Maternity & Women's Health Plan

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Utilise national communication assets to normalise pregnancy planning and ensure our population have information to self-support e.g. video resources • Develop partnerships to include third sector organisations to support multiple areas of Women's Health including preconception counselling, pregnancy planning, menstrual health and healthy lifestyle	• Expand access to parent education sessions to meet the needs of our communities • Establish Women's Health Hubs within the community to equitably deliver the women's health plan. • Strengthen collaboration to create efficient care pathways across local authorities and agencies, that communicate effectively with each other, during pregnancy care	• Strengthen acute support systems for perinatal wellbeing, health and early interventions. • Standardise access to emotional and psychological support services for families with a child in Special Care Baby Unit (SCBU). • Re-design Labour Suite to a 'Women's Health Suite' to reflect the broader range of services offered and to develop accommodation that is	• Promote geographical equity of access to resources across geography of the Borders. • Strengthen Regional Model of care for delivery of complex cases through clinical networks and service level agreements including clear protocols for information sharing

	• Cancer screening and prevention will be equitably across NHS Borders • Deliver the Maternity chapter of our obesity strategy	• Enhance and deliver the current perinatal mental health and support pathway. • Agree and implement comprehensive and standardised pathways in maternity and gynaecology for GP's and community midwifery. • Ensure there is fair and equitable access to minority groups to meet individual needs	supportive of patient-centred care & meets patients' needs. • Standardise triage pathways, aiming to improve integration and offer a standardised service in a dedicated space. • Reform outpatient service and expand day case procedures to deliver a modernised gynaecology service • Deliver the national bereavement care pathway	
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Remote Digital Consultations • Remote Monitoring to enable care closer to home • Build and sustain a skilled Maternity & Women's Workforce • Re-design labour suite to offer accommodation that meets patient needs and is person-centred			

Children and Young Peoples Services

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Strengthen support systems for perinatal wellbeing, health, early interventions and prevention strategies. • Build coordinated, multi-agency, including third sector, utilising evidence based approaches to support early intervention and prevention, including mental health and neurodiversity within care experience children. Ensure accessibility to these services and utilise these as a tool for promoting health behaviours and education in children.	• Include paediatric care into community hubs and ensure capacity and capability • Establish multi-disciplinary teams which create a shared and holistic understanding of well being • Align the delivery of Children and Young Peoples Services with the principles of United Nations Convention on the Rights of the Child (UNCRC)and Getting it Right for Every Child (GIRFEC)	• Ensure timely access to acute and specialist services for neonates, children and young people. • Develop standardised triage protocols for acute services • Deliver elective and emergency surgery for appropriate groups. • Reduce avoidable hospital admissions through short-stay, ambulatory care and community models.	• Develop clinical networks with regional partners to manage the safe transfer and repatriation of patients.

	• To record, use and share local population data to support service development and sustainability, for Children and Young People services. • Ensure children and young people safeguarding measures and systems are in place to keep children and young people safe.	• Enhance CTAC to deliver paediatric care to all children and young people across all GP practices. • Support the expansion of speech & language therapies in Children and Young Peoples services • Create coordinated pathways for Children and young people transitioning to adult services	• Deliver enhanced bereavement care across all ages of children and young people	
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Children and Young People's Workforce • Remote Digital Consultations • Remote Monitoring to enable care closer to home			

Children and Young People's Mental Health Service

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Work together with families and partners to improve outcomes for the Children and Young People of the Scottish Borders • Establish a joint governance group with health, education, social care, housing, and public health to oversee early intervention initiatives. • Develop a shared data dashboard to identify children and families at risk of poverty or poor health outcomes. • Create multi-agency referral pathways for early	• GP engagement in referral thresholds and managing adolescent mental health • Co-design stepped care multi-agency pathways Integrated pathways that support neurodevelopmental and mental health needs from early intervention through to specialist care. • Promote holistic support in community settings, within our professional remit, with our partners including caregivers • Engage in the development of multi-	• Deliver high-quality specialist Mental Health Services Tier 3 and Tier 4 CAMHS, including intensive support and equitable access to specialist inpatient resource and care for CYP in the Borders. Develop clear, accessible referral criteria with changes and updates communicated widely to referrers. Ensure timely access to assessment and treatment. • Strengthen targeted pathways for children and young people with highly	• Work with sub national colleagues to develop clear and accessible national tertiary service for Children and Young People with complex mental health needs.

	signs of distress, ensuring smooth handovers between services. • Launch a community-wide health education campaign on healthy behaviours, using local media and social platforms. • Roll out NES National Training Framework across agencies to equip staff (school nurses, social workers, health improvement specialists) with skills for early identification and response. • Embed evidence-based interventions (e.g., smoking cessation, nutrition programmes) into routine contacts with families. • Ensure children and young people safeguarding measures and systems are in place to keep children and young people safe.	agency day services and resource hubs within Primary Care and Education, aligning with local authority, regional partners and existing Early Years Centres.	complex needs and/or vulnerability including those with learning disabilities, care-experienced children, and under-5s with possible neurodevelopmental and psychosocial challenges. • Contribute to the development of Regional/National models of access to specialist resource • Create coordinated pathways for CYP transitioning between services, and transitioning to adult services, in line with relevant national guidance.	

Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Children and Young People's Workforce • Embed Quality Improvement Culture to improve sustainability and resilience • Improve accessibility for Children and Young People by expanding the use of alternative venues for patient facing consultations.

Cardiology

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Promote cardiovascular health through evidence-based Health Improvement interventions and work with colleagues in Education, Healthy Working Lives and other local partners to promote healthy living in schools and workplaces, aiming to improve population health overall and reduce inequalities between groups. • Support the new Direct Enhanced Service cardiovascular risk assessments happening locally in General Practice to enable early detection and timely intervention for	• Support educational development opportunities & information sharing between GPs with special interest in Cardiology This could include shadowing opportunities for GPs within the Cardiology Department. • Develop a technology strategy for Cardiology, specifically looking at the benefits of using technology for cardiac rhythm monitoring. • Standardise referral pathway criteria into the Cardiology service to ensure appropriate	• Provide skilled Hospital at Home (H@H) and community rehabilitation services to support timely discharge and recovery in familiar environments. Work collaboratively to develop a Heart Failure protocol and pathway to ensure evidence-based care is provided and access to appropriate investigations is available, including access to remote monitoring. • Embed MDTs into routine care to ensure holistic, coordinated support across hospital and community settings.	• Explore mutual agreements between NHS Borders and regional health boards to expand service offering and ensure equitable access to diagnostics and treatment. Establish mutual agreements to manage patients with complex cases, including having SLA's in place specifically: ○ pacemaker insertion ○ implantable cardioverter-defibrillator insertion ○ angiography

	at-risk individuals. Evaluate to ensure these risk assessments are delivered in a way which reduces inequalities in health experience and outcomes between populations. • Provide mental health support for those affected by illness and adverse experiences and embed psychology services throughout the cardiology care pathway, focusing on evidence-based interventions as part of cardiac rehabilitation. • Work across specialties and with multi-agency partners to develop an over-arching NHS Borders strategic approach to obesity considering the local environmental, social and commercial drivers of obesity in our population. A weight management programme should also	investigations are undertaken prior to referral. • Work with academic partners to develop research projects within the Cardiology service e.g. handheld echocardiography. • Establish multidisciplinary teams to support rehabilitation across specialties, with clear referral criteria and links to secondary care for stroke and heart patients. • Offer individualised discharge planning to patients ensuring follow up takes a Value-based Health and Care approach. • Provide access to physiological medicine tests and remote monitoring tools in primary care to support early	Improve access to tertiary MDTs. Implement frailty focused MDT within the Borders. • Optimise virtual consultations according to patient wishes where appropriate to ensure consistent access to cardiac follow-up care across geographic areas and ensure equitable access to patients in more rural parts of the Scottish Borders. • Utilise appropriate staffing levels to improve service provision and reduce waiting list pressure. Establish joint working with primary care to ensure all patients on waiting lists remain appropriate for follow-up.	• Scope and plan for how a regional cardiology service could be equitably and sustainably delivered.

	consider optimising patients' nutrition and healthy weight.	detection and management of cardiac conditions. Develop a palpitation pathway. Consult with GPs in relation to widening access to physiological measurement investigations and development of standardised criteria like those in place for radiological imaging. • Support those who are given life limiting diagnosis to have realistic and value-based conversations around Future Care Planning. This should include equal access to Palliative Care services		

Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Cardiology Workforce and ensure succession planning • Remote Digital Consultations • Remote Monitoring to enable care closer to home • Utilise digital tools to support clinical investigations

Respiratory

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Deliver targeted interventions on smoking cessation (especially for pregnant women) and the risks of vaping, supported by cross-sector engagement and consistent messaging. Partnerships with third sector organisations and Scottish Borders Council. Use information on specialist respiratory services • Embed smoking cessation and wellbeing initiatives into care pathways, expand social prescribing, and promote patient empowerment through education and goal setting,	• Establish multidisciplinary teams to enable early supported discharge and admission avoidance, with clear referral criteria and links to secondary care. • Create Integrated Care Pathways across Primary and Community Settings by standardising referral processes and embed future care planning to ensure consistent, equitable access and continuity of care for respiratory patients. Explore pathways for early diagnostics where appropriate.	• Update and roll out RefHelp, standardize and review referral criteria, and optimise respiratory care pathways to reduce delays and improve patient flow. • Identify and address gaps in post-discharge care and develop integrated discharge planning protocols to ensure smooth transitions between acute and community settings including Hospital at Home. • Establish MDTs for complex cases, improve	• Explore mutual agreements between NHS Borders and regional health boards to expand service offering and ensure equitable access to diagnostics and treatment. • Establish mutual agreements and SLA's to manage patients with complex cases. • Ensure equitable access to holistic future care planning for all people with chronic respiratory disease, including non-malignant

	including pulmonary rehab support. • Ensure patients transition where appropriate to evidence based treatments aligned to national guidelines and Commit to sustainable prescribing. • Map specialist respiratory services across NHS Borders, SBC, third sector and neighbouring regions to identify gaps and use this information to ensure patients have access to support self-management.	• Make future care planning a routine part of primary and secondary respiratory care, to enable early identification of deterioration and personalised support including early psychological support.	access to diagnostics, and use data insights including AI to inform service planning, quality improvement, and workforce needs.	life shortening conditions.
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Respiratory Workforce and ensure succession planning • Remote Digital Consultations • Remote Monitoring to enable care closer to home • Utilise digital tools to support clinical investigations			

Stroke

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Work with colleagues in Education, Healthy Working Lives and other local partners to promote healthy living in schools and workplaces, aiming to improve population health overall and reduce inequalities between groups. Collaborate with SBC and third sector partners to encourage physical activity and health literacy. • Embed routine cardiovascular risk assessments in primary care.	• Ensure smooth transitions and shared understanding across all care settings, particularly in managing cognitive and emotional difficulties post-stroke. Introduce consistent discharge planning and post-discharge follow-up for stroke patients to improve • Establish and enhance multidisciplinary community rehabilitation teams with clear referral criteria to support recovery and reduce hospital dependency.	• Optimize use of Hospital at Home (H@H) to have stroke specialist input and community stroke rehabilitation services to support timely discharge and recovery in familiar environments. Work towards establishment of an Early Supported Discharge team. • Establish joint discharge planning protocols and embed MDTs—including psychologists and neuropsychologists and third sector —into routine care to ensure holistic support. Continue	• Establish and maintain effective clinical networks with SLA's in place to manage the quality and timeliness for stroke thrombectomy, CA's and neurosurgical services.

	• Identify socio-economic and geographical variability in service access and plan outreach initiatives to ensure equitable prevention and early intervention across NHS Borders.	• Support patients and staff with access to technology to support self-recovery. • Implement tools like the eFrailty Index and future care planning to identify at-risk patients early and tailor interventions accordingly.	development of the spasticity service. • Launch outreach clinics and expand virtual consultations to ensure consistent access to stroke follow-up care across geographic areas. • Integrate psychological support for individuals during admission and post-stroke throughout the stroke care pathway. • Continue working towards national stroke targets across the whole stroke pathway including all aspects of stroke care, including rehabilitation.	
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Stroke Workforce and ensure succession planning • Remote Digital Consultations • Remote Monitoring to enable care closer to home • Utilise digital tools to support clinical investigations			

Orthopaedics

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Embed evidence-based interventions to encourage active lifestyles, uptake of recommended levels of weight-bearing physical activity and smoking cessation to reduce future MSK burden. • Develop and implement screening, education, and exercise programmes to reduce falls risk, particularly among older adults and those with early MSK symptoms. • Provide accessible MSK self-management resources and community ambassadors to support	• Develop and expand local hubs that deliver MSK rehabilitation, falls prevention, and education, ensuring care is accessible and tailored to community needs. • Implement early identification of risk and use of Patient Reported Outcome Measures in the community. to detect MSK deterioration and falls risk, enabling timely intervention and support. • Standardise referral criteria using Right Decision Service to support appropriate	• Implement MSK triage tools and standardised referral criteria to ensure patients are directed to the most appropriate care pathway efficiently and safely. • Establish inpatient physio service to minimise deconditioning. • Expand and standardise 23 hour / same day discharge arthroplasty including post-operative support. • Balance orthopaedic trauma and elective	• Explore clinical networks to establish SLA's and mutual agreements between NHS Borders and other East of Scotland boards to optimize service deliver and contribute to Scotland East Orthopaedic Recovery Plan.

	informed health choices and reduce dependency on clinical services. • Design and deliver Waiting Well programmes that support patients physically and mentally whilst waiting on specialist advice, improving outcomes and recovery times, using the national toolkit. • Invest, upskill and recruit to community teams working in MSK triage, frailty management, and therapeutic interventions, fostering collaborative care through regular MDT engagement. • Work across specialties and with multi-agency partners to develop an over-arching NHS Borders strategic approach to obesity considering the local environmental, social and commercial drivers of obesity in our population. A	referrals to the secondary care orthopedic service. Should include escalation criteria to support prioritisation. • Frailty Identification and Development of a Prehabilitation Service • Apply the principles of Value Based Health & Care and shared decision making. • Identify frailty at time of referral and identify at pre-assessment clinic who would benefit from targeted prehabilitation. • Develop consistent post-operative trauma rehab and discharge planning pathways. Improve timely multi-disciplinary team access to support recovery, reduce readmissions and maximise outcomes of surgery.	service demand and capacity. • Review procedures done infrequently and rationalize what is undertaken at NHS Borders. Focus on what NHS Borders is doing well.	

	weight management programme should also consider optimising patients' nutrition and healthy weight.			
Organisational Enabler	• Digital Shared Records • Build and sustain a skilled Orthopaedic Workforce and ensure succession planning • Remote Digital Consultations • Remote Monitoring to enable care closer to home • Utilise digital tools to support clinical investigations			

Ophthalmology

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Standardisation of information and language to professional groups and families promoting vision awareness, ensuring children and families understand the importance of regular eye checks and screen time management. • Co-locate services to support early intervention and reduce progression of preventable conditions. Prioritise early prevention with vulnerable populations. • Standardise age-specific vision checks and embed	• Strengthen community optometry as a frontline resource by clarifying, expanding and promoting the role of community optometrists in patient engagement, shared decision-making, and early intervention, including standard registration and support for patients on waiting lists. Reinvigorate the Community Optometry Forum. • Establish and promote clear, standardised pathways and accurately capture activity across optometry and	• Reduce waiting times through capacity expansion and streamlined referrals Implement national referral pathways, including emergency community optometry presentation. Hospital eye services will right-size our capacity based on demand. • Optimise and deliver as routine bi-lateral cataract surgery supported. Ensuring MDT approach for safe delivery and efficiency with robust pathways and feedback mechanisms.	• Explore mutual agreements between NHS Borders and regional health boards to expand service offering • Ensure equitable access to diagnostics and treatment. Establish mutual agreements and SLA's to manage patients with complex cases.

	screening programmes to align with national policy, supported by sustainable funding and updated clinical guidance. • Data reporting within the Health Board to understand gaps in the pathway.	ophthalmology by standardising pathways and contractual expectations to measure productivity against this, ensuring people receive visual care in the right place. • Develop integrated low vision services across localities. Formalise and scale community-based low vision clinics (e.g. Specsavers-HES pathway), ensuring consistent access to magnification aids and rehabilitation support. • Promote participants in the community to participate in paid placements and supported training for optometrists and NESGAT participants, fostering collaboration between acute and community settings.	• Fully implement and maintain Open Eyes functionality to support referral management and data sharing, and invest in diagnostic equipment like auto refractors to improve clinical efficiency. • Introduce MDT reviews for patients with complex needs and develop a ‘see & treat’ model (macular) to streamline care pathways and reduce fragmentation.	

		• Formalise shared care pathways and co-location of services to improve continuity, reduce hospital dependency, and embed vision metrics into local health frameworks.		
Organisational Enabler	• Build and sustain a skilled workforce for preventative eye health • Strengthen workforce through upskilling and placement opportunities.			

Frailty

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?

Clinical Specialty Deliverables	• Develop a programme to promote wellness as we age. This will include:
	  • Expanding supported self-management and early intervention programmes.
	  • Raising awareness about the benefits of future care planning specifically in relation to power of attorney.
	  • Development of systems of inter-professional education to promote understanding of frailty
	• Include involvement of unpaid carers and create
		• Ensure timely access to MDT services that provide wrap around care and help people to remain in their own homes as long as possible and offer alternatives to admission.
		• Implement frailty screening within the community and ensure appropriate future care planning is implemented for patients with Clinical Frailty Score of 5 or above.
		• Ensure a person-centred approach to all aspects of frailty care.
			• Set up and open an Acute Frailty Unit to ensure rapid access to Cognitive Geriatric Assessment to reduce length of stay and deconditioning.
			• Train acute ward staff in frailty-sensitive care and embed treatment escalation plans into admission process and future care planning into discharge processes.
			• All medical and surgical patients admitted at BGH over the age of 65+ years, presenting to the front door of the BGH, will have a Clinical Frailty
				• Establish remote and rural frailty research group and draw conclusions for our local service planning
				• Map specialist frailty services across NHS Borders / Third Sector / SBC and neighbouring regions to identify gaps and respond.

	more opportunities to consider future planning. • Explore opportunities to develop strong partnerships to support people maintaining strength and mobility • Evaluate frailty initiatives and embed effective values-based models in service planning	• Provide access to comprehensive geriatric assessment closer to home. • Expand polypharmacy reviews with an aim to reduce inappropriate use and potential harms of medication.	Score assessment which is communicated to relevant department. This should include pre-operative consideration and out-patient care. • Enhance polypharmacy reviews via HEPMA with an aim to reduce inappropriate use and potential harms of medication.	
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Frailty Workforce and ensure succession planning • Remote Digital Consultations • Remote Monitoring to enable care closer to home			

Palliative Care

	What are we doing to support people to keep themselves well?	How do we ensure that Primary & Community Services can support as many people back to good health as possible?	How do we make Secondary Care fast, efficient and effective?	How do we ensure equity of access for our patients who require access to Tertiary Services or care delivered out with NHS Borders?
Clinical Specialty Deliverables	• Improve public information on services, information and resources that are available to people about living with a life shortening condition, future care planning, death and dying and bereavement. • Gather and report experiences on palliative care and care around dying and bereavement for patients of all ages and their families and carers utilising the tools as recommended by the national delivery plan. • Ensure patients have access to well-trained staff	• Expand and integrate services to ensure comprehensive support for people with life-shortening conditions in their home setting. • Embed general palliative care approach into Community Services including collaborative care and integration across Health and Social Care Services. • Review community pharmacy systems, strengthen palliative pharmacy network and improve knowledge and processes around	• Strengthen discharge processes and referral pathways to ensure seamless transitions and continuity of care for people with a life shortening condition across all settings and to support a culture of patient centred conversations at every specialty. • Promote Early Identification and Planning for Life-Shortening Conditions where patients will benefit including conversations around future planning	• Develop a framework and process for patients who require interventions outwith NHS Borders • Enable access to existing out of hours general and specialist palliative care clinical advisory services • Repatriation of out of hours patients to ensure end of life care closer to home

	who are comfortable having open, honest conversations to support living well with the ongoing uncertainty of life-shortening conditions. • Adhere to national guidelines and test innovative models to ensure patients receive timely, compassionate care around dying. • Utilise the national framework for palliative care around improving future care planning.	palliative medication, prescribing and use. • Ensure patients with life-shortening conditions have access to robust medicine reviews including polypharmacy reviews. • Improve access to supportive therapies and equipment for patients with life-shortening conditions • Ensure patients are able to explore supportive therapies and can get timely access to equipment that supports their care. • Recognise the expert generalist role of GPs in palliative care provision. • Support GPs to continue to deliver high-quality palliative care both in and	using approved tools and frameworks • Increase knowledge and skills around prescribing in palliative medications in secondary care • Identify and improve care around dying transitions from secondary care to primary care including developing rapid access to services and equipment and strengthening communications and discharge processes. • Implement a Managed Care Network for Palliative Care to provide strategic leadership, financial oversight, and continuous improvement across secondary care services.	

		out of hours with MDT support as appropriate.		
Organisational Enabler	• Digital Shared Records • Trauma Informed Workforce • Build and sustain a skilled Palliative Care Workforce and ensure succession planning • Remote Digital Consultations