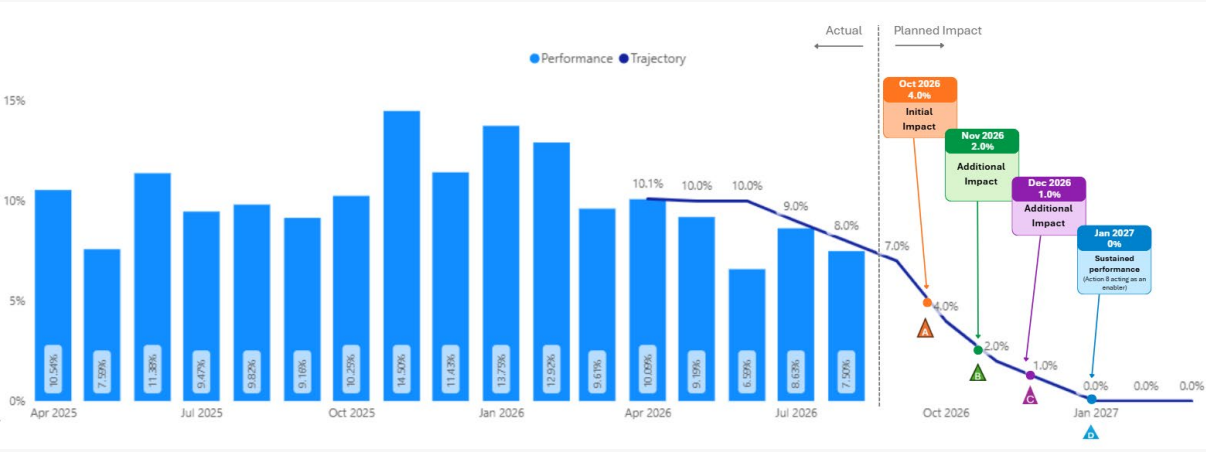
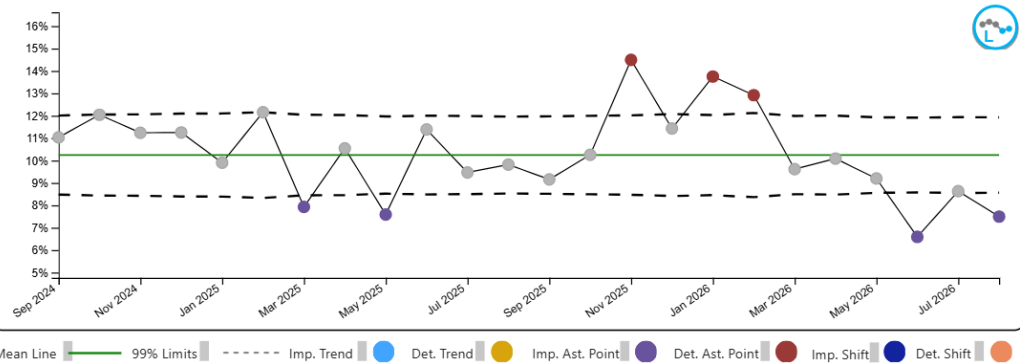
What is driving this performance gap: AAU attendances consistently improve month on month performing above high end variation. Gaps attributed due to unexpected staffing shortfalls both medical and ANP have impacted on viability of booked appointments.

Improvement Actions	Impact
Introduction of back shift for medical cover 1.30 - 9pm.	Improved cover in line with workload
Daily identification and active pull of appropriate pts from Emergency Department.	Increased flow of ambulatory pts through AAU
Review Acute Assessment Unit attendances at workstream meetings with named lead and monitor actions.	Improved pathways and performance of AAU

Strategic Objective: Ensure that Primary & community services can support as many people back to good health as possible

Risk No: 1575
Risk Grading: High
Target Risk Level: Medium
Risk Approach: Treat

Aim Statement: Reduce 12-hour breaches to 0 % by January 2027.
August Performance: 7.5%



Risks to delivery:

- Levels of delayed discharge
- Demand on urgent care
- Competing organisational pressures
- Workforce gaps and associated impact on patient flow

Governance route taken: Urgent & Unscheduled Care Board – Delivery Group

Decisions/steps taken at groups: Captured through Urgent & Unscheduled Care programme board action tracker

Escalations for decision/support: Risk of meeting trajectories escalated

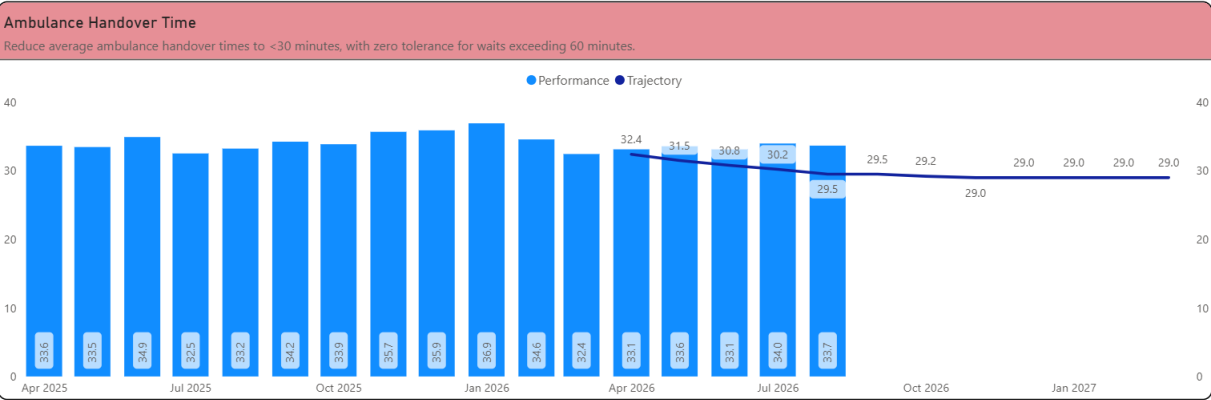
What is driving this performance gap: Continues to be impacted by whole-system flow, high acute occupancy and delayed discharges.

Improvement Actions:

	Improvement Actions	Anticipated Performance	When
A	Progress Active Wards principles within the Frailty Unit, including patient mobility, activity, independence, deconditioning and patient experience.	1% reduction	Initial outputs by 9th October 2026; further actions through October
A	Complete the AAU workforce review, secure the decision on the permanent ANP post and complete review of the patient information leaflet.	0.5% reduction	By 9th October 2026
A	Confirm MAU multidisciplinary leadership, roles, responsibilities and escalation arrangements; begin standardising MDTs and huddles.	1.5% reduction	Leadership milestone by 9th October; MDT work starts 5th October 2026
A	Prepare SHOP-method training and use the learning from NHS Tayside to support a revised MDT approach, initially focusing on MAU, Ward 4 and Frailty.	1.5% reduction	5th – 20th October 2026
B C	Review ward safety huddles and criteria-led discharge processes as part of the standardised ward-process workstream.	1% reduction	5th – 30th October 2026, with work commencing during this four-week period
B	Progress the Enhanced Reablement IJB proposal and agree an affordable funding, governance and budget-monitoring route.	1% reduction	Target milestone 7th October 2026
A	Start structured Hospital at Home PDSA testing for remote monitoring and implement agreed referral and admission pathway improvements.	0.5% reduction	From 1st October 2026
D	Develop and appraise Community Hub model options, agree the preferred access, coordination and MDT model, and identify a proportionate test setting.	Enabler during this period	Options work from 1st October; test-setting work from 12th October; preferred-model work starts 19th October 2026

Aim Statement: Reduce average ambulance handover times to <30 minutes, with zero tolerance for waits exceeding 60 minutes.

August Performance: 33.7 minutes



What is driving this performance gap:
Lack of capacity within ED are driving prolonged ambulance handovers due to the inability to move patients from ED into inpatient beds due to whole system congestion.

Improvement Actions:

Improvement Actions	Anticipated Performance	When
Escalation process under review to ensure real time operational grip and control	Improve visibility of ambulance handover delays. Reduce the number and duration of waits.	October 2026
Embed fit to sit principles for all ambulant pts with review of those pts in cubicles and if the requirements remain	Increased cubicle capacity improving access and reducing ambulance handover time.	October 2026
Delivery Unscheduled workstreams for inpatient flow and acute pathway redesign	Reduction overcrowding in ED, therefore increasing capacity within the dept and reducing handover time.	December 2026

Risks to delivery: Continued high attendances with exit block

Governance route taken: CMT and Urgent and Unscheduled Care Programme Board

Decisions/steps taken at groups: Escalation SOP to be reviewed and updated with clear actions

Escalations for decision/support: Unscheduled care project manager

Quality & Performance Indicators: Planned Care

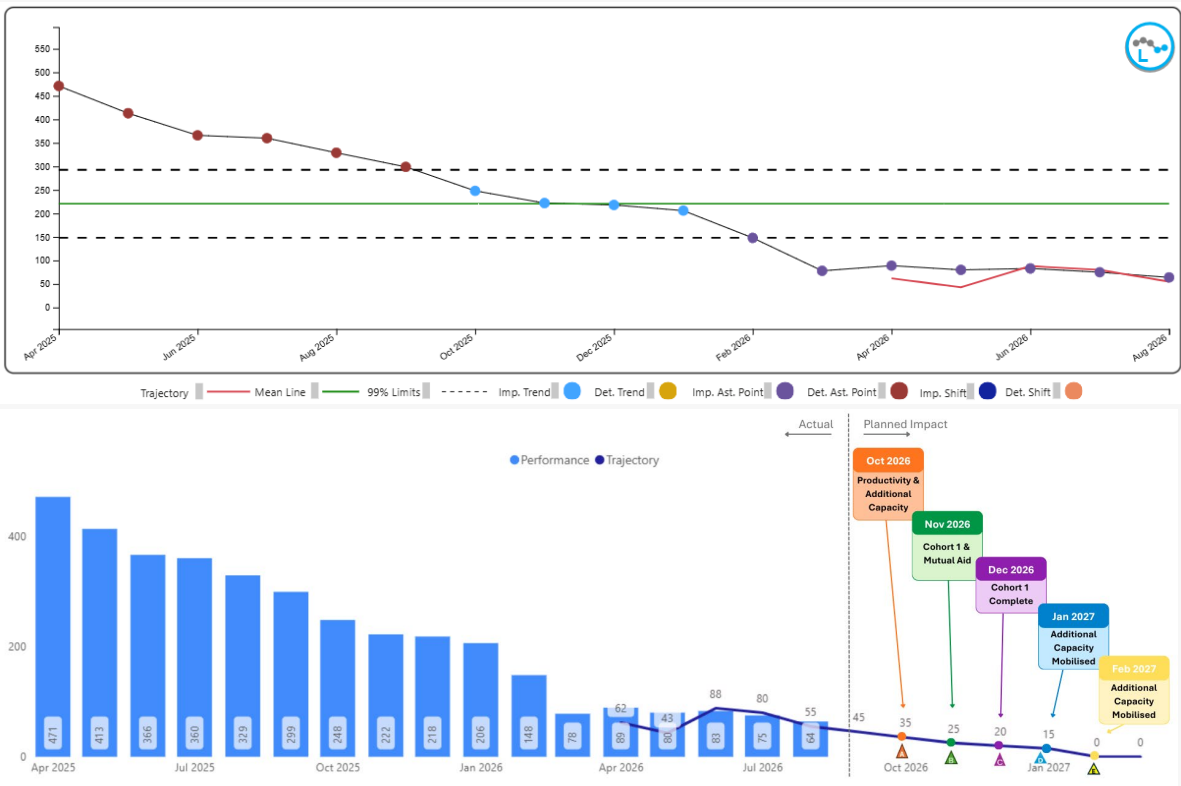
Strategy Alignment	Aim Statement	Lead Executive	Governance and Assurance Route	Performance/RAG
Making Secondary Care fast, efficient and effective.	Deliver sustained compliance with outpatient waiting times by achieving zero 52-week waits from April 2027 maintaining zero tolerance for 78+ week waits.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	13
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.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	64
Making Secondary Care fast, efficient and effective.	Maximise elective theatre productivity by achieving at least 85% utilisation by July 2026.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	76.3%
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.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	84%
Making Secondary Care fast, efficient and effective.	Achieve and sustain 95% performance on the 31-day cancer pathway by March 2027.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	100% (July 2026)
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.	Oliver Bennett	Acute Performance Oversight Group Hospital Management Board Delivery Group	72.2% (July 2026)

Planned Care Strategic Objective: Making secondary care fast, efficient and effective

Risk Number: 1958 Risk Grading: Very High Risk Approach: Treat Target Risk Level: High Executive Lead: Oliver Bennett

Aim Statement: 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.

August Performance: 64



Risks to delivery:

- Outsourcing sufficient activity
- Theatre staffing resilience

Governance route taken: Acute Performance Delivery Oversight Group

Decisions/steps taken at groups: Agreement to outsource 50 patients to Spire Washington. NHS Northumbria pending. Further patients to Spire Washington pending Mini Comp.

Escalations for decision/support: Via Acute Performance Oversight Group

What is driving this performance gap: An increase in Outpatient appointments during FY 25/26 has created additional demand for Inpatient procedures. This is particularly pronounced in orthopaedics.

Improvement Actions

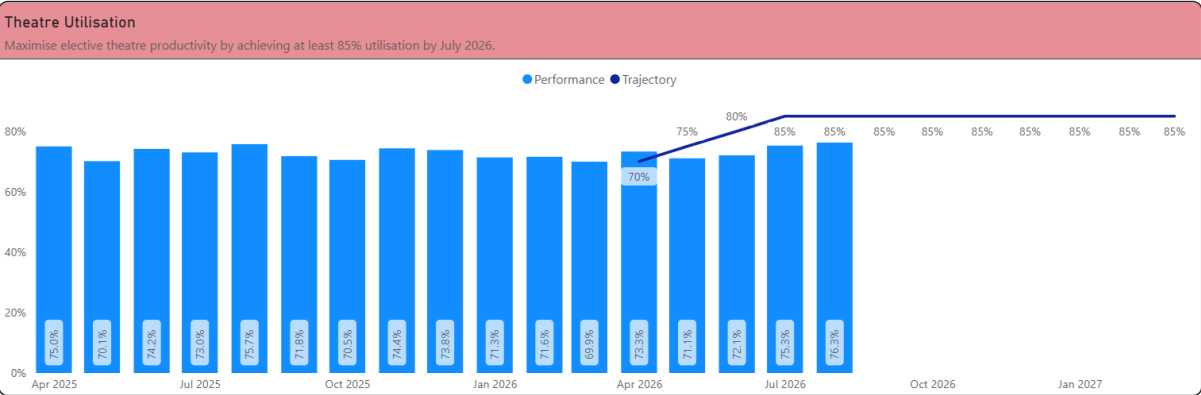
	Improvement Actions	Anticipated Performance	When
A B C D	Initiatives to drive productivity improvement within core baseline operating capacity	Reduction in 52 week waits by 5 per month from October to March 2027	September 2026
A B C	Commission additional capacity (cohort 1) for orthopaedic joints from Spire Washington (independent sector provider)	Reduction of 52 week waits by 50 patients: October 20 November 17 December 13	Commission in September, Deliver cohort 1 by December 2026 latest.
D E	Seek executive approval for the commissioning of additional capacity (cohort 2) from Spire Washington	Reduction of 52w waits by 50-70	Commission October 2026 Deliver by January 2027
E	Optimisation of Golden Jubilee allocation for orthopaedics	Reduction of 52 week waits by 69 between October and March 2027	Activity already commissioned/allocated. Delivery from October and March 2027.
A	Targeted waiting list initiatives	Reduction in 52 week waits by 8	October 2026
B D E	Collaborating with NHS Northumbria FT to provide 'mutual aid' for orthopaedic joints	Reduction in 52 week waits by 5 per month from October to March 2027	Commission and delivery from October 2026.
A B	Allocation additional operating capacity to General Surgery in October and November to clear long-wait backlog	Reduction in 52 week waits by 8 per month in October & November	Start October 2026 and complete November 2026.
A	Commission Synaptic to deliver capacity for long-wait oculoplastic cases	Reduction in 52 week waits by 5 in September and 3 in October	Commission September and complete October 2026.

Planned Care Strategic Objective: Making secondary care fast, efficient and effective

Risk Number: 1958 Risk Grading: Very High Risk Approach: Treat Target Risk Level: High Exec Lead: Oliver Bennett

Aim Statement: Maximise elective theatre productivity by achieving at least 85% utilisation by July 2026.

August Performance: 76.3%



What is driving this performance gap: The main drivers of impact to utilisation remain elective cancellation and early finishes.

Improvement Actions:

Improvement Actions	Anticipated Performance	When
Weekly meeting on short notice cancellations leading to lost elective theatre capacity. Task and finish approach to identified process or systems issues resulting in avoidable cancelations.	Aimed at reducing time lost to avoidable cancellations	Weekly
Targeted review of early finishes to identify reasons and required actions to support improvement where this is not linked to cancellations.	Early finishes account for 5% of the performance challenge.	Weekly
Reviewing Theatre Productivity and performance by Theatre/Service with an aim of understanding overall contribution of service to both. Aim is to target improvement to biggest opportunity areas	A targeted improvement approach	Oct 2026

Risks to delivery: Staffing Levels in ITU and theatres leading to cancelations

Governance route taken: Clinical Management Team, Surgical Care Group and Hospital Management Board.

Decisions/steps taken at groups: Review of recruitment times lines and weekly scheduling meeting to prioritise capacity to higher priority lists.

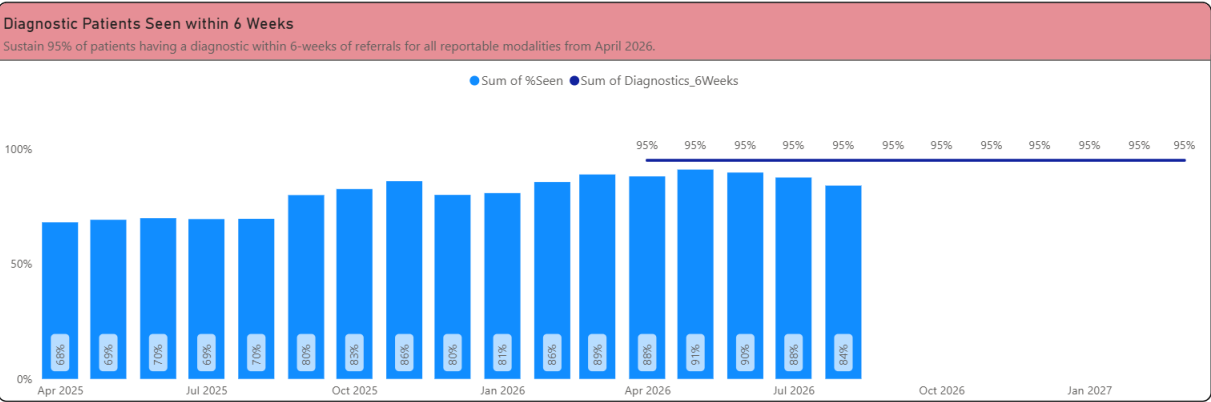
Escalations for decision/support: Ongoing delays in essential clinical recruitment times lines leading to staffing shortfalls

Planned Care Strategic Objective: Making secondary care fast, efficient and effective

Risk Number: 1958 Risk Grading: Very High Risk Approach: Treat Target Risk Level: High Executive Lead: Oliver Bennett

Aim Statement: Sustain 95% of patients having a diagnostic within 6-weeks of referrals for all reportable modalities from April 2026.

August Performance: 84 %



Risks to delivery: Dependant on mobile scanners for routine waits

Governance route taken: Acute Performance Delivery Oversight Group

Decisions/steps taken at groups: Capacity plan in relation to Endoscopy

Escalations for decision/support: Recruitment escalated regarding Radiology recruitment to Delivery Group

What is driving this performance gap: Overall performance for Radiology in August was 91%. (96% MRI, CT 84%, US 92% and Barium Studies 100%). CT performance was affected by the breakdown of the Main CT Scanner as well as issues with the mobile CT scanner. Please note that these figures do not include all Diagnostics i.e. this is radiology only and excludes ‘scopes’.

Improvement Actions

Improvement Actions	Anticipated Performance	When
Radiology recruitment has been frozen pending agreement over concerns raised that the agreement in 2025 for additional workforce to support the out of hours requirement was incorrect. This recruitment freeze is currently affecting the ability to recruit into vacant hours in Ultrasound. Discussed at HMB in September and to be considered by the Delivery Board. This may delay recruitment into the new year.	Following recruitment decision, capacity plan to be developed	October 2026
Additional CT days scheduled with external provider due to mechanical issues with Mobile technology. In addition, continue to make up lost reporting capacity to bring down waits to report.	Target patients waiting over 6 weeks	October 2026

Quality & Performance Indicators: P&CS, MH/LD

Strategy Alignment	Aim Statement	Executive Lead	Governance and Assurance Route	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.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	100%
Ensure that Primary & Community Services can support as many people back to good health as possible.	90% of patients received Psychological Therapy treatments within 18 weeks of referral.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	80.2%
Supporting People to Keep Themselves Well.	90% of patients received treatments within 3 weeks of referral.	Gareth Clinkscale	Community & Mental Health Management Board Delivery Group	100%

Meeting: Borders NHS Board

Meeting date: 7 October 2026

Title: Integration Joint Board Minutes

Responsible Executive/Non-Executive: P Moore, Chief Executive

Report Author: L Shillinglaw, EA to CE

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 30 September 2026
- Integration Joint Board 5 August 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 20.05.26
- Appendix No 2. Integration Joint Board minutes 05.08.26



Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 20 May 2026 at 10am** via Microsoft Teams

Present:

(v) D Parker (Chair)	(v) F Sandford, Non-Executive
(v) R Tatler	(v) J Ayling, Non Executive
(v) E Thornton-Nicoll	(v) L O'Leary, Non Executive
(v) T Weatherston	(v) J Pepper, Non Executive
(v) N Richards	

L Turner, Chief Financial Officer
N Istephan, Chief Executive, Eildon Housing Association
S Horan, Director of Nursing, Midwifery & AHPs
L Jackson, LGBTQ+
J Smith, Borders Care Voice
J Amaral, Chief Executive, Borders Community Action

In Attendance:

I Bishop, Board Secretary
A Bone, Director of Finance (NHS)
S Bhatti, Director of Public Health (NHS)
K Steward, Community Nurse Manager, (NHS)
M Fleming, Finance Manager (SBC)
G Clinkscale, Interim Director of Urgent Care, Community Services & Mental Health (NHS)
L Jones, Director of Quality & Improvement, (NHS)
S Burt, Chief Social Work Officer (SBC)
J Stacey, Chief Internal Auditor (SBC)
S Laurie, Senior Communications Officer (NHS)
H Megson, HR Manager (SBC)
C Smith, Head of Workforce (NHS)
L Wilson, Manager (SBC)
C Wilson, General Manager Primary & Community Services (NHS)

1. APOLOGIES AND ANNOUNCEMENTS

- 1.1 Apologies had been received from J McLaren, Non Executive, R Duncan GP, D Bell, Staff Side, SBC, P Moore, Chief Executive, NHS Borders, D Robertson, Chief Executive, SBC, N Hood, Borders Carers Centre, C Myers, Director of Adult Social Work & Care and L McCallum, Medical Director
- 1.2 The Chair welcomed J Pepper to her first meeting as a newly appointed Non-Executive Director of NHS Borders, noting her extensive experience across Scotland.
- 1.3 The Chair also advised members of the appointment of G Main as the new Chief Officer, due to commence in post on 3 August 2026.

- 1.4 The Chair welcomed attendees and members of the public to the meeting.
- 1.5 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 18 March 2026 were approved.

4. MATTERS ARISING

- 4.1 **Action 2025-1:** L Jackson raised continuing concerns regarding equality impact assessment activity since the departure of the previous postholder, advising that both LGBTQ+ representatives and Borders Care Voice had seen very limited evidence of equality impact assessment engagement. Concern was expressed that this could indicate a reduction in organisational focus on equality and human rights considerations. The Chair acknowledged the concern. The discussion recognised the dependency on the appointment of the new Chief Officer and acknowledged that a number of strategic improvement actions remained outstanding. Members noted the governance risk associated with prolonged delays in progressing equality and human rights duties and agreed that outstanding actions should remain under active review.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that the Chief Officer, on appointment, be asked to review progress on Equality Impact Assessment activity and provide assurance to the IJB regarding compliance with Equality and Human Rights duties.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Action Tracker.

5. PERFORMANCE AND DELIVERY REPORT

- 5.1 The Board considered the Performance and Delivery Report. F Sandford sought clarification regarding a significant increase in home care waiting lists between March and April 2026. G Clinkscale advised that pressures had been concentrated within rural communities where independent providers had experienced difficulty meeting demand. He reported that the position had improved significantly over the previous five to six weeks through additional capacity being provided by Scottish Borders Council home care services. Members were advised, however, that approximately ten patients remained within the Home First reablement service pending assessment and development of longer-term care packages and that those delays did not formally appear within delayed discharge reporting.

- 5.2 J Pepper queried the inconsistency between delayed discharge information and other performance information contained within the report. G Clinkscale explained that delayed discharge information reflected formal national reporting datasets whereas other performance indicators reflected more current operational management information.
- 5.3 F Sandford welcomed the development of the Integrated Psychological Trauma Steering Group and Distress Brief Intervention Programme. Whilst supportive of both initiatives, she stressed the importance of understanding measurable outcomes and effectiveness, observing that ongoing investment decisions should be informed by evidence of impact rather than solely activity levels.
- 5.4 During discussion the Board recognised ongoing dependencies relating to workforce availability, community care capacity and discharge pathways. Members also requested access to more recent delayed discharge data to support effective scrutiny.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested access to more recent delayed discharge data to support effective scrutiny.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested a future report outlining the impact and effectiveness of the Integrated Psychological Trauma Steering Group and Distress Brief Intervention Programme to support evaluation of service outcomes and value.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. OUR FUTURE SELVES: IMPROVING THE HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE IN THE SCOTTISH BORDERS

- 6.1 The item was withdrawn from the agenda.

7. FINANCIAL PLAN 2026/27

- 7.1 The Board considered the proposed 2026/27 financial plan. L Turner presented the NHS Borders payment offer and associated financial assumptions. Members were advised that the delegated services offer totalled £156.6m and when combined with the Scottish Borders Council offer, resulted in a total delegated budget of approximately £245m. The plan relied upon delivery of £4.9m of savings and currently projected an anticipated NHS delegated services overspend of £2.8m.
- 7.2 The Board scrutinised the assumptions underpinning proposed savings programmes. N Istephan sought further explanation regarding proposed mental health income generation opportunities. F Sandford raised concerns regarding the future of the Primary Care Improvement Programme (PCIP), noting significant previous investment and implementation effort. She emphasised that any future funding decisions should be underpinned by robust evaluation of effectiveness, citing concerns about delays and non-attendance levels within some service areas.
- 7.3 J Amaral highlighted wider strategic concerns regarding financial sustainability and questioned how the Partnership intended to shift investment towards prevention and early intervention to reduce future demand. The Chair advised that strategic planning

and service transformation would form a major area of work following the appointment of the new Chief Officer.

- 7.4 G Clinkscale outlined the challenges arising from withdrawal of Scottish Government PCIP demonstrator funding. Members heard that service reviews would examine CTAC, pharmacotherapy, vaccination services, urgent care support, first-contact physiotherapy and other components of the programme. He advised that decisions would need to balance financial pressures, contractual obligations and patient safety considerations.
- 7.5 S Burt provided further detail regarding mental health income generation and collaborative regional service models. He described examples of cross-board arrangements that generated income whilst improving patient outcomes and reducing reliance on higher-cost placements. Members welcomed examples of regional collaboration and noted potential lessons for wider service redesign.
- 7.6 The Board recognised material risks associated with the withdrawal of PCIP funding, delivery of savings plans, unresolved NHS Borders and Scottish Borders Council resource transfer discussions and wider financial sustainability challenges.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** accepted the payment offer of £193.37m from NHS Borders.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the indicative 2026/27 budget.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the anticipated year end overspend of £2.8m in delegated services and £3.7m in Set Aside based on the current anticipated expenditure if spend cannot be reduced in year.

8. SCOTTISH BORDERS HSCP WORKFORCE PLANNING UPDATE

- 8.1 The Board received an integrated workforce planning update covering NHS Borders and Scottish Borders Council services. H Megson reported continuing recruitment and retention challenges across a range of critical professions including social workers, Mental Health Officers, occupational therapists, consultants, psychiatrists, GPs and nursing staff. Workforce pressures arising from retirement profiles, reduced working hours and limited training pathways were highlighted.
- 8.2 Members examined sickness absence data and associated workforce sustainability risks. S Bhatti queried whether the Borders workforce demographic profile contributed to sickness absence levels. H Megson advised that whilst absence levels broadly reflected national trends, the age profile of the local workforce was likely to be a contributing factor.
- 8.3 N Istephan expressed disappointment that information from independent and third-sector providers had not been available, observing that workforce planning could not be fully effective without understanding workforce dynamics across the whole health and social care system. C Smith explained that capacity limitations and the absence of key leadership posts had affected data collection and acknowledged the need for a more integrated approach.

- 8.4 E Thornton-Nicol challenged language describing social care roles and stressed the importance of recognising the value of care workers. She sought further information regarding workforce wellbeing, stress management and sickness absence causation. In response, members heard about improved management information systems, stress risk assessment activity and enhanced attendance management support.
- 8.5 S Horan reflected that the report highlighted gaps in intelligence and suggested that the Board use the workforce update as a form of gap analysis to inform future integrated planning. J Stacey noted that workforce planning constituted a key strategic enabler and emphasised the importance of regular reporting to the IJB.
- 8.6 During discussion the Board noted that the risks identified included workforce shortages, ageing workforce demographics, sickness absence levels, incomplete system-wide data and leadership capacity constraints pending appointment of the new Chief Officer.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the updated Integrated Workforce Planning template

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** considered Integrated Workforce Planning priorities for the coming year and requested the continued development of the integrated whole-system workforce approach.

9. AUDIT COMMITTEE MINUTES: 08.12.25

- 9.1 The Board received the Audit Committee minutes for noting. J Stacey advised that whilst J Pepper had been appointed as an NHS member of the IJB she had also been identified to fill the NHS vacancy on the IJB Audit Committee.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes and the appointment of J Pepper to the membership of the IJB Audit Committee.

10. PUBLIC BODIES (JOINT WORKING) (INTEGRATION JOINT BOARDS) (SCOTLAND) AMENDMENT ORDER 2025

- 10.1 Members received an update regarding emerging changes associated with amendments to the Public Bodies Joint Working legislation. It was acknowledged that further information from national bodies was anticipated.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

11. ANY OTHER BUSINESS

- 11.1 **PRIMARY CARE IMPROVEMENT PROGRAMME (PCIP):** C Wilson provided a detailed update regarding the Primary Care Improvement Programme following withdrawal of Scottish Government demonstrator funding. Members were advised that approximately £2.5m of annual funding had ceased, requiring the Partnership to evaluate the future configuration of services and identify efficiencies whilst maintaining service quality and patient safety.

- 11.2 The Board heard that a comprehensive options appraisal process would examine all PCIP service components and involve key stakeholders, including patient representatives, clinicians and partner organisations. Members discussed the importance of evaluating the programme's impact, using robust data and ensuring that services were not withdrawn without understanding wider system implications.
- 11.3 F Sandford sought assurance regarding evaluation methodology and comparability with future Scottish Government findings. C Wilson advised that national expectations remained unclear and that flexibility would likely be required once national conclusions were known.
- 11.4 J Amaral highlighted the importance of involving service users and community representatives in shaping future decisions. C Wilson confirmed that extensive stakeholder engagement and equality impact assessment activity would form part of the review process.
- 11.5 J Ayling emphasised the importance of timely and reliable data to support future decision making and sought assurance that financial and operational evidence would be sufficiently robust. Members were advised that baseline data quality was strong and that options would be supported by detailed financial appraisal.
- 11.6 S Bhatti raised concerns regarding potential future disinvestment in community-based services which could conflict with strategic ambitions to shift care closer to home. A Bone acknowledged the complexity of the issue and stressed the importance of considering future strategic direction alongside financial affordability and service effectiveness.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the PCIP Executive Committee report the outcome of the PCIP options appraisal and evaluation process to the IJB to enable governance oversight and decision making regarding future service configuration.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

- 11.7 **REQUEST FROM THIRD SECTOR REPRESENTATIVES:** L Jackson requested a future discussion between third-sector representatives and key IJB leaders regarding future strategic direction, financial pressures and implications for the voluntary sector. The Chair advised that a formal written request should be submitted for consideration through appropriate channels.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Third Sector Representatives submit a formal written request regarding future strategic discussions with IJB leadership in order to clarify the scope, and purpose of the discussion.

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 5 August 2026, from 10am to 12noon through MS Teams.



Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 5 August 2026 at 10am** via Microsoft Teams

Present:

(v) D Parker (Chair)	(v) F Sandford, Non-Executive
(v) R Tatler	(v) J Ayling, Non Executive
(v) E Thornton-Nicoll	(v) L O'Leary, Non Executive
(v) T Weatherston	(v) J Pepper, Non Executive
(v) N Richards	

G Main, Chief Officer
L Turner, Chief Financial Officer
N Istephan, Chief Executive, Eildon Housing Association
J Smith, Borders Care Voice
N Hood, Borders Carers Centre
J Amaral, Chief Executive, Borders Community Action
D Bell, Staff Side (SBC)
V Mann, Partnership (NHS)

In Attendance:

I Bishop, Board Secretary
A Bone, Director of Finance (NHS)
K Steward, Community Nurse Manager, (NHS)
M Fleming, Finance Manager (SBC)
L Jones, Director of Quality & Improvement, (NHS)
S Burt, Chief Social Work Officer/General Manager MHL D (SBC/NHS)
J Stacey, Chief Internal Auditor (SBC)
C Myers, Director of Adult Social Work & Care (SBC)
C Oliver, Head of Communications & Engagement (NHS)
S Henderson, Manager (SBC)
K Kiln, Consultant in Public Health (NHS)

1. APOLOGIES AND ANNOUNCEMENTS

- 1.1 Apologies had been received from J McLaren, Non Executive, R Duncan GP, L Jackson, LGBTQ+, L McCallum, Medical Director, S Horan, Director of Nursing, Midwifery AHPs, P Moore, Chief Executive, NHS Borders, D Robertson, Chief Executive, SBC, S Bhatti, Director of Public Health, and G Clinkscales, Interim Director of Urgent Care, Community Services & Mental Health.
- 1.2 The Chair formally recorded the appointment of G Main as Chief Officer of the Integration Joint Board (IJB) and welcomed her to her first meeting of the IJB.
- 1.3 The Chair welcomed attendees and members of the public to the meeting.
- 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 20 May 2026 were approved.

4. MATTERS ARISING

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the Action Tracker.

5. PERFORMANCE AND DELIVERY REPORT

- 5.1 The Board received the routine Performance and Delivery Report. Discussion focused on Child and Adolescent Mental Health Services (CAMHS), social work assessment waiting times, care at home performance, commissioning activity and delayed discharge arrangements.
- 5.2 Members sought clarification regarding CAMHS reporting. It was confirmed that national performance data related only to non-neurodevelopmental pathway patients and did not include neurodevelopmental demand. Concern was expressed that the current reporting framework could provide an incomplete picture of service pressures. Members requested greater visibility of neurodevelopmental demand, follow-up appointments and wider service performance indicators. The Board further discussed whether a future focused report on CAMHS would provide more meaningful assurance regarding service demand, waiting times and improvement activity.
- 5.3 The Board also examined rising social work assessment waiting times. Members highlighted the risk that increased waits may obscure underlying unmet need, resulting in individuals seeking support through other parts of the health and care system. Officers advised that pressures reflected workforce vacancies and that recovery plans were in place. Assurance was provided that care at home unmet need had fallen to its lowest level since 2021, although members recognised the continuing operational risks associated with workforce capacity.
- 5.4 Members requested that future reporting provided a more integrated description of system pressures, particularly links between delayed discharge, assessment waiting lists, community capacity and overall performance.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the General Manager for MH&LD and the Chief Officer develop future reporting on neurodevelopmental demand and wider CAMHS performance, including consideration of a dedicated CAMHS update for the Board in order to improve the Boards assurance regarding service demand, performance and outcomes.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Chief Officer develop and present an integrated overview showing the relationships between delayed discharge, assessment demand, community capacity and overall system performance in order to strengthen the Boards understanding and strategic oversight of whole-system pressures.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. HSCP ANNUAL PERFORMANCE REPORT 2025/26

- 6.1 The Board considered the statutory Annual Performance Report. The Chief Officer acknowledged the significant work undertaken by officers in preparing the report and emphasised the importance of using performance information not only to demonstrate achievement but also to inform future commissioning decisions and improvement activity.
- 6.2 Members welcomed the report but challenged whether additional contextual information should be included regarding the prolonged vacancy in the Chief Officer post during 2025/26. It was considered important that the report accurately described the strategic governance context affecting the Partnership during the reporting period.
- 6.3 Members also raised accessibility concerns and questioned whether future reports could be produced in a format more accessible to the public. The Chief Officer committed to improving accessibility and readability in future years while maintaining statutory reporting requirements.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** proposed a change to the draft APR which was to include the extended Chief Officer vacancy during 2025/26 and the associated strategic impact.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the APR for publication, subject to the IJB directed change being made.

7. IJB AUDIT COMMITTEE ANNUAL REPORT 2025/26

- 7.1 The Chair of the Audit Committee presented the Committee's Annual Report. Members were advised that significant attention had been given during the year to the governance impacts of the Chief Officer vacancy, strategic planning arrangements and the Board's oversight responsibilities.
- 7.2 Discussion highlighted a continuing need to strengthen scrutiny of strategic commissioning, directions and associated governance processes.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Audit Committee Annual Report 2025/26 (Appendix 1) which presented the self-evaluation of the IJB Audit Committee's performance, impact and effectiveness, and areas of improvement.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the assurances from the IJB Audit Committee to the Integration Joint Board

(set out in bullet points a-g in Appendix 1) and its identified areas of improvement (nos.1-2 in Appendix 1) to enhance its impact and effectiveness as a scrutiny body.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Chief Officer undertake a review of strategic commissioning governance, directions arrangements and the role of the Audit Committee in supporting assurance and scrutiny in order to strengthen governance and oversight arrangements.

8. 2026/27 MEDIUM TERM PLAN

- 8.1 The Board considered the Medium-Term Financial Plan against a backdrop of significant national and local financial pressures. Members noted forecast deficits associated with delegated NHS services, uncertainty regarding resource transfer arrangements and ongoing system-wide funding constraints.
- 8.2 Substantial discussion focused on the relationship between financial sustainability, prevention, strategic commissioning and risk appetite. Members highlighted the importance of investing in preventative approaches whilst recognising the need to make difficult decisions regarding disinvestment and resource reallocation.
- 8.3 The Board debated differences between operational and strategic risk, the need for positive risk-taking, and the necessity of clearer articulation of those matters within future Board development and governance arrangements.
- 8.4 The Chief Officer advised that further work was required to clarify the Board's strategic commissioning role, improve risk management arrangements and ensure that performance, finance and transformation agendas were considered together.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJBs Medium Term Financial Plan for 2026/27 to 2030/31.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the ongoing work in relation to resource transfers and associated activity and the impact on the Medium-Term Plan.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Chief Offer and Chief Internal Auditor review and refresh the IJB Strategic Risk Register, risk management approach and risk appetite arrangements in order to support strategic commissioning and Board decision-making.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Chief Officer develop proposals describing the Board's strategic commissioning role, risk framework and requirements for future assurance reporting in order to strengthen governance, strategic oversight and decision-making.

9. IJB 2025/26 QUARTER 4 FINANCIAL MONITORING POSITION

- 9.1 The Board reviewed the 2025/26 year-end position. Members noted continuing overspends in learning disability and social care services, together with pressures associated with demand, workforce costs and prescribing expenditure.

- 9.2 Discussion highlighted the strategic risk arising from increasing complexity of need, particularly in learning disability services and children's transitions. Members reiterated the importance of preventative investment, support for carers and ongoing transformation activity.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the final year end position of the IJB for the year ended 31st March 2026.

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.

10. RESOURCING EQUALITY, DIVERSITY AND HUMAN RIGHTS FUNCTION

- 10.1 The Chair advised that the paper had not followed the agreed governance process and therefore would not be considered for decision. However, members agreed that the underlying issues raised were important and required further work.
- 10.2 Discussion focused on the Board's statutory responsibilities under the Public Sector Equality Duty, assurance arrangements, proportionality, governance responsibilities and the distinction between Board-level duties and operational responsibilities held by partner organisations. Members also highlighted concerns regarding reduced engagement with stakeholders in equality impact assessment processes.
- 10.3 The Chief Officer undertook to conduct a comprehensive review of current arrangements and return with proposals clarifying Board responsibilities, assurance mechanisms and governance arrangements.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the current risk relating to equality, diversity and human rights statutory compliance.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested the Chief Officer review current Public Sector Equality Duty arrangements and develop proposals clarifying Board responsibilities, assurance requirements and partner accountability arrangements to ensure statutory compliance and effective governance.

11. CHILDREN (CARE, CARE EXPERIENCE AND SERVICES PLANNING) (SCOTLAND) ACT 2026

- 11.1 The Board received an overview of the implications of the new legislation. Members were advised that the Act strengthened the IJB's role in children's services planning while not requiring delegation of additional children's services functions.
- 11.2 The discussion highlighted the inter-dependence between adult services, carers, mental health, transitions and outcomes for children and families. Members recognised opportunities to strengthen prevention, commissioning and joint planning arrangements.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the IJB Chief Officer will bring back a paper to the Integration Joint Board in December 2026 to set out how the IJB can optimally contribute to Children's Services Planning arrangements.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** considered the areas that the IJB Chief Officer should address in the December 2026 paper. They should include as a minimum:

- Setting out how the IJB contributes to Children's Services Planning through Officer involvement, partnership forums and governance arrangements.
- Mapping the IJB's potential contribution to the Children's Services Plan, particularly where adult services support whole-family wellbeing, transitions, unpaid carers, young carers, care leavers, cluster working and prevention.
- Providing assurance that the IJB is meeting its statutory responsibilities under the Children (Care, Care Experience and Services Planning) (Scotland) Act 2026, including how compliance will be monitored and reported.
- Setting out how relevant data and performance information can be shared with the IJB to support oversight of joint planning and outcomes for children, young people, families and carers.
- Considering how the developing Strategic Commissioning Plan can complement children's plans, avoid duplication and support shared priorities across adult and children's services.

12. SCOTTISH BORDERS COMING HOME PROGRAMME UPDATE

- 12.1 The Board received an update on progress delivering the national Coming Home Programme for adults with learning disabilities. Members were advised of ongoing challenges relating to housing availability, workforce capacity, funding arrangements and the growing complexity of need.
- 12.2 Discussion recognised the significant financial and clinical risks associated with out-of-area placements and prolonged hospital stays. Members were advised that local solutions centred on housing, enhanced multidisciplinary support and person-centred "good life planning" offered the best opportunity to improve outcomes and reduce long-term costs.
- 12.3 The Board welcomed progress made through local test-of-change work and supported the principle of building services around individual aspirations and needs. Members requested continued oversight of workforce, housing and financial implications.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made against the Coming Home Programme tests of change.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged that housing availability remained the principal factor affecting delivery timescales.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the completion of Good Life Plans by Lives Through Friends and the discontinuation of that service, with relevant planning now being led in-house by the Learning Disability Service.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted progress on housing workstreams including the YMCA development, Poynder bungalows, Tweedbank bungalows and St Ronan's as a potential development option subject to Council governance and approval.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Community Living Change Fund allocation from Scottish Government had been fully utilised to support local implementation activity.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that recruitment to the enhanced clinical team was underway, with Psychology and Occupational Therapy posts filled, Nursing interviews had been planned for 15 July 2026, and Speech and Language Therapy resource was still to be secured.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Learning Disability Service continued to make quarterly DSR returns to Public Health Scotland, with local recording of young people used for future planning but not included in the national adult return.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the decision-making process for continued funding remained to be agreed between NHS Borders and Scottish Borders Council.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the completion of the Learning Disability Needs Assessment by NDTi and the reports produced to inform future planning.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the alignment of the local programme with the Coming Home Action Plan 2026, the Housing Options Guide and the Coming Home Training Guidance.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the ongoing local contribution to national Coming Home workstreams, the Peer Support Network and the National Support Panel pilot.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** supported continued work with housing partners, care providers, NHS Borders and the IJB to progress future transition arrangements over the next 12 to 24 months.

13. IJB VOTING RIGHTS

13.1 The Board received an update on legislative changes requiring voting rights to be extended to lived experience representatives from 1 September 2026. Discussion focused on governance responsibilities, conflicts of interest, training requirements and implications for Board decision-making.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the legislative changes extending voting rights to lived experience members, who are unpaid carers, service users and third sector representatives on Integration Joint Boards from 1 September 2026.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** remitted the Chief Officer and Board Secretary to review the implications and report back to the next meeting (September) of the IJB with proposed changes to the IJB's governance and membership arrangements.

14. AUDIT COMMITTEE MIUTES: 30.03.26

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

15. STRATEGIC PLANNING GROUP MINUTES: 22.04.26, 17.06.26

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

16. ANY OTHER BUSINESS

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted there was no further business to discuss.

17. DATE AND TIME OF NEXT MEETING

- 17.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 30 September 2026, from 10am to 12noon through MS Teams.

Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	Resources & Performance Committee Minutes
Responsible Executive/Non-Executive:	J Ayling, Chair, Resources & Performance Committee
Report Author:	L Shillinglaw, EA to CE

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Resources & Performance Committee 3 September 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:

- R&PC Minutes – 07.05.26

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 7 May 2026 at 9.00am via MS Teams.

Present:

- F Sandford, Chair
- J Ayling, Non Executive (Chair)
- L O'Leary, Non Executive
- J Pepper, Non Executive
- L Livesey, Non Executive
- D Parker, Non Executive
- P Williams, Non Executive
- P Moore, Chief Executive
- A Bone, Director of Finance
- S Bhatti, Director of Public Health
- L McCallum, Medical Director
- S Horan, Director of Nursing, Midwifery & AHPs
- J Smyth, Director of Planning & Performance
- O Bennett, Interim Director of Acute Services
- G Clinkscale, Director of Urgent Care, Community Services & Mental Health
- L Jones, Director of Quality & Improvement

In Attendance:

- I Bishop, Board Secretary
- A Patterson, Deputy Director of HR
- A Carrington, Partnership Lead
- C Smith, Head of Workforce
- C Oliver, Head of Communications & Engagement

1. Apologies and Announcements

- 1.1 Apologies had been received from J McLaren, Non Executive and A Keen, Director of People & Culture.
- 1.2 The Chair welcomed A Patterson who deputised for A Keen, Director of People & Culture.
- 1.3 The Chair welcomed C Smith, who would present the Annual People Metrics Report.
- 1.4 The Chair welcome A Carrington, Acute Partnership Lead.
- 1.5 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

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

3. Minutes of Previous Meeting

- 3.1 The minutes of the extraordinary meeting of the Resources and Performance Committee held on 19 March 2026 were approved.

4. Matters Arising

- 4.1 **Action 2025-4:** S Bhatti advised that the paper was scheduled for consideration by the Clinical Governance Committee on 13 May 2026 and would thereafter be presented to the next meeting of the Committee in September.
- 4.2 **Action 2025-5:** G Clinkscale confirmed that related matters were addressed in the Urgent & Unscheduled Care paper before the Committee. The Chair noted that actions relating to reporting on delays within Hospital at Home and Home First pathways were being addressed through the urgent and unscheduled care review and reiterated the expectation that future reporting should explicitly demonstrate how agreed actions had been discharged.
- 4.3 **Action 2026-5:** The Deep Dive session was pushed back to the 3 September 2026 meeting.
- 4.4 **Action 2026-6:** A Bone advised that draft terms of reference were being finalised, L O'Leary had agreed to chair the group, and a first meeting was being planned for June. It was further noted that membership would be confirmed following discussion with Executive Directors and that the group would report into the Committee as part of the wider financial planning cycle.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 2025-7 and 2026-6.

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

5. Integrated Performance Report

- 5.1 J Smyth introduced the end-of-year Integrated Performance Report and advised that it represented the final report in the existing format prior to implementation of a revised performance framework aligned to the emerging clinical strategy and wider organisational priorities.
- 5.2 G Clinkscale highlighted the principal urgent and unscheduled care messages arising from the March position. He drew the attention of the Committee to the emergency access standard performance that had improved to 69.6%, representing an 8% improvement from the start of the year, albeit remaining below the 75% target. He further commented that performance in relation to 8-hour and 12-hour delays remained below the desired trajectory and that delayed discharges had increased to 56 at the month-end, though recent operational work had reduced that position back towards the mid-40s.

- 5.3 G Clinkscale also reported record activity through the Acute Assessment Unit, on-target performance in relevant planned service measures, and continued challenges in neurodevelopmental pathways and psychological therapies, with funding secured to support waiting-list reduction activity.
- 5.4 P Moore requested that future reporting more clearly quantified delays arising within Home First and the extent to which health services were providing interim support pending social care arrangements.
- 5.5 G Clinkscale confirmed that such delays were monitored operationally on a daily basis and agreed to explore additional measures, including equivalent bed days and care hours.
- 5.6 F Sandford sought assurance regarding resilience at the front door and the interaction between AAU activity and ED performance. L McCallum emphasised the importance of maintaining focus on patient safety and outcomes, rather than solely on target performance and suggested that internal analysis excluding AAU activity may support more meaningful benchmarking.
- 5.7 J Pepper requested that future narrative provide a more balanced view of flow, including the proportion of patients discharged without delay and a clearer breakdown of delays by setting.
- 5.8 O Bennett provided further context in respect of elective, diagnostic and cancer performance, noting progress in reducing long waits and improving productivity.

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

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

6. Annual People Metrics Report

- 6.1 C Smith presented the Annual People Metrics Report to 31 March 2026 and drew the Committee's attention to key trends across workforce establishment, appraisals, employee relations activity, sickness absence, turnover, vacancies and progress with e-rostering implementation.
- 6.2 Discussion focused on the gradual upward trend in whole-time equivalent staffing within Acute services, modest growth in Primary & Community Services, relative stability in Mental Health & Learning Disabilities, and a slight downward trend within Support Services. It was noted that appraisal completion remained materially below the 100% target across all business units, with Mental Health & Learning Disabilities continuing to perform most favourably and Acute services performing least favourably. It was also noted that appraisal performance remained under review through the Staff Governance Committee and that improvement was expected during the forthcoming year.
- 6.3 In relation to absence, C Smith reported a consistent seasonal pattern, with anxiety, stress and depression remaining the most significant cause of sickness absence across all business units; musculoskeletal absence remained particularly pronounced within Primary & Community Services and Acute services; and colds, coughs and flu

continued to contribute materially during winter periods. It was noted that turnover had reduced overall, though remained highest in Mental Health & Learning Disabilities, in part reflecting the age profile and retirement patterns within that workforce. It was also noted that vacancy volumes had increased and that recent performance issues within the East Region Recruitment Service had contributed to delays, although that position had now improved and recruitment timeliness were recovering.

- 6.4 S Bhatti sought clarification regarding the scope of appraisal data and queried whether occupational health data might provide greater insight into chronic conditions contributing to absence.
- 6.5 S Horan highlighted the importance of appraisal completion in supporting staff wellbeing and requested additional recruitment timeliness metrics, including the interval between successful interview and commencement in post.
- 6.6 L McCallum requested inclusion of professional and medical appraisal performance in future reporting to strengthen assurance.
- 6.7 L Livesey requested consideration of possible links between training compliance and musculoskeletal absence.

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

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

7. Urgent & Unscheduled Care – Phase One Review

- 7.1 G Clinkscale presented the Phase One Review of the Urgent & Unscheduled Care Programme and linked the work undertaken during 2025/26 to earlier whole-system modelling and discharge improvement analysis.
- 7.2 He drew the attention of the Committee to the principal changes implemented during Phase One, including establishment of the Frailty Unit, creation of the Integrated Discharge Team, expansion of Home First reablement capacity, growth in the Hospital at Home model and work to increase diversion of GP referrals through the Acute Assessment Unit rather than the Emergency Department.
- 7.3 Evidence of improvement in emergency access standard performance and a sustained reduction in delayed discharges compared with earlier peaks were noted as well as that 12-hour waits and the absolute number of delayed discharges remained above target.
- 7.4 G Clinkscale further highlighted that the system had operated through the winter period with fewer funded and utilised beds than in the corresponding period of the previous year and advised that early modelling suggested the revised model of care may prove less costly overall, subject to further financial validation.
- 7.5 Discussion focused on how benefits were being realised and the extent to which health services were carrying responsibilities that would traditionally sit within social care arrangements.

- 7.6 P Williams noted the extent of adaptation and service redesign undertaken by core community services in response to reduced bed capacity and emphasised that that contribution should be recognised alongside newly funded programmes.
- 7.7 F Sandford welcomed the emphasis on patient experience and requested clearer evidence of cost reduction and skill-mix change over time.
- 7.8 L O’Leary sought an update on integration of Home First and home care arrangements. G Clinkscale advised that work was underway with partnership colleagues to develop future options, including possible third-sector investment and home care provision, while retaining the operational grip achieved through the current arrangements.
- 7.9 L McCallum highlighted the positive feedback received from patients and carers and suggested that should be shared more widely.
- 7.10 P Moore emphasised the need for robust quantification of cost and activity where NHS services were bridging social care gaps.
- 7.11 S Bhatti requested clearer articulation of thresholds and operational criteria governing movement across pathways.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the findings of the Urgent & Unscheduled Care Phase One Review.

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

8. LIMS Update

- 8.1 G Clinkscale provided a verbal update on the Laboratory Information Management System (LIMS) programme. He reminded the Committee that the system had gone live in June 2025 and that a number of post-implementation issues had required sustained management attention in order to secure safe and effective operation.
- 8.2 He advised that the principal outstanding issues relating to transmission and display of results, including matters affecting sexual health reporting, had now been resolved to a level that relevant clinical leads had formally signed off. He further advised that a clinical safety case had been undertaken, including external expert review of the system, associated standard operating procedures and governance arrangements, resulting in a report with recommendations for ongoing management. He further clarified that the programme had now formally closed and that responsibility for residual business-as-usual matters had transferred to O Bennett.
- 8.3 During discussion the Committee welcomed the use of a clinical safety case and noted the view that it should become standard practice for future major digital and clinical system change.
- 8.4 The Chair sought assurance that contractual and financial risks remained under active management, particularly in relation to future decisions associated with national systems.

- 8.5 G Clinkscale advised that a decision would be required by December 2026 on whether to continue under the relevant national contractual arrangements and confirmed that IM&T and Finance colleagues were actively managing the associated position.

The **RESOURCES & PERFORMANCE COMMITTEE** commended the laboratory leadership, IM&T colleagues and wider teams involved in the delivery of a complex and high-risk programme.

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

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.

9. Internal Audit Reports

- 9.1 A Bone introduced the internal audit reports relating to Theatre Management (Productivity) and Management of Change. He reminded members that both reports had already been considered by the Audit & Risk Committee, which retained oversight of the internal audit programme and monitored the delivery of agreed actions, and advised that the purpose of referral to the Resources & Performance Committee was to ensure visibility of findings relevant to the Committee's remit and to allow any further scrutiny if required.
- 9.2 It was noted that both reports had concluded moderate assurance in respect of design and effectiveness and that neither report contained any high-risk recommendations.
- 9.3 In relation to the Theatre Management report, areas of good practice identified by internal audit, including theatre scheduling processes, governance arrangements and the use of the InPhase system were noted. The improvement actions identified, including the need to refresh theatre budgets more routinely, strengthen action tracking within oversight groups, improve data quality in relation to session timing and sequencing, and consider enhanced theatre-specific patient feedback and KPI benchmarking were also noted.
- 9.4 In relation to the Management of Change report, the generally positive conclusion that the organisation's change framework was robust and maturing, while also identifying opportunities to improve governance forum focus, clarify the interaction between national templates and local change methodology, formalise governance transitions for specific programmes and strengthen benefits realisation and lessons learned arrangements was noted.
- 9.5 In response to a procedural query, A Bone confirmed that it remained open to Governance Committees to identify any matters on which additional assurance was sought, but his recommendation was that the Audit & Risk Committee continue to monitor delivery of agreed actions and escalate only where required.

The **RESOURCES & PERFORMANCE COMMITTEE** is asked to note the internal audit reports as recommended by the Audit and Risk Committee.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance given the role of the Audit and Risk Committee in terms of oversight and monitoring actions.

10. Finance Report

- 10.1 A Bone presented the Finance Report for the period to 31 March 2026 and provided an overview of the year-end financial position. He emphasised that the Board would achieve a break-even outturn through receipt of £10m deficit support funding from the Scottish Government.
- 10.2 A Bone advised that an improving trend in the underlying position had emerged during Quarter 4; however, the forecast outturn had been deliberately retained at the agreed £10m deficit control limit following discussion with Scottish Government, reflecting that the deficit support funding had already been confirmed and that no benefit would have arisen from reporting a different position at the year-end. It was noted that the draft outturn reflected a material improvement against forecast, driven by a combination of additional funding movements, improved in-year savings delivery during Quarter 4 compared with earlier assumptions, and non-recurrent benefits including slippage on investment plans and vacancy-related underspends. It was further noted that the reported position had been aligned to the deficit control limit through additional allocation to the Scottish Borders Integration Joint Board (IJB), enabling some flexibility to be retained via IJB reserves in support of transformation and risk mitigation in 2026/27.
- 10.3 The Chair sought clarification regarding the movement in the IM&T risk provision. A Bone advised that it reflected improved visibility of underlying commitments during the latter part of the year and that work would be undertaken to strengthen forecasting methodology and earlier release of contingency where appropriate. Members noted that, notwithstanding the improved outturn, the Board had not achieved the required 3% recurring savings target and therefore entered 2026/27 with an underlying recurring deficit. It was also noted that financial sustainability remained a very high strategic risk.
- 10.4 S Bhatti sought clarification regarding the income category described as patient charges for primary care and was advised that it related principally to dental charges.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board was reporting a breakeven position at 31st March with anticipation of £10m deficit support funds as confirmed by Scottish Government.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that there was significant improvement (Section 3, 6) in financial performance during Quarter 4 resulting in a reduced outturn deficit against forecast, and that the position had been adjusted in line with forecast through allocation of additional funds to the Scottish Borders Integration Joint Board.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board did not achieve the required 3% recurring savings in 2025/26 (section 7), and that – as previously reported – it was reflected in the underlying (recurrent) deficit position carried into 2026/27.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the overall position remained draft pending external audit of the Board's final accounts for the financial year 2025/26.

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

11. Financial Recovery Update

- 11.1 A Bone presented an update on the Board's financial recovery work for 2026/27 and the wider medium-term position. Progress in relation to recruitment of the Director of Strategic Projects, with the appointment made and commencement expected shortly, subject to completion of pre-employment processes was noted.
- 11.2 A Bone drew the attention of the Committee to the refreshed business unit savings plans that had been submitted and that early analysis suggested identification of approximately £6.2m of savings together with a further £2m–3m of non-recurrent cost avoidance that would support the in-year position, albeit remaining below the full recurring requirement.
- 11.3 A Bone further advised that the Strategic Budget Review Group was being established, with draft terms of reference nearing completion and the first meeting anticipated in June with a Non-Executive Chair. National and local mitigations were also noted, including the national invest-to-save programme, mitigation of allocation risks associated with PCIP and the Operational Improvement Plan funding, and work to establish a transformation fund via IJB arrangements.
- 11.4 During discussion it was noted that some previously referenced actions, including activity-based commissioning procurement and consideration of external diagnostic support, had been deferred or paused pending the arrival of the new strategic projects capacity and further maturity of the recovery programme. The importance of ensuring that the recovery approach delivered genuine transformation rather than continued incremental reductions across support services was highlighted.
- 11.5 L Jones advised that corporate services had delivered recurrent savings over many years and cautioned against further unmanaged erosion of enabling capacity, particularly within estates and improvement functions.
- 11.6 F Sandford reiterated the need for robust evaluation of new initiatives before any recurrent adoption, highlighting the risk that short-term national funding could lead to long-term local liabilities if schemes were not properly assessed.
- 11.7 Discussion also focused on the question of when and how "difficult choices" should be brought forward. Committee members expressed differing views: some considered that that work should follow further development of the clinical strategy and recovery programme, while others emphasised that waiting for perfect information risked continued delay and that apparently incremental decisions were already having material effects on services.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed that the financial recovery action plan should continue to be reported routinely to each meeting in a clear and consistent format.

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

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed that it had received moderate assurance for systems and processes and limited assurance for outcomes from the report.

12. Capital Plan Update

- 12.1 A Bone presented an update on the capital outturn position for 2025/26 and the forward position for 2026/27 within the national Whole System Infrastructure Planning framework. He highlighted the constrained capital environment, the increasing national emphasis on business continuity, statutory compliance and resilience, and the limited flexibility available to Boards to progress wider service modernisation projects through local capital allocations.
- 12.2 He reported that capital expenditure for 2025/26 totalled £9.95m against a revised budget of £12.33m, with slippage arising mainly within business continuity and core capital programmes and an anticipated carry-forward of approximately £1.94m against committed expenditure. A Bone highlighted the scale of the estates backlog, currently reported at approximately £32m and likely understated, together with the existence of a local pipeline of around 70 projects for which no clear funding route presently existed. He advised that it created a significant tension between the need to maintain a safe and compliant “do minimum” estate and the requirement to modernise infrastructure in order to support the emerging clinical strategy.
- 12.3 It was noted that many significant capital decisions were effectively constrained by national policy and funding routes; however, local prioritisation remained necessary in relation to business continuity planning submissions and the development of up to three Strategic Assessments for national submission by March 2027. A Bone outlined potential strategic assessment themes including a Borders General Hospital refresh, digital infrastructure and HEPMA, mental health estate consolidation and primary care estate priorities. It was proposed that detailed prioritisation and decision-making should be taken forward through the Delivery Board, with the Resources & Performance Committee providing broader strategic direction and scrutiny of risk.
- 12.4 During Discussion Committee members noted the complexity of prioritisation and the absence of straightforward solutions given the mismatch between resource and requirement.
- 12.5 L McCallum emphasised that capital prioritisation decisions must be explicitly reflected in the risk register so that the rationale for decisions and the residual exposure of the organisation remained transparent.
- 12.6 A Bone also advised the Committee that the Head of Capital Planning had resigned, adding to delivery and planning pressures in the short term.

The **RESOURCES & PERFORMANCE COMMITTEE** considered:

Category	Decision(s)
Core CRL	▪ The Committee are requested to consider whether they would require any changes to the existing budget set for rolling

	programmes and capital planning, either to prioritise specific projects or to create additional programme budgets within existing resource. ▪ Should existing programme budgets be retained, this will limit any ability to progress capital pipeline projects however options for funding individual projects will continue to be explored on case by case basis.
BCP	▪ The Committee are requested to consider whether they would wish to approve submission of BCP plan in advance of November 2026 and any other requirements applicable.
Strategic Assessments	▪ The Committee are requested to consider whether there are any other proposals they would wish to see developed for submission, and to consider the governance route required for approval of submissions to Scottish Government.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the work in progress to develop a property enabling strategy in support of the clinical strategy and that this is expected to be aligned to the process set out above.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance for systems and processes and limited assurance for outcomes from the report.

13. Any Other Business

The **RESOURCES & PERFORMANCE COMMITTEE** noted there were no further items notified for discussion.

14. Date and Time of Next Meeting

- 14.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 3 September 2026 at 9.00am via MS Teams

Meeting:	Borders NHS Board
Meeting date:	07 October 2026
Title:	Audit & Risk Committee Minutes
Responsible Executive/Non-Executive:	A Bone, Director of Finance
Report Author:	L Shillinglaw, EA to CE

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 21 September 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 24.06.2026

Minutes of a Meeting of Borders NHS Board Audit & Risk Committee held on Wednesday, 24th June 2026 @ 10 a.m. via MS Teams.

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

In Attendance: A Bone, Director of Finance
J Boyd, Director, Audit Scotland
B Everitt, Personal Assistant to Director of Finance (Minutes)
S Harkness, Senior Finance Manager
S Harold, Senior Audit Manager, Audit Scotland
L Jones, Director of Quality Improvement
G MacLeod, Risk Advisory Services Manager, BDO
A McCloy, Senior Finance Manager (Items 6.1 & 6.2)
E Montgomery, Senior Auditor, Audit Scotland
C Robertson, Head of Risk Advisory Services (Scotland), BDO
K Rodgers, Deputy Director of Finance
J Smyth, Director of Planning & Performance (Item 5.1)

1. **Introduction, Apologies and Welcome**

Lynne Livesey welcomed those present to the meeting.

Apologies were received from P Moore, Chief Executive and G Clinkscale, Director of Urgent Care, Community Services and Mental Health.

Lynne confirmed that today's meeting was quorate.

2. **Declaration of Interest**

There were no declarations of interest.

Andrew Bone apologised for the late issue of the final pack of papers due to some late updates to the accounts which would be covered later on the agenda.

3. **Minutes of Previous Meetings – 25th May 2026**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The Committee noted the action tracker.

5. **Internal Audit**

5.1 *Internal Audit Report – Management Structure & Procedures (Draft)*

Gemma MacLeod introduced the report which was the final audit from the 2025/26 audit plan. It was noted that management had confirmed acceptance of the recommendations but had been unable to provide the full management responses due to annual leave. It was proposed that a revised report with the management responses to address recommendations be brought to the next meeting of the Committee.

Gemma advised that the audit had an overall rating of moderate assurance for design and moderate assurance for effectiveness. The finding ratings were noted as 5 medium and 2 low.

Gemma went on to take the Committee through the medium rated findings where it was noted that in regard to decision making the staff interviewed had highlighted areas where the efficiency of the structure could be improved, including unnecessary escalation of minor decisions, duplication of effort and lengthy meeting agendas whereby not all items are covered within meetings.

It was noted that the Terms of Reference for the Borders Delivery Group, Operational Planning Group and Borders Executive Team required to be updated to reflect the changes that had been put in place and to ensure there was a clear distinction between their roles and responsibilities. There were also opportunities to improve the tracking of decisions and actions, including minutes to make it clearer where decisions/actions had been identified.

Gemma advised that the job descriptions requested for sample testing were not readily available for all staff. It was noted that there was currently no process in place for centrally storing job descriptions and ensuring these were kept up to date and therefore had been identified as an opportunity for improvement.

In regard to performance management arrangements, it was noted that staff appraisal completion rates were noted to be low, partly due to appraisals being completed but not marked as completed in Turas and therefore not picked up in the statistics. It was also noted that there was no monitoring of the completion of objectives or personal development plans.

Gemma referred to the two low significance findings, namely that the Code of Corporate Governance had not been updated to reflect changes in decision making structures and that there was an opportunity to update the annual communication plan to include outcomes from key decisions or discussions at the Borders Delivery Group and Borders Executive Team.

June Smyth advised that she could not comment on behalf of the Director of People & Culture, who had been on annual leave, on the HR related items, however the Deputy Director had reviewed the relevant recommendations and confirmed acceptance of these.

June recognised that following the introduction of the Borders Delivery Group there would be bedding-in issues and felt that the audit had provided helpful feedback to support it to its next level of maturity whilst clarifying roles and responsibilities and tightening corporate governance support to the organisation.

Lynne Livesey enquired if the Director of People & Culture had since seen the report and the recommendations made. Andrew Bone advised that due to annual leave she had not yet seen the report but assured that her deputy had reviewed it and duly confirmed that the recommendations would be accepted.

Lucy O'Leary enquired about the decision making responsibilities arising from the "rewiring" work and assumed that these would be owned by the Chief Executive. June confirmed that Peter Moore had commissioned the audit and was sighted on the report and had agreed with the recommendations.

Lynne asked if the Board Executive Team (BET) had reviewed the report. Andrew advised that audit reports do not routinely go to BET but are reviewed by the relevant Directors. As the report was cross-cutting Lynne felt that it may be beneficial for it to be reviewed by BET.

James Ayling appreciated that individual directors were considering their own areas, however felt that it was important there was oversight of the whole position to ensure that all elements fitted together and supported the most efficient decision making route.

James also noted that some of the issues highlighted related to decision making at a higher level and asked whether there was a process to cascade learning to lower levels within the organisation to ensure there was no ambiguity around decision making responsibilities and that decisions were taken at the appropriate level.

June advised that she was the only member of BET who attended all three groups referenced (BET, Borders Delivery Group and the Operational Planning Group, which she chaired). June advised that the next phase of the work would look below these groups making high level decisions and into individual business units.

Lynne asked for assurance that all the correct people would be sighted on the report and that the full management team would drive and monitor the actions where appropriate. June confirmed that all relevant people would be sighted and that the Internal Audit recommendations were regularly received by BET.

Lynne highlighted that the assurance level recommended for the Committee to take was moderate assurance for systems and processes and moderate assurance for outcomes.

James felt that it was difficult for the Committee to take assurance from the report until the management responses, actions and timescales had been received. Lucy agreed with this comment and highlighted that one of the themes of the audit related to arrangements being established but not followed through with the appropriate paperwork so felt that the Committee should demonstrate good governance by awaiting the final report with management responses.

Andrew appreciated this point and noted that the report itself did not identify significant weaknesses and had provided an overall moderate assurance rating based on the findings so suggested that the Committee take moderate assurance subject to receipt of the management responses.

Following discussion the Committee agreed to record that, while the report did not identify significant issues, it would defer providing an assurance level at this stage but would anticipate giving moderate assurance once the management responses and timescales had been received. The final report and action plan would be brought back to the next meeting in September.

The Committee agreed that it could not provide an assurance level at this stage, however anticipated giving a moderate level of assurance for systems and processes and moderate assurance for outcomes. This would be confirmed following receipt of the final report, including management actions and timescales, at the September meeting.

The Committee noted the draft report which would also have oversight by the Resources & Performance Committee once finalised.

5.2 *Draft Internal Audit Annual Report 2025/26*

Gemma MacLeod introduced this item which provided Internal Audit's overall annual audit opinion. Gemma confirmed that there had been no deviations from the audit plan and that the overall opinion was generally satisfactory with improvement required.

Gemma referred to page 5 of the report and the table which summarised the level of actions implemented, noting that this was lower than expected and if it did not improve over the coming year this could have a negative impact on the annual audit opinion for 2026/27.

Gemma advised that in an attempt to improve timely completion of recommendations diary reminders had been sent to action owners and the Director of Finance would receive a quarterly update on priority actions, including those that were particularly aged or of high significance.

Gemma highlighted that no reports had received no assurance, however attention was drawn to the two reports which had received limited assurance, namely Medicines Governance and Prescribing and Nursing Workforce Management.

Gemma referred to pages 6 and 7 of the report which included thematic reporting and noted that there were generally appropriate structures and frameworks in place, however there were common areas of weakness across a number of reviews, including data quality and system limitations, resource constraints and

reliance on manual processes. Gemma also referred to pages 8 and 9 which summarised the audits and opinions throughout the year. It was noted that as this was BDO's first year as the Board's Internal Auditor future reports would include comparators to show progress.

Andrew Bone advised that he had discussed outstanding actions and aged recommendations with BET colleagues and planned to bring forward a trajectory for improvement throughout the year, including target levels of progress. An update would be provided at the next Committee meeting where he hoped progress would already be evident.

James Ayling noted the overall audit recommendation for 2025/26 which he was content with and asked Internal Audit to comment on this. Gemma felt that this was a positive opinion but stressed the need for improvement around recommendations being actioned going forward.

Lynne Livesey enquired if there was a system in place to ensure that there is appropriate diary time and access to staff so that audits are progressed in a timely manner, whilst recognising resource constraints. Gemma advised that after having undertaken year one they now had a better understanding of how NHS Borders worked and would factor this into future planning, making contact as early as possible and escalating any access issues through regular touch points with the Director of Finance.

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

The Committee noted the draft Internal Audit Annual Report for 2025/26.

6. Corporate Governance Framework

6.1 *Corporate Governance Framework Review 2025/26*

Anita McCloy spoke to this item and went on to provide an update on the changes made since the last version received. It was noted that the revised report now included reference to the draft Management Structure & Procedures audit report and the draft Internal Audit Annual Report.

Gemma MacLeod asked if the table listing the management comments could be changed to reflect that these had been received from management rather than BDO as the Internal Auditor. Anita agreed to make that change following the meeting and share the updated version with the Committee.

Anita advised that the Third Party Assurance Reports had been circulated along with the pack for noting. Anita reminded the Committee that these reports are received due to NHS Borders' reliance on national systems run by external organisations. It was noted that the majority of these reports were positive, with only minor IT access control issues and a gap in relation to the PECOS report as NHS Borders does not receive a copy of this which was consistent with the previous year.

Anita confirmed that the minor comments received from External Audit had been reflected within the report. Anita also advised that the Audit & Risk Committee Annual Assurance Report had been updated to reflect the limited assurance received for the Medicines Governance and Prescribing and Nursing Workforce Management audits and that the number of outstanding prior year recommendations from Internal Audit recommendations had been corrected from 6 to 2.

Anita felt that the report supported the view that NHS Borders was well governed, with effective systems of control, oversight and accountability in place. The disclosures highlighted a small number of key pressure areas which were significant but were being actively managed.

Andrew Bone reminded the Committee that it had taken moderate assurance at the last meeting due to the items which were awaited, namely the remaining Internal Audit report and the Third Party Assurance Reports.

James Ayling noted his thanks to Anita for the work undertaken in producing the report as he was aware of the enormity of the task.

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

The Committee noted the report.

6.2 *Audit & Risk Committee Assurance Report*

Anita McCloy spoke to this item and advised that the changes to the Audit & Risk Committee Assurance Report had largely been covered under the previous item, namely that the report had been updated to reflect the two limited assurance audit reports, the outstanding Internal Audit recommendations and to clearly show the start and end dates of the outgoing and incoming Chair.

James Ayling enquired whether any reference to the Borders Delivery Group, and its role across the organisation, was required. Anita confirmed this was already captured within the review. James also referred to financial sustainability and savings and asked if reference required to be made to this. Andrew Bone felt that assurance around this sat with the Resources & Performance Committee rather than the Audit & Risk Committee, although appreciated that it remained a matter of concern for the Committee.

Lucy O'Leary referred to page 196 of the pack and queried whether a line stemming from the Management Structure and Procedures audit was required regarding the need for the work of the Board Executive Team, Operational Planning Group and Borders Delivery Group to be reviewed and streamlined. Andrew felt that if both the incoming and outgoing Chairs were content then this could be added noting that the pack had already gone to the Board but a verbal update could be given at the meeting the following day. Both the incoming and outgoing Chairs agreed that the point made should be captured within the report.

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

The Committee noted the report that would be signed by James Ayling and Lynne Livesey.

7. External Audit

7.1 *Proposed External Audit Annual Report (including ISA 260 Requirement) 2025/26*

John Boyd spoke to this item and apologised for the late issue of the report. John highlighted the tight delivery for NHS Boards and that he had held back to issue the report as complete as possible. It was noted that although the report was presented as draft it was anticipated that this would be the final version.

John highlighted that the report was split into two key aspects, namely the audit of the Annual Report and Accounts and External Audit's conclusions and findings in relation to the wider scope audit work as defined under the Code of Audit Practice.

In terms of the financial statements audit John was pleased to report that it was the intention to issue an unqualified opinion on the annual audit. It was noted the audit had been delivered on time and subject to Board approval the 30th June deadline would be met for submitting the accounts.

John highlighted the key materiality threshold of £315k and explained that any error or adjustment identified during the course of the audit above this threshold would be reported to members. John referred to one significant finding which was an adjustment to the accounts and related to transactions with the Integration Joint Board which had resulted in the overstatement of both income and expenditure figures by £6.1m. It was noted that this had been corrected in the amended accounts and did not have an impact on the outturn position.

John referred to the appendix attached to the report which noted a number of adjustments to the financial statements and advised that these had not impacted on the core primary statements. It was noted that one of these related to assets held by the Board that were no longer operational. John explained that this was not uncommon across Health Boards and had been an increased area of focus during this year's audit testing where it had been identified there were non-operational assets still on the asset register. It was also noted that management had undertaken a review and had written off assets which had depreciated over a specified threshold and that they were satisfied with this approach. It was noted that management had proposed a detailed annual review of the asset register going forward. John confirmed that this did not have an impact on the primary statements and was a disclosure note within the accounts.

In relation to financial management, John noted that the Board had delivered a break-even position, reflecting the £10m of Scottish Government deficit support. John highlighted that the Board had not delivered all of its savings targets, with approximately 73% being achieved in-year. The outturn reflected ongoing demand in regard to staffing, prescribing pressures and backlog work. John noted that delivery of the break-even position was testament to management but

highlighted the importance of delivering savings plans, particularly recurring, for medium to longer term financial sustainability.

It was noted that External Audit's wider scope work included looking at the new organisational and clinical strategies and the focus on transforming and shifting care closer to home to reduce pressure on acute services. John noted continuing challenges in relation to some KPIs, including national performance targets, although improvements had been seen in waiting times and delayed discharges. John stressed that the strategies could only be delivered from a sound financial footing and highlighted the budget gap of just over £70m over the next three years and stressed the need to align clinical and operational strategies with financial strategies and savings plans.

John highlighted the financial sustainability risks for the Board and the reliance on identifying and delivering robust savings programmes, as well as the need for a fundamental review around the services that the Board can deliver within the financial envelope.

Lynne Livesey noted that the report would go to the Board the following day in its current format but appreciated that some minor amendments may still be required prior to final sign-off.

James Ayling noted reference to "broadly satisfactory governance arrangements" and enquired what had been found to have not been satisfactory during the course of the audit. John advised that the areas identified were already known to the Committee, namely the limited assurance Internal Audit reports, the control deficiencies identified through the PECOS review and the service auditor reports which limits the level of assurance available regarding controls within systems operated by third party service providers. John confirmed that overall the governance arrangements were found to be satisfactory subject to these points.

Lynne asked if assurance could be given that any of the matters outstanding would not be of any significance. John confirmed that to date there were no significant matters and that the work was substantially complete.

Lynne referred to the adjustments recommended by External Audit. John referred to appendix 2, which noted the adjustments made during the course of the audit and appendix 3, which summarised the adjustments identified where management had chosen not to amend. John confirmed that he was comfortable that these were immaterial to the accounts and had no impact on the audit opinion.

Lynne enquired if NHS Borders was an outlier with the targets it had set itself to break-even. John advised that in terms of the financial forecast projected the Board was not an outlier, however in regard to the financial support for the current financial year from Scottish Government, NHS Borders was one of 4 Boards in this position which highlighted the situation faced by the Board.

Andrew Bone advised that information on the financial position of Health Boards and savings progress was shared regularly at the Directors of Finance meetings and that the 3% savings target per year was broadly consistent across NHS Scotland. It was noted that the scale of NHS Borders' deficit when compared to other Boards was higher which was the reason why the Board was currently on an escalated framework.

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

The Committee noted the report.

8. Annual Accounts 2025/26

8.1 *Annual Report and Accounts 2025/26 incl Track of Changes*

Karlin Rodgers spoke to this item and explained that this was version 2 of the accounts which had been shared with External Audit at the end of the previous week. Karlin referred to the tracked changes report at appendix 2 which provided an update on the changes made to the accounts following the version presented at the informal session on the 10th June 2026.

Karlin went on to take the Committee through the changes made. It was noted that some of the amendments were minor and had no effect on the accounts. Karlin referred to the write-off of approximately £16m of assets which were fully depreciated following a review of the fixed asset register. It was noted that this did not have an impact on the face of the accounts and only affected notes 6 and 7. Karlin advised that other changes included reclassification of cash, addition of a related party transaction in regard to the Integration Joint Board and a further reclassification of secondment income which she confirmed made no change to the reported figures.

Karlin advised that the Board, at its meeting the following day, would also receive an update on the changes made.

Lynne enquired about the planned review of assets during 2026/27 and asked whether this had potential to make a material difference to the accounts. Karlin confirmed that there were processes and procedures in place for staff to notify of disposals and sales, however it was not possible to say that there would definitely be no impact to the accounts as something could always arise when a full review is undertaken. Karlin assured that if there were any significant matters arising from the review these would be brought back to the Committee for noting but at this point this was not expected.

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

The Committee noted the changes made to the Annual Report and Accounts for 2025/26 following the session held on 10th June 2026 and recommended they be put forward to NHS Borders Board for approval at its meeting on 25th June 2026.

8.2 *Final NHS Borders Health Charity Annual Report and Accounts 2025/26*

Karlin Rodgers spoke to this item and advised that these were being brought to the Committee for awareness as they formed part of the Board's qualified accounts. It was noted that they had been approved by the Board of Trustees at its meeting on 15th June 2026.

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

The Committee noted the NHS Borders Health Charity Annual Report and Accounts for 2025/26.

8.3 *Final Patients' Private Funds Annual Report and Accounts*

Karlin Rodgers spoke to this item which related to patients' private funds which had been audited by Thomson Cooper, the External Auditor, and formed part of the Board's consolidated accounts. It was noted that a clean audit opinion had been received.

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

The Committee reviewed the Patient's Private Funds Annual Report and Accounts and recommended they be put forward to NHS Borders Board for approval at its meeting on 25th June 2026.

9. **For Noting**

9.1 *Third Party Audit Reports*

It was noted that these had been referenced at item 6.1. Andrew Bone advised that no specific issues had been highlighted within the reports, although one report included a point around the scope of the audit not being fully comprehensive, otherwise the assurances received were reasonable or moderate and the reports had all received clean audit opinions.

The Committee noted the Third Party Audit Reports.

10. **Any Other Competent Business**

Andrew Bone noted his thanks to both the Internal Audit and External Audit teams for all the work undertaken during the course of the audits. Lynne Livesey endorsed this comment as well as noting her thanks to the Finance Team for all their input.

John Boyd noted his thanks to Andrew and the Finance Team for all their assistance and support throughout the audit. Gemma MacLeod also noted her thanks for the engagement throughout the year.

James Ayling asked for an update in regard to the Integration Joint Board annual accounts. Andrew confirmed that any transactions with the IJB had been reviewed within the audit and, where required, corrections made to the draft accounts were reflected in the External Audit annual report.

Lynne Livesey enquired if there were any items arising from today's meeting which required to be escalated to the Board, noting that a number of the reports were already going to the Board for consideration. It was agreed that there were no further items requiring escalation outside of the reports which were already being presented.

James felt that it would be helpful for the Committee to have criteria for escalating items to the Board. Andrew advised that current practice was that any items with limited or no assurance would automatically be escalated, with further items being escalated where the Committee deemed this to be appropriate.

11. **Date of Next Meeting**

Monday, 21st September 2026 @ 10 a.m. via MS Teams.

BE
02.07.26

Audit & Risk Committee – 24th June 2026
Assurance Summary Table

Agenda Item No	Item Name	Level of Assurance
5.1	Management Structure & Procedures Internal Audit Report	Deferred until receipt of the final report at the September meeting – anticipated Moderate Assurance for systems and processes and Moderate Assurance for outcomes
5.2	Draft Internal Audit Annual Report 2025/26	Moderate Assurance
6.1	Corporate Governance Framework Review	Moderate Assurance
6.2	Audit & Risk Committee Assurance Report	Moderate Assurance
7.1	External Audit Annual Report (incl ISA 260 Requirement) 2025/26	Significant Assurance
8.1	Final Annual Report and Accounts 2025/26 incl Track of Changes	Moderate Assurance
8.2	Final NHS Borders Health Charity Annual Report and Accounts 2025/26	Moderate Assurance
8.3	Final Patient's Private Funds Annual Report and Accounts 2025/26	Moderate Assurance

NHS Borders



Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	Clinical Governance Committee Exception Report & Minutes
Responsible Executive/Non-Executive:	E Dickson, Associate Director of Nursing – Corporate Services (Deputy)
Report Author:	R Roberts, PA to Director of Quality & Improvement & H Stirling, PA to Director of Nursing, Midwifery & AHPs

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes and exception report of the Clinical Governance Committee with the Board.

2.2 Background

The minutes and exception report are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes and exception report are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes and exception report.

2.3.2 Workforce

As detailed within the minutes and exception report.

2.3.3 Financial

As detailed within the minutes and exception report.

2.3.4 Risk Assessment/Management

As detailed within the minutes and exception report.

2.3.5 Equality and Diversity, including health inequalities

An HIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Clinical Governance Committee 16 September 2026
- Clinical Governance Committee 22 July 2026

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 22.07.2026
- Appendix No 2, Clinical Governance Committee Exception Report

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 22 July 2026** at 10am via Microsoft Teams

Non-Executives:

Lucy O'Leary, Non-Executive Director (Chair)
Lynne Livesey, Non-Executive Director
Paul Williams, Non-Executive Director

Members:

Sarah Horan, Director of Nursing Midwifery and Allied Health Professionals (Exec Lead)
Peter Moore, Chief Executive
Laura Jones, Director of Quality & Improvement
Gareth Clinkscale, Director of Urgent Care, Community Services and Mental Health
Oliver Bennett, Interim Director of Acute Services
Lynn McCallum, Medical Director
Sohail Bhatti, Director of Public Health
Olive Herlihy, AMD/Director of Medical Education (Acute/CGQ)
Imogen Hayward, Associate Medical Director, (Planned Care)
Jonathan Manning, Associate Medical Director, Primary Care (Unscheduled Care)
Amanda Cotton, Associate Medical Director, (MH/LD)
Rebecca Green, Associate Medical Director, Primary & Community Services
Malcolm Clubb, Director of Pharmacy
Louise Kerr, Interim Director Psychological Services
Julie Campbell, Lead Nurse for Patient Safety and Care Assurance
Peter Lerpiniere, Associate Director of Nursing, Mental Health, & Learning Disabilities
Philip Grieve, Associate Director of Nursing, Acute Services
Kirsteen Guthrie, Associate Director of Midwifery, Women and Children Services
Kathy Steward, Interim Associate Director of Nursing, Primary & Community Services
Paul Williams, Associate Director of Nursing, Allied Health Professionals
Samuel Whiting, Infection Control Manager
Lettie Pringle, Risk Manager
Ben Brewis, Director of Strategic Projects
Heather Stirling, PA to Director of Nursing, Midwifery and Allied Health Professionals (Minute)

1 Apologies and Announcements

- 1.1** The Chair welcomed members and attendees to the meeting. S. Horan was on annual leave and M. O'Reilly attended in her place as Executive Lead. The Chair congratulated S. Horan on her forthcoming appointment as Chief Midwife for Scotland and recorded the Committee's appreciation of her contribution to NHS Borders. The Chair also thanked report authors for responding to work led by S. Horan to streamline committee papers. She acknowledged that producing concise summaries was demanding but confirmed that the revised approach, using short headline summaries with detailed supporting material, was improving accessibility despite the overall volume of the pack.

Apologies were received from:

A. Cotton, virtual attendee – Amanda did not attend due to clinical commitments

P. Williams
S. Horan – deputy M. O'Reilly
B. Brewis
P. Moore
G. Clinkscale – deputy C. Wilson
L. Pringle
M. Clubb
L. Kerr

Absent

J. Manning

The Chair confirmed the meeting was quorate.

2 Declarations of Interest

- 2.1 Chair sought any verbal declarations of interest pertaining to items on the agenda.
- 2.2 The Clinical Governance Committee noted that there were no new declarations of interest. Members remained responsible for identifying any interest arising later in the meeting if the relevance became apparent during discussion.

3 Minutes of Previous Meetings

- 3.1 The Committee considered the amended minute of the meeting held on 25 March 2026 and the draft minute of the meeting held on 13 May 2026. The Committee approved the minutes of 25 March and 13 May as an accurate record.

4 Matters Arising and Action Tracker

- 4.1 In relation to the East Region Health Protection Service, the Chair advised that S. Horan had written to the Chair of the Audit Committee and proposed that the Clinical Governance Committee action be closed, with any residual issue to be raised through the established committee interface. Recognising that L. Livesey had assumed the Audit Committee chair role, the Chair clarified the handover. L. Livesey responded that she would ask James to forward the relevant email to her. The Committee accepted that this maintained visibility while avoiding duplication of oversight.

- 4.2 The Chair sought clarification from P. Grieve on a Clinical Board update action, asking whether the required information was included in the paper before the Committee.

P. Grieve confirmed that it was not. He explained that the issue had been identified in February and that substantial work had taken place to rationalise the report, but the requested material had not featured in the current paper. The response did not provide evidence that the underlying requirement had been fully discharged; accordingly, the position was treated as incomplete rather than assumed complete. The Committee's approach reflected active follow-through: actions were removed only where there was a clear governance route or evidence of completion, while missing content remained visible for further management. The outstanding Clinical Board update requirement was to remain under review and be addressed through subsequent reporting.

- 4.3 Matters arising from the previous meeting were noted and the Action Tracker was updated accordingly.

5 Effectiveness/Annual Assurance (exception reports for Clinical Boards)

5.1 Clinical Board Update – Acute Services

- 5.1.1 P. Grieve presented the Acute Services exception report and described evidence of active governance, quality improvement and generally positive patient experience across planned and unscheduled care. He highlighted improvement activity relating to theatre utilisation, discharge processes, the WHO checklist, surgical site infection, the Emergency Department, Hospital at Night, the Care Assurance Programme and implementation of the daily care record. NEWS2 scoring reliability was reported as consistently above 95%; however, reliability of observation frequency and escalation remained variable. Falls, particularly on Ward 14, required targeted improvement, and infection prevention indicators, including MRSA screening opportunities and screening gaps in the Medical Assessment Unit, remained areas requiring attention.

The most material concern was workforce fragility within critical care outreach and the acute pain service. The service was operating below establishment while managing substantial referral demand, and a high proportion of trainee practitioners required supervision. Proposed mitigation included recruitment, secondment and workforce planning aligned to advanced clinical practice, although a funding gap remained unresolved.

- 5.1.2 P. Grieve also drew attention to controlled clinical information: only 42% of clinical documents and 40% of patient information leaflets were in date, with 15 clinical projects overdue for closure or submission. He advised that users received an alert when information was out of date and that migration to the Right Decision Service provided a framework for improvement, but stronger local ownership was required. The Chair asked where the plan for addressing this information risk was held. The response indicated that a task-and-finish approach and clearer accountability were required, with progress to return through governance reporting. L. Jones reinforced that concise exception reporting must not omit high-risk matters and requested continued visibility of risks including endoscopy surveillance.

The Committee recognised strong improvement activity and governance grip, but did not consider the workforce, reliability and controlled-information risks sufficiently mitigated to support significant assurance.

5.1.3 FUTURE DEVELOPMENT:

P. Grieve to ensure future Acute reporting continues to identify material high-risk areas, including endoscopy surveillance where relevant; progress on the clinical information and patient leaflet backlog to be addressed through a task-and-finish approach and report back.

- 5.1.4 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for Acute Services governance and delivery, with **Limited Assurance** regarding workforce sustainability, reliability of key patient-safety processes and the controlled-information backlog.

5.2 Clinical Board Update – Mental Health and Psychology Services

- 5.2.1 P. Lerpiniere presented the Mental Health and Psychology Services reports, noting effective governance arrangements and continued oversight of quality, performance and restrictive practice. He explained that the service's small numbers could produce apparently significant movement in performance measures and that the SHINE electroconvulsive therapy network improvement plan contained several areas requiring

recovery to the service's usual range, although performance was not substantially outside national benchmarks.

- 5.2.2 Restrictive-practice monitoring remained under review by the Mental Welfare Commission. P. Lerpiniere described restrictive practice as including enhanced engagement or close observation, unplanned restraint and seclusion, and advised that use was generally low, with the greatest activity relating to close observation for vulnerable patients. The service awaited national benchmarking and expected to compare favourably, although this had not yet been evidenced.
- 5.2.3 Workforce sustainability remained a consistent concern. The Chair and members explored the continuing fragility of regional CAMHS inpatient provision and the implications of bed reductions and access difficulties for children and young people from NHS Borders. The discussion recognised that the risk extended beyond local control and required sustained regional and executive oversight. Questions were also raised about workforce timelines and the interim leadership position. L. McCallum confirmed that interim arrangements were progressing and that further assurance would be provided at the next Committee.
- 5.2.4 The Committee noted weaknesses in ethnicity recording and the need to strengthen the approach, including consideration of whether recording should operate on an opt-out rather than opt-in basis.
- 5.2.5 In Psychology Services, governance arrangements, supervision and professional oversight were recognised as strengths, while administrative capacity and workforce gaps constrained delivery and diverted clinical time. The Committee concluded that clinical governance and day-to-day service oversight remained credible, but that unresolved workforce and regional bed-capacity risks materially limited assurance.
- 5.2.6 **FUTURE DEVELOPMENT:**
P. Lerpiniere to strengthen ethnicity recording arrangements; CAMHS inpatient bed access and regional bed-reduction risks to remain under oversight; further assurance on workforce timelines and interim leadership arrangements to return to the next Committee.
- 5.2.7 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for clinical services and governance in Mental Health and Psychology Services, with **Limited Assurance** for workforce sustainability and unresolved regional CAMHS bed-capacity and system risks.

5.3 Clinical Board Update – Learning Disability Services

- 5.3.1 P. Lerpiniere presented the Learning Disability Services report and focused the Committee's attention on the Coming Home programme, where the principal risks related to funding arrangements, provider capacity and the absence of a settled delivery model. The Committee was advised that people supported through the programme had highly complex needs and that placement breakdowns required careful review to identify what could have been anticipated or planned differently.
- 5.3.2 Members sought to understand why some arrangements had broken down and what had been learned. P. Lerpiniere explained that the service was working with the individuals concerned and with providers to examine the circumstances of breakdown, including whether earlier planning, different support arrangements or greater provider preparedness might have improved sustainability. He noted that some individuals were now settled in alternative placements and experiencing a more positive position than

previously. This provided evidence of responsive case management but did not remove the structural risks affecting the programme.

5.3.3 The Committee recognised that these were not isolated operational matters: successful delivery depended on a viable market, appropriate funding, skilled staffing and robust multi-agency planning for people whose needs could change or escalate.

5.3.4 The report and discussion provided evidence that risks were understood and actively governed, but the Committee did not receive evidence of an agreed long-term funding model or sufficient provider resilience.

5.3.5 **FUTURE DEVELOPMENT:**

Learning Disability Services to continue reviewing placement breakdowns and applying learning to future planning; funding, provider capacity and delivery-model risks within the Coming Home programme to remain visible through Clinical Board and Committee reporting.

5.3.6 The Clinical Governance Committee noted the contents of the report and confirmed **Limited Assurance**, reflecting material unresolved risks relating to the Coming Home programme, funding and provider capacity, notwithstanding evidence of active governance and individual service oversight.

5.4 Clinical Board Update – Primary and Community Services

5.4.1 K. Steward presented the Primary and Community Services report, highlighting positive quality outcomes alongside continuing workforce and capacity pressures.

5.4.2 The Committee welcomed the community hospitals' performance on pressure damage, with no pressure ulcers developed in the reporting period and a reported rate of 0.22 per 1,000, aligned with the national level. This was recognised as evidence of effective preventative practice, oversight and staff focus on fundamental care. The report nevertheless described a challenging operational environment in which services continued to prioritise workload daily, manage rising demand and operate with limited resilience in small teams covering a wide geographical area.

5.4.3 Members examined whether governance information demonstrated not only activity but the impact of workforce gaps on clinical quality and access. Particular attention was given to role-mandatory training, where visibility and compliance required strengthening, and to rehabilitation capacity, where unmet need remained.

5.4.4 M. O'Reilly emphasised the importance of future reports distinguishing core mandatory training from role-mandatory requirements and demonstrating targeted improvement where gaps persisted. K. Steward confirmed that this would be included in subsequent reporting.

5.4.5 The Committee also recognised that some risks originated in workforce availability and service capacity rather than failures of local governance but agreed that these risks must continue to be transparently reported because of their potential effect on timeliness, continuity and equitable access.

5.4.6 Members were satisfied that the Clinical Board understood its quality risks and could evidence positive clinical outcomes, but the evidence did not support significant assurance while workforce fragility, training gaps and rehabilitation capacity remained unresolved.

- 5.4.7 **FUTURE DEVELOPMENT:** Future Primary and Community Services reporting to include clear progress on mandatory and role-mandatory training; workforce fragility and rehabilitation capacity to remain under oversight, with clinical impact measures strengthened where available.
- 5.4.8 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for clinical outcomes and governance, with **Limited Assurance** for workforce sustainability, role-mandatory training compliance and unmet rehabilitation capacity.
- 5.5 Clinical Board Update – Maternity and Paediatrics**
- 5.5.1 K. Guthrie presented the Maternity and Paediatrics update, including progress against the maternity inspection action plan.
- 5.5.2 The Committee noted that leadership and governance arrangements were supporting delivery of identified improvements and that several immediate environmental and medicines-storage actions had been completed. Refurbishment of the Labour Ward had progressed with Estates and Facilities, medical gases were confirmed to be stored correctly following the work, medicines formerly stored insecurely had been addressed and were subject to spot audit, and a missing fire-exit sign had been replaced with ongoing monitoring incorporated into the Fire Officer's arrangements.
- 5.5.3 The report was transparent that the current estate did not fully meet contemporary health and safety standards and that longer-term replacement accommodation remained a capital-planning consideration. Members scrutinised staffing and training. Daily real-time staffing assessments were embedded, but work remained underway to improve completion of staffing-tool runs and introduce triangulated reporting using quality, safety and workforce data. A further workforce-tool run was scheduled for November 2026. Mandatory training had improved from 69% to 77%, with monthly review through the Clinical Management Team and further work led by the Clinical Director to align role-specific requirements to staff profiles.
- 5.5.4 The Committee also considered delays in significant adverse event reviews and noted the options appraisal commissioned by the Executive Team to examine interventions, resource implications and implementation of the new national adverse event framework. Regional collaboration on external reviewers was proposed. Recruitment, reinstatement of home birth provision and wider regional sustainability remained incomplete. A correction was required to the paper at page 99.
- 5.5.5 Members recognised clear leadership grip and measurable progress, while maintaining oversight of actions not yet fully delivered.
- 5.5.6 **ACTION:**
K. Guthrie to correct and resubmit the identified amendment at page 99.
- 5.5.7 **FUTURE DEVELOPMENT:**
Progress on staffing-tool completion, mandatory training, SAER timeliness, recruitment and restoration of home birth provision to continue through governance reporting.
- 5.5.8 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance**, reflecting positive inspection follow-up, action-plan governance and leadership oversight, while recognising that workforce, home birth, SAER timeliness, estate and regional sustainability actions remained in progress.

5.6 Corporate Services Update – Public Health, Oral Health and Health Improvement

- 5.6.1 C. McElroy presented the Corporate Services update covering oral health, health improvement and healthcare public health.
- 5.6.2 The Committee noted progress in bringing related public health functions together and sharpening the focus on prevention, intelligence and reducing inequalities. The discussion recognised positive delivery across oral-health improvement and health-promotion activity, while also acknowledging the vulnerability created by small specialist teams and vacancies.
- 5.6.3 Members sought assurance that prioritisation decisions were explicit and that workforce constraints did not lead to unmanaged gaps in statutory or safety-critical functions. The response indicated that risks and priorities were being considered through departmental governance and that the revised reporting approach was intended to improve visibility of exceptions and required escalation.
- 5.6.4 The Committee revisited the relationship with the East Region Health Protection Service and the need for useful, timely data to support local assurance. It was clarified that medicines and prescribing information did not fall within that service's remit and therefore should not be expected from the regional report.
- 5.6.5 The Committee recognised that workforce sustainability and administrative capacity were material enablers of good governance because gaps could shift monitoring and coordination work onto clinicians and reduce time available for patient care. Members nevertheless noted evidence of productive partnership working, delivery against prevention objectives and a clear understanding of the principal risks.

Given that some workforce and data-development actions remained incomplete, the Committee did not support significant assurance. It agreed that future reports should continue to distinguish positive delivery from areas where capacity, prioritisation or regional dependencies limited resilience.

5.6.6 FUTURE DEVELOPMENT:

Public Health to continue strengthening exception reporting and visibility of workforce sustainability; regional health-protection reporting issues to remain under review through the appropriate governance route; statutory and safety-critical activity to be clearly prioritised where capacity is constrained.

- 5.6.7 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for the governance and delivery of Public Health, Oral Health and Health Improvement, with continued oversight required for workforce sustainability, prioritisation and data-reporting dependencies.

BREAK

6 Effectiveness/Assurance (exception reports for Clinical Boards)

6.1 Dental Services Annual Report

- 6.1.1 M. Muir and colleagues presented the Dental Services Annual Report and described strong progress during the year across prevention, access and service development.
- 6.1.2 The Committee heard that investment and collaborative working had supported improvement across the system and that the Childsmile team had exceeded its targets.

Links between the clinical strategy and oral-health planning were recognised as a strength, as was the service's work with speech and language therapy and other partners.

- 6.1.3 L. McCallum commended the team's performance, noting the scale of delivery achieved with limited capacity and the importance of prevention work in schools and communities. The report was also candid about unresolved waiting times and service-capacity constraints. Paediatric procedures requiring general anaesthetic, orthodontics and oral surgery continued to present material access risks, and workforce sustainability remained dependent in part on locum input and the ability to retain scarce expertise.
- 6.1.4 The Chair asked whether the workforce information, which was presented largely as headcount, could be expressed as whole-time equivalent and whether geographic hotspots or access gaps could be identified. The response explained that general dental practitioners were independent contractors, which limited the completeness of standard workforce measures, but agreed that further work could be undertaken to strengthen the picture and support engagement.
- 6.1.5 The Committee concluded that the majority of the service demonstrated effective governance, positive outcomes and credible improvement, but that the evidence did not justify a single moderate rating across all domains because the capacity and waiting-time position for specific services remained unresolved.
- 6.1.6 **FUTURE DEVELOPMENT:**
Dental Services to explore how general dental practitioner workforce information can be strengthened beyond headcount, including whole-time-equivalent or distribution information where feasible; paediatric GA, orthodontic and oral-surgery waits and capacity to remain under active oversight.
- 6.1.7 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for the majority of Dental Services, with **Limited Assurance** for paediatric general-anaesthetic waiting times and orthodontic and oral-surgery capacity and provision.

6.2 Stroke Services Paper

- 6.2.1 G. Butterfield and Dr S. Kerr presented the Stroke Services paper, supported by L. Jones.
- 6.2.2 The Committee heard that performance was mixed but improving, with the latest published result reported at 100% for one measure and performance above average for several standards, although the service was not consistently achieving all required standards.
- 6.2.3 Brain imaging and aspirin administration were identified as relative strengths, alongside access to the stroke unit. Thrombolysis performance remained affected by the availability of timely medical assessment, urgent scanning and delays across the pathway. Dr Kerr explained that patients arriving at Borders General Hospital required rapid assessment and scanning, with support available during the day but limited resilience outside those arrangements.
- 6.2.4 The Committee recognised that this reflected the vulnerability of a small service with a single-handed consultant model and wider dependencies. L. McCallum acknowledged that previous performance had not been sufficiently strong but commended the significant improvement achieved with limited resources and the sustained contribution

of the clinical team. L. Jones highlighted the fragility associated with reliance on a single consultant and external partners, including community rehabilitation provision. K. Steward asked whether thrombolysis delay was principally attributable to ambulance delay or in-hospital factors. Dr Kerr responded that the target required treatment shortly after arrival and that availability of the right medical resource was a key factor. K. Steward also asked why the service's self-assessment remained amber. Dr Kerr explained that some elements of the pathway were not consistently available across all postcodes, preventing a green assessment.

6.2.5 Members recognised tangible progress but remained concerned about consultant workforce resilience, thrombolysis reliability, rehabilitation equity and regional or national dependencies.

6.2.6 **FUTURE DEVELOPMENT:**

Stroke Services to continue improvement against national standards; workforce fragility, thrombolysis delays and equitable access to rehabilitation across all localities to remain under Clinical Board and Committee oversight.

6.2.7 The Clinical Governance Committee noted contents of the report and confirmed **Limited Assurance**, explicitly recognising marked improvement and strong team effort, but constrained by consultant workforce fragility, thrombolysis challenges, rehabilitation inequity and wider system dependencies.

7 **Patient Safety**

7.1 **Child Death Review**

7.1.1 K. Guthrie presented the Child Death Review Report and reminded the Committee that the multi-agency review process covered all deaths from birth to 18 years.

7.1.2 The service described a robust process supported by dedicated leadership and Scottish Government expectations, with cases reviewed to identify learning for services and partner agencies. Twelve cases were open at the time of reporting.

7.1.3 Members sought clarity on the age of those cases and whether delay was concentrated in a particular period. The discussion established that workforce absence had affected the pace of review and that the aggregate figure did not show how long individual cases had remained open.

7.1.4 The Committee asked that future reporting break the open cases down by year so that timeliness, backlog and recovery could be assessed more transparently. The presenter confirmed that this could be incorporated into the Women and Children's governance report.

7.1.5 Members recognised the sensitivity and complexity of the process and the importance of completing reviews rigorously rather than drawing conclusions from incomplete evidence. At the same time, the Committee emphasised that delay could impede timely organisational learning and therefore required visible management.

7.1.6 The quality of the established process and practice provided a reasonable basis for assurance, but the workforce-related delay prevented the Committee from concluding that arrangements were fully effective in all respects.

7.1.7 The assurance conclusion was therefore calibrated to recognise both the strength of the review framework and the limitation arising from open and delayed cases.

7.1.8 **FUTURE DEVELOPMENT:**

K. Guthrie to include a breakdown of open Child Death Review cases by year in the next Women and Children's Governance Report; the impact of workforce absence on review timescales and recovery to remain under oversight.

7.1.9 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance** for the quality and governance of the Child Death Review process, with assurance constrained by workforce absence and delays in completing open reviews.

7.2 **Research Governance Report**

7.2.1 J. Dawson and L. Jones presented the Research Governance Report, outlining the systems used to approve, monitor and support research activity across NHS Borders.

7.2.2 The Committee considered whether governance arrangements provided sufficient control over study set-up, recruitment, participant safety, regulatory compliance and escalation.

7.2.3 The report demonstrated established review processes, clear professional oversight and transparency about current constraints.

7.2.4 A specific risk related to laboratory accreditation and the effect this could have on opening or recruiting to studies that depended on accredited laboratory support. The presenters explained that this risk was known and managed, with the implications considered on a study-by-study basis rather than assuming that all research activity was unaffected.

7.2.5 Members recognised that the existence of a managed constraint did not in itself undermine the wider governance framework, provided that studies were not opened or continued without the necessary controls.

7.2.6 The Committee tested whether the report distinguished research delivery performance from governance assurance and accepted that the core assurance related to the reliability of systems for approval, monitoring and escalation. No evidence was presented of an unmanaged participant-safety issue or failure of research governance.

7.2.7 The discussion also acknowledged that research capacity and the ability to open individual studies could vary depending on specialist support, and that future reports should continue to make such dependencies visible.

7.2.8 On the evidence available, the Committee was satisfied that governance arrangements were mature and operating effectively, while retaining oversight of the accreditation-related risk.

7.2.9 **FUTURE DEVELOPMENT:**

Research Governance leads to continue monitoring the laboratory accreditation risk and its impact on individual studies, escalating any material effect on participant safety, regulatory compliance or the ability to open or recruit to studies.

7.2.10 The Clinical Governance Committee noted the contents of the report and confirmed **Significant Assurance** for research governance systems and oversight, with a specific managed risk relating to laboratory accreditation and associated study availability.

7.3 Adverse Event Overview – Bi-Annual Report

- 7.3.1 J. Campbell presented the Bi-Annual Adverse Event Overview, supported by L. Jones.
- 7.3.2 The Committee welcomed the transparency of the report, the use of control-chart analysis and evidence that established review processes were operating.
- 7.3.3 L. Livesey and M. O'Reilly recognised the work of the Clinical Governance team but questioned whether sufficient protected time and capacity were available to turn investigations into sustained organisational learning.
- 7.3.4 M. O'Reilly identified minor date inaccuracies in sections 3.3.12 and 3.3.15 and requested correction. She also challenged the proposed significant assurance rating, stating that the data required validation and that the Committee needed evidence that implemented actions were reducing recurrence, particularly because some reported events were significant.
- 7.3.5 J. Campbell accepted the inaccuracies and agreed with the challenge. She advised that the Quality Strategy's insight domain would place substantial emphasis on adverse-event management and learning. She referenced work within Acute Services where learning from a significant case review had been shared with staff and feedback gathered through Microsoft Forms and indicated that similar approaches were being considered more widely.
- 7.3.6 K. Steward agreed that the central question was "so what" after high-quality investigations and recommendations, emphasising the need to demonstrate changed practice and improved outcomes.
- 7.3.7 The Committee requested a supplementary analysis separating events associated with staffing and waiting times from other adverse-event data, so that apparent trends could be better understood. It also asked that the next Bi-Annual Report explicitly state what had been learned from the previous reporting period and whether actions had reduced recurrence.
- 7.3.8 Members concluded that systems for capturing and reviewing adverse events were well established, but that assurance about outcomes, timeliness and embedded learning was lower.
- 7.3.9 **ACTION:**
J. Campbell to correct the identified date errors.
- 7.3.10 **FUTURE DEVELOPMENT:**
L. Jones and J. Campbell to provide a supplementary trend update separating staffing and waiting-time events where practicable. The next Bi-Annual Report to include a clear section on learning and evidence of impact from previous actions.
- 7.3.11 The Clinical Governance Committee noted the contents of the report and confirmed **Significant Assurance** for the systems and processes used to capture and review adverse events, with **Moderate Assurance** for outcomes, timeliness and evidence that learning and actions were reducing recurrence.

7.4 Infection Prevention and Control Report

- 7.4.1 S. Whiting presented the Infection Prevention and Control Exception Report.

- 7.4.2 The Committee noted strong routine admission-screening compliance for MRSA and CPE, reported at between 95% and 100%, and agreed that positive performance should be made visible in exception reporting as well as areas of concern.
- 7.4.3 L. McCallum asked what proportion of patients screened were positive and how the clinical benefit compared with the cost of universal screening.
- 7.4.4 S. Whiting explained that national requirements informed the approach and that NHS Borders screened more broadly than a purely risk-factor-based model. He considered the approach worthwhile from a patient-safety perspective but agreed that positivity data and cost should be reviewed with the relevant colleague outside the meeting.
- 7.4.5 Members also considered the loss of quality-improvement facilitation capacity and the effect this could have on sustaining improvement, audit and feedback. The report provided evidence of active surveillance, strong compliance and established governance, but the Committee did not have complete information at the meeting on positivity yield, cost-effectiveness or the impact of reduced improvement support. It therefore resisted a higher assurance conclusion.
- 7.4.6 The Chair encouraged all report authors to include important positive results alongside exceptions, as this supported a balanced assessment and helped the Committee distinguish effective controls from residual risk.
- 7.4.7 The Committee accepted that screening compliance represented a significant operational strength, while retaining scrutiny of whether the current model delivered proportionate value and whether improvement capacity was sufficient.
- 7.4.8 **FUTURE DEVELOPMENT:**
S. Whiting to review MRSA screening positivity and cost/value data with the relevant lead and provide follow-up through appropriate governance; future exception reports to include material positive assurance as well as areas requiring escalation; the impact of quality-improvement capacity on IPC delivery to remain visible.
- 7.4.9 The Clinical Governance Committee noted the contents of the report and confirmed **Moderate Assurance**, recognising strong screening compliance and active Infection Prevention and Control governance, with incomplete assurance regarding screening positivity, cost-effectiveness and the effect of reduced quality-improvement facilitation capacity.

8 Items for Noting

- 8.1 The Committee received the Clinical and Care Governance minutes from Acute Services, Mental Health, Learning Disability Services and Primary and Community Services, together with the Public Protection Committee minutes listed in the agenda pack.

Other Clinical Board Minutes:

Acute C&C Governance Minutes 24.04.26

Acute C&C Governance Minutes 17.06.26

Mental Health C&C Governance Minutes 17.06.26

LD C&C Governance Minutes 22.04.26

LD C&C Governance Minutes 17.06.26

PACS C&C Governance Minutes 28.04.26

PACS C&C Governance Minutes June 2026

PPC Minutes 24.06.25

- 8.2 The Committee noted that receiving minutes from subordinate and related governance groups supported line of sight across clinical quality and patient-safety business but did not substitute for explicit exception reporting where a material risk required Committee oversight. Members therefore treated the papers as an information source and confirmation that local governance forums were meeting and recording their business, rather than as evidence sufficient to alter the assurance ratings reached on substantive agenda items.
- 8.3 No new facts were introduced through discussion, and no item was removed from an existing governance route. The absence of questions was not interpreted as confirmation that every issue within the source minutes had been resolved; responsibility for escalation remained with the originating group and responsible executive or clinical lead.
- 8.4 **FUTURE DEVELOPMENT:**
The papers were noted. Material risks arising from the noted minutes should continue to be escalated through future exception reports or action trackers where they meet the Committee's reporting threshold.

9 Any Other Business

- 9.1 No other competent clinical governance business was raised. The Committee did, however, consider the practical scheduling of future meetings, noting the potential for conflict with in-person Delivery Group arrangements and the need to allow sufficient travel and break time between commitments. The Chair sought to ensure that diary arrangements did not inadvertently reduce attendance, disrupt quoracy or limit the ability of senior clinical and executive colleagues to participate in scrutiny. The immediate position for the next meeting appeared manageable, but members agreed that future dates should continue to be checked against other established governance forums. This was treated as an administrative governance matter rather than a change to the assurance conclusions already reached. The discussion did not identify any additional patient-safety incident, service risk or escalation requiring substantive consideration under Any Other Business.
- 9.2 The Committee's focus was therefore on maintaining an effective meeting schedule that supported attendance and good governance.
- 9.3 **FUTURE DEVELOPMENT:** H. Stirling and the Chair to keep Clinical Governance Committee scheduling under review alongside in-person Delivery Group meetings and allow reasonable travel and transition time when coordinating future dates.

10 Date and Time of Next Meeting

- 10.1 Members noted the date and the expectation that papers and action updates would be prepared in accordance with the established timetable and the streamlined exception-reporting approach discussed at the opening of the meeting.
- 10.2 Any diary interaction with other governance meetings was to be managed through the follow-up identified under Any Other Business.

10.3 No questions were raised regarding the date, format or proposed arrangements.

The Chair confirmed that the next meeting of the Borders NHS Board Clinical Governance Committee would be held on **Wednesday, 16 September 2026** at **10.00am** via Microsoft Teams.

The meeting concluded at 12.25pm

Clinical Governance Committee - Agreed Level of Assurance

Item #	Agenda Item	Level of Assurance
5	Effectiveness/Annual Assurance	
5.1	Clinical Board Update – Acute Services	Moderate (services governance and delivery) Limited (workforce sustainability)
5.2	Clinical Board Update – Mental Health and Psychology Services	Moderate (governance) Limited (workforce and CAMHS system risks)
5.3	Clinical Board Update – Learning Disability Services	Limited
5.4	Clinical Board Update – Primary and Community Services	Moderate (clinical outcomes and governance) Limited (workforce fragility)
5.5	Clinical Board Update – Maternity and Paediatrics	Moderate
5.6	Corporate Services Update – Public Health, Oral Health and Health Improvement	Moderate
6	Effectiveness/Assurance System/Service	
6.1	Dental Services Annual Report	Moderate (majority of Dental Services) Limited (paediatric general-anaesthetic waiting times and orthodontic and oral-surgery capacity and provision)
6.2	Stroke Services Paper	Limited
7	Patient Safety	
7.1	Child Death Review	Moderate
7.2	Research Governance Report	Significant
7.3	Adverse Event Overview Bi-Annual Report	Significant (systems and processes) Moderate (outcomes, timeliness and

Item #	Agenda Item	Level of Assurance
		evidence that learning and actions were reducing recurrence)
7.4	Infection Prevention and Control Report	Moderate

Clinical Governance Committee – September 2026
Agreed Level of Assurance

Item #	Agenda Item	Level of Assurance
5	Effectiveness/Annual Assurance	
5.1	Mental Health and Psychology Services	Moderate; Limited for workforce, specialist gaps and regional bed dependency
5.2	Learning Disability Services	Limited
5.3	Primary and Community Services	Moderate; Limited for workforce sustainability
5.4	Maternity and Paediatrics	Moderate
5.5	Acute Services	Moderate; Limited for workforce and material operational dependencies
5.6	Corporate Acute Pharmacy	Moderate for governance; Limited for workforce and digital resilience
6	Effectiveness/Assurance System/Service	
6.1	Cancer Services	No assurance reached — deferred to November 2026
6.2	Medical Education	Moderate
6.3	Public Protection	Moderate
6.4	Baby Friendly Initiative	Noted for awareness
7	Patient Safety	
7.1	Infection Prevention and Control	Moderate
7.2	Clinical Risk Register Overview	Moderate
7.3	Duty of Candour	Significant for systems and processes; Moderate for outcomes
7.4	Mortality Review and Learning	Significant for systems and the developing InPhase process; Moderate for outcomes and dissemination of learning
8	Claims	
8.1	Claims Annual Report	Significant for claims- management systems and processes

Meeting:	Borders NHS Board
Meeting date:	7 October 2026
Title:	Staff Governance Committee Minutes
Responsible Executive/Non-Executive:	D Parker, Chair Staff Governance Committee
Report Author:	L Shillinglaw, EA to CE

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 29 October 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 30.07.26

STAFF GOVERNANCE COMMITTEE

Date: Thursday 30 July 2026

Time: 11.00am

Location: MS Teams

Chair: D Parker

Minute: T Chapman, PA to the Director of People & Culture

1. Attendance and Apologies

Attendance: L Pringle; I Bishop; S Kean; D Parker (Chair); M Colquhoun; M O'Reilly; A Keen; L Livesey; K Lawrie; E Dickson; C Smith; C Wilson; K McLachlan; V Mann; and T Chapman.

Apologies: J McLaren; R Brydon; A Paterson; J Ayling; and R Devine.

The Committee noted the attendance and apologies and proceeded with the business set out on the agenda.

2. Declarations of Interest

The Chair invited members to declare any interest relevant to the business under consideration, either at this point or when the relevant item arose. No declarations were made during the meeting.

Outcome: The Committee noted that no declarations of interest were made.

3. Minutes of the Previous Meeting held on 30 April 2026

The Committee reviewed the minutes of the meeting held on 30 April 2026. No amendments were raised and members confirmed that the record accurately reflected the discussion and business conducted.

Outcome: The Committee approved the minutes of 30 April 2026 as an accurate record.

4. Matters Arising and Action Tracker

The Committee reviewed the action tracker as a formal governance control and was invited to raise any matter not otherwise covered by the agenda. No additional matter was raised during the meeting and the tracker was approved. The tracker recorded a mixed control position. Completed or green-rated actions included workforce dashboard reminders and access, member feedback on dashboards, obtaining J McLaren's feedback, the workforce-risk deep dive and risk-methodology work, further analysis of training constraints, the protected learning time short-life working group, and development of the Anti-Racism Committee structure and terms of reference. Outstanding amber actions included the policy update, Acute Services' consolidated

iMatter action plan, exit-interview analysis, Women and Children's workforce-risk reporting, and statutory and role-mandatory training escalation. Red or overdue actions included development of the People and Wellbeing Strategy delivery plan, the Staff Wellbeing Group work plan, review of the Staff Governance reporting model, and amendment of the reporting template to demonstrate the link between iMatter feedback and improvement. The Confidential Contacts development action also remained overdue, with progress paused because of workforce pressures and further review and rollout planned. Several outstanding items had been carried forward to 29 October 2026 because of capacity constraints, including the absence of a Head of Organisational Development.

Although no new tracker action was agreed under this item, later discussion on the Health and Care Staffing report explicitly linked reduced assurance to historic slippage and the inability to progress some governance actions because key personnel were unavailable. This confirmed that action delivery, ownership and capacity remained material assurance issues rather than purely administrative matters.

Outcome: The Committee approved the action tracker. The record nevertheless demonstrates continuing slippage and capacity-related delivery risk; no separate assurance level was formally agreed for this item.

5. Primary and Community Services Annual Governance Report

The annual governance report was not available for consideration. A Keen advised that C Wilson had managed a considerable workload during the preceding month, including preparation of papers for several governance routes, and had requested that the report be deferred to the October meeting. Members accepted the capacity constraint and agreed the revised timing.

ACTION: C Wilson to present the Primary and Community Services Annual Governance Report to the Staff Governance Committee on 29 October 2026, providing the Committee with the deferred annual governance assurance report.

Outcome: The Committee agreed to defer the report to the meeting on 29 October 2026. No assurance was taken because the report was not considered.

6. iMatter Update

M Colquhoun reported a 57% survey response rate, representing 1,856 responses from 3,266 recipients. The process had moved into the action-planning stage, but only 10% of action plans had been completed, compared with 57% at the equivalent point in the previous year. Managers were receiving weekly reminders and a wider communication was being issued. The low completion rate created an immediate governance risk because staff feedback could not be translated into evidenced local improvement without completed and uploaded plans.

A Keen clarified that the local authority had not participated in iMatter because its own survey overlapped with the process, which could affect comparison of headline figures. Electronic action plans were due by 11 August 2026 and mixed paper/electronic directorates by 28 August 2026, allowing final completion rates to be available by the end of August. L Livesey requested that headline results from the Council's survey be

shared with NHS Borders where relevant, to identify common themes and support transparency. D Parker advised that such results were normally public and could be shared, but no owner was assigned.

ACTION: All managers and team leads to ensure their teams complete and upload iMatter action plans by the applicable deadline of 11 August 2026 for electronic returns or 28 August 2026 for mixed paper and electronic returns, so that staff feedback is converted into recorded improvement action and organisational completion can be reported accurately.

ACTION: M Colquhoun to provide a full report on iMatter action-plan completion rates at the next Staff Governance Committee meeting on 29 October 2026, including the final position after the August deadlines.

ACTION: Owner TBC to obtain and share relevant headline findings from the local authority staff survey with NHS Borders, where available, to support comparison of common workforce themes. Timescale: TBC.

Outcome: The Committee noted the update for awareness, highlighted the significant shortfall in completed action plans and requested a full completion report at the next meeting. No formal assurance level was assigned.

7. Health and Care (Staffing) (Scotland) Act 2019: Quarter 1 2026/27 Compliance Report

E Dickson presented the Quarter 1 compliance position across the ten statutory duties. Progress included continued use of staffing-level tools and the Common Staffing Method, wider use of professional judgement, development of escalation processes and ongoing implementation of e-rostering and SafeCare. The report proposed reasonable assurance using the Healthcare Improvement Scotland matrix and recorded two duties as green, six as amber and two as red, with commissioning arrangements also amber. The principal red-rated areas were the ability to provide protected clinical leadership time and release staff for training. Further pressures included recruitment, sickness absence, supplementary staffing, fragility in small and specialist teams, succession planning, the reduced working week, low appraisal completion and inconsistent documentation of staffing decisions and mitigations.

L Livesey challenged whether reasonable assurance was defensible given the scale and persistence of gaps, the limited progress in several areas and the inability to advance actions where key governance capacity was absent. E Dickson explained that assurance had been assessed across all clinical staff and duties using the national matrix: some staff groups would individually warrant limited assurance, while others had the required controls, leadership time and staff release in place. A Keen sought evidence of external regulatory concern. E Dickson confirmed that reporting was quarterly, that previous reasonable-assurance reports had been accepted, and that Scottish Government and biannual engagement had generated questions but no stated concerns that NHS Borders had been unable to answer.

The Committee distinguished formal statutory compliance reporting from its own governance assurance. L Livesey maintained that external acceptance did not resolve weaknesses in local action delivery and governance effectiveness. The improvement

required for higher assurance was defined as a stronger system for progressing escalated issues, sufficient capacity to deliver agreed actions, and clearer evidence that problems identified through governance routes were acted upon. E Dickson confirmed that staffing challenges had been escalated through executives and were due for Board discussion. Members agreed that a focused discussion should align future reporting with the assurance evidence required by the Committee.

ACTION: L Livesey, E Dickson and the relevant Executive Lead to meet before the next quarterly report to define the evidence, governance improvements and action-delivery information required to support a higher Staff Governance Committee assurance rating. Timescale: before the next report; exact date TBC.

Outcome: The Committee noted progress and the national reasonable-assurance assessment but, for its own governance purposes, agreed LIMITED ASSURANCE because of persistent workforce, leadership-time, training-release, documentation and action-delivery gaps.

8. Equal Pay Statement

C Smith reported that the Equality and Human Rights Commission had notified NHS Borders that an Equal Pay Statement and updated equality outcomes had not been published within the required four-year reporting period. Although mainstreaming reports, employee information and gender pay-gap data had been published, the specific required documents were outstanding. The gap arose during a period without an HR Director and from a misunderstanding that the Equality Mainstreaming Report met the requirement. A draft Equal Pay Statement based on 2024 data was developed within four weeks, approved virtually by five Committee members, published on the NHS Borders website and shared with the Commission. Public Health was addressing the separate equality-outcomes requirement through the Clinical Governance route. The Committee recognised equal pay as integral to inclusive employment, the Staff Governance Standard and wider equality, diversity and inclusion ambitions. National job-evaluation processes support consistency and transparency in pay banding. A Keen and the Chair recognised the speed of corrective action while noting the earlier period of non-compliance and the risk that statutory reporting requirements can fall between governance arrangements when leadership continuity is absent.

Outcome: The Committee homologated the Equal Pay Statement, noted that the legal publication requirement had now been met and agreed MODERATE ASSURANCE, reflecting prompt corrective action alongside the previous period of non-compliance.

9. Workforce Risk Update

L Pringle advised that the strategic risk register was in transition to align risks directly with organisational strategies. The former workforce risk had therefore been superseded by a risk concerning achievement of the People Strategy objectives. The replacement risk was progressing through management approval and would link to the new Board Assurance Framework report scheduled for the Audit and Risk Committee in September 2026. A complete risk report was not yet available, which limited the Committee's ability to scrutinise current controls, risk movement and residual exposure.

ACTION: L Pringle to bring a full workforce and People Strategy risk report to a future Staff Governance Committee once management approval is complete, including the link to the Board Assurance Framework and sufficient information to support scrutiny of controls, risk movement and residual exposure. Timescale: TBC.

Outcome: The Committee noted the transition in risk architecture and agreed that a fuller report should return once finalised. No assurance level was agreed at this stage.

10. Statutory and Mandatory Training Update

M O'Reilly presented the statutory and mandatory training update. Core statutory and mandatory e-learning compliance continued to improve, with most modules exceeding 80% and Basic Life Support achieving 95% compliance. However, significant challenges remained in role-specific training, particularly Manual Handling and Prevention and Management of Aggression and Violence (PMAV), where compliance was lower and staff release continued to be affected by workforce pressures, vacancies and service demands.

S Kean highlighted the associated health and safety risks and advised that ongoing claims relating to aggression and violence, together with a restraint complaint, reinforced the importance of maintaining compliance. Although a substantial number of PMAV places had been made available, attendance levels remained below expectations, indicating that workforce release, booking arrangements and non-attendance all contributed to the current position.

A Keen acknowledged the challenge of balancing safe staffing requirements with training commitments and emphasised the need to improve appraisal completion to strengthen oversight of training requirements. L Livesey noted that compliance levels should be significantly higher given the potential impact on staff and patient safety and supported a single limited assurance rating.

ACTION: M O'Reilly to ensure future statutory and mandatory training reports include relevant health and safety, claims and complaints information to support assessment of governance risk. Timescale: Next reporting cycle.

ACTION: Service leads and line managers to strengthen learning plans, booking arrangements, staff release and attendance management for Manual Handling and PMAV training to improve compliance and utilisation of training capacity. Timescale: Ongoing.

ACTION: A Keen to progress the 2026/27 appraisal improvement programme to support identification and oversight of statutory, mandatory and role-specific training requirements. Timescale: During 2026/27.

Outcome: The Committee acknowledged improvement in core statutory training but agreed **LIMITED ASSURANCE** overall due to continued concerns regarding role-specific training compliance, workforce constraints and associated safety risks.

11. Anti-Racism Committee Terms of Reference and Committee Update

C Wilson and A Keen updated the Committee on progress to establish the Anti-Racism Committee. Draft Terms of Reference had been developed and work was ongoing to finalise membership, governance arrangements and reporting structures. The Committee was advised that the new governance framework would provide oversight of delivery of anti-racism commitments and wider equality and diversity activity across NHS Borders.

Discussion focused on governance, reporting and data management considerations, particularly the need to protect confidentiality where workforce reporting involved very small numbers. Members also discussed the importance of ensuring staff were aware of how to report racially motivated incidents and noted concerns that incidents may currently be under-reported. Existing policies and reporting mechanisms remained available, although further communication and education would be required to support consistent reporting and culture change.

ACTION: C Wilson to circulate the draft Anti-Racism Committee Terms of Reference to Committee members following the meeting. Timescale: Following the meeting.

ACTION: C Wilson and A Keen to finalise the Terms of Reference, confirm membership and convene the inaugural Anti-Racism Committee. Timescale: TBC.

ACTION: C Wilson, C Smith and A Keen to develop an approach to reporting race and ethnicity workforce data which provides assurance while maintaining confidentiality. Timescale: TBC.

ACTION: C Wilson and A Keen to develop a communications and education plan to support implementation of the Anti-Racism Plan and promote appropriate reporting of racist incidents. Timescale: TBC.

Outcome: The Committee supported the proposed governance arrangements, acknowledged the risks associated with under-reporting and data governance, and agreed MODERATE ASSURANCE while governance and reporting arrangements continue to be established.

12. Occupational Health and Safety Action Plan Assurance Statements

S Kean presented the annual assurance position arising from quarterly Occupational Health and Safety action plans. Clinical Boards and services were expected to submit quarterly plans and an annual statement demonstrating compliance with safety-management actions. Only four compliant plans had been received by the year-end cut-off; five areas were non-compliant and seven had provided no assurance statement. Primary and Community Services and Allied Health Professions were excluded from those figures because they were piloting a revised model. One late compliant return received in May was noted but did not retrospectively change the year-end figures. The absence of returns left the organisation unable to evidence that occupational health and safety risks were being managed consistently.

A proposed two-stage escalation mechanism would require a formal explanation after two consecutive missed quarterly plans and attendance by the relevant portfolio Director at the Occupational Health and Safety Forum after four consecutive missed quarters. A Keen challenged whether the proposed mechanism had completed the correct route through the Board Executive Team and advised that operational executive

agreement was required before onward escalation. L Livesey distinguished between process and outcomes, initially proposing no assurance for outcomes and limited assurance for systems because controls had not produced the required compliance. S Keen advised that 2026/27 submissions, including the Primary and Community Services and Allied Health Professions pilot, were already improving. The Chair concluded that limited assurance most accurately reflected recognition of the problem, work underway and the material outcome gap.

ACTION: A Keen and S Keen to confirm the correct executive governance route for the proposed two-stage Occupational Health and Safety action-plan escalation mechanism, present the proposal to the Board Executive Team for operational agreement, and report the agreed arrangements and any further escalation to the Staff Governance Committee. Timescale: TBC, with an update at the next appropriate meeting.

Outcome: The Committee noted the 2025/26 non-compliance, supported further development of stronger escalation controls through the correct executive route and agreed LIMITED ASSURANCE because systems existed but had not delivered acceptable submission and assurance outcomes.

13. Fraud Risk Management and Whistleblowing Report

I Bishop summarised four whistleblowing-related recommendations from the internal audit of fraud risk management and whistleblowing. Version control had been added to the Whistleblowing Governance Group terms of reference. The whistleblowing intranet page had been reviewed and updated with additional national guidance and standards. Work remained underway to consider a standalone local whistleblowing policy by the end of 2026 and to improve training for staff and managers, particularly where manager completion remained incomplete. A Keen welcomed the audit and reported progress in resolving a long-running complex concern whose route had been affected by interaction with other policies and procedures.

L Livesey raised two audit-trail issues. First, the action owner for whistleblowing recommendations should reflect the Director of People and Culture rather than the Director of Finance. Second, the Whistleblowing Governance Group had previously questioned whether a separate local policy was appropriate where a national Once for Scotland framework already existed, because duplication could create inconsistency and confusion. A Keen agreed to discuss the matter further, noting that the audit report had not been available during the earlier discussion and that the Board's requirement needed to be understood before determining the correct local response.

ACTION: I Bishop and A Keen to continue delivery of the outstanding internal-audit recommendations on whistleblowing training and the proposed local policy or guidance response, ensuring the action ownership is correctly recorded and the agreed response is completed by 31 December 2026.

ACTION: A Keen and L Livesey to review the internal-audit recommendation for a standalone local whistleblowing policy, reconcile it with the existing national framework and the earlier Whistleblowing Governance Group position, and confirm the appropriate response and accountable owner. Timescale: TBC.

Outcome: The Committee noted progress against the audit recommendations and agreed MODERATE ASSURANCE, with unresolved governance questions concerning action ownership and whether a standalone local policy would duplicate the national framework.

14. Staff Wellbeing Group Work Plan

A Keen and K McLachlan advised that the Staff Wellbeing Group had not met recently because key stakeholders, including the Employee Director, were unavailable. Consequently, the work plan had not progressed as intended. A meeting was scheduled but its ability to proceed remained uncertain. Related discussions were planned on wellbeing champions and wider wellbeing initiatives, including potential organisational rollout. The absence of stakeholder capacity was therefore a direct dependency affecting the governance and delivery of the work plan.

ACTION: K McLachlan and A Keen to progress the Staff Wellbeing Group, including consideration of health and wellbeing champions and organisational wellbeing initiatives, and provide a substantive update to the Staff Governance Committee on 29 October 2026. If the planned meeting cannot proceed, the update should state the revised governance route and recovery plan.

Outcome: The Committee noted the lack of progress and accepted that a further update would be required. No assurance level was agreed.

15. Items for Noting

15.1 Staff Wellbeing Group Work Plan

The Chair confirmed that this entry duplicated agenda item 14 and no separate discussion took place.

Outcome: The Committee noted the duplication. No separate decision or assurance judgement was made.

15.2 Occupational Health and Safety Forum Minutes

The Committee received the Occupational Health and Safety Forum minutes. No questions or comments were raised.

Outcome: The Committee noted the minutes.

15.3 Training, Education and Development Board Minutes

The Committee received the Training, Education and Development Board minutes. No questions or comments were raised under this noting item; statutory and mandatory training had been substantively considered under item 10.

Outcome: The Committee noted the minutes.

15.4 Area Partnership Forum Minutes

The Committee received the Area Partnership Forum minutes. No questions or comments were raised under this noting item.

Outcome: The Committee noted the minutes.

15.5 Whistleblowing Governance Group Minutes

The Committee received the Whistleblowing Governance Group minutes. No separate question or decision was recorded.

Outcome: The Committee noted the minutes.

15.6 Whistleblowing Quarter 1 Report

The Quarter 1 whistleblowing report was considered for noting. L Livesey confirmed that the Whistleblowing Governance Group had agreed that staff training data should be added to section 11 of the report. This amendment was required to strengthen the audit trail on staff awareness, manager readiness and implementation of the National Whistleblowing Standards.

ACTION: I Bishop to add current staff and manager whistleblowing training data to section 11 of the Quarter 1 Whistleblowing Report before the report is finalised or submitted onward, so that the governance record evidences training uptake and remaining gaps.

Outcome: The Committee noted the Quarter 1 report subject to inclusion of staff training data in section 11.

16. Any Other Business**16.1 Area Partnership Forum Terms of Reference**

A Keen advised that proposed changes had been considered by the Area Partnership Forum. The purpose was to introduce partnership and executive vice-chair arrangements so that meetings could continue if either the Chief Executive or Employee Director was unavailable. The principle had been supported, but the agreed position still required consolidation and return through the relevant governance route.

ACTION: A Keen to consolidate the agreed Area Partnership Forum position on executive and partnership vice-chair arrangements and return the revised Terms of Reference through the appropriate approval route. Timescale: TBC.

Outcome: The Committee noted the update and supported the principle of resilient deputy chairing arrangements.

16.2 Call for Staff Governance Committee Papers

A Keen raised concern about late submission of papers. T Chapman had issued the call for papers approximately four to five weeks in advance and provided the annual work plan, but few papers had been received when she returned from two weeks' annual leave, despite further time remaining before the meeting. The delay weakened the control environment by compressing quality review, circulation and member reading time. C Smith supported sharing a schedule showing the required frequency of each paper so that authors could plan submissions in advance. L Livesey suggested learning from the Clinical Governance Committee, which had improved timely returns after experiencing similar problems. **ACTION:** T Chapman to circulate the annual Staff Governance Committee paper schedule and reporting-frequency document to all paper

writers, enabling submission requirements to be placed in diaries and planned in advance. Timescale: before the next call for papers.

ACTION: T Chapman to contact the Chair or administrative lead of the Clinical Governance Committee and identify transferable controls that improved timely paper submission, with recommended changes brought back to the Staff Governance Committee.

Outcome: The Committee recognised late paper submission as a governance-control weakness and supported advance scheduling and learning from the Clinical Governance Committee. No assurance level was assigned.

16.3 Quarterly People Metrics Report

C Smith presented the Quarterly People Metrics Report, which had been prepared for the NHS Board and provided an overview of workforce performance across business units. The report highlighted trends in workforce establishment, appraisal completion, sickness absence, turnover, vacancies and implementation of Optima e-rostering. While some areas showed improvement, appraisal rates remained below target and sickness absence continued to present challenges across a number of services.

Discussion focused on sickness absence data, particularly musculoskeletal absence. S Kean queried whether work-related absence could be distinguished from non-work-related absence. C Smith confirmed this was not currently reflected within workforce reporting, while K McLachlan advised that Occupational Health could only provide this level of detail for staff who had accessed the service. Members also requested comparative sickness absence information from other NHS Boards. The Committee agreed that the report provided useful workforce oversight and supported its introduction as a standing agenda item.

ACTION: C Smith to include Medical and Dental appraisal data within future Quarterly People Metrics Reports once available from the separate appraisal system. Timescale: Future reporting cycle.

ACTION: C Smith to include comparative sickness absence data from other NHS Boards within a future report, where available, and identify any limitations in the data. Timescale: Future reporting cycle.

ACTION: C Smith to present the Quarterly People Metrics Report as a standing Staff Governance Committee agenda item, aligned where possible to the NHS Board reporting cycle. Timescale: From the next meeting.

ACTION: A Keen to discuss future reporting arrangements with the NHS Board to ensure workforce reporting provides appropriate oversight without unnecessary duplication. Timescale: At the next Board discussion.

Outcome: The Committee welcomed the report, supported its inclusion as a standing agenda item and requested further comparative and workforce-wide data to strengthen future scrutiny.

17. Date and Time of Next Meeting

The next meeting was scheduled for Thursday 29 October 2026 at 11.00 am via Microsoft Teams. D Parker advised that he could not attend because of an immovable

pensions commitment. A substitute Chair or an alternative meeting date would therefore be required to preserve meeting governance and continuity.

ACTION: T Chapman to confirm either an alternative Chair for the Staff Governance Committee meeting scheduled for 29 October 2026 or a revised meeting date, and communicate the agreed arrangement to members before the meeting papers are issued.

Outcome: The Committee noted the scheduled date and the unresolved chairing dependency. Further clarification is required on whether the meeting will retain the scheduled date.

Summary of Decisions and Agreements

The minutes of 30 April 2026 were approved as an accurate record and the action tracker was approved.

The Primary and Community Services Annual Governance Report was deferred to 29 October 2026.

The Committee homologated the Equal Pay Statement and noted that the legal publication requirement had been met.

The Committee agreed limited assurance for the Health and Care Staffing compliance report, notwithstanding the report's national reasonable-assurance assessment.

The Committee agreed limited assurance overall for statutory and role-mandatory training.

The Committee supported establishment of the Anti-Racism Committee and agreed moderate assurance.

The Committee agreed limited assurance for Occupational Health and Safety action-plan submissions and required the proposed escalation mechanism to follow the correct executive route.

The Committee agreed moderate assurance for the fraud risk management and whistleblowing report.

The Committee agreed that Quarterly People Metrics would become a standing agenda item.

Strategic and Assurance Points

The Committee's scrutiny identified a recurring control theme: policies, reporting routes and governance forums were generally present, but outcome assurance was weakened where workforce capacity, leadership vacancies, staff release, data quality or delayed actions prevented consistent operation of those controls. The Committee therefore did not treat external acceptance, process existence or positive activity as sufficient evidence of effective local governance outcomes.

LIMITED ASSURANCE was agreed for Health and Care Staffing compliance, statutory and role-mandatory training, and Occupational Health and Safety action-plan assurance. MODERATE ASSURANCE was agreed for the Equal Pay Statement, Anti-Racism governance and the fraud risk management and whistleblowing report. No formal assurance level was assigned to the remaining items.

Material dependencies included recruitment and sickness absence, protected clinical leadership and learning time, appraisal completion, availability of key governance and partnership roles, consistent documentation of decisions and mitigations, reliable training and incident data, safe handling of small workforce datasets, executive approval routes and reliance on manual report production.

Meeting: Borders NHS Board

Meeting date: 7 October 2026

Title: Area Clinical Forum Minutes

Responsible Executive/Non-Executive: P Williams, Non Executive

Report Author: L Shillinglaw, EA to CE

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 10 September 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 09.07.2026



Area Clinical Forum
9th July 2026

Microsoft Teams

No	Item
	Welcome and Apologies Chair: P Williams Present: M Cunningham, R Duncan, R Gorman (admin) A Harrisson, M Clubb, C Proudfoot, L Livesey, T Sporle, N Hall Apologies: Lynsey Russell ,I Hayward, Iris Bishop, M O'Dwyer. Kyna Harvey, P Grieve <i>Please note that co-pilot was used to assist in transcribing these minutes as a trial to improve meeting efficiency.</i>
1	Previous Meeting Minutes Previous minutes were approved without further amendment.
2	Action Tracker Action tracker amended and updated as appropriate.
3	Sub National Planning Paul described ongoing work in sub-national clinical work streams focused on planned care and unscheduled care, including objectives for front door services, emergency department redirection, and acute hospital patient management. Paul reported that new operational director posts for Scotland East Planned Care and Unscheduled Care have been advertised, with announcements on next steps expected in September. Paul explained that standardizing clinical pathways across boards is challenging due to differences in board operations, but there is interest in sharing best practices and potentially changing pathways, governance, and leadership structures. Paul clarified that while there is discussion about levelling up services in the sub-national planning, each board remains responsible for its own service delivery and finances, with potential alignment mainly in infrastructure and digital areas. Amanda asked whether regional planning arrangements would help address variation in service provision and support areas that currently operate below national standards.

4	Board Papers Lynne described the board's discussion about the ongoing CAMS pilot for the neurodevelopmental pathway, highlighting the significant work and challenges involved. The board approved the track care upgrade business case, which will benefit clinical services. Paul reported that the clinical system links across acute, community, and mental health services and is considered critical for regional and sub-national work. Paul shared that the board had an overspend of £2.5 million by the end of June, with only £6 million of the required £10 million recurring savings identified, raising concerns about delivering the savings plan. Robert expressed concern that staff involvement in change was not adequately reflected in the financial escalation measures paper, referencing page 8 of the document. Paul announced the formal strategic partnership between NHS Borders and Queen Margaret University, aiming for mutual benefits in research, innovation, and clinical training. Lynne highlighted that the partnership with Queen Margaret University is expected to enhance recruitment and provide trainees with valuable clinical practice experience in the Borders. Lynne emphasized the importance of staff and managers actively participating in strategic discussions to identify priorities and potential areas for cost-effective changes. Paul encouraged clinical teams to share their perspectives on the feasibility of transformational ideas within the current context, aiming to inform board members and non-executive directors. Paul explained that NHS Borders participates in Scotland East sub-national planning work streams, mainly through operational directors, and that these work streams are increasingly influencing local priorities.
5	PCIP Options Appraisal Paul introduced concerns about the ongoing options appraisal process examining Primary Care Improvement Plan workstreams following funding reductions. He explained that services were developing options that would eventually be shortlisted, assessed, and scored. Throughout the discussion he sought collective professional advice, invited concerns from colleagues, and identified recurring themes, including legal obligations, service impact, contractual responsibilities, workforce anxiety, and alignment with the clinical strategy. Malcolm raised substantial concerns regarding the legal basis of decisions being considered within the Primary Care Improvement Plan process. He argued that understanding the exact legislative obligations of the organization is essential before service reductions are assessed or approved. He stressed the need for definitive legal advice regarding what services must

	legally be provided and how those obligations should influence decision-making. Malcolm explained that he was participating in service-shortlisting exercises despite feeling uncomfortable proceeding without legal advice. He voiced concern about being expected to make recommendations that could carry accountability implications while lacking sufficient legal assurance. He emphasized that he wanted legal clarification before decisions progressed further. During discussions on Primary Care Improvement Plan services, Robert stressed that services under consideration should not be viewed merely as support for general practitioners. Instead, he argued that they form part of commitments made to patients and represent organizational responsibilities. He sought greater clarity about how leaders intended to address situations where contractual obligations might not be fulfilled. Paul proposed formally escalating concerns to senior leadership, including the board chair and chief executive, and committed to drafting a letter on behalf of the forum.
6	Advisory Committee updates – Paul advised that any updates brought to ACF were to be on the template that had previously been circulated but that a flash report could also be used
7	AOB Nothing for noting
Date and Time of Next Meeting: 10th September 2026, 12:30-13:30	

Meeting:	Borders NHS Board
Meeting date:	7 October 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, 2 new consultants have been interviewed, offered and accepted a consultant post.

New Consultant	Post	Start Date
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Dr Mihaela Gunjaca	Consultant General Physician	December 2026
Dr Sarah Richardson	Consultant in Emergency Medicine	October 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:	7 October 2026
Title:	Appointment of Registered Nurse as Professional Advisor to the Scottish Borders Integration Joint Board
Responsible Executive/Non-Executive:	Peter Moore, Chief Executive
Report Author:	June Smyth, Director of Planning & Performance

1 Purpose

This is presented to the Board for:

- Decision

The Board is asked to approve Lynn Barker's appointment as the registered nurse non-voting member of the Scottish Borders Integration Joint Board for the period 5 October 2026 to 4 October 2029.

This report relates to:

- Other – IJB Committee Membership

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

- Safe
- Effective

2 Report summary

2.1 Situation

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 requires NHS Boards to appoint a registered nurse as a non-voting member of the Integration Joint Board. Sarah Horan, who has fulfilled this statutory role on the Scottish Borders Integration Joint Board, is stepping down following her secondment to the Scottish Government.

This paper seeks Board approval for Lynn Barker, Director of Nursing, Midwifery & Allied Health Professionals for NHS Borders, to be appointed as the registered nurse non-voting member of the Scottish Borders Integration Joint Board with effect from 5 October 2026.

2.2 Background

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 governs appointments to Integration Joint Boards. The appointment considered in this paper is a statutory professional appointment made by NHS Borders rather than an appointment to one of the Board's own committees.

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 determines the membership of Integration Joint Boards. The NHS Board is required to appoint a number of non-voting members to the IJB in accordance with Article 3(1), including:

“a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract.”

The Order provides that a member's term of office must not exceed three years, except for the Chief Officer, Chief Finance Officer and Chief Social Work Officer. A member may be reappointed for a further term at the end of their term of office.

Sarah Horan, the former Director of Nursing, Midwifery and Allied Health Professionals, has held the position specified in Article 3(1)(g) on the Scottish Borders Integration Joint Board. She has advised that she will step down from this role following her secondment to the Scottish Government.

The Board wishes to acknowledge and thank Sarah for her contribution as the registered nurse non-voting member of the Scottish Borders Integration Joint Board and the leadership, professional advice and assurance she has provided during her tenure.

Lynn Barker will take up post as Director of Nursing, Midwifery and Allied Health Professionals for NHS Borders on 5 October 2026. As a registered nurse employed by NHS Borders and the Board's executive professional lead for nursing, she has been nominated to replace Sarah Horan in the position specified in Article 3(1)(g) of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

The appointment will ensure continued compliance with the statutory membership requirements of the Scottish Borders Integration Joint Board and maintain appropriate professional nursing representation within the governance arrangements of the Integration Joint Board.

2.3 Assessment

2.3.1 Quality/ Patient Care

There are no direct quality or patient care impacts arising from the appointment itself. The appointment will, however, maintain professional nursing advice within IJB

governance and support continued oversight of matters affecting the quality and safety of integrated services.

2.3.2 Workforce

There are no direct Workforce implications arising from this appointment.

2.3.3 Financial

There are no Financial implications arising from this appointment.

2.3.4 Risk Assessment/Management

If the Board does not approve an eligible registered nurse appointment, the Scottish Borders Integration Joint Board may not meet the statutory membership requirement in Article 3(1)(g). Approval will mitigate this governance risk by maintaining continuity of professional nursing advice and assurance.

2.3.5 Equality and Diversity, including health inequalities

The proposed appointment is not expected to have a differential impact on people with protected characteristics or to affect health inequalities. The decision concerns statutory membership of the Integration Joint Board rather than the design or delivery of services.

2.3.6 Climate Change

There are no Climate Change implications arising from this appointment.

2.3.7 Other impacts

Not Applicable.

2.3.8 Communication, involvement, engagement and consultation

No public engagement or consultation is required because the proposal concerns an individual statutory appointment and does not change the planning, design or delivery of health and care services. The Executive Team has been consulted as part of the governance route for the appointment.

2.3.9 Route to the Meeting

No prior committee approval is required. The Executive Team has been consulted on the proposed appointment of the registered nurse professional member of the Integration Joint Board.

2.4 Recommendation

It is recommended that the Board **approve** the appointment of Lynn Barker as a non-voting member of the Scottish Borders Integration Joint Board and specifically as a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract **with effect from 5 October 2026 until 4 October 2029**.

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

It is suggested that the Board can take **Significant Assurance** that the proposed appointment is consistent with the statutory requirements governing Integration Joint Board membership and with the Scottish Borders Health and Social Care Integration Joint Board Standing Orders. Approval will maintain compliant governance arrangements and continuity of professional nursing representation on the Integration Joint Board.

3 List of appendices

None.