Delivering our Strategies 2026/27 Deliverables

Our True North Statement

Our mission is to enable our communities to keep themselves well, and work towards long-term health equity for our communities. When our communities need us, we are easily accessible, delivering compassionate, efficient, high-quality, person-centred care at the right time and place.

Supporting People to Keep Themselves Well

A3 Plan and Report for Project: Embed Prevention in Every Pathway Date Plan Agreed:	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Supporting people to keep themselves well

High Level Schedule 2026/27

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Establish PB										
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Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Supporting self-management
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Supporting people to keep themselves well

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To be developed as Programme Board is established.

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

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

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Supporting people to keep themselves well

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Escalations for support or decision:

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Supporting Documents:

A3 Plan and Report for Project: Women's Health Hub
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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Supporting Documents:

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

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Supporting people to keep themselves well

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Supporting Documents:

A3 Plan and Report for Project: Healthy Weight
Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Supporting people to keep themselves well

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Escalations for support or decision:

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Supporting Documents:

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

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

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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

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To be developed as Programme Boards Reset

Escalations for support or decision:

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Supporting Documents:

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

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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

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To be developed as Programme Board Resets

Escalations for support or decision:

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Supporting Documents:

A3 Plan and Report for Project: Primary Care Improvement Plan Review Date Plan Agreed:	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

- Undertake Option Appraisal for PCIP future model

Alignment to Organisational Strategy

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

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To be developed as Programme Board Resets

Escalations for support or decision:

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Supporting Documents:

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

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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

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To be developed as Programme Board resets

Escalations for support or decision:

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Supporting Documents:

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

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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

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Supporting Documents:

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

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

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

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Supporting Documents:

Making Secondary Care fast, efficient and effective

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

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

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Supporting Documents:

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

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

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Project Plan										

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

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

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Making Secondary Care fast, efficient and effective.

High Level Schedule 2026/27

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

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

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

NHS Borders

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

Making Secondary Care fast, efficient and effective.

High Level Schedule 2026/27

Phase	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Not Aligned to a Programme Board Currently

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

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

A3 Plan and Report for Project: Develop a strong, collaborative approach with East Region Date Plan Agreed:	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

High Level Schedule 2026/27

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

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

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

Date Plan Agreed:

Senior Responsible Officer:
Project Lead:

Date Last Updated:

Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

High Level Schedule 2026/27

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

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

A3 Plan and Report for Project: Develop a strong, collaborative approach with East Region – Mental Health / LD Date Plan Agreed:	Senior Responsible Officer: Project Lead:	Date Last Updated:	Status Overall

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

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

Assessment (Current and Future State)

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

Aim Statement (Goal)

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

Recommendations (Delivery Approach inc. Performance Measures)

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

Alignment to Organisational Strategy

High Level Schedule 2026/27

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

Specific Actions Next 8 Weeks

Issue	Action	When	Whom

To be developed as Programme Board resets

Escalations for support or decision:

Measures

Deliverable Measures.docx

Supporting Documents:

Programme Management Approach

Delivering Our Strategy – Programme Structure for 2026/27 Deliverables

Clinical Transformation

Supporting People to Keep Themselves Well

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

Making Secondary Care Fast, Efficient and Effective

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

Population Health Programme Board

Urgent & Unscheduled Care Programme Board

Planned Care Programme Board

Mental Health & Learning Disabilities Programme Board

Women & Children Services Programme Board

Business Transformation: Enabling Strategies

QMS: Leadership Pillar

- Quality
- Risk
- Research & Innovation

QMS: Business Process Pillar

- Digital*
- Property & Sustainability
- Finance

QMS: Partnerships Pillar

- Partnerships

QMS: Staff Pillar

- People

Financial Recovery & Sustainability

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

Business Systems

- Workstreams TBC

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

Programme Boards Aims & Executive Leads

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

Programme Boards Aims & Executive Leads

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