Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 24 April 2025** at 10.00am via MS Teams.

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**DECLARATIONS OF INTEREST**	Chair	*Verbal*
10.02	**3**	**MINUTES OF PREVIOUS MEETING**	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.10	**5**	**STRATEGY**		
	5.1	NHS Borders Organisational Strategy	Chief Executive	*Appendix-2025-32*
	5.2	Full to the Brim – Director of Public Health Annual Report 2024	Director of Public Health	*Appendix-2025-34*
11.59	**7**	**ANY OTHER BUSINESS**		
12.00	**8**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 26 June 2025 at 10.00am in the Roxburgh Suite, Scottish Borders Council and via MS Teams (HYBRID)	Chair	*Verbal*

At the conclusion of the meeting the Board will meet IN PRIVATE for matters of reserved business

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 3 April 2025 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mrs L O'Leary, Non Executive
Ms L Livesey, Non Executive
Mr J Ayling, Non Executive
Mrs H Campbell, Non Executive
Mr J McLaren, Non Executive
Cllr D Parker, Non Executive
Mr P Moore, Chief Executive
Mr A Bone, Director of Finance
Dr S Bhatti, Director of Public Health
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr L McCallum, Medical Director

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of HR, OD & OH&S
Mr O Bennett, Interim Director of Acute Services
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement
Mr S Whiting, Infection Control Manager
Mrs C Oliver, Head of Communications & Engagement
Ms L Henderson, Communications Officer
Mr M Clubb, Director of Pharmacy
Mr A Elton, R Hamilton MSP Office
Mr C Faldon, Logie Legacy
Ms M Taylor, Staff Nurse

1. Apologies and Announcements

1.1 There were no apologies received.

1.2 The Chair recorded the thanks of the Board to Mrs Harriet Campbell who would conclude her appointment as a Non Executive Director on 4 April 2025. She also announced that Mrs Campbell would continue to chair the Organ Donation Committee in her capacity as a member of the public and recruitment for a replacement Non Executive was under way through the public appointments unit.

1.3 The Chair announced that Mr John McLaren had been reappointed for a fourth term as Chair of the APF (Stakeholder Non Executive) with effect from 1 April 2025.

1.4 The Chair welcomed Ms Meri Taylor, Staff Nurse who was shadowing the Director of Nursing, Midwifery & AHPs.

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

1.6 The Chair confirmed the meeting was quorate.

2. Register of Interests

2.1 The Chair advised that the declaration of interests for Mr John McLaren had been circulated the previous day and would be included in the pack presented to the Board.

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

The **BOARD** noted there were no verbal declarations.

The **BOARD** approved the Register of Interests.

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

3. Minutes of the Previous Meeting

3.1 The Chair advised that a late amendment to the minutes had been circulated the previous day and with that amendment the minutes of the previous meeting of Borders NHS Board held on 6 February 2025 were approved.

4. Matters Arising

4.1 **Any Other Business:** The Chair clarified that on the back of the discussion about staff governance, the Staff Governance Committee was scheduled to meet 4 times per year, it would receive an HR data report at each meeting, the Resources & Performance Committee received an HR data report twice a year and the Board received an HR Data report on an annual basis. In moving forward the Board would receive the whistleblowing quarterly reports instead of the Staff Governance Committee.

4.2 She further commented that new arrangements in terms of accountability and responsibility were being worked up for whistleblowing and she was assured by the Director of HR, OD & OH&S that whistleblowing concerns had been appropriately raised and dealt with.

4.3 **Action 2025-3:** Mrs June Smyth advised that the query had been responded to quickly and information on the pooling of patients had been attached to the last report presented to the Resources & Performance Committee. For completeness the same information was included in the performance report to the Board. She suggested the action could be closed on the Action Tracker.

The **BOARD** agreed to mark Action 2025-3 as complete.

The **BOARD** noted the Action Tracker.

5. Chief Executives Report

5.1 Mr Peter Moore provided a brief overview of the content of his report and highlighted managing the pressures from a service and financial perspective.

The **BOARD** noted the Action Tracker.

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

6. Health Board Collaboration and Leadership

6.1 Mr Peter Moore provided an overview of the content of the paper and the background and context to asking the Board to sign up to the collaborative effort.

6.2 Discussion focused on: welcoming the approach; impacts in terms of NRAC; implications for governance on plans for 3-5 years; cross fertilisation of care across health boards; closer collaboration with neighbouring health boards; potential to collaborate across the English border; funding flows to where the patient is treated; mechanism for patient level costings; mechanism for best value; understanding the impact, being clear on the implications and having an impact statement to review in 12 months' time.

The **BOARD** noted:

- the commitment set out by the First Minister to progress the renewal and reform of the NHS in Scotland, and associated requirement for the Board to seek assurance on delivery of these commitments;
- the evolution of the new governance arrangements which are intended to enable and foster stronger collective accountability whilst underpinning the strength of local accountability mechanisms.

The **BOARD** acknowledged and endorsed:

- the duality of their role for the population/Board they serve as well as their contribution to population planning that will cross traditional Board boundaries and approves local implementation of this approach, consistent with DL(2024)31 and 12 (J) of the 1978 NHS Scotland Act;
- the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there is requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform documents.

The **BOARD** noted that in response to these changes, it is recognised that there is requirement to refresh the traditional approach to Board performance framework and indeed Executive personal objectives, which was referenced in Caroline Lamb's letter of 7 February.

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

7. Developing NHS Borders Strategy

7.1 Mr Peter Moore commented that the development of the strategy was fundamental in taking the organisation forward and he articulated the process followed and that the formal launch of the strategy would take place at the Extraordinary Board meeting to be held on 24 April 2025. He was keen for the document to become embedded in the work that the organisation carried out on a daily basis and in enabling that to happen there would be changes to the internal governance arrangements.

7.2 Mr Moore acknowledged the work of the teams involved in developing the strategy and the input of staff and local communities in engaging and answering the 5 key questions.

7.3 Mrs June Smyth commented that at the last meeting of the Board she had provided the Board with a brief update on the engagement exercise that had concluded that week. Since that point the full engagement responses had been collated and key themes had emerged. The outputs of the engagement exercises had been put into a poster format and would be displayed at the various venues used, so that the public could see that they had been listened too. The feedback would also be used to inform the next stage of the organisational strategy, the development of the clinical strategy and enable the development of the people strategy.

7.4 The Chair recorded her thanks to those involved in the engagement process which had been very well organised and had built on engagement activities carried out in previous years.

7.5 Discussion focused on: managing the expectations of the public on the services they value being offered close to them; potential recruitment of 2 consultants in dermatology; an understanding that complex therapies and treatments would be delivered further from home through specialist centres; equitable access through the delivery of transformative services; and reiterating the responsibility of individuals to take care of their own health needs through diet and exercise.

The **BOARD** noted associated timescales for the development of NHS Borders Organisational, Clinical and Enabling Strategies

The **BOARD** endorsed the approach set out in this paper to develop a clear Strategic Direction for NHS Borders for the next five years

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

8. Pharmaceutical Care Services Report Update

8.1 Mr Malcolm Clubb provided a brief overview of the content of the update to the pharmaceutical care services plan and specifically highlighted workforce planning and medicines shortages.

8.2 Dr Lynn McCallum highlighted: the work that pharmacy colleagues undertook in regard to recruitment of pharmacists under the PCIP umbrella; the progress of the pharmacotherapy workstream to aid GP colleagues; and the appointment of an accountable officer from an aseptics perspective.

8.3 Mrs Sarah Horan recorded her thanks to Mr Clubb and his team for the exceptional support they provided to non medical prescribers and she highlighted that access to digital records for community pharmacists would assist them moving forward.

8.4 Mrs June Smyth advised that there was a wider national conversation underway on broader primary care digitalisation.

8.5 Mrs Fiona Sandford suggested a small investment in technological change could reap big rewards in pharmacy services.

8.6 Mr Peter Moore commented that pharmacy was often discussed in terms of drug spend and cost savings and beneath those were individual patients who received medications and had their lives improved and the team should be commended on the difference they made to those with often complex co-mobidities.

The **BOARD** endorsed the Pharmaceutical Care Services Plan report update 2025. The author also requests that the Board notes the challenges, and that any updates or concerns will be escalated via relevant channels including OPG as required.

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

9. Risk Appetite Policy

9.1 Mrs Laura Jones provided an overview of the content of the report and the change to 2 statements within the risk appetite for finance and organisational reputation.

9.2 Mr James Ayling provided feedback from the Audit and Risk Committee in regard to a discussion that took place about a proposed change to the risk appetite for governance and the decision to leave it as previously graded.

The **BOARD** approved the revision to the risk appetite approach for Finance and Reputation as detailed in Appendix 1.

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

10. Resources & Performance Committee minutes: 16.01.25

The **BOARD** noted the minutes.

11. Audit & Risk Committee minutes: 16.12.24

The **BOARD** noted the minutes.

12. Endowment Fund Board of Trustees minutes: 07.10.24, 25.11.24

The **BOARD** noted the minutes.

13. Finance Report

13.1 Mr Andrew Bone provided an overview of the finance report and he highlighted: the report was to the end of February 2025; year to date there was a £13.45m

overspend after 11 months; current forecast was an £18m overspend; £14.8m support from the Scottish Government was expected; a further £3.5m of non-recurring support that would not be repayable had been agreed with the Scottish Government and would ensure a balanced position by the end of March 2025.

13.2 Mr James Ayling enquired about the costs of responding to the RAAC issue at the Knoll hospital. Mr Bone confirmed that the current estimate was £2.4m and the Scottish Government had agreed to provide separate funding.

The **BOARD** noted the content of the report including:

YTD Performance	£13.45m overspend
Outturn Forecast at current run rate	£14.67m overspend
M11 Review Forecast (adjusted trend)	£18.00m overspend
Projected Variance against Plan (M11 Forecast)	£7.76m improvement
Actual Savings Delivery (current year effect)	£8.43m (actioned)
Projected gap to SG brokerage	£3.20m (M11)

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

14. Financial Plan 2025/26

14.1 Mr Andrew Bone provided an overview of the content of the paper and financial plan as submitted to the Scottish Government and the changes made following the Resources and Performance Committee meeting held in March. He advised that the Board remained at level 3 of the NHS Scotland Support and Intervention Framework given the Board did not have a balanced financial plan.

14.2 Further discussion focused on: 3% savings targets to deliver each year over the term of the financial plan; brokerage no longer available from 2025/26; replacement for the brokerage mechanism for Boards; internal budgeting setting mechanisms; transforming the financial position over the next 3 years; and how financial decisions would be considered in the context of other issues, including patient safety.

The **BOARD** approved its medium-term financial plan for the period 2025/26 to 2027/28 on a provisional basis subject to final agreement with Scottish Government.

The **BOARD** endorsed the budget setting approach set out in the paper.

The **BOARD** confirmed it had received Limited Assurance from the report, recognising the current status of the financial plan and level of risk attendant on identification and implementation of savings plans.

15. Provision of Resources to the Scottish Borders Integrated Joint Board

15.1 Mr Andrew Bone provided an overview of the content of the report and highlighted that the offer to the Integration Joint Board was consistent with the financial plan.

The **BOARD** approved the interim budget offer to the IJB, noting the terms of the offer and remitted to the Chief Executive and Director of Finance responsibility for negotiation of a

final budget offer to the IJB which encompasses agreement of the outcomes expected by the Health Board in relation to the IJBs overall use of resources.

The **BOARD** confirmed it had received Limited Assurance from the report.

16. Clinical Governance Committee minutes: 15.01.25

The **BOARD** noted the minutes.

17. Quality & Clinical Governance Report

17.1 Mrs Laura Jones provided a brief overview of the content of the report and highlighted: the work at the Knoll Community Hospital in regard to the relocation of patients; growing demand for mental health services for children and the tertiary provision; access to stroke beds; urology service performance; Laboratories and the impact on accreditation; child death and mortality; and the annual work plan.

The **BOARD** noted the report.

The **BOARD** confirmed it had received Limited Assurance from the report.

18. Infection Prevention & Control Report

18.1 Mr Sam Whiting provided an overview of the content or the report and highlighted: new infection control targets to be achieved by March 2026; and hand hygiene compliance.

The **BOARD** noted the report.

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

19. Equalities Mainstreaming Report 2025

19.1 Dr Sohail Bhatti presented the equalities mainstreaming report and commented that the organisation was fulfilling its legal duty to have evidence of mainstreaming protected characteristics and reflected on what still needed to be done in terms of development as both an employer and an anchor institution.

19.2 Mrs Lucy O'Leary welcomed the report which was an improvement on the previous report as it contained evidence of facts, statistics and analysis.

19.3 Mr James Ayling enquired when the Board might receive a report on health inequalities. Dr Bhatti commented that work on such a report was being taken forward but had slowed due to maternity leave. However he suggested a report might be available later in the year.

19.4 Mrs Lynne Livesey noted that waiting lists were analysed for protected characteristics and enquired if other areas were also analysed such as complaints. Dr Bhatti commented that it was for individuals to self declare, therefore it was difficult to identify true representation in a balanced way if only a small proportion declared any protected characteristics.

19.5 Mr Peter Moore welcomed the report and suggested consideration be given to unconscious bias and how to support the workforce with the journey through that, as well as heath inequalities. Both elements would feed into the forthcoming clinical strategy and people strategy. He further commented that each Director would be taking on a champion role to be the lead for a protected characteristic in order to establish them within the organisation.

19.6 The Chair commented that gender recognition was also an area that the Board should be cognisant of.

The **BOARD** noted the report.

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

20. NHS Borders Performance Scorecard

20.1 Mrs June Smyth provided an overview of the content of the report.

The **BOARD** noted Board performance as at the end of February 2025.

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

21. The Logie Legacy

21.1 Mr Chris Faldon presented the Logie Legacy update to the Board as well as the Annual Report. He advised that unfortunately Mrs Alison Aitken, secretary to the Logie Legacy had unfortunately passed away.

21.2 Mr Faldon spoke of his experiences being part of the Logie Legacy and the cross fertilisation of staff and processes through the close working arrangements between both NHS Borders and St Francis Hospital in Zambia and how it related to the global citizenship initiative.

21.3 He explained that St Francis Hospital was a 400-550 bedded hospital serving a population of 1.5m with 400 staff. He was keen to strengthen and reinvigorate the work of the Logie Legacy and attract more volunteers and explained the key elements that the Logie Legacy was looking for which included:

1. Communications expertise: raise awareness, recruit new volunteers
2. Fundraising expertise (“The Difference”)
3. Project management support
4. Occupational Health support – vaccines, anti-malarial
5. Payroll giving
6. HR support for volunteering – leave, sabbatical etc
7. Endorse importance of global health engagement with staff
8. Leverage influence with SG in supporting funding applications
9. Opportunities to connect with SBC to broaden support base
10. Surplus equipment donations
11. Visible presence in BGH – noticeboard, office, charity table
12. Continued access to IT – emails, microsite, file storage

21.4 Mrs Fiona Sandford enquired what the top 2 asks would be that would make a big impact. Mr Faldon commented that Communications was the top priority and if a bulletin could be released on staff snapshots to inspire others, he suggested that would make the biggest impact.

21.5 Mrs Sarah Horan commented that when she was the Head of Midwifery it was clear that those staff who had visited and worked alongside staff in St Francis Hospital had gained a different perspective on their role and she was fully supportive of closer links between the 2 organisations.

21.6 Mrs June Smyth commented that her teams may be able to support with some of the asks and in the first instance she would ask Mrs Clare Oliver to contact Mr Faldon in regard to communications requests.

21.7 Mr Andy Carter also offered to take forward work around HR support and payroll giving.

21.8 The Chair thanked Mr Faldon for presenting the Logie Legacy to the Board and welcomed the positive discussion.

The **BOARD** noted the presentation.

22. Scottish Borders Health & Social Care Integration Joint Board minutes: 20.11.24, 22.01.25

The **BOARD** noted the minutes.

23. Board Committee Memberships

23.1 The Chair provided a brief overview of the content of the report.

23.2 The Chair recorded the thanks of the Board to Dr Kevin Buchan and Mrs Harriet Campbell on the conclusion of their Non Executive Director appointments.

23.3 Mrs Laura Jones also thanked Mrs Campbell for her input to the Clinical Governance Committee and that the Committee was likely to be impacted in terms of quoracy given the departure of both Non Executives.

23.4 The Chair advised that recruitment was underway to replace Mrs Campbell and that the election of a new ACF Chair had been dependent on the election of a GP Sub Committee Chair before that election could take place. She further advised that she would be happy to attend the Clinical Governance Committee to enable quoracy.

The **BOARD** noted the changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart (Appendix 1).

The **BOARD** confirmed that it would continue to operate with one Non Executive vacancy for the period 2025/26 which will continue to contribute to the savings target of the Board.

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

24. Any Other Business

24.1 There was none.

25. Date and Time of next meeting

25.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 26 June 2025 at 10.00am in the Roxburgh Suite, Scottish Borders Council and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 3 October 2024

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-5	16	The **BOARD** noted that the ACF Chair would progress linking the ACF through the Clinical Governance Committee in terms of activities across independent practitioners.	**ACF Chair**	**In Progress: Update 05.12.24:** Mrs Laura Jones advised that Dr Kevin Buchan, Mrs Sandford and herself had met and discussed linkages between the ACF and Clinical Governance Committee. Some issues required a more operational reporting line and it was agreed to keep the item open on the Action tracker whilst further discussions took place. **Update 06.02.25:** The Chair advised that the Chair of the ACF had resigned and an election would be held for a replacement. Mrs Fiona Sandford commented that it was important for the Board to receive a strong voice from independent practitioners particularly GPs. **Update 26.03.25:** The Chair of the GP Sub election was required to take place before the election of the Chair of the ACF. The election for the Chair of the GP Sub was scheduled for 31.03.25.

Meeting held on 5 December 2024

Agenda Item: British Sign Language (BSL) Plan 2024 to 2030

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-1	15	The **BOARD** noted that it had previously requested to receive a regular report from the Staff Governance Committee on staffing.	**Andy Carter / Cllr David Parker**	**Update 06.02.25:** It was noted a discussion would take place under any other business in regard to the Staff Governance Committee. The action would remain live on the action tracker.

Meeting held on 6 February 2025

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2025-3	17	The **BOARD** agreed that a report on "pooling patients" be submitted to the Resources & Performance Committee.	**June Smyth**	**In Progress:** Report scheduled for 8 May R&PC meeting. **Complete:** Mrs June Smuth advised that the query had been responded to quickly and information on the pooling of patients had been attached to the last report presented to the Resources & Performance Committee. For completeness the same information was included in the performance report to the Board. She suggested the action could be closed on the Action Tracker.

NHS Borders

Meeting:	**Extraordinary Borders NHS Board**
Meeting date:	**24 April 2025**
Title:	**NHS Borders Organisational Strategy**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Author:	**Katy George, Planning and Performance Officer** **Stephanie Errington, Head of Planning & Performance**

1 Purpose

This is presented to the Board for:

- Discussion and Approval

This report relates to a:

- NHS Borders Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

In January 2025, NHS Borders initiated a comprehensive engagement exercise involving all staff and the Borders communities. This effort provided valuable insights and feedback regarding the significance of NHS Borders to both staff and the public, highlighting the valued aspects of our services and identifying areas for improvement.

The feedback revealed key themes that have been instrumental in shaping our Organisational Strategy. The Organisational Strategy is being presented to NHS Borders Board for final approval and this paper details the next steps that will be taken on the engagement of the document, alongside the development of our Clinical Strategy and supporting Enabling Strategies.

2.2 Background

It was identified that NHS Borders required a new Organisational Strategy for 2025 – 2030. The development of this strategy provided us with the following opportunities:

- To reconnect with our staff and public
- To understand what was important to them
- To link this back to our staff's purpose
- To provide a clear vision of where we were going, and how this linked to our NHS Borders values
- To provide the blueprint for our bridge towards this 2030 vision

Alongside this, there was recognition that we also needed to develop our Clinical Strategy. The engagement outputs and themes collected were crucial in informing this work.

Our aim throughout the development phase of this Strategy document was to ensure that the feedback and responses from both staff and public were considered and reflected in our Mission and Strategic Goals.

2.3 Assessment

NHS Borders and the services we deliver belong to the communities we serve. While we as a Board, run these services, they belong to and need to meet the needs of our communities. Therefore, to make sure we are continually delivering the right care through the right services, we need to be in conversation with those who know our services best. The Strategy is a response to the answers we heard in our conversations and the responses to the questions we asked. The answers highlighted several key areas that are important to our staff and communities.

The Organisational Strategy is the first key step to setting out the direction of travel for NHS Borders for the next five years. Supporting the delivery of this will be a new Clinical Service Strategy, a new Operating Framework and a new approach to Quality Improvement.

Organisational Strategy

Engagement with both staff and public across the Scottish Borders commenced on the 7th January 2025 in a variety of ways that enabled people to share their feedback and thoughts with us. We used a survey approach with five key questions that we asked staff and public.

To enable as many people as possible to access these questions and provide their thoughts, we developed and coordinated a range of options for people to participate, which are listed below:

- Focussed engagement with groups including multiple staff meetings online and in person, rotary clubs and local businesses
- Face to face conversations in public spaces to record people's views and promote the survey questions including supermarkets, libraries, leisure centres, community hubs, Borders College

- Targeted communication with groups identified through the diversity database to participate and share the engagement survey for those to share with their wider networks
- Postal option was also made available with pre-paid envelopes provided
- Electronic option for people to access the survey online through the development of a QR code and online survey link

In total we received 1,347 responses to the engagement survey which have then been reviewed, themed and used to inform the content of NHS Borders Organisational Strategy document for 2025 – 2030.

Using all of the information collected throughout the engagement in January, we then began drafting our Organisational Strategy. It was important for this document to provide direction for NHS Borders over the next five years, whilst also reflecting the comments and thoughts from both our staff and public. The Strategy sets out our role as NHS Borders, our Mission and Strategic Goals and our delivery approach. This is detailed within a storyboard within ***appendix 1***.

Once the Organisational Strategy has been formally approved, we will initiate a comprehensive engagement process. This process is designed to ensure that every member of our staff, as well as the public, has ample opportunity to review and fully understand the strategic direction our organisation will be pursuing over the next five years. Through a series of informative sessions, detailed communications, and interactive discussions, we aim to promote a clear and shared vision, enabling everyone to align with our goals and contribute to our collective success. An overview of this next phase of engagement is outlined within ***appendix 2.***

Clinical Strategy

Our Clinical Strategy will be the blueprint for the future of clinical services delivered in the Borders, and over the forthcoming months we will be working collaboratively across our clinical services, teams and with our communities to determine what this vision will be. It is important that all voices are heard during this engagement and that every perspective and contribution is valued.

This engagement will take place at speciality level and will include multi-disciplinary workshops taking place between the end of May – end of August 2025 where professional leads for specialities and clinical departments will work with colleagues to outline what their service will look like in five years' time and the key annual deliverables that will be required to implement that future vision.

Developing our Internal Operating Model

In order to both operate more effectively and deliver the level of change required through the NHS Borders Strategy 2025 - 2030 we will need to effectively engage the combined effort of the whole organisation. The current internal governance architecture is complex, and teams often comment that it is difficult to understand where and how decisions get made. We need to streamline this so that our decision-making processes are clearer, and to ensure that all formal groups / meetings focus on delivering the new strategy once it is finalised.

Along with streamlining the architecture and the decision-making structures we will look to enhance clinical leadership and engagement in that decision making process,

set clear direction for Business Units and empower teams via the strategy and clear communication of our priorities. This will help encourage agency in our teams which will in turn enable effective and transparent planning for improvement, capture innovation and ideas at team level, driving up standards across the organisation and delivering our agreed priorities for the year. Further detail and information on our revised Governance arrangements can be found within ***appendix 3***.

Instilling Improvement in our Workforce

To deliver the care that our patients need, within the resource structure we have, we need to be continuously improving. Our goal is that every member of staff understands their role in achieving our organisational priorities, knows what is expected of them, receives feedback on how well they are doing, and, if there is a gap, knows how to close this through the use of improvement methodologies and techniques. Key to this will be a concerted approach to broadening the spread of quality improvement knowledge and skills, enabling every staff member to seek to make improvements to their own service areas.

These three fundamental building blocks, along with the development of wider enabling strategies, will support delivery of our overall Organisational Strategy and priority objectives over the next five years.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

The engagement with staff to date during the engagement exercise received a positive response. All comments and responses from this work have been analysed and themed and there are some great areas we want to continue to discuss along with ideas and suggestions for improvement. This feedback along with continuing conversations will help to develop and shape our People Strategy. This work will continue to give our staff the opportunity to shape the future direction of NHS Borders ensuring we have a dedicated and appropriately skilled workforce for future service delivery.

2.3.3 Financial

A financial strategy will be prepared setting out the resources available to the Health Board, the method by which these will be directed in support of the strategy, and the actions required to ensure that expenditure is aligned to the priorities outlined in the strategy and with due regard to efficiency, effectiveness and the principles of best value and value-based health and care.

2.3.4 Risk Assessment/Management

A full risk assessment will need to be considered for the delivery and implementation of the Organisational Strategy. We will also require a separate risk assessment for the Clinical Strategy engagement and the implementation plans for these specialities.

2.3.5 Equality and Diversity, including health inequalities

Engaging with the public and staff is crucial for supporting the Public Sector Equality Duty the Fairer Scotland Duty, and the Board's Equalities Outcomes. This engagement exercise was the start of conversations that will continue throughout the development and implementation of NHS Borders Strategy. As we continue with this work we will:

- Identify barriers by gathering insights from diverse groups
- Ensure that our Strategy considers the needs and experiences of all groups to inform decision making
- Continue to encourage participation from underrepresented groups to foster a more inclusive environment

2.3.6 Climate Change

Individual elements of the strategy will require an assessment however should have a positive impact on climate change.

2.3.7 Other impacts

These will be assessed as the Strategy is implemented.

2.3.8 Communication, involvement, engagement and consultation

This engagement phase has been designed through multiple discussions and groups including:

- Staff Engagement QMS Pillar
- BET
- NHS Borders Board Development Session
- Quality & Sustainability Board
- Communication and Engagement Team
- Strategy Taskforce

2.3.9 Route to the Meeting

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

- Staff Engagement QMS Pillar
- Board Executive Team
- NHS Borders Board Development Session
- NHS Borders Board
- Quality & Sustainability Board
- Senior medical staff committee
- GP sub committee
- Area Staff Side

2.4 Recommendation

- **Approve** – For Board Members to approve NHS Borders Organisational Strategy set out within **Appendix 4.**

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

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

3 List of appendices

The following appendices are included with this report:

Appendix 1: NHS Borders Organisational Strategy Storyboard

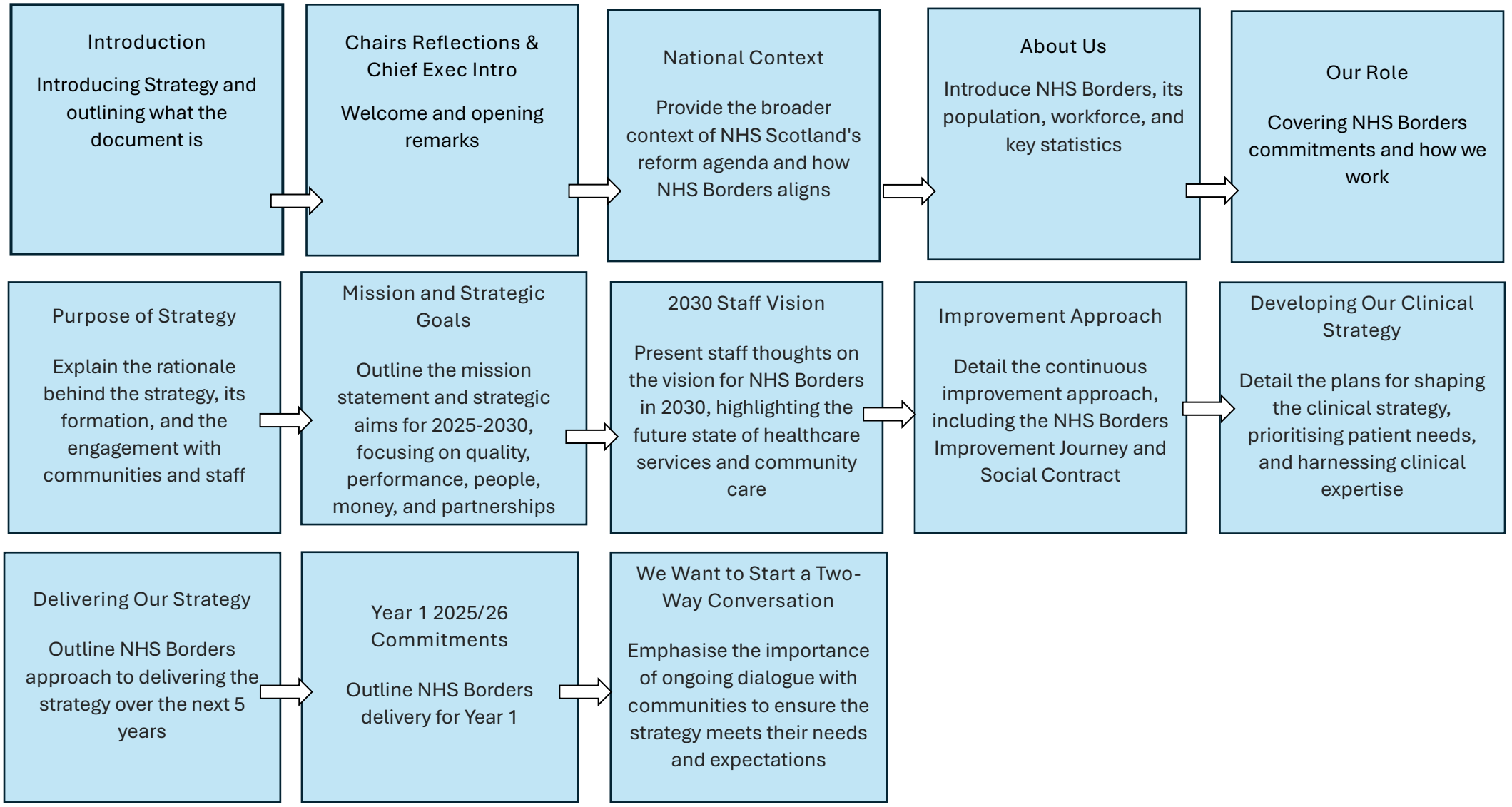
Appendix 2: Communications & Engagement Plan Overview

Appendix 3: NHS Borders revised Governance arrangements

Appendix 4: NHS Borders Organisational Strategy

Appendix 1: NHS Borders Organisational Strategy

Story Board



Appendix 2

Communications and Engagement Overview for NHS Borders Organisational Strategy Launch

Our staff and members of our community have been at the forefront in the creation of our Organisational Strategy. We have engaged with people throughout the Borders about what is important to them and the Strategy is our response to this. Through the creation and implementation of the Strategy we aim to provide a clear vision of our organisation's future and outline the steps and milestones towards achieving our 2030 vision.

Aims of the Communications and Engagement Plan

This plan aims to actively involve and inspire everyone to embrace our new strategy. By promoting our vision, we will encourage our stakeholders to align with our goals and contribute to our collective success. Through engaging activities and transparent communication, we seek to create a sense of ownership and commitment to the strategy, ensuring its success.

Pre-Launch Phase (Mid April)

- Soft Launch Staff: Share initial details with staff at Chief Executive's all staff call to build anticipation and set expectations.
- Soft Launch Social Media: Announce that the strategy is launching imminently.
- Media Release: Encourage public and media attendance at the Extra Ordinary Board.
- Media Interviews with Leadership: Offer interviews with Chief Executive to discuss the strategy immediately following the board meeting.

Launch Phase (From 24 April – 30 April)

- Staff Share: Officially announce the strategy to all staff.
- Desktop Post-it Note: Use desktop notifications to remind staff of the launch.
- Intranet Featured Advert: Highlight the strategy on the intranet homepage.
- Intranet Microsite: Develop a microsite on the intranet with detailed information.
- Posters: Place posters in high-traffic areas within the organisation.
- Media Release: Prepare and distribute a media release to announce the launch.
- Social Media Post: Announce the launch on social media.
- Set up Web Page: Create a dedicated web page with key information and resources.
- Target Key Community Contacts: Email / letter from Chief Executive to local MP/MSPs & Councillors, Community Council's and relevant community groups to encourage their buy-in and support for the strategy.

Post-Launch Phase (May – October)

- Staff Share: Share updates with staff on what has been accomplished and future goals.
- Internal Bulletins: Include relevant information and call to action in the weekly digest and on the staff intranet homepage to keep actions front of mind.
- Media Release: Share updates with public on what has been accomplished, highlight future goals and encourage involvement (where applicable).
- Social Media: Post updates and relevant call to action on social media about the organisation's activities and progress.
- Engagement sessions: Host regular engagement session both in the community and virtually to engage with our staff and the public on key aspects e.g. creation of the clinical strategy.

Additional Considerations

- Feedback Mechanisms: Utilise channels for receiving and acting on feedback from both staff and the public.
- Visual and Interactive Content: Use videos, infographics, and interactive content to make the strategy more engaging.
- Regular Updates: Keep all stakeholders informed with regular updates on organisational progress aligned to the strategy.

Appendix 3

Internal Governance Arrangements Briefing Paper

01 April 2025

Introduction

This paper is one of three that will define how we restructure NHS Borders Governance functions to ensure that we have effective and clean delivery architecture of our operational and transformational delivery.

This first paper describes this. The second paper we will develop following this, will use our QI approach to develop our performance management framework which sits within this as our Quality Management System. The third and final paper which will be developed in consultation with our wider Board, and those Non Executive Members who oversee our assurance functions, will be to ensure that our Assurance Committees are effective in their constitution and scope, and that these provide assurance in the context of our revised delivery governance structure. It is proposed that the time frame for this 3rd paper is after Q1 of 2025/26, and that we consider an external review of our governance in Q3 of 2025/26, to ensure that our new processes are effective in what they do.

Background

In order to both operate more effectively and deliver the level of change required through the NHS Borders Strategy 2025 - 2030 we will need to effectively engage the combined effort of the whole organisation. The current internal governance architecture is complex, and teams often comment that it is difficult to understand where and how decisions get made (see appendix 1). We need to streamline this so that our decision-making processes are clearer, and to ensure that all formal groups / meetings focus on delivering the new strategy once it is finalised

Along with streamlining the architecture and the decision-making structures we will look to enhance clinical leadership and engagement in that decision making process, set clear direction for Business Units and empower teams via the strategy and clear communication of our priorities. This will help encourage agency in our teams which will in turn enable effective and transparent planning for improvement, capture innovation and ideas at team level, driving up standards across the organisation and delivering our agreed priorities for the year.

This proposal focuses on the internal decision-making processes for the organisation and does not impact on the formal Committee structure of NHS Borders Board.

The accountabilities set out for individual directors and management roles within the Scheme of Delegation remain unaffected by the proposed changes set out below. Any proposed changes to these powers will be brought forward separately through review of the Code of Corporate Governance.

Aim

Increasing the breadth of those engaged and enhancing clinical involvement in the decisions that are required to enable NHS Borders to deliver its potential is fundamental to resetting our culture.

We also need to create some tension in the organisation where different groups of clinicians and managers are openly able to have their competing priorities recognised, discussed, and then we jointly and openly agree ways forward which balances these interests.

In summary, through revisiting and redesigning our internal governance and decision-making architecture we aim to:

- Streamline Governance: Simplify decision-making structures to provide clear direction and empower teams
- Enhance Clinical Leadership: Encourage team agency and transparent planning, capturing innovation at the ground level
- Broader Engagement: Increase clinical involvement in decision-making to reset the organisational culture
- Balance Priorities: Create a space for open discussion of competing priorities among clinicians and managers to find balanced solutions

The initial focus of our changes will impact on our highest-level internal decision making, at a whole system level and so will impact on the following:

- Borders Executive Team meetings
- Quality & Sustainability Board
- Operational Planning Group

Once new arrangements are in place (see next section) we will review the remainder of the existing governance and decision-making map with a view to replicating the principles of the new arrangements at whole system level and ensuring the decision making is fit for purpose and links to the delivery of our organisational strategy and in time, our clinical strategy.

Proposed Future Meeting & Decision-Making Structure

Borders Delivery Group

The introduction of a Delivery Group as the new internal leadership decision body will provide clear routes for escalation and seek to embed transparency to our performance and encourage clinical and operational agency to build on the talent and capability we have in the organisation.

Alongside this we will develop a more mature annual performance framework where the business units will plan their activity and finance a year in advance, with monthly reporting to track progress and delivery.

We will also develop robust underpinning business processes for the Delivery Group to ensure we move to a coordinated, commissioned approach to Business Cases, linking to the delivery of our strategies or to mitigate significant organisational risk.

The Delivery Group will replace the Business Meeting of the Borders Executive Team and the Quality & Sustainability Board (QSB) and will be responsible for whole system decision making across the organisation, chaired by the Chief Executive, with a Vice Chair selected from the clinical members of the Board Executive Team (BET). The Delivery Group will be accountable directly to the Board and will comprise the Executive Directors and selected members of their direct reports, with a focus on clinically led decision making. The Group will provide a monthly report to the Board reporting progress, highlighting risks and issues with recommendations and escalation of any decisions as required.

In year organisational priorities will come into operation in 2025/26 and priorities will be clearly defined and agreed within the NHS Borders Organisational Strategy. System Improvement and Transformation Groups will be created that will report into the BDG – Planned Care (Acute), Unplanned Care (Whole System), Primary & Community Services and Mental Health and Learning Disabilities. Further Improvement Groups may be added once the wider governance and decision-making review has concluded.

All programmes of work currently reporting to QSB will be reviewed to assess how they align to the Improvement Groups, and an assessment of where they sit given the new Organisational Strategy and the developing Clinical Strategy.

Quality & Sustainability Board

This Board would be stood down on the introduction of the Delivery Group.

Borders Operational Planning Group

The Borders Operational Planning Group (BOPG) is the current whole system delivery group which provides cross & whole system management for in year service delivery, taking collective responsibility across the organisation. It also acts as the Risk Management Board and has an operational role in ensuring that a risk management framework is in place. OPG is also responsible for approving wider organisational policies. It reports currently to BET and escalates issues out with its decision thresholds to BET for final approval.

Through the introduction of the new Delivery Group the role and remit of OPG may require changing. The proposal is to continue OPG (reporting to BDG) as is until we are clearer on the new arrangements, change it if required or stand down, but only stand down when we are assured there is a 'home' for the relevant business.

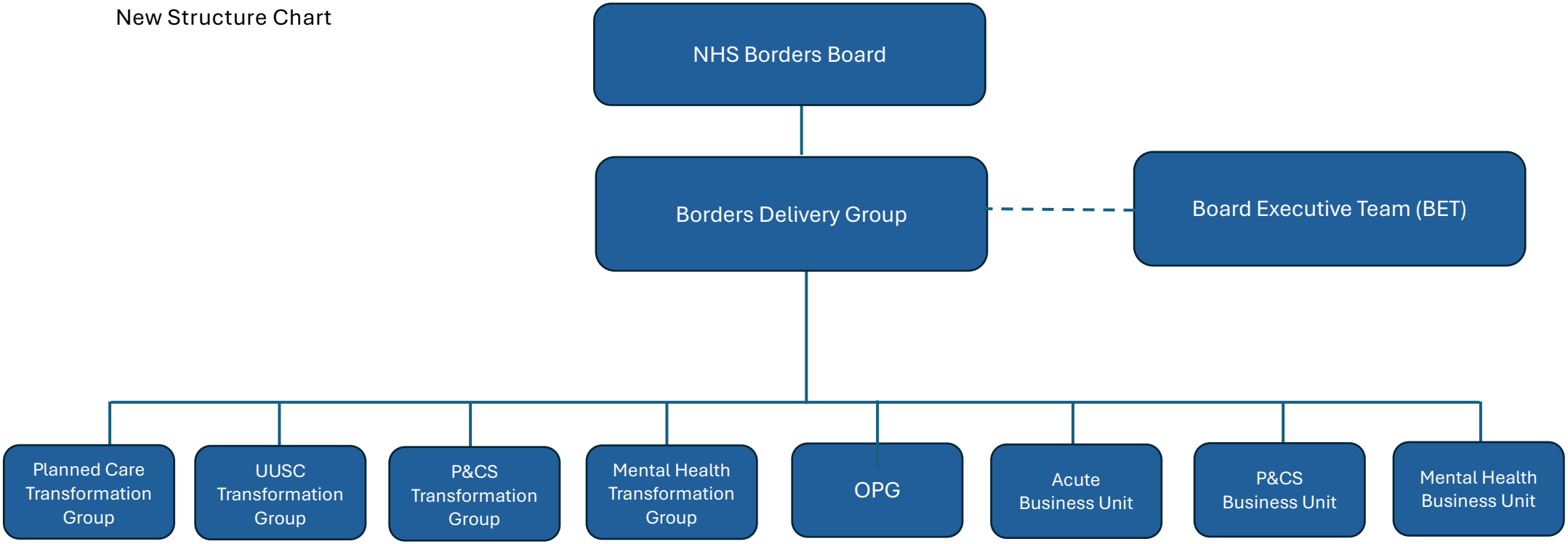
Business Units

The 3 clinical business units governance and decision-making process will be reviewed during 2025/26 to ensure they operate within a standard framework and will report into the Delivery Board.

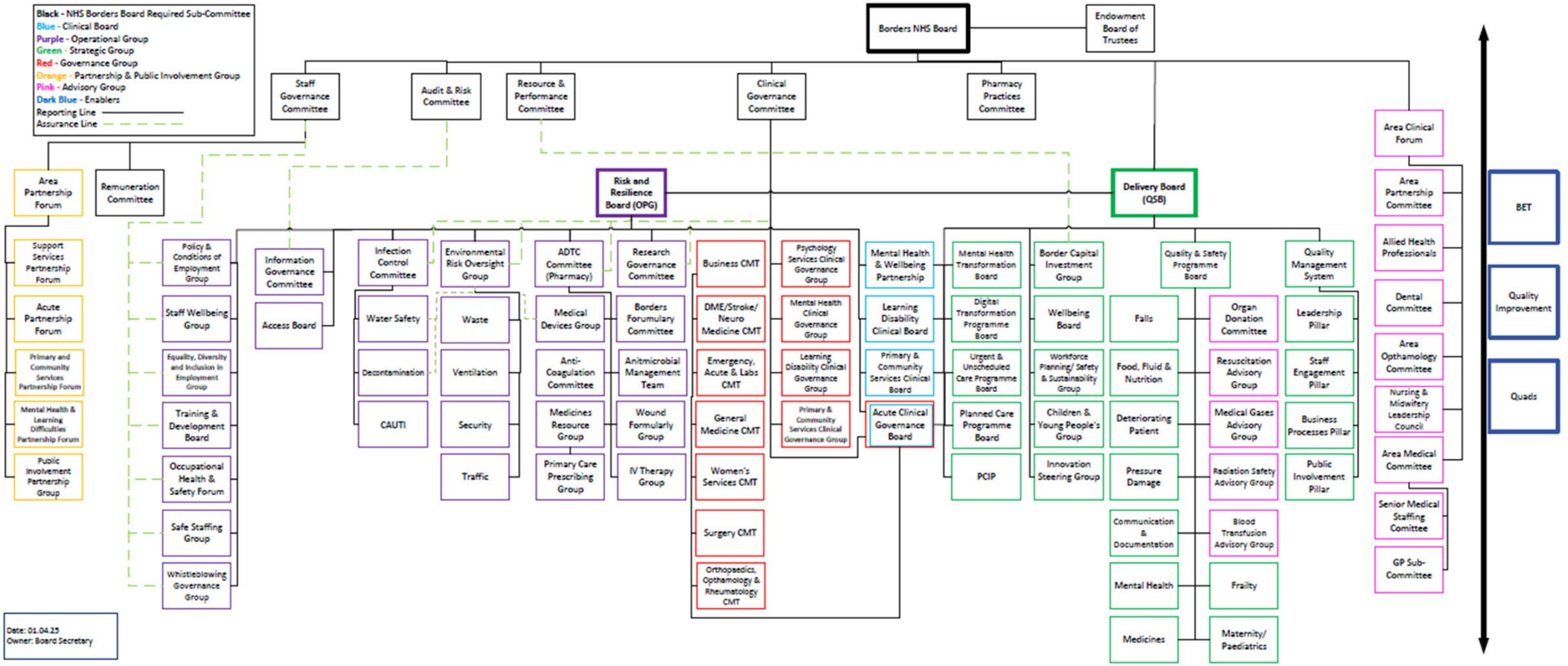
BET

The weekly Board Executive Team will transfer all operational decision-making responsibility into the Delivery Group. It's new focus will be on strategic and longer term issues and would continue to meet weekly, chaired by the Chief Executive.

New Structure Chart



Appendix 1 - Current Internal Governance Architecture



NHS Borders
Organisational Strategy

Contents

Introduction

This document outlines the strategic direction for NHS Borders from 2025-2030. This overarching strategy is the product of thousands of responses and conversations during our engagement exercise. In it we set a clear direction for the future in which people are at the centre of everything we do, we commit to delivering consistent care to a set of high standards, and developing an organisation that is continually improving through the continuous development of our most valuable asset, our staff.

> *The staff at my local clinic are always so friendly and helpful. They make me feel comfortable and well cared for every time I visit. (Public)*

> *I appreciate the opportunity to make a real difference in the lives of our patients. Knowing my work has a positive impact on the community is very rewarding. (Staff)*

Chair’s Reflections

I am delighted to introduce our 2025-2030 Organisational Strategy. It is the product of an amazing amount of work by our staff and our public and sets clear direction for the future: a future in which we are committed to improving performance and delivering more timely care for patients, developing sustainable services that are future-proofed, and creating an environment where people in our communities are empowered to take control of their own health and wellbeing; with a focus on prevention to enable people to live their best lives. A heartfelt thanks to all those who took the time to talk to us and give us their views.

As I joined the Board in 2019 the first part of my tenure was overwhelmed by the Covid-19 pandemic. We are still living with some of the consequences from this difficult time - the impact of which is not to be underestimated - but we must now look forward and ensure that we use the many valuable lessons we learned. It is well documented that many health services have not recovered to ‘pre-pandemic’ levels of service delivery, and that is having an impact on the time that people are waiting for treatment. As we draw a line under the past five years and look to the next, waits for treatment are something we are determined to address, and you will see more information on how we intend to approach that in this strategy.

Despite those difficulties I am so proud to celebrate our staff who continue to provide the most amazing care and achieve fantastic recognition, some of which are highlighted here.

My tenure as Chair of NHS Borders is due to finish in 2027 and over the next couple of years I want to see this Strategy and the priorities within it come to life. I look forward greatly to this and continuing conversations with our people, patients, partners and the public over the coming months and years.

Karen Hamilton
Chair

Royal College of Nursing Award Winners

Golden Hip Award

Queen’s Nurse Award

Chief Executive Introduction

I want to start by describing what I saw in my first three months in the role as NHS Borders Chief Executive. I purposely spent very little time in my office, and much of my time visiting and listening to teams in the community and social care services, acute and community hospitals, mental health services, and meeting our partners in the voluntary sector and Scottish Borders Council. I also visited the towns and villages we provide care for; seeing how people live locally, listening to them and learning about how they use our services. I reached three conclusions from this:

Firstly, we have a truly exceptional workforce; I haven't worked for an organisation which receives as much really positive feedback from patients and their families. It is genuinely humbling to read about the level of care and compassion that is provided, even more so in the words of patients or family members who have taken the time to write to us. What is also evident is how well our staff work together in teams and how they treat each other with respect and kindness.

Secondly, our staff and our communities have a really unique bond. I know the vast majority of the workforce live in the communities we serve, and this really shines through in the commitment to meet our patients' needs and do the very best with the resources we have.

Thirdly, every team I met expressed a real need for direction; an inspiring description of what services could look like in the future, of how our systems could talk to each other more effectively, how our teams could be better joined up, and how we could fix some of the underlying issues which make it more difficult to do what is most important to us; meeting the needs of our communities and supporting each other to keep improving how we do this.

These conclusions led to the development of this strategy; this started with a conversation with our staff and our communities to define where we are now and where we can be in 2030, to understand how we need to change to make this possible and finally to put those who know our communities best in the driving seat for this journey.

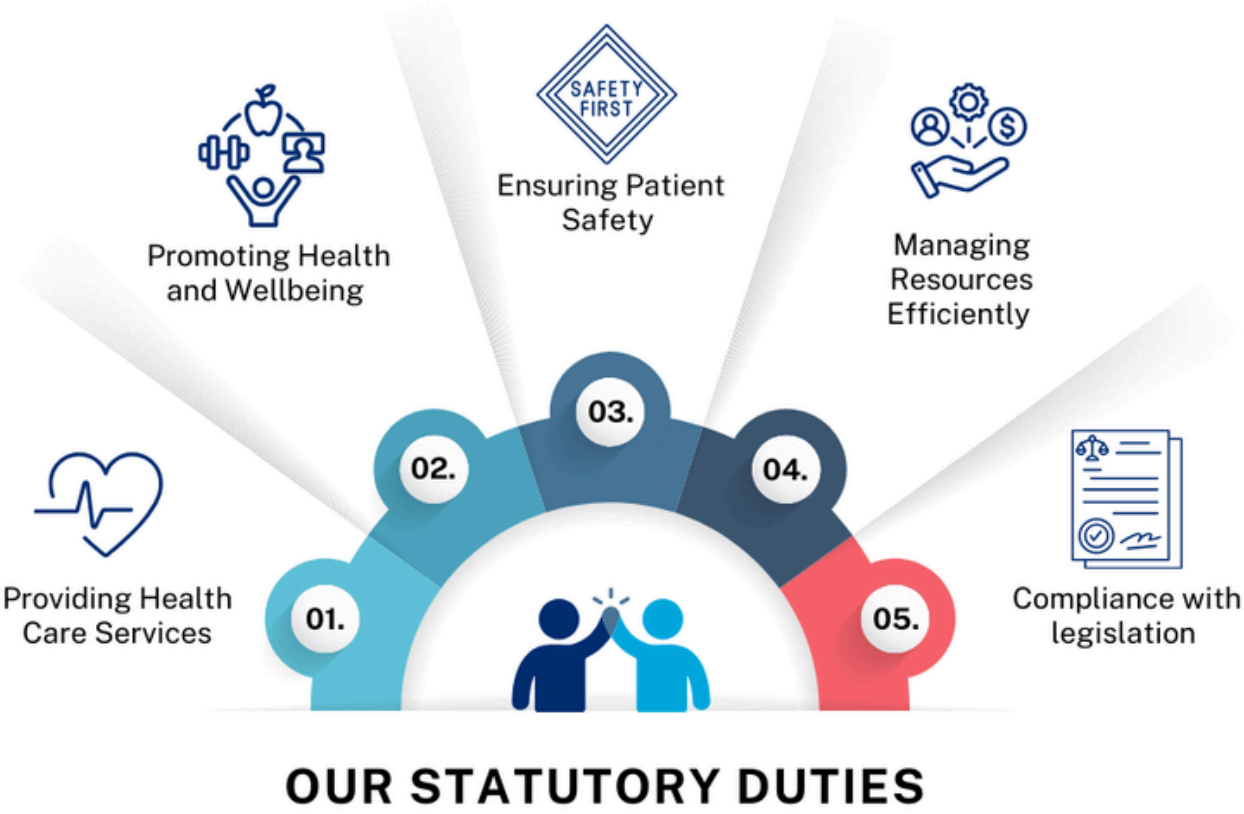
Peter Moore
Chief Executive

NHS Scotland: National Context

NHS Borders is responsible for protecting and improving the health of our population and delivering frontline health care services in line with Scottish Government's policies and priorities. This includes our responsibilities as a partner in the Integration Joint Board within the Health and Social Care Partnership. Responsibilities include formulating strategy, delivering value for money and managing risks effectively. This will enable increased collaboration to help improve the health and wellbeing of our citizens and communities.

During 2024 NHS Scotland launched a reform agenda to transform health and social care services, involving workforce, service leaders and public engagement. Key elements of this agenda include improving population health, ensuring quality services, maximising access and fostering collaboration.

NHS Borders aligns with this national direction, supports broader objectives and remains committed to delivering exceptional care while adapting to updates and directives from the national reform agenda.



About Us

NHS Borders serves 116,000 people with a dedicated workforce of over 3,400 staff, focused on improving patient lives and community health.

Whilst the Scottish Borders is a beautiful place with multiple small villages and towns, this presents challenges when delivering healthcare. Our population have increasing healthcare needs and we must adapt our system to meet these in the future. This will include looking at new roles within our workforce and maximising self-care and community support to avoid hospital admissions. Despite financial constraints, we focus on providing safe, effective, sustainable and affordable care to the people within our communities. Improving population health and wellbeing can reduce healthcare demand. Additionally, our ageing digital infrastructure means there is a need for technological upgrades such as digital health tools and electronic health records to improve efficiency. We know that people often face long waiting times for treatments and appointments, which is frustrating and delays their return to full health. We are committed to addressing these challenges and improving processes to ensure timely access to care, aiming to reduce waiting times and enhance service efficiency.

We acknowledge and celebrate the growing diversity of our workforce, recognising it as a vital strength that enriches our organisation and enhances our collective ability to serve our communities.

Who We Are

With an increasingly diverse workforce NHS Borders is committed to championing the creation of an inclusive culture that reaps the benefits from this diversity. This commitment means we will build a deeper understanding of the issues that affect individuals who reflect our diverse workforce. It is well known that those staff who experience bullying, harassment and abuse, they are less included to admit to mistakes or raise concerns. It is also well known that people from Black and Ethnic Minority Backgrounds are more likely to experience bullying, harassment and abuse. In creating an inclusive environment, we aim to work towards addressing the root causes of these issues. Our outcome needs to be that NHS Borders operates psychologically safe working environments. This also underpins our commitment to Compassionate Leadership.

The detail of this will be within our People Enabling Strategy, but for example we will prioritise iMatter data as this reflects the lived experience of staff and we will act on the findings with an annual plan, changing each year reflecting the renewed outcomes of the iMatter Survey. Wellbeing and Inclusion neds to be part of our Appraisal discussions ensuring that our staff feel that they have places. Refresh of our Whistle Blowing policy and supporting structure.

For 2025/26, each Executive will take the lead on one of the 9 Characteristics protected by law and commits to:

Firstly, supporting a colleague through reverse mentoring programme,
Secondly, acting as a champion for this protected characteristic, and importantly
Thirdly, feeding back their learning through the organisation to ensure we embed these experiences to improve the way we work in the future.

Development of our People Strategy will be in partnership with our Equality Staff Networks; Minority Ethnic Staff Network, Disability Staff Network and LGBTQIA+ Staff Network. This will be supported by our Area Partnership Forum.

Part of what is special about NHS Borders is its sense of belonging, we need to make sure that this extends to all staff which supports us all to work at our best.

Our Role

NHS Borders is dedicated to promoting good health and supporting those who need our care. We are committed to delivering high-quality care and supporting the wellbeing of our staff and communities. Our role extends beyond healthcare provision; focusing on continuous improvement, learning and innovation to provide effective, sustainable services. We aim to set the standard for healthcare excellence by reducing health inequalities, enhancing community wellbeing and preventing illness whenever possible.

We are committed to working collaboratively and being a supportive partner, fostering trust through constructive and transparent actions. Our goal is to align with our partners' aims and objectives to collectively deliver the highest quality of care. By supporting people to stay well, we aim to reduce the need for hospital care, shifting services to better meet community needs and keeping the population healthy.

As an Anchor Institution here in the Borders, we own our responsibility to set the standards as a responsible employer being considerate to the needs of both our workforce and the communities we serve.

We strive to provide convenient services, minimising the time it takes for patients to receive treatment and ensuring they can return home quickly. As a trusted organisation, we recognise our vital role in supporting the public, staff and partners to achieve the best health outcomes. As one of the largest employers in the Scottish Borders, we are committed to promoting inclusion, raising aspirations, being a good employer and significantly contributing to the local economy.

Purpose of Strategy

NHS Borders and the services we deliver belong to the communities we serve. While we as a Board, run these services, they belong to and need to meet the needs of our communities. Therefore, to make sure we are continually delivering the right care through the right services, we need to be in conversation with those who know our services best.

We have engaged with people throughout the Borders about what is important to them. Feedback from our communities highlighted key areas that are important for us to address. This conversation will continue as we progress through this journey to make sure our changes are making improvements to our communities.

It is clear staff do their best consistently and services are delivered with care, compassion and to a high standard. However, we take too much of people's time to diagnose and treat them, patients have to repeat their story too many times, delays between services are too long, and services aren't joined up. Our communities also expressed a clear desire for more support to keep themselves fit and well.

This strategy is a response to the above issues.

Our Strategic Approach

Developing our Clinical Strategy

The purpose of NHS Borders is to meet the needs of our communities by empowering those best placed to do so; our frontline clinicians and service professionals.

We will harness the understanding and experience of our clinical and professional teams to drive improvements through innovation to deliver holistic care by joined up services.

Rewiring our Internal Operating Model

To benefit from our strategy, we need to reconfigure our organisation and build on our exceptional workforce. This involves changing our operating framework to enable broader and more representative decision-making to support the effective delivery of our clinical priorities.

This approach allows our enabling services to better prioritise improvements and changes based on the needs of our clinical services and the communities we serve.

Instilling Improvement in our Workforce

To ensure optimal patient care with available resources, continuous improvement is essential. Every staff member should understand their role, receive feedback, and know how to address any gaps. While this often occurs naturally, the goal is to embed a 'Continuous Improvement' approach across the organization, applying the same improvement process in all areas.

The NHS Borders Improvement Journey has been developed to support this, outlining how to consistently achieve quality improvement.

Agreeing our Social Compact

The Social Compact details the level of improvement needed, our investment in workforce development, the space created for this and how we will maximise employment benefits for our staff.

Developing our Clinical Strategy

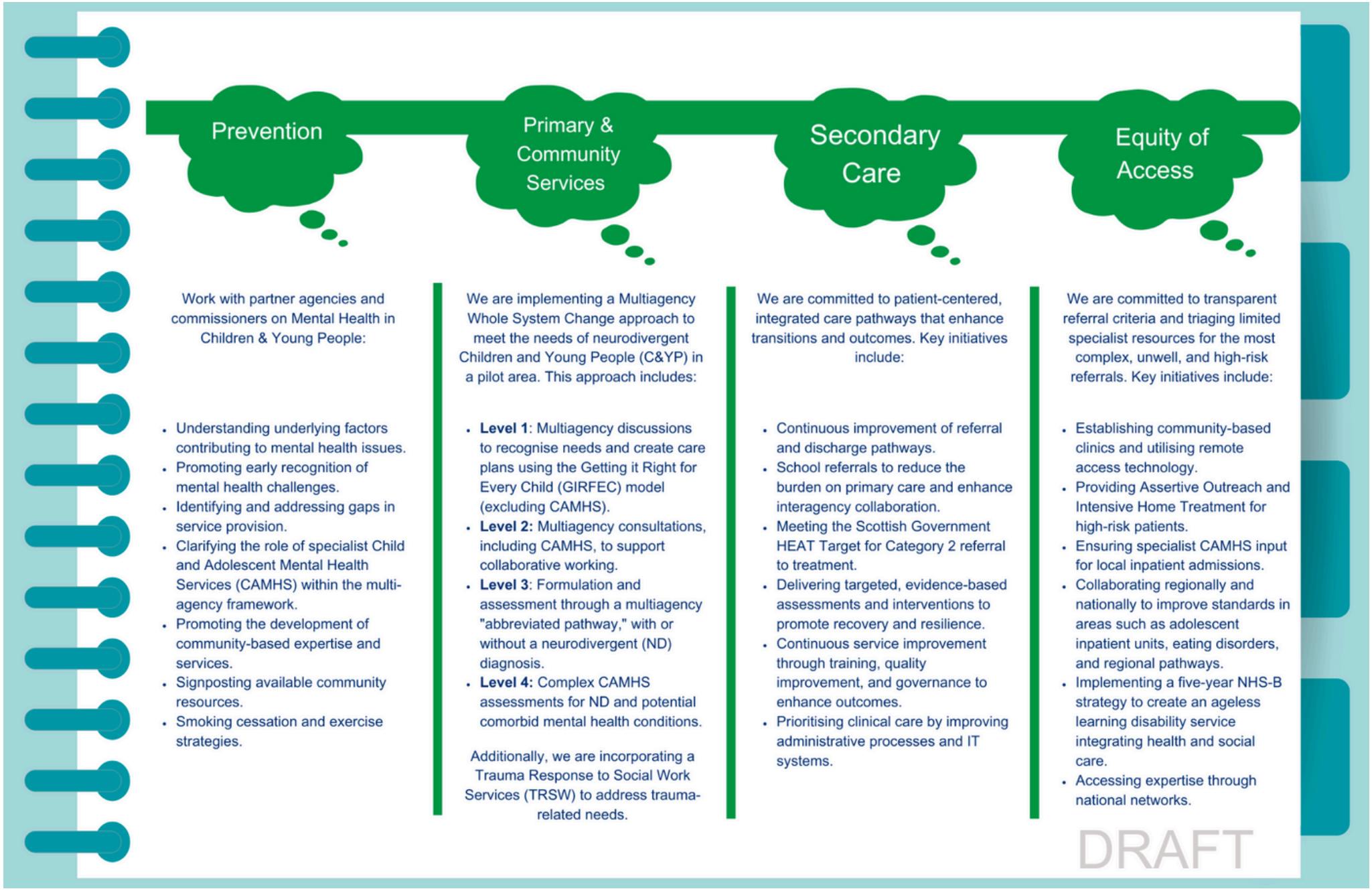
A commitment to excellence and innovation in healthcare will drive our clinical strategy. Our vision for 2030 is ambitious, encompassing a comprehensive approach from prevention to specialist services, and everything in between. Our strategy will be developed in partnership and collaboration, ensuring that every voice is heard, and every perspective is valued. We are truly excited to work with our clinical services, teams and communities to collaborate on this vision. Together, we will build a healthcare system that is responsive, inclusive and forward-thinking.

We will focus on prevention, primary and community services, and secondary care, creating a seamless continuum of care that meets the needs of our population. This collaborative effort will set out our social contract, defining what you can expect from us and what we expect from you.

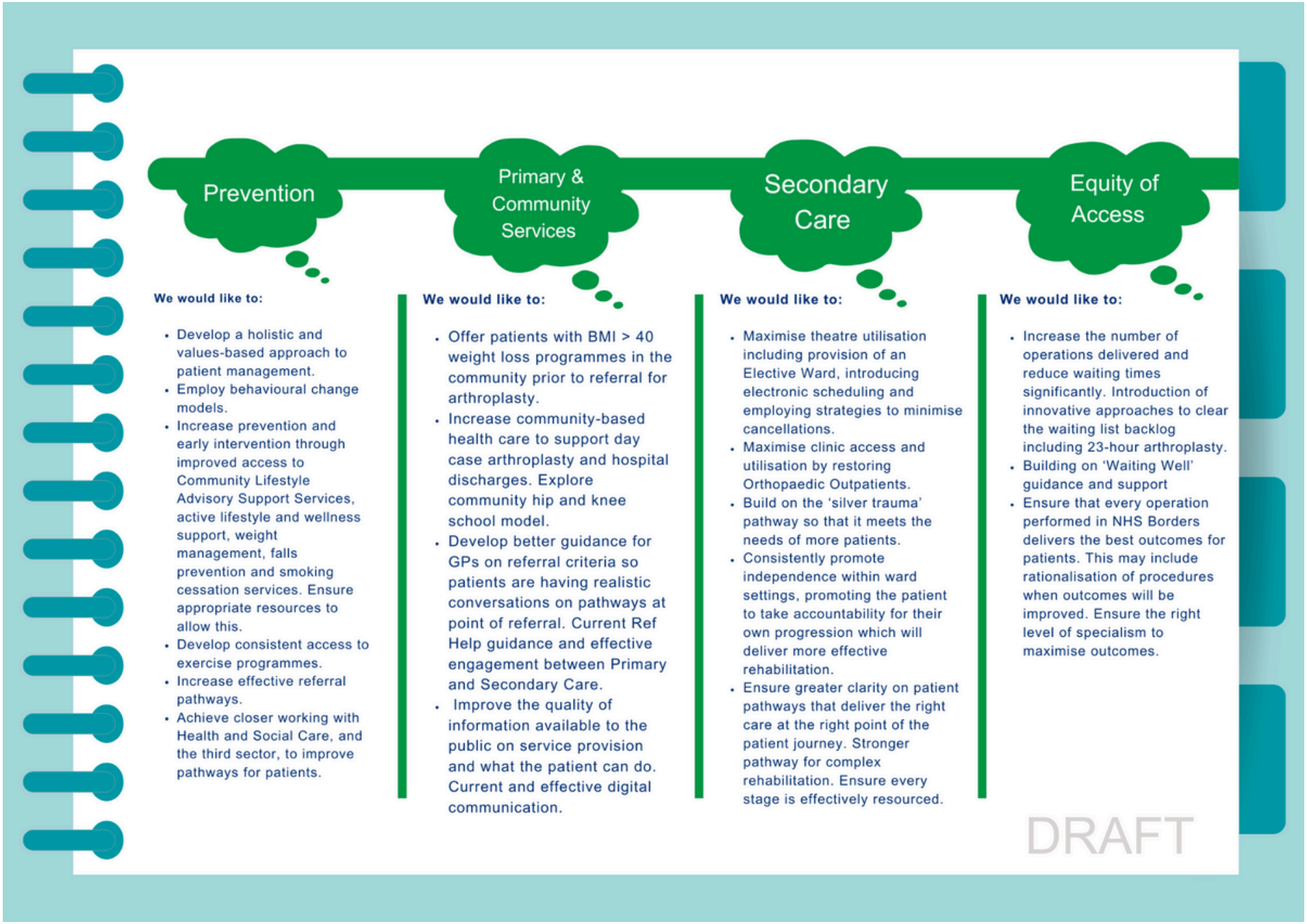
Initial Thinking and Demonstration

To demonstrate how our Clinical Strategy could look we have included examples of initial thinking across three of our services. These examples are just the beginning. As we move forward we will continue to refine and expand our strategy in partnership with our clinical services, teams, and communities. Together, we will create a healthcare system that is effective, compassionate and equitable.

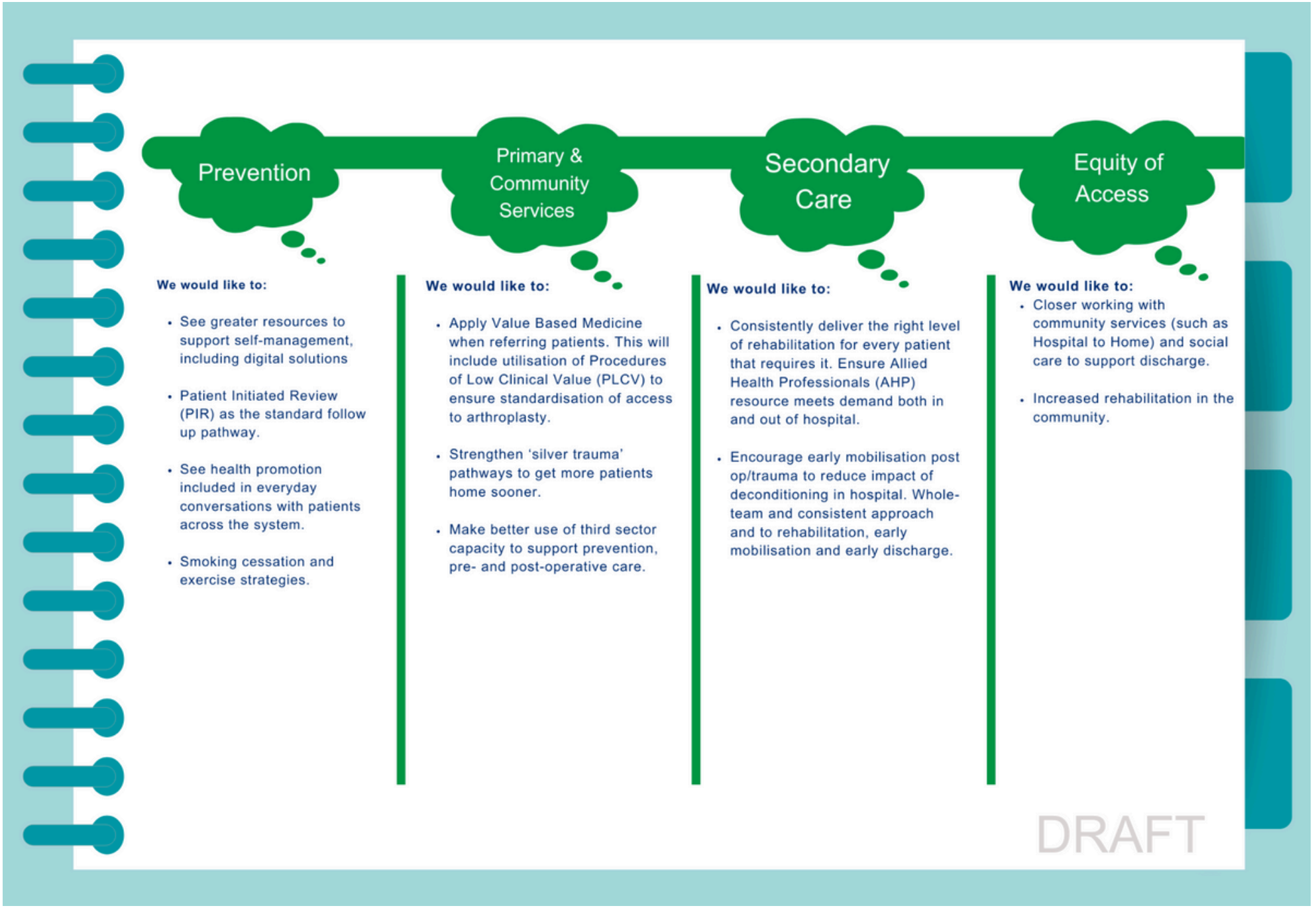
Initial Thinking - Child and Adolescent Mental Health Clinical Strategy



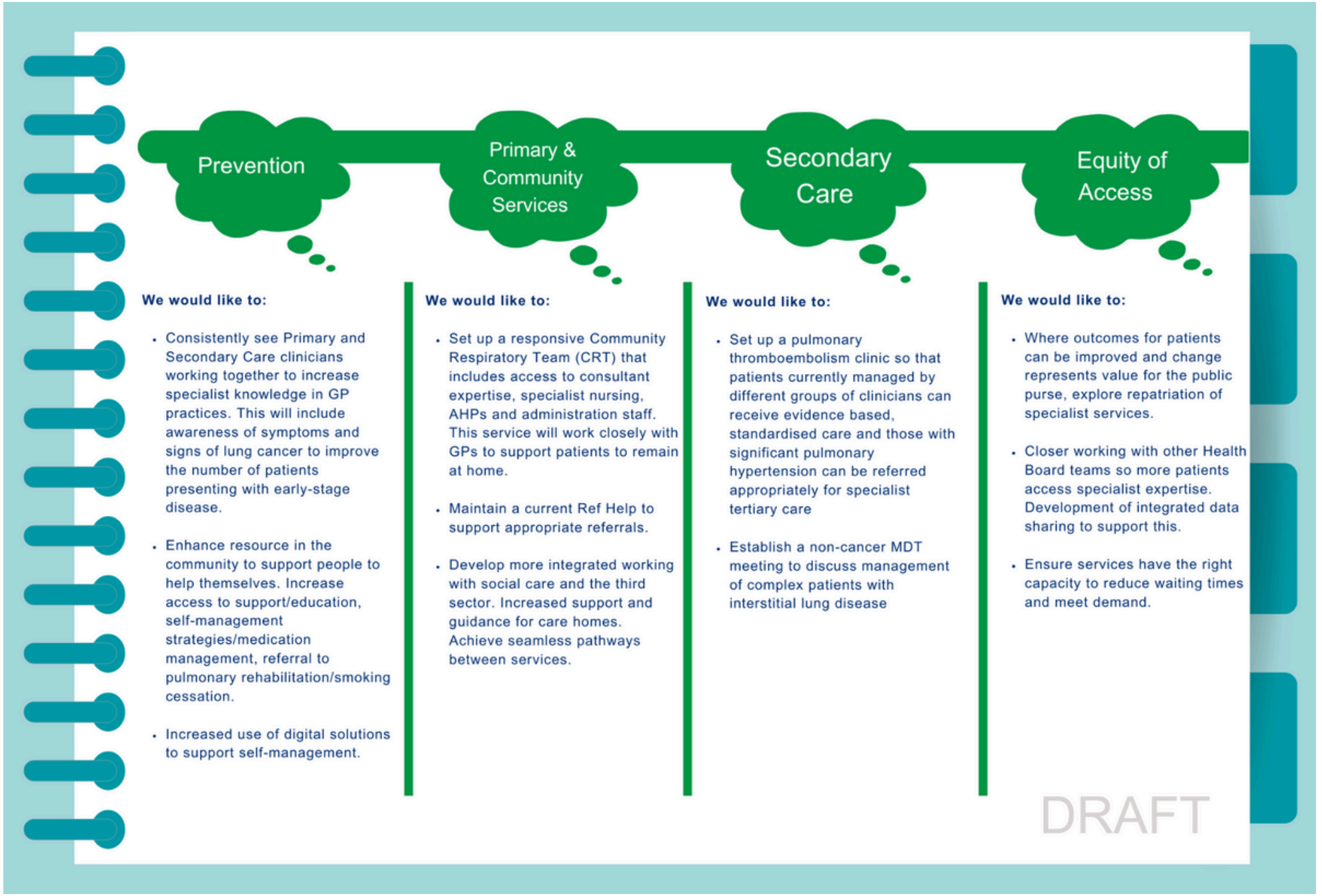
Initial Thinking - Trauma and Orthopaedics Clinical Strategy



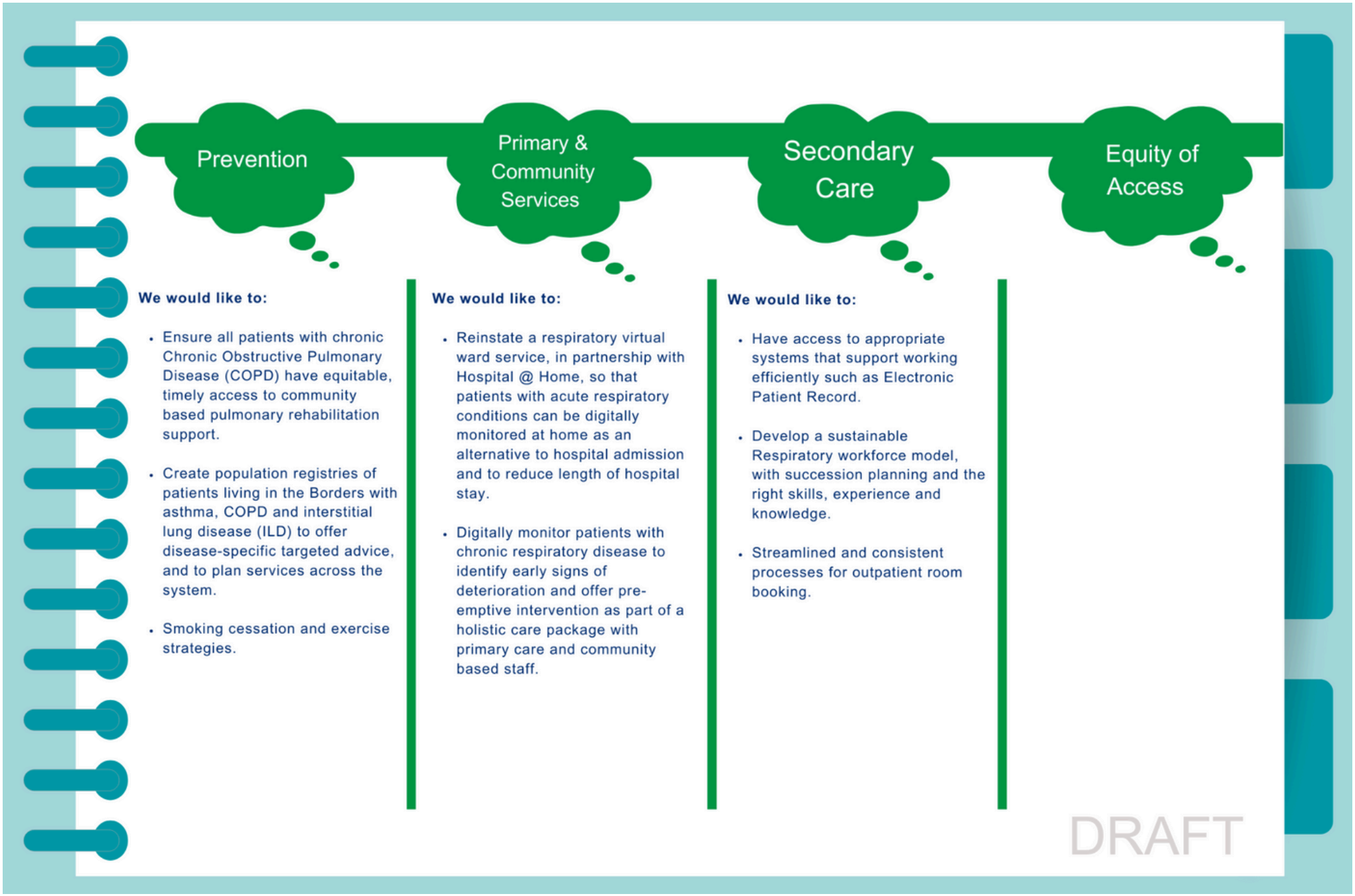
Initial Thinking - Trauma and Orthopaedics Clinical Strategy



Initial Thinking - Respiratory Clinical Strategy



Initial Thinking - Respiratory Clinical Strategy



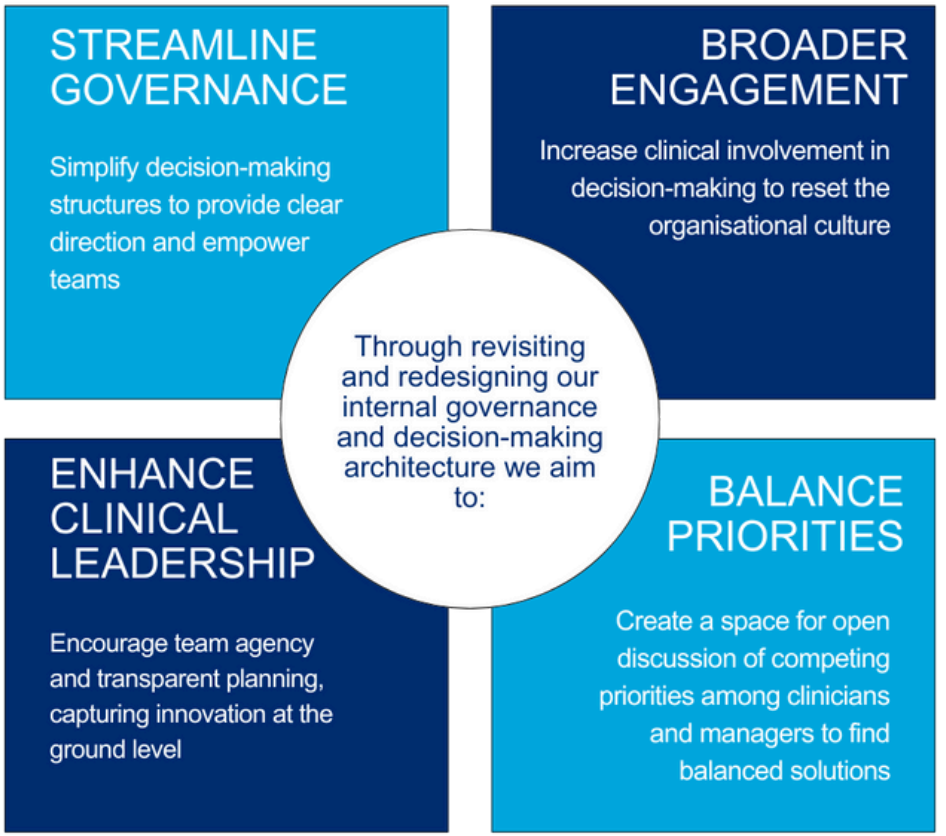
Rewiring our Internal Operating Model

In order to both operate more effectively and deliver the level of change required through the lifetime of this Strategy we will need to effectively engage the combined effort of the whole organisation. The current internal governance architecture is complex, and teams often comment that it is difficult to understand where and how decisions get made. We need to streamline this so that our decision-making processes are clearer, and to ensure that all formal groups / meetings focus on delivering our commitments within our Strategy.

Along with streamlining the architecture and the decision-making structures we will look to enhance clinical leadership and engagement in that decision making process, set clear direction for Business Units and empower teams through the strategy and clear communication of our priorities. Increasing the breadth of those engaged and enhancing clinical involvement in the decisions that are required to enable NHS Borders to deliver its potential is fundamental to resetting our culture.

This will help encourage agency in our teams which will in turn enable effective and transparent planning for improvement, capture innovation and ideas at team level, driving up standards across the organisation and delivering our agreed priorities for the year.

We need to create an environment where different groups of clinicians and managers are openly able to have their competing priorities recognised, discussed, and then we jointly and openly agree ways forward which balances these interests.



Our Improvement Approach

To deliver this strategy our Board is committed to equipping all of our teams with the skills they need to resolve the issues they encounter, understand how they are doing and what they can do to improve as part of a continuous cycle of improvement. The underpinning improvement approach will enable us to deliver the best possible outcomes for patients, families and our colleagues and achieve the most from the resources we have available to us.

This approach will grow our improvement capability and confidence throughout our workforce. We will create an environment which gives our teams autonomy to act and be accountable for their actions; empowering everyone to improve the way they work supported and enabled by managers and leaders. The method will be adopted at Board level; leading by example in the use of our improvement approach to deliver our true north goals.

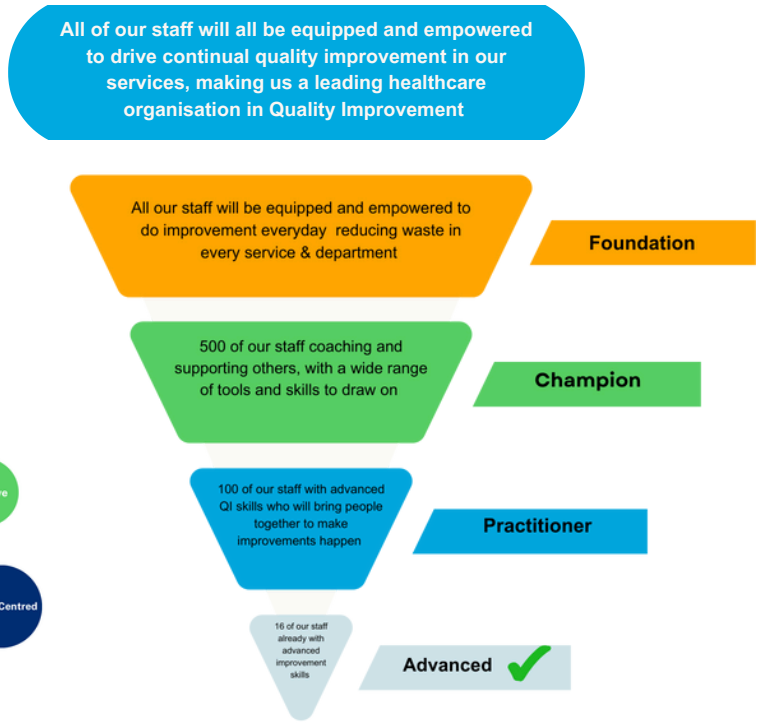
Our governance and delivery structures will be set up to scrutinise the approach, bringing consistency. To achieve this a range of quality improvement training will be available to our staff.

Our approach will be underpinned by an understanding of human behaviour and will focus on reducing waste and variation to build reliable systems and processes to support the delivery of care across the seven domains of quality.

This approach will not only focus on the technical skills to improve but will also form the ethos of the way we work and the way we do things in NHS Borders.

We will place emphasis on developing our teams to understand themselves and how they as individuals and teams contribute to the delivery of the organisational strategy. We want all staff to have a sense of belonging and recognition for the value they bring.

Our compassionate leadership programme will continue to build leadership capabilities at all levels in the organisation. Creating the conditions for continual learning and improvement individually and in teams.



Agreeing our Social Compact

We recognise our staff as our greatest asset and prioritise creating an environment where they can excel, enhancing our standards. We call on all staff to commit to continuous improvement, which is fundamental to our ethos and the agency we promote. By fostering a culture of excellence, we aim to achieve better outcomes for patients and a more fulfilling work environment. This Social Compact is being developed through conversations with our Area Partnership Forum.

There are four elements to the Social Compact;

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

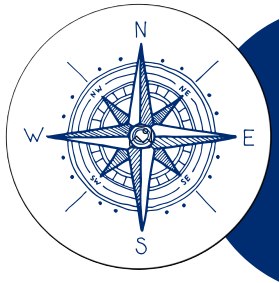
Secondly, to support this performance improvement we are investing in the improvement capability of our workforce. The people who see the issues and opportunities on a day to day basis are those best placed to make improvements, so we will train our workforce in improvement methodology.

Thirdly, we recognise that this takes time, and we cannot be successful if we just ask teams to add this into their already busy days. In a structured way, we will create time for teams to spend 1 hour a fortnight on improvement activities.

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

Our Mission & Strategic Goals

Our Mission



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 Goals 2025 - 2030

Quality

Promote a positive safety culture, to improve the health and wellbeing of patients, staff and the community. Improve effectiveness and patient experience of care to achieve the best health outcomes

Performance

Deliver timely, efficent, and evidence-based services that exceed national standards

People

Promoting a compassionate, supportive and safe culture which generates the right attitude, behaviours and values and keeps skills up to date

Finance & Infrastructure

Optimise the use of resources (finance, technology, estates) by ensuring robust planning, accountability and innovative approaches to achieve financial balance and statutory compliance while delivering high quality, patient-centred care

Partner Organisations

Strengthen collaboration with local communities, stakeholders and partner organisations to deliver integrated, patient-centred care

Our Values and Behaviours

Compassion

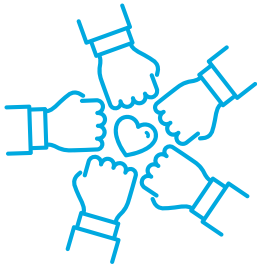
Treating people with compassion and honesty

Kindness

Showing kindness and respect across the organisation

Integrity

Showing integrity and having effective, respectful and honest conversations



Teamwork

Working as a team within the organisation and wider

Excellence

Providing excellence in care and an excellent place to work

We will revisit these values through a focused engagement exercise with our teams over Summer 2025. These values will be underpinned by a clear set of behaviours, highlighting those we strongly encourage and clearly identifying those that are not acceptable.

Our Employees Vision for 2030

In 2030 NHS Borders will be delivering sustainable and tailored health services to the population of the Scottish Borders. Services will be person-centred and be available as close to people's homes and communities as possible. NHS Borders will have recognised the importance of enhancing and investing in community based care, promoting value based health and care, supporting people to be partners in their own care to make informed choices and decisions relating to their health

Philip Grieve
Associate Director of Nursing for Primary & Community Services

By 2030, NHS Borders will prioritise sustainability by focusing on primary and community services. Our goal is to ensure that individuals receive care at home whenever possible, reserving acute facilities exclusively for acute care needs. We will implement clear and efficient discharge systems to facilitate this transition. Additionally, we will place a strong emphasis on mental health, ensuring comprehensive support and services are integrated into our community care model.
NHS Borders will lead locally, exemplifying fair and just systems for both staff and patients, setting a standard for equitable healthcare and employment practices.

John McLaren
Employee Director

We know that NHS Borders is a huge employer in the region. That means that when we look after our workforce with policies that embrace and support marginalised groups, support employability initiatives in our work with partner agencies, and take seriously our responsibility to reduce our carbon footprint we will benefit the population of our region. By 2030 we can show how NHS Borders is a force for good, above and beyond the healthcare we deliver.

Rebecca Devine
Public Health Consultant

NHS Borders will be a streamlined, efficient, focussed organisation that has a clear, unified goal that everyone working there is aware of and signs up to. This will drive improved performance on a daily basis regardless of role or position. NHS Borders will deliver key services that align to the most relevant needs of the local population and consolidate these by avoiding diversifying too much or providing niche services. Standardising care will mean pathways are clear and familiar to staff, improving efficiency and allowing the organisation to deliver the best possible care for our patients and their families.

Dr Imogen Hayward
Associate Medical Director & Consultant Anaesthetist

NHS Borders in 2030 will be a small but vital part of a greater integrated, capable and inclusive 'whole', acting as one with our statutory partners, third sector and communities. We will be clear about the healthcare outcomes citizens of the Borders wish to prioritise and we will have effective means of measuring success, ensuring our services continually develop in line with those goals.

Dr Amanda Cotton
Associate Director & Consultant Psychiatrist

Delivering Our Strategy

Horizon 1
Stabilisation and Continuous Improvement Years 1-2

Horizon 1

Focus on re-establishing performance standards and building a culture of quality improvement.

Horizon 2
Innovation and Systems Redesign Years 3-4

Horizon 2

Once stable performance is achieved, shift focus to fostering innovation to enhance efficiency and outcomes.

Horizon 3
Sustainable and integrated care Year 5 and beyond

Horizon 3

Drive long term changes that reshape the organisation for sustainable and integrated care.

NHS Borders Delivery Plan 2025/26

What we will deliver	Why this is important	When will we do this by
Develop and agree our Clinical Strategy	This will engage our clinical and professionals who know our patients best, in co-designing the pathways which shift care into the community, and maximise our utilisation of resources to ensure effective and efficient delivery of patient care	September 2025
Develop and agree a set of Enabling Strategies, including Digital, Quality, People, Property, Research & Development, Partnership and Finance	The prioritisation of our enabling strategies will be driven by the Clinical Strategy and provide the necessary support structure for our organisational, ensuring that all components of the organisation are working collaboratively towards the common goal of delivering high-quality patient care	November 2025
Implement a revised internal Operating Model	This will allow us to operate more effectively and deliver the level of change required through the lifetime of our Strategy. This will ensure clinical leaders are central to our decision-making processes	June 2025
Develop and agree our Social Compact	This will establish a clear mutual understanding with our staff regarding expectations, responsibilities, and values. This will create a foundation for a collaborative, equitable, and sustainable healthcare system that benefits everyone involved	November 2025
Further engagement with our Staff regarding our Organisational Values & Behaviours	Co-designing our behaviour framework with our teams is central to respecting our values and ensuring this encourages our best performance at work. This will ensure that staff are part of creating the organisation's values and behaviours promoting a consistent approach to patient care and internal operations. This alignment helps in creating a unified culture where everyone works towards common goals	September 2025

NHS Borders Delivery Plan 2025/26

What we will deliver	Why this is important	When will we do this by
Develop a set of local performance trajectories that are more ambitious than those set out within our Annual Delivery Plan	This is our recognition that our communities want improved access to services and treatment. This will help us drive excellence, foster continuous improvement and most importantly improve patient outcomes	June 2025
Deliver our annual 3% Financial Efficiency savings	This is crucial for maintaining financial stability, enabling reinvestment in care, improving operational efficiency, and enhancing the organisation's adaptability to future challenges	2025/26
Ensure 100% staff receive an annual appraisal and complete appropriate Statutory & Mandatory training	This is essential for maintaining quality and safety, ensuring compliance, supporting professional development, enhancing engagement and morale, and promoting consistency in healthcare delivery	2025/26
Consistency celebrating staff and team learning and achievements throughout the year	A fundamental part of any improvement journey is ensuring confidence in our teams; to develop this confidence we will co-design consistent learning and celebration events throughout the year to ensure we are constantly learn from each other's improvements	2025/26
Continued 2-way conversations with our Staff, Communities and Partners	To ensure continued open dialogue to ensure we provide services that meet our communities needs	November 2025

We want to start a two way conversation

An essential part of our strategy and continuous improvement approach is to ensure that the changes we implement make a positive difference. This requires regular conversations with the communities we serve. Firstly to understand their needs, and secondly to ensure that the changes are improving our services and the support we offer in order to meet those needs.

We are committed to maintaining regular dialogue with our communities to adapt and respond to evolving needs. This engagement ensures our efforts align with their expectations and priorities. By fostering a collaborative environment, we aim to create an effective healthcare system that reflects the voices and experiences of those we serve.

This document outlines our commitments and priorities. We may not achieve everything but we will strive to do our absolute best. Our strategy sets clear expectations for what you can expect from us and what we need from people and communities in return. Partnerships are crucial to our success, and we value active collaboration and support. Our strategy provides us with clear direction and will remain fluid and adaptable as circumstances change and develop. Whilst we transition to a different way of working, we must ensure that we do not loose momentum or the good progress made around our efficiency savings.

We hope you enjoy reading our strategy and if you would like to support with the development of our Clinical Strategy please contact **bor.strategy@borders.scot.nhs.uk**

NHS Borders

Meeting:	**Extraordinary Borders NHS Board**
Meeting date:	**24 April 2025**
Title:	**Full to the Brim – Director of Public Health Annual Report 2024**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti**
Report Author:	**Dr Sohail Bhatti**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

We are faced with an obesity crisis with numerous attendant health consequences. I have chosen to use this year's annual report to focus on the problem in NHS Borders, the causes, consequences and what we can do as partner agencies to improve the situation. The Board is required to receive a Director of Public Health Report, which is an independent report produced to inform the board about the state of the public health of NHS Borders residents. The report is intended to independently assess the health of the local population, provide evidence-based recommendations, inform public health strategy and priorities and serve as a public-facing document to promote transparency and accountability.

As well as focusing on the major topic of obesity, the report includes, within its appendices, an analysis of the overall health of the Borders population and includes

updates across a range of key public health functions carried out by the Department, as was appended last year.

2.2 Background

32% of Scottish Adults have a BMI of 30 or over. This equates to 32,000 adults in Scottish Borders. Additionally, 11% of Scottish Children at risk of Obesity and this equates to around 2,000 children locally. As an Anchor Institution, we are likely to have around 1,000 or our 3,200 staff with BMI of 30 or over.

I propose a multi agency pathway approach to tackling the problem, as described in my report. It is easy to blame individuals but in reality much of the problem is outwith individual control, given that we live in an obesogenic environment.

2.3 Assessment

There are significant health effects of obesity in terms of high blood pressure, cardiovascular disease and stroke, diabetes type 2 and osteoarthritis. This costs the local economy and the NHS significant amounts of money annually.

2.3.1 Quality/ Patient Care

As the clinical strategy is being developed, it is important to consider underlying causes of ill-health and hence demand. The Report, Full to the Brim, draws the attention of the Board to obesity and poor nutrition as something that impacts clinical activity but may not merit much consideration, as it appears to be out with the remit of a Board focussed on treatment, but is very much in the remit of an Anchors Institution providing cradle to grave care, including primary prevention.

2.3.2 Workforce

None identified.

2.3.3 Financial

Work described in the report has shown that by investing money in community-based multi agency initiatives to encourage active lifestyles and educate about nutrition choices, there are significant savings to be made. One large scale initiative in Birmingham has reported a 23:1 return on investment.

Weight loss drugs are likely to play a bigger role in the future and this will pose a great strain on prescribing budgets. The availability of cost-effective drugs to tackle obesity threatens to destabilise the entire system financially, but restrictions may create greater health inequalities as some people can afford to access these drugs privately.

2.3.4 Risk Assessment/Management

None identified.

2.3.5 Equality and Diversity, including health inequalities

There are great variations in nutrition and obesity with deprivation and an inequalities based approach is fundamental to public health work.

2.3.6 Climate Change

Any intervention that encourages active travel, as proposed, will have a positive impact on climate change through the reduced use of fossil fuels

2.3.7 Other impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

This report is presented to the Board as part of the statutory duty of the Board to receive the DPH report.

2.3.9 Route to the Meeting

This has not been previously considered as it is the work of the Director of Public Health in his role as an independent advocate for the health of his population in the Scottish Borders.

2.4 Recommendation

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

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- **Appendices Relevant to Report**
  - Appendix A – Improving Scotland's Diet and Weight
  - Appendix B – A review of the clinical and cost effectiveness evidence for a digital type 2 diabetes remission programme in Scotland

- **Appendices – Key Public Health Programme Updates**
  - Appendix 1 – A Rapid Review and Analysis of the Health of the NHS Borders Population
  - Appendix 2 – Joint Health Improvement Team Annual Report 2023-24
  - Appendix 3 – Alcohol and Drug Partnership Update 2023-24
  - Appendix 4 – Screening Programmes Report 2023-24
  - Appendix 5 – Joint Health Protection Plan 2025-27

Full to the Brim

Report of the Director of Public Health

NHS Borders

2024

Acknowledgements

I would like to acknowledge the help given by my colleagues in the Directorate, the wider NHS Borders team, colleagues in Scottish Borders Council and our multi-agency partners in the Health and Social Care Partnership.

Contents

Chapter 1: Introduction

Welcome to my 2024 Annual Report for NHS Borders. Last year's report, "Real Action for Prevention" (1), emphasised prevention, and detailed various primary, secondary and tertiary interventions. It also highlighted the work of the Public Health Department and referenced several key reports on public health functions such as population-based screening and immunisation. I made several recommendations, and I will provide an update on these, in this report.

The Director of Public Health (DPH) Report is an independent report produced annually by the only population physician who is an Executive Director of the NHS Borders Board, which it is required to publish & receive. This is important, as health organisations tend to be drawn into the tailored packages of healthcare treatments for individuals rather than for populations.

The first recognisable report dates from 1840 and was delivered by Dr William Henry Duncan leading to the Liverpool Sanitary Act 1846. These reports challenged those in power to improve the health and wellbeing of those they were responsible for, and were therefore unwelcome because of the additional costs required. The first Medical Officer of Health (MoH) in Scotland was appointed in Edinburgh in 1862, a Dr Henry Littlejohn, though it only became a statutory requirement for each burgh/county in 1889. These leaders helped create the Victorian era improvements in public health, and demonstrated the use of data as well as the importance of independence to deliver "truth to power." In 1988 the NHS Circular (1988 [GEN]15) obligated all health board to receive a report from their chief administrative medical officer, (ie MoH). In 1999 *Towards Healthier Scotland* (para 82)

recognised the pivotal nature of the DPH and their report. The professional body that oversees DsPH is the Faculty of Public Health and states quite clearly that the DPH is an independent advocate for the health of the population and will produce an independent report on the health of their population. Unlike many reports to the Board it is not subject to a consultation period but is a professional discourse about an issue or problem that might otherwise be overlooked. Nor does it need to be a conventional report – Wakefield DPH produced a graphic novel as her report in 2018, for example. This report can only make recommendations; their implementation, or otherwise, is the remit of the Board.

Someone with the right skills and knowledge needs to bring the attention of the system back to look at the overall impact on communities and populations; most people are not ill and want to live happy fulfilling lives.

Sometimes these messages can be controversial, or unpopular and unwelcome. But in the same way that a person attends their doctor and is given a diagnosis or advice in good faith, the DPH report is such feedback to the population of the people of the Scottish Borders, given to the NHS Borders Board and its stakeholders and partners.

NHS Borders is transitioning to a more holistic way of providing for the health of the population and the NHS Borders Board is now consulting on the development of a clinical strategy. This strategy will place a greater emphasis on "upstream" public health activities aimed at prevention. This year's report continues the theme of prevention, recognising that it requires co-ordinated and collaborative efforts beyond just healthcare provision. Primary prevention was a key focus in last year's report, so it is encouraging to see the NHS Borders Board moving in this direction. Embedding change takes time, but it is essential for lasting impact.

Given its significant public health importance, this year I have chosen to focus on obesity prevention. *Appendix A* is a position statement by the

Scottish DsPH issued in autumn 2024 underlining the significance and complexity of the issue. I will discuss how our environment can contribute to weight gain and its associated consequences. Additionally, I will outline what Governments, institutions, and employers can do to help, as well as actions we can take individually. In the section on my Ten Top Tips, we can all individually take action to combat obesity.

There has been growing public and professional interest in weight-controlling drugs such as Ozempic®, and I will explore the public health implications, as it is likely to become an increasingly important topic.

Recently there has been growing recognition that non-pharmaceutical interventions can benefit many health conditions. I explore how social prescribing – i.e. promoting physical activity and social interaction instead of medications – can contribute to this effort.

While this agenda is challenging, there are reasons for optimism. We have begun to make good progress with last year's recommendations and are confident in the positive impact social prescribing can have on the health and wellbeing of our residents. By addressing these issues, we can collaboratively work towards a healthier, more equitable future for the people of the Scottish Borders and similar rural communities across the country.

As well as a focus on the public health challenge of obesity, it is important that as a public health directorate we report on the wider health of the population. I have therefore carried out a rapid review of the physical and mental health of the NHS Borders population which appears as an appendix. Also appended are the latest reports relating to other key public health functions delivered by the department. These are the screening report, the Joint Health Improvement Team report, the Alcohol and Drugs Partnership report and the Joint Health Protection Plan.

Chapter 2: Update on Last Year's Recommendations

We need a strong leadership focus on prevention, and this needs to be connected to mainstream work within the NHS Borders Board.

Despite numerous challenges, including financial pressures, the principle of joint working is well-established in the Scottish Borders. The Wellbeing Board, along with the Integrated Joint Board (IJB), maintains a strong public health focus. NHS Borders and Scottish Borders Council have a long history of close collaboration through the Health and Social Care Partnership.

Effective prevention requires focusing resources on "upstream" public health measures. The Public Health Department is actively contributing to the development of the NHS Borders Clinical Strategy, which will facilitate this approach.

Over the past year, the health and care system's focus and energy have been directed towards key challenges, particularly patient "flow", through hospitals and issues related to delayed discharges. Financial pressures have also been prominent, with significant managerial efforts spent in both NHS Borders and Scottish Borders Council aimed at reducing overspend. The underlying issue of increasing demand for services can only be addressed when people are more comfortable in managing their own minor illnesses, and we invest more time and effort in prevention. Unfortunately, measuring prevention as an outcome is challenging, leading the system to habitually cycle through crises. These crises have a significant impact on the "flow" of patients.

We must break this cycle.

We need to work collaboratively with our anchor institutions and get Health in All Policies clearly established

In the T.H.I.S. Borders Inequalities Strategy (2), we advocate for a health-in-all policies approach through the Joint Health and Social Care Partnership with colleagues in Scottish Borders Council. We are developing the role of Community Planning Partnership member organisations as anchor institutions, recognising the impact that large employers and service providers can have on the health and wellbeing of their staff and wider communities through their procurement, employment and broader policies. We also share good practice guidelines with partner organisations to ensure that health and wellbeing are promoted in all community initiatives, including those related to food and nutrition.

Unfortunately, due to a reduction in leadership capacity, our progress in this area has not been as robust as we had hoped. Moving forward, we are revitalising our collaboration with the Community Planning Partnership and will relaunch our inequalities workshops on a quarterly basis.

It is imperative that as people age, they age well and are equipped to deal with minor ailments

In our T.H.I.S Borders Health Inequalities Strategy, we recommended developing a cohesive system of social prescribing that integrates existing services such as the Wellbeing Service, Local Area Co-ordinators, What Matters Hubs, housing Registered Social Landlords (RSLs), and localities to address the social challenges many people experience.

Throughout the year, locality-based prevention interventions have been discussed across various agendas in the Scottish Borders. An emerging locality model is built around the revised Local Area Co-ordinators (LAC) as discussed at the Health and Social Care Partnership.

Unfortunately, the connection with the Wellbeing Service, and the need for a unified system providing seamless care has been overshadowed by the need to manage the LAC reform as well as the challenges within Live Borders. This is an inevitable part of the reform process but has hindered progress in other areas.

Nevertheless, it is evident that community-led support (CLS), Local Area Co-ordination, the Wellbeing Service, Live Borders, the tenant support services of the RSLs (the four largest being Berwickshire, Eildon, Scottish Borders and Waverley Housing Associations), and social prescribing have shared characteristics: they are locality-based interventions that help people address their (mostly) social problems. Over 90% of people consult their GP in any typical year; this is why social prescribing, where the GP directs and prescribes social support, is such a crucial part of an egalitarian system. Whilst there are now some pilots in general practice in the Scottish Borders, they are not yet at the scale or the reach I had hoped for. Connecting all these elements is essential for progress, including the flow of pertinent and useful information - with appropriate data protection safeguards - across these disparate bodies.

We have examined what has worked well, and not so well, in other areas of the UK to inform a proposal for delivering a social prescribing model in the Scottish Borders that meets our population's needs. There is still much to do, and the shift towards upstream to prevention will help.

We need to back a solution for social prescribing at scale

The Earlston GP Practice provides a Wellbeing Service pilot which enables people to:

- Get support to improve physical health
- Find employment or volunteering opportunities or learn a new skill
- Tackle money, housing, work or benefits issues

- Cope with a particular condition or difficulty
- Access ways of improving emotional wellbeing such as befriending schemes, peer support or arts and leisure activities

The Community Planning Partnership will work to expand social prescribing. The goal is to establish a system that helps people manage at home using community resources, rather than relying on overburdened statutory services, which spreads scarce resources even thinner.

Reflecting on the past year, while the response to last year's report was promising, progress has been hindered by logistic, financial and staffing challenges. We plan to continue to build on the progress made so far but acknowledge that there is still much work to be done.

Chapter 3: Why is Healthy Weight Important?

There are numerous physical and mental health effects of being significantly under & overweight. We will restrict this discussion to the latter issue. The risks of many health conditions are increased with obesity, including:

- Type 2 diabetes
- Cardiovascular disease
- Stroke
- Arthritis
- Mental health
- Cancer
- Gut & kidney health

These are illustrated in Figure 1.

Figure 1: Health Effects of Obesity

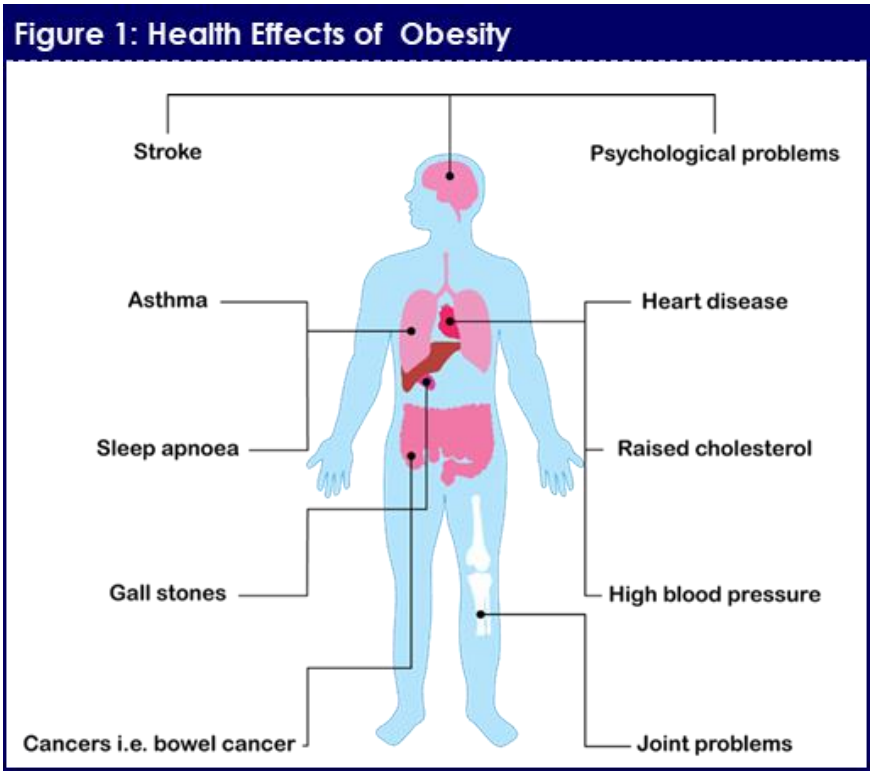


Figure 1: 'Health Effects of Obesity' – Graphics produced by Holly McKay

These health conditions come with very significant costs. As shown in Table 1 below, the cost of obesity/overweight per person in 2023 is approximately £1,500. This translates to £3.3m in healthcare costs, and around £165 million in total costs for the Scottish Borders, 75% of these costs related to quality-of-life issues. Consequently, out of our workforce of approximately 3,000 staff, around 1,000 are at risk.

Table 1: UK Healthcare costs per overweight individual (2023) Frontier Economics (3)

UK (2023) £	Male	Female
Type 2 diabetes	83	79
Hypertension	171	178
CHD (w/o diabetes)	8	8
CHD and diabetes	5	5
Musculoskeletal disorders	42	30
Stroke (w/o hypertension)	3	2
Stroke and hypertension	7	6
Colorectal cancer	3	2
Ovarian cancer	0	0
Kidney cancer	0	0
Liver cancer	0	0
Oesophageal cancer	1	0
Breast cancer	0	1
Depression	68	74

Table 2: Highlighted NHS and Societal Costs (UK) of being overweight Frontier Economics - £billion (2023 estimates) (4)

	Obese	Overweight	Total
Individual Costs	**53.6**	**9.5**	**63.1**
Quality-adjusted life years	*48.1*	*8.5*	*56.6*
Informal social care	*5.5*	*1.0*	*6.5*
NHS costs	**11.3**	**7.9**	**19.2**
Obesity related illness	*11.3*	*7.9*	*19.2*
Mental health	*0.0*	*0.0*	*0.0*
Wider society costs	**9.3**	**6.3**	**15.6**
Productivity losses	*8.9*	*6.2*	*15.1*
Formal social care	*0.4*	*0.1*	*0.5*
Total costs	**74.2**	**23.6**	**97.8**

These are not trivial costs, and amount to an additional cost arising from having excess weight which costs the NHS, the individual and indeed the entire system financial burdens we can ill afford.

Based on a study on the morbidity linked to obesity carried out by the Scottish Public Health Observatory (ScotPHO, 2003) for the Scottish population, attributable fractions of diseases linked to obesity were calculated. With the help of pharmacy colleagues we calculated the approximate cost drug expenditure in the Scottish Borders for those conditions as below:

Table 3

CONDITION	Female Expenditure	% Obesity	Male Expenditure	% Obesity	Cost of drugs	Comments
ANGINA	£25,745.77	17.2	£42,842.23	15.0	£10,854.61	
HYPERTENSION	£47,023.70	45.4	£53,151.97	26.0	£35,168.27	
STROKE	£3,922.19	7.2	£4,102.30	6.2	£536.74	Used a sub-section of Hypertension
MYOCARDIAL INFARCTION	£312,160.96	36.6	£524,801.11	9.9	£166,206.22	
GALL BLADDER DIESEASES	£31,655.00	17.2	£10,007.07	15.0	£6,945.72	
OSTEOARTHRITIS	£273,989.40	9.4	£192,203.27	16.5	£57,468.54	Paracetamol tablets
TYPE 2 DIABETES	£763,284.44	75.3	£1,140,374.25	48.0	£1,122,132.82	
Ovarian Cancer	£352,344	15.4		n/a	£54,260.98	Secondary Care only. Assume all are female
Colon Cancer	£1,295,038	30.7		30.6	£397,576.67	Unable to separate male:female
TOTAL					**£1,851,150.57**	

This is the cost excluding the newer GLP-1 type agonists. Also excluded are the costs for investigations and interventions that may be required. This would suggest that the estimated £3.3m in healthcare costs above might be a conservative estimate in the Scottish Borders. We know, for example, there are other conditions strongly linked to overweight such as Polycystic Ovary Syndrome (PCOS) or sleep apnoea both of which are chronic conditions requiring intensive support.

A deeper look at the impact of obesity on two conditions listed above illustrates the harm caused by associated obesity (see also p21). We know that operating on individuals carrying an excess weight can hinder recovery and lead to complications. One of the most common operations we carry out is hip and knee replacement, often causing pain and discomfort, and as the chart above shows, can be linked to being overweight. We carried out a rapid review of the age and number of planned operations carried out for hip and knee operations in 2024 using an extract from NEXUS, the theatre booking system:

Figure 2

Trauma & Orthopaedics - Elective
Knee Replacement

	BMI																											
Age	17	19	20	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	45	46	47	48	49	Grand Total
46-50														1						1						1					3
51-55																1	2	1	1		1	1									7
56-60		2			1									1	2			3	1				1		1			1	1		14
61-65						1		1	3			1		1	1		4			2	1	1	1	1	1						19
66-70				2		1				1	3	3	1	2			1		2	1	2		1	2			1				23
71-75						2	3	1	1	2		2	3	3	1		1	2	3			1	1							1	27
76-80	1					2	1	5	2	2	1	4	2	1	3		2	2		1	2	1									32
81-85			1			1		2		2		2			1																9
86-90					1		1		1	1																					4
Grand Total	1	2	1	2	2	7	5	9	7	8	4	12	6	9	8	1	10	8	7	5	6	4	4	3	2	1	1	1	1	1	138

Figure 3

Trauma & Orthopaedics - Elective
Hip Replacement

	BMI																											
Age	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	Grand Total
41-45																								1					1
46-50														1												1			2
51-55				1			1	1	1							1					1							1	7
56-60							1	1	1	1			1		1	1			1	1		1	2						12
61-65					1			1		2			1	2	1	1		1	2								1		13
66-70				1				1		1	1			1	2		1	1				1							10
71-75			1				1		1		1	2	2		2	1			1	1	1								14
76-80		1						1	1		1	2	1	3				3	1				1		1				16
81-85	1			2	1				1	1	2	2					1			1									12
86-90							1																						1
91-95						1																							1
Grand Total	1	1	1	4	2	1	4	5	5	5	5	6	5	7	6	4	2	5	5	3	2	2	3	1	1	1	1	1	89

This showed that between 9 - 13% of the procedures were carried on individuals who fall into the morbidly obese category with a BMI of 40 and

over. There is a strong case for delaying these operations as there are likely to be complications during recovery and healing. It could be also argued that anyone with a BMI 35 or above should be given intensive support for reducing their weight, before operation, in order to optimise their recovery and reduce complications and hence length of stay. There is a cost of each operation; prolonged care for complications adds to that cost.

As will become clearer later on, there are now effective drugs that can reliably reduce weight by 10% -20%. Any restricted access to those drugs will inevitably result in people with a strong motivation (eg needing joint surgery) to access these drugs privately. This will therefore result in health inequality based on ability to afford to pay for these expensive drugs.

Chapter 4: Food, Nutrition and Healthy Weight

Obesity and poor nutrition are critical public health issues in the UK, with significant social, economic, and health-related impacts. Although these problems affect the entire of the population, disadvantaged groups disproportionately bear the burden. This disparity results of a complex interplay of socio-economic, environmental, and cultural factors – collectively known as the obesogenic environment in Figure 4.

Figure 4: The Obesogenic Environment

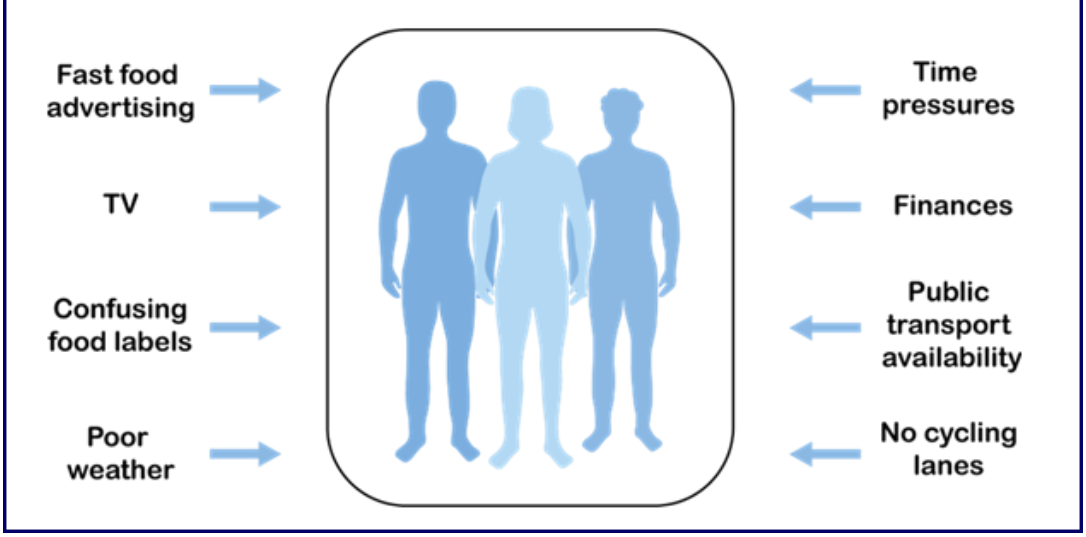


Figure 4: 'The Obesogenic Environment – Graphics produced by Holly McKay

Environmental factors

Many of us struggle with weight due to various factors. We are often encouraged to consume excessive calories and discouraged from engaging in physical activity. In many areas of the Scottish Borders, access to fresh fruits and vegetables is restricted while fast food outlets are plentiful. Our schools follow Setting the Table guidance (5) so don't offer

sugary snacks; however, many workplaces offer few healthy options. For those living in towns and cities, it is often more convenient to drive than walking or cycling. Additionally, in the Scottish Borders, covering large distances using public transport is challenging. Home entertainment options like video games or streaming services also contribute to a sedentary lifestyle. Advertising campaigns for unhealthy food and beverages – designed to be hyperpalatable but packed with sugar, fats, and salt, along with the costs of accessing gyms or nutritious meals, further exacerbate the problem.

As highlighted in my 2023 Annual Report, addressing this issue requires a multifaceted approach. This section outlines my recommendations for overcoming the obesogenic environment and improving our health and wellbeing, building on Appendix A.

Work carried out in 2023 showed that in 2016 and 2019, 65% of the adult population in Scottish Borders who took part in the Scottish Health Survey (SHeS) (6) were overweight or experiencing obesity, compared to 67% of the same population across Scotland. This is shocking; and shows how "normalised" it has become. When looking specifically at obesity, 28% of those who participated in the SHeS in Scottish Borders were in this category, compared to the national figure of 28%.

Within Scottish Borders, more men than women were overweight (including obesity); 59% of women in the SHeS were overweight compared to 72% of men. The same is true when obesity is looked at alone; 26% of women had obesity whereas 32% of men had obesity. Interestingly, the reverse is observed with regards to morbid obesity (where it is linked to illness). More women (7%) who participated in the SHeS had morbid obesity compared to men (4%).

The SHeS also reports on the proportion of the adult population within the health board who are a healthy weight. For Scottish Borders this was 31%

(i.e. 31% of those who took part in the SHeS had a BMI between 18.5 and 24.9). This is lower than the national figure, where 32% of the population is a healthy weight. Any difference appears to be driven by the percentage of males who are a healthy weight. In Scottish Borders this figure is 26%, whereas the national figure is 30%. In Scottish Borders, 36% of women are a healthy weight which is higher than the national percentage of 35%.

If NHS Borders staff are representative of all working-age Scots, we could expect just over 1,000 of our colleagues (out of a workforce of around 3,300) to have a BMI of 30 or over, although this would require a modelling exercise to get an accurate figure.

The Scottish "Food Futures" Strategy (7) highlights how dietary inequalities have grown in recent years, with healthier foods becoming less affordable compared to calorie-dense, nutrient-poor options. As recently stated in the Scottish Consensus Statement (8), until we get to the place where the healthy option is as accessible and affordable as the unhealthy, we cannot say our population has a free choice.

Importantly, as well as adults, many of our children and young people are affected. Table 3 below shows the Scottish Borders and National figures for childhood weight, and whilst an encouraging 78% of those measured in Borders were of a healthy weight - slightly more than the Scottish figure - a significant proportion were at risk of overweight or obesity.

Table 4: Scottish Borders and National figures for childhood weight

Number of children	***2021/22*** *Local (National)*	***2022/23*** *Local (National)*	***2023/24*** *Local (National)*
Measured with a valid height and weight	**1113**	**942**	**702**
Healthy weight	**75.7%** (74.7%)	**76.8%** (76.8%)	**78.1%** (76.5%)
At risk of overweight	**12%** (12.4%)	**12.3%** (11.4%)	**11.0%** (11.7%)
At risk of obesity	**11.2%** (11.8%)	**9.7%** (10.5%)	**10.3%** (10.5%)
At risk of overweight and obesity combined	**23.3%** (24.2%)	**22.0%** (21.9%)	**21.2%** (22.2%)
At risk of underweight	**1.1%** (1.1%)	**1.3%** (1.3%)	**0.7%** (1.2%)

Many people find the current classification of body weight stigmatising and demoralising for those trying to manage their condition. It can also be misleading as muscle tissue is heavy, and very fit people can often have a high BMI. A recent Lancet (Diabetes & Endocrinology) editorial (9) calls for a reclassification of weight in terms of functionality, recognising that people with moderately high BMIs can still be relatively fit. The paper emphasises the importance of a non-judgmental approach to obesity, noting that two-thirds of the risk is genetic, and the western food environment – characterised by snacking, processed food, a lack of sleep, high stress and a sedentary lifestyle – is a major contributing factor. In Japan, where obesity levels are low, multiple measurements are used to determine the impact of excess fat on health instead of relying on a single metric. Responsibility for managing weight understood on a structural, systematic level, is in contrast in the UK focussed on individual will power and behaviour change - Centre for Food Policy (10).

Other countries mentioned in the review, for example Denmark and the Netherlands have examples of good practice. Encouragingly, Scotland's legislative and food policy arrangements are also singled out for mention – in particular, Good Food Nation (Scotland) Act 2022 (11), for which a multi-agency group has been established in the Scottish Borders.

This prescription includes promoting greater awareness of nutrition, adopting a healthier diet and addressing the widespread "snacking culture". The Government can play a crucial role by implementing measures to reduce the access to high-fat, high-sugar "junk" food and increasing regulation of ultra-processed foods. We should encourage exercise – including walking, wheeling and cycling to work – as these activities offer both physical and mental health benefits. Obesity Action Scotland and the University of Edinburgh (12) have produced a useful guide to local actions that we can take. Some of these suggestions are revisited in my recommendations.

Weight loss drugs

The recent increase in bariatric surgery, such as gastric banding, has shown that it can be very effective in reducing BMI in people with clinical obesity. It can drastically reduce blood pressure and have a beneficial impact on type 2 diabetes. See Scottish Government / NHS Scotland consensus statement (19). There can be significant side effects of such procedures though, and there has been much interest in the last few years in pharmaceutical interventions. GLP-1 agonist drugs such as Ozempic® work by activating receptors in the pancreas, which leads to enhanced insulin release and reduced glucagon release, see Figure 5.

Figure 5: How GLP-1 Agonists Work
Adapted from Fernando Grover-Páez et al.

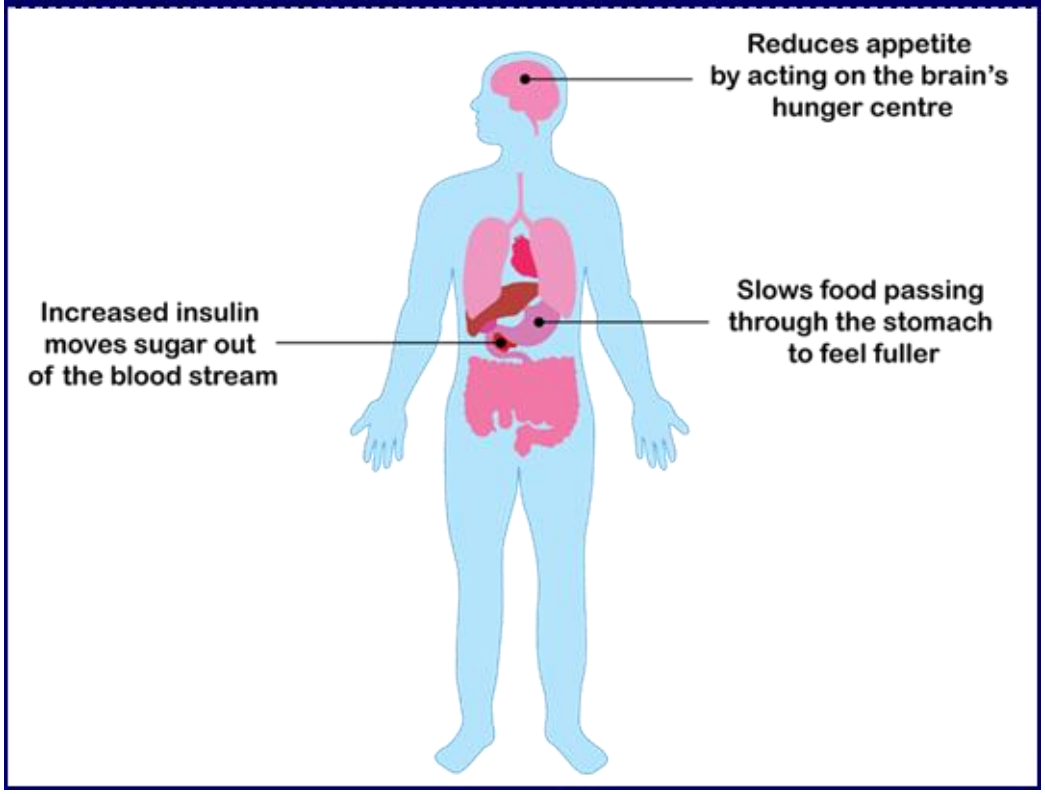
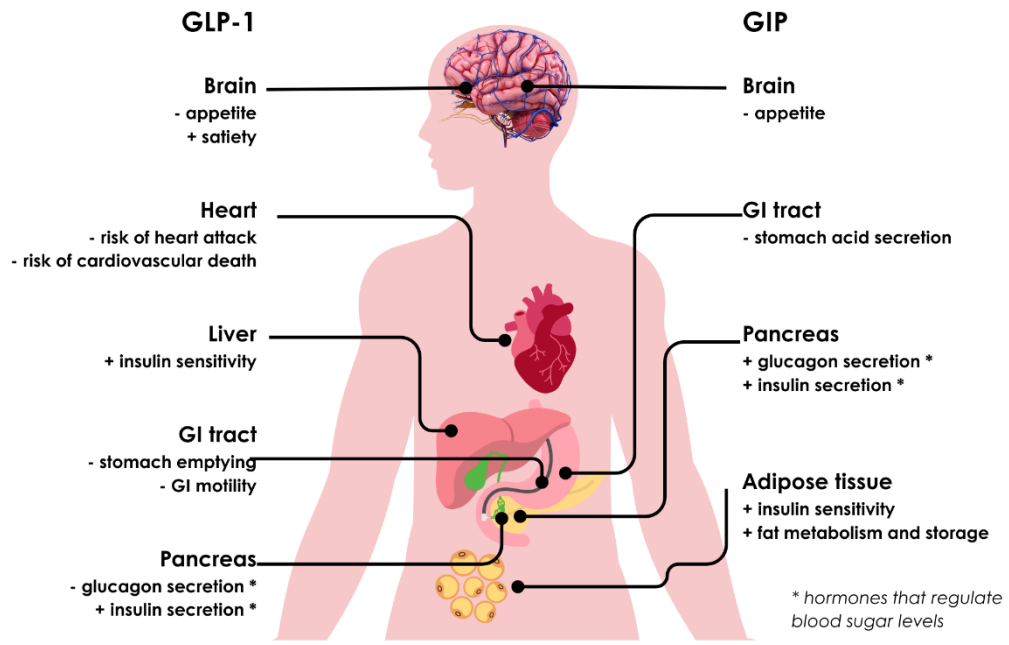


Figure 5: 'How GLP-1 Agonists Work – Graphics produced by Holly McKay

Figure 6: How do GLP-1 Medications Work?

GLP-1 medications work by mimicking or two naturally produced hormones: glucagon-like peptide-1 (GLP-1) and gastric inhibitory polypeptide (GIP).



Many GLP-1 drugs (like Ozempic and Wegovy) act by binding to GLP-1 receptors, resulting in the same effects of GLP-1 seen above.

However, some medications (like Mounjaro and Zepbound) are unique in that they bind to GLP-1 and GIP receptors, resulting in a combined effect.

Figure adapted from Heathline

The use of GLP-1 agonists raises several challenges. Their high cost – around £250 per month - makes them inaccessible for many, especially disadvantaged groups who might benefit the most. If NHS Borders were to provide GLP-1 agonists (based on 500 or so patients), the costs would likely be around £600,000 per year although there would be considerable future healthcare cost savings. Work is ongoing to look at the costs and benefits of these drugs. It is worth keeping in mind that around 30% of the population would benefit from weight reduction.

The second condition worthy of a deeper look is Type 2 Diabetes Mellitus (T2DM) .There were around 6,236 people in the Borders who have type 2 diabetes in 2021. On some estimates there are as many people who are pre-diabetic all of whom would benefit from using these medications to improve their weight and hence glycaemic control.

The Scottish Diabetes Survey highlights how many people with T2DM also have a high BMI. Within NHS Borders in 2021, nearly a third of people (30.8%) with Type 2 Diabetes who had a BMI recorded in the past 15 months were overweight (nationally this was 31%). The percentage of people with T2DM who had a BMI between 30 and 34.9 was 29.3%, slightly higher than the national percentage (29.1%).

Overall, over 50% of people with T2DM in Borders had a BMI in the obese category. Only 13.3% of people with Type 2 Diabetes had a BMI which was considered normal or underweight. The Scottish Diabetes Survey also has some data regarding those with T2DM in Borders who had achieved significant weight loss in 2021. This is relevant, as Counterweight Plus (a diabetes remission programme) incorporates significant weight loss in order to achieve remission - see *Appendix B* .

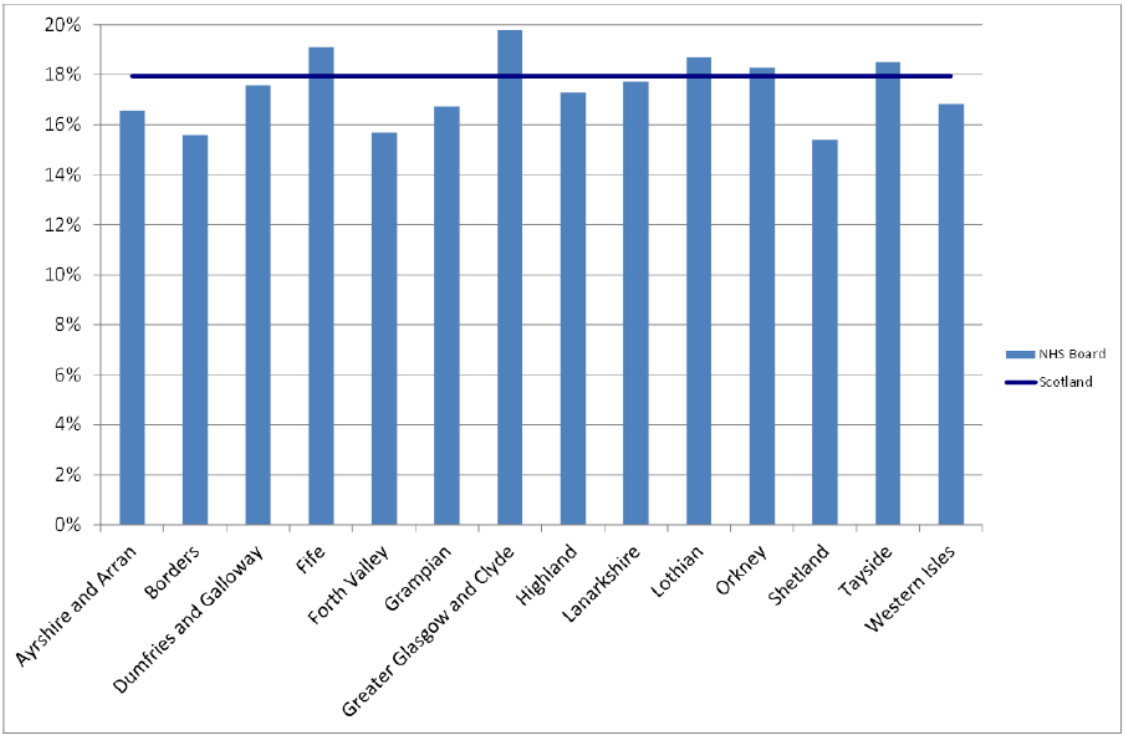
Table 5 - Percentage of people with type 2 diabetes with a record of BMI in the last 15 months grouped by BMI category, NHS board and ranked from low to high by percentage with BMI >= 40kg/m2, Scotland 2021 – Scottish diabetes survey

NHS board	BMI (kg/m², %)						Total recorded (n)	Not recorded (n)
	Under-weight	Normal	Over-weight	Obese				
	<18.5	18.5-24.9	25-29.9	30-34.9	35-39.9	≥40		
Greater Glasgow and Clyde	0.5	13.6	32.4	28.2	14.6	10.7	39,718	21,384
Borders	0.5	12.8	30.8	29.3	15.6	11.0	4,634	1,598
Tayside	0.3	11.9	31.2	29.5	16.0	11.1	15,380	6,580
Grampian	0.5	12.0	31.3	29.4	15.7	11.1	20,954	6,678
Lothian	0.6	13.2	31.7	28.3	15.0	11.2	27,250	12,694
Highland	0.4	11.9	31.1	29.9	15.2	11.5	13,365	3,957
Ayrshire and Arran	0.6	11.8	30.1	29.5	16.3	11.6	14,726	8,817
Dumfries and Galloway	0.6	11.2	30.3	30.1	15.7	12.3	6,610	2,515
Lanarkshire	0.6	11.4	29.9	29.5	16.2	12.3	23,344	15,359
Western Isles	*	*	28.6	30.9	16.8	12.8	1,108	335
Forth Valley	0.3	10.7	30.0	29.2	17.0	12.8	10,919	6,102
Orkney	0.0	10.2	30.9	28.9	16.9	13.1	962	164
Fife	0.4	11.0	29.2	29.3	16.5	13.5	13,875	7,379
Shetland	0.7	7.5	27.5	30.6	18.7	15.0	862	181
Scotland	**0.5**	**12.2**	**31.0**	**29.1**	**15.6**	**11.6**	**193,707**	**93,743**

Note: * Indicates a figure between 1 and 4 or a figure that indirectly reveals such figures. Excludes children under 18 years of age or who have no recorded date of birth (n = 156).

The data is slightly skewed as only those with T2DM who had two BMIs recorded at the desired time points were included, but it does offer some insight into the fact that Borders had the second lowest percentage of these patients achieving >= 5% body weight reduction in the last year. The Board was also below the national average for this measure. Significant weight loss can be achieved, but requires intensive support, and the investment of resources - *see Appendix B*.

Table 6 - Significant weight loss among people with BMI >=30 kg/m2 - Type 2 Diabetes and other aged 18+ years with BMI recorded by NHS board, Scotland 2021



Restricting access to these drugs, will drive those who can afford them, to get them privately, and hence create health inequality between those who can access potentially effective medication and those who cannot.

Reliance on pharmaceutical solutions is likely to divert attention from addressing the root causes of obesity, such as the obesogenic environment, poor diet and inactivity, whilst creating health inequalities or unaffordable financial pressures.

To maximize the impact of GLP-1 agonists, they should be integrated into comprehensive care plans that include dietary counselling and physical activity. The NHS Borders Board must also ensure equitable access to these medications to avoid widening health inequalities. It may be more cost-effective to prevent obesity than to instigate lifetime treatment

Private clinics will provide these interventions to people who don't meet the criteria agreed in the Scottish Government's Short Life Working Group consensus statement (9). Indeed, the media are highlighting that this is currently happening at scale. As relatively new medicines, these drugs may cause as yet unknown long-term effects and these must be monitored, especially if they are to be used widely. It is likely that they will need to be taken long term as their weight reduction effect is lost over time on cessation.

The role of a healthy diet

Nutrition plays a fundamental role in preventing obesity and promoting overall health, yet, for many in the UK, maintaining such a diet is challenging. When young children who are weaning are given free choice of foods, they tend to choose a balanced diet both in terms of nutrients and calories – we are programmed to achieve a healthy weight by default.

One significant barrier is the cost of healthy food. Obesity Action Scotland (12) has shown that the cost per 1,000kcal for a healthy diet was £8.51 compared to £3.25 for less healthy foods (2022 figures, so now significantly more). People in the most deprived areas of Scotland would need to spend 50% of their disposable income to eat a healthy diet compared to 11% for those with the highest income. The rise of food deserts (areas with limited availability of affordable, fresh produce) further exacerbates the issue. The prevalence of fast-food outlets in economically deprived areas contributes to poor dietary habits.

To address these issues, the UK and Scottish Governments have implemented initiatives such as the Best Start Grant Scheme (13), which provides financial support for low-income families to purchase fruits, vegetables, and milk. However, uptake of such schemes is often low due to lack of awareness or administrative barriers.

We need to raise awareness of the Best Start Grant Scheme, using our access to families and also work with our partners.

On a positive note, there has been local success in promoting breastfeeding. NHS Borders has recently been awarded the UNICEF gold award for maternity and health visiting whilst the Special Care Baby Unit achieved a level 3 grade. This supports maintaining a healthy weight for both mothers and infants. For mothers, it aids in the gradual return to pre-pregnancy weight, supports the mother-baby relationship as well as mental health of the mother and baby. It also helps regulate hormones like insulin and oxytocin, which contribute to fat metabolism and appetite control. For infants, breastfeeding provides perfectly balanced nutrition, helping to regulate their weight gain and reduce the risk of obesity later in life but more immediately protects children from a vast range of illnesses including infection, diabetes, asthma, heart disease as well as cot death.

We should continue to do all we can in the Scottish Borders to effectively support new mothers to breastfeed given the significant short- and long-term health benefits for both mother and child.

The impact of ultra-processed foods

The rise in obesity is linked to an increased consumption of ultra-processed foods (UPFs). These foods are often high in calories, sugars, and unhealthy fats while being low in essential nutrients. The list of UPFs is long and includes ice cream, ham, sausages, crisps, mass-produced bread, breakfast cereals, biscuits, carbonated drinks, fruit-flavoured yoghurts and instant soups. Their affordability, long shelf life, and aggressive marketing make them

particularly appealing and families in disadvantaged circumstances may well find them hard to avoid because of the barriers we have discussed.

Research is still emerging but has shown that diets high in UPFs are associated with weight gain, poor metabolic health, and increased risk of obesity. The "addictive" nature of these foods, driven by their attractive packaging, and engineered flavours and textures, further complicates efforts to reduce their consumption.

Policy interventions such as the UK and Scottish Governments' Soft Drinks Industry Levy (14), which taxes sugary drinks, have shown some success in reducing consumption. Expanding such measures to include other UPFs could help to change dietary habits. Additionally, clearer food labelling and public awareness campaigns are essential to educate people about the health risks associated with UPFs.

It is striking how little regulation or control is in place regarding these processed foods, particularly when compared to the safeguards around medicines. The end consumer is in a weak position to make affordable and considered choices when it comes to their diet.

Physical activity, including active travel (walking, wheeling and cycling)

Regular physical activity not only helps to manage weight but also reduces the risk of chronic diseases such as diabetes, cardiovascular disease, and certain cancers. Mental health benefits are also widely known. Despite these benefits, many disadvantaged groups struggle to engage in sufficient physical activity due to barriers such as lack of time, unsafe environments, and limited access to recreational facilities.

The Scottish Borders Council Plan (15) contains the aim to publish and begin implementing the active travel strategy and delivery plan. This aims to encourage travel which promotes physical activity and good health by

developing cycling infrastructure (including bike parking and secure storage) and improves linkages with public transport.

NHS Borders works in partnership with Paths for All and Scottish Borders Council to co-fund Border Wheels to deliver Walk It across the Scottish Borders.

Walk It is a physical activity prevention programme that aims to:

- Work in partnership to reduce health inequalities
- Build peer support networks
- Improve the health and wellbeing of people with one or more long term health condition

Walk It currently offers 48 Active Walks, led by 35 Walk Leaders, engaging 1,470 participants. Walks are dementia friendly and have adapted, for 2025, to include Indoor Walking Sessions to keep people well in their community all year round.

Evidence based tools have been used to estimate NHS cost treatment savings from this intervention over a ten-year period amounts to £375,000.

These initiatives can be cost effective way of improving health. The "Be Active" intervention (16) – a large-scale community physical activity initiative in Birmingham – has been estimated to show a whole systems return of £23 for every £1 invested. The scheme provides support and guidance to inactive people with long-term medical conditions to participate in regular physical activity. It offers free activities such as swimming, gym-access, and fitness classes at specified times during the week. Additionally, Birmingham's Be Active scheme has set up six new cycle hubs at leisure and community centres across the city, offering regular bike rides for beginners and free bike hire for community groups.

Active travel i.e. walking, wheeling or cycling instead of driving, is a practical way to increase daily physical activity. However, disadvantaged

communities often face challenges that hinder active travel including the affordability of equipment, poorly maintained pavements, lack of cycle lanes, and concerns about road safety all discourage walking and cycling. Sadly, poor weather also discourages people from active travel, though it should be noted that the maritime climate of the Netherlands or Denmark is not markedly different, but which both have far higher rates of participation.

Local authorities play a critical role in promoting active travel by investing in safe, accessible infrastructure like pavements and cycle lanes. The UK Government's *Active Travel Fund (17)* aims to encourage cycling and walking, but sustained investment and targeted interventions are needed to benefit disadvantaged areas specifically. Scottish Borders Council has worked actively with Live Borders to provide an infrastructure that supports this, though there have been some challenges in maintaining this.

Obesity and inequality

Obesity and poor nutrition are not merely individual health issues but also symptoms of broader social inequalities. Disadvantaged groups are more likely to face barriers to maintaining a healthy lifestyle, from low wages and food insecurity to inadequate housing and limited access to healthcare and open spaces. The Community Planning Partnership has a role in reducing these inequalities and we have been working with it to increase awareness and knowledge.

To tackle obesity effectively, public health strategies must address these underlying social determinants. Policies such as increasing the minimum wage, expanding free school meals, and investing in community health programmes can help create an environment where healthy choices are accessible and affordable for everyone.

The role of education and community interventions

Education has a critical role in combating obesity and poor nutrition. School-based programmes that teach children about healthy eating and the benefits of physical activity can instil lifelong habits. Similarly, community initiatives such as cooking classes, gardening projects, and physical activity groups can empower individuals to take control of their health.

Disadvantaged communities often lack such resources, highlighting the need for targeted investment. Collaborations between local governments, charities, and businesses can help bridge this gap. For example, food banks could partner with nutritionists to provide not just food but also guidance on preparing healthy meals.

Local community-led and multi-agency interventions such as the social prescribing pilot in the Earlston GP surgery are showing how we can work together as Anchor Institutions and Community Planning Partnership members to improve health and wellbeing. We need to involve School Nurses and Health Visitors in this work so that we can establish good nutritional behaviour in early life. Equally there may be a role for Health Visiting to support our older population in this regard. These pre-emptive preventative interventions must be co-ordinated so that they can provide a comprehensive support system.

Dr Bhatti's ten tips to fight back!

Our surroundings can make us gain weight because they encourage unhealthy habits, such as easy access to high calorie, processed foods, sedentary lifestyles due to technology, lack of spaces for physical activity, and very persuasive food advertising! Whilst the thrust of this report is on collective actions, individual responsibility involves changing our own behaviours and expectations. Collectively, we can induce a change in the commercial environment that seeks to profit from our choices.

By following these suggestions, we can create a personal environment that fights back against external pressures like advertising, marketing and convenience. People can take control of their own health and thrive despite these challenges.

Dr Bhatti's 10 practical tips to help you fight back an obesogenic environment!

NHS Borders

1 Plan and prepare your meals ahead of time

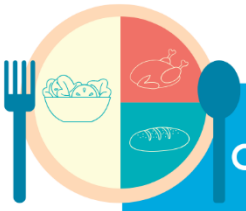
Why? Fast food and convenience snacks are everywhere, making it easy to eat poorly.

My Tip: Try to get organised. By preparing balanced meals and snacks at home in advance. You can batch cook and freeze if you are short on time. This will help you and your family to avoid impulsive, unhealthy choices.

2 Keep healthy food visible and accessible in your home

Why? You and your family eat what they see. By having more healthy snacks within reach at home you won't be as tempted!

My Tip: Place fruit, vegetables, and healthy snacks front and centre in your kitchen and home workspace if you have one.



3 Control portion sizes

Why? Oversized portions in restaurants and packaged foods encourage overeating. The more food, the more calories!

My Tip: Use smaller plates, bowls, and cups. Serve appropriate portions and avoid "super-sizing" meals.

4 Limit screen time when eating

Why? Eating while watching TV or using devices can lead to mindless overeating. Some people call this "ambient eating" – it's easy to consume a lot of calories and barely notice!

My Tip: Focus on your meal, savour your food, and listen to hunger and fullness cues. Put your phone away and enjoy your meal!

5 Choose active transport

Why? Modern conveniences such as cars, lifts and escalators reduce physical activity, contributing to weight gain.

My Tip: Walk, wheel or cycle for short trips. Take the stairs rather than the lift or escalator. If you drive to work, park farther away to include movement in your day. If you take the bus, get off a stop earlier and walk the rest of the way!

6 Be aware of ultra processed foods and keep junk foods out of the house

Why? If unhealthy options are around, it's easier to give in. If you are tempted by an unhealthy snack but there aren't any in the cupboard, you're less likely to go out specially to buy some.

My Tip: Look carefully at the ingredients on food packaging and try to avoid things with many long chemical names. Stock up on healthier alternatives and reserve indulgent treats for special occasions outside the home.

7 Be mindful of marketing traps

Why? Advertisements and promotions encourage overconsumption of high calorie, processed foods. The packaging, tastes and textures are all carefully worked out to lure us in!

My Tip: Avoid falling for deals like "buy one, get one free" or other upselling offers. Stock to a shopping list.

8 Make sure you get enough sleep

Why? Lack of sleep disrupts hunger hormones and can increase cravings for unhealthy foods.

My Tip: Aim for 7–9 hours of quality sleep per night. This will help to support healthy eating and maintain your energy levels.

9 Cook meals at home

Why? Restaurant meals and carry-outs often have excessive calories, sugar, and fat.

My Tip: Prepare meals using fresh, whole ingredients, and experiment with nutritious recipes. There are loads of ideas online.

10 Buddy up for support and accountability

Why? Modern conveniences such as cars, lifts and escalators reduce physical activity, contributing to weight gain.

My Tip: Walk, wheel or cycle for short trips. Take the stairs rather than the lift or escalator. If you drive to work, park farther away to include movement in your day. If you take the bus, get off a stop earlier and walk the rest of the way!

NHS Borders

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Chapter 5: Conclusion and Recommendations

Obesity and poor nutrition in Scotland are complex problems rooted in social inequality. While disadvantaged groups face the greatest challenges, they also stand to benefit the most from targeted interventions. By prioritising access to healthy food, encouraging physical activity, regulating ultra-processed foods, and the appropriate use of pharmaceutical innovations like GLP-1 agonists, we can help reduce the prevalence of obesity and its associated health risks.

The medicalisation of obesity has the potential to disrupt our NHS by creating a demand and need for expensive medication that deals with it. This medication has good evidence of effectiveness, but the financial costs are such that it is simply unaffordable. Alternatives, such as our weight management services experienced a greater than 50% cut in 2022/3. As resources are moved upstream, as a result of the modernisation, reform underpinning the clinical strategy, the possibility exists for us to use these to help address complex and persistent problems such the obesogenic environment which is more sustainable and economic.

We have shown that many factors conspire against us achieving and maintaining a healthy weight. Physical activity is clearly also important. But the NHS, Councils and Government have key roles to play in improving the landscape. This can be through transport policy, education initiatives such as promoting school meals, planning restrictions on fast food outlets and through appropriate regulation around the food industry. We do not know how many people with overweight and obesity use or provide our services,

so it is difficult to provide solutions if we do not hold and use that information routinely. Achieving a healthy weight can be life changing.

We have seen how our environment encourages us all to consume more calories than we use. Much of our food is very dense in calories and our increasingly sedentary lives mean that many of us put on weight.

Obesity can lead to several chronic diseases that significantly worsen our health. These include type 2 diabetes and cardiovascular diseases like hypertension and heart attacks. Obesity is also linked to stroke, certain types of cancer (e.g., breast, ovary, bowel), osteoarthritis from excess weight stressing joints, and sleep apnoea, which disrupts breathing during sleep. Importantly, it can contribute to fatty liver disease and worsen mental health issues like depression.

Action needs to be taken by organisations at local, regional and national (indeed international) level. What then, are my recommendations to tackle this obesity crisis? I recognise, of course, that sometimes a change requires a shift in resources and this can take time, but it is consistent effort that makes it happen.

1. We cannot help those who are victims of the obesogenic environment if we cannot correctly identify those who will go onto to develop obesity in later life nor those currently at risk or suffering from problems related to being overweight. Therefore, as a healthcare system we should:

a. Look to recreate a register of those who are obese, and those who are overweight, preferentially held by general practitioners.

It was easier to identify and target support to those who needed help and support with weight when there was a unified register for those identified as obese or overweight. The advantage of using GPs is 90% of people attend their GP practice at least once in a year, and 95% over any 3-year

period. This represents a near universal service to which there is little stigma attached by attending (unlike other services). In a previous GP contract, this was a routine part of practice (Quality Outcomes Framework). We need to be able to proactively identify those at risk of hypertension, and other obesity-related conditions, to prevent their occurrence and a register is the first step to help us target support.

b. **We should empower our school nurses to help identify those at risk of adult obesity as well as those currently suffering from persistent excessive weight gain (or loss). They will be able to link in with teaching staff at school to provide tailored support, advice and could even attend parent evenings to identify issues. In some places in the country, children have been taken into care due to the impact that persistent weight is having on the health of the child, despite supportive interventions with their carers/parents, as a sign of persistent neglect.**

School is a setting which is nearly universal for all children. It is where peer pressure and life-skills development take place. An assessment of a child's weight and propensity to weight gain should be made at least twice in their journey through primary and secondary school to provide a timeline which can flag up problems of issues relating to weight. An individual interview may help highlight issues and group sessions might help build up skills to address low esteem, eating healthily, physical activity, as well as identify poor home circumstances. An active conversation between School Nurse and Teacher would help identify individuals and issues for which there may be common themes that could be addressed in potential joint sessions in association with teaching staff. We need to review our school nursing role so as to provide this support, in addition to other core roles as identified in their local service review. The seamless interchange of information between GPs, Health Visitors, School Nurses and teaching staff about the wellbeing of the child should include issues relating to weight. The growing role of social media has been widely reported as causing harm in terms of body dysmorphia. We must also remember that with easy access to a child, a smart phone represents a

vehicle that industry can use to advertise and promote their goods all day and night. Advertising is no longer restricted to mainstream media eg tv, magazines or posters.

c. **Schools should review their policies with respect to access to smart phones, and work with parents to control access to social media which is full of heavy promotion of messages leading to harmful behaviour, including on diet and weight.**

d. **Health Visitors have a key role in identifying households which are specifically vulnerable to the adverse impacts of the obesogenic environment as it effects children under their care, and their parents/guardians. We need to develop tools and support that can provide sustainable support delivered through the universal health visiting service. Health visitors attend children in their home, and can therefore, almost uniquely, assess the environment that a child is being brought up in.**

Health Visitors have begun to measure the adverse childhood experiences (ACEs) of the children under their care. This information can be used to inform those who look after that child in their journey through childhood. We need to ensure this information is used to build a wrap-around set of support around that child, which is sometimes manifested through their weight. It has been posited that for some adults, eating is a form of comfort, a form of self-medication for harms that have occurred during childhood, especially in the early years. Identifying people who may be at risk enables us to put in support and help early enough so that they are prevented from future harm, including from the obesogenic environment.

e. **We should work with schools to measure the accumulating ACEs of our children as they go through school so we can identify those children who require more support.**

There is very good evidence that ACEs predict future educational attainment, employment and earnings, as well as morbidity and premature mortality. We all have a shared duty to protect our children from current and future harm. This allows us to provide a wrap-around safe and evidence-based environment targeted to those most in need.

Health Visitors have already reported that the issues are not always about monetary poverty as some parents are primarily time poor and utilise pre-packaged food or even takeaway food. We need to support those parents and help them organise their time better so they can prepare food for the rest of the week. Group work can sometimes provide the peer support needed to support this kind of behaviour change. We recognise that often shift patterns of staff means that when parents are able to attend activities that might support this change, is often in the evening and at weekends when staffing is scarce. We need Health Visitors to link better with community-based link workers to ensure that targeted support can be provided throughout the week. Reviewing the purpose and scope of Health Visiting services may also yield some additional benefits – the children's and young persons' services are currently undergoing a service review. This area of support must not be overlooked.

2. We should work with UK, Scottish and Scottish Borders Council to restrict food advertising, particularly for signage close to schools, social media access and for TV advertising at times when children are likely to be watching.

Restricting food advertising, especially for unhealthy products, can lead to significant public health benefits. It reduces the exposure of children and vulnerable populations to marketing that promotes high-calorie, low-nutrient foods. Limiting such advertising encourages healthier eating habits and can create awareness about the importance of balanced diets. Progress with these policy discussions is being made both at Westminster and Holyrood. This advertising is no longer limited to television or traditional media but proliferates in social media on popular platforms such as TikTok, YouTube, Instagram and Snapchat. Scottish Borders Council should work with schools to review their policies with respect to access to smart phones during school

hours and we collectively need to work with parents to encourage ways of building resilience within our children to resist poor health messaging.

3. Local authorities should use their planning processes to reduce exposure to low-quality "fast food" and increase the availability of better choices.

Using planning laws, including "Health In All Policies" (19) to restrict junk food sales helps improve public health by reducing access to unhealthy options, particularly in areas with high obesity rates. Limiting outlets near schools encourages healthier eating habits among children and can support local fresh food sellers, thus reducing the likelihood of "food deserts".

4. Strengthen public food procurement and provision standards, including the food we provide in-house to both staff and patients.

Annual public sector expenditure on food and drink in Scotland is nearly £150 million (12). With the passing of the Good Food Nation (Scotland) Act in 2022 (11), local authorities and health boards have a significant opportunity to use this public spend to promote healthy diets and support healthy weights. Anchor Institutions like schools and hospitals can improve dietary quality and reduce health risks. They should be setting the benchmark for quality food and report on an annual basis. Places like the hospital or council canteens could open more to local communities and this would increase their ability to source healthy food at competitive prices. They could also consider providing meals-on-wheels services, as well as remote provision of meals which again could improve nutrition and provide revenue. Additional revenue will help support the often financially hard-pressed canteen such as in the Borders General Hospital while influencing

the amount of high-quality food that is provided throughout the Scottish Borders.

Local procurement supports regional agriculture, reducing reliance on ultra-processed foods and harmful additives. **We should try to ensure that all the food we provide is adequately labelled by calorie count, with supplementary information as to composition.**

5. Work with the out of home sector to reduce calories on the menu.

In 2021, people in Scotland, on average, took three out of home food trips per week. Quick service restaurants, particularly fish and chip shops and Chinese takeaways, make up a large proportion of these trips. The taste, ease, and quickness of eating out of home are the main motivators. However, out of home food tends to have larger portion sizes, resulting in greater caloric intake when compared to in the home (12).

Encouraging the out-of-home (OOH) sector to reduce calories and offer healthier options in their menus can significantly improve public health. Customers are then empowered to make healthier choices, hopefully establishing long-term habits. Businesses can benefit too, as consumers increasingly value health choices. We know that sustained behaviour change requires not just a change in the system that promotes harmful behaviour, but it also requires peer support networks such as those found in schools, and self-help groups that supports beneficial ones. **In order to reduce the impact of the obesogenic environment on those becoming pre diabetic (around 7,000 people), NHS Borders should commission a significant increase in access to and support from the diabetes remission programme of calorie restriction which is an evidence-based programme that is cost-effective and uses peer support effectively to encourage sustained behaviour change.**

6. Improve uptake of school meals.

We should continue to provide free school lunches to children in Primary 1 to 5 (P1-5) and continue to provide and encourage uptake of free school lunches to eligible pupils in Primary 6 to Secondary 6. UK wide data show that children and young people who consume school provided lunches are more likely to meet minimum recommendations for vegetables, protein- rich foods, and fibre compared to those consuming packed lunches. Currently 50% of pupils in Scotland eat meals (free or paid for) provided by their school, and this percent continues to decline. **We should continue to work with Scottish Borders Council to continue to improve the uptake and accessibility of high-quality school meals.**

7. Promote and support physical activity.

The benefits to physical and mental health of physical activity are well known. In 2021, 69% of Scottish adults self-reported meeting physical activity guidelines, continuing an upward trend since 2012. The proportion is similar for children with 71% meeting the physical activity guidelines. Adults living in the most deprived areas of Scotland are least likely to meet the recommendations (12).

We should support public health measures to increase physical activity, as described in this report. These include infrastructure (cycle routes, open spaces etc.) and community programmes, like fitness classes and sports leagues. Schools and workplaces can also play their part. Policies supporting active transportation, such as walking, wheeling or cycling, further enhance accessibility, helping to reduce sedentary lifestyles and improve overall health. **In order to encourage active travel NHS Borders should promote and develop salary sacrifice schemes for the purchase of**

bicycles including electric ones which are shown to be more effective at encouraging activity as well as the purchase of other equipment such as gym equipment or even electric cars. Salary sacrifice schemes are beneficial for staff as it reduces their tax payments and for the employer through reduced national insurance. Where possible, this should be aligned across the anchor institutions in the Scottish Borders.

Anchor Institutions in the health and care sector should support patients and care residents to be as physically active as much as they can. Even less mobile people can do chair exercises. Scottish Borders Council should consider providing more street furniture to encourage physical activity. For example, "Trim Trails" in public green spaces could be built to provide stationary cycles, frames to do pull-ups. As highlighted in last year's report, "waiting well" (19) can improve outcomes and potentially reduce future demand. For example, people waiting for lower limb joint replacements will have better outcomes if they can reduce their weight whilst awaiting surgery. **The NHS should provide a programme of targeted support for those waiting for assessment and treatment, on waiting lists, to help improve their physical condition, and also consider delaying access to certain treatments that are likely to fail quicker when conducted on patients who have severe weight issues, when appropriate and safe to do so. The Wellbeing Service in Public Health could provide this outreach support alongside partners such as Live Borders. This promotes a partnership approach between patient and clinician consistent with value-based health and care principles**

8. Protect, promote, and support breastfeeding and healthy diets for children.

We have seen in this report the benefits of breastfeeding for both mother and infant and noted that there has been local success in its promotion. We

should continue to do all we can in the Scottish Borders to encourage new mums to breastfeed.

9. Continue with work to develop place-based preventative interventions.

Place-based interventions, including social prescribing can target many of the complex root causes of obesity. We should continue to implement our T.H.I.S Borders Health Inequalities Strategy and press on with developing a joined-up system of social prescribing. This will bring together existing services such as the Wellbeing Service, Local Area Co-ordinators, What Matters Hubs, Housing - Registered Social Landlords, Live Borders and localities to respond to the social challenges that many people experience.

a. Community-based link workers are working within their communities to help provide support for people with often multiple social problems. Carrying excess weight has an impact on self-esteem as well as setting up an individual to additional health-related harm (such as hypertension, type 2 diabetes, depression which are often hidden harms). Someone who is isolated and cannot get access to high quality food will be at particular risk from the obesogenic environment. We need these workers to be equipped to begin discussions openly about the harms of the obesogenic environment as well as utilise the structure of the "ten tips" to fightback against it.

Place-based prevention interventions, including social prescribing, community led support, what matters hubs, Local area coordinators, RSL tenant support services, and Live Borders all need to be able to raise the topic of the obesogenic environment individually and with whole families. Hypertension is a hidden health challenge linked to being overweight and being physically inactive, so we need to encourage people to "know their number" and pay particular attention to it throughout their lives. The aim is not to medicalise this population, but to identify those at greatest risk and intervene earlier with non-medical interventions before they are medicalised. We know that both weight loss and more physical activity

can lead to remission from pre-diabetes as well as incipient hypertension. This is better than life-long treatment with medication that can have serious side-effects.

b. **Though not strictly a place-based intervention, investing in a calorie restriction programme such as counterweight plus supports new diabetics to put them into remission and is a largely home-based intervention. With around 7,000 type 2 diabetics in the Scottish Borders, potentially going on life-long therapy with the added risks arising from metabolic harm (e.g. cardiovascular disease, small blood vessel disease in organs leading to blindness and renal failure) this is a particularly beneficial outcome for healthcare services. The financial saving over a lifetime has been calculated to be around £1,337 making it cost saving intervention within 6 years** (20).

Counterweight Plus (21) is a regime that seeks to restrict the caloric input of new Type 2 diabetics and can put around half into remission. Type 2 diabetes development is linked to obesity, and therefore one of the harms that can be prevented by tackling the issue. There has been no growth in investment in this programme, yet this is a cost-saving intervention and also provides significant benefit for those with the condition (Appendix B). We should certainly look to see how we can expand our offer to the population and do so in a way that encourages self-help networks to sustain beneficial behaviours.

10. As Anchor institutes, we should become exemplary in the way we help support those with weight challenges, and ensure that any underlying health issues are identified and dealt with.

NHS Borders employs around 3,300 staff with a similar if not greater number employed by Scottish Borders Council. We know from economic analysis that the cost of being overweight (4) is an additional, approximate £1,500 per person, which is an additional cost to staff who are often subject to significant cost of living challenges. With an estimated 1,000 of the staff we

employ in NHS Borders suffering from being overweight or obese, 75% of which is felt through indirect costs such as food, drink, clothing, avoiding healthy opportunities, avoiding socialising, having low self-esteem, as well as suffering direct health costs from linked illnesses which also impacts on sickness absence rates. **Public Health should work collaboratively with trade unions, occupational health, and HR to develop a programme of welfare and health that supports staff to tackle any issues they have with weight, identify any underlying health issues – with a focus on trying to avoid lifelong medication when appropriate and safe – and build a group methodology that supports "good" behaviours. Evidence suggests that for every £1 invested in these programmes, the return on investment is £1.17** (22). **The hidden harms suffered by these individuals is not trivial and could impact on sickness absence rates which often cite stress at work or musculoskeletal issues both of which would benefit from people moving closer to their ideal weight for their age.**

NHS Borders should identify those employees more likely to need support when facing an obesogenic environment. Evidence shows that those with more ACEs are more likely to need support and could provide a powerful way of building resilience and targeted wrap around support for those with greatest need.

11. When people enter the "care journey" either through the waiting list, or for a procedure or treatment or care package, do we do enough to help people with weight challenges address their underlying response to the obesogenic environment? It is often fruitless to provide a hoist or a larger chair for someone in social care, if we do not address the underlying problem with weight. It is often not seen as relevant to the presenting problem, but it is fundamental. In addition, we know that actively helping

people with their physical conditioning and weight improves their recovery from surgery, the time they need to recover, and this includes those undergoing treatment for cancer. We need a comprehensive system of support for everyone on the "care journey" in the Scottish Borders to have access to and be supported to improve their mental, physical and social wellbeing.

The Wellbeing Service hosted in public health proactively reaches out to people as well as takes referrals to help assist people who often have a mix of mental, social and physical problems/issues. Therefore, a focussed programme of identifying those on waiting lists, those who are under the care of Community Nurses/Social Workers and also are known to GPs would help reduce the recovery phase from many interventions, as well as help build up social capital within their community. Dietetic Services also have a role to play but they need to evidence their effectiveness more explicitly. Live Borders are another partner that is keen to participate.

12. As the Clinical Strategy is developed for NHS Borders, it is important to identify the impact of obesity as an underlying or aggravating factor. Being overweight leads to less physical activity and further aggravates health harm both physically and mentally as well as in social aspects. We need to keep these underlying issues to the fore or we will be at risk of dealing only with the symptoms rather than the causes.

There are a range of service reviews and also a mid-term financial plan linked to the development of the Clinical Strategy. However, we are destined to repeat the errors of the past, where we constantly treat symptoms and not the underlying causes - for example, knee joint issues can almost always benefit from reducing weight and improved physical tone in

the leg. It is not always clear how much this impact is considered in service redesign nor whether anyone on the waiting list for it has demonstrated significant reduction in weight and improvement in muscle posture? We spend a lot of effort and time in the hospital and in primary care dealing with arthropathies, as well as depression, treating cancer and type 2 diabetes. Nearly 50% of people aged over 70 are suffering from or are treated for hypertension, and stroke and cardiovascular disease remain two of our biggest killers. Tackling obesity and overweight is worth the effort, in terms of reducing demand for services.

Underlying causes are by their nature complex and require working in collaboration with others, where we are one (but a powerful one!) voice amongst many. Together with Scottish Borders Council, and the other anchor institutions within the Scottish Borders, we can shape the lives of our workers, who together with their families, may constitute around half of the adult population within our area.

Chapter 6: A Final Word

In this report, I have looked at the pressing public health challenge of obesity, and especially how it applies to our community here in the Scottish Borders. This is clearly a complex, "wicked" problem with no easy solutions. The fundamental challenge, as we want to act on the best evidence, is that we are at risk of medicalising a social condition which if sustained produces long-term harm. We cannot afford to do so.

I believe that the Scottish Government in its new Population Health Framework will prioritise obesity and its prevention. We have seen how the environment conspires against us in trying to maintain a healthy weight. We are bombarded by unhealthy, sugary, salt-rich and calorie dense things to eat and drink. Snacking has become the norm and eating home-prepared nutrient rich healthy food has become increasingly difficult. The disadvantaged in our society are particularly affected by this, as healthy ingredients become ever more expensive.

We have strong partnership arrangements in the Scottish Borders, and I have highlighted some ways in which our organisations can work together to improve matters. As Anchor institutions, we can do much to help our own employees and their families, as well as the communities which we serve.

There are reasons for optimism. The success of initiatives in other parts of the UK – such as the Birmingham's "Be Active" scheme (18) - and the fact that we are developing community-led multi-agency interventions locally give reasons to be positive. Possible pharmaceutical options are developing, and although expensive, they may be of great benefit to some individuals. NHS Borders has recently introduced a salary sacrifice scheme to enable

employees to obtain e-bikes and I hope that this will move people towards active travel both to work and in their lives outside of the workplace.

More can be done by Scottish Borders Council and national Government regarding planning around fast food outlets and advertisements near schools (and in schools in every pocket via social media). Equally there should be much more regulation around the formulation and advertising of factory-produced foods.

We will report on progress in next year's report. I have also attached, as appendices, the most recent reports covering other important aspects of our Public Health work here in the Scottish Borders.

In preparing this report, we have made use of AI tools, in the initial drafting stage as well as some graphics.

Dr Sohail Bhatti
Director of Public Health

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Appendices

Appendices - Relevant to report

- **Appendix A** – Improving Scotland's Diet and Weight

- **Appendix B** - A review of the clinical and cost effectiveness evidence for a digital type 2 diabetes remission programme in Scotland.

Appendices - Key Public Health Programme Updates

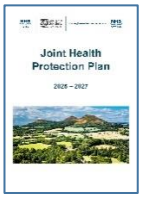
- **Appendix 1** - A Rapid Review and Analysis of The Health of the NHS Borders Population

- **Appendix 2** - Joint Health Improvement Team Annual Report 2023-24

- **Appendix 3** - Alcohol and Drugs Partnership Update 2023-24

- **Appendix 4** - Screening Programmes Report 2023-24

- **Appendix 5** - Joint Health Protection Plan 2025-27



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Improving Scotland's diet and weight

A position statement on behalf of the Scottish Public Health System

July 2024

The benefits of healthy eating, active living and maintenance of a healthy weight are widely recognised and directly associated with a wide range of health benefits. These are important routes to improving population health.

As our working age population is set to shrink in the coming years, it is vital that everyone is supported to live a long, healthy and independent life. In addition to the obvious benefits at an individual level, making improvements to Scotland's diet and weight at a population level is also critical for protecting public services and enabling our economy to thrive and prosper.

Why we need to act

Health Impact:

The Scottish Burden of Disease analysis indicates that of all healthy years lost in Scotland; one in ten are attributable to excess weight, and one in ten attributable to poor diet.[1]

The Scottish diet remains too high in calories, fats, sugar and salt, and too low in fibre, fruit and vegetables, and other healthy foods like oil-rich fish. Progress towards the Scottish Dietary Goals has been slow.

Around two-thirds of all adults in Scotland (67%) are living with overweight (including obesity), with one third (33%) of children starting primary school being at risk of overweight (including obesity).[2]

Social and economic impact:

In Scotland's most deprived communities, adult obesity rates persistently exceed those living in the least deprived areas. Children living in our most deprived communities are twice as likely to be at risk of overweight compared to those in our least deprived, with the gap widening in recent years.[3,4]

Affordability can be a barrier to being able to eat a healthy balanced diet. Research has shown that those with the lowest income currently must spend around 50% of their disposable income to eat a healthy diet compared to only 11% for those with the highest income.[5]

1 Disability Adjusted Life Years https://vizhub.healthdata.org/gbd-results?params=gbd-api-2019-permalink/7650c24c4858e81770b1e875e825dd5b
2 https://www.gov.scot/publications/scottish-health-survey-2022-volume-1-main-report/pages/12/
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The stigma associated with obesity makes the difficulties associated with weight issues more challenging. This can be felt at an individual level in terms of discrimination and can present barriers to accessing support. It is also experienced at a societal level in terms of the attitudes, responses and interventions proposed to support people to maintain a healthy weight and live healthy lives.[6,7]

The annual cost of obesity in Scotland in 2022 was estimated to be £5.3billion of which £4.1billion is the value lost to people through reduced quality of life.[8]

Future Impact:

Excess weight in childhood and adolescence can affect children and young people's immediate health and is associated with overweight and obesity into adulthood and the early emergence of associated health problems.[9]

Having a healthy, balanced diet and being physically active, means we are more likely to have a healthy weight, whilst also supporting good physical and mental health. However, our current food environment does not support equitable access to healthy food options, further increasing health inequalities and the likelihood of increasing rates of people living with overweight and obesity across the Scottish population now and in the future.

Having an environment where healthy food is available and affordable and where physical activity is part of everyday life will help improve the health of everyone in Scotland, prevent illness and save money.

Areas for action

1. Policy and Strategy

Successive Government policies, including A healthier future: Scotland's diet and healthy weight delivery plan, have laid the foundations for action. The Good Food Nation Act presents an opportunity to adopt a 'Whole of Government' approach to the development of food and drink policy, that prioritises actions to address the social, commercial, economic, and environmental factors that influence health inequalities.

We now need to see this policy intent translated into practical actions and underpinned by clear leadership commitment at both a local and national level. In particular:

- Those living in the most deprived areas experience the most significant diet and health related inequalities. Access to safe, affordable healthy food is a basic human right and, as such, all food-related policies in Scotland must ensure they are contributing to a reduction in these diet and health related inequalities.
- A comprehensive evaluation and monitoring framework needs to be developed and implemented to provide evidence of what works to improve Scotland's diet, maintain a healthy weight, and reduce inequalities.

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- We need to recognise that having a healthy diet and maintaining a healthy weight is influenced by many factors. These include access; availability; affordability of healthy food; food industry marketing; the influence of social circles; and access to appropriate weight-management and support services which are free from stigma. Action plans at a local and national level must consider this full range of factors.

2. Leadership to promote healthy diet and weight, including how we frame the narrative about obesity and weight

- We need to change the way we talk about obesity and poor diets. This means shifting the narrative from individual responsibility to the environmental, broader building blocks for health to enhance public understanding and build consensus for societal action.
- And we need to be clear, until we get to the place where the healthy eating option is as accessible and affordable as the unhealthy, we cannot say our population has a free choice.
- Directors of Public Health must ensure work on diet and healthy weight is clearly located within place-based approaches.

3. Ensuring children have the best start in life

We must address food insecurity as a priority to ensure infants and children have the best nutritional start in life. The actions below should seek to target families from the six priority groups[10] in Best Start Bright Futures, at highest risk of poverty, in particular:

- Strengthening connections between financial inclusion interventions, employability services and access to affordable healthy food for families to maximise family incomes through fair work and social security, preventing poverty and ensuring no child experience's hunger.
- Ensuring children and young people entitled to free school meals have access to nutritious food over school holidays.
- Building on universal maternal and early years services to develop a coherent approach to improving nutrition; by implementing a robust framework for optimal maternal and infant nutritional status, including pre-pregnancy diet and weight gain; increasing breastfeeding rates; introduction to solids and healthy diets for infants.
- Implementing and evaluating innovative community-based or digital food and activity programmes for families which address parent and child skills development, food literacy and food insecurity to promote child health, increased physical activity and support a healthy weight.

4. Places where we live, work, learn, care and play prioritise healthier food options and opportunities to be physically active

The places where we live, work, learn, care and play must prioritise health. We must accelerate efforts to ensure all communities have access to sustainable, affordable and healthy food and drink options and opportunities to be physically active.

10 The six priority groups are each more likely to experience poverty than all children in Scotland (24%) and households which do not have any of the priority family characteristics (10%). The six priority family types are: Lone Parents, Minority Ethnic, Disabled, 3+ Children, Youngest Child Aged <1, Mothers Aged <25

- The public sector must lead by example on the delivery of food and drink standards. This should include a commitment by all Anchor Institutions [11] to support the provision of healthy food options to their staff and those using their services.
- There must be a clear plan of action to work with the food industry, including retailers and out-of-home outlets, to increase availability and affordability of healthy and sustainable food and drink options. Working with local food systems to reduce barriers and increase access to affordable food to meet basic dietary requirements is essential.
- The Scottish Government should explore and fully implement fiscal measures (taxation) and legislation to drive improvements in the nutritional quality of food through reformulation and restrictions in the promotion/ marketing of products high in fat, sugar or salt.
- Community Planning Partnerships working with the community food sector must take action to strengthen food related knowledge, practical cooking skills and community connections to build local capacity and nutritional resilience beyond emergency food provision. Local Good Food Nation Plans present an opportunity to work together to deliver longer-term outcomes.
- Local Authorities, drawing on local planning, licensing and advertising powers, must take account of public health evidence and continue to increase access to outlets that offer healthy foods and to reduce the prevalence of unhealthy food outlets. This is particularly important in areas next to schools. Action must be taken to ensure effective public health measures are added to planning requirements to enable local authorities to ensure their decision making pays sufficient focus to population health impacts.
- We need to ensure adequate capacity for local regulatory and enforcement functions.
- Community Planning Partnerships should prioritise work to enable everyday active living at all ages, bringing a physical activity focus to policy and planning decisions affecting neighbourhoods in which we live, work, learn, care and play.[12]

5. People have access to effective weight management support and services

It is essential to enhance the provision of tailored, cost-effective weight management and support services for people living with overweight and obesity, in non-stigmatising ways. This should include digital and group based approaches and the use of prescription medications as part of a comprehensive and fully inclusive range of treatment options.

11 The term Anchor Institutions is used to describe large, locally rooted organisations that have a major presence and impact in a local area such as public sector, large private, voluntary and community organisations.

12 https://publichealthscotland.scot/media/16184/a-systems-based-approach-to-physical-activity-in-scotland.pdf

Healthcare Improvement Scotland | SHTG Advice on health technologies

SHTG Assessment
June 2023

In response to enquiry from the Accelerated National Innovation Adoption collaborative

A review of the clinical and cost effectiveness evidence for a digital type 2 diabetes remission programme in Scotland.

What were we asked to look at?

We were asked by the Accelerated National Innovation Adoption (ANIA) collaborative to assess the evidence for a digitally delivered type 2 diabetes remission programme. The programme is a weight management intervention comprised of a total diet replacement plan and longer-term support for weight-loss maintenance. A digital delivery model involves the use of videoconferencing and online self-monitoring tools alongside the remote provision of meal replacements; there are no in-person appointments with health professionals unless patients require intervention for other reasons.

Why is this important?

Type 2 diabetes (T2D) occurs in approximately 88% of all patients with diabetes nationally. Reducing risk factors for developing T2D, and remission of the condition are key indicators in the Scottish Government's T2D prevention, early detection and intervention framework. There is a strong evidence base linking weight reduction with T2D remission. Dietary change based weight management programmes appear to be a scalable and relatively low-cost intervention that can be delivered both remotely and in community healthcare settings. The potential avoidance of diabetes-related complications as a result of disease remission can significantly improve outcomes and quality of life for individuals living with T2D.

What was our approach?

We conducted a review of the evidence on the clinical effectiveness, cost effectiveness and safety of a digital T2D remission programme.

More information about SHTG Assessments is available on our website.

What next?

ANIA will use our assessment to inform a value case and subsequent decision making regarding the national implementation of a digital T2D remission programme.

Key points

1. There is strong evidence demonstrating the effectiveness of weight management based diabetes remission programmes, for example, the Diabetes REmission Clinical Trial (DiRECT).[7,8] Almost half (46%) the participants with T2D who completed an in-person weight management programme were in remission one year later, and 36% were in remission at two years. Recent long-term results show that 23% of participants continue to be in remission at five years with an average weight loss of 8.9 kg.[12]

2. We found no published evidence on the relative effectiveness of digitally delivered remission programmes compared with in-person, face-to-face diabetes remission programmes. We found no published economic studies assessing the cost effectiveness of digital remission programmes. There is evidence from a nationally implemented diabetes prevention (as opposed to remission) programme in England that people using a digital intervention achieved greater levels of weight loss than those using either remote or group-based, face-to-face interventions. [18]

3. Interim results from predominantly remotely delivered remission programmes in England and Wales suggest that participants have been able to achieve levels of remission and weight loss comparable to those observed in DiRECT.[13]

4. An economic evaluation based on the DiRECT study found that he total intervention cost was £1,411 per person.[20] Whilst immediate intervention costs were only partially offset in the short-term, the longer-term benefits of being in remission led to average cost savings to the NHS of £1,337 per person over their lifetime. Longer-term savings accrued from a reduction in medication and need for diabetes-related healthcare with the intervention predicted to be cost saving within six years. Break even analysis found that at levels of remission and relapse observed in the trial, the total intervention cost would need to be in excess of £2,964 per person to cease being cost saving.

5. A comprehensive cost analysis based on registry data for T2D patients in Scotland estimated that on average, diabetes patients used between £2,500 and £6,900 of healthcare resources per year, depending on their risk of developing cardiovascular disease.[21] These figures illustrate the value of a remission programme in terms of the potential reduction in healthcare expenditure arising from diabetes-related complications and comorbidity.

Full report available **here**

A Rapid Review and Analysis of The Health of the NHS Borders Population

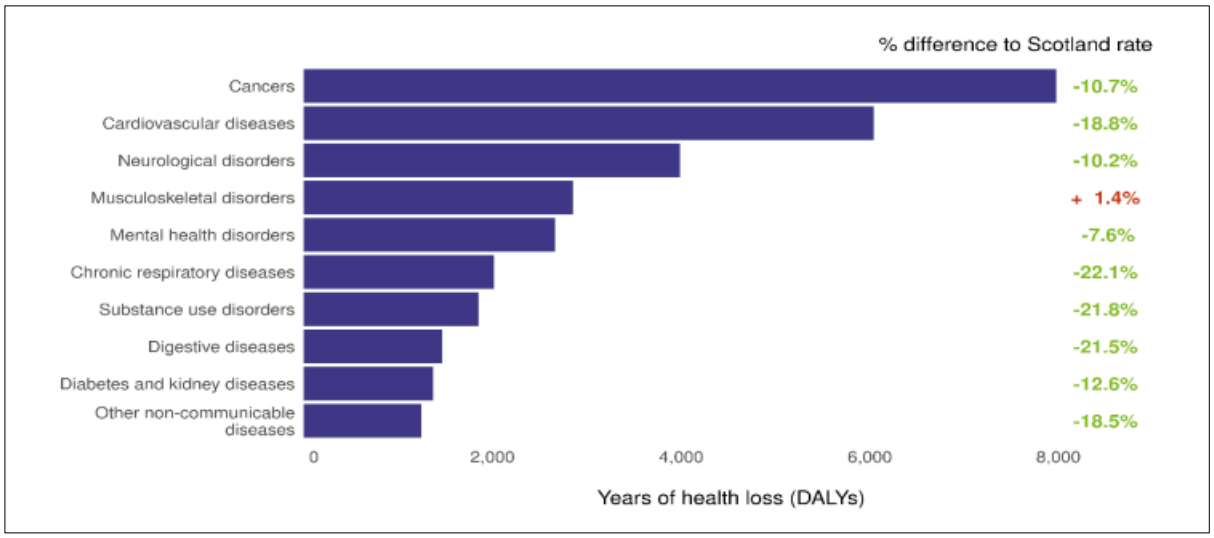
This appendix looks more widely at the health of the Scottish Borders population using data from the Scottish Burden of Disease Study (latest revision September 2022) and the Scottish Public Health Observatory (most recent data to end of 2023). Both of these resources are produced by Public Health Scotland and are available online at ScotPHO profiles and Scottish Burden of Disease Study 2019. Please note that the Burden of Disease resource is subject to periodic review and update and is provided as non-official statistics which may be in the process of being transitioned into official statistics.

An overview of leading causes of ill health and early death in Scottish Borders

The figure below shows that the three leading groups of causes of ill-health and early death in Scottish Borders are cancers, cardiovascular diseases, and neurological disorders. These groups of causes account for 50% of the total burden of health loss.

The largest differences in burden - compared to Scotland - occur due to chronic respiratory diseases, substance use disorders and digestive diseases.

Overall, the rate of health loss in Scottish Borders is 13% lower than the Scottish rate. We estimate the total burden in 2019 has increased 0.8% compared to the burden in 2016.



Leading Grouped Causes of Ill Health and Early Death

The table shows that the leading cause of ill health in Scottish Borders is low back pain and neck pain – the rate is 2.9% higher than Scotland overall. Other areas where our rates are higher than the national average are headache, arthritis, and hearing loss.

Regarding early death (under 75 years), our leading cause is ischaemic heart disease, but the rate is almost 28% lower than for Scotland as a whole. Deaths from colorectal cancer are the 6th most common category of early death but the rate is almost 16% higher than Scotland as a whole. Looking at years lived with disability (DALYs), the charts show the individual conditions that create disability and that most cluster in the 65-84 age band except for mental health, substance misuse and musculoskeletal disorders (25 to 64 year age band).

	Ill health	% difference from Scotland
1	Low back and neck pain	2.9%
2	Depression	-7.1%
3	Headache disorders	6.7%
4	Anxiety disorders	-6.8%
5	Osteoarthritis	1.8%
6	Diabetes mellitus	-1.9%
7	Cerebrovascular disease	-5.5%
8	Other musculoskeletal disorders	3.6%
9	Age-related and other hearing loss	5.7%
10	Skin and subcutaneous diseases	3.4%

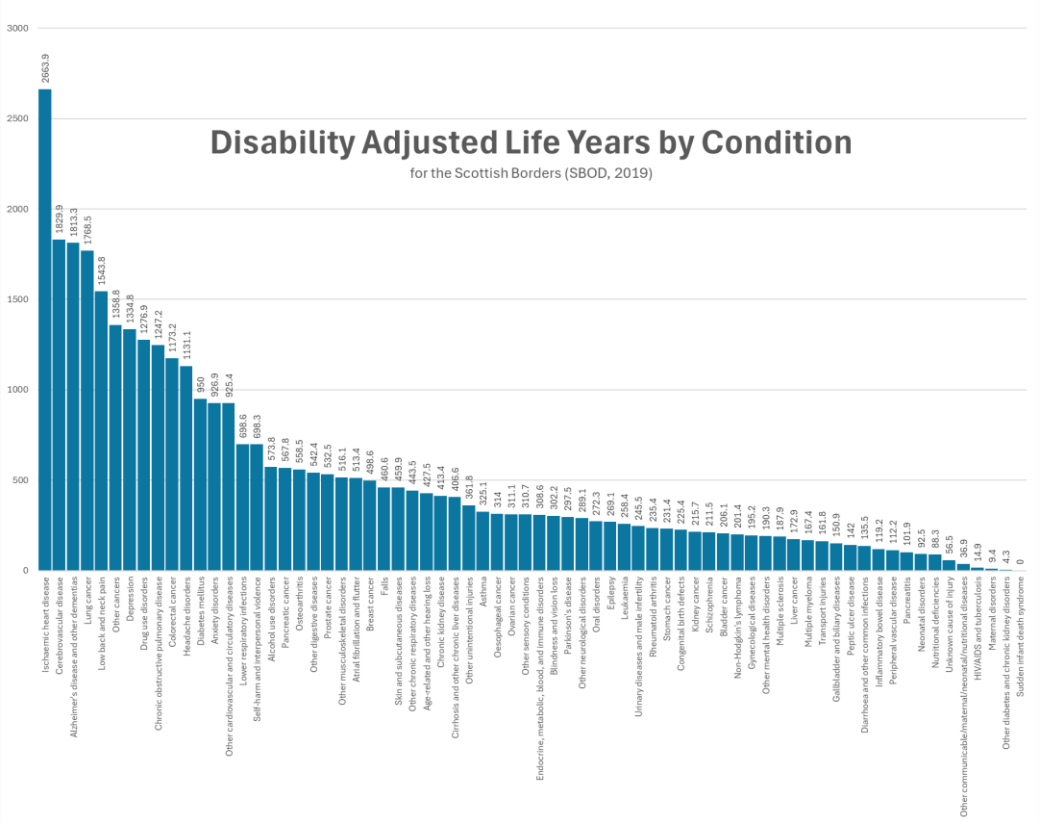
Ranking based upon the total YLD
% change based upon age-sex standardised YLD rates

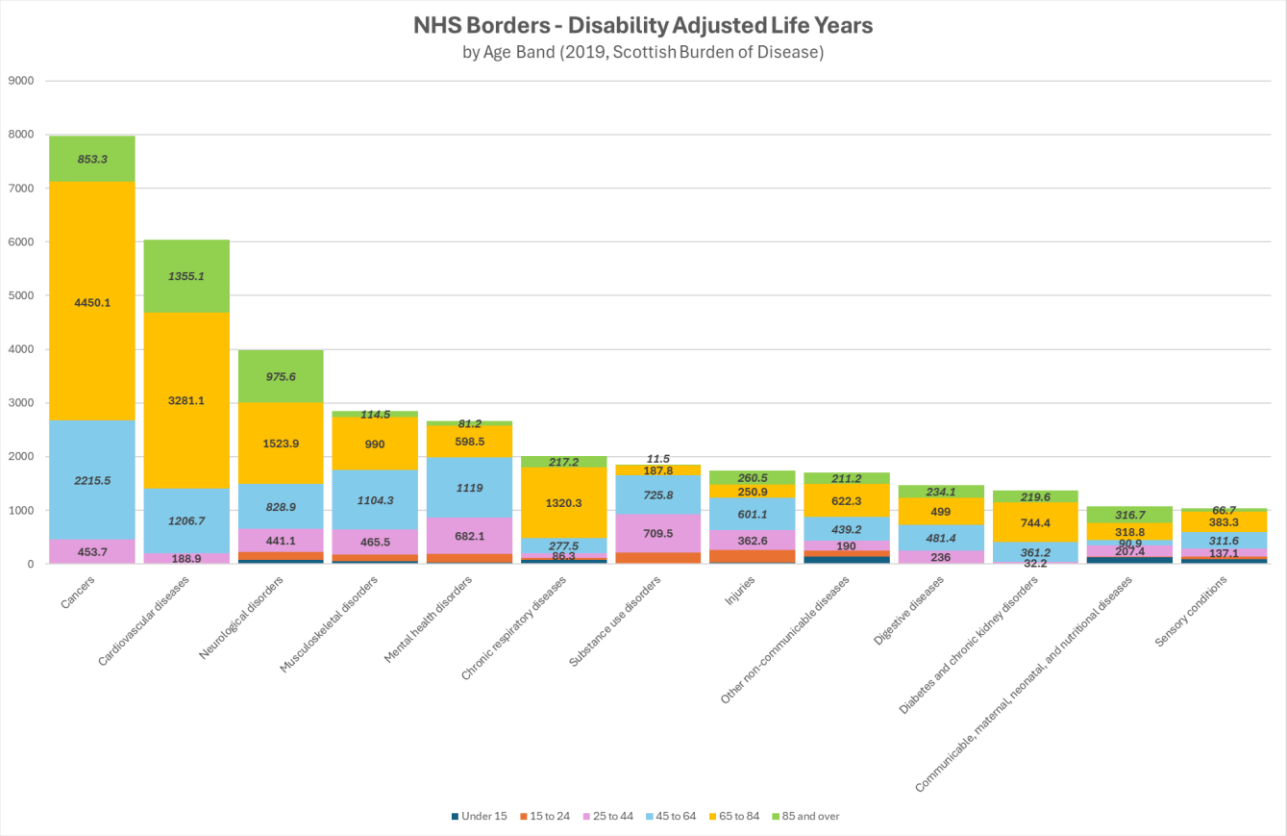
	Early death	% difference from Scotland
1	Ischaemic heart disease	-27.8%
2	Lung cancer	-21.3%
3	Alzheimer's disease and other dementias	-26.5%
4	Cerebrovascular disease	-8.5%
5	Other cancers	-14.2%
6	Colorectal cancer	15.9%
7	Chronic obstructive pulmonary disease	-38.2%
8	Drug use disorders	-20.8%
9	Other cardiovascular and circulatory diseases	-27.5%
10	Lower respiratory infections	-13.2%

Ranking based upon the total YLL
% change based upon age-sex standardised YLL rates

Rate lower than Scotland | Rate higher than Scotland

Leading Individual Causes of Ill Health and Early Death

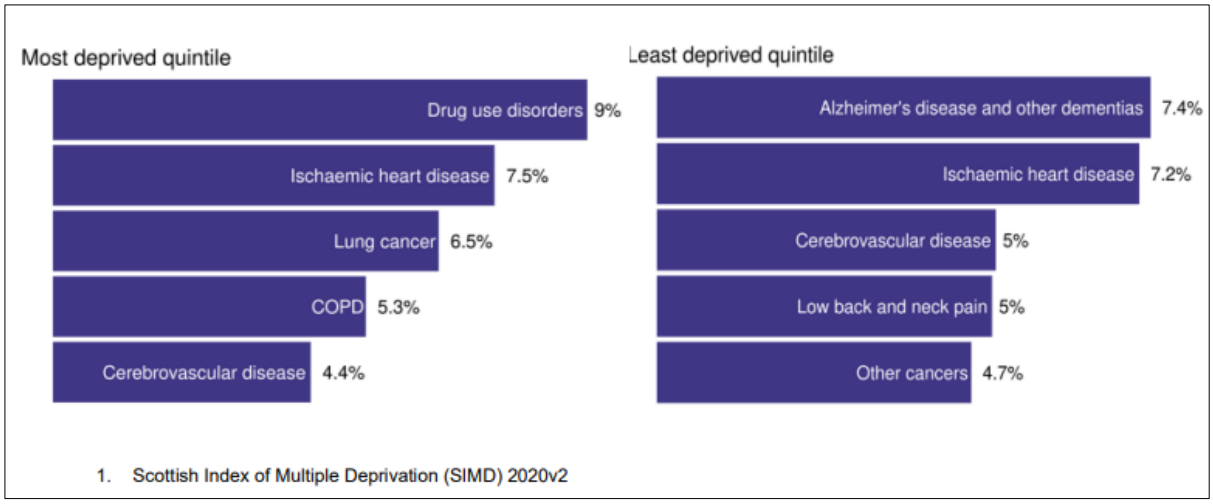




Public Health Scotland has carried out an analysis of how different levels of deprivation affect people's experience of these illnesses and the figure below shows their analysis for the East region of Scotland

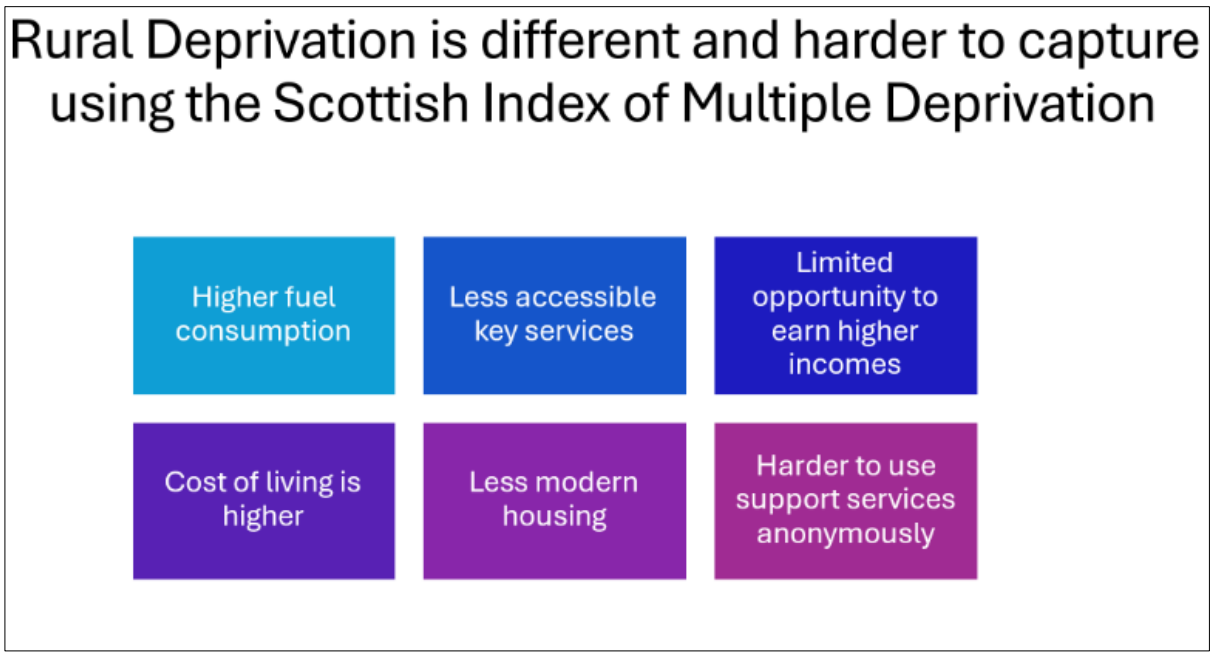
Estimates of the burden by deprivation level (population fifths) were produced for each NHS region in Scotland (North, East and West). Estimates were not produced at smaller geographic level due to the uncertainty in the data which would be introduced owing to small numbers.

There are well documented problems with using the Scottish Index of Multiple Deprivation (SIMD) in very rural areas such as the Borders (see below), and our experience may differ from other "East" Boards, but Public Health Scotland estimated that the rate of health loss in the most deprived 5th of the population in the East region was 1.9 times as high as the rate in the least deprived 5th of the population and that 47% of the health loss in the most deprived 5th of the population could have been avoided if the population in this quintile experienced the same rate as those in the least deprived 5th of the population.



Leading Individual Causes of Ill Health and Early Death by Proportion in the Most and Least Deprived Quintiles

The figure shows how rural deprivation is different and harder to capture using the traditional SIMD.

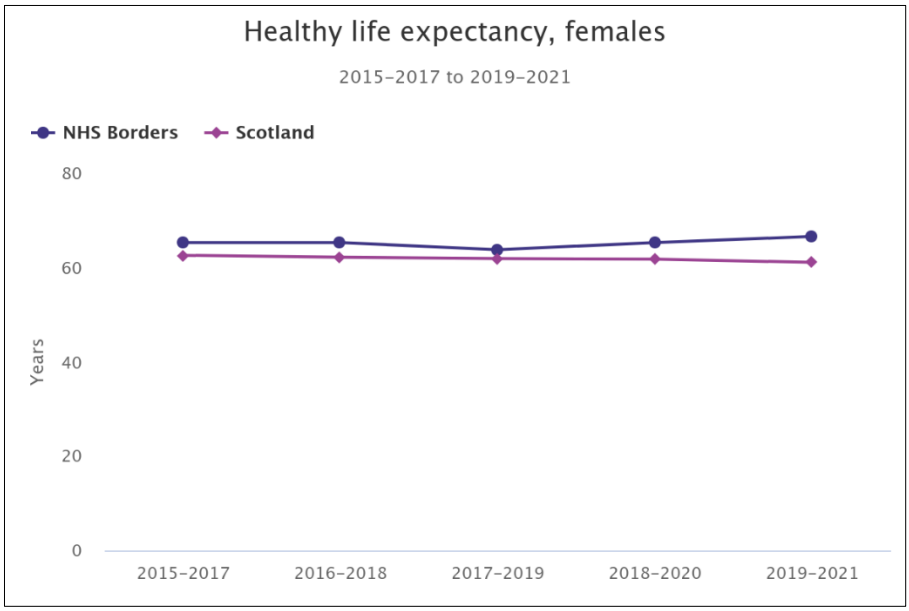


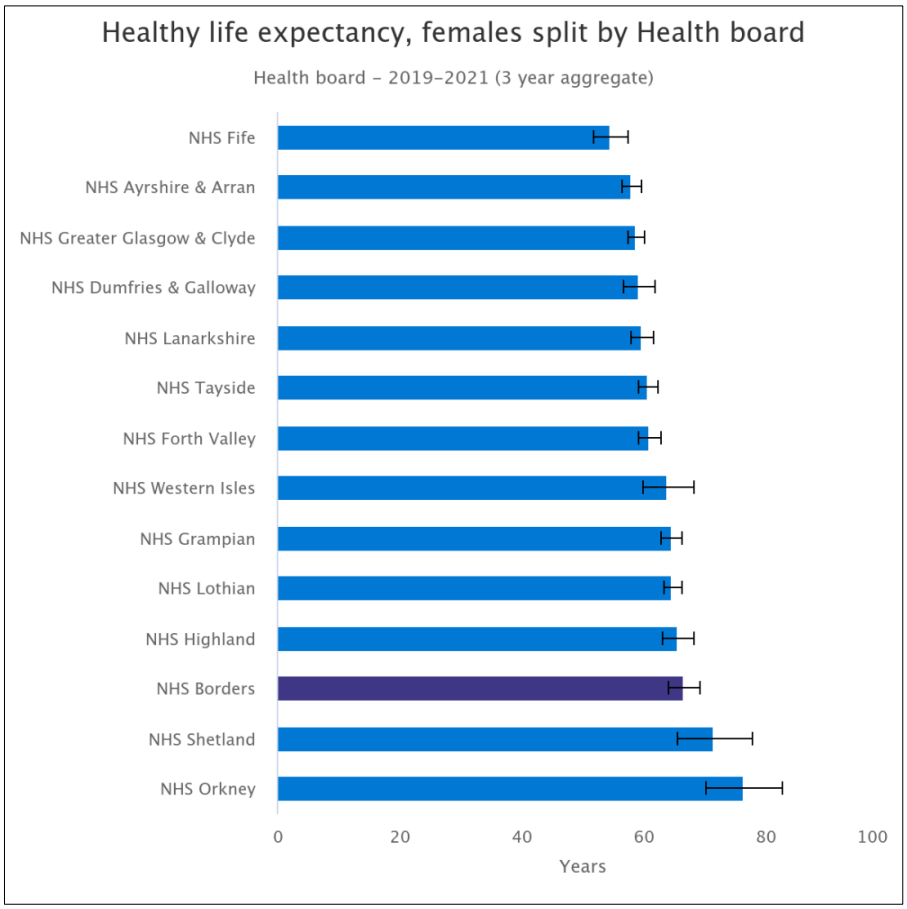
Life Expectancy in Scottish Borders

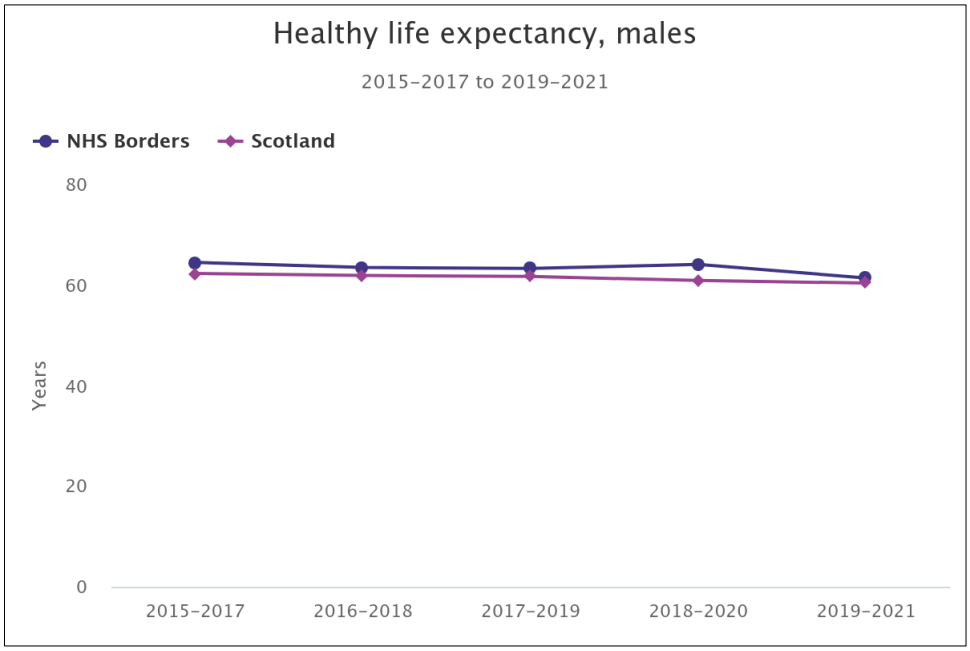
Life Expectancy and Healthy Life Expectancy have long been used as indicators of the health of a population. Life expectancy refers to the average number of years a person is expected to live based on current mortality rates. Healthy life expectancy, on the other hand, measures the number of those years a person can expect to live in good health, without major illness or disability. While life expectancy has generally increased globally, the gap between it and healthy life expectancy remains significant in many regions. This gap reflects years lived with chronic diseases, disabilities, or poor health. Closing this gap requires better healthcare,

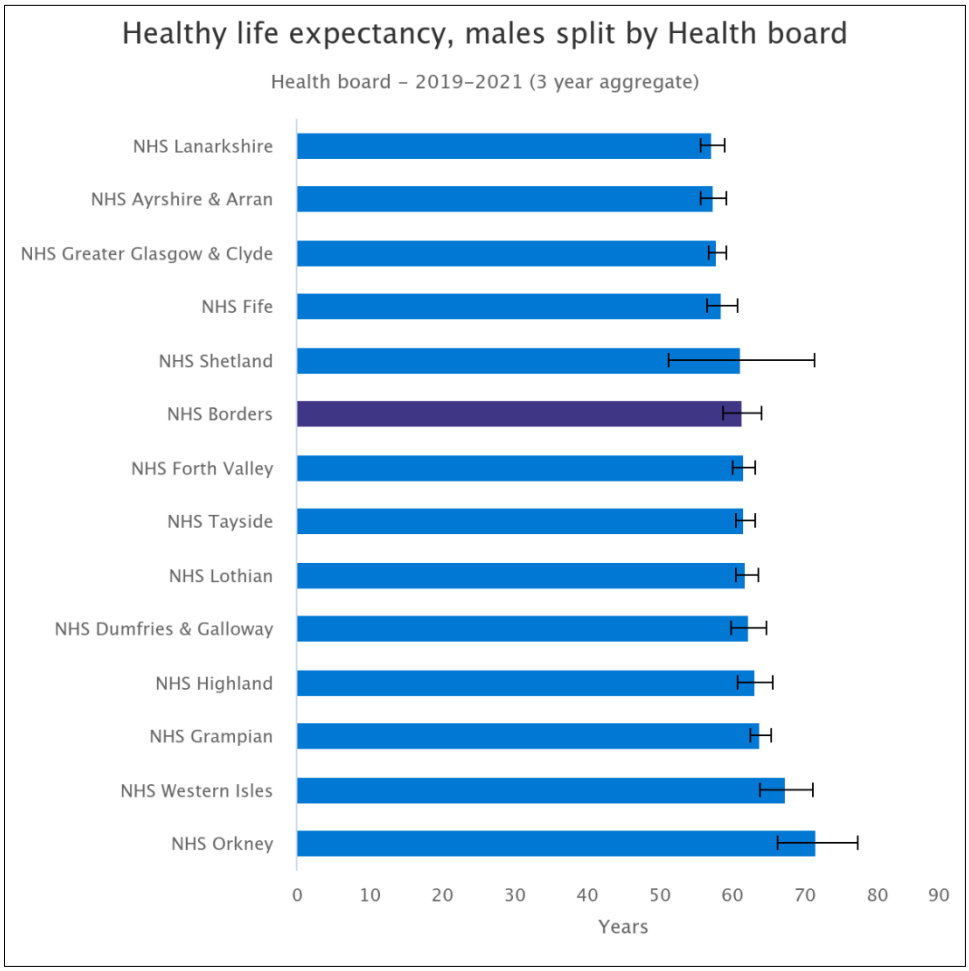
disease prevention, and lifestyle changes to ensure people not only live longer but also healthier lives.

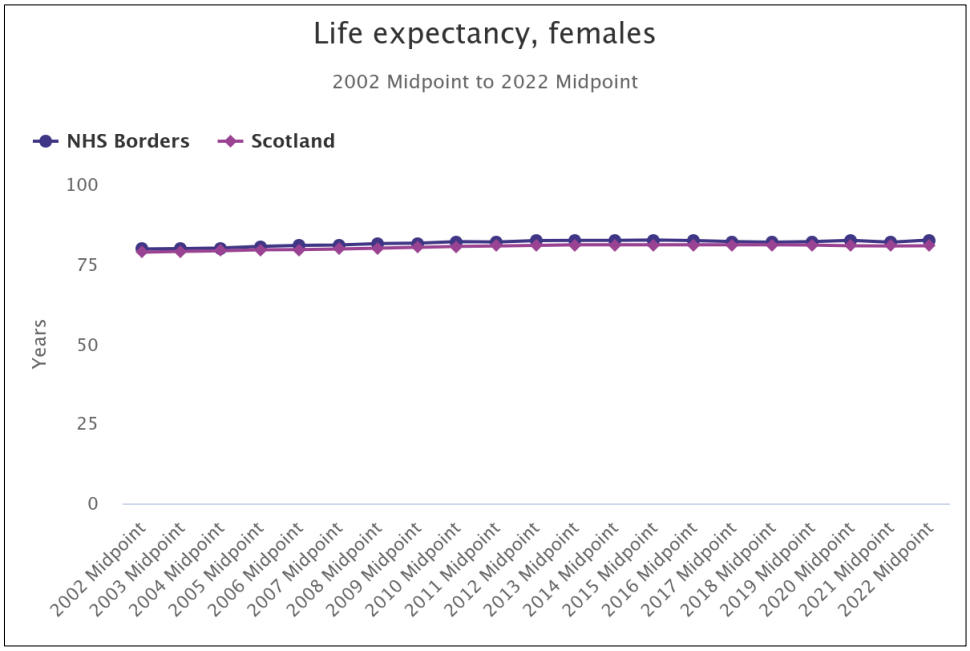
It can be seen in the following charts that in the Borders, our life expectancies have been static over the last decade, with the suggestion of a slight fall in healthy male life expectancy recently. Our male and female life expectancies are the highest of all mainland Boards. Female healthy life expectancy is also amongst the highest in the country, but for male healthy life expectancy our figure ranks only 9th out of the 14 Boards.

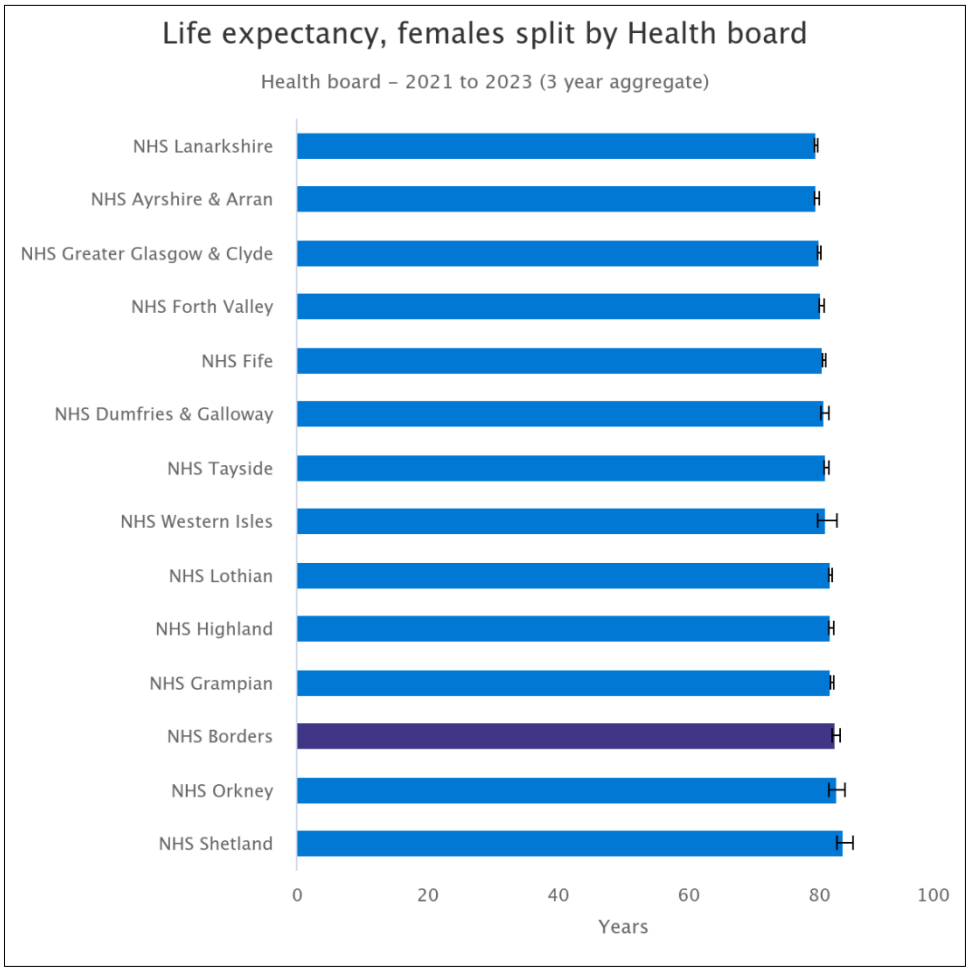




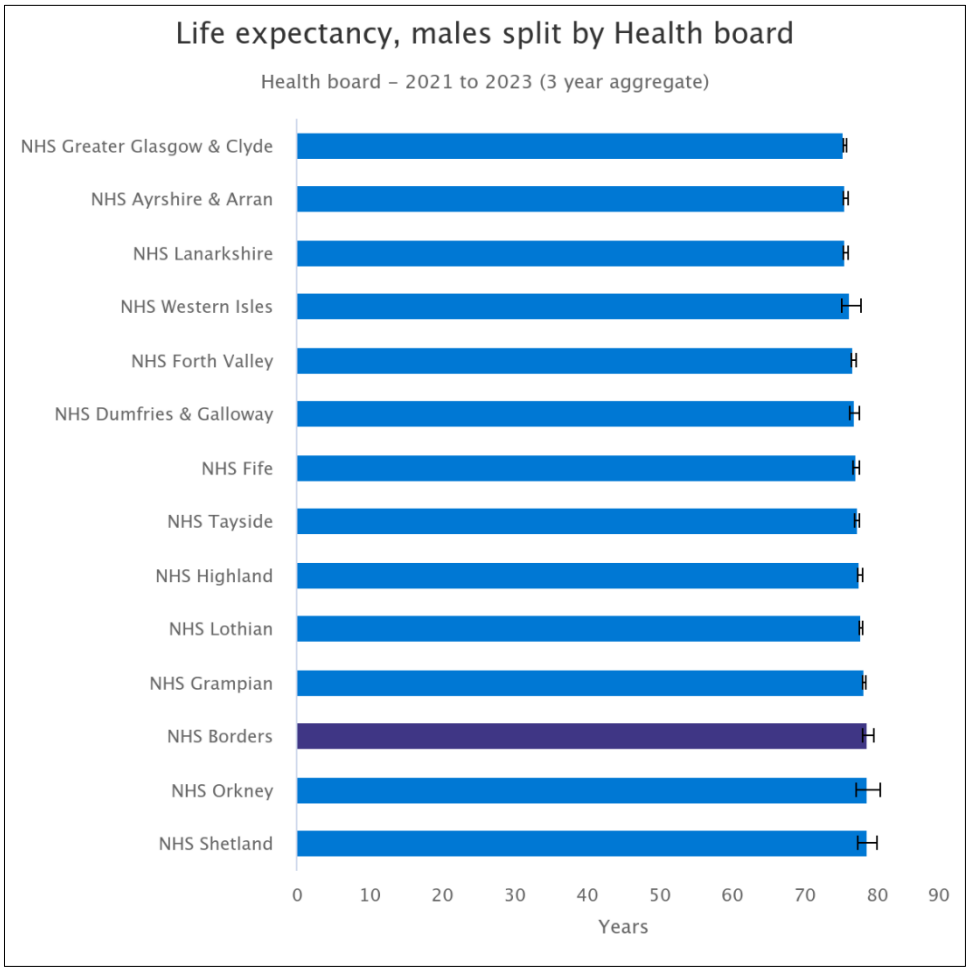

Healthy life expectancy, males
2015-2017 to 2019-2021
NHS Borders
Scotland
80
60
40
20
0
Years
2015-2017
2016-2018
2017-2019
2018-2020
2019-2021


Healthy life expectancy, males split by Health board
Health board - 2019-2021 (3 year aggregate)
NHS Lanarkshire
NHS Ayrshire & Arran
NHS Greater Glasgow & Clyde
NHS Fife
NHS Shetland
NHS Borders
NHS Forth Valley
NHS Tayside
NHS Lothian
NHS Dumfries & Galloway
NHS Highland
NHS Grampian
NHS Western Isles
NHS Orkney
0
10
20
30
40
50
60
70
80
90
Years


Life expectancy, females
2002 Midpoint to 2022 Midpoint
NHS Borders
Scotland
100
75
50
25
0
Years
2002 Midpoint
2003 Midpoint
2004 Midpoint
2005 Midpoint
2006 Midpoint
2007 Midpoint
2008 Midpoint
2009 Midpoint
2010 Midpoint
2011 Midpoint
2012 Midpoint
2013 Midpoint
2014 Midpoint
2015 Midpoint
2016 Midpoint
2017 Midpoint
2018 Midpoint
2019 Midpoint
2020 Midpoint
2021 Midpoint
2022 Midpoint

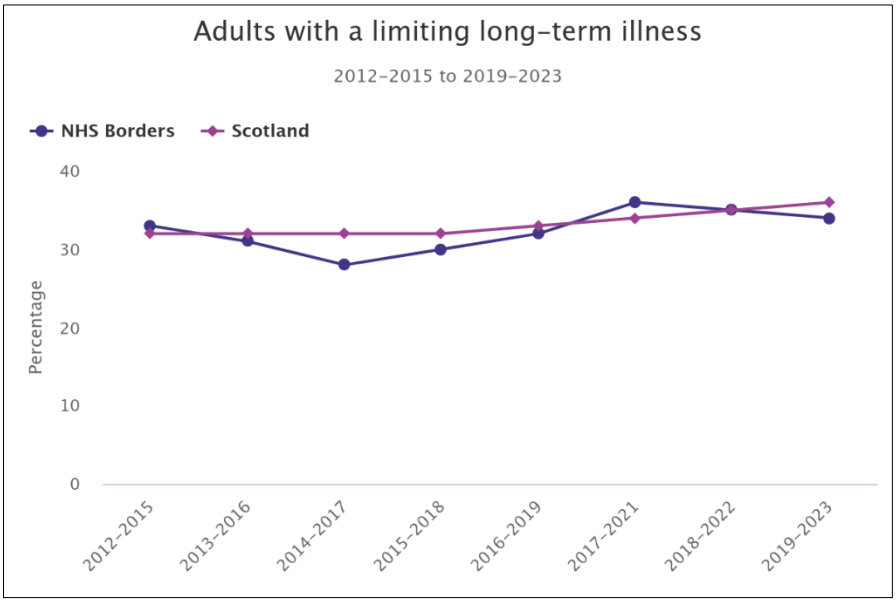

Life expectancy, females split by Health board
Health board – 2021 to 2023 (3 year aggregate)
NHS Lanarkshire
NHS Ayrshire & Arran
NHS Greater Glasgow & Clyde
NHS Forth Valley
NHS Fife
NHS Dumfries & Galloway
NHS Tayside
NHS Western Isles
NHS Lothian
NHS Highland
NHS Grampian
NHS Borders
NHS Orkney
NHS Shetland
0
20
40
60
80
100
Years

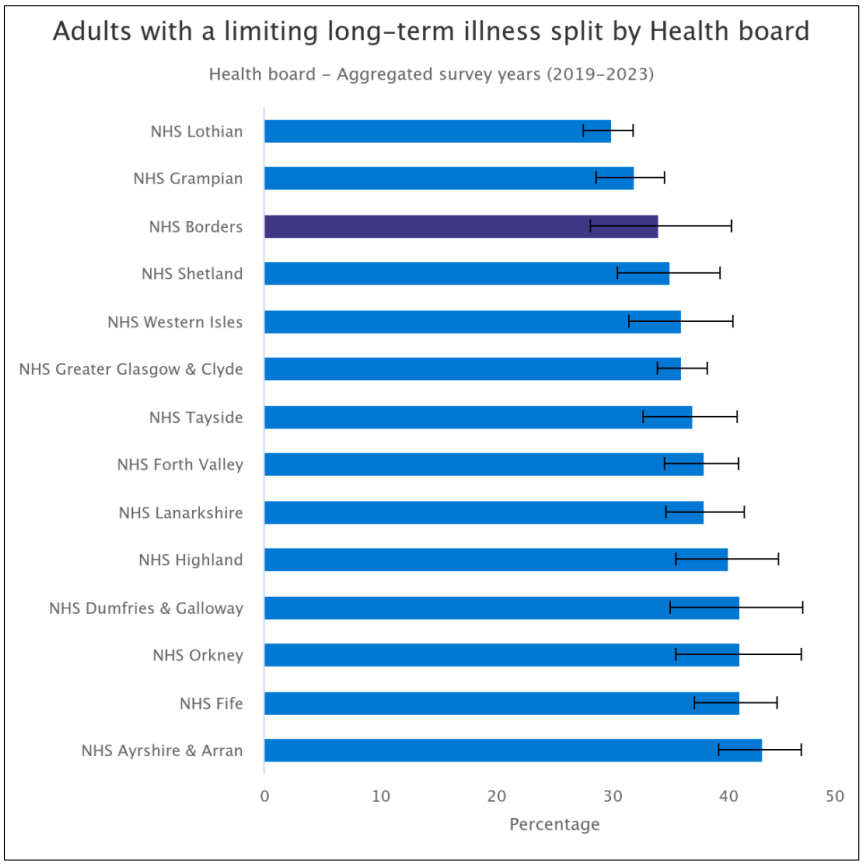

Life expectancy, males
2002 Midpoint to 2022 Midpoint
NHS Borders
Scotland
100
75
50
25
0
Years
2002 Midpoint
2003 Midpoint
2004 Midpoint
2005 Midpoint
2006 Midpoint
2007 Midpoint
2008 Midpoint
2009 Midpoint
2010 Midpoint
2011 Midpoint
2012 Midpoint
2013 Midpoint
2014 Midpoint
2015 Midpoint
2016 Midpoint
2017 Midpoint
2018 Midpoint
2019 Midpoint
2020 Midpoint
2021 Midpoint
2022 Midpoint


Life expectancy, males split by Health board
Health board – 2021 to 2023 (3 year aggregate)
NHS Greater Glasgow & Clyde
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Western Isles
NHS Forth Valley
NHS Dumfries & Galloway
NHS Fife
NHS Tayside
NHS Highland
NHS Lothian
NHS Grampian
NHS Borders
NHS Orkney
NHS Shetland
0
10
20
30
40
50
60
70
80
90
Years

Limiting Long Term Illness

Adults in the Borders are less likely to report living with a limiting long-term illness than many other areas, with NHS Borders having the third lowest reported rate of the 14 Boards. There is a suggestion from the trend graph (below) that the rate has been rising slightly, along with the rest of the country, but our small population means that there is some random year to year variation. Limiting long term illnesses would include things like mobility problems (e.g. arthritis, heart disease) or chronic conditions such as chronic obstructive pulmonary disease.





Early Deaths and Chronic Conditions

This section of the Rapid Review concerns early deaths (defined as under 75 years), cancer registrations, and deaths and admissions due to Coronary Heart Disease, Chronic Obstructive Pulmonary Disease and Childhood asthma.

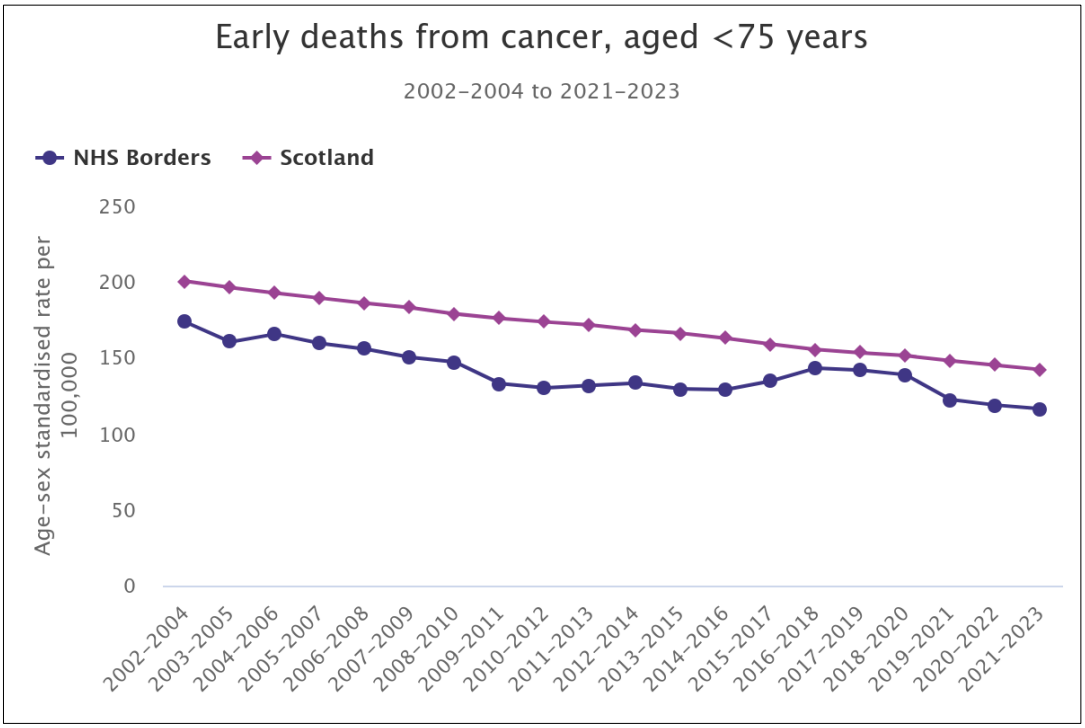
The rate of early cancer deaths in Borders is low, second only to Shetland. It is also on a long-term downward trend over the last two decades. Registrations are also low in NHS Borders – the lowest of all Boards between 2019 and 2023 – and on a fairly even trajectory with a slight drop in recent years.

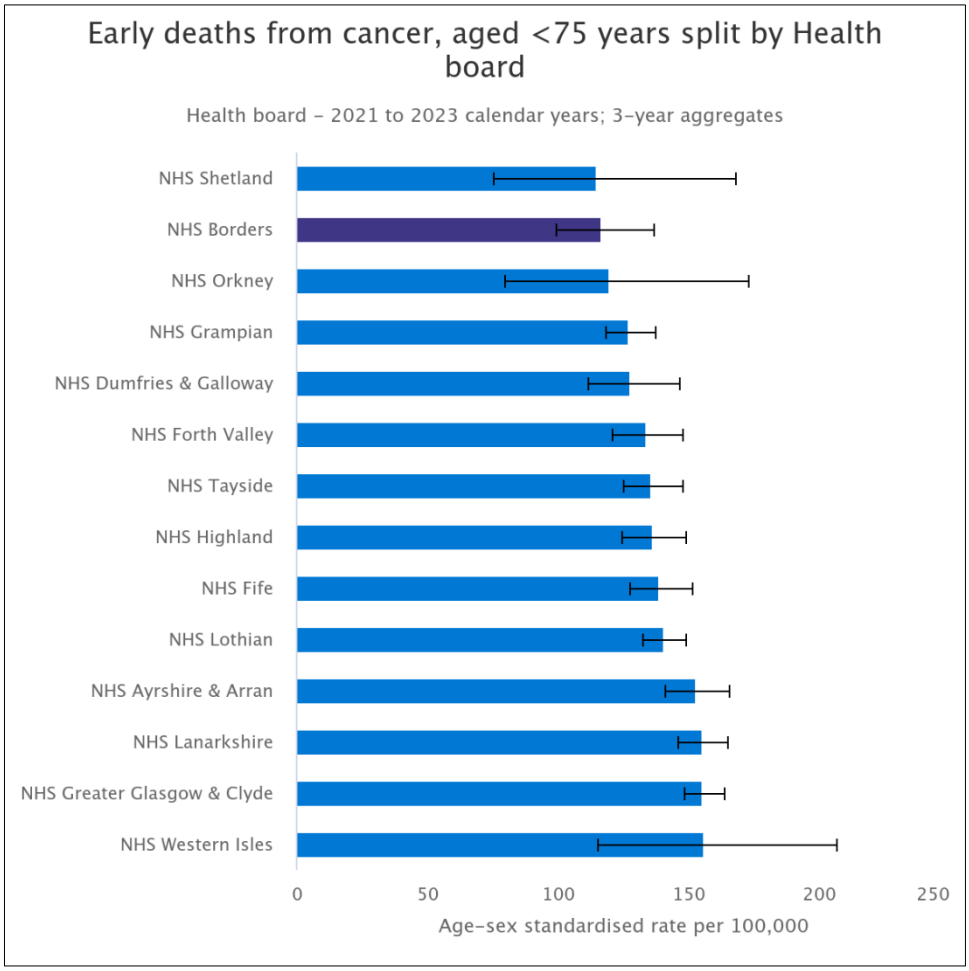
Early deaths from coronary heart disease have been on a marked downward trend since the beginning of the century, although the rate of decline has slowed, and the rates actually risen slightly over the last five years. Borders does have the third lowest rate of all Territorial Boards in Scotland.

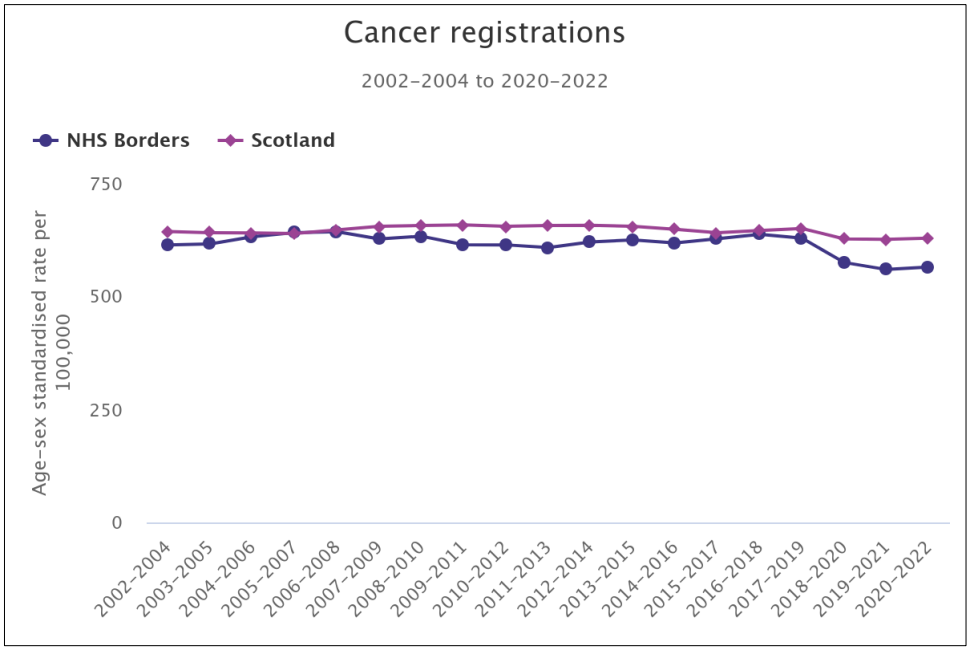
Chronic Obstructive Pulmonary Disease deaths under 75 years have fallen in Scotland and NHS Borders since the early 2000s. Again, Borders has a low rate compared to other areas, in this case second only to NHS Orkney.

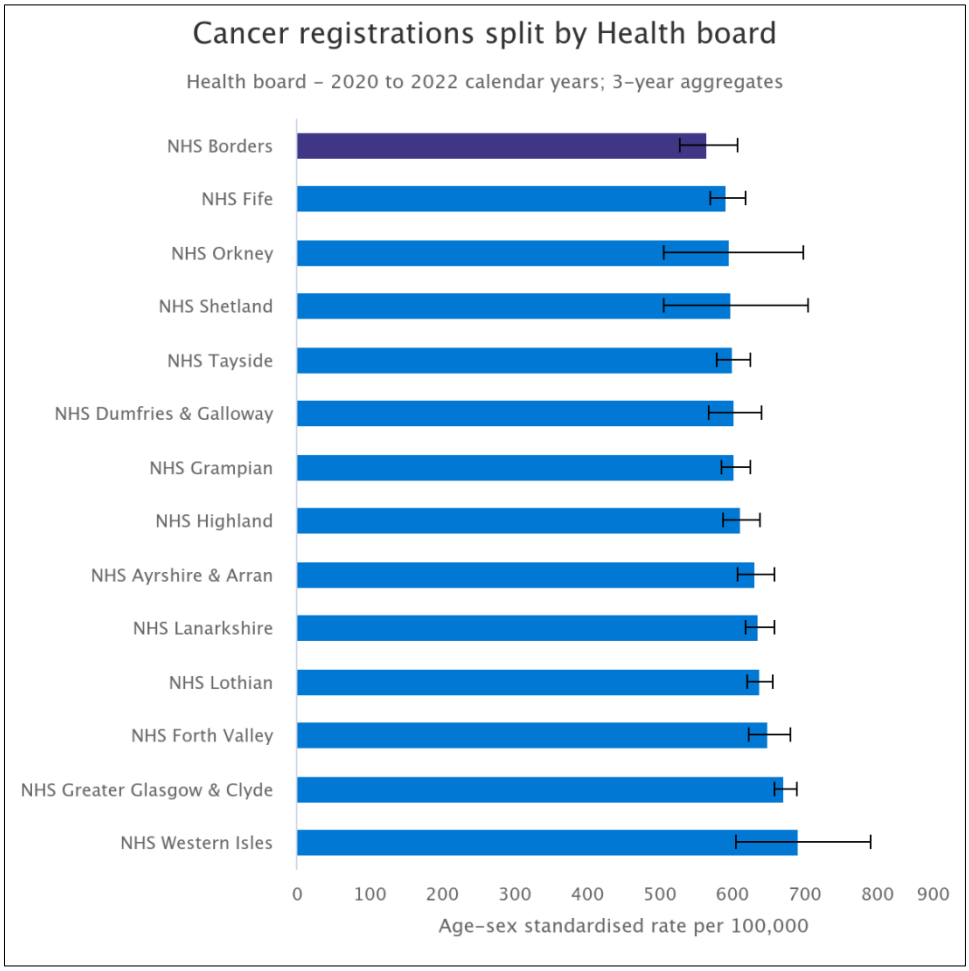
As highlighted above and also in the main report, many of these indicators affect disadvantaged communities more than their more affluent neighbours.

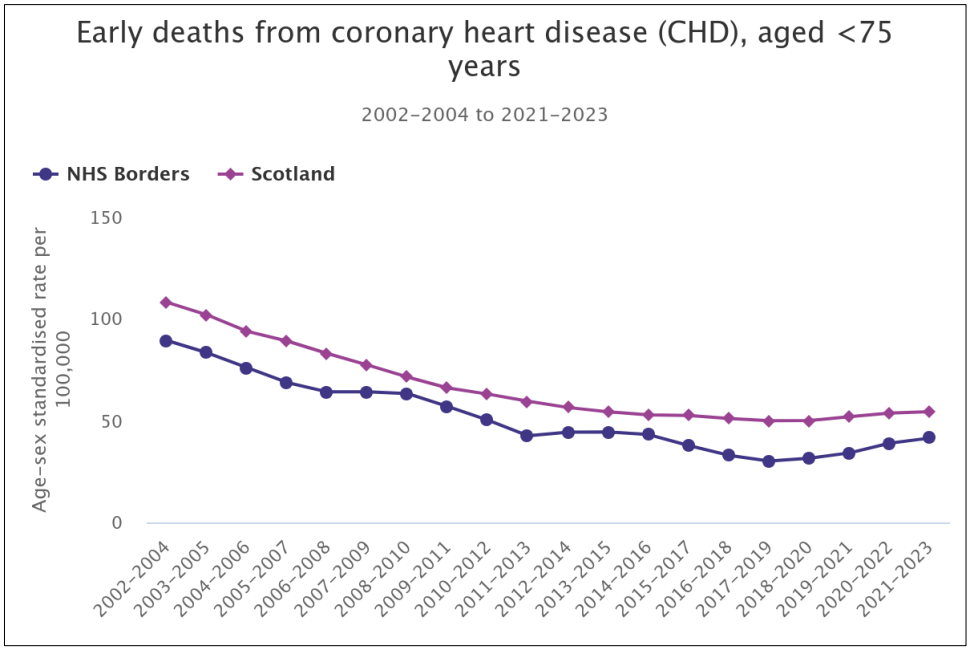
The final charts in this section show that the rate of children being admitted to hospital with asthma is low in Borders and, as with the rest of the country has been falling over time, with a slight increase for the most recent period which should be monitored.




Early deaths from cancer, aged <75 years split by Health board
Health board – 2021 to 2023 calendar years; 3-year aggregates
NHS Shetland
NHS Borders
NHS Orkney
NHS Grampian
NHS Dumfries & Galloway
NHS Forth Valley
NHS Tayside
NHS Highland
NHS Fife
NHS Lothian
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Greater Glasgow & Clyde
NHS Western Isles
0
50
100
150
200
250
Age-sex standardised rate per 100,000


Cancer registrations
2002-2004 to 2020-2022
NHS Borders
Scotland
750
500
250
0
Age-sex standardised rate per 100,000
2002-2004
2003-2005
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
2013-2015
2014-2016
2015-2017
2016-2018
2017-2019
2018-2020
2019-2021
2020-2022


Cancer registrations split by Health board
Health board – 2020 to 2022 calendar years; 3-year aggregates
NHS Borders
NHS Fife
NHS Orkney
NHS Shetland
NHS Tayside
NHS Dumfries & Galloway
NHS Grampian
NHS Highland
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Lothian
NHS Forth Valley
NHS Greater Glasgow & Clyde
NHS Western Isles
0
100
200
300
400
500
600
700
800
900
Age-sex standardised rate per 100,000


Early deaths from coronary heart disease (CHD), aged <75 years
2002-2004 to 2021-2023
NHS Borders
Scotland
Age-sex standardised rate per 100,000
150
100
50
0
2002-2004
2003-2005
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
2013-2015
2014-2016
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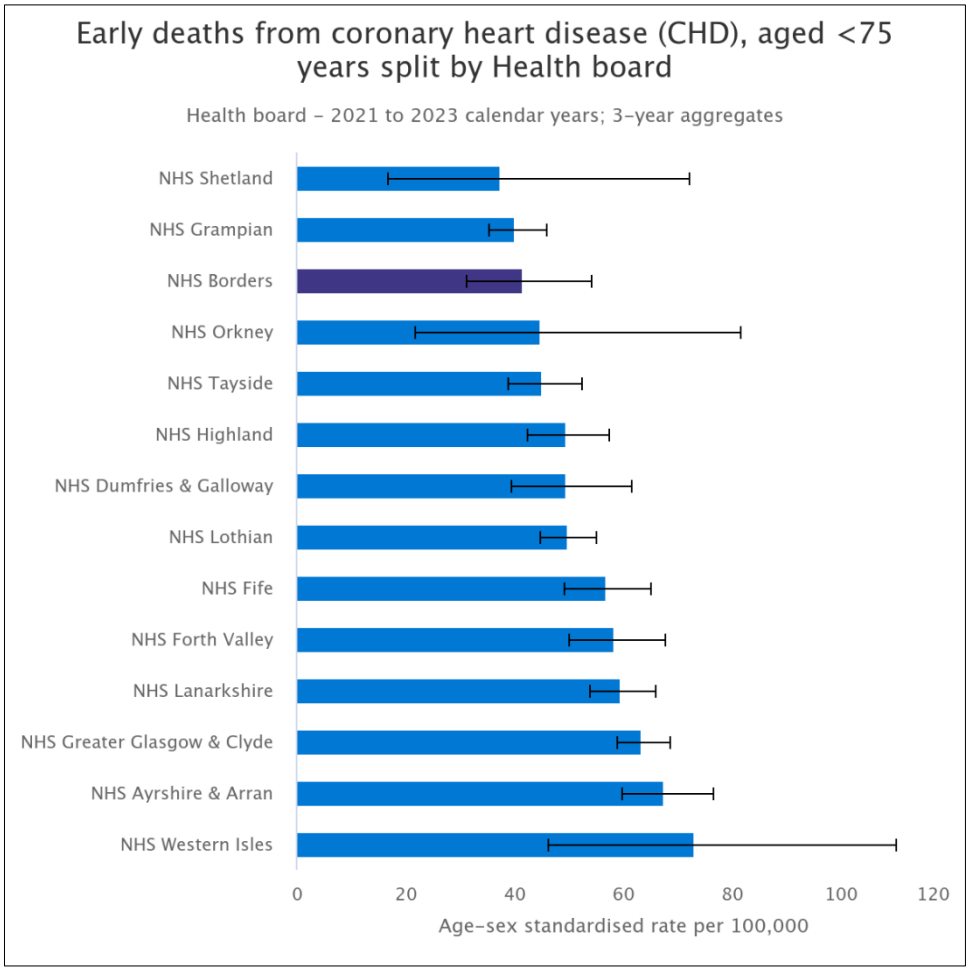
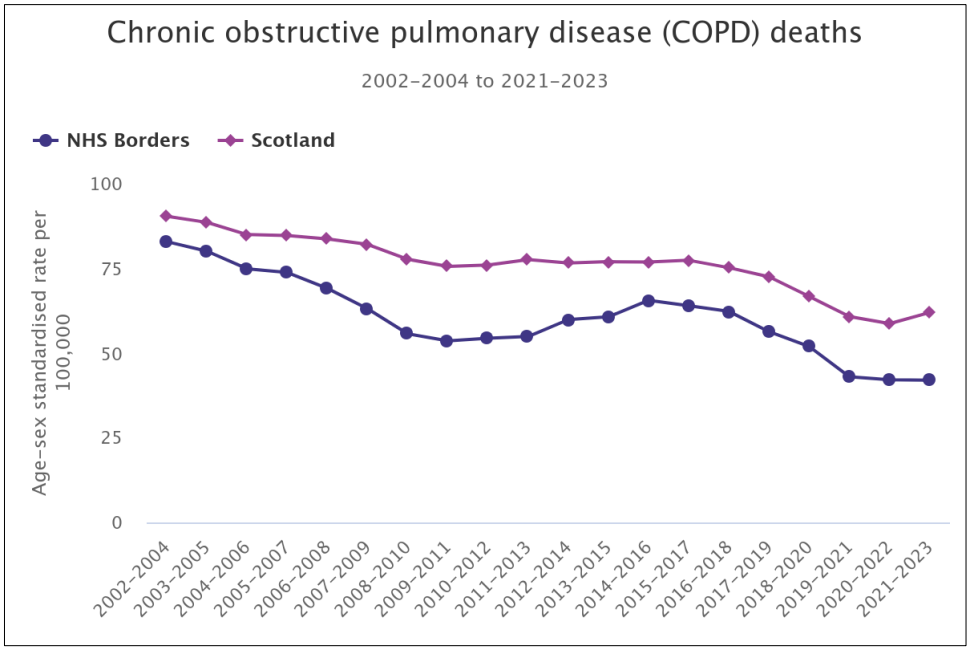
2017-2019
2018-2020
2019-2021
2020-2022
2021-2023


Early deaths from coronary heart disease (CHD), aged <75 years split by Health board
Health board – 2021 to 2023 calendar years; 3-year aggregates
NHS Shetland
NHS Grampian
NHS Borders
NHS Orkney
NHS Tayside
NHS Highland
NHS Dumfries & Galloway
NHS Lothian
NHS Fife
NHS Forth Valley
NHS Lanarkshire
NHS Greater Glasgow & Clyde
NHS Ayrshire & Arran
NHS Western Isles
0
20
40
60
80
100
120
Age-sex standardised rate per 100,000


Chronic obstructive pulmonary disease (COPD) deaths
2002-2004 to 2021-2023
NHS Borders
Scotland
Age-sex standardised rate per 100,000
100
75
50
25
0
2002-2004
2003-2005
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
2013-2015
2014-2016
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2018-2020
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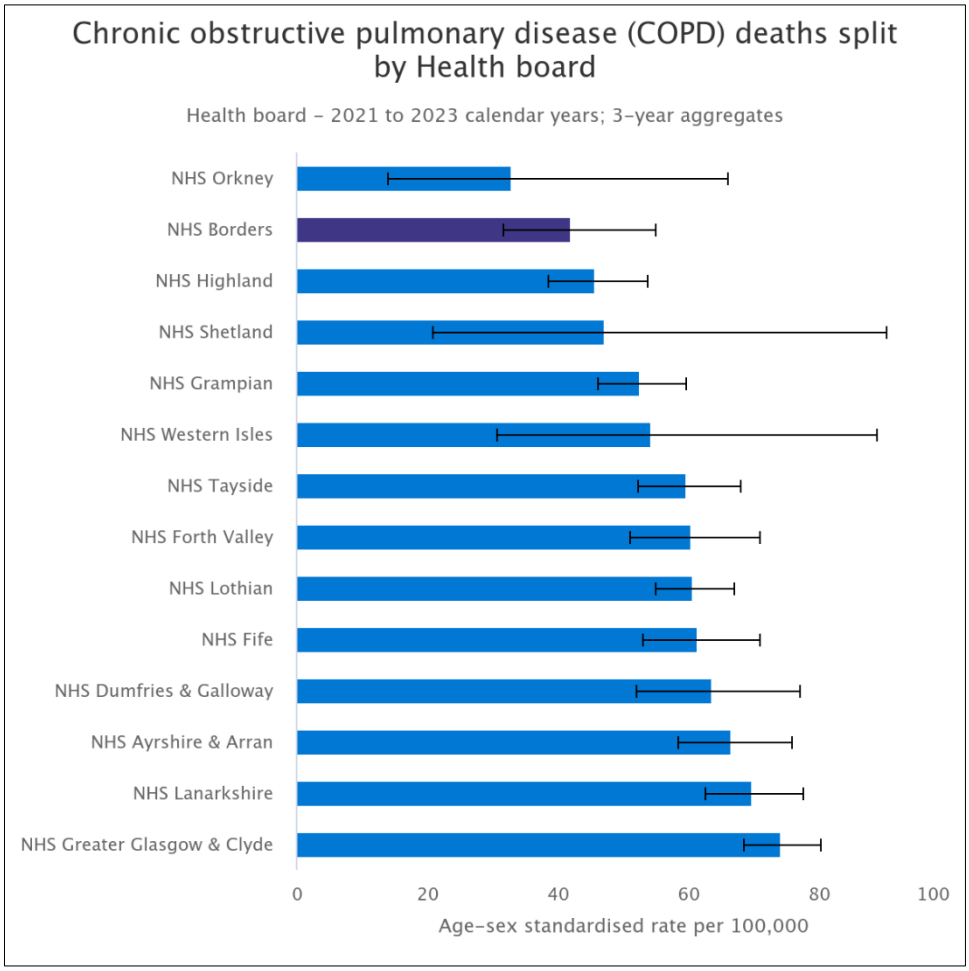
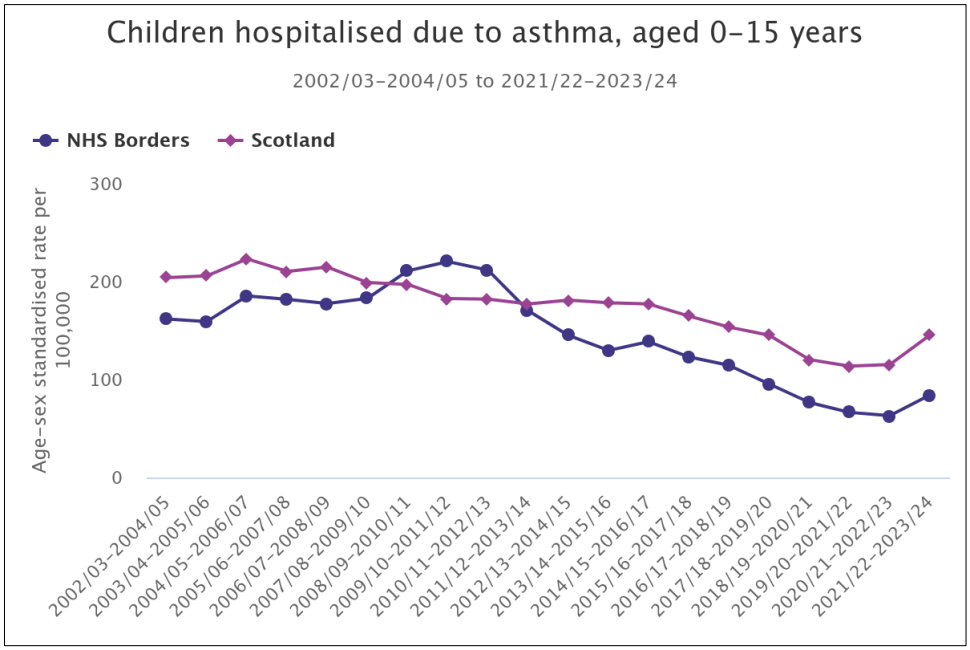
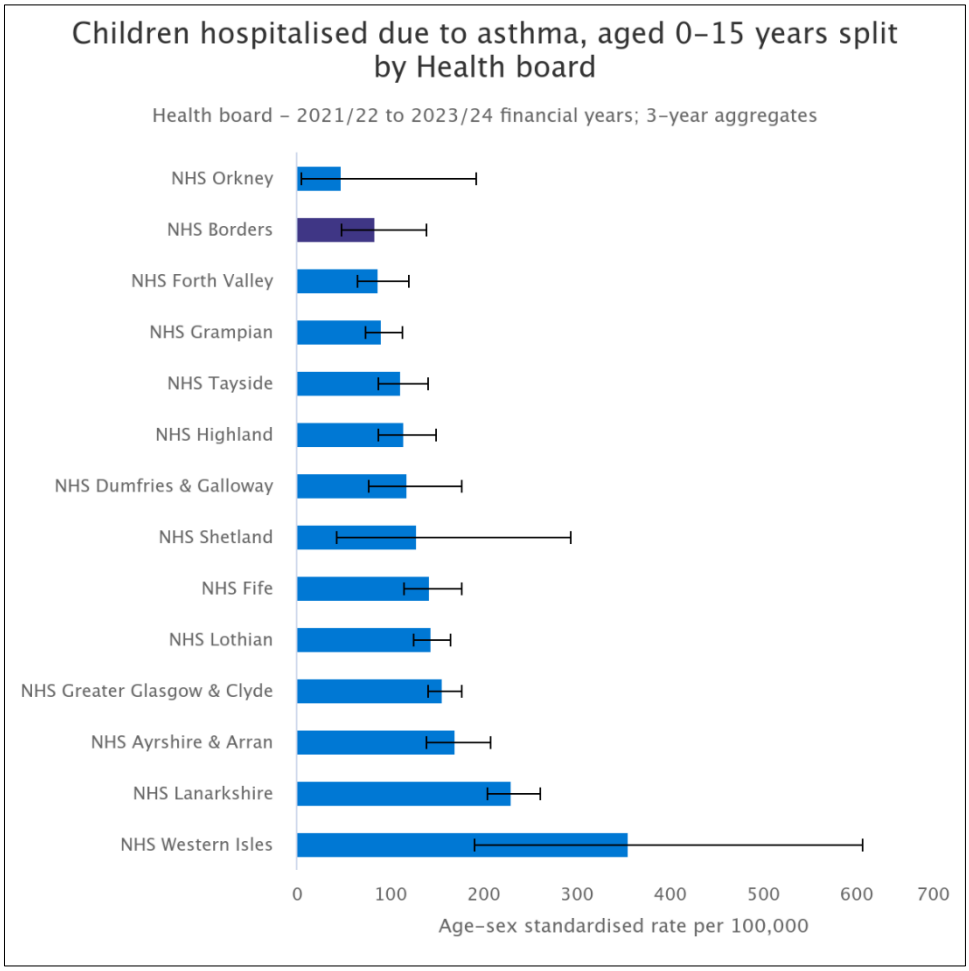
2020-2022
2021-2023


Chronic obstructive pulmonary disease (COPD) deaths split by Health board
Health board – 2021 to 2023 calendar years; 3-year aggregates
NHS Orkney
NHS Borders
NHS Highland
NHS Shetland
NHS Grampian
NHS Western Isles
NHS Tayside
NHS Forth Valley
NHS Lothian
NHS Fife
NHS Dumfries & Galloway
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Greater Glasgow & Clyde
0
20
40
60
80
100
Age-sex standardised rate per 100,000


Children hospitalised due to asthma, aged 0-15 years
2002/03-2004/05 to 2021/22-2023/24
NHS Borders
Scotland
Age-sex standardised rate per 100,000
300
200
100
0
2002/03-2004/05
2003/04-2005/06
2004/05-2006/07
2005/06-2007/08
2006/07-2008/09
2007/08-2009/10
2008/09-2010/11
2009/10-2011/12
2010/11-2012/13
2011/12-2013/14
2012/13-2014/15
2013/14-2015/16
2014/15-2016/17
2015/16-2017/18
2016/17-2018/19
2017/18-2019/20
2018/19-2020/21
2019/20-2021/22
2020/21-2022/23
2021/22-2023/24

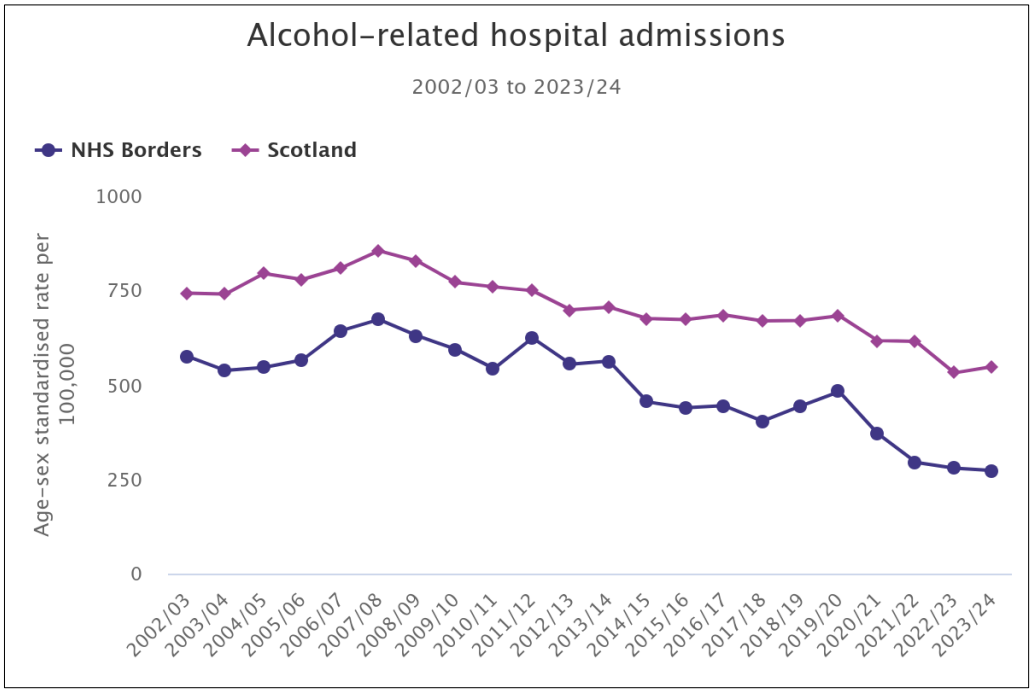


Alcohol and Drugs

This section looks at hospital admissions and deaths related to alcohol and drug use.

NHS Borders has the lowest admission rate for alcohol-related causes of all Boards, and – as with the rest of the country – the trend is downward. There has been a notable fall which coincided with the introduction of minimum alcohol pricing in 2018. Deaths are low in Borders and have been on a fairly level trend. Any reduction in deaths which are related to the minimum pricing policy is yet to be seen.

Drug-related deaths are also low in NHS Borders – the third lowest of all Boards. In common with Scotland, the trend has steeply upward between 2002 and 2017 but there has been a sustained fall since then.


Alcohol-related hospital admissions
2002/03 to 2023/24
NHS Borders
Scotland
Age-sex standardised rate per 100,000
1000
750
500
250
0
2002/03
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
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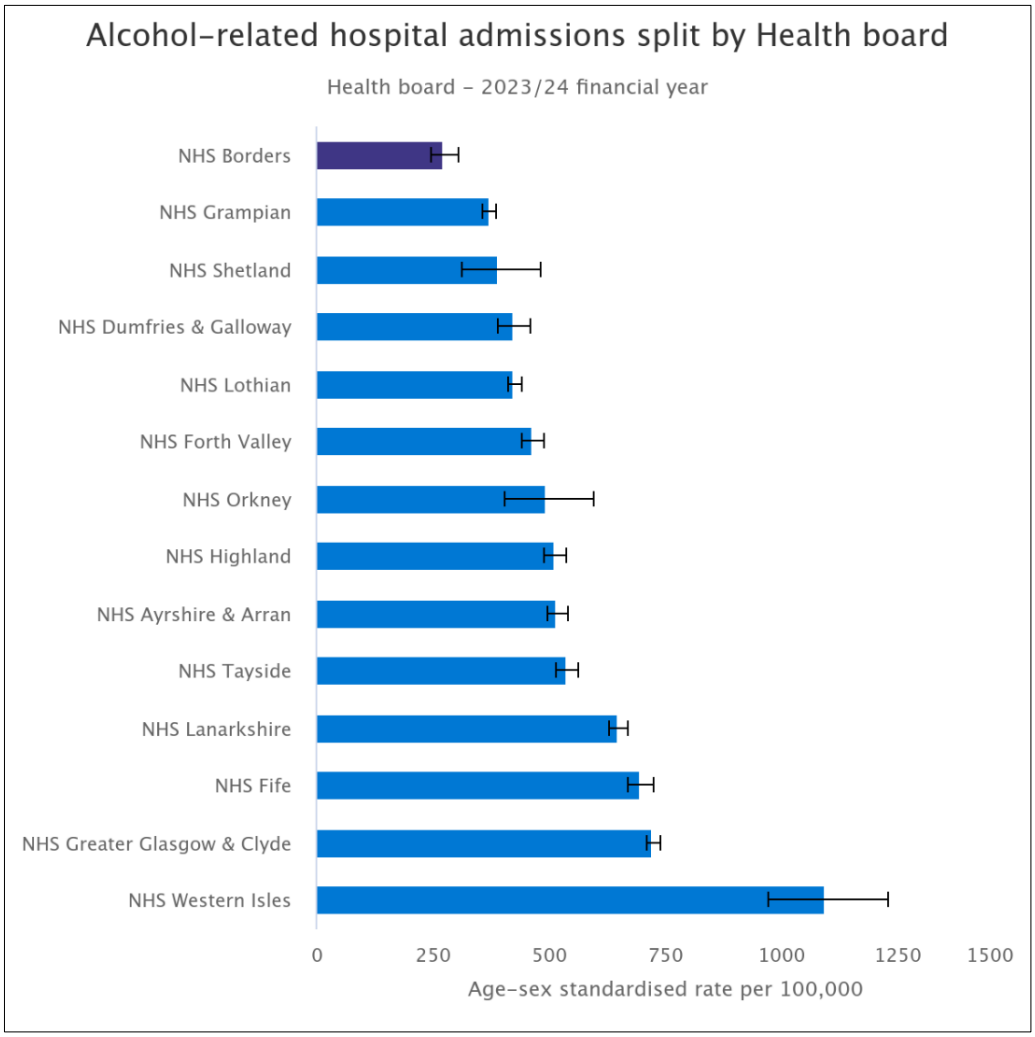
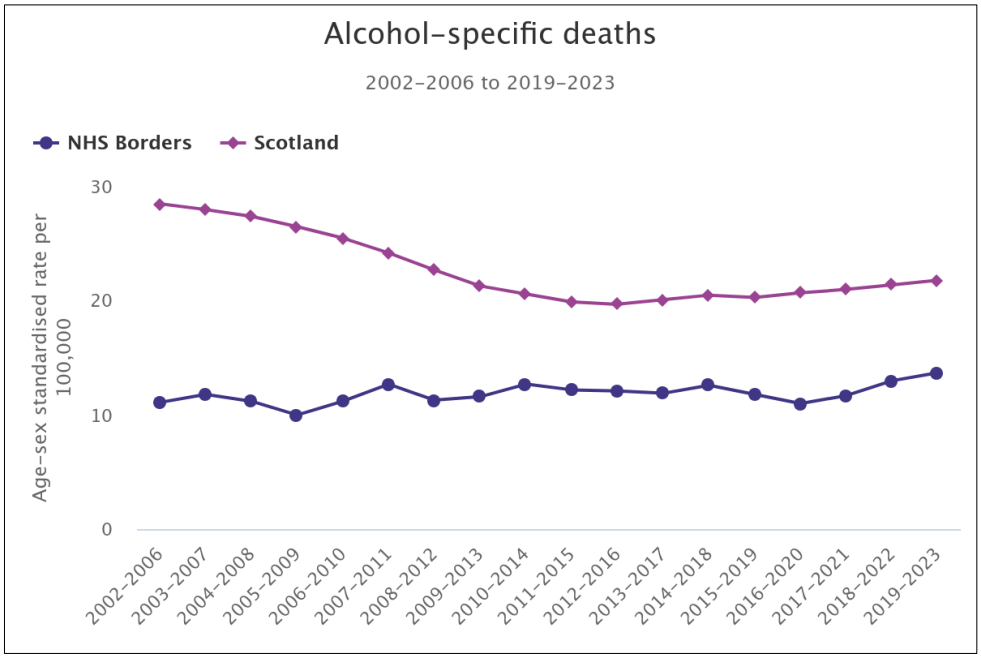
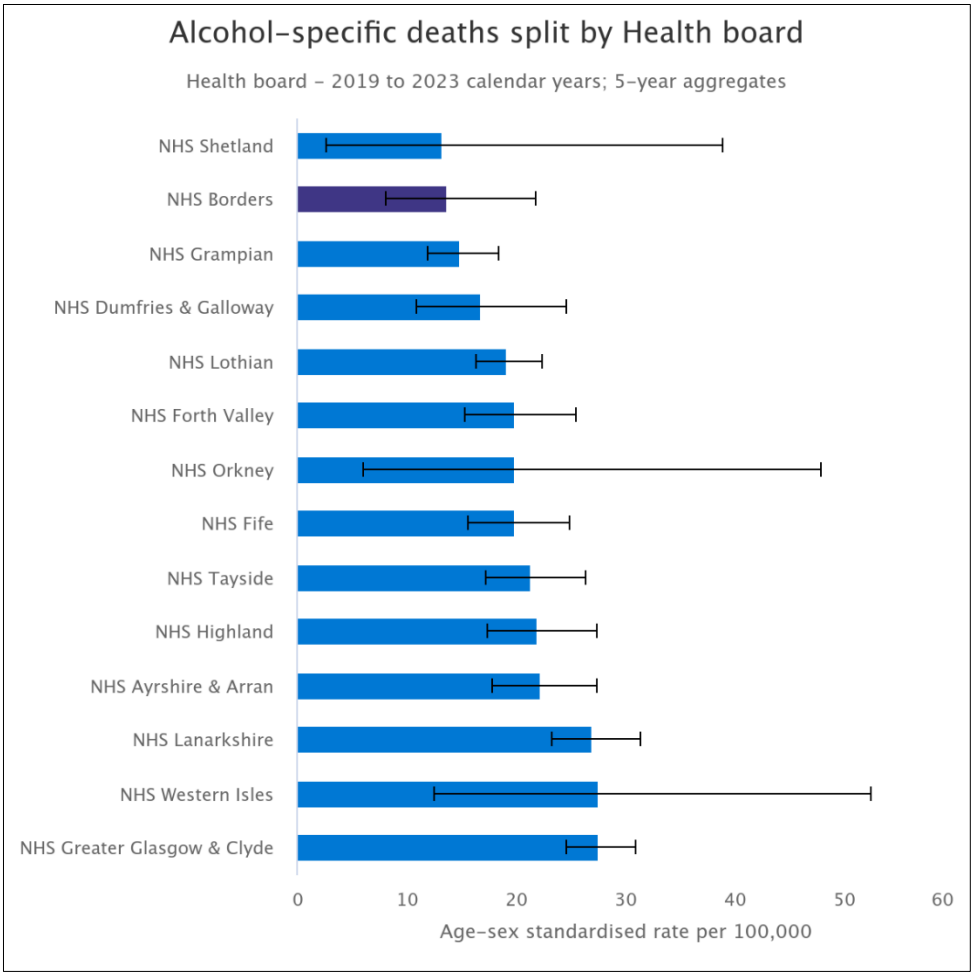
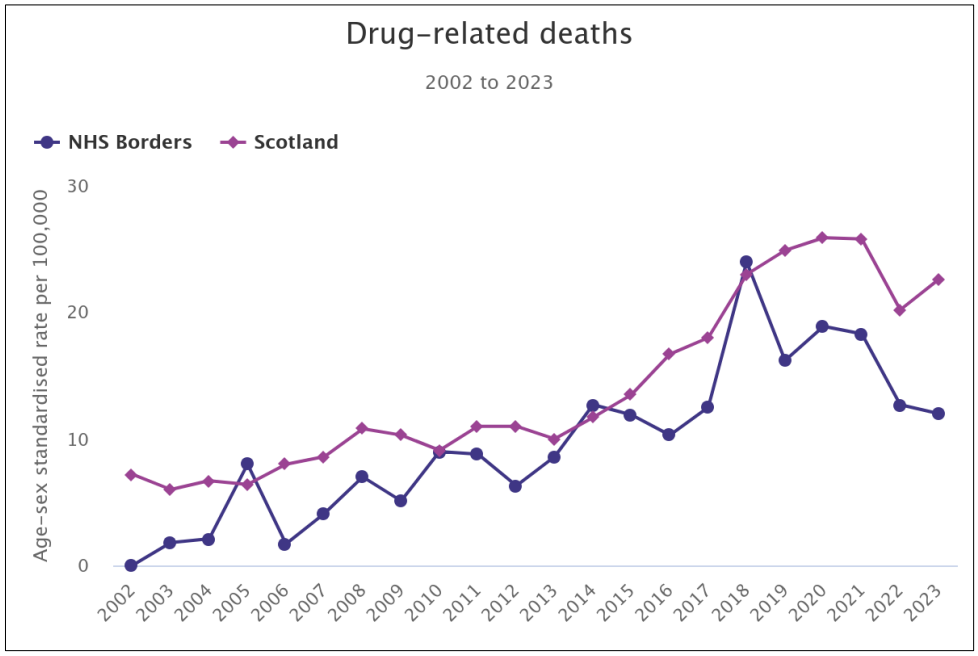
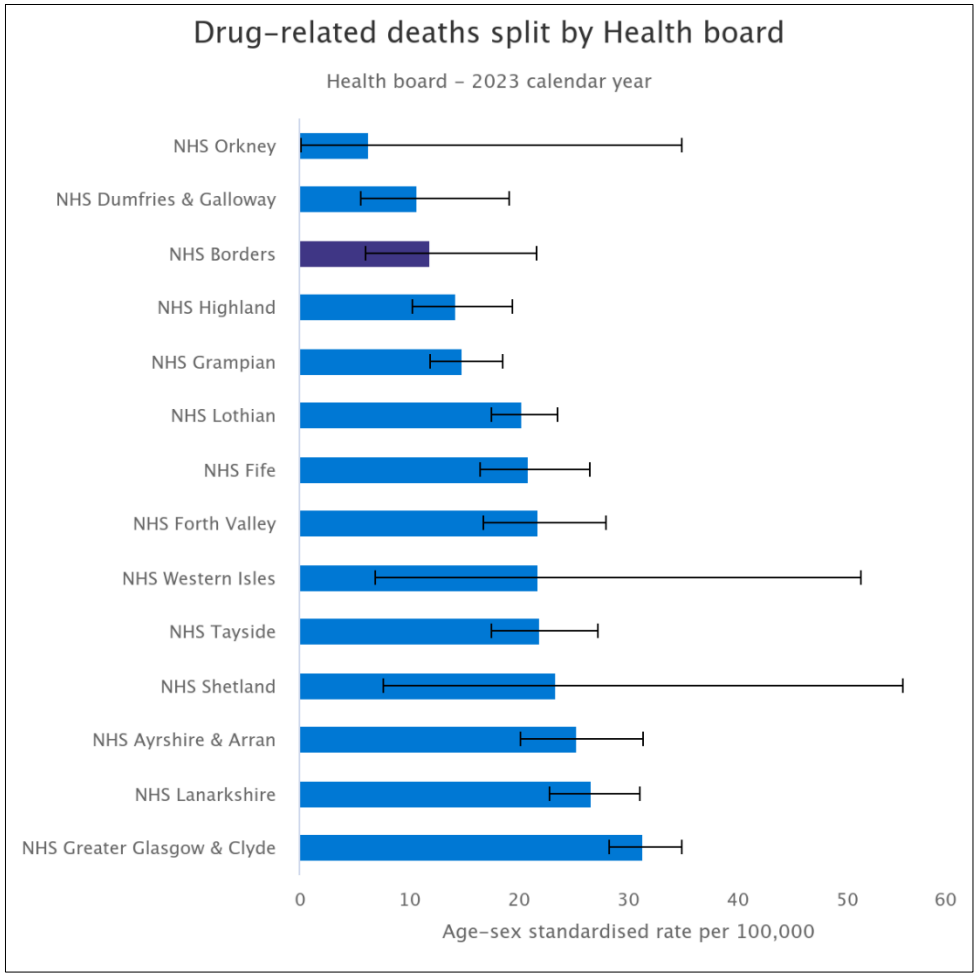
2021/22
2022/23
2023/24


Alcohol-related hospital admissions split by Health board
Health board - 2023/24 financial year
NHS Borders
NHS Grampian
NHS Shetland
NHS Dumfries & Galloway
NHS Lothian
NHS Forth Valley
NHS Orkney
NHS Highland
NHS Ayrshire & Arran
NHS Tayside
NHS Lanarkshire
NHS Fife
NHS Greater Glasgow & Clyde
NHS Western Isles
0
250
500
750
1000
1250
1500
Age-sex standardised rate per 100,000


Alcohol-specific deaths
2002-2006 to 2019-2023
NHS Borders
Scotland
Age-sex standardised rate per 100,000
30
20
10
0
2002-2006
2003-2007
2004-2008
2005-2009
2006-2010
2007-2011
2008-2012
2009-2013
2010-2014
2011-2015
2012-2016
2013-2017
2014-2018
2015-2019
2016-2020
2017-2021
2018-2022
2019-2023

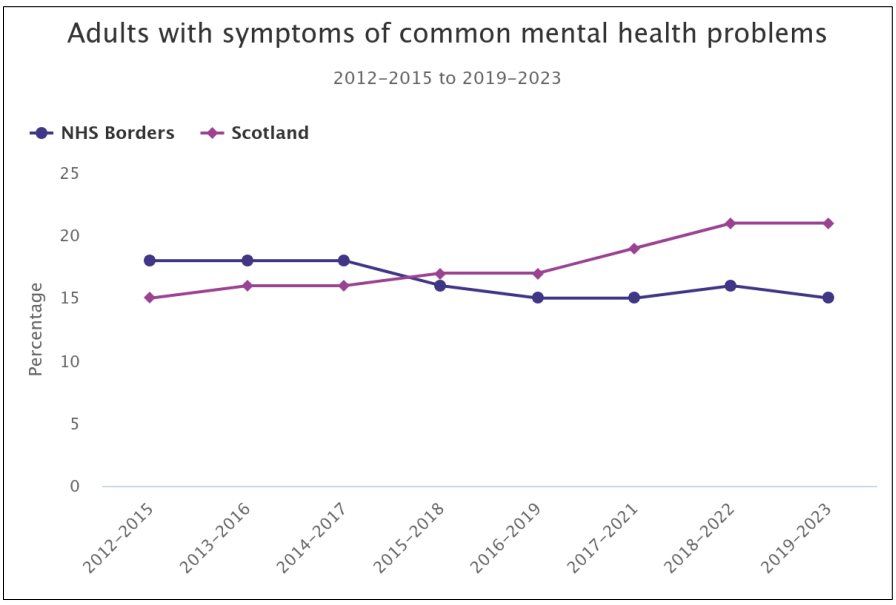

Alcohol-specific deaths split by Health board
Health board - 2019 to 2023 calendar years; 5-year aggregates
NHS Shetland
NHS Borders
NHS Grampian
NHS Dumfries & Galloway
NHS Lothian
NHS Forth Valley
NHS Orkney
NHS Fife
NHS Tayside
NHS Highland
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Western Isles
NHS Greater Glasgow & Clyde
0
10
20
30
40
50
60
Age-sex standardised rate per 100,000

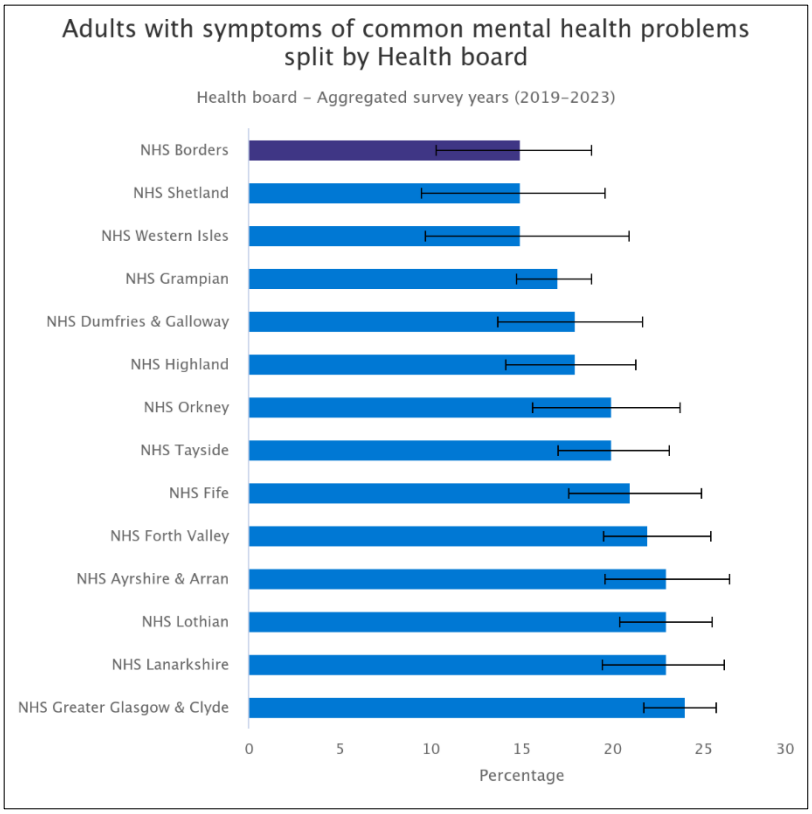

Drug-related deaths
2002 to 2023
NHS Borders
Scotland
Age-sex standardised rate per 100,000
30
20
10
0
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023


Drug-related deaths split by Health board
Health board - 2023 calendar year
NHS Orkney
NHS Dumfries & Galloway
NHS Borders
NHS Highland
NHS Grampian
NHS Lothian
NHS Fife
NHS Forth Valley
NHS Western Isles
NHS Tayside
NHS Shetland
NHS Ayrshire & Arran
NHS Lanarkshire
NHS Greater Glasgow & Clyde
0
10
20
30
40
50
60
Age-sex standardised rate per 100,000

Mental Health

Public Health Scotland have collected data regarding mental health symptoms and the following two charts show that the percentage of respondents reporting symptoms of a common mental health problem (for example low mood, anxiety, sleep disturbance) is lowest of all Boards in Scotland. In 2012 the rate was slightly above the national rate but has fallen in recent years, whereas the Scottish rate has risen.





Key Points and Conclusion

This Rapid Review of the health of NHS Borders population has looked at a wide range of indicators available.

Regarding the overall burden of disease, the top three reported issues locally are lower back & neck pain, depression, and headache. These three areas make up a large proportion of the primary care workload. For deaths, the top three causes were ischaemic heart disease, lung cancer and dementia, although our absolute rates were lower than other East region Boards.

Scottish Public Health Observatory data show that for the conditions examined, many rates are lower than other boards. Life expectancy for males and females is amongst the highest of all Boards, as is female healthy life expectancy. For males, healthy life expectancy is less good – ranking seventh among the 14 Boards.

Chronic diseases deaths and hospitalisations are on a downward trend, but the rates for children asthma admissions may be rising slightly and needs monitoring.

There has been a fall in alcohol admissions since 2018, which may be associated with the introduction of minimum unit pricing.

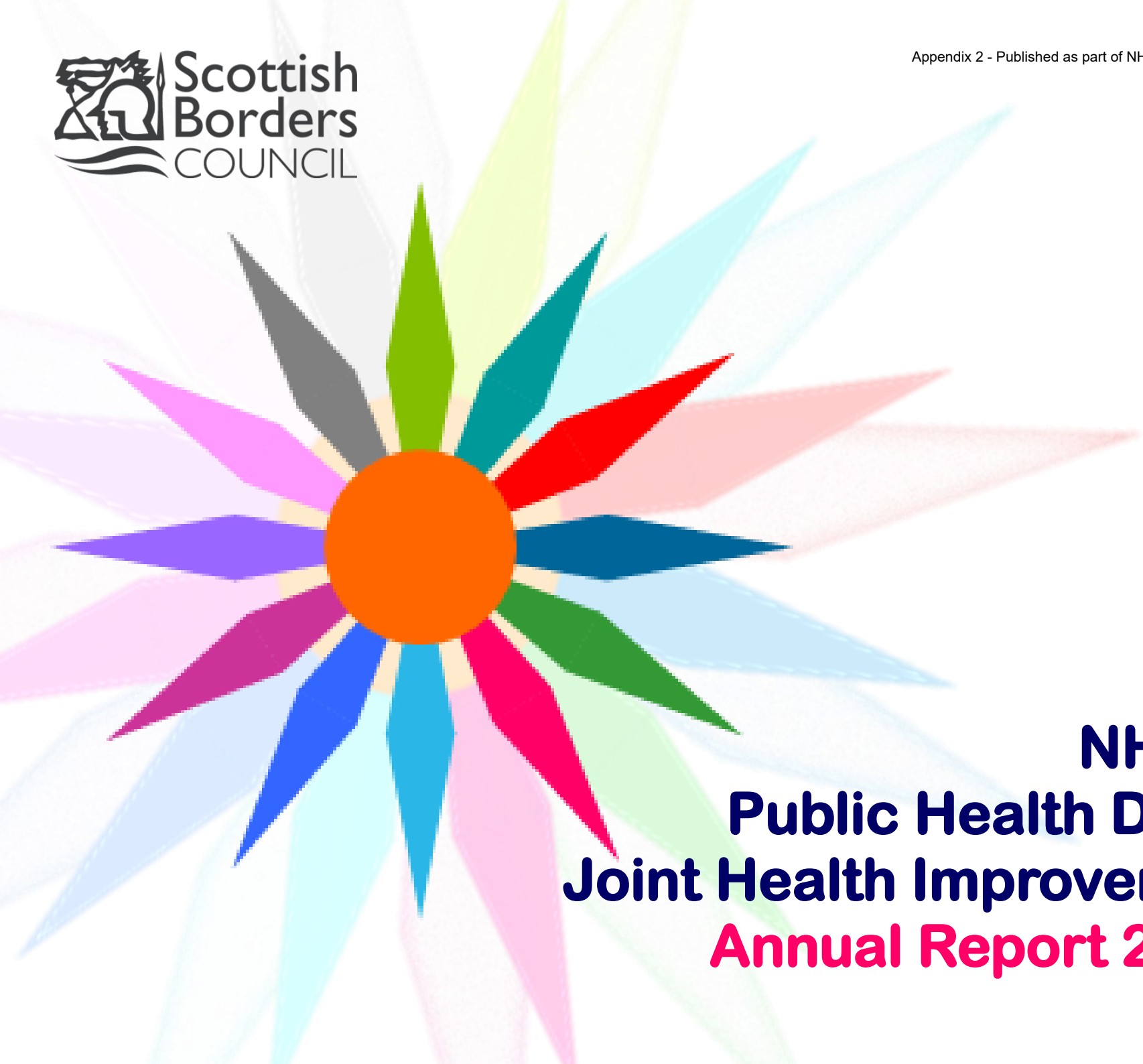
Regarding future public health reporting, it should be noted that we are currently lacking detailed metrics in several key areas such as:

- Housing affordability – e.g. average house price compared to average local income
- Distance to nearest large supermarket (capturing price and availability of food)
- Multiple house ownership
- Average fuel cost

In future, efforts will be made to capture metrics such as these and to monitored and reported on trends Director of Public Health Reports.

Scottish Borders COUNCIL

NHS Borders



NHS Borders
Public Health Department
Joint Health Improvement Team
Annual Report 2023 - 2024

Contents

Introduction

The year's Public Health - Joint Health Improvement Team's (JHIT) Annual Report is presented to reflect each of Scotland's six Public Health Priorities and aims to share highlights or insights into the work of our skilled and experienced team members. On that basis not all of our work is presented within the report.

The overall aim of JHIT is to reduce inequalities in health by promoting good health throughout the life stages; building capacity and capability within our communities and workforce and creating a healthier future for all.

We are pleased to include updates in relation to our plans for 2023 - 24 outlined in last year's report including the further delivery of our plans relating to Mentally Healthy Communities and Suicide Safer Communities through community workshops; contributing to national research into understanding parent and carers view about relationships, sexual health and parenthood (RSHP) education and re-launching the C-Card condom and ongoing work to support healthy eating.

During the year we were pleased to support delivery of NHS Borders Staff Wellbeing Week through Public Health staff participating in the planning group and also co-ordination and delivery of health improvement activities.

I would like to note the changes within our Senior Leadership Team. Pippa Walls, our Public Health Lead for Mental Health and Suicide Prevention/Wellbeing Service retired in June 2023 and we thank her for her passionate service. We are pleased to welcome Claire McElroy into this role.

This report was written during the process of a Public Health Service Review. I would like to thank all concerned for their ongoing commitment over the year and through this process.

Fiona Doig

Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership

NHS Borders Public Health Department Joint Health Improvement Team (JHIT)

JHIT is part of NHS Borders Public Health Department and the staff team includes members from both NHS Borders and Scottish Borders Council.

Our team is led by the Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership.

We have three lead roles who support their dedicated teams in the following areas:

Public Health Lead for Children and Young People/Child Health Commissioner	Public Health Lead for Mental Health/Wellbeing Service Lead	Health Improvement Lead for Communities
• Maternal & Infant Nutrition • Child Healthy Weight • Emotional Health and Wellbeing • Children's Rights • Substance Use Education • The Promise • Child Poverty & Financial Inclusion • Young People's Engagement	• Wellbeing Service • Adult Mental Health and Wellbeing • Creating Hope Action Plan	• Health Inequalities and Anti-Poverty Work • Food Security, Physical Activity and Diabetes Prevention • Communities • Older People • Sustainable Communities

This work is delivered with the support of our Administration Team.

Public Health Priorities for Scotland

Public Health Priorities

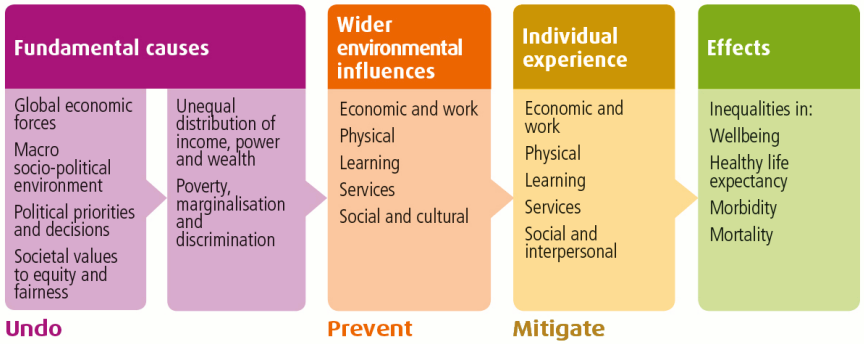
The Scottish Government has agreed a clear set of related and inter-dependent priorities for Scotland which are:

1. **A Scotland where we live in vibrant, healthy and safe places and communities**
2. **A Scotland where we flourish in our early years**
3. **A Scotland where we have good mental wellbeing**
4. **A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs**
5. **A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all**
6. **A Scotland where we eat well, have a healthy weight and are physically active**

The agreed priorities reflect public health challenges to focus on over the next decade to improve the public's health.

Public Health Scotland

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. The gaps between those with the best and worst health and wellbeing still persist, and some are expected to increase due to the impact of COVID-19 pandemic. For example, in the most recent data at the moment the difference in life expectancy in Borders for women in the most deprived communities compared to least deprived is 13.9 years (76.4 compared to 90.3) while for men it is 10.6 years (73 compared to 83.6).



As the diagram shows, significant influences on health inequalities are due to what is referred to as the 'fundamental causes', or 'structural causes' of inequality such as geopolitical, environmental; and income distribution and unlikely to be impacted at a local level. However, at a local level, including within JHIT, we can seek to prevent wider environmental influences such as the impact of planning, for example, safe walking or cycling routes. We can also work to mitigate the impact of inequalities on individuals, families and communities through activities such as training and skills building.

Activities Overview and Data

Walk It

- Walk It Groups **48**
- Active Walkers **1470**
- Active Walk Leaders **35**
- Dementia Friendly Walks **29**

Information as of January 2024

Healthy Start Vitamins

- Women's **1911**

Vitamin D

- Women's **1038**
- Children's **2952**

Quit Your Way Apr 23 - Jan 24)

- Quit attempts **387** (459 in 2022-23)
- Successful quits at 3 months post quit date **81** (121 in 2022 - 23)

Local Delivery Plan - Our LDP target is based on quits in the most deprived 40% of the Borders population (effectively SIMD 2020 1 and 2) rather than all quits.

- Quit attempts **210** (279 in 2022-23)
- Successful quits at 3 months post quit data **38** (80 in 2022 - 23)
- Three month quit rate: **18%** (29% in 2022-23)

Data from NHS Scotland Smoking Cessation System

JHIT Training

- Participants **395**
- Courses **26**

Wellbeing Service

- New referrals **1284** (New referral split - Mental Health 58%, Smoking 26%, Lifestyle 16%)
- Average **107** per month
- Consultations **7135**

Money Worries App

- Total downloads **1947**
- Year 3 - 23/24 downloads **320**
- Testing phased - Year 2 - 22/23 downloads **1627**

Breastfeeding in the Borders (BiBs)

- Volunteers **28**
- BiBs requests at discharge **301**
- Seen on ward **100**
- Attendance at groups **638**

Community Food Work (CFW)

- Weaning (virtual & face to face) **103** parents/carers and **3** health professionals
- Early Years Centre summer programmes **42** parents/carers and **72** children
- Other CFW **43** parents/carers and **27** children

Training and Capacity Building

The table below presents the range of courses and number of people who attended these across the Public Health Priorities.

Public Health Priority Area	Participants & Courses Offered
1 - A Scottish Borders where we live in vibrant, healthy safe places and communities	**Participants - 19** • Low and Slow
2 - A Scottish Borders where we flourish in our early years	**Participants - 65** • Solihul • Infant Feeding and Relationship Building • Healthy Beginnings: MAP Training
3 - A Scottish Borders where we have good mental wellbeing	**Participants - 247** • Be Suicide ALERT • Applied Suicide Intervention Skills Training (ASIST) • Mental Health Improvement/Suicide Prevention Informed Children & Young People • Six Ways to Be Well • Mental Health Improvement/Suicide Prevention Awareness Session • Creating Hope CPD • Self-Harm and Suicide Prevention - Children & Young People
4 - A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs	**Participants (delivered via Alcohol and Drugs Partnership (ADP) not included in total on right) - 330 * see footnote**
5 - A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all	**Participants - 41** • Money Guiders Training
6 - A Scottish Borders where we eat well, have a healthy weight and are physically active	**Participants - 23** • Royal Environmental Health Institute of Scotland (REHIS) Elementary Cooking Skills

2023 - 24 Data

395

Individual attendances

26

Courses

+ ADP delivered courses

Compared to 467 in 2022 - 23

*** Link ADP Highlight Report**

Training and Capacity Building

Mental Health Improvement / Suicide Prevention Training Highlights

We took a blended approach to training and capacity building which included both online and face-to-face delivery, some sessions delivered were:

- 5 x 2 day ASIST course, we have increased the course participation on ASIST by 78% from 22/22 - 23/24, this has been attributed by one of our team becoming a trainer to deliver
- Delivery of a number of training sessions to various partners and staff groups e.g. Allied Health Professionals, Live Borders (Training for Trainers), Skills Development Scotland, Borders College, Eildon Housing
- Wave after Wave training commissioned and rolled out by Border Care Voice, this training is designed to promote a compassionate response after suicide bereavement
- Development and delivery of self harm and suicide prevention for young people

Some feedback from the recent ASIST courses include:

"What an excellent course! The trainers were engaging and created a safe space to really take in the training, The course was intense but I felt supported and cared for throughout. I have learned so much and gained insight and confidence for suicide intervention. The workshop was extremely interactive and the trainers really got the best of the group through role play and encouraging us to speak up. Highly recommended - one of the best workshops I have attended. Thankyou :)"

Some feedback received from participants include:

"I thought the training was delivered brilliantly. It felt well timed and evenly spread across the morning. Despite being a topic that can evoke various thought and emotions, the delivery meant there were many moments that were jovial and the emphasis on the importance of hope could be felt amongst the room. The trainers worked really well together and I felt they complimented each other as trainers. A really enjoyable training session where I left feeling well informed."

Training and Capacity Building

Children, Young People and Families Training and Capacity Building Highlights

Breakfast Club Food and Drinks Guidance

SBC identified schools and settings requiring additional resources for breakfast clubs. Scottish Borders Council funding was available to support established breakfast clubs or to start new ones, with twenty applicants receiving funding .

As part of this process it was identified applicants may require support regarding current food and drinks regulations and guidance to ensure suitable foods and drinks were provided.

We developed a Breakfast Club Guide, including relevant regulations and recommendations with examples of suitable foods to offer at breakfast clubs both to fit in with the guidance and in keeping with a health promoting school/ community.

In partnership (JHIT/SBC) offered an information session to all 20 recipients of breakfast club funding to go through the guide, answer questions, and offer support. All applicants received supporting documents.

NES Healthy Beginnings: The MAP of Health Behaviour Change Learning Program

This programme continued to be offered as an early intervention and prevention approach to child health for Early Years Practitioners, covering structuring a behaviour change conversation and using techniques with parents/carers to support healthy lifestyles changes for children and the whole family according to a family circumstance. The training was adapted during 2023 to be delivered successfully in person making it much more flexible to a wider audience. Work also focused on developing coaching support in collaboration with NES. Six Health Visitor colleagues were supported in this first pilot process. A structured coaching program is now available to all early years practitioners who have completed the core program.

NHS Education for Scotland

Training and Capacity Building

Supporting a Person at Risk of Self-Harm and Suicide - Children and Young People

This is a bespoke half day training session and has been developed and is delivered as a rolling programme, in person. It is supported by guidance for professionals which includes recent national developments in self harm and suicide prevention, and approaches to support. It is aimed at anybody working with children and young people who are likely to have direct and/or substantial contact with those who may be at risk of self-harm or suicide.

The content is drawn from the NHS Education for Scotland Skilled Level packages for Self-harm and Suicide Prevention.

The session covers:

- Facts and trends associated with self-harm and suicide in young people
- Common risk, protective and stress factors related to self-harm and suicide in young people
- An awareness of the impact a sensitive, compassionate approach can achieve when discussing self-harm and suicide (using the principles of Time, Space and Compassion)
- The links between self-harm, suicidal thoughts and trauma informed practice
- Approaches to support including the steps involved in safety planning

Anyone attending this training must first complete the short informed level e-module 'Promoting children and young people's mental health and preventing self harm and suicide' on the NHS 'TURAS' website. The first two courses in March 2024 attracted 14 participants from partner organisations including education.

Communicating With Our Public

Public health messaging can play an important role in promoting health and preventing ill-health by providing people with information in relation to staying well and avoiding health risks. This can help to increase awareness and, potentially support people to make positive health choices.

However, our health is impacted by broader social, economic and environmental factors therefore we need to ensure that our messages focus on solutions and are clear and accessible to the populations we're aiming to reach and do not focus responsibility on individuals.

Throughout this year we have continued to use our Small Changes Big Difference social media to promote positive messages to support wellbeing and routes to accessing support and more information. We develop a monthly planner of key messaging from across the range of public health work and promotion of partners' activities.

We have had support from NHS Borders and Scottish Borders Council communication teams to issue press information on a range of topics.

Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Communities Team

During 2023 - 24, the Communities Team focused their work across three areas of the Scottish Borders – Langlee, Burnfoot and Eyemouth and were also involved in Borders wide health improvement activities.

The team took a collaborative partnership approach to plan and deliver a range of programmes, including:

- Supporting school holiday programmes with a range of activities
- Christmas for Less programmes
- The Royal Environmental Health Institute of Scotland (REHIS) food and health and cooking skills courses
- Promotion and delivery of outdoor activities
- Leadership for Sustainable Communities (Climate Change and Sustainability)
- Continued support for the Eyemouth Gateway to Good Health project, including cycling
- Promotion of Money Worries App
- Wellbeing events

Sustainable Communities

'We all want Scotland to be a place where everybody thrives and has a better quality of life. Vibrant, healthy, safe and sustainable places are key to improving health and wellbeing and reducing inequalities. The growing threat to public health from the climate emergency increases the need for action. We all have a clear responsibility to respond in a way that nurtures good health for the population and the planet'.
(NHS Scotland climate emergency and sustainability strategy 2022 – 2026)

Public Health provides leadership for the Sustainable Communities theme of the NHS Borders Climate Emergency and Sustainability Action Plan 2022 - 2026. One of the actions outlined in the plan, aimed at building community resilience is to work with our partners, including Public Health Scotland, to understand the risks to each area and different population groups.

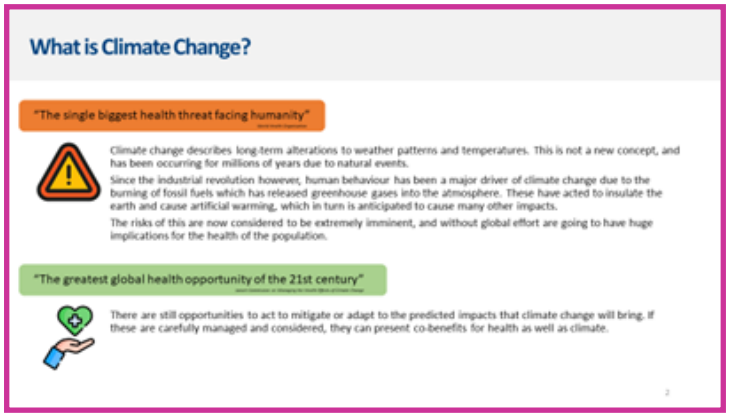
The Climate Change Health Impacts Scottish Borders report was published in March 2024 and contributes to our understanding of the potential impacts on health that are expected as a result of climate change, from a local Scottish Borders context.

Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

The report can support partners and community groups to talk about the impacts on health as part of wider climate change conversations.

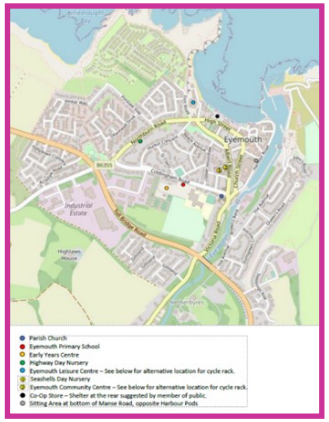
The next stage is to engage with partners and communities, particularly those who work in areas or with groups where health inequalities are highest, to use the evidence base to inform work to mitigate and adapt to climate change.



Safe Walking and Wheeling to School and Nursery in Eyemouth

During the reporting year some of the work started as part of the Eyemouth Gateway to Good Health, Whole Systems Approach (WSA) came to fruition. The WSA project identified a number of improvements that would support safe cycling, these included areas for proposed cycle racks and the need to identify areas for a public bicycle repair stand. Safe storage of people's bikes was a consistent concern when working with the Eyemouth Primary School and wider partners.

Throughout the process of consultation, areas were identified where cycle racks and a cycle repair tower would be of most benefit to the community and tourists in Eyemouth. The Communities Team worked collaboratively with SBC Traffic and Road Safety Department to develop a plan for the installation of this equipment in 2023.



Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

In addition to this, land permission caused an issue for one Nursery which initially prevented them from being able to install cycle racks next to their premises. However, a collaborative approach between Scottish Borders Council, the Communities Team and the Nursery resolved this matter and SBC were able to adopt a small area of land to install the cycle racks on. Purchase of equipment through grant funding enabled the nurseries to take children out for bike rides.

Priority 2
A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

UN Convention in the Rights of the Child (UNCRC)

Article 42 - Everyone Should Know About Children's Rights

NHS Borders Public Health is committed to ensuring all children, young people and their families have their rights valued and respected. We do this by providing the very best in evidence-based practice that supports prevention opportunities. Our staff is highly trained and appropriately skilled in the provision of projects & services. We aim to provide support to all parents, carers and guardians to make the decisions in the best interest of a child.

We strive to ensure children young people and families are treated with dignity, feel valued and heard. Services and projects have either adopted or in the process of adopting rights-based approach to ensure children's rights are respected, protected and fulfilled. We aim to continue to take forward measures that improve children's wellbeing.

Promotion and awareness work continued in 2023 on Children's Rights and The Promise supporting article 42 of the UNCRC Incorporation Bill which is now the UNCRC (Incorporation) (Scotland) Act 2024.

On behalf of NHS Borders, JHIT contributed to the Scottish Borders Children's Rights Report 2023. Highlighting the breath of children's services that use a rights-based approach to services provided to children, young people & their families incorporating the articles of the UNCRC themed on:

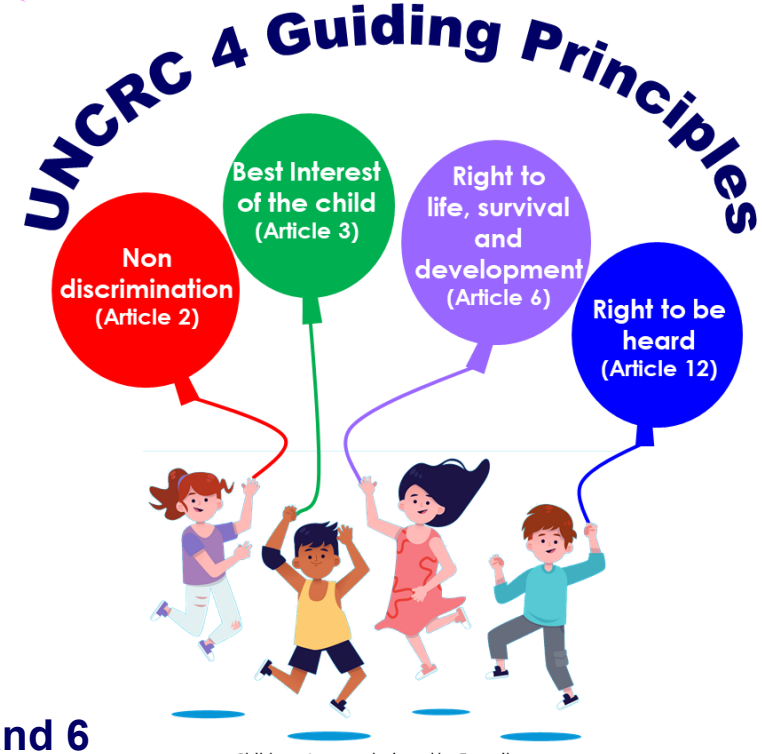
Provision - Protection - Participation - Promotion

JHIT supported the national development of the UNCRC knowledge and skills framework and in collaboration with partners on behalf of Scottish Government conducted a survey with NHS Borders staff to feed into national findings on staff development needs. A survey was conducted in person and online as well wide distribution with support from NHS Borders Coms and had the support of the Training & Education Board.

Over 170 staff responded to the survey. Additional questions helped gather a picture of training and support needs more specific to the Board. A report with recommendations is in development to help draw up specific actions.

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS



Childrens Images designed by Freepik

Articles 2, 3 and 6

Free Vitamin Distribution

Between April 2023 and March 2024 a total of 5901 bottles of free vitamins were distributed across the eligible population which includes all pregnant and breastfeeding women and all children under 3 yrs. These were provided through developed pathways with colleagues in community and hospital midwifery, health visiting, NHS Borders dental reception and direct orders to JHIT. Key messages were shared through all staff channels and social media.

A review of the free vitamins distribution and its reach has been conducted to identify further opportunities, gaps and reach. Oral health colleagues gathered feedback on current awareness of the free vitamin and entitlement from families and parents during routine visits between March 2023 and June 2023. The feedback will be included in the wider review report and will inform steps going forward.

Key Messages

Healthy start vitamins are available for all pregnant women. Each vitamin tablet contains folic acid, vitamin C & vitamin D, supporting a pregnant woman's general health. Additionally these vitamins lower the chance of babies having spinal problems, help the body's developing soft tissue and bones.

Vitamin D supplements in adults supports the health of bones & teeth whilst in infants and children helps bones and muscles to develop properly.

Infant formula is fortified with vitamin D, formula-fed babies or mix fed babies should not be given a vitamin D supplement until they are having less than 500ml (about a pint) of infant formula a day.

Priority 2
A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Article 12 - Respect the Views of the Child

Youth Engaged Listen to Learn (YELL) Youth Participation and Engagement Strategy

NHS Borders Public Health is committed to ensure all children, young people and their families have their rights valued and respected. As part of a multiagency approach for children and young people services in the Borders, the Children and Young People Planning Partnership (CYPPP) identified a need to develop a youth Participation and Engagement Strategy as part of its subgroup of planning and building capacity.

This Project, otherwise known as Youth Engagement Listen to Learn (YELL) is being co-produced with young people in the Scottish Borders, giving young people the opportunity to lead in the creation of a strategy that will outline how adults and/or organisations should be working with children and young people, to involve them in decision making and have their voices heard.

The YELL group meet every Monday and are supported by NHS Borders Health Improvement Team and Scottish Borders Council to design, launch and promote the strategy, as well as engage other Young People in the Borders to hear their views and opinions.

ABA Feed Research Trial

ABAfeed
Infant feeding help

NHS Borders are taking part in a national research trial, ABA-Feed. The study is a large UK-wide, randomised control trial, testing out a new way of supporting first-time mothers with feeding their baby called the 'ABA-feed intervention'.

The ABA-feed intervention starts when a woman is around 30-weeks pregnant. The Infant Feeding Helper arranges to meet the woman before she has her baby. The purpose of this meeting is for the Helper and the woman to get to know each other and to discuss how the woman is thinking about feeding her baby. At this meeting the Helper develops a 'Friends and Family' diagram with the woman to explore what support the woman has available to her, and also gives the woman a leaflet outlining the support available in the local area.

Once the baby is born the Helper texts or calls the woman to see how she is getting on, daily for the first two weeks, and then less frequently until the baby is 8 weeks old.

During 2023 - 24, NHS Borders had 5 active volunteers supporting women in this trial. A total of 52 mothers were recruited into the trial, 31 onto the intervention arm of the trial and 21 into usual care. Recruitment ended in February 2024 with the trial closing in April 2024; we await the results expected later in 2024.

Priority 3
A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Mental Health Improvement / Suicide Prevention

Creating Hope Scottish Borders

Creating Hope in the Scottish Borders has been developed by the multi-agency Mental Health Improvement and Suicide Prevention Steering Group; taking a Public Mental Health approach.

Work in 2023 – 2024 has focused on programme 1 and 2:

- Promoting mental health and wellbeing
- Preventing suicide and self-harm

Work that has informed some these programme areas include:

- Targeted work
- Communication, engagement and awareness raising
- Training

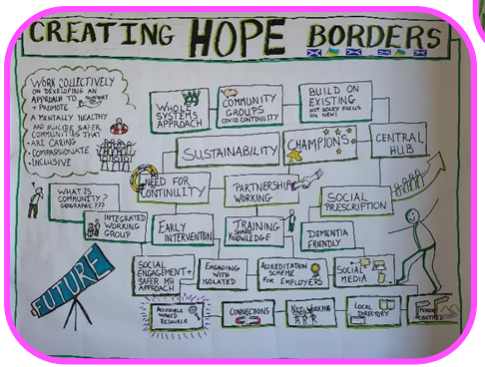
Targeted Work

Multi agency workshops and conversation cafes have formed the development of Mentally Healthy and Suicide Safer Communities and built on the concept of 'thriving', connecting up across the children's, young people's and adult's programmes, putting in place the building blocks of a social movement that will nurture positive environments within communities, create hope, empower people to thrive and contribute to building a 'wellbeing society'.

This themed 3 main ideas:

- The need for a better directory to enhance connectivity and information sharing
- The need for better public visibility – something like a brand or award scheme
- Working in partnership better, networking and shared training and resources

From these workshops and further working groups to develop around the better public visibility formed "Creating Hope Awards in the Scottish Borders" which we have spent time developing in partnership with the mental health improvement and suicide prevention steering group.



Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

The fifth annual Memorial Event for People Bereaved by Suicide took place at Haining House, Selkirk in November 2023, the event was well attended and was supported by Quarriers, SOBs, Samaritans and Breathing Space.

We marked Suicide Prevention Awareness Week in September with several activities linked to the international theme 'Creating Hope Through Action', these included an information and awareness stand with Police Scotland at the Galashiels Transport Interchange; 'Creating Hope' and 'Be Suicide ALERT' training sessions with the Recovery Forum, Eildon Housing and the NHS Borders Allied Health Professionals team; and, a 'Hopeful Steps' walk which over 50 people came along to.

Working in partnership with the Scottish Borders Council "What Matters Hubs", we developed "What Matters Information Station for Mental Health and Wellbeing", starting in Kelso and Galashiels we provided a drop in service once a month to help people find out more about sources of support, information about self-care and links to early intervention and recovery of mental health.

Communication, Engagement and Awareness

In Partnership with the After A Suicide Working Group and NHS24 a new 'Breathing Space' bench was fitted at the Clootie Tree at the Haining House in Selkirk this was launched on 24th May. The bench is located where the annual memorial event for people bereaved by suicide takes place. The bench provides a special place to pause, breathe, and embrace nature.

The After A Suicide Working Group is group of people with lived experience of bereavement by suicide. The group is not a support group, but offers members the opportunity to use their lived experience to contribute to the local suicide prevention action plan. The group has spent time in 2023 developing a series of videos which will provide information to people who have been bereaved by suicide and will be launched in 2024.

Time, Space and Compassion principles were advocated and weaved through training delivered across the Scottish Borders including GP surgeries. This is an approach launched nationally. This is a person centred approach to suicidal crisis and has been developed by people and services who regularly come into contact with people experiencing suicidal crisis. The approach promotes the principles of trauma informed practice.

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

3 Dads Walking, Walk of Hope 2024; we joined 3 Dads Walking as they made their way through the Scottish Borders, promoting the ongoing work within the Scottish Borders. The 3 Dads who lost their daughters to suicide have raised more than £1 million for PAPYRUS Prevention of Young Suicide.

We were pleased to participate in the Scottish Mental Health Arts Festival in 2023 with the theme 'Revolution' and supported a day of free relaxed and creative workshops, music and live performances at the Corn Exchange. The day included uplifting music and art workshops led by Health in Mind, Health in Harmony Choir, the NHS Borders Arts Therapies Team and was hosted by Live Borders Arts & Creativity Team.

Adult Communities Mental Health and Wellbeing Funding

We have been a key partner in the allocation of round 3 Community Mental Health and Wellbeing Fund. In round three, £15 million was available to community organisations across Scotland for 2023 - 24 with £319,680 allocated to the Scottish Borders. The Fund was open to projects supporting those aged 16 and over and has a strong focus on prevention and early intervention. It aimed to help tackle the impact of social isolation, loneliness and mental health inequalities made worse by the cost of living crisis.

National Suicide Prevention Creating Hope Action Plan – Borders GO-LIVE Event

We hosted the GO-LIVE event for the "Creating Hope Together" strategy and action plan. Joined by various partners, Scottish Government and COLSA (Convention of Scottish Local Authorities). The Borders was chosen in recognition of the work done locally by partners on suicide prevention including developing our own local action plan.

The new National Delivery Lead for Suicide Prevention Scotland was presented and the organisations leading the outcomes for the national Strategy were also announced – they included Samaritans, SAMH, Penumbra, Change Mental Health and Public Health Scotland.

We presented our local plan and how this links to the national plan as well as hearing from various partners across the Scottish Borders and their involvement within the local work.

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Mental wellbeing is about both feeling good and functioning effectively, maintaining positive relationships and living a life that has a sense of purpose. It is shaped by our life circumstances, our relationships and our ability to control or adapt to the adverse circumstances we face. Good mental health improves outcomes in education, employment and health and benefits individuals, families, communities and society.

Healthy Relationships

C-card

We continue to deliver the condom distribution C-card service for young people between the ages of 13 - 25 in partnership with colleagues in both the NHS, SBC and third sector. There are 68 distribution points throughout the Borders and a short training session is available for those who want to sign up to deliver the service, new staff, and those who want a refresher. This is delivered on our behalf by colleagues from Youth Scotland and in this year 24 participants have attended.

"The Chat"

This research is a Scotland wide project and has been commissioned by a group of Health Boards: NHS Borders, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Tayside and NHS Eileanan Siar (Western Isles). "The Chat" is a conversation with parents and carers about where, what, when, why and how children and young people learn about relationships, sexual health and parenthood – it aims is to establish what support parents need to ensure they can, in turn, support their children and teenagers to develop healthy relationships and seek appropriate support when they need it. The first part of the research took place during 2023 - 24 in the form of in depth focus groups with 153 parents and carers participating. The information gained during these focus groups has informed a wide reaching survey for the second part of the research, which will be completed with recommendations in session 2024 - 25.

Trusted Adult

A Service Level Agreement has been drawn up to enable our partner organisation YouthBorders to deliver a programme of awareness raising about the role of the trusted adult in ensuring healthy emotional development of our children and young people. This will be an ongoing piece of work over the next 2 years (2024 - 2026).

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Wellbeing Service

The service provides evidence based, early interventions to support lifestyle change to increase physical activity, reduce weight and eat healthily, quit smoking and improve emotional wellbeing.

Along with advice and support the advisers will provide resources, signpost and refer to other services that will be of benefit to the patient for additional support. These may include LIVE Borders, NHS Borders dietetic service, community groups and many more.

Referrals

The Wellbeing Service is embedded into primary care and operates across the Borders.

We received 1378 new referrals from 1 April 2022 to 31 March 2023 and from 1 April 2023 to 31 March 2024 1284 new referrals.

The reduction in referrals can be seen from the change from Tier 2 delivery to Tier 1 delivery within Emotional Wellbeing. Since the end of 2023 we have continued to promote the services and build stronger relationships with other services to refer in.

The Service has met with all GP practices in July and August, informing of changes within the services and promoting relationships. The service has been invited to present several team meetings both within NHS Borders and external, this has increased the visibility of the service and increased referrals from out with our usual referrals.

Feedback

Care Opinion is an online platform which allows people to share their experiences of using our service in a safe and simple way. We use these stories to help inform service improvements. Care Opinion builds on our existing patient feedback methods.
A number of patients used Care Opinion over the last year to leave feedback on our service; **one of these comments is below:**

"Over 4 months *'adviser'* not only listened to and validated a lot of feelings she also gave me the tools I needed to move into a much more positive headspace about my situation. I have become more accepting of the situation, more self compassionate, self advocating, less guilty and less anxious, all through working with *'adviser'*. My time with her has undoubtedly helped my mental health and will continue to do so now I have the tools and strategies in place to help myself."

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Our staff use a wall of feedback for any feedback given to the service direct to the adviser or through our evaluation methods.

Some comments received include:

"All the tools we've spoken about and you have sent me by email have been so helpful and made a big difference. I can't thank you enough, you've helped me so much"

Emotional Wellbeing

Tier 2 to Tier 1 Support - Within the year there were changes in our service for emotional wellbeing and we no longer offer Tier 2 support for patients for their emotional wellbeing. These patients are supported by Renew Service with whom we maintain a close relationship and who provide us with coaching sessions on a quarterly basis. Our advisers continue to support patients at Tier 1 level of emotional wellbeing, ensuring early intervention. The service has spent time informing all services throughout the Borders of the change and continue to work with referrers to improve early referrals to support patients.

Peer to Peer Reflective Practice - Advisers have spent time in the last year involved in reflective practise training to allow them all to learn skills to lead peer to peer reflective practise sessions and support the team with referrals.

Macmillan - We have been working closely with Macmillan Cancer and attend their Health and Wellbeing Events twice a year to provide information on how to help anxiety, along with promotion of the service and information on how to self-refer.

Tobacco

Smoking Cessation

In order to improve quit rates across the Borders, we have been focusing on the following key areas;

Smoking in Pregnancy - We now have an established Smoking in Pregnancy (SIPs) group of advisors, who continue to provide specialist support to pregnant women across the Borders. Through this group, we have developed strong links with the Family Nurse Partnership and Health Visiting teams and have continued to develop our relationships with maternity services too. We are currently in the process of expanding our access to Badgernet across the team to improve both the referral process and patient experience.

Vaping - The previous report highlighted an increase in e-cigarette use. We have been working alongside the children and young people's health improvement team to support the development of the Vaping Action Group and Vaping Action Plan aimed specifically at children and young people.

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Through this work we have established strong links with school nurses and have so far delivered one presentation to Berwickshire High School resulting in two referrals for vaping cessation. This work is informing our work with our adult patients.

Smoking Cessation Governance – We have identified a problem with our data uploading from EMIS to the national database and are piloting direct entry with an aim of improving this.

The Tobacco Control Group was reinstated post Covid, with the first meeting held in September 2023. A second meeting was held in February 2024. The membership and Terms of Reference for this group is currently under review and regular meetings and action planning will comment later in 2024.

A drive to work closely with other regions in Scotland has continued to develop, particularly in light of the Tobacco and Vaping Framework published in November 2023. NHS Borders now has representation at both the National Smoking Cessation Coordinators Network (meeting monthly) and the Scottish Smoking Cessation in Pregnancy Group. This ensures we develop and standardise our tobacco and vaping policies alongside the national picture and in alignment with other health boards.

Lifestyle

Weight Management Service – The Wellbeing Service is now able to offer support to patients currently awaiting specialist input from Borders Weight Management Team (BWMT) Tier 1 and 2. Our advisers provide evidence-based interventions to support patients in making positive changes to their lifestyle in regards of healthy eating and weight management while on the waiting list for BWMT.

Physical Activity – The service continues to promote all forms of physical activity through holistic approach at the appointments with patients whether their reason for referral is emotional wellbeing, smoking or lifestyle. Wellbeing advisors are mindful of promoting physical activity at all levels and continue to refer patients wishing to become more active, to LIVE Borders Health programme as well as local community-based walking groups supported by Walk It. Our advisors are aware that some individuals prefer use of NHS activity apps and will encourage patients to use them.

Cancer Screening - Our advisers actively encourage patients to be aware of cancer screening programmes, in particular pregnant patients to take part in cervical cancer screening.

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

A short list of 'Things to do when you get home' is shared with them and checking with GP eligible screening is one of the points. It is evidence based that mentioning screening within other important things, like registering the baby's birth will increase uptake of cervical cancer screening.

Tobacco and Vaping Action Plan

Following the launch of Jenny and the Bear, a programme rolled out to all P1 pupils on the harmful effects of second-hand smoke, national and local data highlighted concern regarding the use of vapes in Children &Young People in the Scottish Borders.

The long-term effects of vaping on our health are not fully understood, this has also been reflected locally with partners having expressed concern over the lack of key messaging around vaping; lack of reliable and consistent information that is being used across all key partners and a need for a clear media approach.

In response to this, Public Health alongside key partners are developing an action plan in line with the **National Tobacco and Vaping Framework: Roadmap to 2034** to reduce the use of vaping and smoking in young people.

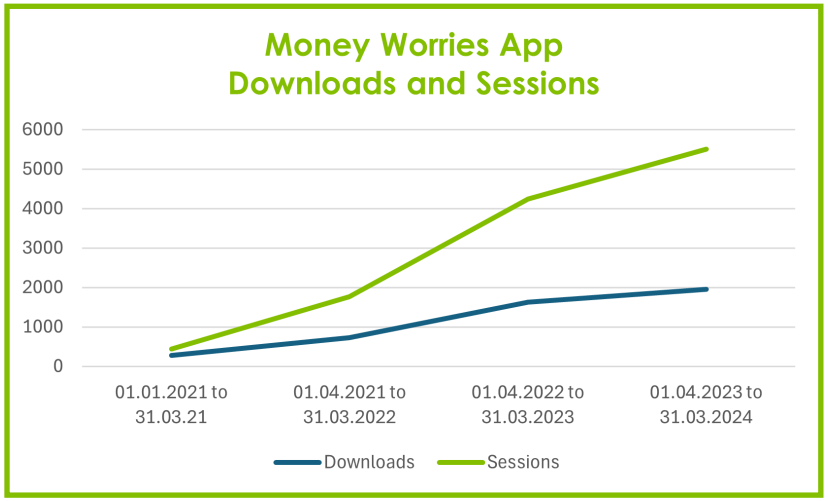
The action plan has a clear rights-based approach focused on youth participation and engagement, education, and media, working closely with national partners ASH Scotland.

Priority 5

A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

NHS Borders Money Worries App

NHS Borders have continued to work in partnership to build on the successful development of the Money Worries App. The App is a digital directory with links to national and local sources of help with: Money; Health; Housing and Work. The App has become an integral part of team promotions across community settings and staff continue to raise awareness of the App and encourage "real-time" download.



Ongoing promotions and engagement with partners and communities has led to a good number of downloads in 2024 and continued engagement beyond the home page amongst existing and new users with a notable number of screen views.

During this reporting year there was an ongoing technical issue which meant that people were unable to download the App to android phones. We have since resolved that and we now have a total of 1947 downloads since the App was launched in 2021 and over 5500 'sessions' where people have used the App. The App is updated regularly with new information from a range of services and reviewed annually to ensure the information is correct and current. The App has attracted an average on the Apple App store of 4.3.

Money Guiders Training

A wide range of statutory and third sector colleagues attended the training and report the positive learning including increased confidence in providing money guidance and advice and signposting for further support.

"I make the most of every engagement, ensuring my knowledge of e.g. benefits is updated as this is constantly changing. I encourage staff in my service setting to attend this training to ensure they can offer holistic health and wellbeing support too" (Training Participant, Borders Addiction Service)

We have also supported the national evaluation of MaPS Money Guiders Training and delivered a session within the Scottish Money Guiders Network.

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Children, Young People and Families Team

Community Food Work

Community Food Workers (CFWs) work with 0 - 18 year olds and their families, in a range of settings and deliver nutrition sessions on a variety of topics such as:

- Eating well for growth and development (all ages and stages including weaning)
- Cookery skills and cooking on a budget
- Healthy breakfast, lunch, snacks and family meal ideas, recipes, tips and advice
- Fussy eating
- Drinks awareness
- Food, mood and well being

CFWs develop resources, signpost, and actively promote and support communities to eat well, be active and feel good. CFWs offer training and support to staff working with children and young people to enable them to continue supporting families to eat well.

'Super Snacks on a Budget' sessions were developed and delivered in Early Years Centres to raise awareness of the variety and benefits of providing low-cost nutritious snacks in comparison to pre-packaged, high-cost, sugary snacks. To address the cost of living as well and increase knowledge of the positive impact on the growth and development of children.

"Learning how to make quicker snacks and trying to be more prepared. Nice to have a taster as well"

"Enjoyed interaction with food and other children"

A wide variety of practical food activities were delivered as part of the Summer programme within Early Years Centres to increase parent/carer confidence and skills to enable them to prepare and provide low-cost, quick and easy, nutritious snacks and family meals at home with their child(ren).

"The food fun day was a great day for our children to try new food and great ideas for making normal food more fun"

"More ways to encourage my wee ones to eat healthier"

"The food day gave me ideas for making a sandwich more exciting and exploring child's name creativity, I'd have never considered this otherwise"

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Training was offered to all Early Years Centre managers to support them with providing families with a nutritious breakfast/ brunch during the School Summer Holidays.

Additional training to increase cookery skills for the staff and managers was provided for one Centre enabling them to deliver future cookery sessions to parents.

Specialist nutrition sessions are delivered including sessions with Post Natal Depression Borders which offers peer support and increases participants confidence, knowledge and skills in cooking healthy family meals.

"Enjoyed interaction with food and other children"

"Learning how to make quicker snacks and trying to be more prepared. Nice to have a taster as well"

Fussy eating resources are being developed for pre-school and primary-aged children to help address issues around fussy eating and to support parents and carers to encourage and offer a wide variety of nutritious foods.

High School Transitions

The "Good Fuel for High School" programme was delivered by the Fit4Fun, Children, Young People and Families Team in June 2023 and was offered to all high schools.

Sessions delivered to P7 pupils as part of their high school transition days aimed to support their health and wellbeing and enable them to make their own informed food and drink choices. The session's topics supported and informed pupils on how important it is to make healthy food and drink choices and how this can affect their growth, learning and behaviour.

Feedback from pupils and teachers who participated in the programme was very positive. Pupils engaged well with the sessions and found the practical activities most enjoyable. They also liked being able to ask questions. Pupils gained valuable knowledge and skills required to make informed food and drink choices in the future, as well as learning the importance of good food and drinks for their health and wellbeing.

3 high schools took part with 19 classes and 532 P7 pupils attending the sessions.

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Partnership Work with Borders Community Action

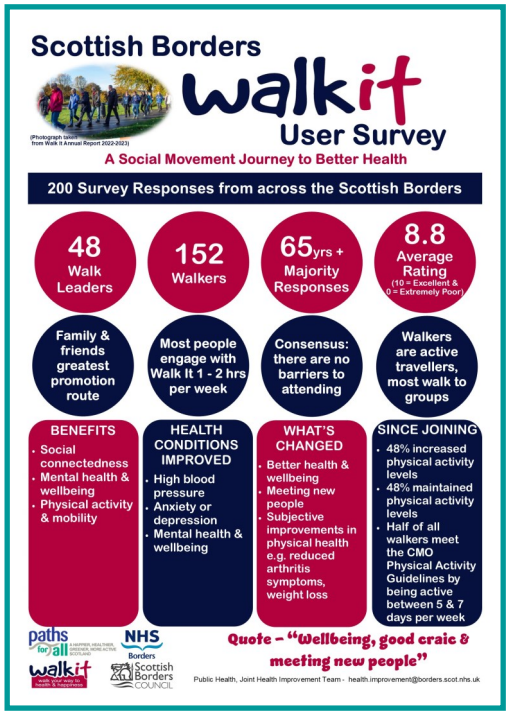
Funding Application Development to Include Food and Drinks Criteria

In partnership with Borders Community Action, criteria and guidance was developed to ensure all future funding requests from applicants who plan to provide food and drinks as part of their funding are providing nutritious food and drinks. The criteria and guidance were in line with current regulations, general healthy eating principles and avoided providing food and drinks high in sugar, fat and salt.

As a result, application forms were amended to include new criteria and information. This is a positive step forward in influencing the wider food environment and supporting people to stay well.

Paths to Health - Walk it

NHS Borders, Scottish Borders Council and Paths for All conducted a survey of Volunteer Walk Leaders and Walkers between February and March 2024 to understand the difference the project has made to this well-established Network. We used Microsoft Forms and offered a mixed methods approach to ensure the survey was accessible to everyone with the option of responding via a QR code, website link and paper questionnaire.



Headline Data reflects:

- 200 Survey Responses
- 48 Walk Leaders & 152 Walkers
- The greatest number of survey respondents are 65+, with almost a quarter of all responses being 75+
- Top Engagement Route: Family & Friends

Walkers reported improvements to a range of health conditions, in particular, high blood pressure, anxiety & depression, mental health and weight.

Walkers also reported on what had changed for them since joining Walk It, survey responses reflect the social impact with the top response being meeting new people.

Looking Forward / Next Steps

During 2024 - 25 we will continue to build on our progress reported during the year. We will be working closely with partners in the Children and Young People's Leadership Group and Networks to take action to support services to respond to the incorporation of the UNCRC.

We will be developing new ways of working for our Wellbeing Service including being part of the pathway for Long Covid support; supporting a 'waiting well' programme for people awaiting treatment and piloting group work for specific areas of work.

We will launch our Creating Hope awards which engages local groups and organisations in promoting good health and nurturing environment. This will enable our local communities to develop their understanding of suicide and its prevention and, importantly, be able to respond in a helpful and informed way when needed.

We will be taking a leadership role within the work to develop a Borders specific Good Food Nation Plan, bringing the evidence of what supports good food and health to the table alongside partners.

We are anticipating that during 2024 - 25 we will review how we work in partnership with the wider Public Health Department while undertaking a Service Review. This Service Review is taking place within the financial constraints faced across the public sector including NHS Borders which are likely to impact on our team.

The review process will allow us to reflect on the outcome and impacts of our interventions and look ahead to developing a service ready to support our community in the face of challenges including climate impact, poverty, emotional health and wellbeing and supporting the Health and Social Care Partnership through effective prevention work.

Need to contact us

@ health.improvement@borders.scot.nhs.uk ☎ 01835 825970

✉ Joint Health Improvement Team, Scottish Borders Council HQ, Newtown St Boswells, TD6 0SA

Update 2023-2024

action on drugs+alcohol BORDERS

Introduction

This report provides an update on key developments and activities during 2023-24 and an update on the ADP Strategy 2024–2027. This report does not include the full extent of work carried out.

Alcohol & Drugs Partnership Role

The Scottish Borders Alcohol & Drugs Partnership (ADP) is a strategic partnership whose role is to deliver Scotland's national alcohol and drug strategy and deliver a reduction in the level of drug and alcohol related problems amongst young people and adults in the Borders, reducing the harmful impact on families and communities.

Membership

The ADP is made up of representatives from the following organisations:

- NHS Borders (Public Health, Mental Health, NHS Borders Addiction Service)
- Scottish Borders Council (Elected Member, Social Work, Safer Communities Team)
- Police Scotland
- Drug & Alcohol Third Sector organisations
- Lived Experience

The ADP is currently chaired by the Director of Public Health for NHS Borders.

ADP Support Team

The ADP Board is assisted in their work by the ADP Support Team. In 2023-24, the ADP Support Teams included 1.0 WTE Head of Health Improvement/Strategic Lead ADP, 1.0 WTE Coordinator, 0.6 WTE Health Improvement Specialist and 0.8 WTC Project Officer.

National Strategies & Policies:

The work of the ADP is informed by the following national strategies, policies and ministerial priorities:

- **National Drugs Mission Plan 2022-26:** The National Mission builds upon Scotland's alcohol and drug strategy with the aim of reducing drug deaths and improving the lives of those impacted by drugs. Within the National Mission

is the implementation of Medication Assisted Treatment (MAT) Standards which have specific implications for service delivery.

- **Public Health Priorities for Scotland 2018:** Scotland's six Public Health priorities were published in 2018 with the ultimate aim of improving the health of the population and reducing health inequalities across Scotland. Priority 4 is 'A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs'.
- **Rights, Respect and Recovery: Alcohol & Drug Treatment Strategy & Alcohol Framework 2018:** The national alcohol and drugs strategy Rights, Respect and Recovery and the Alcohol Framework set out a series of national outcomes and priorities to reduce risk and harm from alcohol and drugs.

Ministerial Priorities

ADPs are required to deliver work to address the following Ministerial Priorities which reflect Rights, Respect and Recovery and the Alcohol Framework. High level outline of ministerial Priorities are:

- Prevention and Early Intervention
- Developing Recovery Orientated Systems of Care
- Getting it right for children, young people and families
- Public Health Approach in Justice
- A reduction in the affordability, availability and attractiveness of alcohol

National ADP Outcomes

- Fewer people develop problem drug and alcohol use
- Risk is reduced for people who take harmful drugs and drink excessively
- People at most risk have access to treatment and recovery
- People receive high quality treatment and recovery services
- Quality of life is improved for people who experience multiple disadvantage
- Children, families and communities affected by substance use are supported.

Medication Assisted Treatment (MAT) Standards

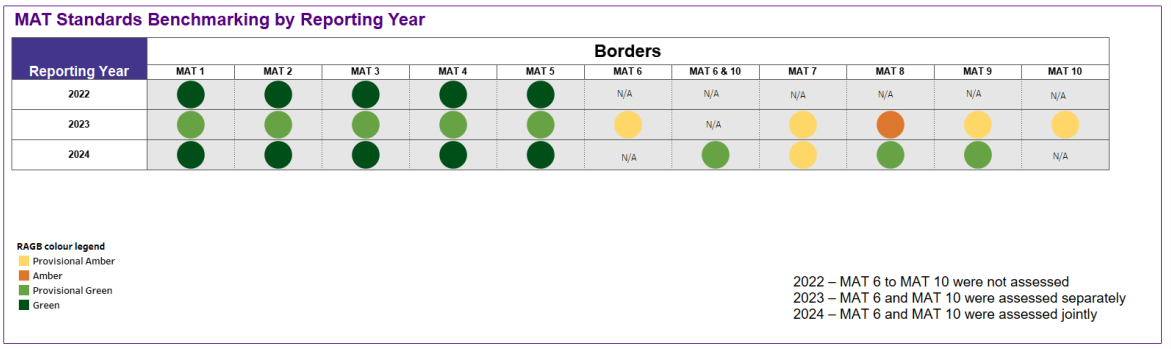
Implementation of MAT is one of the key areas of the National Mission based on evidence[1] that being in treatment is protective against the risk of death. MAT is the provision of medication alongside psychological and social support in the treatment of people who are experiencing issues with their drug use.

The MAT standards enshrine a rights-based approach to immediate, person-centred treatment for problem drug use, linked to primary care, mental health and

[1] Drugs-related deaths rapid evidence review - Publications - Public Health Scotland

other support services. The most recent benchmarking report2 published on 14th July 2024 provides an assessment of progress of implementation across all 10 standards for the 29 ADPs in Scotland.

The table below provides a summary of Borders performance in implementation of all ten standards with each standard apart from MAT 7 achieving green or provisional green.



Drug & Alcohol Services

There are three ADP commissioned drug and alcohol services in the Scottish Borders: Borders Addiction Service; WithYou and Chimes. These services provide a range of harm reduction, treatment, psychological interventions, as well as wider support including employment, housing and support for family members. For more information on local services click here.

Drug and alcohol services in the Borders consistently met the Local Delivery Plan Standard of 90% of people starting treatment within three weeks. The table below provides a breakdown over the four reporting years.

Waiting Times			
Year	**Total Assessed for Treatment**	**Started Treatment within 3 weeks**	**Percentage**
2020-21	496	492	99%
2021-22	564	562	99.6%
2022-23	532	532	100%
2023-24	512	509	99%

Source: Public Health Scotland

In 2023-24, 28 (74%) of people started MAT on the same day as initial assessment and 10 (26%) within 7 days.

[2] National benchmarking report on the implementation of the medication assisted treatment (MAT) standards: Scotland 2023/24 - National benchmarking report on implementation of the medication assisted treatment (MAT) standards - Publications - Public Health Scotland

MAT Improvement Plan

Trauma Walkthrough events were held with staff from all three drug and alcohol services and people with lived and living experience in the Borders to review how trauma informed our staff and services currently are, identify what we do well and areas of improvement. Feedback from this event was combined with feedback from the experiential programme for MAT and developed into an action plan. These actions are being taken forward via appropriate ADP Subgroups.

Residential Rehabilitation

Increased access to residential rehabilitation is a priority of the National Mission. In 2023-24, 20 new places for Borders clients were approved compared to five people to access residential rehabilitation in the previous year.

A self-assessment of the Borders Residential Rehabilitation pathway was completed and feedback has been received from Healthcare Improvement Scotland. Improvements on the pathway have been identified within an action plan and submitted to Healthcare Improvement Scotland.

The pathway document and patient information are available on the ADP website

Near Fatal Overdose Pathway

A local Near-Fatal Overdose (NFO) pathway has been in place since May 2021 and referrals are received from Scottish Ambulance Services; Police Scotland and the Emergency Department (ED) at the Borders General Hospital. Twice weekly multi-agency meetings are held to respond to new referrals and review actions arising from previous meetings. Referrals received between meetings are also reviewed and responded to by Borders Addiction Service.

If people are already in service they are contacted by their key worker. People who are not active clients of service are contacted by the assertive engagement team (ESTeam). If there is no response to telephone contact, home visits are attempted and, where appropriate and with consent social media (e.g WhatsApp) is used or family and friends are asked to pass on a message.

In 2023-24 there were 78 referrals to the NFO pathway compared with 124 in the previous year. 100% were contacted within 48 hours of overdose. The NFO pathway has been received positively by people referred and staff.

Take Home Naloxone (THN)

The Take-Home Naloxone (THN) program provides naloxone kits to individuals at risk of opioid overdose, as well as their families and friends. Naloxone is a medication that can temporarily reverse the effects of an opioid overdose, whilst an ambulance is called. The program includes training on how to recognise an overdose, administer naloxone, and respond appropriately in an emergency. In

2023-24 there were 60 first supplies (compared with 102 in previous year) and 116 resupplies (compared with 148 in previous year) of THN provided across Borders to people in need, families and other members of the community. Of the 116 resupplies of THN in 2023-24, 32 (28%) were used to treat an opioid overdose potentially saving 32 lives.

Alcohol Specific Death Audit

During 2023-24, the ADP Support Team with support from Public Health Scotland undertook reviews of alcohol specific deaths for individuals who died in 2021. Using Alcohol Focus Scotland guidance case notes were reviewed to help understand people's experiences and identify areas of good practice and potential improvement ideas. Key findings from this report were presented within a workshop and recommendations identified are being taken forward.

NHS Borders ADA 2021 Poster - V1.pdf

Recovery Communities

Borders in Recovery celebrated their 2nd Birthday on 1st March 2024. Borders in Recovery is a recovery community open to anyone over 16years old who is in recovery from substance use or mental ill health and is run by people with lived experience. The group offer activities six days a week with recovery cafés across the Borders, breakfast club, and SMART group meetings. For more information on the recovery community click here

Lived and Living Experience

Borders Engagement Group

The Borders Engagement Group is an independent group of people with living experience who during 2023-24 met weekly at the Focus Centre, Galashiels. This meeting is a safe space for people to share their experiences both positive and negative. Experiences are then discussed with alcohol and drug services, the ADP Support Team and wider services in order that we can address concerns. For more information click here

Themes provided in 2023/24 have included:

- Stigma: people report experiencing stigma when accessing wider services. We have shared this directly with services identified.
- Housing: a variety of individual experiences about their housing situation were shared. We have successfully identified named contacts within each provider and have welcomed housing providers joining our local management group to respond to concerns
- Information about how services work: a variety of individual experiences about it not being clear how services work, for example, accessing residential

rehabilitation. In response to these queries there have been amendments to existing and new information leaflets developed

Lived Experience Forum

The Borders Lived Experience Forum meets quarterly in the Focus Centre and aims to give people who have previous experience of using alcohol and drug services a voice so that they have the opportunity to help inform the work of the ADP and the alcohol and drug services. A representative from the group attends the ADP. In 2023-24 the group participated in Scottish Recovery Consortium Lived Experience Forum training and subsequently updated their Terms of Reference; participated in the Experiential Evidence Programme for MAT standards and our Trauma.

Walkthrough events to support MAT Standards 6&10 including providing improvement ideas based on feedback. For more information click here

ADP also funded a Scottish Drugs Forum National Traineeship post in 2023/24.

Workforce Development

The ADP publish a Workforce Development Training Directory every year. All our courses are free and are delivered online via Microsoft Teams. In 2023/24 275 people attended 21 training courses. 191 people completed e-learning provided by Scottish Drugs Forum.

ADP Strategy 2024-2027

In 2023-24, the ADP developed an updated Strategy for 2024-27, Delivery Plan, and Equality & Human Rights Impact Assessment. These were developed in partnership with stakeholders and people with living and lived experience of alcohol and drug use. This can be viewed here

NHS Borders

Public Health Screening Programmes Report

April 2023 – March 2024

Completed by:

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Public Health Department NHS Borders
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Executive Summary

Screening is a Public Health service offered to specific population groups to identify those who are at higher risk of potential health conditions. This allows individuals to receive timely information and further tests and appropriate treatments if required. In NHS Borders, screening services align with guidelines from the UK National Screening Committee (UKNSC) and Scottish Screening Committee (SSC). Screening Oversight Assurance Scotland (SOAS) oversees their implementation and performance monitoring in collaboration with local health boards.

This report evaluates the performance of each of the six Public Health National Screening Programmes delivered across the Scottish Borders from April 2023 to March 2024 and highlights achievements and identifying areas for improvement.

The six programmes include:

- Abdominal Aortic Aneurysm (AAA) Screening
- Bowel Screening
- Breast Screening
- Cervical Screening
- Diabetic Eye Screening (DES)
- Pregnancy and Newborn Screening

NHS Borders shows strong performance in several screening areas in this reporting period, consistently achieving higher uptake rates compared to the national average. Notably in some programmes, NHS Borders achieved the highest uptake of a Scottish mainland board (Bowel and Cervical). NHS Borders AAA, bowel and breast screening programmes achieved the national standards for uptake, underscoring the region's commitment to public health initiatives. This success is a testament to effective public engagement and well-executed programme delivery. Despite these successes in uptake, the cervical and DES programmes did not meet the national target of 80% uptake for the reporting period. Across Scotland, several NHS Boards struggled to meet the national target in both programmes in recent years with considerable variation across different age groups. This indicates the need for targeted strategies to boost participation, especially in demographics with lower engagement rates. Since the move to a new DES programme I.T. system in 2020, there is a national challenge in obtaining accurate Key Performance Indicators (KPI) for reporting purposes.

The quality of procedures for those referred for further investigation in the bowel and breast screening programmes is particularly noteworthy. NHS Borders Colon Services reported an improved completion rate for colonoscopies, whilst breast screening nationally achieved both acceptable and achievable standards across all cancer detection metrics.

Timeliness in service delivery is also commendable. Most patients in the bowel screening programme with a positive result received a telephone pre-assessment appointment shortly after their referral, demonstrating efficient service delivery. Additionally, NHS Borders

consistently met the standard for conducting annual surveillance appointments on time for those referred by the AAA screening programme.

Achieving the local target of waiting time for colonoscopy continues to be challenging due to increasing number of referrals. There was some improvement compared to previous years due to NHS Borders receiving more consistent national waiting time initiative funding for weekend clinics. However, waiting times will deteriorate significantly if this national funding is discontinued. This ongoing challenge underscores the need for permanent increased capacity in this critical diagnostic service.

The Pregnancy and Newborn Screening Programme faces unique challenges due to fragmented data across various teams and systems. Evaluating performance is complex without a unified national IT system as well as local issues, for example, training, staffing, and auditing, further complicate data collection and quality assurance.

A significant inequality in screening uptake exists between those who live in the most and least deprived areas within the Scottish Borders Local Authority area. Current data reveals substantial differences in breast, bowel, and cervical screening uptake based on deprivation levels. Additional barriers, such as rural accessibility, language differences, and learning difficulties, further exacerbate these inequalities.

NHS Borders is dedicated to increasing screening uptake across all communities. Efforts are underway to enhance accessibility and address inequalities by offering appointments at varied locations and times. Local initiatives in cervical screening aim to improve participation, particularly by addressing issues related to defaulting during pregnancy. For Pregnancy and Newborn Screening, a data quality project is planned to streamline data management and reporting. Additionally, a national SMS reminder service and online booking system for Diabetic Eye Screening (DES) will soon be introduced to reduce missed appointments and improve uptake

To enhance screening services, key recommendations were identified in this report:

- **Strengthening overall performance monitoring** and development of a “screening dashboard” and evaluation for all screening programmes with dedicated resources and the development of a regular process of audit supporting quality improvement and assurance to meet the local/national reporting requirements.

- **Improving data quality** in the Pregnancy and Newborn Screening programme requires a review of data capture, staff resource/training/protected time within midwifery services supported by Public Health.

- **Addressing health inequalities** through the delivery of Equity in Screening Strategy Action Plan is essential for all programmes to close gaps in uptake, especially for cervical and diabetic eye screening programmes.

In Summary, NHS Borders performs well overall in screening programme uptake compared

to national averages. However, challenges remain in meeting specific standards, addressing health inequalities and improving data quality. With ongoing projects and strategic plans in place, NHS Borders aims to enhance the effectiveness of its screening services for all residents of the Scottish Borders.

Introduction

Screening is a preventative health measure designed to identify individuals at risk of specific diseases or conditions before symptoms appear. The goal is to detect potential health issues early, enabling timely treatment that can improve outcomes, reduce complications, and enhance overall quality of life. By focusing on at-risk populations, screening programs help prevent disease progression and alleviate the burden on healthcare systems.
The core principle of screening is to identify individuals who may have a particular condition and distinguish them from those who are unlikely to have it. This is typically conducted by done using simple and accessible tests, examinations, or procedures that can be applied to large groups. It is important to note that screening is not meant to diagnose a condition, but to flag individuals who may need further tests for confirmation.

For a screening program to be effective, it must meet specific criteria set by the UK National Screening Committee (UKNSC). The condition being screened should be a significant health concern with a predictable progression that can be detected early. Additionally, the screening test should be safe, reliable, cost-effective, and acceptable to the target population. The benefits of early detection and treatment should outweigh any potential risks, and appropriate treatments or management strategies should be available for those who test positive.

Screening programmes can be categorised based on the target group and the health condition. Universal screening involves testing an entire population within a certain age range, whilst selective screening focuses on individuals at higher risk due to factors such as family history, lifestyle, or pre-existing conditions. Examples include cancer screening (e.g., breast, cervical, and bowel cancers), newborn screening (to detect genetic or metabolic disorders), and antenatal screening (to identify potential risks during pregnancy).

While screening offers numerous benefits, including early disease detection and improved treatment outcomes, it also has limitations. False positives, where a test incorrectly identifies a condition, can lead to unnecessary anxiety, additional testing, and interventions. Conversely, false negatives can provide false reassurance by missing a condition. Therefore, screening programs must be carefully designed and continuously evaluated to ensure they offer more benefits than risks.

The scope of screening services provided by NHS Borders is largely determined by the UK National Screening Committee (UKNSC), which advises Government and the NHS in all four nations. The Scottish Screening Committee (SSC), established in 2017, reviews the UKNSC recommendations and decides if the evidence-based recommendations are appropriate for implementation Scotland. NHS National Services Scotland (NSS), in conjunction with NHS Boards, is responsible for commissioning national screening programmes and developments and Screening Oversight and Assurance Scotland (SOAS) provides national governance, support and monitoring of the screening programmes.

In NHS Borders, each screening programme is supported by a multidisciplinary team responsible for overseeing its performance, participation rates, and quality assurance. Addressing health inequalities and promoting uptake in screening services are local priorities. Successful screening requires collaboration among various sectors, including

primary care, community services, local government, emergency services, and third-sector organisations. For some programmes, partnerships extend beyond the local area, involving staff from other Health Boards.

All screening programmes have a national governance group comprised of screening coordination leads and other programme partners. These groups meet to discuss national planning, Key Performance Indicators (KPI's) and operational issues. These feed down to local governance groups (called steering groups) which are coordinated and chaired by the board screening coordination lead and includes the local programme clinical lead, laboratory, call recall, screeners, GP's and nurses (bowel, cervical, DES, P&NB). Some of these steering groups are joint governance groups with NHS Lothian (AAA, Breast).

KPI's are used to assess the performance and ensure the quality of all screening programmes. KPI's provide an overview of service functionality but are not sufficient alone to guarantee quality. There are often two performance thresholds for KPI's: "achievable/desirable," indicating optimal service levels, and "acceptable/essential," representing the minimum standards that must be met.

This report provides an overview of the screening programmes available to residents in the Scottish NHS Borders, utilising the latest available data. Its primary goal is to evaluate the operational performance of each programme, identify areas for improvement, and highlight any changes in local or national policies related to screening services. This report will also identify disparities in service delivery. Addressing these disparities is crucial, as failure to do so can result in an increasing gap in health outcomes for the most disadvantaged groups in the Scottish Borders due to missed early detection, and intervention.

1. Abdominal Aortic Aneurysm (AAA)

The aorta is the largest blood vessel in the body and carries blood from the heart to the abdominal area. The section of the aorta that lies within the abdomen can swell, and this is termed an abdominal aortic aneurysm (AAA). In many cases, those with an AAA are unaware and experience minimal or no symptoms. The risk of an AAA is that over time, the wall of the aorta where the swelling has occurred becomes weakened, increasing the risk of rupture and subsequent death.

There are certain risk factors which have been identified as increasing the likelihood of an AAA occurring. These include smoking, age, sex (with men at more risk), family history, high blood pressure, high cholesterol, and Caucasian background. It is estimated that 5% of men in Scotland between 65 and 74 years old have an AAA. It is thought that in Scotland, up to 170 lives each year are saved because of the AAA screening programme, and that screening for an AAA in the eligible group by ultrasound scanning reduces death from a ruptured AAA by 50%.

AAA screening looks to identify AAA in men aged 65 years old and over, with the aim of reducing deaths from their rupture. The screening test is an ultrasound scan of the abdomen. This is a painless and non-invasive test which takes approximately 10 minutes to complete.

Eligibility

Men and Trans-women become eligible for screening when they reach age 65 and should be invited for screening before their 66th birthday. Across Scotland men in their 65th year of age are invited to be screened for AAA. Men over 65 years of age, who have not been screened previously can refer themselves to the screening programme.

Trans-men are at lower risk of AAA, but if they have a male CHI number, they will be automatically invited to attend. Individuals who are non-binary and were assigned male at birth should attend AAA screening and will be automatically invited if they have not changed their CHI number.

Service delivery in NHS Borders

The AAA Screening programme is a delivered in partnership as a collaborative model with NHS Lothian. The Collaborative commenced delivery of the screening programme in Borders in August 2012.

AAA screening is currently available at the Borders General Hospital (BGH) as well as several community venues (Duns, Kelso, Peebles and Hawick), and is delivered by NHS Borders sonographers. All invitations for eligible participants are issued by the collaborative call/recall office hosted in NHS Lothian.

Areas of good practice

To maximise attendance, text messaging, and where capacity allows phone calls, are used to remind patients about their upcoming appointment. AAA screening in Borders is available

in five locations across the Borders to reduce barriers to access and mitigate inequalities and increase equity in access to screening.

Follow up and treatment

Participants are informed of their result verbally during the appointment. This is followed up with a letter within a few weeks. If no aneurysm is detected, then the person is discharged from the screening programme.

If an aneurysm is identified, follow up depends on the diameter of the aneurysm. Just over 1% of participants screened have a small sized aneurysm (3cm to 4.4cm across), and around 0.5% of participants screened have medium sized aneurysms (4.5cm to 5.4cm across). The likelihood of an aneurysm rupturing at these sizes is low, and so immediate treatment is not necessary. Those with small aneurysms are invited to attend an annual monitoring screen, and those with medium sized AAAs are invited for a quarterly monitoring screen.

If a large aneurysm is detected (measures≥5.5cm), an urgent referral is made to vascular specialist services in Lothian for further investigation and consideration of treatment. Around 0.1% of men screened have a large AAA.

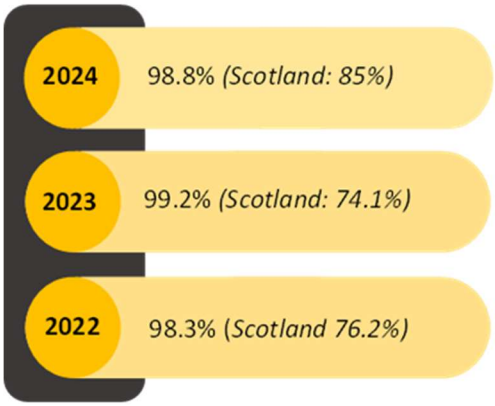
AAA screening Key Performance Indicators (KPI's) in NHS Borders

The KPI's for the AAA Screening Programme are intended to assess the critical achievement of the following aspects of the screening pathway: Invitation, Attendance, Quality of Screening, Referral, Clinical Intervention, and Outcomes. Each KPI has two thresholds:

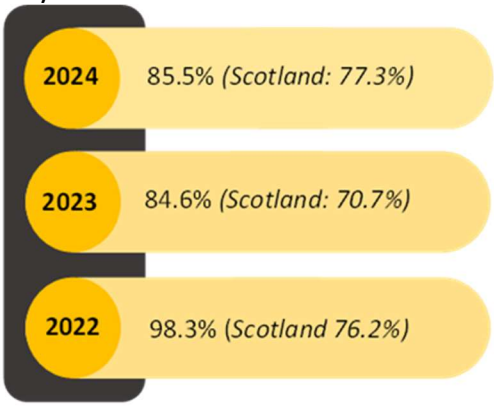
Essential: minimum level of performance which the screening programme is expected to attain.
Desirable: programme should aspire towards attaining and maintaining this level of performance.

Uptake of AAA screening in NHS Borders

KPI 1.1 Percentage offered screening before aged 66yrs 3months



KPI 1.2a Percentage tested before aged 66yrs 3months



The percentage of those offered screening before 66 years and 3 months for 2023/24 was 98.8%, Borders performance was better than Scotland overall, it met the essential national

standard (≥ 95% for 2023) and just fell short of the desirable standard (100%). Ideally individuals should also be tested before 66 years and 3 months. 85.5% of individuals in the NHS Borders were tested before age 66 and 3 months. Borders performed better than Scotland overall, it met the essential national standard (≥75%) and just fell short of the desirable standard (≥85%).

Table 1 shows uptake of AAA screening tests shown by deprivation quintile. The Scottish Index of Multiple Deprivation (SIMD) is a measure of socio-economic deprivation calculated for over 6,000 small areas covering the whole of Scotland. It is published by the Scottish Government, and is based on a range of factors, including income, education and housing. It provides a basis by which population measures and indicators can be broken-down by levels of socio-economic deprivation.

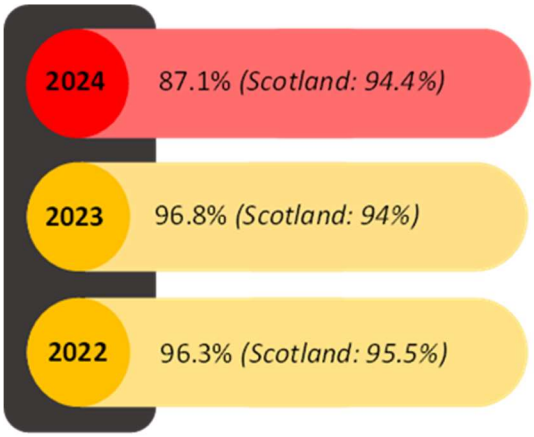
In 2023/24 NHS Borders met the essential standard for **KPI 1.3a** (≥75%) across all SIMD quintiles but was below the desirable threshold (≥85%) in quintiles 1 and 2. The national average of uptake in quintiles 3, 4 and 5 has fallen compared to previous years.

Table 1.1 showing the uptake of AAA screening tests by deprivation quintile (data source PHS 2025)

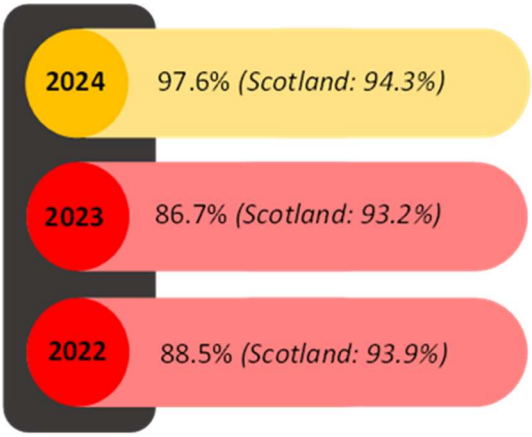
NHS Borders	**Percentage tested before age 66 and 3 months** ***2021-2022***	**Percentage tested before age 66 and 3 months 2022-2023**	**Percentage tested before age 66 and 3 months 2023-2024**
1 (Most deprived)	83.8%	91.9%	77.8
2	83.1%	85.5%	77.9
3	87.2%	84.9%	85.8
4	89.9%	84.5%	88.8
5 (Least deprived)	94.4%	76.3%	92.5

KPI 1.4a Participants who require ongoing surveillance at the Vascular department in NHS Lothian, the target is that they are screened within 6 weeks of the date of either their annual or quarterly surveillance. NHS Borders met the essential standard (≥90%) for percentage of annual surveillance appointments where men are tested within 6 weeks of due date in NHS Borders and fell short of the desirable standard of 100%.

KPI 1.4a Percentage of NHS Borders residents tested within 6 weeks of due date for annual surveillance



KPI 1.4b Percentage of NHS Borders residents tested within 4 weeks of due date for quarterly surveillance



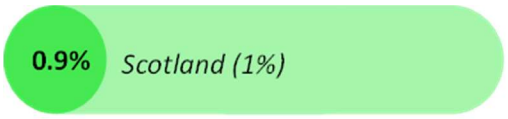
NHS Borders did meet the essential standard (≥90%) for KPI 1.4b percentage of quarterly surveillance appointments where men are tested within 4 weeks of due date in NHS Borders and performed above the national average. There are less than 5 patients in Borders undergoing quarterly surveillance; if someone fails to attend or reschedules their appointment it can affect this KPI disproportionately in such a small board as NHS Borders.

Screening performance and outcomes

KPI 2.1a The percentage of failed to scan encounters where the aorta could not be visualised Borders was 1.3% achieving the essential target in 2023/24 (<3%).

KPI 2.2 Percentage of screened images that did not meet quality assurance and required immediate recall

In 2023/24 NHS Borders met both essential (<4%) and desirable (<1%) standards for KPI2.2; percentage of screened images that did not meet quality assurance and required immediate recall.



KPI 3.1 AAA ≥5.5cm seen by vascular specialist within two weeks of screening, Borders achieved 66.7% which did not meet the essential KPI for 2023/24. Small numbers can disproportionately affect overall performance metrics.

KPI 3.2 NHS Borders achieved 33.3%, which did not meet the essential target of 60% for those participants with a AAA deemed appropriate for surgery and operated on within 8 weeks of screening. There is a risk noted around the inability to meet the essential target for KPI 3.2 (percentage of men with AAA ≥5.5cm deemed appropriate for intervention who were operated on by vascular specialist in Lothian within 8 weeks of screening).

As all men are referred for specialist intervention in Lothian, this is out with the control of Borders. Thia KPI is challenging to achieve across Scotland 19.1%.

Identified Risks and Challenges

KPI 3.2 as above
In NHS Borders, the relatively small number of cases being processed can significantly impact Key Performance Indicator (KPI) performance, even with a few failed encounters. This means that minor fluctuations in attendance or outcomes can disproportionately affect overall performance metrics.

NHS Borders Radiology department staff carry out the AAA Ultrasound scan (USS) and are resourced for a fixed number of clinics each year. To date the BGH Radiology department has been able to provide and additional clinics when needed, but this is a fragile arrangement and therefore there is a risk that Borders may breach target KPIs if the sonographers other service commitments prevent them providing additional goodwill AAA clinics.

The DNA rate (did not attend) and the subsequent rebooking requirement, can mean clinics, additional to the original programme funding, are regularly requested from the radiology dept sonographers who have other competing clinical commitments. This can impact on the KPI to screen before age 66, in some screening locations.

The anatomy of the individual as well as the increasing number of participants with significant abdominal adipose tissue can affect the clear imaging of the aorta. Staff are aware of participant re-positioning which may improve the visualisation of the aorta and new ultrasound machines have also improved sonographic penetration and a significant improvement in image quality has been noted. Sometimes, the aorta cannot be visualised during a scan. If this occurs, the participant will be invited for a second screen at the BGH. If it is not possible to visualise the aorta on the second scan, participants are discharged from the screening programme without a result and their GP is informed.

Adverse events

An issue was identified with the new AAA scanning equipment. An algorithm in the software was inappropriately “rounding” patients results on the scanner screen, but not on the participants result letter. This means that some surveillance patients may have been inadvertently given incorrect information about their recall status / frequency or may have been incorrectly advised that they would be referred to vascular services. The programme has resolved this issue.

2. Bowel

In Scotland, bowel cancer is the third most common type of cancer. Approximately 4,000 people nationally are diagnosed with bowel cancer each year.

Bowel cancer screening aims to detect the disease in the early stages before symptoms appear and when treatment is more likely to be effective, leading to improved outcomes. If detected at the earliest stage, more than 9 in 10 people will survive for 5 years or more. The Scottish Bowel Screening Programme (SBoSP) was introduced in 2007 and is a population-based screening programme which aims to reduce mortality and incidence rates from bowel cancer. Borders Health Board started the bowel screening programme in December 2009.

The bowel screening test is currently the only screening test to be performed at home. It involves sending a stool sample to the screening centre using the materials provided. The test used is the Faecal Immunochemical Test (FIT) It measures the amount of blood in the sample. Levels of blood above the determined programme threshold may indicate a higher risk of pre-cancerous growths (polyps) or other changes in the bowel.

Eligibility

Everyone with a CHI number across Scotland between the ages of 50 and 74 years old is invited to take the test every 2 years. Those over the age of 75 years old can also self-refer for a test by calling the bowel cancer screening helpline. This needs to be requested every 2 years if desired as there is no routine automatic recall in this age group.

Service delivery in NHS Borders

Bowel cancer screening is managed centrally within Scotland from the Scottish Bowel Cancer Screening Centre located in NHS Tayside. The laboratory and helpline are based at the screening centre and all call-recall is handled from this central location. The test kits are sent out to the address that a person used to register with their GP. It is possible to request a replacement kit by using an online form or contacting the screening centre. NHS Borders is responsible for delivering the diagnostic pathway for participants who have received a positive result.

Areas of good practice

The pre-assessment stage of the referral process to colonoscopy continues to work well with 94% of patients being offered a telephone pre-assessment appointment with a nurse within 14 days of referral.

The overall uptake of bowel screening in the Scottish Borders remains one of the highest of any mainland health board and is higher than Scotland as a whole.

Deprivation can impact negatively on uptake rates however in the Scottish Borders, uptake in the most deprived SIMD category rose steadily for all persons from 46% in 2010 to 60% in 2023. The gap in uptake between least and most deprived remained at 18% in 2023, which

is less than Scotland as a whole, where the gap has increased from 20.9% to 21.5%. High quality colonoscopy was demonstrated. Screen detected cancers are early stage and are usually followed by curative treatment.

Follow up and treatment

The Scottish Bowel Cancer Screening Centre (SBSC) aims to issue individual's results within 2 weeks. If the test is negative, no further investigation is required, and the person can continue with routine screening every 2 years. If the test is positive, then further assessment is required. Approximately 1 in 50 people who complete the screening test require further investigations. The Bowel Screening IT System (BoSS) refers the patient for this further investigation at their local colorectal cancer service. This usually involves a colonoscopy as an outpatient. This is an examination of the internal parts of the large bowel using a small flexible camera. Of those people who have a colonoscopy following a positive bowel screen test, 1 in 10 will have bowel cancer.

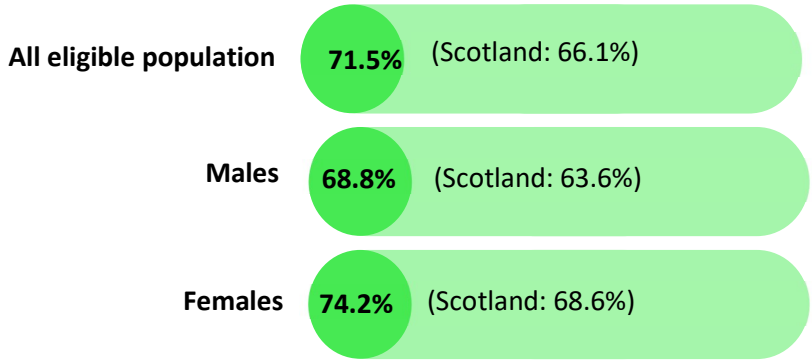
Healthcare Improvement Scotland (HIS) Standards: Bowel Screening Standards

The Bowel Screening Standards are a key component in supporting the SBoSP's approach to quality assurance. Monitoring performance against these standards at local and national levels aim to improve the quality of the programme. Healthcare Improvement Scotland (HIS) published updated standards in August 2023. NHS Borders continue to use the criteria set out in the Standards to monitor performance for the local health board regarding timeline from referral to preassessment, colonoscopy and reporting of histology.

Standard 1: All eligible people are invited for bowel screening once every two years - Uptake of Bowel screening in NHS Borders

KPI 1 The total Borders screening population for the 2- year cycle 2022-2023 is estimated at 49,206, an increase of 5% when compared to the previous cycle (2020-2021, n= 46,863).

Percentage uptake of bowel screening in NHS Borders from 1st May 2021 - 30th April 2023



Borders uptake for 2023 was 71.5% which is above the overall uptake for Scotland (66.1%). The uptake was greater in females than in males, but across both groups, NHS Borders performed above the Health Improvement Scotland (HIS) standard of 60%.

Table 2.1 shows a comparison of NHS Borders bowel screening activity since 2016, showing an increase in uptake from 62% in 2016 to 73% in 2023.

Table 2.1 – Comparison of Borders Bowel Screening Activity Data since 2016

	BGH Activity 2016	BGH Activity 2017	BGH Activity 2018	BGH Activity 2019	BGH Activity 2020	BGH Activity 2021	BGH Activity 2022	BGH Activity 2023
Estimated Screening Population	42,507		44632		46863		49,206	
Positives / year	261	256	453	363	199	472	364	396
Borders Uptake (%)	62%	61%	69%	71%	66%	72%	70%	73%
Scotland Uptake (%)	55%	55%	63%	65%	61%	67%	64%	68%

Uptake can also be reviewed by SIMD/deprivation category as in Figure 2. Bowel cancer uptake in Borders between 2021 to 2023 showed a strong trend by deprivation, with lowest uptake in the most deprived group and highest uptake in the least deprived group. Uptake was above the 60% HIS standard across SIMD quintiles two to five, but uptake for the most deprived quintile was marginally below the HIS standard at 59.5% (had been 60.2% between 2020 and 2022).

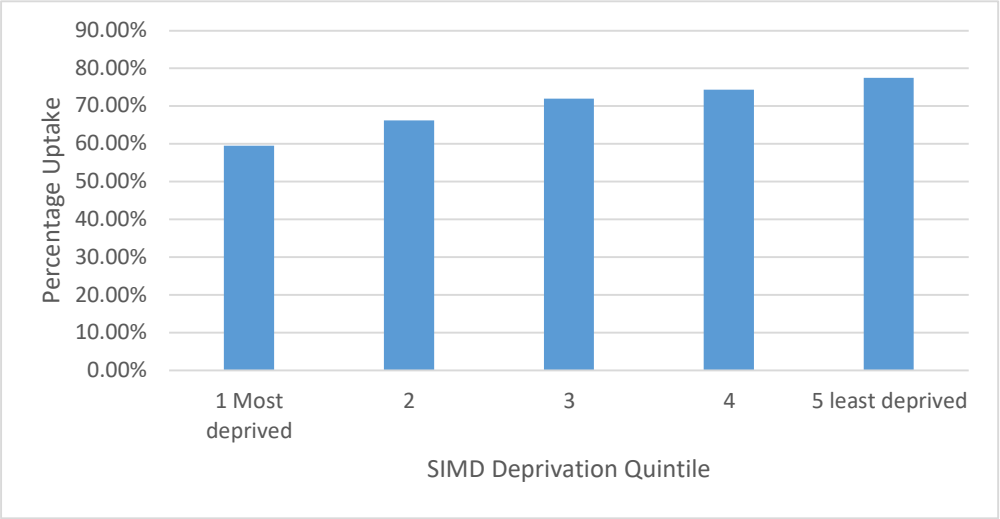


Figure 2.1 Uptake of screening for NHS Borders between 1st May 2021 and 30th April 2023, by deprivation category

The deprivation gap which is the uptake rate between the least and most deprived has remained at 18% in NHS Borders for 2023, the figure for Scotland as a whole, has increased from 20.9% in 2022 to 21.5% in 2023.

Bowel Screening Positive Referrals, Demographic Data

KPI 2 A total of 396 positive results on screening were received over the period January to December 2023. Figure 4 shows the age and gender distribution of positive bowel screening tests taken from BoSS (Bowel Screening IT System) during 2023. The largest proportion of positive screening tests came from people 65-69 years old (26%), followed by 60-64 age range at 19%.

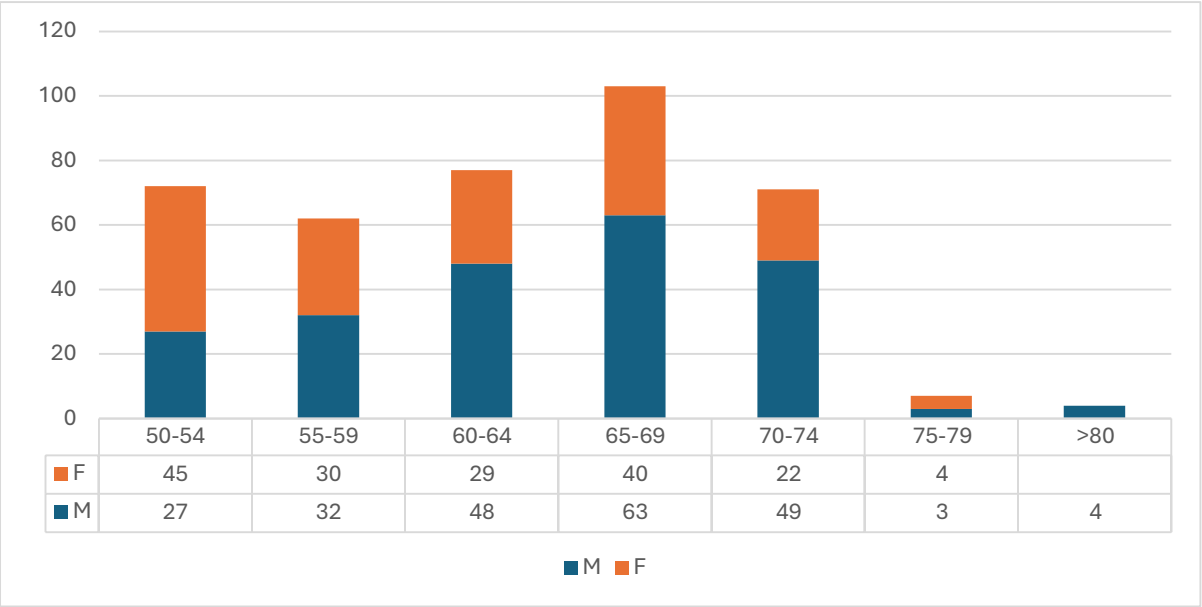


Figure 2.2- Number of positive screening tests by age band and gender (data source NHS Borders Bowel Screening Database)

Standard 2: Bowel Screening Laboratory Service

The SBSC ensures that the bowel screening laboratory service and processes are carried out in line with nationally required recognised standards

NHS Borders continues to apply the criteria from the previous 2007 standards i.e. 80% of specimen reports should be authorised within 7 days of receipt of the specimen by the histopathology laboratory.

Only 7% of the specimen reports submitted from colonoscopy were authorised within 7 days of receipt of the specimen by the histopathology laboratory in 2023. This is a further reduction from 2022 where 20% of the specimen reports were authorised within 7 days (Essential 80%) (2007 standard). This delay in authorisation of histology reports is common across most other screening programs and is thought to be due to demand/capacity issues.

Table 2.2 showing yearly percentage of specimen reports submitted from colonoscopy that were authorised within 7 days of receipt of the specimen by the histopathology laboratory

2018	2019	2020	2021	2022	2023
↑33%	↓20%	↑44%	↓14%	↑20%	↓7%

Standard 3: Bowel screening test result

The SBSC ensures that every bowel screening test result is accurate and reported in a timely manner

The positive predictive value (PPV) is the probability that subjects with a positive screening test truly have the disease.

Table 2.3 shows the PPV of the screening test to detect colorectal cancer.

Table 2.3 Percentage of people with a colorectal cancer, out of those with a positive screening test result and a colonoscopy performed in NHS Borders compared to Scotland by 2-year reporting period and by sex (data source PHS Bowel Screening KPI report February 2024)

	Positive predictive value for colorectal cancer in Borders by sex 2021/23	Positive predictive value for colorectal cancer in Scotland by sex 2021/23
Males	5.6%	5.5%
Females	3.7%	5.1%
All	4.8%	5.3%

Within Borders in 2021/23, 2.21% of those who took part in bowel screening had a positive result and would have been referred for colonoscopy. This has increased slightly from the previous 2-year period. More males than females who participated in bowel screening had a positive result within the most recent and previous 2 years periods.

Standard 4: Pre-investigative assessment

NHS boards ensure people with a positive bowel screening result are offered a high quality, timely and person-centred pre-investigation assessment

A total of 396 positive referrals were received in 2023. 30 patients were excluded from having a pre-assessment appointment. 366 patients were invited to attend a pre-colonoscopy assessment and of these 334 were fit for colonoscopy. 23 patients were unfit to proceed within the programme and 9 did not attend (DNA) or declined further investigation.

Participants should be offered a pre-assessment appointment within 14 days of their positive screening result.

The time between the receipt of a positive screening test result by the NHS board and the offered appointment date for pre-colonoscopy assessment is within 14 days 94% of the time (Desirable 95%).

Table 2.4 showing yearly percentage when the time between the receipt of a positive screening test by the NHS Board and offered appointment date for pre-colonoscopy assessment was within 14 days.

2018	2019	2020	2021	2022	2023
↓33%	↑81%	↓65%	↓59%	↑88%	↑94%

The time between NHS Boards being notified of the positive screening test and the date offered for colonoscopy is within 31 days for 95% of cases.

Table 2.5 showing yearly percentage when the time between the NHS Board being notified of the positive screening test and the date offered for colonoscopy was within 31 days.

2018	2019	2020	2021	2022	2023
7%	30%	21%	43%	25%	58%

Standard 5: Diagnostic investigation

NHS boards ensure high quality, safe and timely diagnostic investigation is available following a positive bowel screening result Colonoscopy timeliness and completion

KPI 4 A total of 326 Bowel Screening colonoscopies were performed in 2023 (302 complete, 24 incomplete). A completion rate of 93% was achieved, which is within the recommended guidelines of >90% completion rate. Some of the procedures performed in 2023 are generated from referrals received within the last quarter of 2022. 36 referrals received at the end of 2022 were performed during Quarter 1 of 2023.

The time between NHS Boards being notified of the positive screening test result and the date offered for colonoscopy should be within 31 days for 95% of cases.

Cancer detection and staging

Within NHS Borders, 0.086% of people who participated in bowel screening in 2021/23 had a colorectal cancer detected, with more males (0.120%) than females (0.054%) having a cancer diagnosed. This is lower than the Scottish detection rate of 0.114%.

15 patients with a positive result were identified with colorectal cancer in 2023. The overall cancer detection rate for the programme (percentage of patients with cancer out of those with a positive screening result) in 2023 was 4% (14/396), consistent with 2022 - 4% (15/364).

The cancer detection rate for colonoscopy patients (percentage of patients with cancer out of those undergoing colonoscopy) was 4% compared to 5% in 2022.

Screen detected cancers are generally at an early stage and usually followed by curative treatment. Less than 1% of individuals in the Borders who participated in bowel screening were diagnosed with polyp cancer, adenomas or high-risk adenomas. The most common location for colorectal cancer to be found in individuals in Borders was the colon (63.3%), followed by rectum (26.7%), and rectosigmoid junction (10%). Borders had more cancers than Scotland in the rectosigmoid junction, but fewer in the colon and rectum.

Positive predictive value for adenoma 2-year period from 1st May 2021 – 30th April 2023:

44.6% (Scotland: 46.4%)

One of the more specific HIS standards for bowel screening is the positive predictive value of the screening test for adenomas. This is the percentage of people with adenoma out of those with a positive screening test and a colonoscopy performed. In Borders for 2021/23 this was 44.6%, which was lower than Scotland and above the HIS threshold of 35%.

Identified Risks and Challenges

As detailed above, the time from positive screening referral to colonoscopy test continues to be a challenge within NHS Borders. The majority are taking place between 4-8 weeks when this should ideally be <4 weeks.

The reporting time for specimens submitted from colonoscopy to date of report being authorised has increased with only 7% of histology reported within 7 days, 21% within 14 days, 18% within 21 days and 54% waiting more than 21 days.

Adverse events

No adverse events were identified during the period of this report.

3. Breast

In Scotland, breast cancer is the most common type of cancer for those assigned female at birth (AFAB). It is estimated that 1,000 people die from breast cancer each year.

Breast cancer screening aims to detect the disease early when symptoms are minimal or non-existent. The objective of this is to allow for early intervention to improve survival rates. If detected at the earliest stage, almost all women will survive their disease for 5 years or more14.

Breast cancer screening involves performing a mammogram (x-ray) of the breast tissue. Two x-rays are taken of each breast. The appointment usually lasts no longer than 30 minutes.

Eligibility

All women between the ages of 50-70 years old are invited to participate in breast screening every 3 years. Women aged over 71 years old are out-with the routine screening age for this programme. During Covid-19, self-referral was paused, but by October 2022, self-referral was gradually phased back in. The Southeast Scotland Breast Screening Centre screens Scottish Borders residents who self-refer, 0.2% of programme capacity is allocated for self-referrals.

AFAB non-binary people and trans-men who have not had breast removal surgery are automatically invited to breast screening if they have not changed their CHI number to reflect their male gender or if their CHI number was changed after 14th June 2015. If their CHI number was changed before this, they can self-refer for screening by contacting the local breast screening centre.

Trans-women, those assigned male at birth, non-binary people who are taking hormones are automatically invited for breast screening if they have changed their CHI number to reflect their female gender after 14th June 2015. If their CHI number has not been changed, or the change occurred before this date, they can also self-refer for screening.

Service delivery in NHS Borders

The Scottish Breast Screening Programme (SBSP) is delivered by six regional screening centres. The Scottish Borders is in the Southeast Scotland area. The Southeast Scotland Breast Screening Programme (SESBSP) is directly commissioned by the NSS. NHS Lothian is the host board with local and regional partnership working with the SESBSP centre. The service is provided by mobile units across NHS Borders with staffing from SESBSP.

Areas of good practice

All mobile screening units are equipped with wireless mobile communications technology, which automatically seeks out the strongest signal from three different mobile networks. This allows for the direct transmission of X-ray images and administrative details to the Scottish Breast Screening System (SBSS) and the Southeast Scotland PACS image storage

system. Images are sent directly to the screening centre for remote quality checks. This enables the team to request backup opinions and technical assistance from the core team at Ardmillan House in Edinburgh at any time. This advancement eliminates the need for manual collection and transport of images back to Edinburgh.

Additionally, the use of this technology has facilitated skill-mix development i.e. allowing mobile screening sessions to be conducted by a team of two Band 4 Associate Practitioners. They instantly consult with senior staff at Ardmillan House for guidance if required. This change has improved screening coverage and allowed the budget to be used more effectively whilst enhancing team capabilities through role development and career progression opportunities. Employing associate practitioners also provides greater flexibility to address staff shortages.

Following resumption of the programme during the Covid-19 pandemic, several adaptations were made to improve capacity. An additional mobile unit was added in January 2021, weekly Saturday clinics were introduced, and appointment overbooking with 2 patients per appointment slot. The last measure created a more efficient use of clinical time as both clients can be accommodated within the allocated time. If one client does not attend, there is at least an alternative client present.

There are robust methods in place to follow up those who have been referred for further investigation at the breast centre in NHS Lothian but who have not responded and/or attended.

The programme successfully trialled insertion of SaviScout surgical localisation markers into all grade 4 and 5 lesions to be referred to Borders or Lothian for treatment. This removed the need for individuals to attend tertiary centres in advance of their day of surgery.

Since May 2022, those resident in the Borders who are diagnosed with non-palpable lesions are referred to their home board for treatment. To enable this change, the Edinburgh Breast Screening Multi-disciplinary meeting is held on Microsoft Teams to allow surgeons and radiologists from Borders and Forth Valley to attend.

NHS Borders initiative, i.e. ‘Bridging the Gap’, was established to raise awareness and provide support for people with a learning disability to make choices about participating in screening programmes and to attend for screening. This initiative evolved as part of core service delivery for the Joint Learning Disability Service. Screening is an integral element of the annual health check offered to all people with a learning disability registered with a GP in the Scottish Borders.

Follow up and treatment

During the screening appointment, a decision will be made about whether the images obtained are of sufficient quality. If they are not, additional images are taken. Results are usually sent by letter within 3 weeks with the individual’s GP also receiving a copy.

The images are reviewed by two specialists. If they disagree about the results of the mammograms, then a third reviewer is used. If they are also unsure about the results, a technical recall is issued, and an appointment will be arranged for further imaging. If both reviewers agree that the mammograms are normal, then a negative result is issued, and the individual will continue to have routine breast screening. If both reviewers agree that there is an abnormality on a mammogram, then further investigation is required. Approximately 1 in 20 people who have a mammogram will require further tests. The individual is invited to the specialist breast centre in NHS Lothian, and may have a breast examination, more mammograms, an ultrasound scan and/or a biopsy. 1 in 5 of those who have further investigations following screening will have breast cancer.

NHS Breast Screening Programme Performance Standards

The breast screening standards are a key component in supporting the SBSP approach to quality assurance. Monitoring and improving performance against these standards at local and national levels aims to improve the quality of the SBSP. Each standard has two thresholds:

Acceptable - The lowest level which a screening service is expected to attain.
Achievable - The level at which the screening service is likely to be running optimally.

The performance report for Breast Screening in Borders is based on the 3-year period from 1st April 2020 to 31st March 2023.

Uptake of Breast Screening in NHS Borders

The achievable standard for uptake is that 8 out of 10 women invited for screening would attend their appointment; 7 out of 10 has been set as the acceptable standard.

79% *(Scotland: 75.9%)*

In Borders, 79% of the eligible population had breast screening in the 3-year cycle between 2020 and 2023, which was higher than the Scotland average. Borders met the acceptable standard and narrowly missed the achievable standard. Uptake can also be reviewed by

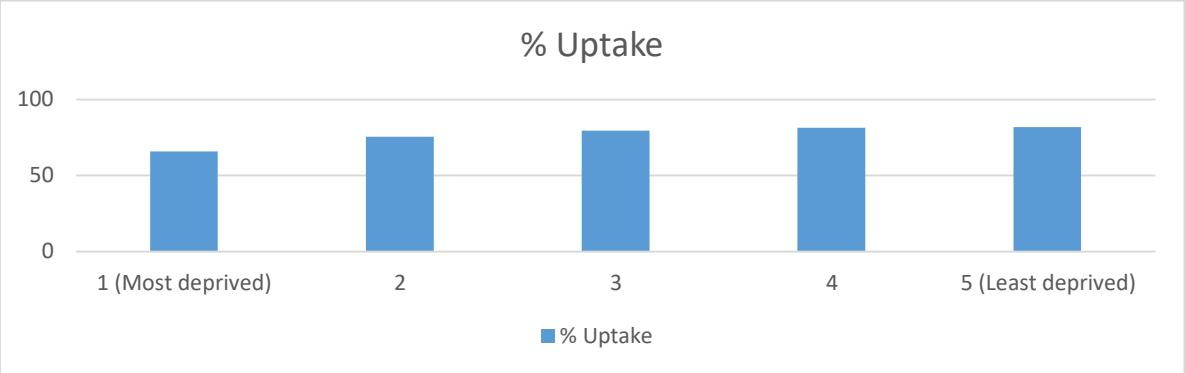


Figure 3.1 percentage uptake of breast screening in each deprivation category for Borders between 2020 and 2023

SIMD category in Figure 10. In NHS Borders, uptake is lowest in the most deprived quintile.

Borders attained the achievable standard of 80% for uptake of the programme in least deprived quintiles SIMD 4 & 5, SIMD 2-3 achieved the acceptable standard 70%. however, this was not met for those in within the most deprived quintile only achieving an uptake of 65.8%.

Screening performance and outcomes

Table 12 shows the breast cancer detection rates for the 3 year cycle between 2018/19 and 2020/21 in Borders. Data show there were 62 breast cancers detected through the screening programme, of which 41 were less than 15mm in size. There were 14 non-invasive cancers detected during the same period.

Table 3.1 Breast cancer detection rates through breast cancer screening for 3-year cycle from 2018/19 to 2020/21 in Borders

	Number of women at their first screening (50-52 yrs old)	Number of women at subsequent screenings (53-70 yrs)
Invasive Cancer detected (all)	10 (6.8 per 1,000)	52 (7.1 per 1,000)
Invasive Cancer detected (<15mm)	5 (3.4 per 1,000)	36 (4.9 per 1,000)
Non-Invasive Cancer detected	1 (0.7 per 1,000)	13 (1.8 per 1,000)

The standardised detection ratio (SDR) for the breast screening programme in Borders for this 3-year cycle was 1.6, which was above both the acceptable (≥1.0) and achievable targets (≥1.4) as well as being the same as the Scotland average.

For 2020-2023, there is no board specific data but nationally the screening programme achieved both acceptable and achievable standards across all cancer detection metrics.

Some women who are referred for further assessment following screening have a biopsy taken but are not diagnosed with breast cancer – instead they have a benign condition. The benign biopsy rates for Borders between 2018/19 and 2020/21 were within the acceptable and achievable thresholds for those having subsequent screens but only met the acceptable target for women having their first screen.

For 2020-2023, there is no board specific data but nationally the screening programme met acceptable and achievable standards in rate of benign biopsies in women having their subsequent screen but narrowly missed the acceptable standard in those having their initial screen. A rate of less than 1.5 in 1,000 surgical biopsies with a normal or non-malignant outcome is deemed acceptable. Across 2020/23 the rate was 1.6 per 1,000 surgical biopsies.

Overall, the Breast Screening Programme is meeting most of the Screening standards. Nationally for the 3-year period 2020-2023, the only un-met acceptable standard was the rate of benign biopsies at the prevalent screen (50 to 52). NHS Borders Board specific data is not available for this 3-year period but for the previous 3-year period 2018/19 – 2020/2021 NHS Borders reassuringly did meet the acceptable standard for this metric. For 2020-2023, the uptake of screening in the most deprived SIMD category (65.8%) was below the

acceptable standard (70%), but uptake overall in Borders (79%) was above the acceptable standard and narrowly missed the achievable standard (80%).

Identified Risks and Challenges

The main challenges relate to the accessibility and suitability of screening sites for the mobile screening units across the Borders. Traveling to more remote locations, such as Newcastleton, Jedburgh and Hawick, takes screening staff longer when travelling from Lothian reducing the available hours for each clinic. Site suitability can also vary. For instance, Galashiels Health Centre was not able to accommodate the siting of the mobile unit due to parking requirements for visitors and staff. An alternative nearby site was secured in the ASDA car park.

The mobile screening units pose a significant risk due to the constant strain on their generators and vehicle structures from operating five full days a week. Each quarter, several days of screening are typically lost because of generator malfunctions or issues with the batteries that power the lights, computing systems, and x-ray equipment.

Prior to the pause in screening during the Covid-19 pandemic, the 20% growth in the eligible population across the Southeast of Scotland meant that the service was already unable to deliver all screening appointments within 3 years of previous appointments. Screening was suspended from April 2020 - July 2020 inclusive, recommencing 3rd August 2020. The pause in screening and restricted capacity following restart increased the screening gap to around 3 years and 10 months by January 2021. This improved by use of an additional mobile screening unit and additional Saturday clinics to 3 years and 2 months by the end of 2023.

Adverse events

Three national adverse events during the reporting period, however there were no Borders patients affected by these incidents.

1. During Summer 2022, four replacement mammography units within the Scottish Breast Screening Programme were suspended from clinical use due to continued sub optimal quality of breast images produced from the mammography equipment. This is combined with concerns that there were lower cancer detection rates for women screened on these units.

2. An adverse event was raised relating to procurement difficulties that delayed roll-out of replacement mobile screening units during 2022/23.

3. In September 2022 there was a problem with GP practice merges on SBSS, whereby eligible women were not moved over to the correct new GP practice as a result of a practice merge. This resulted in women remaining on a closed practice, and while still able to be recalled, may not have been recalled at the same time as the new practice or not invited appropriately for breast screening.

4. Cervical

Cervical cancer is the most common cancer in young women in Scotland (aged 25-35 years old). Approximately 5 women across the country are diagnosed with this cancer every week17. Ninety-nine % of cervical cancers are caused by human papilloma virus (HPV). 4 in 5 women will develop an HPV infection at some point in their lives. Some types of HPV do not cause any noticeable symptoms, and the infection will pass without treatment. 1 in 10 infections18 are harder to clear and eventually over many years they may cause changes to the cervix. The primary aim of screening is to detect individuals who have HPV so that further investigation for early pre-cancer cell changes can be carried out. These changes can then be monitored or treated with the aim of reducing the number of people who go on to develop cervical cancer and mortality rates from this disease.

The cervical screening test involves a healthcare professional taking samples of cells from the cervix. This is usually carried out within local GP practices and the appointment takes 15-20 minutes.

Eligibility

Cervical screening is routinely offered to anyone with a cervix in Scotland between the ages of 25 and 64 years every 5 years. Those up to the age of 70 will continue to be invited for screening if they are on a non-routine screening pathway due to previous abnormal results.

AFAB (assigned female at birth) non-binary people and trans men who still have their cervix are automatically invited to cervical screening if they have not changed their CHI number to reflect their male gender, or if their CHI number was changed after 14th June 2015. If their CHI number was changed before this, they can self-refer for screening by contacting their GP.

Trans women and AMAB (assigned male at birth) non-binary people who have changed their CHI number to reflect their female gender after 14th June 2015 will be automatically invited to screening but they do not need to attend as they do not have a cervix and so are not at risk of this type of cancer.

Service delivery in NHS Borders

Eligible individuals receive an invitation for screening through the post and most screening tests are performed within primary care. Since 30th March 2020, the programme changed so that all samples taken are first tested for high-risk HPV that is found in 99.7% of cervical cancers. If HPV is found, then the sample will be looked at under a microscope to detect any changes to the cells.

Oversight for call-recall in the cervical screening programme is managed within local boards with support from a national IT system called SCCRS (Scottish Cervical Call Recall System). This multi-module platform coordinates the call recall functions, GP sample taking, colposcopy and laboratory information.

Areas of good practice

Since January 2017, to improve uptake of cervical screening within staff in NHS Borders, the Public Health Screening team has arranged evening clinics for employees who are due, or overdue, cervical screening.

The Bridging the Gap project was initiated by NHSB screening team to raise awareness of cervical screening amongst people with a learning disability. Those who are excluded or opted out have the opportunity for further discussions and accurate recording of their decision. Furthermore, the new learning disability health check explicitly asks about cervical screening in the assessment.

Borders used its allocation of the 2023 Cancer Inequalities Fund to address a concern that women due cervical screening whilst pregnant may not have the appropriate pregnancy exclusion applied to their SCCRS record by their GP practice. This exclusion would postpone the cervical screening invitation/reminders for those due screening whilst pregnant until 6 weeks after their baby is born. The 25–34-year age group has the lowest uptake in Scotland and pregnancy exclusion issue could be a contributory factor. The Cervical Call Recall Offices are not informed of who is pregnant or their due date however this project enabled them to obtain this information and ensure the pregnancy exclusion is applied correctly. The project includes midwives, GPs and practice managers, educating them on how pregnant participants may be disadvantaged if the pregnant exclusion is not applied to SCCRS. This project also encourages them to promote the importance of cervical screening to their pregnant patients and inform their patients of the need to be screened 6 weeks post-delivery for those who were due screening whilst pregnant. Shared learning of the work in Borders was presented to SOAS (Screening Oversight & Assurance Scotland) who are considering our findings and the implications of the variation in applying the exclusion to the cervical screening programme across Scotland. An FAQ document that highlights the process for pregnancy exclusions is in development. A Borders leaflet with information on attending for cervical screening after pregnancy was added to the national baby box programme.

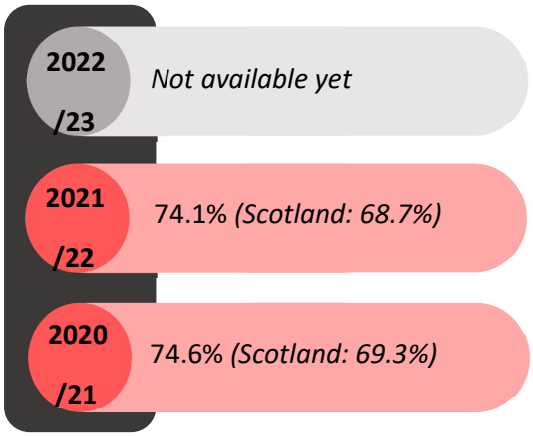
Follow up and treatment

Results of the screening test should be reported by the screening laboratory within 2 weeks and posted to the individual. If HPV is not found in the sample, then the individual will be invited again in 5 years. If HPV is found but there were no cell changes, then they are invited for screening in 12 months. If both HPV and cell changes are seen on the sample, then a referral is made to a colposcopy clinic for further investigation and treatment where necessary to prevent any abnormal cell changes becoming cancer. Finally, if the sample result was unclear for any reason, then the individual is asked to return for another screening appointment in 3 months.

Uptake of Cervical Screening in NHS Borders

This report is based on the data that is available up to 31st March 2022. The National Data for this programme is presented as National Programme Performance Statistical Report. Data for 2022/23 and 2023/24 data is currently unavailable due to validating the results from the performance data for the programme. At national level there is development of KPI reporting for this programme which is expected available in June 2025.

Uptake Coverage - Percentage uptake of cervical screening among NHS Borders residents



The uptake of cervical screening in Borders has been declining over the past 4 years of available data. Uptake was 77.3% in 2018/19 but only 74.1% in 2021/22. It is difficult to know if this is due to interruption of the programme and other impacts of the Covid-19 pandemic. A similar trend has been seen across Scotland, although uptake locally is still higher than the Scottish average (68.7% in 2021/22). The HIS standard for coverage is a minimum of 80%, and so Borders did not meet this target in 2020/21 or 2021/22.

There is variation in uptake of cervical screening by age in Borders, with lowest percentages seen in the 25 -29year age group (61%) and 60 - 64-year age group (71.6%) in 2021/22. This pattern is the same as the one observed in 2020/21, although the uptake has dropped over those two years across almost all age groups. The trend is also seen across Scotland, although Borders performed better than the Scottish average for all age groups in 2021/22.

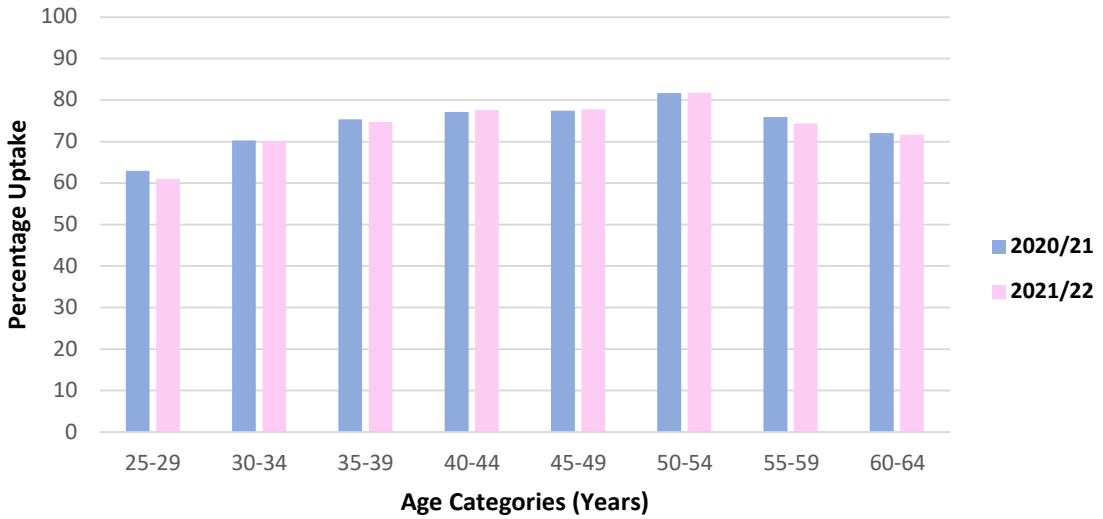


Figure 4.1 Percentage uptake of cervical screening within NHS Borders, by age for 2020/21 and 2021/22

Additional inequalities in uptake exist across age categories within the cervical screening programme as well as across deprivation categories.

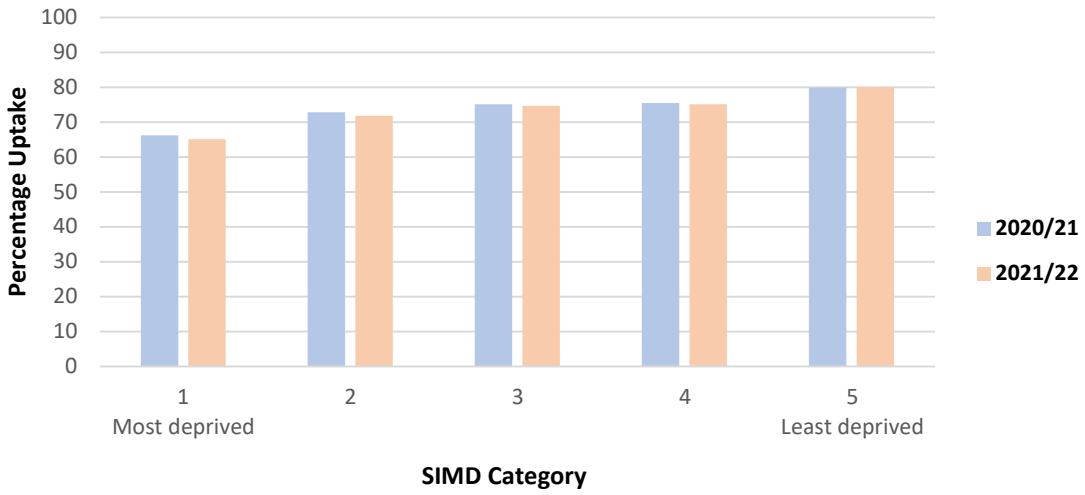


Figure 4.2 Percentage uptake of cervical screening within NHS Borders, by deprivation quintile for 2020/21 and 2021/22

Uptake of cervical screening shows a very clear trend in Borders, with uptake being lowest in the most deprived parts of the population (65.1% in 2021/22) and highest in the least deprived (80% in 2021/22). This is a gap of 14.9% between the most and least deprived areas of Borders. This trend was observed in 2020/21, with uptake decreasing across the two years for almost all categories except for the least deprived. The HIS standard of 80% uptake was only achieved in the least deprived category in 2021/22.

HPV vaccine was introduced in 2008 and is now offered to all individuals between 11 and 13 years old in Scotland. In 2021/22, uptake in screening amongst those 25-31 years old who were fully vaccinated was 70.4% in Borders. Uptake was only 61% in those of the same age with incomplete vaccination and was even lower (45.8%) in those with no HPV vaccine history. This may be due to immunised women being more aware of the risk of cervical cancer because of their previous contact with the immunisation programme.

The UK National Screening Committee (UK NSC) opened a consultation on whether to offer an HPV self-sampling option to under-screened people in the cervical screening programme. The consultation closes at the end of February 2025 and recommendations will follow.

Screening performance and outcomes

The HIS standard requires a minimum of 80% of individuals receive their screening results within 14 days from the date of the sample being taken, excluding postal time. This information is not available for Borders specifically, but some information does exist for the 2 laboratories in Scotland.

In 2021/22, the turnaround time for 95% of all screening tests processed within Scotland varied between 18 and 38 days across the quarters. The range was slightly wider in 2020/21, with turnaround time varying between 14 and 43 days that year.

The number of new cases of cervical cancer diagnosed each year is very low in the Borders and fluctuates from year to year, as would be expected given the small numbers.

Identified Risks and Challenges

NHS Borders is a small, rural board, which could lead to non-engagement with the cervical screening programme for women who have no choice other than their local GP practice for their routine smear. As a single point of access for this programme there is risk that local practice at times do not have trained sample taker for a period of time, resulting in access to service for those registered with a practice.

There are now only 2 national laboratories who analyse and process cervical smear tests. Initial demand modelling for cytology is being reviewed nationally as the laboratories have struggled to meet the 2-week time-to-result KPI due to the cytology test demand and capacity issues. This can be distressing for screening participants due to some participants waiting 2–3 months for their result.

Colposcopy waiting times in Borders are usually well within national targets but have recently come under pressure in line with other health boards due to staff retirements and absence.

There is a risk to resilience within the call-recall function of the cervical screening programme in Borders. The team is small and gaining competence in delivery of the specialist requirement of call recall duties, therefore, any absence has a significant impact on function.

Adverse events

1. No Cervix Audit June 2021. National incident whereby individuals who had a Subtotal Hysterectomy were incorrectly excluded from the cervical screening programme. All Borders cases were identified and invited for assessment and no cancers or adverse outcomes because of not being screened were found. To provide reassurance to the Scottish Government the audit was extended to include all women who had undergone a Total Hysterectomy in Scotland, to check they were correctly excluded.

   NHS Borders Public Health Cervical Screening and Hysterectomy Audit Team completed a review of 4191 Borders patients' medical notes from March 2023 - March 2024. No cancers or adverse outcomes due to not being screened were found.

2. Incorrect Management National Incident – Cervical Screening Laboratory Incident where women with three consecutive cervical screening results of HPV positive with negative cytology were not referred to colposcopy as per the nationally agreed pathway.

3. Northern Ireland Incident - The cervical screening programme in Northern Ireland (NI) has identified an underperformance in a small number of Biomedical Scientists (BMS) carrying out screening within their Cervical Cytology Service between January 2008 and October 2021. As a precaution, they are reviewing records to double-check that the correct information was provided. Some of the individuals affected now live in Scotland, however their last screening record on the NI system falls between the dates in question. 99 individuals in total across Scotland are affected by this incident and under

10 of these now live in the Borders. Call Recall Office (CRO) checked their records on SCCRS to check whether they had recent screening history in Scotland. The Northern Irish Government advised that 17,500 women to have their cervical screening rechecked from a 13-year period, and they may request these participants are followed up where they now reside.

5. Diabetic Eye Screening (DES)

The Diabetic Eye Screening programme (DES) was formerly known as the Diabetic Retinopathy Screening Programme. The programme aims to check for diabetic retinopathy, which is a condition caused when high blood sugar levels damage the small blood vessels in the retina.

People with both type 1 and type 2 diabetes are at risk of developing the condition and often there are no symptoms in the early stages of the condition. If the damage is not treated then it can lead to serious complications, including blindness. Untreated diabetic retinopathy is one of the most common causes of sight loss in working age people. When the condition is found early, treatment is effective at reducing or preventing damage.

The screening test involves a screener taking a digital photograph of the back of the eye to detect any damage. The test usually takes 10 minutes. Some people require eye drops to dilate their pupils to take successful images and are advised in their invitation not to drive following this. The retinal images are then downloaded for assessment and grade assignment in Optomize, the DES IT system.

Eligibility

Everyone diagnosed with diabetes, and on the Scottish Care Information (SCI) Diabetes database, over the age of 12 years old is invited to have DES every 2 years if they are at low risk of sight loss. Those who are at high risk of sight loss should be invited every 6-12 months for screening. Pregnant women with diabetes are invited three times during/post pregnancy due to the risk of gestational diabetes.

Service delivery in NHS Borders

NHS Borders commissioned NHS Lothian in 2008 to provide some programme management, external quality assurance, retinal image grading and call recall admin services for the Borders DES programme. NHS Borders provides the DES screeners and cameras.

The DES service currently screens at the following locations:

- Borders General Hospital
- Coldstream Health Centre
- Eyemouth Health Centre
- Hay Lodge Health Centre, Peebles
- Hawick Community Hospital
- Hawick Health Centre
- Jedburgh Health Centre
- Kelso Community Hospital
- Knoll Hospital, Duns
- Selkirk Health Centre

The DES programme in the Borders is delivered by two screeners, supported by the Borders Screening Team as well as NHS Lothian's Princess Alexandra Eye Pavilion programme

manager, graders, and call recall administration, who manage all screening appointments for Borders screening participants. NHS Borders Ophthalmology Department provide all OCT (Optical Coherence Tomography) 3D imaging for the DES programme in the Borders. This is due to the numbers eligible for OCT imaging following DES screening (circa. 150 p.a.) are too low to justify the procurement costs of an additional screening OCT machine.

Where a satisfactory retinal image cannot be obtained by retinopathy screeners, then patients are asked to make an appointment with a local community optometrist who deliver the slit lamp examination element of the programme. Results are recorded within the screening system.

Areas of good practice

Delivery of slit lamp examination by community optometrist allows individuals with limited mobility or access to affordable public transport to visit a local optician for their screening rather than traveling to the Borders General Hospital for an ophthalmology appointment.

Increasing access to screening by delivering regular Saturday clinics are available for those who have difficulty attending routine DES appointments during the working week. Additionally, the DES program aims to accommodate in-patients at the BGH who have missed their screening, often arranging a walk-in appointment on the day the issue is identified.

Patients invited to the programme are given a phone call to remind them of their appointment and to discuss any issues with attending the appointment. This has often led to elderly patients being given an appointment much closer to home than the one they originally received from the Lothian call-recall office. Text message reminders of DES appointments is due for implementation in the Borders in 2024/25 by the programme which should also help reduce Borders DNA rate.

Follow up and treatment

Results are usually sent to participants within 4 weeks. An individual's image grading outcome and screening history are used to determine their risk profile and recall interval. In Scotland, approximately 1 in 50 people who have a screening test will be referred to an eye specialist for investigation or treatment.

Uptake and screening performance of DES in NHS Borders

The DES programme moved from Vector to Optomize IT system in June 2020 and since then the national programme has continued to struggle to refine and validate the KPI's due to technical and reporting issues, which now are not completely resolved. **Therefore, KPI's reported for this programme in this report should be viewed with caution.**

Worth noting that from 1st January 2021 revised screening intervals (RSI) were introduced, which corrupted the KPI denominator are as it was based on a 12-month screening round.

Low risk patients, who met the RSI criteria, were moved to a 2-year recall. To avoid distorting the demand curve, RSI was phased in gradually, using a random allocation algorithm, across Scotland, not by Board. The proportion allocated either a 1-year or 2-year screening interval varied in each Board. To smooth the demand peaks and troughs created by post covid catch-up efforts, boards pulled patients forward for appointing which unwittingly affected the low-risk patient's routine recall interval, moving them back to a 12m recall from a 24-month recall, further increasing demand unnecessarily. An automated demand smoothing tool has been developed for Optomize, which will negate the requirement to manually recall patients early to fill clinics and smooth demand peaks and will prevent unwanted recall interval changes. The implementation of this smoothing tool has been delayed but is expected in June 2025. Meanwhile, the call recall office ensures screening participants are not recalled earlier than two months to avoid unnecessary changes to recall intervals.

Uptake of screening

For period from 1st April 2023 to 31st March 2024

KPI 1: Percentage of eligible people in NHS Borders regardless of personal circumstances or characteristics who are offered an opportunity to attend a screening appointment (Essential standard 100%)

2023 80.5% *(Scotland: 81.6%)*

The percentage of those eligible for DES who were offered a screening appointment was below the essential national standard in NHS Borders, the Scottish average was also below the essential national standard. However, the findings for this KPI should be interpreted with caution, as the data is believed by DES to be inaccurate or potentially unreliable.

KPI 2: Percentage of eligible population in NHS Borders who attended a screening appointment after invitation (Essential standard – 80%)

2023 60% *(Scotland: 68.2%)*

Of those eligible, 60% attended a screening appointment. NHS Borders did not meet the national standard of 80% and was below the national average of 68.2%.

KPI 4: Percentage of eligible patients who were successfully screened in NHS Borders (Essential standard – 80%)

2023 58.4% *(Scotland: 66.6%)*

Of the eligible population in 2023/24, 58.4% were reported as successfully screened. This was below the national KPI, and below the Scottish average.

As there are only 2 screening staff, long term absence of 1 of these staff members in this reporting period has impacted on capacity in the Borders region. The call recall office was inviting patients with a 24 month recall a few months early, to smooth demand peaks created during the Covid-19 recovery period and to fill clinics, but due to a quirk of the Optimize IT system this inadvertently resulted in the reversion of these participants back to a 12 month recall interval from their previous 24 month recall interval. This resulted in the inflation in the number to be screened and was at a time when we had reduced capacity.

KPI 5 is a more useful overall indicator of DES screening performance – Biennial successful screening rate which takes into account the 12m and 24m screening intervals. Borders achieved 76%, and not meeting the essential standard of 80% for this KPI.

2023 76% *(Scotland: 81.4%)*

Screening performance and outcomes

Failure rates

KPI 6 - Technical recall failure rate/the proportion of the eligible population who have been successfully screened during the report range

2023 0% *(Scotland: 0%)*

The technical recall rate for people attending a DES appointment in Borders was 0% for 23/24, which was within national targets (as low as possible).

KPI 7A - Photographic technical failure rate/the proportion of photographed RDS (fundus) encounters that were graded as unsuccessful during the report range. (Essential standard, maximum of 2.5%).

2023 4.3% *(Scotland: 3.4%)*

The photographic technical recall rate was higher than Scotland as a whole. Both were above the essential standard.

R6 is a technical failure, which is almost always due to the presence of cataracts. This means the images of the retina are unsuitable for DES grading, resulting in an automatic referral for a screening slit lamp exam. During the last few years NHS Borders ophthalmology department has had very long waiting times for cataract operations. If Ophthalmology has not appointed those screening patients within 15 months of the referral, then the patient will failsafe back to the DES programme whilst waiting to be appointed to ophthalmology. Waiting times have been an issue across Scotland in this reporting period, but in a small Board such as Borders, clinicians have many competing demands on their limited capacity and cataract s do not usually result in permanent sight loss.

KPI 7B - Slit lamp technical failure rate (Essential standard, maximum of 2%)

2023 2.2% *(Scotland: 3.5%)*

NHS Borders was narrowly above the national standard for slit lamp technical failure rate but performed better than Scotland as a whole. The combined overall technical failure rate in 2023/24 was 4.18%, which was higher than the Scottish figure of 3.4%.

In NHS Borders DES slit lamp exams are carried out by community Opticians (optometrists). The patient is sent a list of accredited optometrists, the patient chooses an optometrist and arranges the slit lamp exam appointment themselves. The optometrist sends the slit lamp result report to the call recall office, who add it to Borders Optomize IT system. As with fundus, the high DES slit lamp technical failure rate is primarily driven by long waits for cataract removal.

Written reports

KPI 9: Percentage of those who are screened are sent their result within 20 working days.

2023 82.75% *(Scotland: 71.23%)*

This KPI is being investigated by NEC and should be interpreted with caution, as the data is believed by DES Programme Board to be inaccurate or potentially unreliable. Within NHS Borders, approximately 83% of individuals were sent their screening result within 20 working days of their appointment over 2023/24. This is below the national target of 95%, but Borders does perform better than the Scottish average for this measure (71.23% in 2023/24).

In 2023/24, the maximum length of time between screening and a results letter being printed in Borders was 66 days, with the average length of time being 3 days.

As mentioned previously, patients are having to wait long periods for cataract operations to be carried out in ophthalmology, which means there is an increase in positive screens due to cataracts. These patients are referred for slit lamp assessment by Community Optometrists, a process in place because of the rurality of the board, to improve access and reduce health inequalities.

Referrals

The percentage of those screened in NHS Borders who were referred to ophthalmology was 1% in 2023/24. The Scottish average was 1.4% for the same year.

The longest waiting time for appointment to ophthalmology was 22 weeks and 3 days in 2023/24, which surpassed the Scottish average of 31 weeks and 1 day. During this time

frame, 42.9% of patients who were referred to a specialist, attended within 90 days of referral, whereas across Scotland this figure was 34.6%. Of those screened in NHS Borders in 2023/24, 1.59% remained under the care of ophthalmology.

Governance and regulation

The NHS Borders Board Screening Coordinator and Screening Services Manager attend the quarterly Lothian DES Governance meeting as Lothian are commissioned to oversee the programme management and call recall duties. Prior to Covid-19 the NHS Borders Diabetes Managed Clinical Network (NHSB MCN) provided governance for our DES programme. The NHSB MCN has not yet resumed since Covid-19, and resumption of a Borders DES Governance group has proved challenging in securing membership, specifically Clinical Leadership.

Internal (IQA) and External Quality Assurance (EQA) activities are undertaken by all image graders, with level 3 graders being assessed by the External Quality Assurance (EQA) system, provided, and hosted by Aberdeen University. Its main purpose is to demonstrate an equitable and high-quality grading standard is maintained across all 9 DES grading centres in Scotland and all graders must participate in at least 3 out of 4 rounds of the EQA scheme.

Identified risks and Challenges

There is an identified risk around the capacity of Ophthalmology Clinical Lead for this programme and Diabetes Consultants to support the assurance process of this programme, with clinical workload and reduction of waiting times being prioritised. As part of the clinical standard HIS 1.3, the programme at board level should have a designated clinical lead.

A risk is noted around clinic transport for the programme, as the current DES transport is aging and diesel and is required to be replaced, funding has been agreed, however it have been challenging to secure an appropriate replacement vehicle.

The pool of optometrists accredited by the Borders Ophthalmology Department to provide slit lamp examinations for the DES programme has declined greatly since pre-Covid. Reasons include: retirals, staff turnover, staff absence and financial pressures. The programme is currently actively working to increase the number of optometrists accredited for DES slit lamp examinations.

The size of the population of NHS Borders with diabetes currently only supports the funding of 2 screeners. This means that staff absence has a large impact on the ability to provide screening in the board. Since the DES programme was implemented in 2008, there has been a 25% increase in the population of Scotland diagnosed with diabetes, with NHS Borders seeing an increase in prevalence of approx. 5 - 6% each year between 2021-2023.

Adverse events

There are no adverse events for the report period.

6. Pregnancy and Newborn

Pregnancy and newborn screening consists of different tests offered to pregnant women and baby, at stages throughout pregnancy and in the early neonatal period.
The pregnancy and newborn screening programme identifies pregnant women and babies who may have rare but serious conditions. Pregnancy and Newborn Screening tests are not compulsory but are offered to help individuals make informed choices about their health and the health of their child. Early treatment can improve their health and prevent severe disability or even death. NHS boards are ethically obliged to ensure that the timely provision of services meets the needs identified through the screening process.

Eligibility

All pregnant women and newborn babies within the UK are eligible for screening at specified time points during pregnancy and after birth.

Service delivery

Pregnancy screening is integrated into routine maternity care for pregnant woman through midwifery services offered at local venues across the Scottish Borders and within the maternity department at the Borders General Hospital (BGH). Ultrasound scans performed by sonographers at the BGH.

Newborn screening is offered to all babies born within NHS Borders. Hearing tests are carried out at the BGH, and blood spot tests are usually performed at home by community midwives. Those babies who move into the Board, and do not have blood spot screening history and under the age of 12 months are offered a blood spot test in Ward 15 Ambulatory Care.

Screening tests offered in Pregnancy and Newborn Screening

Table 6.1- Haemoglobinopathies KPI for period 2023/24

Pregnancy Screening	When
Communicable Diseases HIV, Hepatitis B, Syphilis	Ideally between 8-12 weeks
Haemoglobinopathies Sickle Cell Disease (SCD), Thalassaemia	Ideally before 10 weeks
Down's Syndrome, Edward's Syndrome, Patau's Syndrome	1st Trimester – Between 11 & 14 Weeks (Blood test +/- nuchal translucency ultrasound test). – 2nd Trimester – Later blood test can be offered between 14 & 20 weeks – only Down's Syndrome
Fetal Anomaly Ultrasound scan	Between 18-21 weeks
Newborn screening	**When**
Newborn Hearing (UNHS)	Birth to 4 weeks
Newborn Bloodspot – 9 conditions Sickle Cell Disease (SCD), Cystic Fibrosis (CF), Congenital Hypothyroidism (CHT), Phenylketonuria (PKU), Medium-Chain Acyl-CoA Dehydrogenase Deficiency (MCADD), Maple syrup urine disease, Isovaleric acidaemia (IVA) Glutaric aciduria type 1 (GA1), Homocystinuria (HCU)	Around day 5

Uptake, performance and clinical outcomes

There are 2 caveats when reviewing the following tables for the reportable KPI's for this programme. **Firstly, data quality** - There are known data quality issues within the BadgerNet system as it does not interface with hospital or lab IT systems; as a result, all test results are required to be manually entered into the system by a member of the midwifery team. Caution should be used when interpreting the KPI tables produced for this programme as user data entry variation was found, and full verification of data should be undertaken to be fully assured of the performance of the programme. Haemoglobinopathies KPI 1.1 is omitted from the current report (2023/24) as we are undertaking data validation and audit for the Haemoglobinopathies programme. The full outcome report for this work is expected by the end of April 2025.

Future improvement plans are being developed to improve data quality in this programme, including a review of standardisation of procedure & data capture, missing information reporting, regular audit programme/ staff resource/training/protected time within midwifery services supported by Public Health. **Secondly, NHS Borders has very small numbers** for some of the KPI's, this can have a large effect on the percentage provided on the performance (i.e. 2 cases and 1 case did not meet the expected KPI target providing a low figure of 50%).

Number of NHS Borders booking appointments aligned with screening KPI's (excludes women out of area, movers in and have evidence of screening results)

910	April 2023 - March 2024
1001	April 2022 - March 2023
967	April 2021 - March 2022

Please note the figures presented in the previous reports (2021/22 & 2022/23) for booking appointment data, the source was BadgerNet and we were unable to validate whether these figures included miscarriages, terminations, or movers into/out of the area and cross border women.

Number of live births in NHS Borders

843	April 2023 - March 2024
808	April 2022 - March 2023
876	April 2021 - March 2022

Table 6.2 Haemoglobinopathies KPI for period 2023/24

Haemoglobinopathies KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
1.1 - Antenatal Coverage - To maximise timely screening for sickle cell and thalassaemia in the eligible population who are informed and wish to participate in the screening programme.	Essential: ≥95% Desirable: ≥99%	KPI data under review	N/A
1.2 – Timeliness of antenatal screen -To maximise the opportunity for informed choice.	Essential: ≥50% Desirable: ≥75%	82.97%	N/A
1.3 – Completion of Family Origin Questionnaire - To maximise the accuracy of the screening test	Essential: ≥95% Desirable: ≥99%	100.00%	N/A
1.4a – Timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant - To complete the screening process to allow PND by 12 weeks + 0 days gestation to maximise the opportunity of informed and timely reproductive choices for all women	To be set	Numerator & denominator equal 0	N/A
1.4b - Timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant - To complete the screening process to allow PND by 12 weeks + 0 days gestation to maximise the opportunity of informed and timely reproductive choices for all women	To be set	Numerator & denominator equal 0	N/A
1.5 – Timely reporting of newborn screen positive results - To ensure parents of screen positive infants receive results at ≤ 28 days of age	Essential: ≥90% Desirable: ≥95%	Numerator & denominator equal 0	N/A
1.6 – Timely receipt into haemoglobinopathy specialist care - To optimise individual and population health outcomes in newborn infants born with conditions where early intervention is likely to be beneficial	Essential: ≥90 % Desirable: ≥ 5%	Numerator & denominator equal 0	N/A

Table 6.3 Infectious Diseases in Pregnancy KPI for period 2023/24

Infectious Diseases in Pregnancy KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
2.1 - Hepatitis B: Coverage - To maximise timely screening for hepatitis B in the eligible population who are informed and wish to participate in the screening programme.	Essential: ≥ 95% Desirable: ≥ 99%	100%	N/A
2.2 - Hepatitis B: Test turnaround time - To maximise performance of the screening test and timely reporting.	Essential: ≥ 95% Desirable: ≥ 97%	100%	N/A
2.3 - Hepatitis B: Treat/Intervene - To ensure timely intervention.	Essential: ≥ 97% Desirable: ≥ 99%	100.%	N/A
2.4 - Hepatitis B: Timely assessment of woman with Hepatitis B - To ensure timely intervention where appropriate.	Essential level: ≥70% Desirable level: ≥90%	100%	N/A
2.5 - Hepatitis B:Timely neonatal vaccination and immunoglobulin - To provide assurance that all babies born to women with hepatitis B receive the appropriate first vaccination +/- immunoglobulin in line with (Green Book) recommendations	Essential ≥ 97% Desirable ≥ 99%	100%	N/A
3.1 - Syphilis: Coverage - To maximise timely screening for syphilis in the eligible population who are informed and wish to participate in the screening programme.	Essential: ≥ 95% Desirable: ≥ 99%	100%	N/A
3.2 - Syphilis: Test turnaround time - To maximise performance of the screening test and timely reporting.	Essential: ≥ 95% Desirable: ≥ 97%	100%	N/A
3.3 - Syphilis: Treat/Intervene - To ensure timely intervention.	Essential ≥ 97% Desirable ≥ 99%	Numerator & denominator equal 0	N/A
4.1 - HIV: Coverage - To maximise timely HIV screening in the eligible population who are informed and wish to participate in the screening programme	Essential: ≥ 95% Desirable: ≥ 99%	100%	N/A
4.2 - HIV: Test turnaround time - To maximise performance of the screening test and timely reporting.	Essential: ≥ 95% Desirable: ≥ 97%	100%	N/A
4.3 - HIV: Treat/Intervene - To ensure timely intervention.	Essential ≥ 97% Desirable ≥ 99%	Numerator & denominator equal 0	N/A

Table 6.4 Down's Syndrome in Pregnancy KPI for period 2023/24

Down's Syndrome KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
5.1 - Down's syndrome: Coverage - To maximise timely Down's syndrome screening (first trimester screening) in the eligible population who are informed and wish to participate in the screening programme.	There are no thresholds regarding coverage as screening is voluntary	95.66%	N/A
5.2 - Down's syndrome screening: test turnaround time - To maximise performance of the screening test and timely reporting.	Essential ≥97% Desirable ≥99%	99.53% National Figure	99.53%
5.3 - Down's syndrome screening: Completion of laboratory request forms - To ensure a timely and accurate individual screening result for all women accepting screening.	Essential: ≥97% Desirable: 100%	97.83%	N/A
5.4 - Down's syndrome screening: Time to intervention - To ensure timely intervention where appropriate.	Essential ≥ 97% Desirable ≥ 99%	100%	N/A
5.5 - Down's syndrome screening: Test performance – Screen Positive Rate (SPR) singleton pregnancies only - To ensure that the correct proportions of screened women are given an increased chance result.	First trimester (Combined) Essential (1.8 to 2.5%) Desirable (1.9 to 2.4%) Second trimester (Quadruple) Essential (2.5 to 3.5%) Desirable (2.7 to 3.3%)	3.28% - First Trimester 2.27% - Second Trimester	N/A
5.6 - Down's syndrome screening: Test performance – Detection Rate (DR) - To provide information on the accuracy of the screening test to enable women to make informed choices.	T21 (combined) Standardised DR - 85% T21 (quadruple) Standardised DR - 80%	80% - T21 combined 0% - T21 Quadruple Small numbers for both denominator and numerator <5	N/A
5.7 - Down's syndrome screening: Diagnose - To maximise timely reporting of diagnostic results.	Essential: ≥90%	92.60% Reported by Lothian Lab	92.60%

Table 6.5 Fetal Anomaly in Pregnancy KPI for period 2023/24

Fetal Anomaly KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
6.1 - Fetal Anomaly: Coverage of the fetal anomaly ultrasound - To maximise timely fetal anomaly ultrasound screening in the eligible population who are informed and wish to participate in the screening programme.	Essential: ≥ 90% Desirable: ≥ 95%	100%	Not available
6.2 - Fetal Anomaly: Test performance of the fetal anomaly ultrasound - To maximise performance of the screening test and timely reporting.	Essential: DR ≥50%	Numerator & denominator equal 0	N/A
6.3 - Fetal anomaly: Time to intervention (18+0 to 20+6 fetal anomaly - To ensure timely intervention.	Local Referral - Essential: ≥97% Tertiary referral - Essential: ≥97%	100% 100%	N/A
6.4 - Fetal anomaly: Diagnose - To maximise timely reporting of diagnostic results	Essential: 90% of rapid aneuploidy QFPCR results Essential: 90% of karyotype results	Reported by Lothian Lab 92.9% 92.86%	92.9% 92.86%

Table 6.6 Universal Newborn Hearing Screening KPI for period 2023/24

UNHS KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
7.1 - NHSP: Coverage - To maximise timely screening in the eligible population who are informed and wish to participate in the screening programme	Essential: > 98% Desirable: >99.5%	99.42%	N/A
7.2 - NHSP: Test Performance (1) Referral rate at AOAE1 for well babies Applicable to sites using AOAE plus/minus AABR protocol - To maximise performance of the screening test	Essential: < 27% Desirable: < 20%	N/A	N/A
7.3 -NHSP: Test Performance (2) Referral rate at AOAE2 for well babies. Applicable to sites using AOAE plus/minus AABR protocol - To maximise performance of the screening test	Essential: <6% Desirable: <5%	N/A	N/A
7.4 - NHSP: Test Performance (3) Referral rate at AABR1 for well babies Applicable to sites using AABR only protocol - To maximise performance of the screening test	Essential: <14% Desirable: <12%	16.37%	N/A
7.5 - NHSP: Test Performance (4) Referral rate to diagnostic audiology assessment (All sites) results - To maximise performance of the screening test	Essential: >2% to ≤2.8% Desirable: ≥0.5% to ≤2%	0.80%	N/A
7.6 - NHSP: Time from screening outcome to initial appointment offered (date of appointment) for audiological assessment - To maximise timely diagnostic tests and entry into clinical pathway where relevant.	Essential: > 90% Desirable: > 97%	71.43% onward referrals to Lothian	N/A
7.7 - NHSP: Time from screening outcome to attendance at an audiological assessment appointment - To maximise timely diagnostic tests and entry into clinical pathway where relevant.	Essential: ≥90% Desirable: ≥95%	71.43% onward referrals to Lothian	

Table 6.7 Newborn Blood Spot Screening KPI for period 2023/24

Newborn Blood Spot KPI & Objective	Performance Threshold	BORDERS	SCOTLAND
8.1 - Newborn Blood Spot: Coverage (NHS Board responsibility at birth) - To ensure that all eligible babies are offered NBS screening and, with consent from a parent, tested within an effective timeframe.	Essential: ≥95% Desirable: ≥99%	90.38%	N/A
8.2 - Newborn Blood Spot: Coverage (Movers in) - To ensure that all eligible babies are offered NBS screening and, with written consent from a parent, tested within an effective timeframe.	Essential: ≥95% Desirable: ≥99%	100%	N/A
8.3 - Newborn Blood Spot: Avoidable repeat tests - To minimise the number of repeat blood samples required due to an avoidable failure in the sampling process	Essential level: ≤2% Desirable level: ≤1%	4.48%	N/A
8.4 Newborn Blood Spot: Timely identification of babies with a null or incomplete result recorded on the Child Health Information System (CHIS) - "To maximise coverage in the eligible population who are fully informed and wish to participate in the screening programme.	Standard Met	YES	N/A
8.5 - Newborn Blood Spot: CHI number is included on the bloodspot card - To maximise accuracy of the screening test from initial sample to reporting the screening result.	Essential: ≥98% Desirable: ≥100%	98.58%	N/A
8.6 - Newborn Blood Spot: Timely sample collection - To maximise accuracy of the screening test and facilitate high quality and timely intervention in those who wish to participate.	Essential: ≥95% Desirable: ≥99%	97.52%	N/A
8.7 - Newborn Blood Spot: Timely receipt of the sample in the laboratory - To maximise accuracy of the screening test and to facilitate high quality and timely intervention in those who wish to participate	Essential: ≥ 95% Desirable: ≥99%	93.04%	
8.8 - Newborn Blood Spot: Timely taking of a second bloodspot sample for CF screening - To maximise accuracy of the screening test and facilitate high quality and timely intervention in those who wish to participate.	Essential: ≥ 95% Desirable: ≥ 70%	Numerator & denominator equal 0	
8.9 - Newborn Blood Spot: Timely taking of a second bloodspot sample following a borderline CHT screening - To maximise accuracy of the screening test and facilitate high quality and timely intervention in those who wish to participate.	Essential: ≥ 95% Desirable: ≥ 99%	100.00%	
8.10 - Newborn Blood Spot: Timely taking of a second bloodspot sample for CHT screening for preterm infant - To maximise accuracy of the screening test and facilitate high quality and timely intervention in those who wish to participate.	Essential: ≥ 95% Desirable: ≥ 99%	81.25%	
8.11 - Newborn Blood Spot: Timely processing of CHT and IMD (excluding HCU) screen positive samples - To facilitate high quality and timely intervention in those who wish to participate	Essential: 100%	100.00%	
8.12 - Newborn Blood Spot: Timely entry into clinical care - To facilitate high quality and timely intervention in those who wish to participate.	Essential: 100%	Numerator & denominator equal 0	

Pregnancy & Newborn Screening Programme Identified Risks and Challenges

There are risks that have been identified and recorded on the maternity department risk register and are under continual review within the pregnancy and newborn screening programme in NHS Borders and are as follows:

- Continued staffing challenges within the Community Midwifery setting placing increased demands on the staff providing an On Call rota for women who are requesting a home delivery. If this pressure continues then the current on call service will become unsustainable resulting in the suspension of a Home Birth service for periods of time, therefore women not being able to have the birth of their choice. This, if it becomes a continued pattern will result in loss of confidence in the Home Birth Service as well as complaints from families. To address this, when staffing levels fall below the optimal requirements for a safe service, a risk assessment will be completed in a timely manner and a decision will be taken at that point.

- No access to label printers in clinical areas for printing blood labels for patients. No access to EMIS for staff to print labels if printer was available. EMIS is not always up to date with patient details. The request for label printers has been ongoing for 3-4 years. There are numerous causes of delays in obtaining these printers including, lack of internet access in community areas, financial constraints, lack of resources to upgrade/install printers.

- Within the sonography department there is a small team and therefore there is a risk of interruption to the fetal anomaly scanning programme if there are absences. Absences in 2023/24 have been successfully managed with no ill effects reported. The sonography workforce is proactively managed, along with their workload to mitigate this risk. There are further risks that a screening result might be inaccurately interpreted or documentation incomplete. This is kept under review, helped by the small team who work closely together, sharing best practice.

- There is a risk that samples may be delayed in transit to the relevant laboratories. The midwifery team factor in bank holidays when arranging blood spot tests, to avoid postal delays to the National Screening Lab in Glasgow. Courier services are used where required.
  There are challenges around collecting robust local data to monitor the pregnancy and newborn screening programme. A Public Health Audit Facilitator will be assisting Maternity Department with BadgerNet data quality, training, reporting and creating standard operating procedures for data entry and collection.

- There is a risk that screening results may not be acted upon. This ties into the work above around monitoring the data, and auditing whether any positive results have been actioned.

Over the past few years there have been some specific challenges within the pregnancy and newborn screening programme. The conflict in Ukraine saw movement of families into Borders from that area. It was difficult to locate these families at times, often resulting in extremely challenging deadlines for the blood spot test to be taken. It was also very difficult to explain the importance of the blood spot test to these families through the translation services available.

Measuring performance of each of the Pregnancy & Newborn Programmes is challenging and complex as there is no single national IT system and locally challenges in training on systems, staffing and auditing complicates data gathering and performance assurance.

Adverse Events

There has been one adverse event in 2022/2023 in the universal newborn hearing screening programme. NHS Borders identified that there were three babies referred for onwards audiology assessment who had a delay in receiving an appointment for diagnostic investigation in Lothian due to a misunderstanding around the correct protocol. In April 2024, a Problem Assessment Group (PAG) was held to investigate the concerns and develop actions to prevent any further occurrences of this issue. As a result of this, a new screening SOP for protocol, communication and escalation within the hearing screening programme was to be implemented. In addition, there was an action to strengthen the communication across the programme with stakeholders including robust clear communication pathways between NHS Borders and NHS Lothian regarding any policy procedural changes. The Adverse Event Management Team investigation concluded there was no adverse impact to the babies involved with the incident.

Areas of good practice

With regards to the blood spot testing programme, Kerry Simmons from midwifery produced a local training guide, engaged in training sessions, one to one supervision and introduced new lancets to eliminate the avoidable repeat tests. This training guide has been adopted by the national screening programme as an example of good practice and resource.

Increased resilience and access to the newborn hearing programme is seen as a positive change in the staffing model for the programme. Through service redesign opportunities have been provided for training of additional maternity staff, providing increased resilience and, increasing availability of staff to screen babies before discharge.

7. Conclusion & Recommendation

NHS Borders generally performs quite well across all screening programmes compared to Scotland and other health boards.

Specifically, the uptake of screening in the AAA, bowel, breast, and cervical programs in Borders was consistently higher than the Scottish average during this period. Additionally, the bowel (May 2021–December 2023), breast (March 2020–March 2023), and AAA (March 2022–March 2023) screening programmes met the essential national targets set by HIS standards and KPIs for screening uptake within their respective time frames.
There are stark differences in uptake seen across deprivation categories in many of the programmes. The latest data shows that the gap in uptake of screening between the most and the least deprived areas of Borders was 16% for breast, 18% for bowel and 14.9% for cervical screening. In most cases, uptake in the most deprived category does not meet the national standards in Borders, whereas it is comfortably attaining them within the least deprived groups. For instance, in breast screening for 2020-2023, uptake of screening in the most deprived SIMD category (65.8%) was below the acceptable standard (70%), but uptake overall in Borders (79%) was above the acceptable standard and narrowly missed the achievable standard (80%).

Interestingly, uptake across deprivation categories in the AAA screening programme reversed this trend, with uptake in the least deprived lowest compared to other quintiles. The reason for this is unclear. It could be due to factors that have not yet been identified or may be due to the small sample sizes in quintiles 1 and 5 leading to high variability, making it difficult to accurately assess trends and patterns.

Although not measured within national standards or KPIs, nor readily available in national data, it is known that there are many other inequalities that are also experienced within the screening programmes. These include differences in uptake due to accessibility (particularly felt in rural areas like the Borders), ethnicity, language barriers and learning difficulties. Work is underway to address these inequalities through the Borders' Equity in Screening Action Plan (2024) that was produced in response to the Public Health Scotland Equity in Screening Strategy.

Overall, the Breast Screening Programme is meeting the majority of the Screening standards. Nationally for the 3-year period 2020- 2023, the only un-met acceptable standard was the rate of benign biopsies at the prevalent screen (50 to 52). NHS Borders Board specific data is not available for this 3-year period but for the previous 3-year period (2018/19 – 2020/2021) NHS Borders reassuringly did meet the acceptable standard for this metric.

Regarding the timeliness of appointments, NHS Borders performs well in certain areas of bowel screening referrals for colonoscopy, with 94% of patients offered a telephone pre-assessment with a nurse within 14 days of referral. In AAA screening, Borders also meets the essential standard for annual surveillance appointments, ensuring that men are tested within 6 weeks of their due date.

It is important that any tests a patient has are accurate and complete. High quality colonoscopy has been demonstrated. Borders achieved a completion rate of 93% for bowel screening colonoscopies which is an improvement from previous years. For breast screening across 2020-2023, there is no board specific data but nationally the screening programme achieved both acceptable and achievable standards across all cancer detection metrics.

Areas Identified for Improvement

On the other hand, there are areas where performance was below required national HIS standards and national KPIs.

The percentage of those taking part in cervical screening in NHS Borders following an invitation in both 2020/21 (74.60%), and 2021/22 (74.1%) did not meet the national standard of 80%. In addition, there is a wide variation in uptake within this programme across age categories (61% in 25-29 age group, compared to 71.6% in 60-64 age group in 2021/22). In diabetic eye screening biennial successful screening rate was 76% which was also below the essential standard of 80%.

In AAA screening, Borders had more fail to scan encounters, where the aorta could not be visualised, compared to Scotland. Subpar image quality due to outdated scanning equipment may have contributed to this unmet KPI. This equipment has now been updated so this KPI should improve in future years. Within diabetic eye screening, Borders high photographic technical failure rate is due to the current long waiting list for cataract surgery, which results in patient's fail-safe back to screening before they have been seen by ophthalmology to remove their cataracts. This unmet KPI is reflected across other Health Boards in Scotland for the same reason.

Achieving the waiting time target for colonoscopy continues to be challenging, with only 58% of patients offered a colonoscopy date within 31 days of receipt of a positive screening test. While this is an increase compared to 2022 (11%) it is still below the desirable standard of 95% set by the Health Board in 2007. The majority are taking place between 4-8 weeks, when this should ideally be <4 weeks. Additionally in AAA screening, NHS Borders did not meet the essential standard (≥90%) for percentage of quarterly surveillance appointments where men are seen within 4 weeks of their due date and performed below national average. However, a small number of people who DNA or reschedule can affect this KPI disproportionately in a small board such as NHS Borders.

Many of the issues highlighted within this report where NHS Borders does not appear to meet national standards are due to problems with data access and quality or problems with national laboratories that are out of the control of the local board. For instance, the waiting time for specimens submitted from colonoscopy to date of report being authorised has increased with only 7% of histology reported within 7 days, 21% within 14 days, 18% within 21 days and 54% waiting more than 21 days.

Significant issues exist with evidencing the national standards for the Pregnancy and Newborn Screening programmes in Borders. This has been raised before through the clinical governance and quality committee, however, the challenge remains around providing assurance of this programmes due the fragmented nature of the data across teams, systems and boards, as well as the lack of a national IT system, leaving boards reliant on their standalone maternity IT system, BadgerNet) with its many inadequacies. Therefore, the task of measuring the performance of the programme requires a large amount of intense resource, which is not dedicated, and this remains a high risk to providing assurance to the board around the performance of this programme.

There are also problems regarding unreliability of KPI data in the diabetic eye screening programme thus findings in the pregnancy and newborn and diabetic eye screening reports should be interpreted with caution.

Areas of Good Practice

Finally, it is worth highlighting some of the areas of good practice that are visible within the different programmes. Accessibility is being improved, with appointments being offered in different areas of the Borders where possible, as well as at different times of day and at weekends. Within the DES programme, appointments are accommodated for inpatients in the BGH, and telephone contact made with invitees to reduce DNAs.

There are initiatives which aim to improve uptake of screening such as Confident Conversations, specific staff screening training, outreach community education sessions, and specific learning disability work to improve conversations around screening in this group, alongside more accurate recording of decision making. In addition, given that screening provides the opportunity to meet and engage with those who may not otherwise attend a healthcare setting, it is important to note the huge number of potential encounters that the screening programmes in Borders offers. If everyone who was eligible for screening in the health board participated in the relevant programmes, this would equate to just over 180,000 points of contact over a 3-year period (see table 10 below). This is a fantastic example of 'Making Every Contact Count', where screening provides a platform to promote other areas of health and wellbeing, as well as signposting to local services.

Table 7.1 – Total estimated eligible population for each of the screening programmes by screening cycle

Screening programme	*Average number of eligible individuals in Borders in a screening cycle*
AAA	859 yearly
Bowel	45,748 2 - yearly
Breast	13,108 3 - yearly
Cervical	27,523 yearly
DES	5,554 yearly
Pregnancy	974 yearly
Newborn	776 yearly

Looking forward

There are projects and developments occurring across many of the different screening programmes going forwards.

Following the National Services Division review of Breast Screening, the service was reviewing which framework of services may best meet the needs of the Southeast Scotland population and demography. The conclusion is that the service would be very keen to lead on a trial of the Satellite Screening Centre concept, along with a pilot of post-code-based invitation if that were feasible.

Borders has developed an action plan to respond to the PHS Equity in Screening Strategy which focuses directly on the equity of programmes in the Board, as well as a Health Inequalities Strategy which has scope over all of health, healthcare and outcomes, including screening.

Nationally, there are new standards for the bowel screening programme. NHS Borders submitted a bid to Cancer Research UK (CRUK) in December 2023, receiving confirmation of funding in January 2024 to develop and deliver innovations to improve colonoscopy surveillance for those individuals at higher risk of developing bowel cancer due to genetic factors, diagnosis of polyps, IBD or bowel cancer. Funding for the co-design phase was received in April 2024, which included recruiting a project manager, data facilitator and wellbeing adviser to support the development of the innovation and work closely with the academic partners (Oxford and Cambridge Universities) and CRUK. The project is due to go live in January 2025 for 12 months, followed by an evaluation period from January-June 2026.The DES programme launched a national appointment SMS reminder service, as well as online booking. This is due to be implemented in Borders in the coming months. In addition, NEC are developing a software tool to assist call-recall managers to smooth the distorted demand curve following Covid-19 recovery. There is also work in development around analysing and publishing KPIs for this programme following the significant changes seen over the last 3 years.

Within the cervical screening programme there is work in progress to create a colposcopy to SCCRS interface which will improve the quality of data in SCCRS and reduce the requirement for duplicate data entry. Scottish Government is also considering the results of the NHS England self-sampling studies (HPValidate), to decide whether this should be incorporated into the national cervical screening programme. As mentioned previously, more work locally has been done on a new project related to deferral of cervical screening invitations for those eligible for screening during pregnancy.

Finally, a data quality project is being scoped out within pregnancy and newborn screening with the hope that a public health practitioner within the team will spend time assessing the quality of the pregnancy and newborn data. This should lead to a discussion of the most effective and efficient ways of managing and reporting on this data going forward.

Recommendations

Work is required around the data quality and availability for the pregnancy and newborn programme. The process and software should be reviewed, alongside possible training for those on the frontline around data entry into the IT system. Assurance of the performance of this programme remains challenging. Dedicated resource should be part of this.
Given the stark differences in uptake in most of the programmes across deprivation categories, wide buy-in from across the Borders is requested for both the Equity in Screening strategy action plan, and the Health Inequalities Strategy to ensure that these differences can be addressed in useful and enduring ways. These will include plans to improve uptake across all the programmes, but particularly the cervical and DES programmes where uptake is below national targets.
Continuation of quality of the AAA USS, should be reviewed locally to decide if further training is required to improve non-completion rates.
Waiting times for colonoscopy remain challenging, this should continue to be monitored closely with clear escalation routes.
Overall strengthen the monitoring and evaluation of all the programmes, with dedicated resource for each programme. This could be enhanced with use of IT and the development of screening dashboards which update regularly, and from which data can be pulled easily.

	AAA Screening Recommendations
	All Screening Programmes Recommendations
	Pregnancy & Newborn Screening Recommendations
	Bowel Screening Recommendations

8. Acknowledgements

This report has been structured based on the recent NHS Borders Public Health Screening Programmes 2020-2023 Report with certain material drawn and adapted to provide an overview of key developments and progress since the previous report.

i. Appendix

Glossary

AAA Screening Programme (Abdominal Aortic Aneurysm)

Abdominal Aortic Aneurysm (AAA): A swelling or enlargement of the aorta, the main blood vessel that runs from the heart through the abdomen.
Ultrasonography: A diagnostic imaging technique used to visualise internal organs, including the aorta, to detect aneurysms.
Screening Age: One off screening test offered to men in their 65th year of age.
AAA Rupture: A life-threatening event where the aortic aneurysm bursts, causing internal bleeding.

Bowel Screening Programme

Faecal Immunochemical Test (FIT): A test that detects blood in stool samples, which can be an early sign of bowel cancer
Colonoscopy: A procedure where a long, flexible tube with a camera is used to examine the inside of the colon and rectum.
Polyps: Non-cancerous growths in the bowel that can be removed to prevent cancer.
Screening Age: Offered to individuals aged 50 to 74 every two years

Breast Screening Programme

Mammogram: An X-ray of the breast used to detect breast cancer early, before symptoms appear
Digital Breast Tomosynthesis (3D Mammography): An advanced form of mammography that creates a three-dimensional image of the breast.
Screening Age: Recommended for women aged 50 to 70 every three years

Cervical Screening Programme

Smear test: A test that collects cells from the cervix to check for cell changes that could become cervical cancer
HPV Test: A test that checks for the presence of high-risk human papillomavirus (HPV) types that can cause cervical cancer
Screening Age: women are routinely invited: from age 25 up until their 65th birthday, and those with a non-routine result, up to their 71st birthday.

Diabetic Eye Screening Programme

Diabetic Retinopathy: A complication of diabetes that affects the blood vessels of the retina and can lead to blindness if untreated.
Retina: The light-sensitive layer at the back of the eye that sends visual signals to the brain.
Digital Retinal Photography: A technique used to take detailed images of the retina to detect signs of diabetic retinopathy
Screening Age: Offered to individuals with diabetes aged 12 and over

Pregnancy & Newborn Screening Programme

Newborn Blood Spot Test: A test that involves taking a few drops of blood from a newborn's heel to screen for serious but treatable conditions
Pulse Oximetry Screening: A test that measures the oxygen levels in a newborn's blood to detect critical congenital heart defects
Hearing Screening: A test to check for hearing loss in newborns
Fetal Anomaly Screening: Tests performed during pregnancy to detect conditions such as Down's syndrome, Edwards' syndrome, and Patau's syndrome

NHS Borders | Scottish Borders Council | East Region Health Protection Service | NHS Scotland

Joint Health Protection Plan

2025 – 2027

Authors

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Version Control

Version	Date	Changes
V2.2	2025-03-26	First Draft
V2.3	2025-04-03	Amendments made: Authorship; heading placements; Page 12 section 4.1; Appendix C – table 2; hyperlinks updated.

Contents

Introduction

The Public Health Etc. (Scotland) Act 2008 requires NHS Boards, in consultation with Local Authorities, to produce a Joint Health Protection Plan (JHPP). The main purpose of the JHPP is to provide an overview of health protection (communicable disease and environmental health) priorities, provision and preparedness for the NHS Board area and to support the collaborative arrangements that exist between NHS Borders and Scottish Borders Council (SBC).

For NHS Borders, the JHPP is authored in partnership with SBC Protective Services, which includes Environmental Health, Trading Standards, Animal Health and the Corporate Health and Safety team within the remit.

This plan covers the period 1 April 2025 to 31 March 2027. Progress against the action plan will be reviewed quarterly by East Region Health Protection Service (ERHPS), NHS Borders and SBC colleagues.

The ERHPS (covering NHS Borders, NHS Fife, NHS Forth Valley, NHS Lothian) came into place in December 2023. The majority of in hours health protection functions have been conducted by the East Region service from December 2023. Over the lifetime of this document, out of hours arrangements will move to a regional model. This regional approach provides specialist knowledge, greater resilience and the ability to respond to pressures. Each health board area continues to have its own JHPP with its respective local authority partners.

This is a public document which can be found on the Scottish Borders Council and NHS Borders websites. This plan intends to protect the health of the population of the Scottish Borders, including those who live, work and visit the area.

Signed

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1. Overview

This Joint Health Protection Plan (JHPP) for NHS Borders and Scottish Borders Council (SBC) has been produced in accordance with the Public Health Etc. (Scotland) Act 2008.

The Act sets out the duties of the Scottish Ministers, health boards and local authorities to continue to make provision to protect public health in Scotland. This Act assigns functions on a corporate basis – health board or local authority – and sets out where specific levels of professional 'competency' are required. In broad terms health boards are now responsible for control for communicable disease involving persons and local authorities are responsible for control of communicable disease involving premises. Action is not confined to notifiable diseases but is to be taken on knowledge or suspicion of 'significant' risk to public health.

The Act defines the public health functions of health boards and local authorities and identifies the following responsibilities:

- Duty of Scottish Ministers, health boards and local authorities to protect public health.
- Designation of competent persons by health boards and local authorities.

1.1 Control of Communicable Disease in the Borders

The Communicable Disease and Environmental Health functions of NHS Borders and SBC aim to:

- Reduce preventable illness and death from communicable disease including immunisation.
- Identify potential outbreaks of communicable disease at an early stage so that effective control measures can be put in place as soon as possible, to improve the ability to prevent further outbreaks.
- Work with other agencies to reduce any adverse environmental impact on health.

1.2 Geographical extent of Plan

This Plan covers NHS Borders Health Board area which is coterminous with SBC.

1.3 Authors

The Plan has been produced by the East Region Health Protection Service (ERHPS) and SBC Protective Services.

1.4 Governance arrangements

This JHPP will be shared for approval of the Board Executive Team through the Resources and Performance Committee of NHS Borders and the Corporate Management Team of SBC.

1.5 Status

This Plan covers the period April 2025 to March 2027 and will be reviewed on a two-yearly basis. It will be available to the public on the NHS Borders and SBC websites with a shortened and full report available. It will be made available in other formats on request.

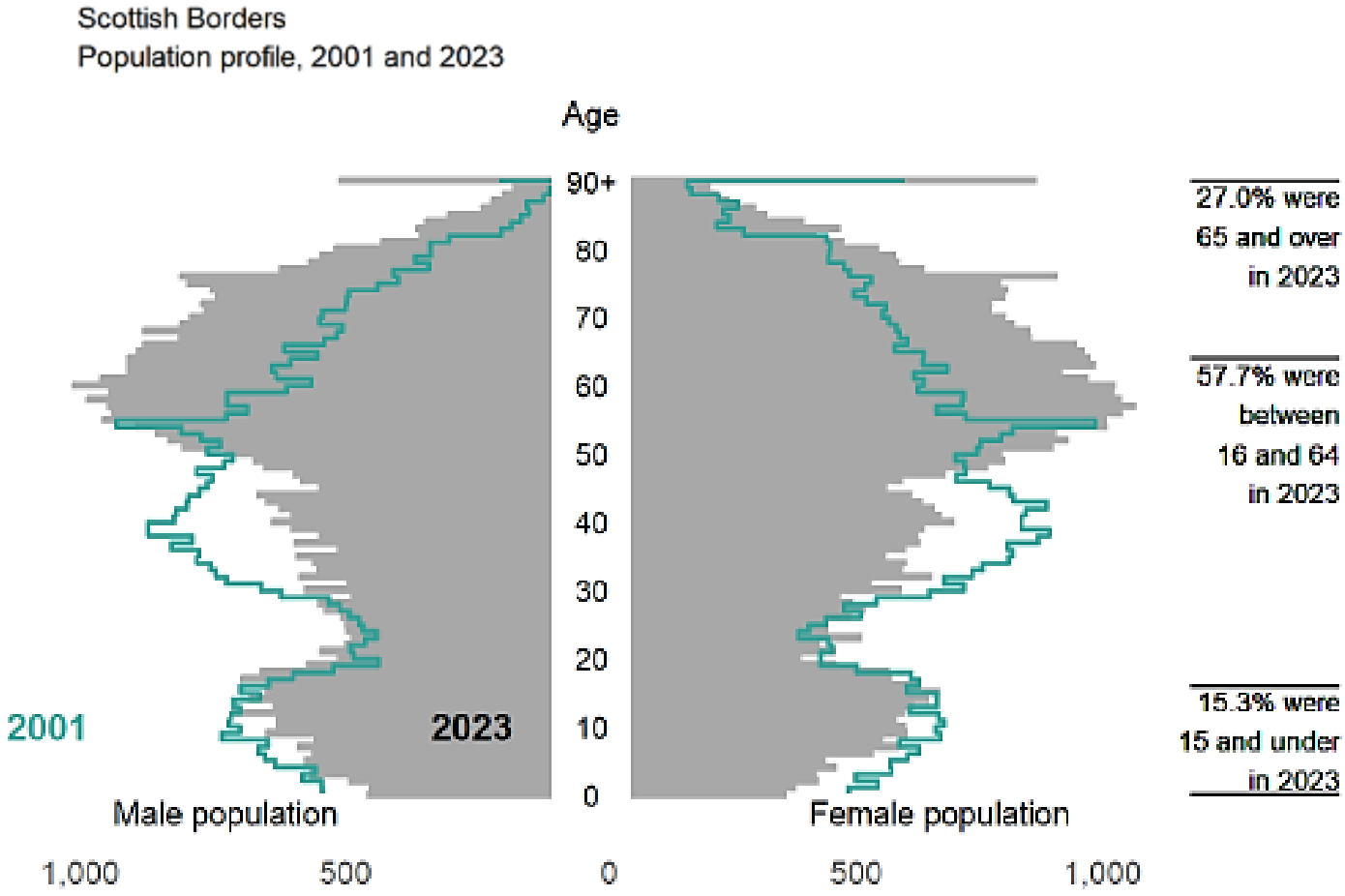
2. Overview of the Scottish Borders population

The Scottish Borders is the sixth largest local authority in Scotland, and seventh largest in the UK. The Scottish Borders has one local authority and covers an area of 4,732 square kilometres and is a mix of mainly rural developments.[1]

According to the mid-2023 population estimate, the Scottish Borders has a population of 116,630. This is a decrease of 0.2% on the mid-2022 population estimate of 116,820, but an increase of 0.5% from 116,020 in 2021.[2] Between 2001 and 2023, the population of Scottish Borders has increased by 9.1%. This is the 13th highest percentage change out of the 32 council areas in Scotland. Over the same period, Scotland's population rose by 8.4%.[3]

This makes it a medium-sized Scottish Council Area in population terms, only with a bigger land area and a lower population density than most other Scottish Council Areas.[4]

Figure 1: Scottish Borders population health profiles 2001 and 2023[5]



[1] http://www.scotlandscensus.gov.uk

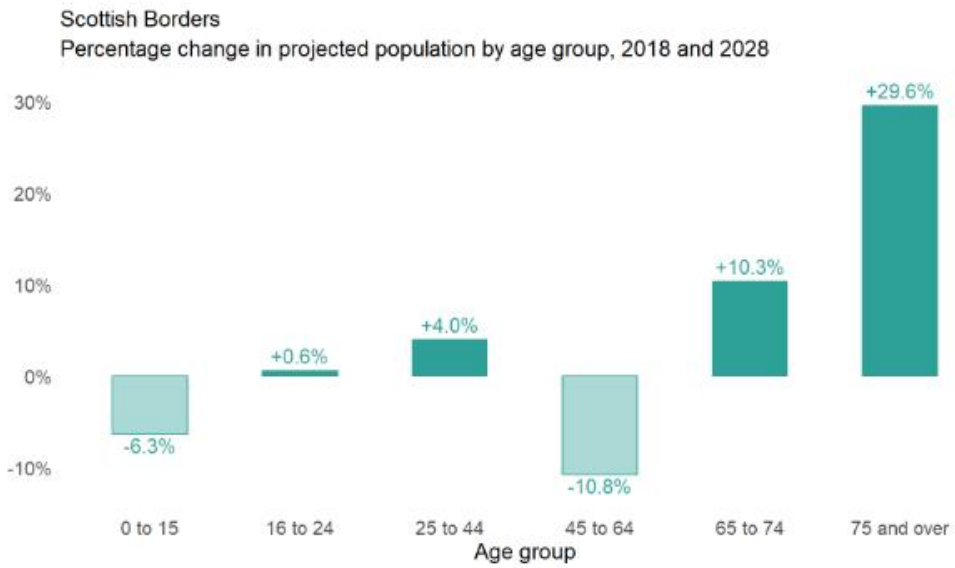
[2] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2020

[3] https://webarchive.nrscotland.gov.uk/20241128124646/https://www.nrscotland.gov.uk/files//statistics/council-area-data-sheets/scottish-borders-council-profile.html

[4] https://www.scotborders.gov.uk/strategies-plans-policies/research-data-scottish-borders-topic

[5] [ARCHIVED CONTENT] Scottish Borders Council Area Profile

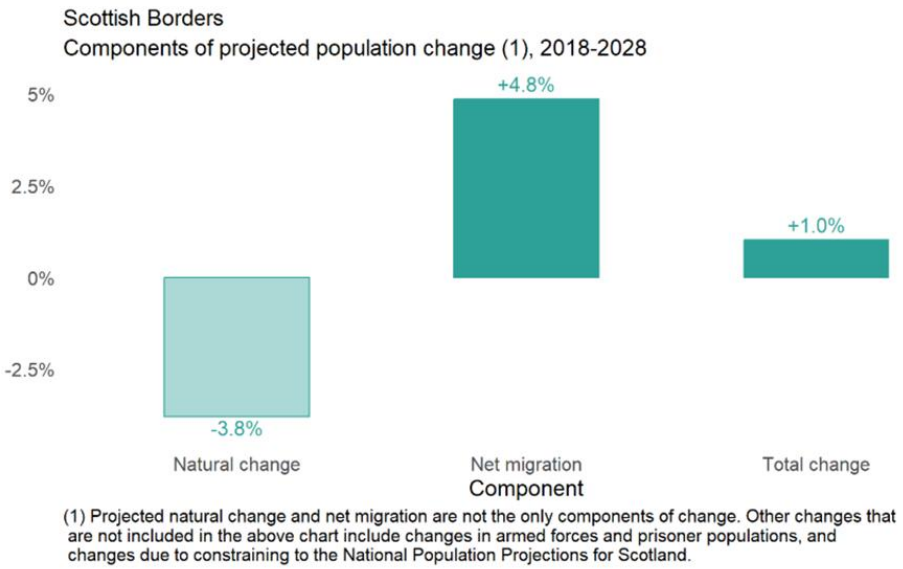
Figure 2: Scottish Borders projected population by age group, 2018 and 2028[6]



In terms of overall size, the 45 to 64 age group was the largest in 2023, with a population of 34,615. In contrast, the 16 to 24 age group was the smallest, with a population of 9,588. The number of people within the 25-44 age group fell by 22.9% in Scottish Borders between 2001 and 2021, considerably lower than the 2.1% decrease in Scotland as a whole.[7]

Over the next 10 years, the population of Scottish Borders is projected to decrease by 3.8% due to natural change (more deaths than births). Total net migration (net migration within Scotland, from overseas and from the rest of the UK) is projected to result in a population increase of 4.8% over the same period, with a total change of +1%.[8]

Figure 3: Scottish Borders projected population change, 2018-2028 including net migration[9]



[6] [ARCHIVED CONTENT] Scottish Borders Council Area Profile

[7] https://www.scotborders.gov.uk/strategies-plans-policies/research-data-scottish-borders-topic

[8] https://webarchive.nrscotland.gov.uk/20241128124646/https://www.nrscotland.gov.uk/files//statistics/council-area-data-sheets/scottish-borders-council-profile.html#Population_Projections

[9] [ARCHIVED CONTENT] Scottish Borders Council Area Profile

3. Health Protection Planning Infrastructure

3.1 East Region Health Protection Service

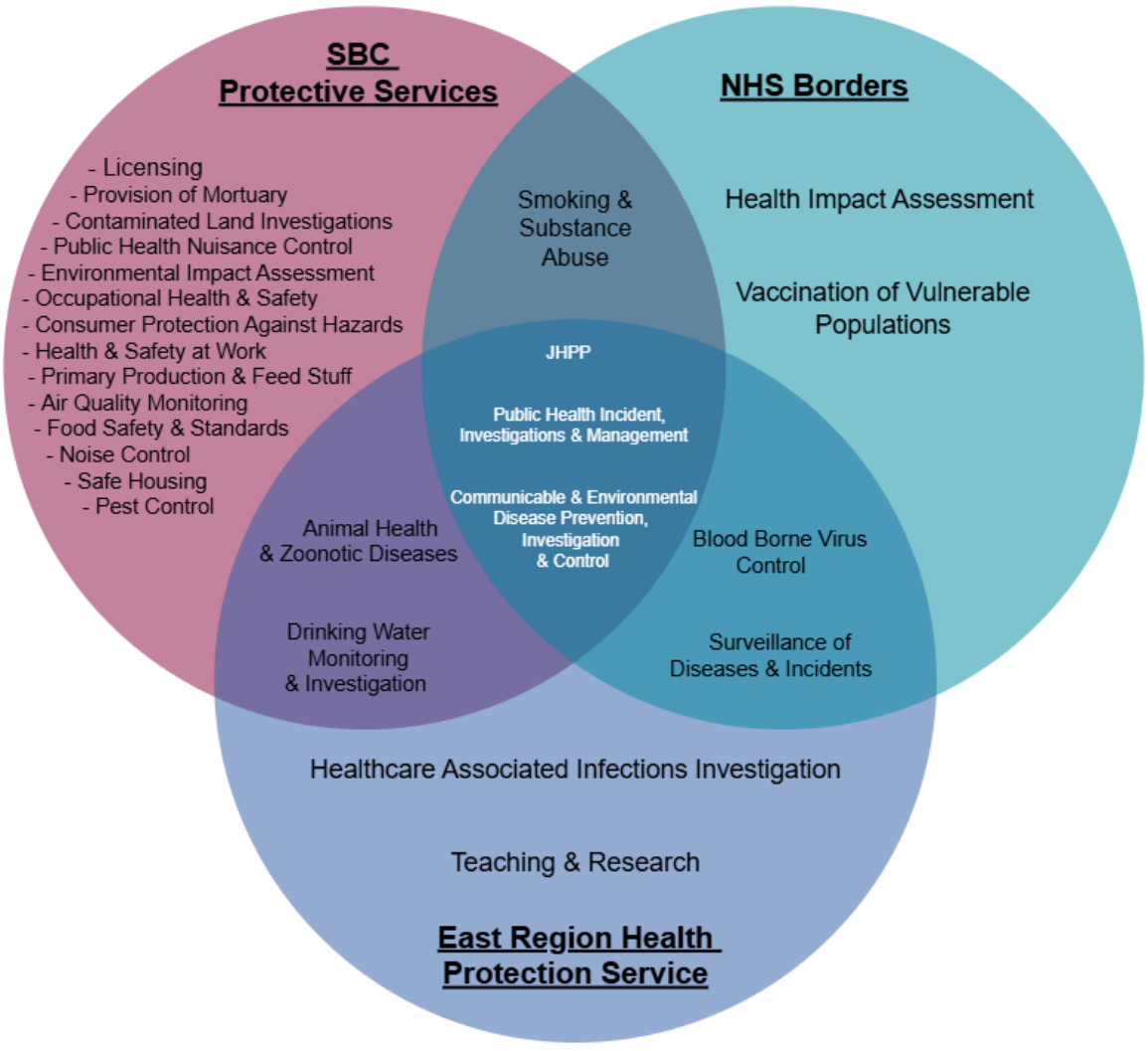
NHS Borders alongside NHS Fife, NHS Forth Valley and NHS Lothian have joined together as the East Region Health Protection Service as of December 2023. This provides improved resilience and availability of specialist expertise, increased career development opportunities and supports shared learning and training opportunities.

3.2 Collaboration

As shown with the overlap of functions across organisations in Figure 4 (below), SBC and ERHPS regularly collaborate to manage health protection issues. Communication required for routine activities includes face-to-face, telephone and electronic communications. Where needed to manage a situation effectively, a problem assessment group (PAG) or incident management meeting (IMT) is held. ERHPS, SBC and NHS Borders health protection staff attend these meetings as appropriate.

Health protection issues and progress towards the workplans discussed in the action plan (Appendix A) will be reviewed quarterly at the Borders Health Protection meeting, including representation from NHS Borders Public Health, Scottish Borders Council and East Region Health Protection Service.

Figure 4: An illustrative summary of the joint working and areas of collaboration between SBC Regulatory services, ERHPS and NHS Borders



4. Risks and challenges in the Scottish Borders

4.1 Private water supplies

Private Water Supplies (PWS) are those that are not provided by a statutory provider (i.e. Scottish Water). In the Scottish Borders, 13% of the population (almost 15 000 residents) is served by a private supply. There are approximately 1400 private water supplies in the Scottish Borders serving around 4000 domestic properties in the area. Private water supplies also serve a number of commercial properties in the Borders including: Hotels, Food production / catering businesses and Caravan parks/Holiday Lets.

Private supplies can be sourced in a variety of ways for example springs, boreholes, wells and rivers. This means that the quality of private water supplies can be highly variable as they are vulnerable to contamination. It is therefore critical that PWS are well managed to protect the health of those living, working and visiting the Scottish Borders. Contamination of PWS can be broadly categorised into: Microbial contamination (e.g. E.coli, salmonella and cryptosporidium) and Chemical contamination (e.g. lead, arsenic, pesticides etc.).

Whilst the responsibility for PWS rests with owners and users of the supplies, local authorities have statutory duties to regulate and monitor PWS under the supervision of the Drinking Water Quality Regulator (DWQR) who acts on behalf of Scottish Ministers. These duties include the obligation to sample and report on the test results of all regulated supplies on at least an annual basis, carry out a risk assessment of all regulated supplies and take enforcement action where a supply is a risk to public health or does not meet the standards required.

4.2 Climate change

The local health impacts of climate change were highlighted in the Climate change and health impacts in the Scottish Borders report, developed in 2024. This report highlights the risk to health of vector borne disease (particularly Lyme disease), and risks to health from contaminated water due to flooding, sea level rises and coastal flooding, as well as risks to mental health. It will be key for organisations across the Borders to work together to mitigate and adapt to the effects of climate change.

5. National Priorities

5.1 Scottish Government national priorities

The Scottish Government set national public health priorities with SOLACE and COSLA, and these direct public health improvement across the whole of Scotland.[10] These priorities are also described in Public Health Scotland's national strategic plan[11] "A Scotland where everybody thrives: Public Health Scotland's strategic plan 2022 to 2025".

This plan details how Public Health Scotland will lead and support action across Scotland to:

- Improve life expectancy and reduced health inequalities
- Prevent disease
- Prolong healthy life
- Promote health and wellbeing

[10] Our context – public health in Scotland Public health reform - Our context - public health in Scotland - Our organisation - Public Health Scotland

[11] A Scotland where everybody thrives: Public health Scotland's strategic plan 2020-2023 A Scotland where everybody thrives: Public Health Scotland's Strategic Plan 2020 to 2023 - Our organisation - Public Health Scotland

Public Health Scotland aim to prevent people from getting diseases and improve life expectancy worldwide with the following identified workstreams:

- Public Health Scotland will lead Scotland's vaccination programme to make sure fewer people – especially those in our poorest communities – die from COVID-19.
- By implementing an infectious disease intelligence strategy, PHS will reduce the harm done by hepatitis C, HIV, and tuberculosis.
- Utilising learning from the COVID-19 pandemic to lead preparations for the next pandemic.

5.2 Reducing vaccine preventable disease

After the supply of clean drinking water, immunisation is the most effective public health intervention for preventing illness and deaths from infectious diseases.

Although vaccination is a well-established intervention, ensuring vaccine uptake remains high remains a key priority. There are currently a number of challenges facing health care services with respect to maintaining high uptake rates. These include the re-emergence of diseases such as measles, the emergence of new outbreaks, service re-organisation and the increasing risks posed by rising vaccine hesitancy across nations.

Locally in the Scottish Borders, there is a dedicated Vaccination and Immunisation service for adult, childhood vaccinations and travel vaccinations. In addition, clinical specialities such as maternity services, paediatrics and sexual health services support the delivery of the selective immunisation programmes.

A Strategic Framework and Delivery Plan is being developed which is aligned to the Public Health Scotland 5 Year National Immunisation and Vaccination Framework and Delivery Plan.

The Delivery Plan's key performance outcomes will be to further increase vaccination uptake, and it is critical that the benefits afforded by successful immunisation programmes are not put at risk by structural changes in delivery. Data on uptake is monitored both locally and nationally (via PHS Discovery) with the model being used to measure uptake and areas for improvement.

Where a decrease in vaccination uptake is identified, quality improvement methodology is used to further understand and mitigate the barriers to vaccination uptake. Barriers to uptake are themed around the geography of the Scottish Borders where citizens often have to travel some distance to a vaccine clinic. To mitigate this, the service utilise treatment rooms in Primary Care, which saves on costs of hiring venues and reduces travel for citizens.

The Vaccination Service is part of the Primary Care Improvement Programme and reports to Primary and Community Care Service (PACS) where there is an established Clinical Governance and Care Assurance Framework for measuring and monitoring quality and safety. Reports are submitted monthly to this group. The Vaccination service also reports via the Public Health Governance Group. Any near misses/ incidents or cold chain issues where there is vaccine wastage is reported through our adverse events reporting system and reviewed by the Community Clinical Nurse Manager. If any key themes are identified these are addressed through education and learning and quality improvement approaches.

5.3 Tuberculosis (TB)

Nationally there has been an increase in cases identified of mycobacterium. The most recorded cases are highest amongst asylum seekers and refugees, but surveillance data also highlights an increase in UK born cases. NHS Borders is one of the Boards who have seen an increase.

NHS Borders' Health Protection remit includes working in partnership with Respiratory Medicine, Microbiology, Occupational Health and Paediatrics, as well as Health & Social Care Partnership (H&SCP) colleagues, to identify at risk groups who require screening and vaccination as part of a prevention strategy.

5.4 Hepatitis C elimination

As part of the national Hepatitis C Elimination plan, Health Protection work in partnership with Borders Addiction Services, We Are With You, Sexual Health, Maternity and Primary Care to promote testing for Hepatitis C. Working collaboratively with partners, harm reduction measures are identified, and prevalence of Hepatitis C is closely monitored.
Pathways have been developed to allow direct referral to Gastroenterology for on-going treatment if a patient is identified has having acute Hepatitis C.

6. Local Priorities

6.1 Reducing health inequalities

T.H.I.S Borders, NHS Borders Health Inequalities strategy, published in 2024 highlights that tackling health inequalities is good for everyone: reducing the stark differences in population health not only reduces human suffering but also benefits the health and care system and the wider economy in access to skills and productivity. The strategy highlights that reducing health inequalities needs to be considered across all pieces of work, and on every agenda.

In the last five years we have seen inequalities worsen since the COVID-19 pandemic and the cost-of-living crisis. Fragile employment and rising household costs have put pressure on households, their support networks, and the services that can offer support. It is an important time to consider how we address and respond to the growing challenges faced by our communities: early intervention and prevention are vital.

There are specific challenges of the Scottish Borders geography that can impact health outcomes. This can be due to higher transport costs, poorer digital connectivity, isolation, and the challenge of providing and maintaining services across a large, rural area.

6.2 Care home communicable disease outbreaks

Outbreaks of communicable diseases in care homes are of particular concern because of the vulnerability of residents to more severe illness than the wider population. These outbreaks often require close management from Health Protection to ensure Care Homes have access to expert advice and can implement appropriate control measures.

7. Public Health Incidents and outbreaks in 2024

There have been national increases reported in incidence of measles, pertussis, and tuberculosis during 2024. More recently an increase within central African countries of clade Ib of mpox has been recorded, causing increased morbidity and case fatality, and being treated internationally as a High Consequence Infectious Disease (HCID). There has also been a UK wide linked outbreak of non-O157 STEC E.coli identified through whole genome sequencing (WGS), including cases regionally.

Towards the end of 2024 there was a marked increase in cases of influenza (driven by Influenza A), with resultant increase in hospital admissions across Scotland, including locally.

7.1 Measles

Although in 2024 there have been a small number of confirmed cases of measles (n=15) across the East Region, workload has increased disproportionately, with 217 possible/probable cases, compared to n=27 in 2023 and n=19 in 2022. The small number of cases, and some probable cases (subsequently ruled out by laboratory testing) has led to significant contact tracing and risk assessment activity by ERHPS. There were six possible cases in the Borders, none of which turned out to be measles.

7.2 Mpox

Mpox has continued to receive international attention, now with five clade Ib (HCID) cases in the United Kingdom, although none in Scotland. Mpox clade IIb cases continue at a low level (n=17 enquiries with n=5 confirmed cases for 2024, compared to n=97 in 2022, for Scotland). However, preparing an ERHPS response, with local adjustments, has taken significant effort. There were no confirmed cases in the Borders in 2024.

7.3 Pertussis

Pertussis (whooping cough) has had a significant impact on ERHPS workload, which not only put pressure on the daytime team, but impacted the out of hours/ on-call workload, and required a change in practice, which was subsequently evaluated. A Quality Improvement project has been undertaken to assess and improve the use of texts (SMS) for notification of pertussis infection.

7.4 Cases and incidents of infectious diseases in the Borders

In 2024, there were 320 cases of infectious diseases in the Borders. Figure 5 shows the cases by infectious disease category, highlighting 183 cases of respiratory infections and 88 gastrointestinal infections. These were the two most common categories reported.

In 2024, there were 59 situations, incidents or outbreaks identified in the Borders. Situations are typically larger outbreaks or more prolonged environmental exposures that may cause health harm. Figure 6 shows situations, incidents or outbreaks that were managed by health protection in 2024: these included 24 water incidents, 22 care setting outbreaks, and seven school/nursery setting outbreaks. These make up the majority of the incidents dealt with by health protection in the Borders in 2024.

Figure 5: Cases of infectious diseases in the Borders (2024)

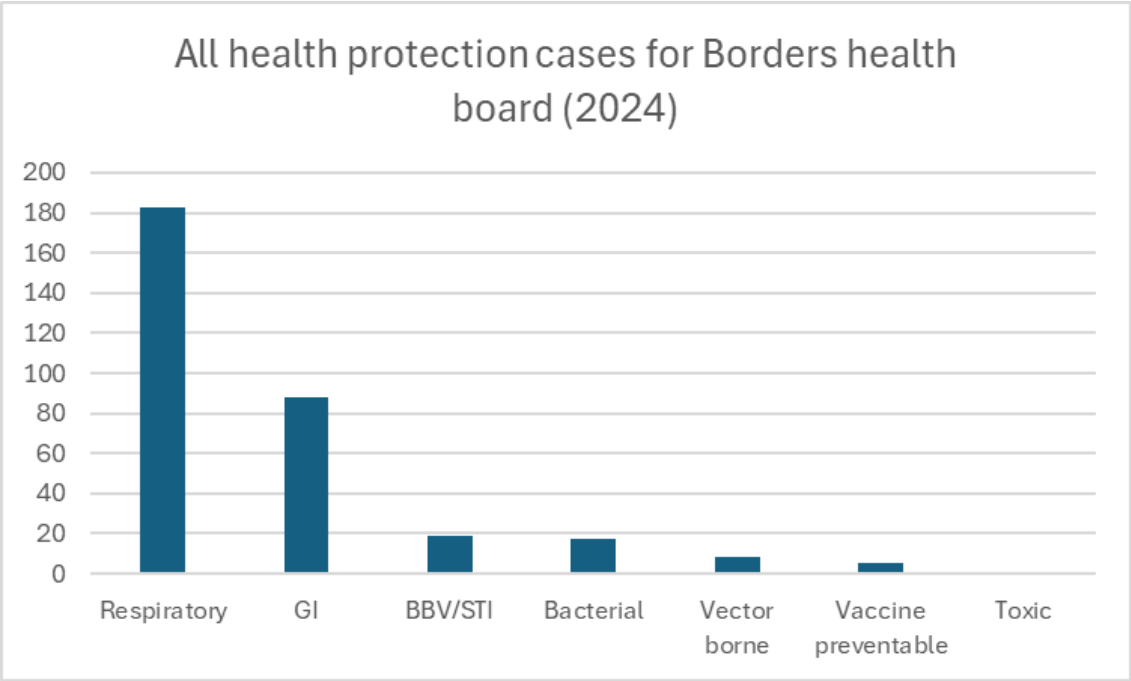
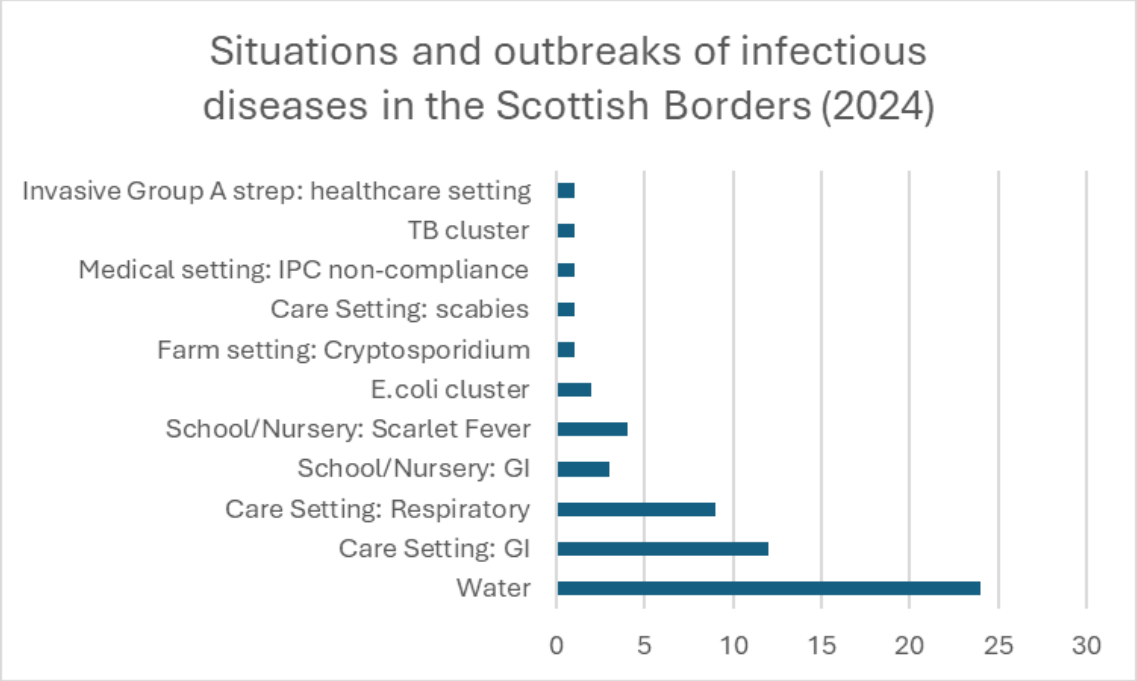
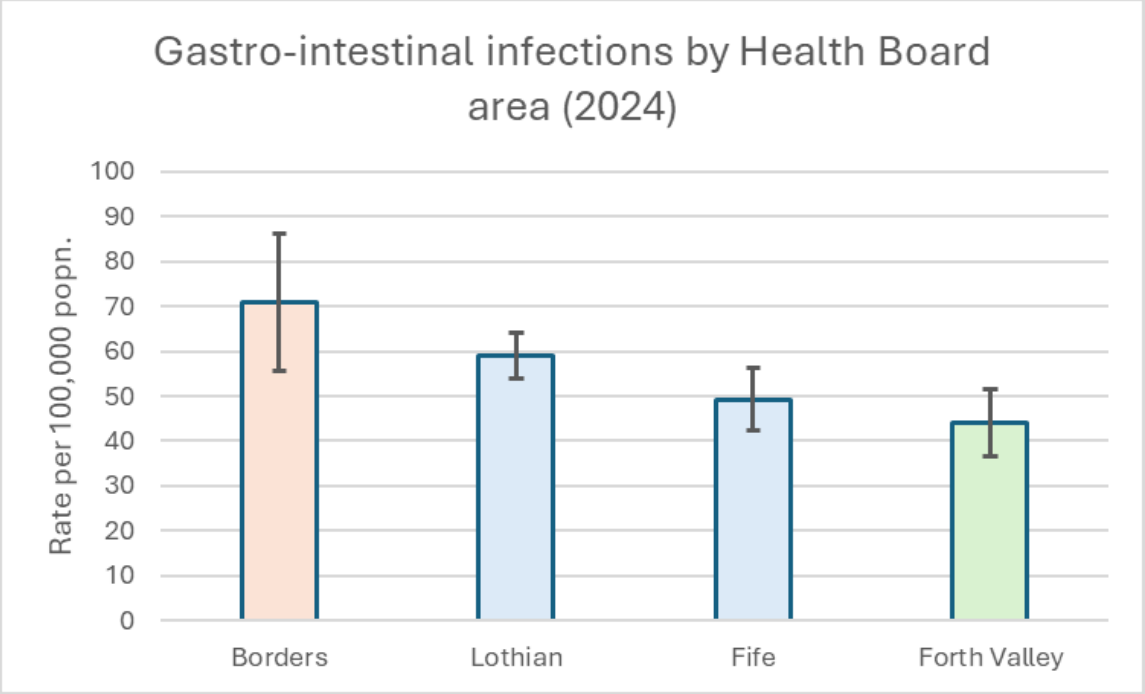


Figure 6: Situations, incidents or outbreaks in the Borders (2024)



When the number of gastro-intestinal infections is considered relative to the population of an area, the Borders had a higher rate of gastro-intestinal infections per 100,000 population compared to other Health Boards within the East Region. It is important to note that this is not a statistically significant difference (as shown by the confidence interval bars overlapping in Figure 7) but is a finding that warrants monitoring. The rural landscape of the Borders; including farms and private water supplies, could pose a higher risk of gastro-intestinal infections such as E. coli.

Figure 7: Gastro-intestinal infections by Health Board (23 Dec 2023-26 Nov 2024)



Quarterly reports on infectious diseases cases and incidents/outbreaks will be provided by ERHPS to health protection colleagues in the Borders.

8. Resources and operational arrangements

8.1 Staffing

NHS Borders is required in the 2008 Act to maintain a list of suitably qualified and experienced staff to exercise the powers available in the Act. Many of the health protection areas are now the responsibility of the East Region, but the Board still maintains a list to cover issues that may arise for the retained responsibilities - including Tuberculosis. There are currently four 'Competent Persons' within the NHS Borders Public Health directorate with one further 'Competent Person' on maternity leave. There are a further four 'Competent Persons' within ERHPS who are listed within the NHS Borders Health Board as they contribute to the out of hours health protection response.

8.2 ICT

Microsoft Teams is regularly utilised for video conferencing and teleconferencing across health boards and local authorities. ERHPS is responsible for disease surveillance. Information collected is entered onto HPZone, a clinical management system that is also used for out of scope work by NHS Borders health protection staff. Data sharing agreements are in development to provide a shared space for live documents across the four boards of ERHPS.

8.3 SOPs / Guidance

For Out of scope (OOS) work, NHS Borders health protection staff use a manual, "action prompts" and a contacts directory of relevant stakeholders who may be required to liaise with for significant sporadic infectious diseases and major outbreaks.

The ERHPS maintains day to day health protection services to a high standard and has systems in place to anticipate potential incidents. A Clinical Manual has been developed and is continually updated to provide a consistent approach and response to health protection cases and incidents in line with the guidance.

Scottish Borders Council Environmental Health ensure the provision of safe and healthy food by businesses in the Borders following guidance provided by Food Standards Scotland's Food Law (Scotland) Code of Practice and associated guidance.

Environmental health also ensures that workplaces in the Borders are safe and healthy places for both employees and the public affected by those businesses activities through enforcement and providing advice and guidance via targeted interventions following the HSE's National Local Authority Enforcement Code.

8.4 Staff knowledge, skills and training

Within ERHPS, NHS staff undergo an annual appraisal to ensure that their knowledge and skills remain up to date. Staff are encouraged to identify their own learning needs and attend external conferences and meetings as part of continuing professional development activities. Nursing staff meet the requirements of the Knowledge and Skills Framework and revalidation requirements for NMC registration. Training opportunities in ERHPS are regularly offered to NHS Borders colleagues involved in health protection out of scope and/or on call provision.

With SBC staff are encouraged to log learning and personal study etc. as part of a scheme of continuing professional development.

All Environmental Health Officers (EHO) are expected to ensure that CPD requirements are maintained and are encouraged to do this through a recognised professional organisation.

EHOs are encouraged to attend training or update events organised by NHS Borders, PHS, Royal Environmental Health Institute of Scotland, Food Standards Scotland, Health and Safety Executive or joint events.

9. Capacity and resilience

9.1 ERHPS in-hours

The ERHPS delivers the majority of the statutory Public Health (Health Protection) responsibilities within office hours, alongside colleagues in SBC.

Within ERHPS, nine strategic work areas have been identified, each supported by up to six consultants, specialty doctors, or senior nurses, and each senior member of the team being allocated to four work areas. As capacity within the nursing team increases in line with recruitment then nurses will also join the thematic work areas.

The work areas that have been identified are:

1. Complex plans and pathways
2. Environmental hazards
3. Gastro-intestinal and zoonotic infections
4. Settings
5. Complex groups and communities

6. Localities (Health Board based geographical areas)
7. Supporting the team
8. Emergency planning
9. Supporting the operational work

The ERHPS Public Health Department undertake health protection audits and quality improvement projects grouped within work area project groups. These aim to ensure that the quality of services is maintained and that lessons are learned from incidents and outbreaks. Debriefs for significant incidents or major outbreaks are held to learn lessons from how they have been managed and put in place recommendations to improve future responses. These debriefs may be multi-agency and multi-disciplinary or internal, as appropriate.

Expert groups and communication links are established internally and with partner organisations. This helps ensure that staff are kept up to date with health protection issues, procedures are kept current and health protection services can be tailored to local demographics. Building a stronger surveillance and health intelligence function within the ERHPS is a priority that depends on additional recruitment of staff with necessary expertise.

Whilst the Borders has dealt very well with outbreaks and incidents in recent years, there have been recent difficulties in staffing the out-of-hour health protection on call service, where NHS Lothian support through the ERHPS has been required. Moving to a regional out of hours service will provide much needed resilience here.

Additionally, the regional Health Protection workforce can provide resilience to respond to a large incident, and if needed staff from the wider public health workforce will be utilised. Regional arrangements for sharing of expertise will further improve resilience.

9.2 NHS Borders Out of Scope provision (OOS)

Whilst the majority of the daytime Health Protection functions for the NHS Borders has been incorporated into the ERHPS, OOS workstreams and the Immunisation Coordinator role remain within the Health Board. OOS work mainly includes the management of cases of acute Hepatitis C and TB but would also include less other health protection roles such as the long-term management of drug harm clusters in the Borders area. The newly introduced National TB Surveillance System will require local staff with an OOS remit to undertake relevant training.

The NHS Borders Public Health directorate is undergoing a service review and restructure (2024-2025). Health Protection duties and the Immunisation Coordinator role will remain within the Public Health Directorate.

9.3 On call/Out of Hours (OOH)

Outside of ERHPS office hours, NHS Borders Public Health Department organises an out-of-hours rota of ‘competent officers’ as defined under the Public Health Act 2008. Officers are contactable via the Borders General Hospital switchboard on 01896 826000. There is planning in place to move to a regional ERHPS on call model in 2025 which will provide resilience to service provision.

Emergency Out of Hours for Scottish Borders Council is provided by East Lothian Council. The contact number is 01896 752111.

The Protective Services Manager and Principal Regulatory Services Officers are contactable for food communicable disease, private water supply emergency provision and Animal Health.

10. Emergency planning and continuity

NHS Borders and Scottish Borders Council need to ensure that robust arrangements are in place to manage major incidents through emergency planning including business continuity plans with clear accountability arrangements. The Civil Contingencies Act 2004 established a new legislative framework for civil protection in the UK. This act placed clear roles and responsibilities on those organisations with a part to play in preparing for response to emergencies. NHS Borders and SBC continue to update their major emergency procedures in accordance with new national guidance Preparing Scotland: Scottish Guidance on Preparing for Emergencies..

Emergency planning arrangements within NHS Borders are monitored by the NHS Borders Resilience Committee and by the SBC Corporate Management Team.

11. Public involvement and feedback

Two representatives from the Public Involvement Partnership Group attended and contributed to the JHPP stakeholder planning meeting, determining local priorities and workplans for 2025-2027.

More generally, information is provided to the public through local media and the NHS Borders and Scottish Borders Council's websites.

APPENDICES

Appendix A: Joint Health Protection Action Plan

A number of priority issues and actions for this JHPP have been agreed for the 2025-2027 period and these are shown in Table 1 below. Progress of these actions will be reviewed quarterly at the Borders Health Protection meeting, including representation from NHS Borders Public Health, Scottish Borders Council and East Region Health Protection Service.

Table 1: Scottish Borders Joint Health Protection Action Plan 2025-2027

	Source	Outcome	Work Plan	Agencies involved
1	National priority	Reduce Vaccine Preventable diseases	• A Vaccination Framework and Delivery Plan is in development. The Delivery Plan will be monitored quarterly, with a focus on uptake and reducing inequalities, and will consider the roles of communication and wider partners to make every contact count. • Work in partnership with Public Health Scotland to ensure the Delivery Plan is aligned to the national Key Performance indicators. • There is a catch-up campaign for RSV and a review will be undertaken to consider inclusion of RSV along with shingles or pneumococcal campaigns for eligible cohorts. • Further understanding of barriers to vaccination uptake for pertussis are required. Antenatal vaccination rates are lower compared with other vaccination programmes and assurance is required around this. To develop an action plan that titrates activity against uptake, considering the role of communications and nursery setting vaccination offers. • Quarterly reports will be provided to the Clinical Governance Committee detailing progress against outcomes within the Delivery Plan and highlighting any areas of risk.	NHS Borders/ Scottish Borders Council/ Scottish Water
2	National priority	Reduce the incidence of tuberculosis (TB)	• Continue with NHS Borders' monthly TB multi-disciplinary meeting to review the management of both new active TB cases and latent TB. • The TB lead will monitor local data and ensure data is recorded and reported via the National TB surveillance system (NTBS). • A Multidisciplinary Group to include, child protection, social work, paediatrics and health protection is being established to review a preventative model for screening and vaccination of asylum seeker/refugee population. • A review will be undertaken on screening for health care workers coming from at risk countries where there is no access to Occupational Health. A screening tool is being developed to support early detection which will be managed by Health Protection within the NHS Borders Public Health	NHS Borders

			Team.	
3	National priority	Progress action towards Hepatitis (HCV) elimination	• The Sexual health and blood borne virus action plan: 2023 to 2026 was published by Scottish Government in November 2023 and will be reviewed against NHS Borders Elimination Plan. • Review of the NHS Borders Health Protection Hepatitis C process and plan. • Continue to collect data on cases as well as those lost to follow up. If lost to follow up the Health Protection Team will attempt to re-engage with the case. • The immunisation coordinator will work in partnership with Borders Addiction Service, We Are With You and Sexual Health to identify cases of Hepatitis C. The immunisation coordinator will ensure cases are supported on a treatment plan which is led by our Gastrointestinal Consultant and Lead Nurse.	NHS Borders
4	National & local priority	Addressing health inequalities	• NHS Borders Public Health published a health inequalities plan in 2024 (Tackling Health Inequalities in the Scottish Borders). Wider public and stakeholder engagement is planned. • Access to employment • Access to affordable healthy food • Access to affordable transport • Access to suitable housing • How to support fuel poverty • Working together with partners to reduce barriers to uptake in disadvantaged groups e.g. accessibility of clinics	NHS Borders / Scottish Borders Council
5	National priority	Minimise the risk to the Public from Shiga toxin-producing E. coli (STEC) infection	• Public Health Scotland published a review of the Guidelines for the identification and management of E-coli STEC in January 2025. This will be reviewed by ERHPS and local implementation considered for the Borders. • Scottish Water monitors the safety of public water supplies and SBC Environmental Health monitors Private Water Supplies and ensures that public health interventions are taken for any failing drinking water supplies, • The HPT along with EHO promote the safe practices and procedures where there is contact with livestock at animal parks and farms. • SBC EHO ensures the implementation of recommendations on the safe use of agricultural ground for recreational events. • The ERHPS lead on investigations of cases of STEC and use national guidance to manage any cases or outbreaks ensuring the implementation of appropriate control measures.	NHS Borders / Scottish Borders Council / Scottish Water
6	National & local priority	Food control	• EHOs undertake the duties as statutory food authority in protecting food safety in the food industry and deliver the councils food safety plan.	Scottish Borders Council
7	National & local priority	Monitoring and improving	• Collaboration between all three agencies in the monitoring and improvement of public and private water supplies.	NHS Borders / Scottish

		drinking water quality	• Work with DWQR to deliver the requirements on Private Water Supplies. • SBC work with supply owners and users through a risk assessment process to continue supply infrastructure and water quality. • HP will increase surveillance of communicable disease locally in the context of potential/regular flooding events.	Borders Council/ Scottish Water
8	Local priority	Control Environmental Exposures which have an adverse impact on health	• Tackle the effects of antisocial or excessive noise in the community. • Deliver on air quality standards within the local authority area. • Review approaches to swimming pools and spas to ensure appropriate controls are in place regarding infection control. • Blue-green algae – Promotion of safe usage of recreational waters where there is a risk of BGA, implementation of signage and responding to incidents that occur. • Progress Contaminated Land strategies and ensure land is made suitable for use through development management. • Monitoring of bathing water quality (designated beaches/lochs) with SEPA. • Apply the regulations for legionella safety in public buildings. • Monitor the levels of lead in drinking water in public buildings especially schools and in relevant private establishments such as nurseries. EHOs monitor sampling.	NHS Borders/ Scottish Borders Council
9	Local & regional priority	Resilience to respond to Pandemic through effective multi-agency response	• The SBC Pandemic Plan was updated in April 2024 following on from lessons learned from the Covid-19 Pandemic. • SBC has updated its Business Continuity (BC) Software and all BC Plans have been updated or are in the process of being finalised to comply with the new system. • The East Region Pandemic Plan has been developed over 2024, bringing a consistent approach to all four partner boards. • SLAs are not currently in place with community pharmacy. A piece of work is required concerning supply and engagement around antivirals for pandemic flu. There is currently no mechanism to get antivirals out into the community, with stock at the BGH but not in the community.	NHS Borders/ Scottish Borders Council and wider partner agencies
10	Local & regional priority	Enhance recovery planning for a major incident	• Review and further develop the generic Recovery Plan outlining multi- agency responses. • Contribute to Regional Resilience Partnerships. • Specific training in respect of Scientific and Technical Advisory Committees (STAC) to NHS and LA staff.	NHS Borders/ Scottish Borders Council
11	Local & regional priority	Effective and proportionate arrangements in place to	• Revise joint health protection policies and procedures using national guidance for example PHS Management of Incidents and Outbreaks through the ERHPS.	NHS Borders/ Scottish Borders Council/

		protect public health	• Review existing arrangements/plans as a routine part of each incident that occurs. • Undertake specific exercises for the purposes of training and evaluation of contingency plans relating to water and waste-water incidents and the recovery phase following an incident. • Consider key performance standards for the response, investigation and actions for public health incidents • Link with the East of Scotland Health Protection Service to develop joint training in managing incidents/outbreaks and chairing these meetings such as STAC. • To investigate and take appropriate action in response to service requests which have the potential to impact adversely on the environment or to public health.	East Region Health Protection Service
12	Local priority	Reducing the impact of tobacco, alcohol and other harmful substances on public health	• Continued regulation of the smoking ban in enclosed and public places including NHS premises. • Trading standards have an enforcement remit for underage sales with EHOs supporting them. • Implement Alcohol and Drug Partnership Strategy and Delivery plan. • Continue regulatory work on age-related sales activity of cigarettes and other products. • Promotional campaign targeted at reducing the under-age sale of tobacco and vaping products to children and young adults. • Review and refine local processes for identifying possible drug harm clusters. Emerging drug harm clusters to be supported initially by ERHPS in-hours and local on-call Public Health Consultant out of hours, with longer-term actions supported by a local Public Health Consultant, as per developed regional guidance (January 2025).	NHS Borders/ Scottish Borders Council and partners
13	Local priority	Strong and safe communities	• The protection of the vulnerable in communities from the impact of cold calling and rogue traders.	NHS Borders/ Scottish Borders Council
14	Local & national priority	Screening	• Support the uptake to the national screening programmes. • Ensure Key Performance Indicators are met. • Support any adverse events associated with screening.	NHS Borders
15	Local priority	Education and advice programme	• Raising awareness of the Outdoor Code and communicable disease and controls through improved public information. • Ensure there are links on NHS Borders and SBC to NHS Inform. • Where possible, consider and coordinate seasonal promotions and awareness raising campaigns e.g. a summer campaign highlighting the risks of ticks and barbecues. • Increase awareness of health protection issues with local businesses through use of alternative enforcement plans.	NHS Borders/ Scottish Borders Council

16	Local priority	Preventing and minimising the spread of infection	• Investigation of suspected and confirmed cases of communicable disease and implementation of appropriate controls to prevent further spread. • Monitoring trends by enhanced surveillance and reporting. • Support appropriate access to testing in the public analyst labs. • Ensure public health actions are taken to minimize risks from zoonotic infections reported by the Animal and Plant Health Agency (APHA). • Develop a plan to address gaps identified due to there being no community infection control team, particularly in respect of support that may be required to Care Homes.	NHS Borders/ Scottish Borders Council
17	Local & national priority	Environmental health	• EHO have responsibility for enforcing health and safety at working within establishments under enforcement regulations, setting priorities and targeting interventions.	Scottish Borders Council
18	Local priority	Horizon scanning and emerging infections	• Locally and regionally, to be aware of new and emerging infections and plan how to minimise their impact locally e.g. Mpox, iGAS. • Within ERHPS, work area groups include GIZ, settings and complex pathways that address new and emerging infections e.g. mpox/HCID group was stood up in August 2024 and work is ongoing through the complex pathways group. • Local HCID pathways are in development.	NHS Borders/ Scottish Borders Council
19	Local priority	Minimise the adverse impact of climate change	• Work together to mitigate and adapt to the effects of climate change. • Support NHS Borders to achieve the aim of becoming a net-zero organisation by 2040 for the sources of greenhouse gas emissions. • Support partners and Scottish Government in meeting climate change and net zero targets. • Public Health to continue to develop actions outlined in the Sustainable Communities theme of the NHS Borders Climate Emergency and Sustainability action plan.	NHS Borders/ Scottish Borders Council
20	Local priority	Animal health and zoonosis	• Respond to current and emerging diseases such as the risks from avian influenza. • Deal with the illegal import of animals. • Carry out animal health and welfare enforcement activities in accordance with Framework Agreements. • Improve preparedness to deal with animal health disease outbreaks.	NHS Borders/ Scottish Borders Council
21	Local & regional priority	Workforce planning and resilience	• Training and support in incident management and response including STAC training. • Continue to support the transition to the ERHPT.	NHS Borders/ Scottish Borders Council/ ERHPS
22	Local priority	Water safety plans	• Progress water safety plans. The Water Safety Plan is now drafted however we await agreement internally on the Risk Assessment Process	NHS Borders/ Scottish

				Borders Council/ SEPA
23	National priority	Coordinated approach to public health	• Actively participate in the ERHPT. • Actively participate in the PHS Health Protection Network and associated governance groups to promote a coordinated approach to protecting public health and developing new guidance and systems.	NHS Borders/ Public Health Scotland
24	National & local priority	Antimicrobial resistance	• Implement measures to control antimicrobial resistance across all health sectors and the local authority. • Public engagement. • Consider the approach to enacting the national action plan locally.	NHS Borders/ Scottish Borders Council

Appendix B: Numbers of Designated Competent Persons

Under the Public Health etc. (Scotland) Act 2008, the following numbers of Competent Persons work within NHS Borders and Scottish Borders Council:

NHS Borders (as at 11/3/2025): 9 Competent Persons

There are 4 Consultants in Public Health within the NHS Borders Public Health directorate. This includes a locum Consultant and a Consultant currently on maternity leave.

1 Senior Clinical Nurse Manager within the NHS Borders Public Health Directorate.

3 Consultants in Public Health and 1 Nurse Consultant within the ERHPS who participate as a 'Competent Person' in the Borders Health Board out of hours health protection service provision.

The ERHPS has 17 'Competent Persons' (inclusive of the four mentioned above), who undertake competent person work related to the Borders in daytime hours.

Appendix C: Resources & Operational Arrangements for Health Protection

Table 2: NHS Borders staffing for out of scope (OOS) health protection duties (as at 11/03/25)

NHS Borders Staff					
Staffing	**No.**	**FTE**	**Health Protection roles and responsibilities**	**Designated competent person**	**Management/ professional/ technical**
Director of Public Health	1	1	Accountable officer for OOS health protection functions, strategic leadership. Duty health protection consultant cover for OOS health protection incidents/situations and out of hours rota	Yes	Professional
Consultant in Public Health	2	1.5	Duty health protection consultant cover for OOS health protection incidents/ situations and out of hours rota	Yes	Professional

Senior Clinical Nurse Manager Health Protection /Immunisation Co-ordinator	1	0.5	Health protection strategic and operational activities for activities out of scope of the East Region HPT. Immunisation co-ordinator Provides support for BBV/TB and contributes to the out of hours rota.	Yes	Professional
Public Health Specialty Registrar	2	1.6	The Public Health Department is a training department, and the Specialist Registrars spend part of their time undertaking health protection training.	No	Professional
Project support officer	1	0.1	Administrative support to health protection function	No	Technical

One health protection nurse specialist role (FTE 0.4) has been incorporated into the ERHPS. Funding has also been placed within the ERHPS for a Consultant in Public Health locality lead for the Borders area.

Table 3: Scottish Borders Council Staffing (as at 11/03/25)

Scottish Borders Council Staff				
Staffing	**No.**	**Health Protection roles and responsibilities**	**Designated competent person**	**Management/ professional/ technical**
Protective Services Manager	1	Service manager for a number of regulatory functions within three teams	no	Management/ Professional
Principal Regulatory Services Officers	1	Operational team managers	yes	Management/ Professional
Environmental Health Officers	5	Operational Environmental Health Officers in Amenity & Pollution, and Food Health & Safety Teams	yes	Professional
Food Safety Officers	3	Operational Food Safety Officers in Food, Health and Safety team	no	Professional
Wider Partners				
Resilience Manager	5	Strategic and operational development of resilience - emergency planning and business continuity functions.	no	Technical

Appendix D: NHS Borders Out of Scope Team Objectives

Health Protection: we work alongside the East Region Health Protection Service to protect the health of the local population from TB and Hepatitis C in hours and from communicable diseases and environmental hazards Out of Hours.

In order to fulfil our aim we will:

- Support production of the Regional Joint Health Protection Plan by providing NHS Borders specific input.
- Ensure clear governance structures are in place for immunisation and embed public health principles into immunisation programmes (including equity and tackling health inequalities) to support high uptake of vaccinations across the population of NHS Borders.
- Support and advise immunisation delivery teams on evidence-based approaches to improve and sustain high uptake and inclusivity in immunisation.
- Develop robust local surveillance system for detecting increases and outbreaks of infectious disease which are OOS.
- Undertake local and regional continuing professional development to ensure preparedness for outbreaks of OOS diseases and ability to support and respond to issues Out of Hours.
- Deliver a health protection service, working with partners, to protect health of local population from communicable diseases deemed ‘out of scope’ of regional working (TB and Hepatitis C virus).
- Develop a plan to embed preventative and proactive work of NHS Borders and partners in relation to TB and BBVs.
- Liaise with NHS Borders Microbiology, IPCT and Clinical colleagues to support development of a regional plan for dealing with a High Consequence Infectious Disease.
- Provide representation and input into the newly developed quarterly Borders Health Protection meeting, alongside ERHPS and SBC colleagues.