NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde

2025-26

Delivery Plan

Our plan to evolve, transform and renew Health & Social care services

East Dunbartonshire Health & Social Care Partnership

East Renfrewshire Health and Social Care Partnership

Glasgow City HSCP

Inverclyde HSCP Health and Social Care Partnership

Renfrewshire Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership

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1.0 Foreword

Our Delivery Plan this year is set within the context of an exciting period of change and renewal within NHS Greater Glasgow and Clyde. Our delivery plan sets out both our priorities for 2025-26 and our vision to transform how we deliver care over the next 3 years to evolve our services and optimise our resources with a focus on whole system working.

Reflecting Scotland's Programme of Reform for Health and Social Care, aligned with the focused policy priorities set out in the First Ministers speech in January 2025, and through the implementation of our 'Moving Forward Together' clinical transformation strategy and our Quality Strategy 'Quality Everyone Everywhere', our key objectives are to:

1. **Improve Access** – Deliver and sustain the changes required to reduce immediate pressures across our system and improve access to treatment
2. **Harness Digital & Innovation** to support access and prevention -Implement digital and technological innovation to support prevention and improve access to and delivery of care
3. **Shift the Balance of Care** – Taking a whole system approach, we will shift the balance of care between acute services & our communities
4. **Improve Population Health** – Working with people to prevent illness and more proactively meet people's needs we will support proactive prevention through our existing work and through the additional investment in general practice and community-based teams. In addition, we will support the implementation of the new Population health Framework when published in Spring 2025.

As the largest Health Board in Scotland, providing for a population of 1.3million people, our programme of reform and renewal is ambitious and will require us to deliver significant transformational change and improvement at pace and scale.

We are committed to working cohesively as a whole health and care system, collaborating with our valued staff, key services, academic and industry partners to achieve the best we can for the people we serve.

We remain committed to being at the forefront of digital and technological innovation which will drive positive transformation, ultimately leading to enhanced performance, increased efficiency, improved access and better outcomes for our patients.

During 2025 we will develop a detailed 3-year transformation plan to describe how we will further transform the delivery of urgent care, through the re-engineering of care pathways to ensure that every person receives the right care, in the right place, at the right time. Central to our transformation plan will be how we better support our immediate and significant urgent care pressures by shifting the balance of care to enable more patients to

be safely and effectively cared for at home. Our plan will be co-created by senior whole systems leaders & senior clinicians from across our system.

The key components of our plan will include expansion of our planned care capacity and the co-creation & development of a whole system interface care division. This will support the development of an FNC+ Plus connecting care model, the development of a new model of eTriage and Rapid Assessment and Care (RAaC) across our front doors, and the creation of an ambitious new 'NHS GGC Virtual Hospital' connecting and building from our virtual bed capacity and the expansion of the range and coverage of clinical support and treatments at home.

In addition, our plan will set out how we will improve access to planned care through further investment to expand our Surgical Hubs at Gartnavel General Hospital and Inverclyde Royal Hospital. We will also maximise our Ambulatory Care Hospitals capacity to direct further elective capacity away from the main hospital sites and separate further the interdependency of emergency and elective care. Lastly, we will and optimise additional National Treatment Centre capacity to reduce waiting times for patients.

Our programme of transformational change will be co-designed and will ensure significant and ongoing staff involvement and engagement. Integral to our success in delivering transformational change will be our ability to effectively engage with staff, fully utilising their passion and expertise A key objective of this programme is to re-engage and empower staff and patients.

We remain committed to ensuring we continue to optimise all our available resources, however, to deliver our ambitious transformational plan at both scale and pace there will be a requirement for significant investment and a drive for effective deployment and utilisation of resources with a continues focus on efficiency, productivity and reduction in non-value added service elements.

We will measure the impact of our programme of transformation to ensure we deliver sustainable change for our patients and staff. This will ensure we deliver enhanced performance, increased efficiency, improved access and better outcomes for our patients.

Professor Jann Gardner
Chief Executive, NHS GGC

2.0 The New Shape of a Transformed NHS GGC

2.1 Developing our 3-year Transformation Plan

During early 2025 we will develop a three-year transformation plan, this will set out how we will reshape and transform our services to deliver significant change and improvement for our patients and our staff.

Our plan will be closely aligned to the objectives set out to deliver both Health and Social Care Reform and our MFT Clinical transformation Strategy.

Our plan will include the key changes to service delivery that we believe will deliver the greatest impact for our patients and staff. Figure 1 sets out the proposed key elements of our plan.

2.2 Key Elements of our Transformation Plan

What will be Different?

Figure 1: Key Elements of our 3-year Transformation Plan

Expanding Primary Care and Community Services

- Support the further expansion of our Pharmacy First and Pharmacy First + Plus model – both increasing capacity & the planned expansion of clinical conditions supported
- Support the delivery of the planned additional investment in general practice and community-based teams. With a focus on pro-active outreach in areas of greatest need & those high risk of Cardio-Vascular Disease (CVD) or frailty.

Co-Creation of a New Interface Care Division

- Our core principle will be to assess, direct and navigate patients requiring urgent care while they are in the comfort of their home
- Supporting more patients closer to home & Reducing ED demand - Development of an FNC+ Plus care model – expand clinical pathways, scale up professional- to-professional advice, evolve pathways into our new virtual hospital and RAaC model, single whole system model for SCDM for care homes & palliative & end of life care, development of TEAL SAS stack pathways.
- Caring for more patients at Home – 'expanding the range & coverage of treatments at home' - we will establish & scale up a new 24/7, 700 – 1,000 bedded Virtual Hospital, supporting wards (both general and specialty) and clinics with 5 Access Points of Care: GP support, SAS, Front Door, Inpatient Discharge, Chronic & Long-term Conditions. Once established our New Virtual hospital will act as a superhub for GGC with close links with our key partners.
- Expand our Home Monitoring Capability & Capacity: Frailty, H@H, OPAT, Remote Monitored Patients, & wider Clinical Specialities
- Establish a RAaC Model at our front doors: increasing ambulatory care pathways and same day urgent care, improving hospital flow and ED wait times
- Improving System cohesion: Our FNC+Plus care model, our MHAU and our RAaC model will be our key entry points for patients requiring assessment beyond community. Whole system cohesion - SAS, NHS24, GP OOH, Community Teams, Diagnostics, system navigation, clinical support etc.
- Whole System Overview: Earlier Escalation and Whole System Resilience
- Patient Access Digital Front Door App (DFD): to provide patients with a seamless and secure digital experience when accessing healthcare services.

Planned Care Capacity Expansion:

Our plan will set out how we will improve access through:

- Surgical Hub Expansion: the further expansion and development of our surgical elective hubs located at Gartnavel General Hospital and Inverclyde Royal Hospital
- Maximise our Ambulatory Care Hospitals Capacity: to direct further elective capacity away from the main hospital sites and separate further the interdependency of emergency and elective care

- Optimising Additional National Treatment Centre Capacity: we will ensure optimum use of all available external NTC capacity which will be nationally allocated and regionally deployed. This will enables us to maximise impact for the longest waiting patients, particularly in Orthopaedics.

Improving Population Health
Our plan will be informed by the new Population Health Framework published in early 2025. This is particularly important within NHS GGC,34% percent of our population residing in the lowest 25% SIMD catchment areas with a 4-5 times higher rate of cardiac mortality. Potential gains of improving this through 'making every encounter matter' are huge. As part of our MFT implementation plan we will take forward key high impact prevention projects, these will be aligned to the key reform prevention priorities including CVD and Frailty.

In addition, we will actively engage in plans to support genetic testing for recent stroke patients, Clopidogrel testing at 1st event will lead to up to ~200 less strokes in GGC alone in year 1 alone – this is an essential component of our prevention plan. In addition, genetic testing for newborn babies with bacterial infections and support 3,000 people newly diagnosed with type 2 diabetes over the next three years.

2.3 Measuring the Impact of our Plan

What will our plan achieve?

As part of our plan, we will develop a quality & performance monitoring framework to closely monitor the impact of each of our whole system changes. Our framework will include:

Quantitative measures - Performance metrics e.g. reduced ED attendances, admissions, delayed discharges, hospital bed occupancy, virtual bed occupancy, care home conveyances, number of patients remote monitored etc. in addition we will agree key metrics to monitor how we reduce health inequalities

Qualitative measures – we will develop innovative and multi – faceted ways to seek patient & staff feedback and to enable patients to take more active part of care decisions.

Our Quality & Performance Framework will set out:

- 2024/25 will be our baseline position
- Trajectories for improvement
- An exception reporting mechanism – with clear escalation / early warning process.

2.4 Refreshing our Target Operating Models

For Primary & Community Care, Urgent Care, and Planned Care

Our plan will be supported by refreshing our target operating models and will build on the work undertaken in 2024 as set out in our MFT clinical roadmap. It will also be informed by the new National Clinical Framework, the Route map for Primary Care Reform, and the new Population Health Framework. Our plan will evidence our current (baseline) state and set out the proposed future state pathways to provide care closer to home and improve access to care and treatment.

3.0 Strategic Planning Context

3.1 Linking our Key Planning Priorities to Health & Social Care Reform

Our 6 key planning priorities align seamlessly with our key objectives of improving access, harnessing digital innovation, shifting the balance of care and improving population health.

Our delivery plan will address our immediate system pressures by enhancing access to primary care, urgent care and planned care. Utilising digital innovation, we will support delivery of our primary care strategy and community care improvements, drive the transformation of urgent care whilst also promoting improved population health and reducing inequalities. Our whole system approach to shifting the balance of care will deliver improved access, improved performance and better outcomes for our patients

Our delivery plan for 2025/26 sets out how we will deliver 6 key planning priorities of:

- Improving Population Health & Reducing Health Inequalities
- Implementing our Primary Care Strategy and Improving Community Care
- Transforming Urgent Care
- Implementing our Mental Health Strategy
- Improving access to Planned Care, Diagnostics & Cancer Care
- Improving Women & Children's Health

Our planning priorities are underpinned & supported by our:

- Workforce plan
- Digital and Innovation plan
- Finance plan
- Whole System Infrastructure plan and our
- Climate and Sustainability plan

Within each section we have set out the key deliverables (actions) we are committed to progressing during 2025/26. Unless specified within our plan, all our actions will be delivered during 2025/26. Actions that require additional investment are clearly highlighted within our plan.

To support the delivery of our plan we have developed an internal action tracker which will monitor both the completion of all our actions and the impact of our actions to ensure that the intended change and improvement is fully realised. A quarterly summary progress report will be developed and shared with Scottish Government.

3.2 MFT Clinical Strategy Implementation: Key Opportunities

Our Clinical Transformation Strategy 'Moving Forward Together' sets out our vision for transforming our clinical services over the three horizons of 0-2 years, 3-5 years and 5 years plus and is closely aligned with the Health & Social Care reform agenda. To deliver this (as set out in our clinical vision) our key focus is to:

- Empower patients through self-management, involvement & knowledge of where to access care & advice
- Provide a 'digital first' approach
- Support early intervention & prevention
- Transform how we provide urgent care
- Protect planned care to improve patient access to treatment

Our clinical vision & clinical transformation strategy are aligns with the programmes of work led by the National Health & Social Care Reform Executive focussing on reform and preventative and proactive care programmes including the development of a 'National Clinical Framework', the 'Route Map for Primary Care Reform' and the 'Mental Health Transformation Programme' and the 'Population Health Framework' and work to 'Deploying Digital Technology to Modernise Services'.

Our delivery plan for 2025/26 sets out the clear actions we will take to further improve services we provide for our patients and deliver on the key priorities for health and Social Care Reform set out in January 2025 by Scottish Government.

3.3 Population Based Planning & Service Sustainability

We remain committed to working with Health Board partners to support delivery of both regional and national services. We continue to provide mutual aid to five NHS Boards supporting vascular services, oral medicine, specialist oncology, Oral maxillofacial surgery (trauma and USOC) and cardiology. In addition, we continue to provide a range of national and regional adult & paediatric services.

We remain actively engaged in the national task and finish groups to support a sustainable planning for vascular surgery, oncology, diagnostics & young people's gender identity across Scotland.

3.4 Value Based Health & Care

We are dedicated to delivering Value-Based Health and Care (VBHaC) through the principles of Realistic Medicine (RM). VBHaC is integrated into our clinical strategy 'Moving Forward Together' (MFT), and our Quality Strategy and is threaded throughout our Delivery Plan for 2025/26. In summary we remain committed to:

- Championing shared decision-making, aligning care with patients' goals, values and preferences
- Supporting and educating our staff to provide person-centred care
- Delivering an equitable and sustainable health and care system through reducing harm and waste
- Achieving better value care to deliver the outcomes that matter most to those we care for.

Our progress in embedding RM and our commitments for 2025-26 will be outlined within our RM action plan to Scottish Government. These efforts aim to support Scottish Government's vision to ensure that by 2030 all health and care professionals will be supported to deliver Value Based Health and Care.

3.5 Whole System Infrastructure Planning

3.5.1 Three Year Planning Horizon (Horizon 1)

The first phase in the development of a Business Continuity & Essential Investment Infrastructure Plan (BCEIIP) has been concluded and was submitted to Scottish Government in January 2025. The BCEIIP and the infrastructure investment which it informs is a key mitigation action against our corporate risk of aging infrastructure.

Our Infrastructure Planning short to medium term delivery objectives will be informed by the BCEIIP and will form two distinct workstreams.

Figure 2: Infrastructure Planning Objectives

Embedding the BCEIIP process	Embedding the BCEIIP as the business-as-usual approach as to how GGC determines its infrastructure investment programme is an immediate planning priority for 2025/26. This will require a new approach to collaborative working across GGC stakeholders, identification of dedicated resource, a change in how we utilise and populate the asset management system (SAMS), and a refinement to the Capital Governance process.
Delivering against the BCEIIP	How we allocate our formal capital will be informed by the outputs of the BCEIIP. Projects identified for scoping or delivery will be resourced accordingly from existing workforce. Any additional funding provided via SG for BCEIIP driven projects is still to be determined but would help accelerate the risk reduction of the aging infrastructure. The practicality of delivering these projects, many of which are within live clinical environment will be a key challenge, minimising disruption to clinical activities and the delivery of service will likely inform much of what can be delivered.
Broader Infrastructure Planning Drivers	Additional priority areas for infrastructure investment include the continued risk reduction across the mental health estate through the ligature reduction programme. Initiatives to drive net zero, climate change and sustainability objectives plus digital and innovation initiatives to support efficiencies and/or clinical strategies are also key areas for focus. Work will continue to be undertaken on design development proposals required to define the mitigations and rectifications that support QEUH/RHC litigation process. These activities will continue to be overseen by the QEUH Legal Governance Group.

3.5.2 Horizons 2 and 3 Developing a Whole-System Infrastructure Plan

In line with the DL (2024) 31 'A renewed approach to population based planning across NHS Scotland' we are committed to working with the National Infrastructure Board over the next few months to progress the development of the second phase of planning to develop a 20 – 30 year whole system infrastructure plan, which we understand will be underpinned by Health & Social Care Reform plans and reflect a national population based planning approach.

Our initial planning to date (in addition to the development of our BCEIIP) has included:

- The development of high-level demand and capacity models for key service areas
- Development of a clinical vision and clinical roadmap to drive forward the implementation of our moving forward together clinical transformation strategy.

Our MFT clinical vision and clinical road map and the national programme of health and social care reform will drive our service transformation work and the infrastructure investment required to support this transformation.

The Institute of Neuroscience (INS) Replacement project has been submitted to the Scottish Government Capital Investment Group (SGCIG), it is understood that this will now be considered within the context of the new whole system infrastructure approach to planning.

3.6 Financial Plan

Our plans for the future are focused on productivity and efficiency, value added services supporting our sustainability and value programme, reform to shift the balance and reduce acute capacity, building greater virtual capacity with initial pump priming and future funding shifts.

Our delivery plan is framed around the exceptional and significant financial challenges that we and our six HSCP partners currently face. Our deliverables for 2025/26 will require a level of additional funding support which will be set out in our 3 year transformation plan and submitted to SG in March 2025.

3.6.1 Three-year Financial Plan

Our Three-Year plan submitted on 27th January 2025 shows a deficit of £47.5m for 2025/26, £43.9m for 2026/27 and £2m for 2027/28. The overall financial challenge for 2025/26 is £210.2m.

Figure 3: Forecast Deficit 2025-2028

	2025/26 £m	2026/27 £m	2026/27 £m
Recurring Deficit c/fwd	(162.8)	(109.4)	(56.0)
Recurring Cost Pressures in year	(40.3)	(40.3)	(42.5)
Recurring Challenge	(203.1)	(149.7)	(98.5)
Non Recurring pressures	(7.1)	(2.9)	(2.2)
Overall Financial Challenge	**(210.2)**	**(152.6)**	**(100.7)**
Recurring Savings Target	93.7	93.7	93.7
Non Recurring Savings	69.0	15.0	5.0
Forecast Deficit	**(47.5)**	**(43.9)**	**(2.0)**

The key risks are:

- The assumption that the increased National Insurance for pay is fully funded which is c£46.6m, however more detailed calculations will be required to fully ascertain the value
- The costs of the band 5-6 review are not yet known and may be more than anticipated however the assumption remains that these will be fully funded by SG
- The remaining hour of the Reduced Working Week has still to be implemented and NHSGGC is awaiting guidance on how this has to be implemented and hence will need to quantify the impact. Again, the assumption is that this will be fully funded
- For planned care there are a number of challenged specialties where delivering the 52 weeks maximum wait will require substantial additionality. The Financial plan does not assume any level of funding as the funding arrangements have yet to be finalised
- No values have been included for any potential enactment of the integration schemes for the IJB's as financial plans are currently being developed, however early indications are that there may need to be some form of provision.

3.6.2 Sustainability and Value Programme

To address the scale of the 2025/26 financial challenge the Sustainability and Value programme will require to deliver £93.7m of recurring savings from a combination of our well-established processes. The initial targets of £73.1m focus on a range of initiatives including housekeeping, infrastructure, service review, workforce, and non-pay/ procurement and prescribing.

In order to increase the savings to the £93.7m a further £20.6m of targeted areas requires to be developed beyond the areas listed above and further work will be undertaken to

source increased or additional targets prior to the final Finance Plan being agreed in March 2025.

In addition to this the Sustainability and Value programme will also drive focus on the efficient use of our resources through the use of benchmarking and best practice to ensure we are as productive as possible and enable the effective control of expenditure.

We are also working with Scottish Government and is pursing all the opportunities that have been identified through the 15-box grid National Programme of work. This is focusing on the following areas, many of which are already well embedded in 2024/25. Key areas include, agency reduction, clinical variation, sickness absence reduction, non-compliant rotas, PLICS roll out Prescribing and non- pay spend reviews.

3.7 Key Risks to Delivery of our Plan

This section of our plan highlights the key risks associated with implementing such significant transformational change and improvement at pace and scale. Please note we have identified key mitigations below; however, it is important to note that our plan relies on significant investment (as outlined in section 3.6).

Patient Engagement: our plan is ambitious and will require ongoing involvement and engagement with our patients. Ultimately with the support of our patients and the public we will work to deliver care in a more integrated way. This will support patients to better navigate our health and social care system, especially when requiring to access care urgently. This may take time and will require a consistent approach both locally and nationally.

Change Management Related Risks: We intend to work with staff and patients to co-design and co-create our 3-year transformational plan. We are particularly aware of the impact that this scale of change can have on staff and patients and will ensure early involvement and continued engagement at all levels.

Workforce Related Risks: Our workforce is central to everything we do, however as with all boards, the availability of a skilled & experienced workforce remains a key challenge across our acute services and our Health and Social Care Partnership areas. Close partnership working and the implementation of our workforce Plan 2025-28 (please see 10.1) will help to mitigate this risk. In addition, pump prime investment in staffing will enable us to recruit and train staff to ultimately fill new posts and or hard to fill positions. Pump prime investment will also ensure we recruit new staff to NHS Scotland and not impact other NHS Boards.

External Dependencies: there are a number of external dependencies, for example, national programmes, that if not realised, will directly limit the advancement of our Delivery Plan. We will continue to work with external partners and SG colleagues to mitigate these risks.

Digital and Technology Related risks: our transformation plan is underpinned by digital first principles and will require investment in digital innovation. This will support empowerment of patients to participate actively in managing their own health and maximise their independence. Deployment of digital technologies will also optimise our resource allocation, helping to reduce health inequalities. There is a need for us to ensure staff and the public are well supported, aware and ready for this change. In addition, we will work with our local authority partners where there are opportunities to expand access to super-fast broadband e.g. within social housing. We are committed to continuing to offer alternative to digital technology for those who are digitally excluded.

Infrastructure risks: Our 3-year transformation plan and MFT clinical strategy will inform the key priority infrastructure investments (as set in section 3.5). Our ability to progress these priority projects will be dependent on available capital funding.

Monitoring Risks: To support the management of risk and to monitor our progress, we have an established an internal reporting framework to monitor the implementation of our Delivery Plan Quarterly reporting is in place to our Corporate Management Team and upwards to our Finance, Planning and Performance Board Sub Committee. In addition, at Board level we continue to ensure our Delivery Plan and ability to deliver on the commitments there-in, is monitored through our Corporate Risk Register.

To reinforce this process, we have also developed a comprehensive internal action tracker detailing the individual actions that will be undertaken over the next year to achieve our key deliverables. The Action Tracker also measures intended impact, monitors individual risks and is used as the basis of our quarterly reporting.

4.0 Improving Population Health & Reducing Health Inequalities

Key Deliverables in 2025/26

Improving Population Health	• Continue work to reduce barriers for all vaccine uptake across all ages, ethnicities and demographics • Develop and deliver educational resources on tobacco and vaping for young people • Implement smoking cessation improvement plans across 'Quit Your Way' settings and services • Deliver effective adult weight management services and child healthy weight programmes in line with national service standards
Reducing Risks to Health	• Develop, deliver and progress monitoring arrangements for the Sexual Health & Blood Borne Virus (SHBBV) action plan • Support alcohol and drug recovery (ADRS) and prison services to develop service-level action plans to identify undiagnosed and untreated hepatitis C infection • Optimise the initiation and completion of treatment amongst those who are diagnosed with active hepatitis C infection • Provide staff training on LARC and other forms of contraception in key services • Align HCID response pathways across secondary care and refresh the West of Scotland transfer protocol for HCID • Progress towards implementation of all 10 MAT standards across GGC in both community and custody setting
Reducing Inequalities	• Develop and use core data set to inform joint strategic needs assessments (JSNA) • Deliver programme of targeted cancer screening awareness and engagement campaigns in communities with lowest uptake • Initiate GP practice level cervical screening activity reports to support improvement in GP practices and clusters with lowest uptake • Focus on transport and digital alternatives to reduce the impact of affordability and accessibility on attendance for healthcare • Co-design, test and launch a resource toolkit to support the delivery of GIRFE principles through our Quality Strategy • Develop a system wide Palliative Care and End of Life Care vision with alignment to GIRFE principles

Our 2024/25 Director of Public Health Report (*'Stemming the Tide'*) presented the updated Public Health priorities (reflecting updated epidemiology evidence and community feedback) with a series of recommendations and local partners designed to meet the needs of all groups in society, with a focus on everyone living longer, healthier, more fulfilling lives while reducing inequalities.

4.1 Population Health Framework

We eagerly anticipate the publication of a new Population Health Framework in spring 2025. Our priorities will align to enhance and accelerate the improvement and recovery of our patients' health through a coherent long-term approach to primary preventative measures.

As we plan for 2025/26, the priorities identified in our DPH Report and Public Health Strategy strongly correlate with those contained within the current Scotland's Framework for Population Health:

- Child Development
- Places and Communities
- Mental Health and Wellbeing
- Prevention
- Healthy Living

These documents set out ambitions to prioritise and maintain good health through delivery of a whole system approach both nationally and locally, with a clear focus on public health being everyone's business. Building on extensive engagement with IJBs/ CPPs and Community Sector on local HWB data and DPH Report Calls to Action, we continue to develop proposals to strengthen Whole System working at Local Authority Level.

The Population Health Framework sets out both 2025-26 actions and the long-term focus, using existing plans (such as the National Strategy for Economic Transformation, National Transport Strategy, Tobacco & Vaping Framework, Screening in Scotland Equity Strategy and Fairer Future Partnerships) as building blocks for the framework. Implementation of the framework will require future focused methods including whole system approaches to achieving healthy weight and prioritising prevention in budgets and plans.

4.2 Improving Population Health

4.2.1 Immunisation

Our vaccination programme is the single largest NHS public health intervention in Scotland, administering over 750,000 vaccines every year. Building on successes in 2024-25 (including revised governance arrangements to support timely, equitable and increased uptake of vaccination programmes), we will continue to develop tailored delivery plans for each programme, with a key focus on reducing inequalities in uptake. Following increase in the

number of venues in Glasgow City (where uptake has been poorer) we will continue to provide more localised access. Our staff flu campaign and delivery were enhanced in 2024-25 and we will build on this, including delivering the peer immuniser programme and increased range of engagement methods. In 2025-26 we will work to reduce barriers for vaccine uptake across all ages, ethnicities and demographies.

4.2.2 Health Improvement Services

Recognising the decline in both physical and mental health, we will continue to deliver a range of health improvement services to support people to improve their health and wellbeing.

4.2.3 Smoking Cessation Services

Our smoking cessation services include specialist and pharmacy services targeted to the most deprived communities. In 2024-25 the implementation of smoking cessation improvement plans (featuring activities such as return to carbon monoxide testing, enhanced pharmacy training and support, maternity opt-out pathways tests of change) allowed us to achieve 98.7% of the annual LDP target, achieving 1,667 against the target of 1,689 for 12 week quit outcomes in our 40% most deprived data zones. To continue to reduce uptake and quit rates in 2025-26 we will:

- Continue to implement smoking cessation improvement plans across 'Quit Your Way' settings and services
- In early 2025, re-introduce Varenicline (nicotine analogue) across community pharmacy to support higher quit rates
- Roll-out the smoking cessation maternity opt-out pathway to all pregnant smokers in NHSGGC (in place in IRH and RAH, will be rolled out to QEUH, VoL and PRM)
- Develop and deliver educational resources on tobacco and vaping for young people

4.2.4 Weight Management Services

As levels of overweight and obesity continue to rise so does demand for weight management and exercise on referral services. In 2025-26 we will:

- Continue to deliver tailored age-appropriate weight management services (including HENRY for families with children and Weigh 2 Go for young people)
- Focus on promoting engagement with early intervention education and weight management interventions for newly diagnosed patients with Type 2 diabetes. We will continue to collaborate with national teams to develop a national digital intensive weight management programme for Type 2 diabetes

4.3 Reducing Risks to Health

4.3.1 Sexual Health and Infectious Diseases

We will develop a local SHBBV action plan that responds to the national SHBBV Action Plan and HIV Elimination Delivery Plan, reflecting existing local services and addressing gaps and challenges.

The prevalence of active hepatitis C infection amongst people who inject drugs across NHSGGC has fallen (around 45% in 2015/16 to 16% in 2022/23) and work continues. (around service provision and engagement) to meet the HCV treatment initiation targets and to enable further progress towards elimination of hepatitis C in our population. In 2025-26 we will support services with high-risk users, including alcohol and drug recovery (ADRS) and prison services, to develop service-level action plans to identify undiagnosed and untreated hepatitis C infection.

Contraception services are situated across a range of service areas including primary care, specialist sexual health services, prison health, maternity services and acute services. In 2025-26 engagement work will continue with services and staff training will be delivered to support improvements to access LARC including post abortion and postpartum.

We will build on our considerable experience in managing high consequence infectious diseases (HCID). Existing secondary care pathways from VHF, MERS and mpox are in place and these three pathways will be aligned. In addition to local protocols, we will continue our significant input to the national HCID development. In 2025-26 we will refresh the West of Scotland HCID transfer protocol (which was recently re-affirmed via the WoS medical Directors group during the Covid-19 pandemic).

4.3.2 National Mission on Drugs

The safer drugs consumption facility (known as the Thistle) opened in Glasgow in January 2025. Safer drug consumption facilities (SDCF) have been in operation across the world for several years and evidence shows these facilities can combat drug-related deaths and improve public health by offering a clean, safe place for people to inject their own drugs (obtained elsewhere, not provided on site) under clinical supervision. People can also access a wide range of treatment and support. As the UK's first SDCF, the success of the Glasgow facility in meeting the needs of the 400-500 local people who inject daily in public spaces will be monitored closely.

Implementation of the MAT standards are planned and led by Alcohol and Drug Recovery Services (ADRS) in local authority areas, monitored and reported via each HSCP and Integration Joint Board (IJB). Across all ten MAT standards, our aggregate assessment meets or exceeds the aggregate assessment for Scotland as a whole (with all six ADP / local authority areas assessed at provisional green or better for all ten standards) and we will focus to maintain or improve this in 2025-26.

Our MAT Standards Implementation Group will remain in place during 2025-26 to ensure consistent and continued progress towards MAT standards across both community and custodial settings. We will work with Alcohol and Drug Partnerships on plans for residential rehabilitation services.

4.4 Reducing Inequalities

Reducing health inequalities is a key driver in our workstreams to ensure the needs of the population are identified and addressed.

4.4.1 Health and Wellbeing Survey

Work to understand population need has included our Health & Wellbeing Survey (2023) featuring an expanded cohort to enable Local Authority level analysis by deprivation, gender and age (with a further BME sample underway). Engagement with IJBs; CPPs and Community Sector on HWB data and local Population Health priorities is currently ongoing to inform and update the JSNA for 25/26. The development of a data profile to support Locality or Place-based programmes is currently being piloted in Gallowhill, Renfrewshire.

Additional equality work streams, including age, gender and disability, are contained within our equality scheme (Meeting the Requirements of Equality Legislation, A Fairer NHS Greater Glasgow and Clyde).

4.4.2 Widening Access

Our Widening Access and Addressing Inequalities in Adult Screening Action Plan (2022-25) sets out key actions across all cancer screening programmes to reduce inequalities in uptake. For breast and bowel screening, deprivation is the single biggest factor for variation in uptake (a 20% difference). The gap in cervical screening uptake linked to deprivation is not as wide as seen for other programmes (4%). Key areas of progress to date include development of targeted approaches to support participation among populations with known lower uptake including individuals with learning disabilities and BME communities.

An updated screening inequalities action plan will be developed in 2025, aligned with National Equity in Screening Strategy. In addition to addressing uptake among populations with known lower uptake, the updated plan will place greater focus on development and coordination of intelligence based geographical focused activities targeting areas of high deprivation and known lower uptake.

4.4.3 Addressing Inequalities Action Plan and NHSGGC Quality Strategy

We are committed to becoming a leading anti-racism organisation, ensuring our workforce at every level represents the communities we serve, and that we are inclusive and welcoming of all patients and staff. There are a series of workstreams in place that relate specifically to anti-racism approaches, (which have been informed by engagement with BME

communities and, for staffing work streams, co-created with our BME Staff Network). Racialised inequalities work reports separately.

Our Anchor Strategic Delivery Plan (2023-2026) outlines our commitment to our role as an anchor organisation to improve community wealth building outcomes. Progress last year included strengthening pathways into NHS employment from local communities, increasing community benefits and improving opportunities for targeted suppliers, and delivery of our Arts and Health programme. Our 25/26 annual action plan will continue to focus on the themes of procurement, workforce and land/assets and we will continue to influence through our partnerships (including the Glasgow City Economic Region, engagement with LEPs and national Anchors Network). Anchors work reports separately.

The DPH Report highlighted the importance of a good transport system to enable reliable access to health services in a way that is safe and affordable. Our digital strategy has resulted in a reduction in travel and associated costs for patients linked to the use of virtual consultations and patient hub services. These have demonstrated high levels of satisfaction and will continue to increase. In addition, work is underway to promote sustainable and affordable travel options to NHSGGC health services. This includes reference to travel reimbursement entitlement on patient information and installation of real-time bus information screens at 6 acute hospital sites. Public Health and Glasgow Centre for Population Health (GCPH) continue to work with local Authority planning partners including Health Impact Assessment of Regional Transport Priorities (such as the Clyde Metro development) to promote sustainable transport and active transport to improve population health.

Our new NHSGGC Quality Strategy – 'Quality, Everyone, Everywhere' aligns with the principles of GIRFE, learning from its pathfinder sites and work with people with lived experience of the health and care system. Building on our 2024/25 implementation and delivery plan we will work towards embedding GIRFE principles including shared decision making and launching person-centred standards. In 2025-26 through our Quality Strategy, we will produce a resource toolkit to support the delivery of GIRFE principles. Additionally, taking into consideration the draft Scottish Palliative Care Strategy 2025-2035 and as a key priority for our MFT programme, we are developing a local Palliative and End of Life Care Vision aligned to GIRFE principles (please also see section 6.3.4).

5.0 Implementing our Primary Care Strategy & Improving Community Care

Key Deliverables in 2025/26

Implementing our Primary Care Strategy	• Developing our first primary care workforce strategy to support a more sustainable, skilled and sufficiently staffed workforce. • Developing a communication & engagement plan, ensuring patients have a clear understanding of available services and are empowered to navigate primary care services more effectively. • Supporting 100% GGC General Practices adopt GP IT re-provisioning (dependent on the national GP IT Reprovisioning programme). • Refreshing our interface group and establish the core principles to design streamlined, effective, and efficient care pathways.
Mitigating Health Inequalities	• Undertaking a scoping exercise to identify opportunities to improve management of existing health conditions in priority areas. • Developing the GGC Healthy Living Hub to enable selfcare for people with long term conditions and/or waiting for planned care. • Continuing to deliver integrated T2DM self-care interventions to all newly diagnosed patients. • Designing and piloting CVD early intervention WMS / Smoking Cessation 'opt out' pathways.
GP Out of Hours Service	• Review the patient pathway to identify areas for improvement • Expand our prof-to-prof partnerships to include FNC, SAS and Community Pharmacy
Oral Health	• Enhance engagement with schools participating in the Childsmile programme, while actively engaging with 100% schools that are not yet participating in the programme • Inclusion dentistry: we will commission a mobile dental unit to support delivery of dental care to priority and vulnerable groups. • General Dental Services (GDS) Deregistration: we will continue to regularly monitor deregistration data, compiling and reporting monthly through performance and on a quarterly basis to the Public Health Primary Care Work Plan Group • We will conduct a comprehensive oral health needs assessment in 2025/26 utilising the newly acquired data, data from local and national Health and Wellbeing Surveys, and data made available by

	Public Health Scotland. This will identify gaps, inform planning, and support targeted service improvement initiatives.
Community Glaucoma Service	• Work to safely discharge a minimum of 750 patients, with plans to continue increasing the number of patients with glaucoma managed in their local communities.

We note the recent First Ministers announcement to further support prevention through additional investment in general practice and community-based teams, and the requirement to focus this on:

- Enabling more proactive outreach in areas of greatest need and
- Working with people who have a high risk of Cardiovascular Disease (CVD) or frailty.

We will work with SG primary care team to focus this resource where it can deliver most impact for our patients.

5.1 Implementing our Primary Care Strategy

Our 5-year Primary Care Strategy was approved by our Board in April 2024 and can be found here Primary Care Strategy 2024-2029 - NHSGGC. The initial key priorities within our strategy are as follows:

- Optimising our workforce: during 2025/26, we will develop our first primary care workforce strategy
- Improving Communications & Engagement: in 2025/26, we will develop a public and staff communication and engagement plan
- Digitally Enabled Care: by 2026/27 we will make a shared care record accessible to all primary care
- Effective Integration & Interfacing: by 2029 we will have robust processes across our whole health and care system for pathway management and agreed standardised professional to professional decision-making

Our medium to long term ambitions include:

- Improving Access: People to access the right service at right time, more flexibly and in ways that suit them
- Increasing Prevention and Early Intervention: Strengthened prevention, early intervention and wellness

- Improving Access to Information: Better access to trusted information on health and care
- Reducing Health Inequalities: Strengthened contribution to reducing health inequalities

A detailed implementation plan has been developed to support the delivery of our strategy. Our implementation plan will be reviewed regularly to ensure alignment with evolving needs, priorities and the national direction for the Route Map for Primary Care Reform which will set out the conditions for achieving sustainable transformation in Primary Care and shared critical priorities. Implementation progress will be reported through our governance structures to ensure the strategy is implemented effectively and delivers the intended impact.

5.1.1 Optimising our Workforce

During 2025/26, we will develop our first primary care workforce strategy to support the development of a more sustainable, skilled and sufficiently staffed workforce in the medium to long term, aligned to support the delivery of our 'Moving Forward Together' Clinical Roadmap.

We will work to protect, develop and retain our current workforce, and improve our ability to attract new, high-quality professionals. Through developing our first primary care workforce plan, we will improve our ability to increase capacity to effectively respond to emerging need and models of care.

5.1.2 Multidisciplinary Team Working (MDT)

In line with the principles of the GP Contract 2018 and our commitment to innovation and improvement, we continue improving the use of multi-disciplinary working to support better, patient-centred care pathways and improve service capacity in General Practice and frontline community services. This is achieved through championing quality improvement methodologies, supported by evidence-based approaches, i.e. review of priority clinical pathways to make best use of MDT.

Additionally, we will continue to promote training and the use of tools including the Right Decision Platform, Triage & Signposting within General Practice, and referral vetting in secondary care to enhance care coordination. Throughout 2025, we will promote consultant connect, in response to developments through urgent care to support professional-to-professional conversations (please also see section 6.2.3). The aim is to align specialties and services, to deliver a consistent, efficient, and effective digital pathway. Through this work, and by utilising the learning from the HIS Primary Care Phased Investment Programme due to report nationally in December 2025, we aim to deliver integrated, person-centred care pathways.

5.1.3 Improving Communications & Engagement

To support our development of a Primary Care communication and engagement plan we will:

- Develop a series of Primary Care videos to support people to use Primary Care confidently when they need to, in ways that suit them, and with fewer unnecessary contacts. (nine videos are being developed in 2025/26)
- Ensure the plan supports both public & staff communication plans, and are developed in easy read and accessible formats supporting translation
- Develop monitoring and evaluation framework for our communication & engagement activities

5.1.4 Digitally Enabled Care

We aim to develop systems allowing patients to share their health information with healthcare providers directly, removing the need to repeat their concerns and improving their overall experience and outcomes. During 2025/26 we will support all our 224 GGC General Practices to move onto the new GP IT system. This advancement will support our aim to make a shared care record accessible to all primary care services in and out of hours during 2026/27.

We will continue to expand on our virtual digital monitoring platforms which currently include Blood Pressure and ANIA (Accelerated National Innovation Adoption) Digital Dermatology. The number of patients monitored remotely will increase, as additional pathways are developed. In 2025 Digital Services will complete procurement of a remote monitoring and management platform to deliver transformational virtual care (please see section 11).

5.1.5 Effective Integration & Interfacing

During 2025 our interface group will be refreshed and will include multidisciplinary leads across primary and secondary care, mental health, and public health. Our focus will be to establish the core principles to design streamlined, effective, and efficient care pathways.

Our ambition is to strengthen the availability of specialist advice to primary care through work to mainstream and standardise professional-to-professional ('Prof-to-Prof') decision making across all services i.e. primary, community and acute services (please also see section 6). By 2029 we aim to have robust processes across our whole health and care system for pathway management and agreed standardise professional to professional decision-making.

5.2 Mitigating Health Inequalities in General Practice

Preventative & Proactive Care Programme

Our Primary and Community care services play an essential role in addressing health inequalities and facilitating a healthier life course, through both opportunistic and routinely integrated intervention as part of wider system actions and national programmes including Waiting Well and cardiovascular disease (CVD) Prevention Programmes. Given the impact of cost of living, and the complexity of the population's need, our services continue to experience an increase in demand. Significant time is required to effectively support prevention, we aim to address this by growing our capacity to provide continuity of care for complex patients, supporting their independence for as long as possible.

Our priorities include:

- **Seeking opportunities to improve:** aligning with the national reform priorities on increasing capacity and access, our Improving Access Workstream will focus on removing barriers to equitable access, especially for populations that will benefit most

  - Our digital health initiatives will take cognisance of the need for a diverse population. Within 2025/26 we will undertake a scoping exercise to identify opportunities to improve management of existing health conditions in priority areas (e.g. Drug harms, Chronic Disease Management, CVD, cancer, diabetes)

  - As part of the GP 2018 Contract HSCP Primary Care Improvement Plans (PCIP) Care and Treatment Services aim to develop a framework to support Chronic Disease Monitoring. This will require links to digital solutions e.g. GP IT Reprovisioning.

- **Inclusion Health Action in General Practice (IHAGP):** Subject to continued funding, we will support General Practices through the key health reform project, IHAGP, to ensure continued targeted investment in areas with the greatest need i.e. deep-end practices

- **Patient Empowerment & Signposting:** to self-help advice, referral or encouragement of self-referral to a wide range of Apps, Tools as well as community programmes and support services through the development of an easily accessible GGC Healthy Living Hub (Refer section 4 Population Health and Reducing Health Inequalities)

- **Waiting Well Framework:** Develop and test our Waiting Well Framework. We will integrate information available to patients through other platforms including pre-operative websites to ensure patients understand what will support them staying Fit/ Ready/ Available for care. We will also continue to develop our community- based Health and Wellbeing Hubs with HSCP and Local Authority partners

- **CVD Prevention:** Prioritise prevention of CVD risk factors by embedding a common risk factor approach within clinical pathways in line with the SG work on secondary prevention and CVD e.g. promotion of smoking cessation, remote BP monitoring, weight management, alcohol intervention and physical activity within chronic disease patient pathways

- **Diabetes Early Intervention Framework:** Continue to deliver the Diabetes Early Intervention and Prevention Framework and promote early identification and intervention in higher risk groups including Black and Minority Ethnic (BME) and mothers with Gestational Diabetes

5.3 Oversight of Planning & Delivery of GP/GP Contract Services

We are committed to regularly monitoring and reporting on our General Practice escalation framework through our internal governance channels, as well as completing Scottish Government general practice capacity returns.

We will continue to report through the Scottish Government PCIP trackers and are committed to developing and improving reporting of our GP Commitments including CTAC activity. During 2025/26 we will work to improve our reporting systems and processes to support the optimisation and utilisation of our services as part of the 6 HSCP PCIP GP Contract with ongoing engagement with the HSCPs and GP Sub Committee.

5.4 GP Out of Hours Service

We have a sustainable GP Out of Hours service model based on a telephone first approach, with 3 geographically spread sites open during the week and extending to Inverclyde at the weekend and public holidays. This is supported by the provision of face-to-face where clinically appropriate. Our service is further complimented by the house visiting service (centralised at Caledonia House) and access to patient transport.

We continue to report performance through our Senior Executive Group and our Primary Care Programme Board as required ensuring regular oversight and monitoring. Our Organisational Change process is expected to be concluded during 2025. Following this we will seek to develop our service further by:

- Reviewing the patient pathway to identify areas for improvement
- Promoting and developing our own workforce, including developing our own Advanced Nurse Practitioners (ANPs)
- Expanding our professional-to-professional partnerships to include FNC, SAS and Community Pharmacy (please also see section 6)

5.5 Oral Health Services

We remain committed to delivering comprehensive oral health services, with the focus on the delivery of services such as The Childsmile Programme, Supporting Priority and Vulnerable Groups, Public Dental Services (PDS) for adults requiring special care and paediatric patients, ensuring equitable and effective care for our communities. Priority workstreams for 2025/26 include:

- **Childsmile Programme:** The teams hosted by the Health and Social Care Partnerships play a crucial role in the delivery of Childsmile in nurseries, which incorporates shared learning and exploring innovative approaches to supporting families; an example is a test of change being undertaken in Glasgow City HSCP, to develop more effective and efficient use of resource with a focus on vulnerable families

    - As part of ongoing efforts to increase awareness and participation in early intervention and prevention, we aim to enhance engagement with participating schools during 2025/26, while actively engaging with 100% schools that are not yet participating in the programme

- **Priority and Vulnerable Groups:** We continue to support priority and vulnerable groups under the banner of inclusion dentistry. As part of our commitment, we plan to commission a mobile dental unit in the next financial year, enhancing access to oral health services directly within communities, reducing barriers to care

- **Public Dental Services (PDS):** In 2025/26 we will continue to support the needs of patients requiring access to adult special care dentistry and paediatric dentistry. We will (utilise the newly acquired data*) to inform service delivery for those patients registered with the Public Dental Service

- **Dental Out of Hours Service:** Our Emergency Dental Service is accessed by calls from patients to NHS 24 on 111. Patients can expect to be led through an algorithm which establishes if the patient needs self-care e.g. pain relief, or whether an appointment should be made for the patient to attend out of hours service for urgent dental care. This service continues to support both unregistered patients and those registered with local General Dental Practices, ensuring they receive the right care at the right time and place. The service will continue to flex to demand and meet the expected levels of care for those with dental problems as set out in Scottish Dental Clinical Effectiveness Programme (SDCEP) Management of Acute Dental Conditions

- **General Dental Services (GDS) Deregistration:** We will continue to regularly monitor deregistration data, compiling and reporting monthly through our performance and on a quarterly basis to the Public Health Primary Care Work Plan Group. We aim to escalate any identified issues in cases of exceptional circumstances, ensuring

alignment with the Primary Care Strategy. There are currently limitations in the data, as this does not differentiate between patients deregistered from GDS and those transitioning to private dental services

- **Targeted Initiatives:** We will maintain ongoing engagement with GDS providers to understand local service pressures, including recruitment and retention challenges, and identify opportunities to support service delivery through targeted initiatives e.g. Scottish Dental Access Initiative (SDAI). We note the recent announcement that student numbers will be increased by 7% in September 2025 and we await further information as to how funding and additional places will be allocated.

Additionally, we will conduct a comprehensive oral health needs assessment in 2025/26 utilising the newly acquired data, data from local and national Health and Wellbeing Surveys, and data made available by Public Health Scotland. The needs assessment will identify gaps, inform planning, and support targeted service improvement initiatives. The nature of the needs assessment will be predicated on receiving the Management Information data, which is understood will still be in testing phase during Q1 25/26.

5.6 General Ophthalmic Service

During 2025/26 as part of our commitment to enhancing hospital-based eye care within our communities, we will continue the expansion of the Community Glaucoma Service. This service is designed specifically for patients who present with lower-risk glaucoma or elevated eye pressure. During the year 2025/26, we aim to streamline patient care through the identification of patients eligible for discharge from Hospital Eye Services across GGC and ensure that those who can be safely transitioned receive the right care, at the right place.

During 2025/26 to further expand the number of glaucoma patients to access care within their local community we have developed a proposal to expand the clinical criteria to increase the number of patients who could benefit from this approach to care in support of this:

- A prospective review of patients will take place at clinic assessment with suitable patients identified for referral for community management when clinically stable

- A retrospective review of patients will also be progressed for those patients waiting for a further return review assessment

- The current model of patient audit will be reviewed to ensure that more rapid assessment of patient cohorts can be progressed using the clinical information available.

- Undertake a trial of weekend virtual clinics and review the effectiveness of this model.

In 2025/26 we aim to safely discharge a minimum of 750 patients which meet the criteria, with plans to continue increasing the volume of registrations over the three-year horizon allowing for more efficient use of healthcare services.

6.0 Transforming Urgent Care

Key Deliverables in 2025/26

Reducing Demand, Direction and Patient Pathways	• Develop a model for Rapid Assessment and Care across our front doors • Implement a digital platform to support remote monitoring and management of patients. The platform will create the framework for a virtual hospital • Strengthen our redirection primary care pathways and support remote assessment of patients who self-present, using a digital patient self-assessment application • Develop an FNC+ plus care model • Develop Consultant Connect, as the preferred digital tool to support professional to professional pathways engaging with a range of specialties • Reduce SAS conveyance of frailty patients, by developing virtual wards • Minimise front door ED presentations for falls through Call Before You Convey, remote monitoring and community rehab pathways • Develop our vision for a single CBYC whole system Senior Clinical Decision Maker pathway for care homes and palliative care • Identify and support early discharge of patients within 72 hours, with frailty diagnosis; over 50% of these patients being managed at the ED front door
Caring for More Patients at Home	• Co-design & develop our model to scale up our virtual bed capacity as part of our new 'Virtual Hospital' • Maintain high levels of throughput in QEUH OPAT service • Further expand our OPAT services in Clyde and establish OPAT virtual beds in North Glasgow

	• Evidence the impact or our current Hospital @Home Services and benchmark to identify the opportunities for expansion to support key patient groups
Reducing Patient Delays and Length of Stay	• Revise assessment processes and working arrangements with care providers to reduce waiting times for social work assessments and care home placements • Increase the number of assessments of care needs carried out in more homely settings to reduce the number of patients delayed >200 days • Improve rates of pre-noon and weekend discharge, through a reset of approaches to discharge planning, strengthened cross pathway working and local implementation of Criteria Led Discharge • Maximise the functionality of cornerstone applications to support discharge planning • Increased promotion of Power of Attorney (PoA), to support reduction in the number of adults with incapacity (AWI) delayed • Improve rates of pre-noon and weekend discharge, through a reset of approaches to discharge planning, strengthened cross pathway working and local implementation of Criteria Led Discharge

6.1 Our Vision

We are committed to advancing a bold transformative programme to reform our urgent care across our whole system. During 2025 we will develop a detailed 3-year transformation plan for urgent care. Central to our transformation plan will be how we better support our immediate and significant urgent care pressures by shifting the balance of care to enable more patients to be safely and effectively cared for at home. Our plan will be co-created by senior whole system leaders & senior clinicians from across our system.

With our patients at the centre of this reform, the key components of our plan will include the co-creation & development of a whole system interface care division. This will support the development of an FNC Plus care model, the development of a new model of Rapid Assessment and Care (RAaC) across our front doors and the significant scale up of our virtual services creating a new virtual hospital supporting 700 to 1,000 virtual hospital beds. This transformation will ensure that over the next 3 years we shift the balance of urgent care between acute and community and ensure our patients receive the right care, in the right place at the right time.

Our bold vision will embrace and integrate new digital solutions for a stronger digital first approach to improve access to care, alongside reshaping our pathways to care for more

patients at home and reduce demand at our front doors. We will co-create and drive this forward through an integrated whole system approach and ensure our staff and patients are involved throughout this journey.

Our urgent care objectives include:

1. **'Right Place'** – Patient Engagement, Direction & Reducing Demand
2. **Shifting the Balance of Care** – Caring for more Patients at Home
3. **Improving Patient Pathways** – Developing a Rapid Assessment & Care Model
4. **Reducing Delays and Length of Stay** – Reducing delays in transfer of care

6.2 Patient Direction & Reducing Demand

6.2.1 Engaging our Patients

To support our transformation programme, we will produce clear consistent messaging, effectively engage our public, and direct our patients to the most appropriate pathways of care. Over the next year we will continue to run local targeted information campaigns and support national campaigns.

- **Direction and Redirection:** We continue to encourage the public to consider alternative pathways, including self-care and community services ahead of calling 111 for advice. We will deliver discrete targeted public messaging to different groups and work with key local influencer groups to help inform the public on how to appropriately use services. We will promote the redirection policy through messaging throughout the year as well.

- **Targeted Campaigns:** Using data and insight from our Patient Experience and Public Involvement and Business Intelligence Teams, we will run discrete campaigns specifically targeting demographics more likely to self-present at ED without looking elsewhere first. This may include specifically men and those in lower SIMD groups. We will also work closely with our Equalities and Human Rights Team to identify and communicate with harder to reach groups and people whose first language is not English.

- **Promoting specific services:** We actively promote our Primary Care and Community Pharmacy services alongside the Flow Navigation Centre to highlight alternative ways to access urgent care. This activity will scale up at specific periods such as in autumn when the student population increases. We will also deliver strong public messaging around the importance of vaccination for both Flu and the COVID vaccination booster.

- **Pharmacy First Plus (PF):** We will enhance the public awareness of Pharmacy First Plus through integration into the overall Primary Care communications strategy. The approach will utilise a suite of channels including social media, press and some community outreach.

6.2.2 Expanding Pharmacy First and Pharmacy First Plus

Our primary care and community pharmacy services are essential in ensuring that patients are supported within their communities to receive the right care, in the right place at the right time.

We are working to enhance our current Independent Prescriber (IP) population who are able to deal with common clinical conditions that would normally have to be seen by staff in General Practice. Over 2024/25 we increased our IPs from 139 to 177 and now have coverage across 56% (158 of 283) of our community pharmacies.

By increasing the number of IPs within community pharmacies we will reduce unnecessary visits to General Practices and / or Emergency Departments through an increased proportion of patients with minor illness, infections and long-term conditions able to access timely assessment and support in their own communities.

From 2026 the vast majority (at least 90%) of our graduating Pharmacists will be IP qualified and we will develop and support a consistency of practice across all our IPs.

We are committed to optimising our current Pharmacy First and Pharmacy First Plus capacity and we welcome the plan through Health & Social Care Reform to widen the service to cover a greater number of clinical conditions.

6.2.3 Professional-to-Professional Advice

We continue to expand our Professional-to-Professional advice supporting access to the most appropriate services whilst potentially avoiding unnecessary referrals to ED.

Currently Professional-to-Professional advice is largely conducted through Consultant Connect. The digital tool provides access to direct advice from multiple acute clinicians/teams, and users include General Practice staff, Primary Care and Community teams. During 2025/26 we will:

- Develop a standardised consistent approach to Professional-to-Professional pathways, maximise opportunities for the utilisation of services offered by Consultant Connect. This includes expanding specialties and operating times, further alignment with the FNC and moving from site based to specialty-based delivery

- Explore the utilisation of specialty professional to professional pathways as an escalation route for SAS colleagues supporting the Call Before You Convey (CBYC) initiative

6.2.4 Redirection from ED

We have continued to increase appropriate redirection of those patients self-presenting at ED by streaming to alternative pathways which include self-care, primary care, community pharmacy and minor injury units. Over the past year colleagues across our adult and paediatric EDs have continued to work closely to review and improve our redirection policies and procedures. The number of people who have been appropriately streamed to alternative pathways from our EDs continues to increase ensuring more patients receive the right care in the right place.

In 2025/26, we will:

- Increase the use of primary care redirection pathways, including GPOOH and further develop the use of redirection outcome data to establish new pathways and avoid ED attendance.
- Commence a pilot of digital self-assessment, using the Odessey Patient app, focused on patients that self-present at ED. This will enable timely self-registration and self-assessment, to support ED triage. Post pilot evaluation we will identify future opportunities for the system to further support redirection pathways.

6.2.5 Call Before You Convey (CBYC)

We will continue to grow our robust 'CBYC' model and develop our Interface with NHS 24, SAS and GP Out of Hours services.

Our Care Home CBYC model supports a significant easing of pressure on EDs, with data showing that only around 2.5% of calls result in care home residents being conveyed to ED, around 55% of calls result in a patient at risk of being conveyed able to remain in the home, and the remainder of patients, while not at immediate risk of being conveyed, supported in the home with an appropriate management plan.

During 2025 we will build on the success of our Care Home test of change and develop our vision for a single whole system Senior Clinical Decision Maker pathway.

6.2.6 Frailty

Our Frailty at the Front Door model (incorporating ED, Immediate Assessment Units and Short Stay Wards) is incorporated within the Home First Response Service, (HFRS) which was implemented in early 2022.

The HFRS delivers virtual multidisciplinary teams (MDTs) at QEUH and RAH, to identify and turn around patients with frailty diagnoses within 72 hours, resulting in more than 50% of these patients being managed at the ED front door, reducing time spent in the ED, and a threefold increase in community rehabilitation referrals.

With additional investment, we will maximise and enhance utilisation of the Frailty Hub model including the Home First Response Service through:

- Increasing community-based Frailty Practitioner activity to target over 75's frequent attenders for frailty review
- Expanding the current HFRS within QEUH to a 7-day service
- Establish a HFRS in GRI & IRH
- Improving links and collaborative working between community frailty teams and secondary care

6.2.7 Community Integrated Falls Pathway

This pathway provides an alternative to ED conveyance for fallers, allowing SAS crews to refer patients through the admin hub to HSCPs for next-day assessment and support by community rehabilitation. This service receives an average of 62 calls per month, and data shows that around 25% of calls support avoiding patients being conveyed to hospital.

Falls in care homes, which occur three times more frequently than in the community, are addressed through the Care Home Falls Pathway. This pathway provides a direct advice line for care homes, taking on average 28 calls per month and preventing 68% of potential ED conveyances.

We continue to work with SAS colleagues to maximise the number of conveyances that can be avoided through both the community and care home falls pathways.

Our falls pathways will also be developed to maximise the benefits of the remote monitoring platform and virtual hospital.

6.3 Sustaining more Patients at Home

6.3.1 Co-designing a Whole System Interface Care Division

A key part of the development of our 3-year transformation plan for urgent care will be working with senior system leaders and clinicians to co-create a plan to establish an Interface Care Division. This will support closer alignment between a number of key urgent care services including Pharmacy First Plus, General Practice, GPOOH, SAS and NHS24. The key developments that may form part of this plan are set out below.

6.3.2 Further Development of our Flow Navigation Centre

Our Flow Navigation Centre (FNC) continues to be a key lever in reducing demand on our EDs. The activity through the FNC remains high, consistently achieving more than 1,850 attendances per month, a discharge rate in excess of 40%. 98% of patients state that they would use this service again.

As part of creating our Interface Division we will consider how we develop our current FNC model to become an FNC Plus model to increase access and provide 24/7 coverage. The likely key areas of development include:

- Further expanding our clinical pathways and build on our use of professional-to-professional pathways, supported by the Consultant Connect digital tool
- Evolving our FNC pathways into our new Virtual Hospital and RAaC model
- Developing a model of a single whole system Senior Clinical Decision Maker pathway for our Care Homes and our Palliative and End of Life Care services
- Work collaboratively with SAS colleagues to identify patients who can be managed in an urgent care pathway

6.3.3 Rapid Assessment and Care (RAaC)

Over the next year we will develop a model for delivering RAaC across all our front doors. This will form a key part of our transformation of urgent care delivering improved flow and waiting times for ED, reduced ED length of stay, reduced waiting times for an inpatient bed, reduced readmission rates and improved patient experience and outcomes. Our wider reshaping of pathways work across our whole system will be central to the success of this work.

This focused piece of clinically led work has already commenced, with significant involvement of our clinical front door teams. Our final model will be informed by the highly successful SDEC unit established in Northumbria Healthcare NHS Foundation Trust. Our proposed model and implementation plan will be completed by late spring 2025 with the expectation that implementation will follow from the summer onwards, subject to governance approval and available investment.

6.3.4 Establishing a New Virtual Hospital – 'Expanding the Range & Coverage of Treatments at Home'

We are committed to scaling up our current virtual bed capacity and expanding range and coverage of treatments at home. With additional investment we propose to establish a new 'Virtual Hospital' to support the significant scaling up our virtual beds. It is envisaged our new 'Virtual Hospital' will provide different levels of care & treatment in line with patient need.

Our interface care work has continued to develop and deliver change and improvement, between our primary and secondary care services to avoid unnecessary hospital admissions and provide step down care for those patients who can be discharged from hospital and cared for safely by our community teams. This has been delivered through short-term, targeted interventions that provide hospital level care in an individual's own home or homely setting.

Central to this work has been the concept of virtual wards and the delivery of appropriate services on an outpatient basis that would traditionally have required a hospital admission, including our Outpatient Parenteral Antibiotic Therapy (OPAT) and traditional models of H@H.

During 2025/26 we will co-design & develop our model to scale up our virtual bed capacity as part of our new 'Virtual Hospital'. This will include the expansion of our existing virtual bed capacity to support key patient groups, scaling up and optimising our OPAT services, and developing new rapid discharge pathways in key specialties and significantly expanding our remote monitoring capacity and capabilities.

- **Hospital at Home Virtual beds:** as we create a plan to expand our virtual bed capacity, we will evidence the impact and integrate the learning and best practice from our current H@H models, and benchmark to identify the opportunities for expansion to support key patient groups.
- **Virtual Beds for Out-patient Parenteral Antibiotic Therapy (OPAT): our** OPAT service, which provides an alternative to hospital admission by delivering IV antibiotics to patients on an outpatient basis, has grown considerably over the past few years providing ~60 virtual beds on a daily basis (primarily supporting patients in South Glasgow). There is significant further opportunity to expand this service. In 2025/26, with additional investment we will expand our OPAT service in Clyde and North, subject to further investment. This would provide up to 50 additional virtual beds. We will also consider how we may develop provision of an OPAT service within the Hospital at Home service.
- **Virtual beds - Remote Patient Monitoring:** we plan to procure a remote patient monitoring system that will provide a safe and effective framework for the scale up of our new 'Virtual Hospital'. This will support:

- the avoidance of unnecessary hospital admissions
- safe and effective early discharge, with reduced length of hospital stays and
- the management of long-term conditions in the community.

- **Palliative and End of Life Care:** as we start to provide different levels of care & treatment in line with patient need, we will ensure Palliative and End of Life Care is supported through our virtual hospital service. To underpin this, over the coming year, we will develop a shared transformational vision for Palliative and End of Life Care. Following the recent publication of the draft national strategy 'Palliative Care Matters for All', our localised vision for palliative care will be co-created with stakeholders from acute, primary, community, independent and third sector services alongside people with lived experience to meet the complex needs of people to live and die well.

6.4 Reducing Delayed Discharges and LoS

6.4.1 Delayed Discharge Reset Programme

The number of our patients who experience delays in their transfer of care remains a significant challenge.

During 2025/26 we will continue our work to improve this position and reduce delays through the following key objectives and actions set out in our Delayed Discharge Reset Programme:

Key Objective	Agreed Actions
Reduce waiting times for social work assessments	• We will review SW assessment processes to ensure efficiency and undertake tests of change to improve the time taken to assess
Reduce waiting times for care home placements	• We will review patients waiting for care home placements to identify any trends and 'hot spots' in areas where there may be particularly long waiting times • We will work with partners in the Care Home Sector to address the underlying reasons for these delays to transferring care and work to resolve them
Reduce the number of people delayed for 200+ days	• We will undertake a whole system approach to supporting the timely discharge of people who have been delayed for over 200 days

	• This will include exploring opportunities to assess patients' care needs in more homely settings, where appropriate, to allow them to be transferred out of hospital
Reduce the number of adults without capacity (AWI) delayed	• We will work with our Communications Team to raise awareness of the importance of having Power of Attorney (PoA) in place to pre-empt legal issues before a person loses capacity • We will also work to ensure that staff are confident to be able to discuss the benefits of PoA and the implications of not having PoA in place with patients, families, and carers
Implement the principles of the 'Final 1,000 Days' Campaign	• We will adapt and embed the principles of Professor Brian Dolan's *Final 1,000 Days* campaign across services to ensure no one spends needless time in hospital. The campaign advocates for compassionate care and proactive measures to minimise wasted time, ensuring that every day counts for patients and their families

6.4.2 Discharge without Delay

Over the calendar years 2023 and 2024, our Discharge without Delay (DwD) programme has delivered significant improvement in Planned Date of Discharge (PDD) accuracy, increasing by 12%. This supports reduction in length of stay through better coordination between multidisciplinary teams (MDTs), reducing unnecessary delays in the discharge process. There has been a more modest improvement of 3% in the rate of pre noon discharges over the same period, and there remains scope to further improve rates of Saturday and Sunday discharges to increase patient flow.

Throughout 2025/26, we plan to refresh our DwD programme across four key areas, to support further improvement against DwD metrics.

- Establish DWD Ward Champions to provide local ward ownership of DWD KPIs
- Implement our new Standard Operating Procedure to PDD setting, initially at the RAH, to strengthen cross pathway working and support a true multi-disciplinary approach to discharge planning for pathway 3 and 4 patients
- Developing our Ward Flow Project, using the total number of actual admissions per week to set flow trajectories for ward level daily discharges

- Finalise local implementation of Criteria Led Discharge on DwD wards, building on the established principles of CLD developed through the test of change programme over 2024/25

We will continue to promote our Discharge Without Delay programme through sector Unscheduled Care teams to maximise patient flow and support reduction in length of stay, including via Proactive Discharge Huddles, Rounds, long stay reviews and specialty level data reviews, and action planning.

6.4.3 Intermediate Care

Our Intermediate Care services deliver rehabilitation and re-ablement to those who are clinically appropriate. Our Discharge to Assess (D2A) policy has been embedded and is supporting the reduction in unnecessary stay in acute wards for suitable patients. This service optimises early discharge, where patients are discharged home or to a setting best suited to their needs with appropriate supports, with assessments planned and undertaken there rather than carried out while the patient is in a hospital bed. Furthermore, the use of intermediate beds to provide time limited intervention can prevent hospital admission, with the aim being to return the individual to their own home following a short stay.

Over the coming year we will refresh and promote the D2A policy, seek to understand variation in Intermediate Care approaches and promote best practice, with the aim of optimising Intermediate Care resource and ensuring maximum occupancy within the service. This aligns with the six principles of good rehab through a person-centred approach that prioritises timely interventions, supports recovery in the most appropriate setting, and maximises independence while reducing unnecessary hospital stays.

6.4.4 Facilitating Efficient Discharge

To improve patient outcomes and facilitate efficient discharge for care home residents who are admitted to hospital, we have relaunched the Red Bag Programme, which ensures care home residents admitted to hospital have essential documents including AWI, medication, and personal belongings, improving communication and therefore speeding up the assessment process in hospital, reducing unnecessary delays. We will work through 25/26 to increase awareness and visibility of this scheme and maximise uptake to support reducing length of stay for this cohort of patients.

Glasgow City HSCP also commission a service from Red Cross which covers the GRI & QUEH, for residents of Glasgow City, East and West Dunbartonshire, East Renfrewshire and South Lanarkshire areas to return home where they are fit to be discharged but have no transport available. This service supports over 700 journeys per year, and throughout 2025/26 we will work to further increase visibility and uptake of this service to facilitate the timely discharge of patients from acute sites back into the community.

As part of the development of our 3-year transformation plan, during March 2025 we will identify and confirm the impact of our changes on key performance indicators for urgent care.

7.0 Implementing our Mental Health Strategy

Key Deliverables in 2025/26

Implementing our Mental Health Strategy	• Conclude options appraisal on provision of community services and shifting the balance of care
Urgent Mental Health Care	• Further implementation of the mental health unscheduled care pathway via Community Mental Health Acute Care Services
Access to CAMHS	• Deliver the national standard of 90% of people starting treatment for Psychological Therapies within 18 weeks of referral • Deliver the national standard of 90% of children and young people starting Child and Adolescent Mental Health services within 18 weeks of being identified as suitable for CAMHS
Implementing National Standards	• Progress the implementation of Core Mental Health Standards and Psychological Therapies, Neurodevelopmental and Eating Disorder Specifications • Subject to funding allocation from the Scottish Government, move towards operationalising the regional Child & Adolescent Intensive Psychiatric Care Unit (IPCU).

7.1 Key Priorities in 2025/26 within our Mental Health Strategy

Our Mental Health Strategy 2023-2028 sits within the wider context of the national Mental Health and Wellbeing Strategy and Mental Health Transformation Programme. Our strategy proposes a system of stepped/matched care, allowing for progression through different levels of care, with people entering at the right level of intensity for their treatment. The aims of our strategy include:

- Integration across services to provide a condition-based care approach
- Shifting the balance of specialist psychiatric delivered care further into the community

7.1.1 Mental Health Service Public Engagement

To inform the implementation of our strategy, our 'Enhancing Community Services Programme' includes significant stakeholder engagement.

Initial engagement in this phase through 2024 included a public facing survey and in-person sessions across the six HSCPs. The next stage, maintaining focus on people with protected characteristics and lived / living experience, will be moving to appraisal of options on shifting the balance of care, resulting in public consultation on the most suitable configuration of inpatient beds and community support.

Our public engagement plan is in line with Scottish Government and COSLA's Planning with People: Community Engagement and Participation Guidance, and in dialogue with Healthcare Improvement Scotland – Community Engagement.

7.1.2 Increasing Community-Based Support

We continue to develop a package of community-based supports that have direct impact on urgent and unscheduled demand, reducing inpatient stays and supporting shifting the balance of care.

Our priorities for 2025/26 include:

- Developing Unscheduled Care via Community Mental Health Acute Care Services: (replacing existing crisis services) for Adults and Older People, which will focus on helping people who might have needed short term care to stay out of hospital and help people to leave hospital early whose stay might have lasted up to 2 months. Psychiatric Emergency Planning guidance to help manage the detention of a patient and support multi-agency working was updated through Mental Health Clinical Governance in March 2024, with the electronic patient record based on the national template. This is next scheduled to be reviewed in March 2026

Priority areas for shifting the balance of care towards increased community support include:

- Development of Community Rehabilitation: This will support transitions through key points along the whole mental health rehabilitation pathway, from initial contact with services, through acute hospital admissions to an inpatient rehabilitation bed, to 24/7 supported accommodation, to lower levels of support including independent living tenancies or home. We will deliver rehabilitation interventions to individuals with identified rehab needs within the community, working in partnership with social care to create and maintain flow through the whole rehabilitation pathway
- Enhanced Care Home Liaison: This will provide more specialist mental health assessment, stress & distress formulations and management plans to support both patients and care home staff. This team allows a broader range of professionals with

different skills to better support care homes with managing the wellbeing and behaviour of residents, providing education, training, and skills to support care home staff

- An Expanded Borderline Personality Disorder Pathway: This will provide access to at least one of two specific therapies (Dialectic Behavioural Therapy or Mentalisation Based Therapy). We also provide therapies for emotional and behavioural dysregulation such as Emotional Coping Skills, and Systems Training for Emotional Predictability and Problem Solving. The co-ordinated Clinical Care best practice framework for all mental health staff ensures that staff work more empathically and in a more coordinated, evidence-based and consistent way with people with a diagnosis of BPD, supporting patients with mild to severe BPD to manage their condition in their own homes and communities wherever possible

7.2 Delivering National Standards and Specifications

7.2.1 Psychological Therapies

Adult and Older People's Mental Health Service

A wider range of services have been brought under the National Specification for Psychological Therapies, which has increased the challenges of delivering waiting times standards as a whole, as additional teams work to meet target. During 2025/26 we will work to maintain the 18-week referral to treatments (RTT) standard (90%) and reduce the longest waiting times. This will be achieved through:

- Support for digital and peripatetic solutions that help balance demand and capacity across the six HSCPs
- Restructured governance process for psychological therapies and management of the balance between treatment and assessment
- Supporting community responses to needs that don't require more specialist mental health intervention

Child & Adolescent Mental Health Service (CAMHS)

During 2025/26 we will work to build capacity to deliver and maintain the CAMHS 18-week referral to treatment (RTT) standard to ensure children and young people are waiting and seen in less than 18 weeks (90%). This will be achieved through:

- Continuous monitoring of demand and capacity, along with vacancies and long-term absences will help to achieve the balance of need and support
- Continuing to undertake analysis on factors that impact engagement with CAMHS. This will be used to inform potential interventions to enhance engagement and reduce non-attendance

- Continuing to work with Public Health Scotland, and other stakeholders on the development of the Child & Adolescent Psychological Therapies National Dataset (CAPTND), including data quality work to identify areas for improvement.

Our Mental Health Strategy aligns with national Core Mental Health Standards. During 2025/26 we expect the Mental Health National Leads Group to instruct boards to use the HIS local assessment and readiness for change tools for the Core Mental Health Standards to self-assess how these are being delivered locally.

7.2.2 Neurodevelopmental and Eating Disorder Specifications

To support the continued implementation of the Neurodevelopmental and Eating Disorder Specifications during 2025/26 CAMHS will:

- Provide young people with online information regarding key conditions and the care offered for those seen by CAMHS, as described in Care Bundles
- In conjunction with adult services, continue to implement the national Eating Disorder Service Specification. This will include consolidating tests of change undertaken or underway in expanding the role of AHPs to support young people with eating disorders, particularly those with neurodevelopmental co-morbidities
- Continue to implement the national Neurodevelopmental Service Specification. This will include reviewing clinical requirements to meet the Neurodevelopmental Service Specification, and demand and capacity modelling to refine options

7.3 Learning Disabilities

The work being undertaken to support people with learning disabilities is detailed in both our Mental Health Strategy and our Multi-Agency Collaborative Group which focuses on the delivery of the 'Coming Home Implementation Report'. This sets out the objectives to:

- Work with HSCPs and third sector partners to develop community capacity and infrastructure to ensure people are supported at home and avoid admission to Learning Disability Assessment and Treatment services where appropriate and, to ensure that people who are admitted are discharged in timely way and do not become delayed
- Close our remaining long-stay provision and reduce assessment and treatment beds, to release resources which can help develop support in communities, working to prevent unnecessary admissions
- Work with HSCPs to ensure the intelligence and data gained from the dynamic support register is used to support current and future commissioning practice, financial planning.

We are also undertaking comprehensive learning disabilities health checks, universal completion of which, presents a significant capacity challenge. We are part of the national

delivery group, and we are working, in agreement with the Scottish Government, to continue delivering person-centered Annual Health Checks, via the nursing service hosted by East Renfrewshire, for people with Learning Disabilities across GGC, within the resources we have available.

7.4 Tackling Inequalities & Delivering the Public Sector Equality Duty

In support of the commitments made in our Strategy for Mental Health 2023 – 2028, we will focus in 2025-26 on supporting the most vulnerable individuals and groups, and those who may have historically experienced challenges in accessing services. Equalities impact assessments have shown that there is a particular need to improve support to patients with hearing loss, those whose first language is not English, and to the LGBT community. During 2025/26 we will:

- Develop programmes of work to address mental well-being within the vulnerable groups and communities, and support Third Sector Interface (TSIs) in the dispersal of Scottish Government Community Mental Health and Wellbeing funding to projects that benefit our most vulnerable groups
- Continue the implementation of the mental health components of the NHSGGC British Sign Language Action Plan 2024-2030
- Utilise the newly developed dashboard to track people with English as an additional language among our mental health in-patients, to better manage interpreting needs as part of our equalities outcomes
- Through the LGBT Charter with CAMHS, Sandyford and the Youth Health Service, continue to support greater inclusion and access to services

The Director of Public Health Report (2024) showed significantly worsening trends in mental well-being across our population (a decline of 5.5% between the 2018 and 2023 Adult Health and Well-being Survey) This decline was steeper for those living in poverty and steepest for young adults (aged 16-24 years).

Progress has been made around delivery of public mental health training and access to non-clinical distress brief intervention services (for age 16+). There has been a modest decrease in probable suicides across the NHSGGC area, counter to the Scottish trend. However, this still represents too many avoidable tragedies and our work on distress and suicide prevention will continue alongside our wider public mental health programme undertaken in collaboration with Community Planning Partnerships and Third Sector Interfaces. In particular, we will continue to focus on suicide prevention activity for groups at highest risk, for example through provision of SafeTALK and ASIST training, available for all staff to support identification of and intervention with individuals who may be considering suicide.

In line with national and UK-wide trends, we have seen a significant increase in referrals for Attention Deficit Hyperactivity Disorder (ADHD) assessment over the past 4-5 years into Adult Community Mental Health Teams. There has also been a continued increase in

referrals to the Adult Autism team (ASD) over the past 10 years. With regard to transitions, CAMHS continue to implement the national Neurodevelopmental Service Specification. We will continue to inform and work with Scottish Government on the burgeoning increase in demand for, and responses to, assessment and treatment of neurological development disorder, the volume of which challenges the delivery of the wider spectrum of community mental health services we currently provide.

7.5 Forensic Mental Health Services

Following the recent establishment of the National Forensic Governance Advisory Board, our senior clinical and operational leadership team hosted the Chair of the Forensic Governance Advisory Group at Rowanbank clinic in early 2025. As part of this engagement process our team discussed the risks and benefits of each of the options being considered, nationally highlighting the advantages of supporting both strategic planning at a national level alongside regional and local commissioning and delivery of forensic services.

We are awaiting the outcomes of the work of the Forensic Governance advisory group, and our forensic mental health team continue to play an active role as members of the Forensic Network and collaborate and co-operate across boards to address & support the priority issues that have been identified.

7.6 Improving Support & Developing the Mental Health Workforce

Strengthening support for mental health and wellbeing, including stress remains a key priority for the Staff Health Strategy. The Workforce section of our Annual Delivery Plan outlines this in detail (please see Section 10), with focus on both strengthening support for mental health and wellbeing including stress, and promoting NHSGGC as a fair and healthy workplace in line with Fair Work Nation principles

Delivery of our programme of reform relies on successfully implementing our workforce action plan, which is based around the principles of Planning for, Attracting, Training and Nurturing our workforce. We continue to take a cross-sector approach to MH nurse recruitment and filling Psychiatrist vacancies. This supports reduced duplication and contributes to our work in ensuring adequate and sustainable staffing across the whole system, and meeting requirements for safe staffing across mental health services.

Specifically for the Mental Health workforce, the bundling of previously separate non-recurring funds such as Recovery and Renewal and Action 15 into the Enhanced Mental Health Outcomes Framework is welcome. However, this has also resulted in reduction in the overall funding envelope, which presents a challenge to maintaining the same level of support to the workforce. Further conversion of government funding into longer term and recurring resource will support sustainability, and delivery of the Programme for Government commitment to support improvement across Mental Health Services.

7.7 Regional CAMHS Tier 4 Developments

7.7.1 Intensive Psychiatric Care Unit (IPCU): We have developed clinical pathways and a workforce plan for IPCU ahead of confirmation of recurring funding from government for the built environment. The first phase upon confirmation of recurring funding is recruitment to the lead roles, which will enable opening one bed in the first instance and then expanding on a phased basis to four beds once fully operational.

7.7.2 Forensic CAMHS Secure Units: Three of the five secure units in Scotland are located within the GGC area, and as a result of the national directive that young offenders under 18 years of age be placed in these units rather than young offenders' institutions, we have further developed our secure pathway, initially utilising non-recurring funding from Scottish Government. We have developed a hub and spoke forensic model for the West of Scotland region, along with a business case, workforce plan, and service specification to allow us to continue delivering this service, however further clarity is needed on funding for 25/26 onwards to support delivery on a sustainable basis

7.8 Improving the Mental Health Built Environment & Patient Safety

As part of the implementation of our mental health strategy, assessment of the quality and safety of the built environment is a key criterion in reconfiguring and shifting the balance of care (please also see section 3.5). This will be informed by appraisal of options and public consultation on site combinations.

Our options appraisal process will include addressing specific service needs such as eating disorders, secure rehabilitation facilities, and mitigation against suicide risk, including an ongoing programme of environmental ligature risk reduction. This will, however, need to be balanced against capital funding available to improve existing accommodation.

8.0 Improving Access to Treatment - Planned Care, Diagnostics & Cancer Care

8.1 Overview

It is important to note that in order to deliver our plan, significant financial investment will be required on a recurring and non-recurring basis.

An estimate has been made of capacity required to support delivery across Outpatients and Inpatient/ Daycase to achieve our trajectories of 52 weeks by March 2026. However further refinement is required to develop specialty plans, while ensuring all appropriate support requirements are understood e.g. impact on Radiology and Endoscopy.

Our plan for imaging incorporated in the National plan outlined a recurring investment profile however this will also require short term funding to enable the sustainable provision to be established.

Our submission as part of the National Endoscopy planning process did not outline resource requirements. Internal estimates have been made of the funding that would be necessary to achieve the required reduction as detailed in the planning guidance.

Additional resource requirements for 2025/26 for improvement of cancer care are being re-evaluated given the ADP request for reduction in core Outpatient and Inpatient/Daycase delivery. There are key cancer types that remain challenged from a performance perspective including Colorectal, Urology and the full impact of the Optimal cancer pathways are being developed into an improvement plan.

Subsequent to further discussions with the SG Planned Care Policy and Performance Team we have included some additional information at the end of this section (please see section 8.7).

Key Deliverables in 2025/26

Outpatients – during 2025/26	• Increase capacity across challenged specialties to achieve a reduction in maximum waiting times and progress achievement of 52-week maximum wait by March 2026. • Build on the redesign of services through workforce change already established in key specialties to create a more sustainable model of care. Embed alternative capacity targeting outpatient care for urgent and routine patients e.g. Orthopaedics including Spinal care, Gynaecology and Ophthalmology. Others include Dermatology, ENT, Gastroenterology, Neurology and Neurosurgery. • Deliver a further expansion of sector wide common waiting lists to offer capacity to routine patients in date order. • Identify further opportunities to increase the efficiency of return outpatient management through virtual care and alternative clinical pathways including Clinical Nurse Specialist and Advanced Nurse Practitioner follow up. • Adopt and monitor the impact of the new ANIA Digital Dermatology pathway across NHSGGC. • Further improve patient centred access to outpatient care, e.g. further develop the use of Patient Hub together with patient-

	initiated pathways including opt-in and Patient Initiated Review (PIR) and Patient Initiated Follow-Up (PIFU).
Inpatient/ Daycase – during 2025/26	• Increase operative capacity for key challenged specialties with appropriate recurring resource and progress achievement of 52-week maximum wait by March 26. • Expand the Orthopaedic elective care delivery within available resources and outline what else can be achieved across NHSGG&C to increase capacity. In addition, following confirmation of recurring funding, we will progress the key Orthopaedic developments at IRH and GGH. • Build on the elective surgical hub model and maximise our ambulatory care hospitals to direct further elective capacity away from the main hospital sites and separate further the interdependency of emergency and elective care • Improve efficiency through further productive opportunities in key specialties. Areas of key focus include improved short stay and day surgery rates, development of regular single procedure lists, and wider adoption of standby processes to limit lost theatre time to patient cancellations • Continue to increase delivery of high-volume operating across cataract and 4 joint arthroplasty theatre lists • Implement improved analytics to support improvement in theatre efficiency • Continue to maximise available capacity increasing short stay surgery activity in key specialties • Ensure optimum use of all available external NTC capacity to maximise impact for the longest waiting patients, particularly in Orthopaedics.
Planned Care Strategy – during 2025/26	• Review specialty plans to ensure the strategic direction and key deliverables of the national plans are incorporated. Support the delivery of national plans for Ophthalmology, Endoscopy and Orthopaedics to further improve patient access to care • Redevelop our Gynaecology strategy taking account of the emerging recommendations from the national Gynaecology Recovery plan • Update the Urology strategy taking account of the planned Regional development of a revised Target Operating Model. Through a short life working group (SLWG) led by a Chief of

	Medicine, consider the opportunities for improving efficiency through economies of scale.
Increasing Diagnostic Capacity – during 2025/26	• Finalise our proposals to optimise capacity for PET- CT through current facilities. It is anticipated that capital funding within NHSGG&C will be required to support this initiative and will be prioritised • Progress the recommended developments from the national strategy for PET-CT • With additional funding progress development of increased sustainable capacity in line with proposals set out in the Target Operating Model • Deliver a service model that achieves reduced reliance on the mobile units. It is anticipated that this will require to be costed for consideration. • Develop a longer-term strategy for Imaging reporting • Further to assessment of the outcomes of the AI reporting research study, we propose to develop a plan to extend the application more widely across GGC • With additional resource continue the training of Specialist Radiologists in ablation techniques to treat cancer and ensure sustainability of service.
Cancer Services – during 2025/26	**Improving Cancer Waiting Times** • Continue to collaborate with colleagues in NHS Lanarkshire to improve Urology pathways within NHSGGC and emulate the success NHS Lanarkshire have seen in improved performance for this challenged specialty • Augment improvements in Urology patient waiting times and continue to direct patients into appropriate clinical streams; through robust referral vetting and using straight to test processes • Implement changes to qFfit screening categorisation to ensure patients deemed the highest clinical risk are prioritised for diagnostic services • Breast pathways – maximise one stop clinic models to manage high volume patient numbers and ensure capacity is utilised efficiently. **Embedding optimal cancer diagnostic pathways and clinical management pathways**

	• Continue to implement Scotland's Optimal Lung Cancer Diagnostic Pathway • Embed Scotland's Optimal Head and Neck Cancer Diagnostic Pathway - a Head & Neck Diagnostic Hub will continue to be implemented at the Queen Elizabeth University Hospital campus **Delivering single point of contact services for cancer patients** • Complete recruitment to lung cancer Navigator posts and roll out the service to all sectors • Ensure that all NHSGGC residents have access to a Holistic needs Assessment as part of Improving the Cancer Journey. **Developing cancer prehabilitation** Complete the pilot project focused on head & neck, prostate, pancreatic and bowel cancer clinical pathways to look specifically at cancer prehabilitation.

8.2 Outpatients - Generating Capacity, Improving Efficiency & Accelerating Service Transformation

We are committed to continuing to reduce outpatient waiting times whilst balancing the needs of clinically urgent patients. A review of the urgency of patient referrals has been undertaken. Overall, specialties are having to deliver higher levels of urgent activity compared to pre-Covid, with increased rates variable at specialty level. Ensuring urgent patient referrals are prioritised for available capacity will continue to be actioned.

In modelling the requirements for capacity, the demands for Adult and Paediatric services have been set out separately. This is to ensure appropriate consideration is given to the very different constraints and necessities for service delivery across both. Also, in the modelling the impact of subspecialty demand and the workforce profile has been taken into account.

We will, with the appropriate resources, increase capacity across challenged specialties to achieve a reduction in maximum waiting times and progress the achievement of a 52-week maximum wait by March 2026.

We will build on the redesign of service delivery already established in key specialties through workforce change to create a more sustainable model of care and embed alternative clinical capacity targeting outpatient care for urgent and routine care.

External capacity at the Golden Jubilee University National Hospital (GJUNH) has supported delivery of outpatient cataract care. It is notable that this capacity has been reduced by 46% in the 2025/26 allocation therefore alternative internal capacity will require to be resourced to ensure the maintenance of a 52-week maximum wait on this patient pathway.

8.2.1 Delivery of 52-week maximum Outpatient Waiting Time

The national objective of a max waiting time of 52 weeks across all specialties is a shared aspiration. Careful review of the urgent and routine demand delivered activity and opportunities for expanding capacity has been undertaken.

Across a range of specialties, the specific variable of subspecialty demand is a consideration, for example in Adult ENT the predominant outpatient demand is concentrated on Rhinology. Only a small proportion of our ENT consultant workforce are Rhinologists therefore opportunities for delivering a significant reduction in the waiting time relies on a limited clinical workforce.

The following sets out a number of the most challenged specialties with a broad indication of the additionality that would be required to make significant progress towards a 52-week max waiting time.

Figure 8: Additional Outpatient Clinic Capacity to meet 52-week waiting time

Adult	Minimum additional clinics additionality
Cardiology	87
Dermatology	887
ENT	580
Gastroenterology	64
General Medicine	202
Neurology	295
Neurosurgery	317
Oral Medicine	89
Pain Management	36
Trauma and Orthopaedic Surgery	2,062
Gynaecology	1,867
Total	**6,486**

There are a range of specialties where subspecialty vacancies are impacting on attempts to reduce overall waiting time. Whilst it is recognised that patient numbers may not appear to be significantly challenged in some areas, the opportunities for generating additionality may be reliant on external insourcing or reconfiguration of direct clinical care sessions at variable costs to create capacity. It cannot be assumed that one size fits all in terms of generating specialty specific capacity.

8.2.2 Increasing Efficiency and Reducing Variation

To improve access for our longest waiting patients, e.g. in Orthopaedics (including the challenged subspecialty of spinal), Gynaecology and Ophthalmology, we are placing a strong focus on increasing efficiency and reducing unnecessary variation. To achieve this, we will continue to standardise clinic templates and drive increased productivity through Active Clinical Referral Triage (ACRT) processes and virtual patient management. Furthermore, we will use our specialty capacity flexibly across GGC to further expand the smoothing of waiting times across individual specialties.

In addition, our plan for outpatients is to continue to optimise our interactions with patients and improve access to information at every part of the patient journey. We have implemented and extended several practices to help with this including:

- Regular waiting list validation
- Reinstatement of patient focused booking as the norm
- Established ACRT of new referrals as standard and
- Expanded discharge PIR and PIFU to strengthen patient-led decisions in their own care.

8.2.3 Optimising Digital Solutions & Technology

We will also make best use of technology to support service efficiency and effectiveness (please also see section 11). During 2025/26 we will:

- Further roll out access to patient hub - increasing and improving patient access to digital information about their referral and treatment
- Following the successful trial for ENT and Neurology in outpatient bookings we are expanding electronic patient booking to other outpatient specialties including diabetes, respiratory and other medical specialties with a programme set for specialty adoption during 25/26
- We will adopt the new ANIA Digital Dermatology pathway GGC wide following launch in all HSCPs, including focused communications, supporting and monitoring uptake in GP practices and setting up a Dermatology dashboard and benefits realisation reporting
- We will develop web-based information to help patients and GPs access information at an early stage to support greater patient self-management and to support patients to wait well for treatment.

- We will scope the development of digital systems to support patient information and referral management being more accessible for patients currently on waiting lists, integrating information available to patients through other platforms including pre-operative websites to ensure patients understand what will support them to stay Fit, Ready and Available for care.
- Building on work in recent years to establish and promote virtual patient management via video, we will continue to explore opportunities to increase this where there is clear benefit for our patients.
- We will seek the support of CFSD to accelerate the validation of our most challenged specialties where demand and capacity are not aligned e.g. in Gynaecology and Orthopaedics.

8.2.4 Further Outpatient Service Redesign

Nurse and AHP-led pathways are well established, we will continue to build on this, developing staff and expanding nurse led pathways, this will enable us to optimise available consultant time.

We will continue to work closely with the Centre for Sustainable Delivery (CfSD) to continue our contribution to the development of National Pathways and work to implement these locally, working with the Specialty Delivery Groups (SDGs). All currently published pathways have been either fully or partially implemented or already reflect our current practice. We are committed to working with CfSD and the SDGs to ensure that all potential opportunities for standardisation and improvement of care delivery are maximised across NHSGGC.

During 2025/26 specific work we are taking forward includes:

- Ear, Nose and Throat (adult service) are testing the effectiveness of a Head and Neck Optimal Cancer Diagnostic Hub (please also see section 8.6.2)
- The Rhinology team are also focusing on the redesign of pathways where clinical intervention is of little clinical benefit to patients. Utilising an opt-in model, patients will be provided with information to manage symptoms at home, reducing overall demand supported through adoption of a realistic medicine approach
- We will develop and implement a programme of work that will enable more effective management of referrals between the acute Trauma and Orthopaedics specialty and the MSK service. Scoping work is underway to map out current referral processes with a view to the development of a single front door referral model covering both MSK and Orthopaedics for applicable referrals only. This approach will ensure that patients are seen at the right time by the most appropriate health care provider(s).

8.2.5 Addressing Service Sustainability

Whilst we are seeing an overall increase in waiting times in some outpatient specialties, there are several specialties where waiting times have reduced. Improvements have been seen in both Dermatology and ENT seeing a reduction in the number of patients waiting

greater than 52 weeks. This has been achieved by smoothing across sites/consultants, implementation of new pathways and the utilisation of waiting list initiatives and additional capacity.

However, within Gynaecology, Orthopaedics, Spinal and Ophthalmology we continue to experience increased demand and as a result we rely on additional capacity through waiting list initiatives, temporary increase in workforce and/or insourcing services. We recognise the impact long waits have on patients and we will continue to review and revise detailed proposals to support further transformational change within these services to implement a plan that will provide a more sustainable service position.

We are committed to and will ensure with appropriate resources that progress continues to be made towards the achievement of a maximum of 52 weeks wait.

We will fully utilise and optimise all allocated external capacity within the National Treatment Centres to achieve a reduction in waiting times available.

Gynaecology: as has been set out in the precursor briefing document to a National Gynaecology plan, the demand for Gynaecology has increased considerably. Through targeted allocation of resource Gynaecology waiting times have been maintained below a maximum waiting time of 78 weeks. Redesign of clinical pathways and development of CNS roles has extended the capacity options for outpatient management within the specialty. Insourcing of consultant services has augmented the Gynaecology capacity for Urgent and routine patient care and the intention is to continue this support into 2025/26.

It is recognised that further investment is required to support this challenged specialty. Reducing the interdependency of Obstetric demands on Gynaecology clinical capacity is a key priority. An increase in consultant headcount will be required to improve the overall Gynaecology position and to date this has proved challenging to secure locum input. Therefore, it is anticipated that substantive appointments will be required in order to sustain the service.

A programme of actions to address well woman needs within Gynaecology is planned (please see section 9.1).

Ophthalmology: The Ophthalmology specialty is managing a large glaucoma caseload with high demand for both new and follow-up outpatient glaucoma appointments exceeding the workforce capacity available. If monitoring and treatment is delayed, this can result in risks to patient's vision. Waiting list initiatives have been implemented to manage return glaucoma patients however a changed approach is required. Options have been explored and the current preferred option recommends testing a weekend virtual hub model at the QEUH. Running as a high-volume clinic this would be the most sustainable long-term option

to increase capacity and efficiency, reduce waiting times and increase the stable glaucoma patients who can be discharged to the community glaucoma service. Recurring funding is required to support this model beyond a test of change at Gartnavel General Hospital.

Orthopaedics (incl. Spinal): Orthopaedics, in line with the Scotland position, Orthopaedics is the largest challenge to achieve a maximum 52 week waiting time. Core Orthopaedic demand for Hip/ Knee in particular is a rising pressure and achievement of a reduction in the max waiting time requires an increase in capacity.

There have been several changes implemented to ensure consistency of delivery across NHSGGC. Smoothing of waiting times across the sectors with capacity allocated to combined patient lists has ensured sustained delivery. Utilising support of Advanced Practice Practitioner (APP), progressing the development of APP led vetting service provision and redirection of AHP support from MSK has created capacity for maximum outpatients waiting. Additional investment in locum consultant capacity has worked well with redirection of longest waiting patients to the sector with capacity.

At a subspecialty level Spinal demand for Orthopaedic care presents a substantial task to construct the level of capacity that is required to achieve this marked reduction in waiting times by the end of March 2026. With a limited consultant base nationally, the recent successful consultant recruitment following retirement should be credited to the clinical and operational team. Without sizeable investment in extending APP and Consultant capacity in a more sustainable way, this element of the Orthopaedic demand will continue to dominate the negative impact on the overall long waiting position. It is worth noting that the changes to lower back pain pathway have reduced considerably the flow of additions to the waiting list.

8.3 Inpatient & Daycase - Optimising Capacity & Improving Productivity

In line with our Clinical Strategy 'Moving Forward Together' over the next 3 years we will maximise available capacity by broadening the separation of scheduled care from unscheduled care, maximising the use of short stay and daycase surgery, and, where appropriate, consolidating areas of higher volume activity. Key to our plan is our ability to further develop our elective surgical hubs at IRH and GGH as well as expanding further the role of our ambulatory care hospitals

Examples include:

- Maintaining our focus on collaborative pan GGC working for high volume ambulatory care provision at specialty level increasing the number of cataracts performed on each high-volume cataract list and on increasing the number of arthroplasty lists containing four procedures.

- We will continue to develop our model of Elective Centres through our Surgical Hubs at IRH and GGH, whilst also increasing the complexity of patients able to be managed at our ambulatory care hospital sites – Stobhill ACH and Victoria ACH. Where there is benefit for patients, we are using the Surgical Hubs to consolidate subspecialty work. We remain committed to protecting capacity for elective surgical care all year round and aim to achieve this by increasing access to daycase and short stay surgery, with specialties such as Gynaecology, Orthopaedics and General Surgery

- We are committed to ensuring we continue to optimise our theatre capacity where appropriate delivering services on a pan NHSGGC basis - for example, in Orthopaedics our surgical hubs at GGH and IRH will be managing an increasing volume of our Arthroplasty activity

- We continue to work to further improve sustainable increased capacity across Endoscopy services that reduces reliance on mobile unit and WLI activity noting that expansion of proposals including substantial development of TNE requires funding. These issues are outlined in more detail in section 8.4.2.

8.3.1 Expanding our Elective Surgical Hubs

In line with our MFT clinical strategy, we propose to further expand elective operating at the GGH site for Orthopaedics in laminar flow theatre capacity. This previously submitted proposal remains a priority for delivery to increase arthroplasty activity. Approval of recurring investment is anticipated however has not been confirmed. The Orthopaedic expansion plan would see an increase in the GGH site from 2 elective theatres to 3 elective theatres and be achieved over a 6-month period. This would be supported with an expanded elective Orthopaedic bed base at GGH rising from 12 to 18 beds.

We propose to augment current staffing at Inverclyde Royal Hospital (IRH) to support increasing activity through existing base elective capacity at IRH. This will support more Arthroplasty operations at IRH, making best use of the full capacity available at IRH.

Our more complex patients will continue to be managed through our Acute Hospitals/Regional Centres, with a similar focus on reducing inpatient length of stay through early rehabilitation after surgery.

Underpinning this model of care will be patient clinical prioritisation and validation of waiting lists (admin, patient and clinical), efficient pre-operative assessment processes that target resources more selectively to match a patient's individual needs, and an emphasis on providing patients with support and advice to help patients 'wait well' for surgery. Building on the Healthy Living Hub development, we will integrate Ready, Fit and Available patient information and tailored self-help tools within priority clinical pathways to optimise current health status.

8.3.2 Maximising Capacity - improving Theatre Efficiency

We will continue to work to maximise our theatre efficiency. Our theatre teams have efficiency programmes in place to maximise patient throughput. We are committed to ensuring there is consistent use of data to inform operational performance management, reduce any unnecessary variation and to help identify areas where further service improvement is required.

The use of common waiting lists for efficient patient management is already in place in some specialties e.g. Orthopaedics. We are committed to the further roll out of this this approach to support cancer, urgent, then date order capacity provision.

In other specialties we will continue to extend our use of high-volume theatre lists; for example, in Ophthalmology (Cataract) and Orthopaedics (Arthroplasty). In cataract surgery we are committed to continuing to increase the overall number of cataracts, the number of bilateral cataracts (ISBC) and the number of procedures performed on our high-volume cataract (HVC) lists. Monitoring of key performance indicator monthly trends and weekly detail of HVC lists will continue to be shared widely. In Arthroplasty we will continue to increase the number of 4 joint lists and to share monitoring data to inform improvement actions. Both these workstreams are supported by a project framework.

New technology has the potential to help improve efficiency, we will further accelerate opportunities around the Infix theatre scheduling tool and learn from early implementers such as NHS Lothian. We have put in place a new electronic process for pre-operative assessment to optimise patient management ahead of surgery to improve theatre scheduling and reduce unnecessary theatre cancellations. We will continue to use this to stream patients electronically into categories of pre-op care. We have extended the validity of the pre-operative assessment to build on the benefits of these developments.

Our teams continue to work with CfSD through the national Peri-operative Delivery Group to improve and innovate; this will include implementation of the data dashboard to drive improvements in perioperative practice and national roll-out of the Infix digital scheduling tool. This will support the improved visibility of data dashboards for all operational teams, and support increasing theatre efficiencies for examples the inclusion of electronic links to the patient standby process to ensure that in the event of a cancellation theatre capacity is not lost and treatment slots can potentially be reallocated for replacement of ‘on the day’ cancellations.

8.3.3 Supporting Workforce Development

Workforce recruitment, retention, and development remains a key focus, we will use expertise pan GGC to share learning, support skills development, and enhance team

flexibility and resilience. For example, we plan further expansion of Clinical Nurse Specialists in outpatient care including in Paediatric ENT and have expanded the use of APPs across Orthopaedic services. This facilitates the release of clinical time for the cover of operating sessions.

Our GGC-wide theatre nurse training delivery continues through 2025/26. This programme looks to maximise training opportunities for our staff, efficiently utilises educator resources, and standardises training programmes for consistency with agreed timescales, support, and shared resources. Our theatre training is now co-ordinated and standardised across acute sectors, benchmarked nationally, and focused on expanding a variety of roles, including ODPs and assistant perioperative practitioners.

8.3.4 Delivery of 52-week maximum TTG Inpatient/Daycase Waiting time

The national objective of a max waiting time of 52 weeks for TTG care across all specialties is a shared aspiration. Careful review of the urgent and routine demand delivered activity and opportunities for expanding capacity has been undertaken. As noted in the Outpatient section, across a range of specialties the specific variable of subspecialty demand is a consideration, for example in adult plastic services the breast surgery element of the TTG demand has been an increasing demand given the prioritisation of risk reduction surgery being balanced against urgent cancer delivery together with the long waiting routine care. A small number of our Plastic surgeons deliver this specialist breast surgery care.

The following table sets out a number of the most challenged specialties with a broad indication of the additional sessional requirement that would be required to make significant progress towards a 52-week max waiting time by March 2026.

Figure 9: Additional IP/DC Clinic Capacity to meet 52-week waiting time

Adult/Paediatric	Minimum additional sessions
Community Dental Practice	340
ENT	244
Neurosurgery	224
Oral Surgery	200
Paediatric Dentistry	130
Plastic Surgery	690
Trauma and Orthopaedics	3,140
Urology	570
Gynaecology	2,031

Paediatric ENT	1,692
Paediatric Ophthalmology	207
Paediatric Surgery	163
Paediatric Plastic Surgery	66
Total	**9,697**

8.3.5 Addressing TTG Service Sustainability

A number of our patients continue to experience very long waiting times for a range of routine operations. This is impacted by increasing numbers on TTG waiting lists and the resource required to meet the increasing needs of urgent and USOC patients. This is particularly evident across Gynaecology, General Surgery, Neurosurgery, Plastic (Breast) Surgery and Ophthalmology. Progress has been made in waiting times for example for the longest waiting Orthopaedic patients however this still requires further development. Detailed plans are being progressed for these specialties as outlined:

Gynaecology: the urgency profile of patients on the TTG Gynaecology waiting list has changed with a considerable increase in the patient cohort categorised as urgent. Increasing the available theatre resource and delivery of sessions is key to holding the maximum waiting time for routine patient care.

As noted previously the interdependency of Obstetrics emergency and on call care has required the realignment of session cover from elective Gynaecology services. Increasing the workforce provision would ensure that the interdependency can be reduced. Increasing the base elective theatre sessions across the NHSGGC sites is imperative. Despite the ongoing non-recurring investment in this specialty the maximum waiting time continues to deteriorate. A profile of investment has been identified though it is clear from recent years that recruitment can be a major constraint to service delivery.

Orthopaedics: Orthopaedics is achieving slow but steady progress with improving the maximum waiting times for routine surgery. We will continue the network of elective surgical hubs focusing on orthopaedic surgery, progress the developments for GGH and IRH with recurring funding to increase the delivery of arthroplasty recognising these changes will deliver benefits for all NHSGGC patients. These changes will also support an increase in the number of 4 joint lists that can be supported and thus improve productivity of theatre resources.

It is recognised that local capacity will be augmented with additional capacity from the National Treatment Centres at GJUNH and in NHS Forth Valley. We will continue to work with the GJNUH team to expand the criteria of patients for management in the NTC facilities

which will improve the allocation of longer waiting patients for treatment. We await confirmation of the allocation of capacity at the NHS Forth Valley NTC.

We also welcome the development of a national plan for Orthopaedics for a collective approach to achieving maximum orthopaedic outputs. From a GGC perspective a range of opportunities for national investment have been identified that would support a reduction in patient waiting times including the realignment of patient care to the outpatient setting for example with the development of procedural room care for carpal tunnel care. Further protecting elective care from the impact of trauma demands has been proposed including the expansion of subspecialty trauma sessions at RAH.

Despite progressing all the above, the capacity requirement to achieve a 52-week maximum wait should be set in context of the 2024 delivered activity. It would require more than an additional 100% activity to be delivered.

Spinal: The long waiting times in Orthopaedic Spinal remains a challenge. As previously noted, whilst the cross-sector management of patients in other subspecialties including Hip/ Knee level supports the long waiting patient management, the patient cohort awaiting spinal care remains confined to a small group of 5 consultants. The current profile of spinal theatre is insufficient to make inroads into the backlog of this patient cohort with priority being given to patients awaiting urgent care. Increasing the spinal consultant workforce has been set out in the National plan as a priority for us.

Neurosurgery: Increasing numbers of urgent patients combined with a maximised theatre capacity have resulted in limited opportunity to reduce longer waits in Neurosurgery. The development of Endoscopic Spinal Surgery is transforming the traditional open approach to surgery and facilitates additional operative care being delivered through the same theatre resource. With consultant training progressing well under the proctor, it is anticipated that an additional 40 cases will be undertaken using the same theatre resource. It also expands the patient cohort who can be considered for surgical intervention from the prioritised longest waiting patient group.

Further investment opportunities have been identified for expansion of theatre capacity in the Institute theatres to facilitate further elective capacity. This together with expansion of operator capacity together with infrastructure funding would support a level of reduction in length of wait. To move closer to the maximum wait time at least a 30% rise in the delivered activity would be required. A further expansion of theatre capacity is required to optimise the delivery of Inpatient care.

Plastic Surgery (Breast): the specialty has experienced increased urgent demand including for risk reduction surgery added to the requirements for longer waiting patients on the repeat waiting list, maximum capacity has been reached, and further funding is required.

Additional locum support has been resourced to the end of March 2025 and an application to extend this support has been submitted. Increasing the specialist consultant workforce and theatre capacity on a more sustainable basis will ensure that the key deliverables of backlog reduction for all TTG patients including the reduction of patients waiting for risk reduction surgery can be achieved.

Further Service Redesign
During 2025/26 we will take forward further service redesign to optimise patient care delivery.

We will redevelop our Gynaecology strategy taking account of the emerging recommendations from the national Gynaecology Recovery plan. Opportunities to reconfigure and increase elective delivery from the current Gynaecology service model will be explored.

We will update the Urology strategy taking account of the planned regional development of a revised Target Operating Model. Through a short life working group (SLWG) led by a Chief of Medicine, we will consider the opportunities for improving efficiency through economies of scale and improved cross sector working.

8.4 Diagnostics

Increasing Diagnostic & Endoscopy Capacity

8.4.1 PET-CT Capacity

PET-CT is a key diagnostic test for patients on the cancer pathway and we provide this scan for all WOS patients. We currently have two PET-CT scanners in Gartnavel General Hospital (GGH), with radioactive tracer being manufactured on site within our PET Production Unit.

Demand for PET-CT has been increasing year on year in line with the increase in cancer referrals PET CT scanning is critical in the diagnostic pathway. There is a National Strategy for PET CT which we are fully involved in. The strategy anticipates significant growth for patients of patients on the cancer pathway. This forecast growth does not include the ongoing research into dementia and medicines development, which will have an additional impact on PET CT scanning.

Between 23/24 and 24/25 there was an increase in new referrals of 5%. This is in line with the predictions demonstrated through the Scottish Clinical Imaging Network (SCIN) and is following the forecast trend.

We have developed plans to meet anticipated demand but have reached maximum capacity, causing longer waiting times and guideline breaches. A short-term solution is to increase the

number of uptake bays to support additional patient throughput, requiring supplementary space adjacent to the PET CT centre. The feasibility of placing mobile uptake bays next to the PET-CT centre will be assessed by 25/26. Without additional uptake bays, throughput will remain at current levels.

Delivery of the whole action plan is dependent on the allocation of additional funding for capital investment and staffing.

8.4.2 Improving Imaging Administration processes

Improvement of administrative workflows will support our ability to continue to prioritise booking USOC and urgent patients, ensuring category 7 and 8 referrals are booked within timelines. Improved cancer tracking and categorisation of imaging referrals will streamline early access to cancer diagnosis, ensuring patients are appointed and scans are performed and reported to support the 31-day cancer pathway.

During 2025/26 we will:

- Continue to utilise the newly rolled out Power BI platform within the cancer tracking team to monitor progress in real time. This dashboard enables input/update of real time information which assists with tracking against due dates and accordingly highlights patients nearing and in breech positions.
- Work towards developing a plan to implement patient focused booking and allow better use of late notice cancelation of appointments in Imaging.

8.4.3 Imaging Workforce Development

Workforce planning and development remains critical to increasing our capacity and ability to provide flexibility and resilience within the service. In 2025/26 we will, with appropriate resource:

- Continue to provide in-house training of Reporting Radiographers including chest Reporting Radiographer which will support reporting capacity and cancer diagnosis
- Continue to provide full training in CT scanning for Band 5 Radiographers across all sectors
- Train Assistant Practitioners to support Digital Radiology (DR) acquisition
- Continue to encourage recruitment to NHSGGC in difficult to recruit to posts in Imaging
- Train Specialist Radiologists in ablation techniques to treat cancer and ensure sustainability of service
- Train Sonographers in MSK and ENT to support cancer diagnosis (this will be dependent on funding)

8.4.4 Renewal of Imaging Equipment to support increase in Diagnostic Capacity

As part of our efforts to increase diagnostic capacity, the renewal of outdated equipment remains a priority for us. A rolling programme of replacement, which includes scoring prioritisation to renew outdated equipment is already in place and will continue.

8.4.5 Imaging Rapid Cancer Diagnostic Service

In 2024/25, we undertook research study (RADICAL) in partnership with Qure.ai to support delivery if the optimal lung pathway. The study detected radiological features of lung cancer on chest x-rays and enabled prioritisation of reporting of those patients, taking the time from initial referral to CT report from 3-6 weeks to around 4 days. The outcome from the study is under evaluation.

The one stop clinic Head and Neck pathway is now operational in all sectors. In the South sector, Sonographer led head and neck biopsy has been implemented. The implementation of the H&N pathway has permitted eligible patients to have waiting time reduced by one week.

8.5 Endoscopy (including new alternatives)

8.5.1 Maximising Capacity and Efficiency

The endoscopy service has benefitted from additional capacity over the last year through the use of the mobile unit and insourcing support to reduce waiting times. There has been a clear improvement for patient management having had this resource given the 4,853 (annual figure) procedures funded at a cost of £4.7 million for the 24/25 fiscal year. It is appreciated that this solution was a costly one and was intended as a temporary arrangement to support the recovery of Endoscopy services and address the challenges related to cancer patient management. Nevertheless, it is imperative that alternative provision for the 4,853 procedures can be generated to replace the loss of the mobile unit capacity. This will remain the priority to ensure a steady state can be maintained in upper GI and colorectal cancer delivery.

The service has put forward a plan to provide sustainable endoscopy capacity in 2025/26, however this is dependent on recurring funding. The base utilisation of endoscopy sessions has improved through an increase in independent nurse endoscopists, and consultant appointments made both within GGC and through the University.

8.5.2 Trans-nasal Endoscopy (TNE)

The service has set out a plan to expand the TNE service across the sites. With capital and recurring revenue investment, this will release sessions currently running in the endoscopy units and increase capacity to allow for the re-provision of activity that is currently being delivered through the Mobile Unit. This is a priority first step to reduce the reliance on the capacity currently being delivered through the Endoscopy Mobile.

8.5.3 Changes to qFIT threshold

In line with the national guidelines, 'qFIT for Patients with New Lower Gastrointestinal Symptoms 2024' changes to qFIT thresholds for USOC prioritisation will come into effect on 3rd February 2025 in NHSGGC. This will ensure that based on the qFIT result patients are prioritised and managed through the appropriate categorisation, ensuring that capacity is targeted towards those at greatest clinical risk and will also reduce the number of patients listed for colonoscopy.

8.5.4 Capsule Sponge Testing

We recognise the impact of this service development. This technology is a minimally invasive way to detect Barrett's oesophagus quickly and early and can be carried out in a clinic environment. This would reduce the number of patients requiring surveillance endoscopy for Barrett's oesophagus and allow resource to be targeted towards those who urgently need care. It is anticipated 1,080 patients a year would benefit from this procedure with approximately 13% of these requiring a follow up endoscopy. Initially this development was funded by Scottish Government. Funding for continuation of this service is required.

8.5.5 Endoscopy Workforce Development

The Endoscopy service has continued to develop the Nurse Endoscopist workforce, with two new trainee nurse endoscopists starting in January 2025. There are expected retirals across the service in 2025 and it is recognised that developing the Nurse Endoscopists will help to maintain service provision. Subject to available funding, consideration will be given to further trainees starting in January 2026.

We continue to support the work of the National Endoscopy Training Programme with many of our endoscopists taking up roles on the faculty. The service has secured places on the training courses run through the Academy which ensures that we have an endoscopy workforce that is appropriately trained and developed. Nurses within our endoscopy units have also benefitted from training sessions, supporting their development and awareness of therapeutic procedures.

8.6 Cancer Care

In the coming year, we will further embed key priorities of the Cancer Strategy for Scotland, 2023-2033. We are committed to progressing rapid cancer diagnosis, optimal treatment delivery and improved outcomes for patients with cancer.

We aim to improve patient centred access to cancer services, with particular focus on challenged patient pathways. We will work across Primary and Secondary Care to progress positive redesign and innovation; and deliver sustainable service provision for the future.

It is important to reflect the additional pressure on cancer pathways from the increased referral rates over recent years as outlined in the tables below.

Figure 10: Increase in Cancer referral rates March 2019-November 2024

	Mar 19	Mar 20	Mar 21	Mar 22	Mar 23	Mar 24
Breast	607	405	865	828	857	841
Gyn	260	187	409	539	1000	868
Colorectal	777	612	1140	1347	1369	1139
H&N	397	257	540	505	530	568
Lung	300	213	278	344	357	242
Lymphoma	48	41	61	65	74	76
Melanoma	561	324	776	882	1041	1028
Upper GI	548	402	623	762	637	606
Urology	353	269	417	584	602	661
Total	**3851**	**2710**	**5109**	**5856**	**6467**	**6029**

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov24
Breast	875	897	756	865	842	723	985	919
Gyn	952	955	849	862	931	859	978	834
Colorectal	1,203	1,238	1,164	1,317	1,208	1,260	1,336	1,301
H&N	578	582	542	604	609	559	638	591
Lung	249	247	195	214	235	175	226	235
Lymphoma	87	110	73	97	79	83	105	108
Melanoma	1,104	1,323	1,411	1,358	1,390	1,232	1,282	1,074
Upper GI	606	655	741	795	752	736	812	830
Urology	601	631	549	518	562	480	632	811
Total	**6029**	**6638**	**6280**	**6630**	**6608**	**5107**	**6994**	**6703**

Despite these increasing demands performance has been maintained across the cancer types with appropriate resource realigned to ensure no detriment to patient management.

8.6.1 Improving Cancer Waiting Times Standards

Recovering performance against the national cancer waiting time standards is a key objective, we aim to achieve over 95% performance for the 31-day decision to treat until first treatment target.

Performance against the 62-day referral to first treatment target remains challenging, with a continued increase in Urgent Suspicion of Cancer referrals, particularly in high volume tumour groups. A suite of improvement actions continues to be implemented with a strategic focus on rapid diagnosis and collaborative working across clinical specialties.

Clinical services will prioritise sustainable waiting time improvement, targeting challenged tumour groups, including Colorectal and Urology. Multidisciplinary work will continue to deliver efficiencies across the whole patient pathway, working in partnership across Acute and Primary Care to ensure optimal referral processes are in place to manage demand appropriately and provide equitable access to cancer care.

We continue to deploy additional capacity, where possible, across cancer pathways with a focus on early diagnosis and access to initial treatment. In particular, we will augment improvements in Urology patient waiting times and will continue to direct patients into appropriate clinical streams; through robust referral vetting and using straight to test processes.

Colorectal diagnostic pathways will be subject to further improvement as we implement changes to Qfit screening categorisation. This will ensure patients deemed the highest clinical risk being streamlined into diagnostic services.

We will continue to support Breast pathways to ensure that we maintain a positive performance against the national waiting time targets. One stop clinic models will be maximised to manage high volume patient numbers and ensure capacity is utilised efficiently.

8.6.2 Embedding Optimal Cancer Diagnostic Pathways

Work continues to further implement Scotland's Optimal Lung Cancer Diagnostic Pathway. This remains a key deliverable and work is ongoing to embed key elements of the optimal pathways. We will work to expand rapid access to key diagnostic tests, to ensure that long term sustainable capacity is available and there is an equitable service for all cancers.

As part of the programme to embed Scotland's Optimal Head and Neck Cancer Diagnostic Pathway, a Head & Neck Diagnostic Hub will continue to be implemented at the Queen Elizabeth University Hospital campus. New Clinical Nurse Specialists have commenced in post and have started their training programme, the impact of this increased capacity will be established across the coming year. The formation of this multidisciplinary diagnostic hub will provide a sustainable, high quality, patient focussed service and will facilitate the

delivery of a model for faster access to initial secondary care consultation and diagnostic testing.

The National Haematuria pathway has been embedded to support the bladder cancer service. This process directs patient referrals into the most appropriate diagnostic pathway and facilitates rapid treatment. The National Breast Pain Pathway has also been embedded, ensuring services are evidence based and are delivered in a patient centred way.

We will also take forward further pathway improvements to enhance diagnostic provision, digital pathology reporting and workforce role expansion.

8.6.3 Improving the Cancer Journey

Our aim is to ensure all people with a cancer diagnosis are supported by a Clinical Nurse Specialist throughout their patient journey to act as a key contact. We recognise the benefits to people using our services of having a main point of contact throughout their patient journey. This single access point allows patients to easily discuss their clinical care; receive advice on their appointments, investigations and results; and feel empowered to input into their own care.

To further improve the patient experience for all patients who are referred with a suspicion of cancer – many of whom do not receive a cancer diagnosis but who, nonetheless, may be suffering from significant physical symptoms and anxiety – in 2024/25, we started embedding Navigator posts within the Lung, Urology and Gynaecology pathways. This will provide all patients with a single point of contact for discussing questions related to their pathway from the point of referral (i.e. pre-diagnosis).

The Navigators support the Clinical Nurse Specialists by managing non-clinical patient queries. Navigators are there to ensure patients receive timely and accurate advice on their appointments, test and results; they also provide patients with information on what non-clinical support may be available for them and their family following a cancer diagnosis.

The Navigator service supports patients from the point of referral. When a referral is received, the patient will often require diagnostic imaging prior to being seen in clinic. The Navigator will liaise with Radiology team to identify and book an imaging slot, following this point the Lung Navigator makes contact with the patient to introduce the service, explain upcoming appointments and what patients can expect at this point.

Contact from the service to patient is primarily by telephone. After the initial introductory call from the Navigator, the patient can make further contact either by telephone or by email via a generic mailbox.

In 2025/26, we aim to finalise recruitment to the Lung navigator posts and complete roll-out of this service to all sectors to match the commitment we have already shown within Gynaecology.

8.6.4 Configuring Services in line with National Guidance and Frameworks

Cancer services are delivered on a hub and spoke model to all West of Scotland residents, with many specialist services also delivered on a supraregional or 'once for Scotland' basis, e.g. CAR-T therapies, donor stem cell transplants, paediatric radiotherapy, pancreatic neuroendocrine tumours (PNET).

In line with the framework for Effective Cancer Management, we will continue to offer local, pan-GGC, regional and national MDTs to support all tumour sites, using team-based approaches to ensure full membership of all relevant clinical professions on a 52-week basis. Patients within our services will continue to be dynamically tracked on an individual basis, and discussed at weekly corporate level meetings, which are led by our Chief Officer and report into all relevant committees.

Our other actions for meeting the eight key elements of the framework for Effective Cancer Management regarding optimal pathways have been detailed above at sections 8.6.1, 8.6.2 and 8.6.3.

Some of the responsibilities for people who are not residents of NHSGGC sit within the HSCPs and NHS Board of residence. This makes the role of our Navigators, Clinical Nurse Specialists and our third sector partners even more important and complex, as patient pathways can involve multiple Health Boards and multiple HSCPs, and our staff have to be able to help our patients to navigate between services.

Ensuring that all of our residents have access to a Holistic Needs Assessment as part of the multi-agency '*Improving the Cancer Journey*' programme is key to putting the individual at the heart of the care provided and supporting all elements of their journey. The Holistic Needs Assessment looks at the physical, emotional, practical, financial and spiritual needs of the individual, and the individual develops a plan with their link worker to address their care and support needs. This also includes signposting to appropriate rehabilitation services, which are delivered across our acute sites and our six HSCPs in line with the six principles of good rehabilitation. We work especially closely with our Third Sector partners within this area of Improving the Cancer Journey, delivering bespoke services within local communities for physical and psychological rehabilitation for people on a cancer journey.

In 2024/25, we started a 14-month project focused on head & neck, prostate, pancreatic and bowel cancer clinical pathways to look specifically at cancer prehabilitation. This project is regional in scope and has a dedicated Clinical lead and two support workers. The main aims are to:

- Identify and map existing services for physical activity, nutrition and psychological support
- Strengthen referral and signposting to these services

8.6.5 National Target Operating Model for Oncology

We continue to support the ongoing national oncology work to support the transformation needed to deliver sustainable oncology services, the WoS and Scotland wide. During 2025/26 we will continue to deliver high-quality patient-centred services which can meet the significant and ongoing increases in demand for solid tumour SACT services, working with our West of Scotland partners to delivery services across a network of 14 hospitals and 5 NHS Boards. We will also continue to support our colleagues in Scan and the Northern Cancer Alliance via both formal and informal mutual aid, ensuring that services are delivered to all of Scotland's residents.

An Oncology Task & Finish Group was convened in 2023 and delivered its interim recommendations in September 2024. It looked at solid tumour oncology and focused on SACT delivery, comprehensively cataloguing the current position of staffing, resources and pathways across Scotland. We continue to experience on going and increased demand for oncology services and it is expected that nationally demand will continue to grow into the 2030's with 5-6% annual growth in radiotherapy and 8-10% annual growth in SACT demand.

During 2025/26 we will continue to participate in discussions to support the development of the detail in support of an agreed national target operating model. This includes governance, operational and clinical leadership considerations that will drive and support the implementation of a sustainable target operating model for oncology services across Scotland.

In addition to the national sustainability work, RCAG has sponsored an update to the extant West of Scotland SACT strategy. This is expected to report during 2025/26.

As part of the development of our 3-year transformation plan, during March 2025 we will identify and confirm the impact of our changes on key performance indicators for cancer care.

8.7 Additional Information

Context

Following the submission of our Planned Care section of the Delivery Plan there have been a variety of discussions with the SG Planned Care Policy and Performance Team regarding further opportunities to enhance activity and reduce long waits. We have set out additional information for the key areas of Planned Care, Diagnostics and Cancer revised activity and

waiting list positions relative to confirmed funding. We also set out proposals for further consideration with SG.

Confirmation has been received with regard to SG funding to support the expansion of Orthopaedic TTG capacity at Gartnavel General Hospital and Inverclyde Royal Hospital relating to the previously submitted proposal document. The details of this activity have been included in the revised templates in line with the written correspondence from 10th of February. For 2025/26 the activity that will be delivered is less than the annual expectation due to the time to establish this activity.

Further consideration has been given to the requirements and potential options for reducing the gap in the previously identified "Red" specialties. In setting these out there is recognition that any staffing proposals will have a lead in time therefore part year effect activity will be noted. Nevertheless, teams have presented a range of proposals non-recurring and recurring that could improve our delivered position by March 26.

The funding to support the Diagnostic mobile units has also been confirmed and the detail of the associated activity has been included in the revised template. For Endoscopy, the mobile unit will not be extended as per the national direction in this regard, however sustainable plans for replacement of the monthly mobile activity remain a priority for financial support in order to maintain the expected activity set out in the 5th of February Delivery Plan submission and plans for offset of the mobile unit have been set out.

8.7.1 Planned Care

Board Assumptions and Points of Clarification

The following table was submitted in the 5th of February summary for activity for base capacity (including a calculated efficiency factor) for 2025 / 2026.

	Baseline activity 2024/25	**Anticipated activity 2025/26 with efficiency**
Outpatients	273,456	284,190
TTG	64,359	69,200
Endoscopy	30,469	31,091
Imaging	127,936	129,228

The revised activity profile for 2025/26 reflecting confirmed funded proposals is as follows:

	Baseline activity 2024/25	Anticipated activity 2025/26 with efficiency and confirmed funded proposals
Outpatients	273,456	284,190
TTG	64,359	70,005
Endoscopy	30,469	31,091
Imaging	127,936	150,521

Points for clarification were set out in the Delivery Plan submission on 5th of February and additional information for some of these are provided below:

- We require to maintain the Mobile C.T. and MRI Imaging units for 2025/26 at an annual cost of £5,891,875. Further to discussions with Scottish Government colleagues it has been assumed that this recurring funding will be made available.
- At this time NHS Forth Valley is unable to confirm Orthopaedic long wait capacity to the level of the original allocation of 1086 procedures due to bed limitations. Specifically, our long waits require a complexity beyond ASA 1 / 2, and we would welcome further discussions around alternatives including FV staff operating within NHSGG&C for a set period. Discussions have been led by the Chief Operating Officer with a proposal developing for a fourth Orthopaedic Elective Theatre at Gartnavel General Hospital supported for three days in the week by NHSFV operators and two days per week by NHSGGC operators.
- The assumption is that NTC capacity at GJNH for non-joint allocation will be no less than the 260 current allocation. We also require confirmation regarding ophthalmology allocation at GJNH as this has significantly reduced by over 2376 procedures in the recent allocation letter. We would ideally request allocation at the same level as 2024/2025.
- No formal notification of non-joint allocations for Orthopaedics has been received, however 260 as a previous allocation has been factored into the waiting list position.
- For Ophthalmology, a proposal for an additional NHSGGC consultant to transfer their sessions to NHSGJNUH has been set out with the intention of two sessions a week being covered for the management of our patients.
- We have assumed no significant demands will be made to support other boards via mutual aid at a specialty level that goes beyond current arrangements. There is no expected change in this position.
- The impact of further changes in cancer and urgent referrals beyond the 2024 demand has not been factored in.

Specialty Assessment for delivery of 52 weeks by March 26 and Key plans

The tables previously shared in the Delivery Plan submission for OP and TTG reflected the initial assessment of the services potential to achieve 52 weeks by March 2026.

- Cat 1 - Outlines those specialties that are expected to deliver 52 week max wait
- Cat 2 - Outlines those that will be within 52 weeks with some degree of additionality allocated e.g. for WLI or temp expansion in EPA's etc, from our access funds
- Cat 3 – Outlines those specialties that will require substantial additionality to achieve 52 weeks. This will require substantive recruitment and or additional NTC / National capacity.

Outpatients

Cat 1	Cat 2	Cat 3
Gastroenterology	Cardiology	Dermatology
General Medicine	Diabetes/Endocrinology	ENT
Oral Surgery	General Surgery (inc Vascular)	Gynaecology
Orthodontics	Ophthalmology	Neurosurgery
Pain Management	Oral & Maxillofacial Surgery	Trauma & Orthopaedics
Paediatrics	Plastic Surgery	Other
Paediatric Surgery	Respiratory Medicine	
Restorative Dentistry	Urology	
Rheumatology		

TTG

Cat 1	Cat 2	Cat 3
Gastroenterology	Ophthalmology	ENT
Orthodontics	Oral & Maxillofacial Surgery	General Surgery
Paediatrics	Other	Gynaecology
Rheumatology		Neurosurgery
		Oral Surgery
		Paediatric Surgery
		Plastic Surgery
		Trauma & Orthopaedics
		Urology

Each of the Specialty teams are working on proposals to reduce the gap. A range of proposals are being worked through with some having a recurring effect and others a non-recurring

impact. It is important to offer a more sustainable reduction in the long waiting patient profile therefore the recurring proposals will be seen as priority delivery. The details shared are proposals presented by specialty teams. There are other potential opportunities for reduction in long waits that are still being worked through with specialty teams.

The summary impact of the confirmed proposals is detailed below at a specialty level with the change in the gap outlined (i.e. the gap figures set out in the initial submission with a new gap number detailed).

Gap description – It should be noted that the gap number may not be consistent with a simple deduction figure. The gap has been derived looking at the anticipated demand for the year minus the activity profile for 2024. The profile of activity that was set against Urgent patient management in 2024 has been taken into account. So too has an efficiency gain against each specialty. Consultant activity only has been accounted for however it is recognised that some of the demand will be picked up by non-consultant activity. What has not been factored in is the entire non consultant waiting list or non-consultant activity. This would significantly skew the gap as what is being worked through is the patients on the consultant only waiting list.

It is recognised that not all of the proposed additional activity will go to the over 52 weeks therefore it cannot be assumed that the same number will give a comparable reduction in the over 52 week patient number.

Total Outpatient ADP March 2026 position for all specialties is expected to be 6107, i.e. 6107 patients who would be over 52 weeks. The identified proposals for the most at risk specialties as in table below would close the gap for these specialties to 704. (n.b. It is recognised that for specialties in the amber category additional activity will be required to achieve the 6107 position)

Specialty	ADP predicted >52 wk position Mar26	Additional recurring funding requirement from ADP version 2 proposals	Additional non recurring funding requirement from ADP version 2 proposals	Proposed additional yearly recurring activity if funded	Proposed additional non recurring activity 25/26 if funded	Total proposed yearly activity if funded	Proposed Activity this would bring in 2025/26 to close gap if funded	Remaining 52 wk gap
Dermatology	12		£535,907.00		4750	4750	312	
ENT	0	£222,807.00	£99,500.00	5397	1060	6457	3160	
General Surgery (inc Vascular)	74		£50,840.00		400	400	400	
Gynaecology	1424	£320,000.00	£820,000.00	7700		7700	720	704
Neurosurgery	310	£614,529.00		1704		1704	940	
Trauma & Orthopaedics	2724	£1,216,883.71	£240,579.20	6366	864	7230	4527	
Urology	167	£253,562.00	£160,000.00	1808	400	2208	1304	
Other	355	£320,000.00	£160,000.00	1227	613	1840	1278	
TOTAL	**5066**	**£2,947,781.71**	**£2,066,826.20**	**24202**	**8087**	**32289**	**12641**	**704**

Total TTG ADP March 2026 position for all specialties is expected to be 17278 for those patients over 52 weeks at the end of March 26. The new identified proposals for the most at risk specialties would close the gap for these specialties to 13718 if fully funded and delivered. (This assumes that all the additional capacity would go to 52 week wait patients)

Specialty	ADP predicted >52 wk position Mar26	Additional recurring funding requirement from ADP version 2 proposals	Additional non recurring funding requirement from ADP version 2 proposals	Proposed additional yearly recurring activity if funded	Proposed additional non recurring activity 25/26 if funded	Total proposed yearly activity if funded	Proposed Activity this would bring in 2025/26 to close gap if funded	Remaining 52 wk gap
ENT	2766	£413,000.00	£189,944.00	696	80	776	544	2222
General Surgery (inc Vascular)	2289	£360,000.00		312		312	208	2081
Gynaecology	2613	£165,000.00	£1,800,000.00	325	450	775	667	1946
Neurosurgery	469	£787,535.00	£150,325.00	290		290	213	256
Oral Surgery	121							121
Paediatric Surgery	717							717
Plastic Surgery	1221	£628,000.00	£158,624.00	235		235	157	1064
Trauma & Orthopaedics	4546	£4,514,436.44	£470,265.31	1317	205	1522	986	3560
Urology	1325	£762,000.00	£473,449.05	612	355	967	785	540
Other	593							593
TOTAL	**16660**	**£7,629,971.44**	**£3,242,607.36**	**3787**	**1090**	**4877**	**3560**	**13100**

Pivotal specialty plans are summarised below in summary format:

Dermatology

The significant USOC and urgent pressure for Dermatology is fully recognised. With consultant recruitment a chronic issue, a peak consultant gap is anticipated with 1.9 WTE consultant maternity leave commencing March / April 25 with an estimate of 2500 new patients' slots and an additional 500 slots minimum loss into 26/27 given accrued leave. Although recruitment of locum cover is being progressed it is not expected to be fruitful. Options for further medical cover will continue to be pursued including locum consultant option for current specialty doctor progressing CESR application.

To maintain the activity of the 1.9 WTE consultants and to reflect the additional sessions needed to maintain 2024 activity levels 370 WLI sessions are required. To cover the identified gap it is proposed that a further 26 WLI sessions are delivered by. This would provide sufficient capacity to cover the remaining 312 gap.

Outpatient Proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Dermatology	To close gap would require 26 WLI x12 patients		£35,186.00	312	312	Immediate
	To maintain current WL position using WLI clinics		£500,721.00	4440		
Total OP			£535,907.00	4752	312	

Outpatients - Expectation of meeting the 52 weeks by end of March with full funding of above.

ENT

The profile of ENT demand and waiting list pressure is reported as a single entity however the challenge for Adult and Paediatrics is different. Similar to Dermatology the profile of consultant recruitment is a picture of compromise particularly at a subspecialty level. Rapid development of CNS staff would offer adult services greater stability of clinical workforce given consultant recruitment limitations. Significant investment in ENT outpatient WLI has been utilised to support the current position. Although ENT appears to have no gap it is recognised that non-recurring investment has to be maintained to ensure no gap occurs.

To ensure no growth of the 52 week position a variety of proposals have been made including pathway changes in adult services for Anosmia; WLI virtual and ambulatory care sessions.

To address Adult TTG gap it is proposed to run additional weekend sessions. It is also proposed that a dedicated specialty doctor is appointed for expansion of tonsil care. Paediatric OPD ENT has been supported through CNS/GP support to release consultant time to support maximum TTG delivery. This needs to be maintained.

The Paediatric TTG challenge would be best supported by investment in increasing theatre resource. A further two full days of ENT consultant operating could be utilised to address long waiting patients. A recurring investment would ensure that a sustained reduction in wait for treatment can be achieved. This however will not close the gap required for TTG. Recognising the time for staff recruitment and training, other options through insourcing or through collaboration with NHSFV could be explored to deliver a non-recurring reduction in 25/26.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Adult ENT	CNS expansion Virtual and pathway change WLIs	£135,562.00	 £99,500.00	4200 1060	2100 1060	6 mths
Paed ENT	CNS and GP support required to maintain current position	£87,245.00		1197		
Total OP		£222,807.00	£99,500.00	6457	3160	

Outpatients - Expectation that 52 weeks will be met in adults and Paediatrics by end of March with the additionality fully funded.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Adult ENT	Specialty doctor 1 WTE for tonsil patient management WLI sessions x42	£118,000.00	 £189,944.00	336 80	224 80	4 mths
Paed ENT	Substantive investment in 4 sessions theatre capacity	£295,000.00		360	240	4 mths
Total IP/DC		£413,000.00	£189,944.00	776	544	

Inpatient/ Daycase - With the proposals above fully funded there remains a significant gap for TTG management. Options for further expansion in Paediatric ENT theatre over and above the two full days is being explored.

Orthopaedics

Within this submission the focus is on elective activity only however it is recognised that particularly in Orthopaedics, there can be regular displacement of elective activity for trauma subspecialty care. In our Orthopaedic plan the impact of this and the requirement to support e.g. subspecialty trauma lists to avoid elective cancellation has been set out. Consideration to fund an increase in trauma provision is an important part of creating sustainable elective orthopaedic provision.

A number of options for reduction of the Outpatient and IP/DC gap are highlighted below and were set out in the National plan submission. Increasing the infrastructure for Outpatient management through the support of APP staff have been fully described in the submission. Expansion of non-spinal and spinal specific APP staff would provide 2265 activity profile within the year 25/26. (An annual figure has been set out and a figure reflecting recruitment time also noted. A reduction has been made from the figure in the national plan to ensure that training time from a more senior role can be allocated to accelerate the delivery from APP staff). It should be noted that some of this activity will cover return patient care.

Additional consultant posts also noted in the National plan across specific sub-specialties and these would have direct impact on the over 52 week patient profile. Inpatient/ Daycase expansion for GGH and IRH have been set out and the related activity of 805 patients for the year 25/26 has been factored into the delivered activity summary table and also to the overall Ortho WL position. Recruitment processes to support these developments have been commenced.

An option for a further expansion of theatre capacity at GGH is now proposed. This will be described as the fourth Elective theatre with the intention that this provides significant capacity for arthroplasty. At the current time theatre nurse staffing, anaesthetic delivery and operator capacity has been factored into an overall costing of £3,418,851. The annual activity associated with this would be 756. However, a lead time of 6 months has been applied reducing the potential activity figure to 378.

Options to generate the appropriate staffing for the fourth elective theatre are being worked through from recruitment to agency staffing options and potential for insourcing staffing capacity. Support from NHSFV NTC team has been suggested with three days' worth of consultant operating time proposed as initial support with NHSGGC operators covering the remaining two days. The costs associated with insourcing would require to be worked through.

Options to generate 6/7 day working at Stobhill Ambulatory Care Hospital have been proposed and will be worked through in more detail for consideration.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Orthopaedics	Additional APP posts	£389,662.00		4530	2265	6 mths
	OPD delivered procedure model	£344,793.00		324	264	2/3 mths
	Elective consultant posts x3	£482,428.71		1512	1134	3/4 mths
	Extension of spinal locum consultant for 12 mths		£160,000.00	504	504	Immediate
	WLI clinics x40		£80,579.20	360	360	
OP Total		**£1,216,883.71**	**£240,579.20**	**7230**	**4527**	

Outpatients - Expectation of meeting the 52 weeks by March 26 with full funding of proposals. There remains a clear subspecialty pressure relating to spinal subspecialty however the proposals assume specific support for this patient group.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Orthopaedics	4 Surgical assistants	£304,360.00				
	Specialty doctor/ middle grade support	£136,980.00				
	Theatre infrastructure including additional consultant activity	£850,745.71	£83,821.31	561	403	3/4 mths
	Extension of spinal locum consultant for 12 mths	Inc in OP		130	130	Immediate
	Saturday GGH WLI sessions x42		£189,944.00	75	75	
	Gartnavel 4th theatre	£3,222,350.73	£196,500.00	756	378	6 mths
IP/DC Total		**£4,514,436.44**	**£470,265.31**	**1522**	**986**	

Inpatient/ Daycase - The additional activity of 986 from the new proposals does not reduce the Orthopaedic gap sufficiently to achieve a 52 week max wait. A gap of 3560 remains. Options for further external support need to be explored to cover the gap. It should also be noted that spinal subspecialty patients are a substantial element of the over 52 week patient group.

Gynaecology

With this specialty under clear pressure from a clinical workforce perspective (currently 5 consultants on maternity leave) there are limited options to support the level of activity required to address the backlog of patients. In the last 18 months successful deployment of insourcing support has benefitted the long patient waiting list. Extension of this contract by 3120 patients over the year would significantly reduce the gap and cost £340,000 to maintain the current position. It should be noted that this level of insourcing supported OPD activity delivery in 2024/25.

Additional WLI sessions would offer non-recurring support of 3500 patients (350 clinics) this would also be required to ensure no growth in the 52 week position.

Additional consultants embedded into the service would offer support to 1080 OPD patients and 325 TTG on an annual basis. A four-month lead in time changes this to 720 OPD and 217 TTG patients. Associated costs with this expansion include additional day surgery theatre and infrastructure costs of £165k.

With an increasing pressure on lengthy waits for TTG procedures a number of options have been considered. With core capacity maxed, options can be explored further to consider potential for an insourcing theatre team to deliver regular Gyn capacity.

Alternatively, consideration could be given to the independent sector for less complex patient procedure management. There are 464 patients currently on the list for Lap sterilisation with 317 of these patients already waiting over 52 weeks. A high-level estimate for these patients to be managed through the independent sector has been made at £1.8m cost based on an average indicative cost of £4k per patient. Other options for clinically supported redirection of patients to independent care are being considered. No direct engagement has been progressed with the independent sector in this regard.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Gynaecology	Insourcing to maintain the current net position includes nursing		£340,000.00	3120		Immediate - maintains current position
	WLI clinics x350		£480,000.00	3500		Immediate - maintains current position
	Additional Consultant x2 permanent	£320,000.00		1080	720	4 mths
Total OP		£320,000.00	£820,000.00	7700	720	

Outpatients - It is imperative that current additionality for Gyn is maintained, all proposals require funding to avoid a worsening position. Despite all these proposals it is not anticipated that Gyn will currently meet 52 weeks by end of March 26. A minimum gap of 704 will remain. The increasing urgent demand in this specialty is a consideration. Options for external support out with those areas of support already utilised will be required.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Gynaecology	Additional Consultant x2 permanent	Inc in OP		325	217	4 mths
	Additional DSU 1 all day (2 sessions) list	£165,000.00				
	Outsourcing of long waiting patients - potential for 450 laparoscopic sterilisation @£4000		£1,800,000.00	450	450	Indicative costs based on UK average
Total IP/DC		£165,000.00	£1,800,000.00	775	667	

Inpatient/ Daycase - There is no internal option for closing the TTG gap. Estimated reduction for 25/26 assumes use of third sector and recurring investment in substantive consultant posts. Despite this a minimum of 1946 patients will remain over 52 weeks at the end of March 26. (It should be noted that there has been continued growth in long waiters in Gynaecology since the initial modelling was undertaken). Other external options for TTG management are required.

Neurosurgery

The substantial gap for this specialty becomes more evident when considered against the subspecialty consultant base. Proposals to develop recurring consultant capacity have been set out with the expansion of 2 consultants to the base at a cost of £376k including infrastructure costs to provide an annual 528 OPD and 210 IP/DC. With a four-month lead time at best this reduces to 352 OPD and 140 IP/DC. The costs of additional theatres to support this activity would be a recurring cost of £713,535 and non-recurring of £150,325 for trays and instrumentation.

With APP's successfully deployed and supporting the management of long waiting patients in the last 3 years it is proposed to expand this clinical staff base by 2 APP staff at a cost £161, 396 to support closure of the gap by 588 patients. (Annual APP delivery is higher at 1176)

Neurosurgery EPA session proposal for extension of endoscopic spinal patient management for 73 additional TTG patients from current consultant cohort could be started from May at £74k to support consultant costs.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Neurosurgery	Additional consultants x2	£376,000.00		528	352	4 mths
	Admin support for new posts	£77,133.00				
	Additional ESP x2	£161,396.00		1176	588	6 mths
Total OP		**£614,529.00**		**1704**	**940**	

Outpatients - With the proposals all fully funded there would be sufficient activity to close the gap however there may still be pressures at a subspecialty level.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Neurosurgery	Additional consultants x2	Inc in OP		210	140	4 mths
	Additional 6 theatre sessions	£713,535.00	£150,325.00			
	EPA consultant changes for endoscopic spinal extension	£74,000.00		80	73	1 mth
Total IP/DC		**£787,535.00**	**£150,325.00**	**290**	**213**	

Inpatient/ Daycase - With the additional theatre funding and additional consultant sessions fully funded there would remain a gap minimum of 256 for delivery of the TTG max 52 week position for the end of March. It should also be noted that the urgent demand in Neurosurgery TTG continues to rise. Other external options should be explored to support reduction.

Urology

With an increasing cancer workload and progression of the urgent demand in particular at subspecialty level, proposals have been shared reflecting the impact of additional medical and APP resource to address the current gap.

A development of the diagnostic hub with appropriate staffing resource would require capital investment and recurring sessional support. £248k of capital cost. The impact of this would be increased efficiency in an outpatient setting rather than theatre setting freeing up physical capacity for development of proposals for TTG care.

The addition of two CNS posts to give 1008 new appointments yearly activity (504 new in 25/26). A proleptic consultant appointment, a further recurring consultant post and a Specialty doctor post could be accommodated to support reduction in long waiting patients.

Additional theatre resource of 2 all day operating lists at £360k would be required to support the expansion in medical workforce. WLI DSU 30 sessions non-recurrently funded for long waiting patients could be delivered.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Urology	Additional CNS posts x2	£135,562.00		1008	504	6 mths
	1x Proleptic Consultant appointment - Prostate		£160,000.00	400	267	4 mths
	1x Consultant post - For Core Urology	Inc in IP/DC		400	267	4 mths
	1x Specialty Doctor - Core and Prostate	£118,000.00		400	267	4 mths
Total OP		**£253,562.00**	**£160,000.00**	**2208**	**1304**	

Outpatients - Whilst the OPD activity would cover the total gap element, the challenge is at subspecialty level given the Andrology subspecialty requirements where there would remain a gap without external support.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Urology	Urology Diagnostic Hub		£246,972.05			
	Additional consultant post x1 and specialty doctor (Inc in OP)	£160,000.00		524	349	4 mths
	2x All Day theatre operating lists	£360,000.00				
	WLI sessions		£226,477.00	355	355	
	RALP 1 additional theatre	£242,000.00		88	81	1 mth
Total IP/DC		**£762,000.00**	**£473,449.05**	**967**	**785**	

Inpatient/ Daycase - With the additional activity that could be delivered being fully funded there would still remain a significant gap to be covered for TTG with subspecialty stone work a particular pressure.

Plastics

The impact of the plastics breast demand was outlined in the previous submission. Support has been confirmed for extension of Locum Consultant breast consultants till the end of March 2026. The related activity info has been submitted. In the main this will not relate to 52 week breacher patient numbers.

Increasing the consultant breast workforce by one substantive consultant would ensure there is a stability in this growing area of challenge.

The skin cancer workload has increased significantly and given this demand takes priority, the current resource that would be aligned to long waiting more general patients is accommodating this additional cancer workload. A consultant for skin cancer management will offset this displacement of elective activity. The TTG position remains compromised however with the additional consultant staff accessing two additional all-day theatres, a

reduction of 157 patients can be achieved with full funding. Non-recurring costs for equipment would be £159k.

Outpatients – The expectation is that Plastics can meet the 52-week outpatient position however there is a significant challenge in Paediatric Plastics thus a rebalancing of consultant sessions will be required to offset the Paediatric risk on non-delivery.

Inpatient/Day Case proposals

Specialty	TTG Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Plastic Surgery	2 additional consultant posts	£320,000.00		235	157	4 mths
	Equipment		£158,624.00			
	Additional theatre sessions	£308,000.00				
IP/DC Total		**£628,000.00**	**£158,624.00**	**235**	**157**	

Inpatient/ Daycase - There is a rising pressure in TTG demand with the urgent activity in 2024 being around 50% of delivered elective activity. It is anticipated this will be an increasing pressure. If the proposals for additional capacity are funded there remains a significant gap of 1064 patient management for delivery of 52 weeks and other internal and external options would need to be pursued for support.

Neurology – identified within "Other"

In the course of the next two years there are three anticipated consultant retirements pending. Ensuring no reduction in activity from the 2024 base is essential. Two consultants are indicating they will progress partial retirement in 25/26. Proleptic appointments to two of the substantive roles are proposed to mitigate the activity loss and provide some additional capacity in 2025/26. In addition, a locum consultant to start within the first quarter would provide additional capacity for the service.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
Neurology	Proleptic Consultants x2	£320,000.00		1227	818	4 mths
	Locum consultant for 1 year		£160,000.00	613	460	3 mths
Total OP		**£320,000.00**	**£160,000.00**	**1840**	**1278**	

Outpatients - With the additional investment it will be possible to cover the outpatient gap before March 2026.

General Surgery

Non-recurring 40 WLI session OPD activity for 400 patients could be undertaken.

The impact of increased colorectal cancer in particular is limiting the reduction in long waiting TTG patient management. An additional two all day theatre lists per week would provide 312 patient procedures (208 for 2025/26) at a cost of £360k.

Outpatient proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
General Surgery	40 x WLI clinics		£50,840.00	400	400	
Total OP			**£50,840.00**	**400**	**400**	

Outpatients - Subspecialty demands are an issue in General Surgery however with additional resource a 52 week max position is achievable by March 2026.

Inpatient/Day Case proposals

Specialty	Proposals	Funding requirement recurring	Funding requirement non recurring	Yearly Activity	Activity this would bring in 2025/26 to close gap	Timescale for delivery
General Surgery	Consultant anaesthetist x1	Inc in Ortho				4 mths
	Theatre operating lists x2 all day	£360,000.00		312	208	4 mths
Total IP/DC		£360,000.00		312	208	

Inpatient/ Daycase - Subspecialty requirements contribute to the challenge in TTG. With the additional theatre capacity being fully funded there still remains a significant gap of 2081 to deliver 52 weeks by end of March 2026. Other options are required to support closing the gap.

8.7.2 Diagnostics

Imaging

The key elements of Diagnostics delivery were outlined in the submission of 5th of February. A clear indication that the Diagnostic imaging plan will be funded in full has been given. It is essential that workforce development is progressed to provide a more sustainable arrangement for service delivery. For NHSGGC the recurring funding to support continued improvement in the national waiting times is £5,891,875. This facilitates 6 months' worth of support utilising the mobile units. The recruitment and establishment of substantive staff is recognised as a challenge and whilst six months has been identified as the period to achieve there is a risk associated with this in terms of availability of staff. The activity in the summary table has now been updated to include the activity associated with the recurring funding.

Funding for staffing the CT POD on a recurring basis could be achieved at a cost of £800k. Achievement of a 6-week maximum wait position and sustainable provision requires additional capacity. The modelling associated with the mobile units and support for recurring staffing for the CT POD is still insufficient to cover all the required activity. There is also anticipated downtime for the replacement of 2 MRI machines in March/ April which will incur downtime, and it is anticipated there will be a replacement of CT machine in this

financial year where the lost activity associated with installation will need to be mitigated. The full detail of additional options for expanding capacity to meet a 6-week maximum wait is being worked through.

PET - CT

Following the 5th of February submission, clarification was sought with regard to the provision of PET CT capacity to support the lung cancer pathway. It is recognised that the target position with the lung optimal pathway is for delivery of seven-day PET – CT. This pathway is being prioritised, and delivery is currently in the region of 10 days. Work is ongoing with regard to a capital development of current services to optimise capacity from current scanners. Progression of this will provide greater opportunity to meet a reduced time to PET – CT for patients in the lung cancer pathway. Feasibility processes and funding requirements are under assessment.

8.7.3 Endoscopy

There has been a significant reduction in the size of the Endoscopy waiting list. This has been further to temporary investment in workforce development together with the use of the capacity in the mobile Endoscopy unit. Prioritising improvement in cancer performance, the focus has been in reducing the wait for investigation in higher clinical risk patients with corresponding improvement noted in colorectal cancer patient pathway.

The DCAQ submission returned to inform the National Endoscopy plan did not factor in a reduction to 6 weeks maximum wait by March 2026. There is further work being progressed to set out all requirements to achieve this target position for Endoscopy.

Addressing the backlog of long waiting patients requires the benefit of longer term and shorter term proposals. The following proposals provide an immediate start to maintaining current levels of activity and will contribute to the reduction in long waiting patients. Offsetting the loss of the mobile endoscopy unit can be achieved through development of the following:

Endoscopy Proposals	Funding requirement	Activity per annum
Expansion of TNE Service supporting closure of the Mobile Unit.	857,347	3,150
Capsule Sponge Testing- improved management of patients with Barrett's oesphagus and reducing demand on	322,939	1,080

surveillance UGI endoscopy releasing capacity.		
Recurring funding to support sustainable delivery of endoscopy capacity through Nurse Endoscopist posts.	793,140	Activity in current base, funding required to maintain this position
Total	**1,973,426**	

It is important to recognise that this activity has already been factored into the modelled activity and waiting list position in the 5th of February submission. The activity related to the nurse endoscopists has also been factored in. Loss of this activity would have a detrimental effect on the current ADP commitment.

It is noted that the National Endoscopy productive opportunities summary notes the following profile for NHSGGC:

NHS GG&C (a)	Backfill fallow session (17 per month)	£ TBC Via Board	Vanguard staff to be job planned to fallow sessions? May need to appoint nurse staff	400 per year
(b)	WLI session – in place of vanguard	£ TBC Via Board	Board to quantify no. of lists required: current backlog: 2971	1500 -2000 per year
(c)	qFIT negative pathway – Demand management		ACRT / time in job plans for north & south of GG&C currently double testing and seeing this co-hort of patients (GGC audit to be explored) 10% -20% achieved in other boards (may need to factor in qFIT funding – double qFIT	2000 – 6000 per year (reduction)
(d)	Cytoscot (sponge) – Surveillance		Creating new capacity - reduce demand: reflux pathway (replacing high risk surveillance with capacity for routine work)	1080 per year

The following feedback should be noted:

- Proposal (a) utilisation of core sessions is included in the initiatives noted above.
- Proposal (b) WLI activity is already in place to a maximum level out with hours thus proposal (b) is not currently deliverable.
- Proposal (c) the gain from changes in the patient management have been factored into the activity/ waiting list position. The estimate as set out is high and as noted, additional funding requirements to support double qFit will be required. A proposal for this will be worked through.
- Proposal (d) noted in NHSGGC table.

We enacted changes to the qFit categorisation during the first week in February 2025 in with new vetting guidelines and education sessions with all vetters. Update sessions were provided to primary care colleagues and new patient and GP letters introduced. The impact of the changes will be seen over the course of 2025/26 with a reduction in patient demand for colonoscopy.

Whilst this change in practice takes effect, it has been agreed that a proposal to support admin and clinical revalidation of the longest waiting patients will be developed based on the new criteria for patient management. The proposal will include a number of clinical sessions to ensure that once reviewed, any patients requiring a clinical appointment including a telephone consultation/ clinic review or colonoscopy, can be managed directly. The expectation is that a validation benefit of 5% minimum will be achieved with a further reduction in the longest waiting patients through the clinical sessions. Full details will be shared in a costed proposal.

8.7.4 Cancer

In the ADP submission of 5th of February key areas for focus to support improvement in cancer performance were set out. A suite of improvement actions continues to be implemented with a strategic focus on rapid diagnosis and collaborative working across clinical specialities.

In the feedback to the ADP submission a number of areas were highlighted for further feedback. The following set outs the updates in relation to these.

a) Cancer – Gynaecology - more information is required to show the wider picture and cervical performance needs more information in the plan

Gynaecology demand continues to present a significant challenge. National pathways for post-menopausal bleeding have been implemented leading to an increase in USOC referrals. Benchmarking is underway with other health boards to seek innovative ways to manage this pressure. In the interim, the service is deploying Outpatient WLIs on a regular basis with

this capacity supporting Urgent and longer waiting patients. Insourcing opportunities have also been utilised to support overall Gynaecology capacity thus supporting management of increased urgent referral rates as noted below.

	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Gyn	260	187	409	539	1000	868	952	955	849	862	931	859	978	834

Enhanced vetting to identify high risk patients for Ovarian cancer now in place, this is streamlining the pathway for those deemed the highest clinical risk. Over the last two years a redesign of colposcopy delivery has been undertaken. Through investment in and the training of specialist nurses, it has been possible to increase the delivery of colposcopy sessions on a recurring and non-recurring basis. The waiting time has reduced significantly and is now two weeks for Urgent care and ten weeks for routine care.

The challenge of balancing urgent and routine care is reflected in the earlier Outpatient and Inpatient/ Daycase TTG sections of the plan. The service has been supported through an increase in substantive and non-recurring investment in workforce direct clinical care in recent years, targeting the expansion of both CNS and consultant session delivery. Regular assessment of demand, capacity and delivery demonstrate a service impacted by a variety of workforce issues and the need to also cover priorities in Obstetric care.

b) Urology – The plan for expediting TP /TRUS

TP/ TRUS plans

Urology are training CNS staff to deliver sessions for TP. Expanding the CNS provision in in the Clyde Sector is the priority. Adding an additional capacity of three TP sessions across Clyde and South through CNS and Consultant delivery could be established and would ensure a further 500 patients could be managed annually.

Whilst these changes focus on TP, by having these dedicated lists for TP Biopsy, it will allow these patients to be managed on these dedicated lists in a timelier manner and should also free up other capacity for diagnostic tests (TRUS) on other lists where these patients are currently being managed.

RALP Backlog clearance

The delivery of Robotic Assisted Laparoscopic Prostatectomy has been supported with non-recurring capacity created at weekends over the last year. This, together with the allocation of additional weekday sessions wherever possible has supported the reduction in the RALP patient backlog and has ensured a maximum waiting time of 42 days. It is recognised that a reduction in treatment time to 31 days is essential.

The Robotic Urology team have been supporting this non-recurring delivery on a less regular basis in recent weeks however the opportunity to deliver WLI sessions will continue to be offered as staffing permits.

Ensuring greater capacity is generated on a sustainable basis is a priority recognising that there has been an increase in the demand that is likely to continue. Reconfiguration of lists in the South and Clyde sectors to move non-Urology RAS activity out with RAS theatre capacity would provide the basis of additional capacity for up to 8 patients per month. An additional full one-day theatre and staffing resource is required to cover this.

c) Upper – GI - how will the qFIT pathway impact this?

Progressing the nationally agreed changes for qFit trigger levels for patient management will remain a priority for the lower endoscopy pathway for colorectal cancer. There is an expected reduction in the patient demand. Creating this capacity will benefit those patients waiting for any endoscopy capacity.

9.0 Improving Women and Children's Health

Key Deliverables in 2025/26

Women's Health	• We will review EQIAs with a focus on gender inequality to ensure the needs of women and girls are considered within any proposed service change or development
Maternity and Neonatal Services	In line with our new Maternity and Neonatal Strategy we will: • Implement the best start neonatal model with revised guidance, staffing and systems to support changes in the care model across neonatal and maternity services • Continue development of maternity systems to support the majority of women to have continuity of carer during their antenatal and postnatal care, with particular focus on increasing continuity of care for global majority women and women living with deprivation and complex pregnancies • Review and reshape our maternity and neonatal workforce including both frontline teams and the clinical risk, practice development, leadership and specialist teams, to ensure a high-quality modern service • Review maternity information resources and prioritise commission of high-volume resources in top 10 languages

Child Health Services	• Continue to work with SG to support the delivery of the National Audiology review • We are working towards improving the completion rates of the 13-15 month, 27-30 months and 4-5 years assessments and reducing the proportion of speech, language and communication concerns reported at 27-30 month development reviews, within available resource • Increase the proportion of child development assessments completed within the assessment window to higher than 2023/2024 • Work to improve awareness of and access to financial inclusion services (for staff and patients) • Support the delivery of Glasgow City Child Poverty Pathfinder and facilitate extension of learning to other LCPAR planning groups
Implementing National Standards	• Progress the implementation of Core Mental Health Standards and Psychological Therapies, Neurodevelopmental and Eating Disorder Specifications • Subject to funding allocation from the Scottish Government, move towards operationalising the regional Child & Adolescent Intensive Psychiatric Care Unit (IPCU).

9.1 Women's Health Plan

We were one of the first Health Boards to progress the action to identify a Women's Health Plan (WHP) lead and work in the past year to deliver the plan has included the revision and publication of gynaecology pathways and implementation of our Menstrual Health and Menopause policy.

To form a complete overview of the health of our female population, further analysis of the Health and Wellbeing Survey was also undertaken. This focused on the reported health of female residents, how this compares to males and how it has changed over time. Key findings include:

- Women's reported health was poorer than that of men, particularly at younger and middle ages and in both deprived and non-deprived areas
- Deprivation had a bigger impact on women's than men's prevalence of long-term conditions, as well as perceived health more generally (specifically mental health)

In 25/26, work will continue to raise awareness of the needs of women and girls as part of planning through our Equality Impact Assessment work (EQIA) alongside public facing work such as contraception awareness campaigns.

9.2 Maternity and Neonatal Services

Our new Maternity and Neonatal strategy approved by our board in February 2025, will lead the direction of travel for these services for the next five years. The strategy aims to continue to implement and embed key areas of the Best Start strategy, including implementation of the new neonatal model of care and increasing continuity of carer.

In 2025/26 our key focus for Maternity and Neonatal services includes:

- Implementation of the Best Start model of neonatal care, with revised guidance, staffing and systems to support changes in the care model across neonatal and maternity services
- Continued development of maternity systems to support the majority of women to have continuity of carer during their antenatal and postnatal care, with particular focus on increasing continuity of carer for global majority women and women living with deprivation and complex pregnancies
- A review and change programme to focus on the development of the maternity and neonatal workforce, to meet changing service needs
- Establishment of systems to support the implementation of the key strategic intents set out in the Maternity and Neonatal strategy

Our strategy sets out eight key areas of strategic intent for our maternity and neonatal services as follows:

Figure 11: Maternity and Neonatal Service Key Elements

Key Elements of our Maternity & Neonatal Service Strategy
1. Delivering personalised, family centred, responsive care, throughout the pregnancy, birth, newborn and family journey 2. Safe high-quality care for all, maximising the potential of specialist services 3. Reducing inequalities 4. Redesigning how we provide the best care for the best value for money 5. Developing our team 6. Engaging with key stakeholders, in particular with women and families, to help shape service improvement 7. Robust clinical governance and effectiveness

8. Public protection

9.2.1 New Pathways for Maternity Care

During 2024/25 we developed our community midwifery caseload holding model as part of ongoing Best Start implementation, to provide greater continuity of care during the antenatal and postnatal periods. This has included the establishment of more community-based clinic venues, the development of individualised midwifery clinic templates and the provision of longer antenatal appointments – the booking appointment was increased during 2023 and 2024 from 60 to 90 minutes and return appointments have increased from 20 to 30 minutes. These longer appointments support midwives to better provide public health advice and support, undertake thorough risk assessments and ensure women are provided with the information and access to support they need to make informed choices about their health and care including smoking cessation, vaccinations and gestational diabetes.

During 2024/25 we introduced a new online model for women to book maternity care, the Single Point of Access (SPA). This included an extensive public marketing campaign. Use of the new online approach has increased steadily through the year, with around 50% of women now accessing our services in this way, rather than the previous model of calling our Central booking system. The SPA is designed to support earlier engagement with maternity care, with provision of the information and forms in key languages other than English and also supports direction of more women to be booked by their named primary midwife at the start of their pregnancy, to embed greater continuity.

The work also included the implementation of a revised model of maternity care, aiming for a greater level of universal care to be provided in community settings, so that women requiring specialist obstetric and other care can receive timely and high-quality care in hospital outpatient services.

The work undertaken so far has led to a steady increase in the proportion of women receiving continuity of care in the antenatal and postnatal periods. We have seen a 10% increase across our teams tracked through our Badgernet digital maternity record, confirmed by a recent survey with women, which demonstrated that 10% more women were indicating that they saw the same midwife for most, if not all their appointments.

Over the next year, we will focus on continuing to build the ability of the service to provide high levels of continuity, through ensuring sustainable community midwifery caseload numbers, and we will also focus on developing continuity of midwifery and obstetric care in the hospital-based outpatient clinics. In 2024 this initially focused on targeted sections of Clyde and during 25/26 we will develop this across the NHSGGC area. Key to the delivery of this will be access to appropriate clinic space within our community settings

There is work underway to increase the use of digital technology to increase the number of clinical appts through Attend Anywhere. This will reduce footfall in outpatient departments as part of the Best Start approach with outpatient clinics in the hospitals being able to target higher risk women in need of specialist input as a higher proportion of universal care will be provided in the community.

The new Parkhead hub opens in February 2025 and the midwifery team have been working to ensure there is good access to clinic space which will further reduce the number of Outpatient appts required in hospitals.

9.2.2 Neonatal Intensive Care Model

We are committed to delivering the new model for delivery of the Level 3 Neonatal redesign and developing a plan to support the implementation. The redesign involves all <28weeks gestational babies to be born and managed in a level 3 Neonatal unit (of which there is currently 3 in WoS) to be centralised to one single level unit in the WoS which has been identified as the Royal Hospital for Children Neonatal unit. This work would also be inclusive of babies born <28weeks who also have a clinical presentation as set out by the Perinatal Network for Scotland.

We have established a number of Best Start work streams looking at key aspects of the work required to proceed with the recommendation outlined above and continue to work in close collaboration with Maternity in planning for implementation. We have proposed a phased approach to this process to accommodate the increase in activity this will bring, and we will educate and train our staff to have the required skills and knowledge to look after these very small babies.

We are working closely with the WoS regional planning to develop a West of Scotland implementation plan. This plan will look to use existing and nationally approved standard operating procedures, guidance documentation and agreed pathways between RHC NNU and all other neonatal sites across the WoS Boards as the plan is implemented.

We will continue to review health inequalities and support our families in Neonatal care with advice and access to supportive teams and agencies for financial and emotional support whilst in our care.

We have been engaging with staff to share information on the process and how we are moving this forward toward implementation, and this will continue during the implementation phase over 25/26 to keep staff as fully informed on progress and next steps. We will also work in partnership with our parents and families to support and improve their experience whilst they are in our care.

We are currently reviewing our model of transitional care and are on plan to progress this in 25/26.

9.2.3 Miscarriage Care and Early Care Pregnancy

In 2024/25 we established a new working group to focus on the work of improving our Miscarriage Care and Early Pregnancy Advisory service. This group will focus on implementing a range of improvements in line with the Lancet series and Scottish Government framework.

Our multi-agency maternity, neonatal and child bereavement group continues to work actively to implement the National Bereavement Care pathways and continue to improve the provision of high-quality bereavement care. Over the last year, this has included a new bereavement project midwife role, leading to a review and redesign of a range of information leaflets for women experiencing any kind of pregnancy loss, MDT training on bereavement care for pregnancy and infant loss and the development of in person midwifery ongoing bereavement support for women when they are discharged home after a pregnancy loss.

9.2.4 Tackling Health Inequalities in Maternity Care

Our work to address health inequalities will include continuation of our work to improve the experience and outcomes of maternity care for the most vulnerable women in our communities, including those living with deprivation and social complexity, asylum seeking and refugee women.

We will continue to identify the health and social needs of vulnerable women through our Blossom service model and access to wider support. We will also continue to work to improve the experience and outcomes of global majority women. Throughout 2024/25, we have undertaken a range of work, collaboratively across professional specialities, community and third sector groups to improve care and experience of global majority women. This has included marketing of the availability of interpreting services, developing exemplary accessible maternity information (Clear to All), education for staff on best use of interpreters and cultural competence, as well as audit of the experience and outcomes of global majority women in relation to a number of aspects of care, including continuity of carer; choice of place of birth and birth planning.

We have established a new Maternity Voices Partnership (MVP) and third sector organisations network, to ensure that we hear the views of all women who use our services to shape and improve them. In early 2025, we will also provide additional training and education for staff in anti-racist and trauma informed approaches to care.

We have also established a very active BAME maternity group, which has implemented a range of actions to measure and improve the care of global majority women. We have an

active action plan, including work to improve interpreting service quality and access, provision of more written information in languages other than English and a focus on increasing diversity in our midwifery and support workforce.

All key service changes have involved an EQIA (equality impact assessment). We have presented this work nationally at a number of forums and have been commended by the Scottish Government Racialised Health Inequalities Network for our groundbreaking work in this area. We will continue to work on this, as part of our wider anti-racism plans throughout 25/26.

9.3 Child Health Services

9.3.1 Delivering High Quality Paediatric Audiology Services

The final report and recommendations for the Independent Review of Audiology Services in Scotland was published in August 2023. We have established a working group with an action plan linked to the recommendations, and a formal reporting structure through our operational and clinical governance structures. We continue to work with the National Project Lead on implementation of the report recommendations and continue to contribute to the works of the National Implementation and Delivery Group.

As part of the recommendations, a key focus for the department will be the review and development of a workforce model to support the sustained delivery of high-quality audiology services. This model will account for the requirement to support the development of extending the scope of roles with links to national training. This will support succession planning and ongoing attainment of CPD requirements within the department. Monthly CPD sessions have also been established. A review of Audiology equipment has been undertaken, and a business case is being prepared for equipment that requires renewal.

Clinical governance structure has been reviewed and continues to progress with an action plan to support this. We will continue to develop and undertake quality measures such as internal audits, whilst also working towards the National Quality Standards in Paediatric Audiology as key priority.

9.3.2 Child Health Reviews for 13-15 months, 27-30 months and 4–5-year-old Children

The revised Universal Pathway (UP) continues to provide an opportunity to assess the child and promote, support and safeguard the child's development and wellbeing. One of our key areas of focus is on programme performance and quality improvement to ensure the maximum impact on children's outcomes from the investment in Health Visiting. Key areas of work that have been initiated and are continuing in 2025/26 include renewing pathways of care for developmental concerns identified at 27-30 months (via Transforming Roles Health Visiting workplan).

Developmental concerns in children at the 27-30 months assessment are high within the GGC area (with nearly 1 in 4 children having a developmental concern). Collaborative work pan-GGC is focusing on actions to address 'speech, language and communication' concerns, given the rise in these concerns and work is also progressing to improve completion rates for the 4–5-year visit to support identification of any new unmet need and action to address pre-school entry and lead to improved outcomes for children.

Work completed to date includes a survey of health visitors to understand needs in supporting children with speech, language and communication concerns, and pilot work in Glasgow City supporting families where health visitors suspect neurodivergence (e.g. autism).

In addition, key areas of focus moving forward will include quality improvement work to encourage completion of the 4- 5-year visit, completion of the antenatal visit, increasing continuity of care, additional HPI recording and compliance with national guidance and improving weighing and measuring of children by Health Visitors. We will also aim attention at further development of pathways for speech, language and communication and ND issues detected by health visitors linked to the SG Early Childhood Development Transformational Change priority.

There are ongoing financial and staffing challenges that impact our ability to fully deliver the universal pathway. Senior leaders actively monitor impact /risk closely via operational and professional routes and oversight of the micro strategy dashboard provides data on pathway delivery. All available mitigations and escalations are in place and HSCP senior management teams, our Board and Scottish Government are sighted on existing challenges.

9.3.3 Local Child Poverty Action Report

Local Poverty Actions Reports (LCPARs) are regularly reviewed to understand and identify good practice to reduce child poverty. Wide support to take forward the actions in the local authority LCPARs include employability and apprenticeship programmes, financial advice for staff and securing funding for co-located financial inclusion services. Work has also been undertaken to embed routine financial enquiry by Health Visiting teams.

10.0 Workforce

Key Deliverables in 2025/26

Workforce Planning	• Finalise the 2025-28 NHSGGC Workforce Plan aligned to the five pillars – Plan, Attract, Train, Employ, Nurture

Health and Care (Staffing) (Scotland) Act	• Continue to reduce agency spend and produce reports for SG as required by the Health and Care (Staffing) (Scotland) Act • Implement activities that underpin assured compliance to the Health and Care (Staffing) (Scotland) Act • Deliver the planned implementation of eRostering, in conjunction with SafeCare for Real Time Staffing and support testing for future use for Staffing Level Tools
Encouraging Attendance and Reducing Unplanned Absence	• Continue to reduce unplanned absence across the organisation by implementing new, and sustaining existing, staff wellbeing initiatives
Health and Safety	• Review promotional and booking systems for face fit testing training (including recording and call/recall), to ensure relevant staff receive testing at required intervals

10.1 Implementation of the Workforce Strategy

Our Workforce Plan 2022-25 is concluding, with our Workforce Plan 2025-28 in late stages of development. The Workforce Plan 2025-28 is aligned to the National Workforce Strategy and reflects the five pillars of the workforce journey:

1. Plan – evidence based, whole system planning to take place
2. Attract – explore alternative routes to recruit staff, incorporating equality and diversity, approaches to domestic and international recruitment as per our Recruitment and Attraction Plan
3. Train – maximise learning and education pathways, develop a digitally enabled workforce in line with our Digital Strategy
4. Employ – focus on T&Cs, fair and meaningful work, professional registration
5. Nurture – improving culture, leadership, staff welfare, inclusion, partnership working such as through the Peer Support and Civility Saves Lives programmes

This is also complemented by the four pillars of our Workforce Strategy 2025-30:

1. Safety, Health and Wellbeing
2. Organisational Culture and Leadership
3. Learning and Careers
4. Recruitment and Retention

We recognise that our workforce is a major driver in ensuring sustainability of services. All workforce related activity will be delivered in line with our Financial Plan and Sustainability

and Value Programme, which will include exploring opportunities for sustainable workforce change linked to the Moving Forward Together clinical and infrastructure plans. The utilisation of the Delivery Plan to seek workforce updates, and the plan to integrate workforce and service delivery is welcomed. The Health and Care Staffing Scotland Act 2019 is also considered in Workforce strategy and planning for the appropriate professions.

10.2 Investors in People

Investors in People (IiP) is an international accreditation for workplace improvement which assesses organisational standards in three broad areas – Improving, Leading and Supporting and supports cultural change. We have successfully attained the IiP standard, marking a significant step in fostering a high performing, engaged, and well-supported workforce, and demonstrating the organisation's commitment to excellence and continuous improvement.

This provides the foundation for continual growth as an employer over the next three-year cycle, striving for the higher levels of the IiP standard, aiming for silver, gold and ultimately platinum in years to come. The plan and milestones for maintaining momentum, further embedding and building on existing initiatives, and building towards achievement of higher levels of the framework in 2025 have been agreed by our IiP Steering group, and implementation for 2025 has begun. By investing in the workforce with the next phase of IiP implementation, in line with our Workforce strategy, we will ensure we remain a healthcare employer of choice, driving staff resilience, wellbeing, performance and high-quality patient care.

10.3 Planning Priorities

10.3.1 Achieving further reductions in agency staffing use and optimising staff bank arrangements

We remain committed to the further reduction in Nursing and Midwifery agency spending in HSCP and Acute Services. The use of Premium Rate Agency resources was eliminated at the end of 2023, evidenced in our legislated quarterly reporting under the Health and Care (Staffing) (Scotland) Act 2019. The use of Standard Rate Agency resources is governed by an agreed set of monitoring and control measures, with specific documented approval processes in place for the use of any agency resource. Executive level sign off is required for all agency resource deployment and usage is now at minimal levels. The level of prescription of one-to-one Mental Health care for patients within an acute setting has resulted in an ongoing resource pressure resulting in continued use of agency Registered Mental Health nurses. This accounts for 85% of all remaining agency use.

Effective recruitment activity, a focus on the recruitment pipeline and increased stability provided by a reducing annualised turnover rate has assisted in the increase of the Band 5 Registered Nursing establishment over recent years. Calendar year 2025 commenced with

92.7% Band 5 Establishment and 94.3% Registered Nursing Establishment, providing a solid foundation to maintain this reduction in agency use.

We have the largest Staff Bank provision in Scotland and operate an efficient, adaptable model. We are progressing with arrangements for using the Staff Bank in the Estates and Facilities directorate. This will provide greater capability to flex and meet demand throughout the year and enable a reduction in agency and overtime spend in this area.

As part of a West of Scotland procurement exercise, we introduced a neutral vendor arrangement covering the engagement of all Nursing, Midwifery and Allied Health Professional and Healthcare Scientist resources. This agreement will increase the amount of direct engagement of agency workers and will help drive down the rates paid by influencing the supply chain.

10.3.2 Achieve Reductions in Medical Locum Spend

We operate the Medical Staff Bank for the West of Scotland and are committed to the reduction of Agency/Locum spend in all services. We are focused on reducing the reliance upon additional doctor in residence shifts as a supplementary workforce. The use of supplementary medical shifts to close roster gaps is unfunded and the financial impact is growing as we look to backfill the gaps created by less than full-time National Education Scotland (NES) funded trainees. A review is underway aligned to reducing resident doctor spend.

At the beginning of 2023, agency use was greater than 280 shifts per week representing over 30% of all Medical Bank shifts. In 2024, this was reduced to circa 150 shifts per week accounting for 24% of Medical Bank shifts. The key focus on reducing this spend is to achieve Establishment position in all roles. This will be supported by continuing to recruit doctors to our Medical Bank and thus provide additional resources for key areas. In addition, a focus on team service planning will ensure that all job planning is complete and that job plans satisfy the agreed policy.

Over 75% of workers are now coming from the Medical Staff Bank rather than agencies. Agency workers are being replaced with bank workers where possible, with the only remaining high-cost agency workers being Consultant Psychiatrists, where hard to fill vacancies persist on a national basis.

10.3.3 Increasing Efficiencies across Administrative and Support Services

We value all our support teams and recognise there are opportunities to deliver more efficient ways of working through maximising the use of technology and removing any unnecessary duplication. We have a Sustainability and Value initiative in place, and directors have identified further opportunities that can be made in this regard. Any change

programmes will be progressed in partnership with our staff and trade unions through our Workforce Change Policy.

We plan to build on our existing digital systems to maximise potential, as well as explore opportunities for new technologies to increase efficiency for example staff having access to the national Microsoft365 'Skills Hub', outlined in more detail in the digital & innovation section of our delivery plan. The use of digital tools aims to maximise efficiency in administrative and support services to ensure the workforce in this job family is equipped to work productively, and to allow teams to balance requirements for support staff with the needs of clinical areas.

10.3.4 Supporting Employees & Implementing the NHS Scotland Attendance Policy

Sickness absence is an ongoing known challenge throughout the year which impacts staff availability. Sickness absence for 2024 was 7.5% (3.2% Short Term and 4.2% Long Term). This peaked at 8.3% (3.7% Short Term and 4.6% Long Term) in December 2024. Calendar year 2025, has commenced with 8.2% (3.7% Short Term and 4.5% Long Term) sickness absence in January. Action plans are in place for each area and at Board level to reduce levels of sickness absence to 6% by March 2026.

All areas of the organisation are supported with detailed reporting providing visibility of those with any periods of absence, absence reasons and volume of absences over agreed periods. This reporting is published on a daily, weekly and monthly basis, enhancing monitoring and supporting a reduction in absence. All directorates have agreed action plans and target trajectories. All long-term sickness cases have been reviewed. Additional HR support is offered to those managing sickness absence cases, to ensure that cases progress, in line with the Attendance Management policy.

Additional actions introduced include:

- Depute Director of Human Resources will regularly review all absences over 12 months to ensure appropriate actions in place to progress in line with Attendance policy
- Absences that reach 9 months require plans in place to support return to work.
- Heads of Human Resources to review all long-term cases over 120 days fortnightly to ensure appropriate progression in line with the Attendance policy
- Our Stress Toolkit was relaunched in January 2025 and has been mandated to be used in all stress related absence cases. Human Resources undertake spot checks every month and provide feedback to managers on absence records and completed return to work paperwork to ensure compliance with Attendance policy
- A performance management approach led by the Directors and Heads of Human Resources to review the worst performing areas each month to discuss additional actions required immediately.

Mental health related absence remains the leading cause of sickness absence in the organisation, with 28% of all sickness recorded against this category. To help address these absences, the Staff Health Strategy 2023-2025 has a number of actions that are being delivered to support and improve staff mental health and wellbeing. The importance of improving staff mental (and physical health) is reflected within the four strategic objectives identified within the Strategy:

1. Strengthening support for mental health and wellbeing including stress
2. Promote NHSGGC as a fair and healthy workplace in line with Fair Work Nation principles
3. Address in-work poverty and promote holistic wellbeing to mitigate inequalities in health
4. Support for managing attendance

There is a wide range of work ongoing to deliver on these priorities, including support around stress, mental health, bereavement, menopause, and physical activity. This includes delivery of an evidence based, high quality Occupational Health Psychology and Mental Health team and a single point of entry into the service to make it easier for staff to access the support that they require.

An early intervention sickness absence pilot is now underway and being delivered by the Occupational Health Psychology and Mental Health team. This pilot programme uses a proactive and reactive approach in agreed areas of high sickness absence due to mental health. This includes proactive education and support aimed at improving staff wellbeing and reducing the risk of future sickness absence as well as reactive early intervention if someone in this area goes off sick due to a mental health reason. The aim is to reduce sickness absence in the short and longer term and improve staff wellbeing.

In addition, all members of the workforce have access to a range of services to help support and manage their mental health. These include:

Direct support

- OH Mental Health Nursing – 1,100 appointments undertaken between January and December 2024
- Occupational Health Psychology support – there have been 1,370 referrals between January and December 2024
- In 2024 90-158 OH Psychology referrals were received per month; in January 2025 89 new referrals were received
- Allocations meeting introduced towards the end of 2024 and continues in 2025. This new process ensures staff requiring OH mental health and psychology support are

allocated to the most appropriate treatment e.g. a treatment group, 1-1 psychology input, CBT, counselling, guided self-help, digital therapy or mental health nurse input

- 71% of the staff who attended psychology sessions and who were off work had returned to work on conclusion of the therapy
- Of the individuals who were in work at the beginning of therapy, 98% remain(ed) at work throughout therapy
- Introduction of two evidence-based psychology treatment groups during 2024: The Compassion Mind Skills Group which is aimed at addressing issues of staff burnout; and The Coping with Anxiety Group which is a Cognitive Behavioural Therapy based group looking to develop understanding and self-management skills for those faced with stressful situations
- Critical incident support developed and introduced– feedback has been positive. In 2024 the team responded and provided input following 37 critical incidents
- The OH Psychology and Wellbeing Team are developing 'Post-acute incident reflective spaces' for staff after a significant incident but in the post-acute' phase, where a reflective space for staff will be provided after a traumatic incident

Training & Learning Resources

- LearnPro module – introduction to psychological health and well being
- Online staff health and wellbeing resources (HR Connect)
- Updated Staff Mental Health and Wellbeing Z card available – listing sources of support and how to access these
- Mentally healthy line manager training, stress awareness sessions and mindfulness
- Almost 5000 staff have completed the 'Looking after Yourself and Others' Module
- Active Staff Programme offers a mixture of face-to-face and virtual classes as well as Walking Challenges and other activities including sports such as Badminton. Annual engagement of 7600 staff per year with these activities. Upcoming taster sessions for Pickleball and Line Dancing being planned. Evaluation shows staff report improvements in both physical and mental health in relation to participation in an Active Staff activity.

Peer Support

- Provision of staff training to become a Peer Supporter using a Psychological First Aid Model
- Introduction of Peer Support Hubs including:
  - Bereavement Hub
  - Menopause Hub
  - Medical Hub
  - Carers Hub
- Peer Support framework continues to evolve with 786 trained Peer Supporters in place across the Organisation

- Pilot planned in a site-specific Hub of low level 'emotional diffusion' training, which is a form of psychological first aid to support individuals or small groups of staff who have dealt with a difficult event in their working day
- Health and wellbeing groups (previously HWL) undertake a wide range of initiatives to support staff in local areas

Specific Services

- 'Let's talk' webinars are ongoing, with topics including stress, anxiety, menopause, women's health, smoking, bereavement, and physical activity run monthly with 665 staff attending a webinar in 2024. Since commencement of the webinars 2,400 staff have signed up
- Over 700 staff in 2024 have attended virtual menopause staff support sessions run by our menopause specialists as part of the 2023-2025 Staff Health Strategy; in addition, smaller monthly group consultations for staff affected by the menopause have been running to capacity and led by the same menopause specialist. These sessions have formed one part of a wide range of support for Women's Health.
- Further virtual menopause staff support session running February 2025 and monthly group consultations in place for 2025
- Staff Witness Support for staff attending formal hearings such as public inquiries, fatal accident enquiries, court proceedings - these will continue throughout 2025

10.3.5 Implementing eRostering

In Autumn 2023 the eRostering programme was brought into the wider Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) Programme as one of the enabling workstreams, as it completed its Project Initiation, Readiness, Deployment and Adoption phases for the Early Adopter areas at Inverclyde Royal Hospital. Resources were provisioned to support the initial business change and roll out of the eRostering application.

The rollout has been planned to prioritise areas that can adopt the system within the funding made available in the Financial Plan. Further resource will be required to support the wider rollout due to the continued lack of interface between the current eRostering product and NHS payroll systems. Resource for double entry was not expected at this stage in the programme and has been modelled in line with other Health Boards who have already demonstrated the need for such additionality.

Our Staff Bank are engaged alongside SSTS and Payroll on the configuration of key systems, including the instances of RL Datix systems already in use. This is designed to ensure optimal integration to maximise the benefits of the eRostering project. Subsequently, in 24-25 the rollout of Optima has continued in Clyde Sector Nursing and Midwifery, and for Emergency Department Medical Consultants in the QEUH.

Additionally, the broader Optima product suite incorporating SafeCare from RL Datix is now becoming the new / replacement system for Staffing Level Tools (currently in legacy SSTS system) as legislated in the Act and the HCSSA Real Time Staffing duty. The continued learning from the current users of eRostering in Clyde, as well as learning from other Health Boards who have, or are rolling out SafeCare as their Real Time Staffing solution, has been used to inform an options paper, providing recommendations on implementation of the Optima suite of systems (HealthRoster and SafeCare) by end of March 2026. We continue to support HIS in the testing of Staffing Level Tools in the new system.

The implementation of SafeCare ensures we can work towards improved assurance and compliance with HCSSA legislation. This dual implementation approach allows us to support further reducing additional spend on temporary staffing and being able to fully realise any system benefits. Utilising our provisioned budget for eRostering and proceeding with roll out and testing followed by rapid deployment of SafeCare across two integrated workstreams allows the continued implementation of Optima whilst rolling out a robust Real Time Staffing solution as required by the HCSSA.

10.3.6 Working with Further/Higher Education Institutions (F/HEIs)

We have regular collaborative operational and strategic meetings held with F/HEIs that ensure compliance with regulatory, statutory and professional standards and quality assurance frameworks for nursing and midwifery education. This meeting infrastructure provides active forums through which areas of workforce education and development can be identified, explored and addressed, for example pre-registration nursing and midwifery programmes. HEIs provide post-graduate training, in line with Scottish Government and regulatory requirements, and work with us to ensure that programmes are flexible and support trainees to develop the competencies that our services need. Examples of these include the Specialist Community Public Health Nursing, District Nursing, Advance Nursing Practice and Non-Medical Prescribing programmes.

These meetings provide an opportunity to ensure educational curricula are aligned with our organisational strategies in response to changing health needs. The development of curricula involves our staff at every level of project development and presents opportunity to discuss and contribute to the leadership and management of educational programmes.

We also collaborate with F/HEIs in the development of new roles to support new pathways to support service delivery, e.g. Assistant Practitioner, Assistant Perioperative Practitioner, and Graduate Operating Department Practitioner.

10.3.7 Face Fit Testing & Preparedness

A range of initiatives are in place to support our preparedness for current and emerging threats, including the provision of appropriate PPE (and training for relevant staff to ensure competent use). Whilst each service is responsible for identifying and training staff who

need to be face fit tested, our Safety Health and Wellbeing (SHaW) team have Trainers and regularly scheduled training sessions taking place to support capacity building for face fit testing in departments/services.

As well as the work underway to develop existing systems to improve the robustness of fit testing programmes, the SHaW team will also continue to engage (via national H&S Heads of Service meetings) on "Once for Scotland" policies and procedures.

11.0 Digital & Innovation

Key Deliverables in 2025/26

Digital Strategy	• Redevelop business intelligence infrastructure to maximise benefits from M365 • Continue to support shift where appropriate to virtual appointments at scale • Digital contact centre and telephony transformation • Health Records transformation programme to maximise efficiencies through digital approaches
Digital Priorities	• Implement a new remote monitoring and management platform to support remote patient management and the establishment of our new 'Virtual Hospital' • Roll out digital appointment notifications via Patient Hub • Support further Cancer MDTs with the successfully proven in-house application development • Procure replacement cornerstone Community System • Implement Dental Charting System • Progress our 'Enabled by AI' Programme including the use of AI tools to predict patient clinic DNA, LoS, risk of readmission and the use of Robotic Process Automation (RPA) to support efficiency • Prepare for implementation of new Laboratory Information Management System
Digital Literacy	• Grow Digital Literacy & Skills Programme focus into core skills for existing 'cornerstone' clinical IT systems

11.1 Digital Strategy

'Optimise use of digital & data technologies in the design and delivery of health and care services for improved patient access'

A core principle of our Digital Strategy 2023-2028 – Digital on Demand is to maximise the benefits of technology and in line with MFT Programme, maximise the opportunities for virtual and remote care using digital channels for patients.
We will deploy digital technologies to modernise services and facilitate patient engagement with health and social care services.

We will innovate and exploit the potential for digital technology to transform service delivery and measure the benefits to track our progress. We will achieve this while supporting and training staff, to ensure they have the necessary skills to use the digital systems they need to maximum potential. We will build on our existing digital tools and implement new technology to maximise value, for example, virtual pathways including appointments, and remote care of patients to support earlier discharge from hospital where appropriate. We will design for digital equality from the start, including Equality Impact Assessments for individual programmes, and the requirement for non-digital alternatives where needed to avoid digital exclusion.

We will support clinical services to expand the reach and grow the uptake of virtual consultations and implement virtual wards with supporting technology. The Patient Hub will be rolled out further, to enable citizens to access services and manage their appointments electronically, while reducing environmental impact and the costs of paper and postage.

We will continue to support our recovery plan by providing data, information and live dashboards to help clinical services monitor and optimise the delivery of planned and unscheduled care. We will work with Mental Health to support the Child and Adolescent Mental Health Services, and Psychological Therapies National Dataset (CAPTND) and associated reporting.

New digital tools to support a Health Records Transformation Programme will be implemented including updated telephony, contact centre technology and software to replace manual, paper-based processes.

11.2 Digital Literacy

The Digital Delivery Plan includes a Workforce Digital Literacy & Skills Programme. The scope of the programme will include learning and education for staff to use existing and emerging digital tools, to ensure that maximum benefit is achieved. All our staff have access to the national Microsoft365 (M365) 'Skills Hub' which provides guidance, as well as access to training on the M365 toolset. We will continue to build the library of learning resources, improve signposting, and develop new opportunities to support staff in getting maximum value from M365 and clinical systems. We will engage with NES to maximise development and sharing of learning resources.

In addition, a series of digital learning sessions will be delivered, targeted to specific staff roles, to deliver learning and training for specific topics including, use of data, dashboards and reporting and clinical systems.

11.3 Digital Priorities

Figure 12: Digital Priorities

Virtual Consultations	eHealth will continue to engage with clinical specialties to identify and remove any digital barriers to increasing uptake of virtual consultations for patients. This will include analysis of performance data to identify improvement opportunities, configuration of TrakCare and other clinical systems to better support virtual appointments, providing required equipment and access to the required tools and systems, benchmarking and ongoing monitoring
Remote Monitoring	We will implement a new remote monitoring platform to support earlier discharge, reduction in length of stay and admission avoidance for patients in hospital. This will align with service redesign for our virtual wards / hospital at home programmes
Digital Dermatology	Following implementation in 2024/25 of the new national Digital Dermatology system, the benefits of sending a digital image with the GP referral will be rolled out across all HSCP areas.
Patient Hub	Following pilot and evaluation of the 2 pilot specialties, the Patient Hub will be rolled out further. The Hub enables patients to access their appointment information including leaflets digitally and to communicate with our Referral Management Centres on the digital platform to help manage the patient's appointment. Further trials of online appointment booking will be undertaken during 2025/26
Urgent Care	Further opportunities for digital technology to support Urgent Care will be implemented including the pilot of a redirection app for use in Emergency Departments and digital tools to support the avoidance of admissions and a redesigned FNC.
Workforce Data Analytics	We will use existing M365 development tools to maximise opportunity for data and analysis. The Workforce Project will focus on fully migrating all services from a range of data sources to the new Azure Fabric Cloud Structure and replace the Excel Spreadsheet distribution of data with new Power Platform and Power BI Structures.

GP IT System	Dependent on position of the national supplier, the planned implementation of system migrations will recommence (see also section
Dental	A new Dental Electronic Patient Record charting system will be implemented and integrated with cornerstone systems, so further building our oral health digital patient record and processes.
Ophthalmology digital patient record	We were an early adopter with implementation completed in December 2024. 2025/26 will focus on benefits realisation
Laboratory Information System	We will continue to prepare for the implementation of a new Laboratory Information Management System (LIMS) following the implementation of our new NHSGGC Laboratory Managed Services Contract which includes replacement analysers and infrastructure; implementation is scheduled for 2025.
Enabled by AI	The Digital Enabled by AI Programme will be implemented to include integrated tools within the Patient Management System (Trakcare) predicting patient DNA, length of stay and risk of readmission within 30 days. Implementation of Robotic Process Automation (RPA) tools to support efficiency and productivity.
Network and Cyber Security	We are fully committed to ongoing compliance with the Network and Information Systems regulations in accordance with the refreshed Scottish Government Public Sector Cyber Resilience Framework and has completed the 2023 audit cycle.
Corporate Records Management	Implementation of a business classification scheme and associated document labelling followed by move to SharePoint Online. This will improve the management of corporate records and have associated cyber security benefits

11.4 Digital Innovation

We will build on our leading role in the innovation space, to transition key programmes to "business as usual", and maximise benefits by rolling out more widely. We will continue to refer proven innovations with national potential to the Accelerated National Innovation Adoption (ANIA) pathway, and support ANIA adoptions where business cases are agreed. We will further progress our experience of Artificial Intelligence (AI) research and innovation into operationalisation focused on corporate priorities, and development of an organisation

strategy for AI including use within non-clinical areas of work, for example discharge planning.

11.5 Analysis of Digital Maturity Assessment

The 2023 Data Maturity Assessment (DMA) report showcased areas of our good practice and progress which will be sustained. It further highlighted the importance of: workforce digital skills which our Digital Literacy & Skills Programme seeks to progress; digital operating models where for example our implementation and rollout of Nursing Digital Clinical Notes will continue; rich intelligence capabilities which we will continue to support through business intelligence platforms and analysis; and the need to continue functional upgrades of core digital capabilities where in 2025/26 we will prepare for TrakCare new user interface and Community System re-procurement.

11.6 Adoption of New Clinical Innovations

In support of the Health and Social Care Reform agenda we are committed to adopting new innovations e.g. genetic testing to deliver improved clinical outcomes and target medications. For example, supporting the roll out of target medications for recent stroke patients, newborn babies with bacterial infections. We will continue to collaborate with national teams to develop a national digital intensive weight management programme designed to put type 2 diabetes into remission, as referenced in section 4.2.

In addition, we will progress innovative programmes of work with partnered support from Research and Innovation to maximise the collaborative potential with industry, academia and health and social care. This includes facilitating access to the significant digital pathology resource for projects developing a foundation model of AI for pathology triage, for lung nodule management and for prostate cancer diagnosis. Building on previous AI imaging projects, we will evaluate the overlay of multiple AI tools for supporting clinical pathways, such as referral from ED for breathlessness. We will also advance evaluation of the use of pharmacogenomics testing at scale, specifically for reducing adverse drug reactions and treatment failures across 15 different medicines.

12.0 Climate & Sustainability

Key Deliverables in 2025/26

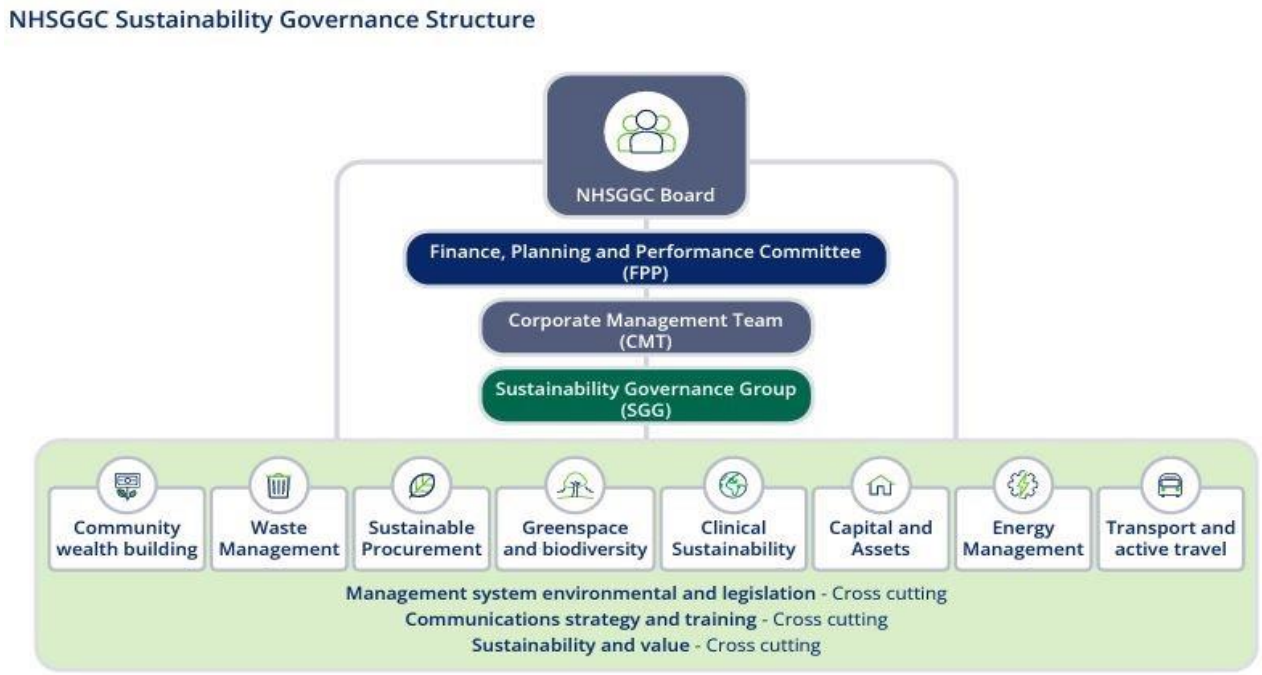
Sustainable Transport and Active Travel	• Grow electric vehicle fleet and progress alternative fuel objectives for existing fossil fuel diesel vehicles. Subject to budget availability, accounting for limited funding opportunities • Decarbonisation software installation, delivering increased monitoring of efficiency

	• Further develop telematics in fleets to monitor use, mileages and Co2 emissions • Promote Public Transport networks and usage across the GGC area e.g. Cycle to work, walking and pool car schemes
Waste Management	• Achieve and improve ScotGov non-clinical waste recycling target of 70% by 2025 • Implement new General Waste & Recycling Contract
Clinical Sustainability	• During 2025/26, system wide approach to implementing actions from the National Green Theatres Programme (NGTP).
Energy Management	• Produce Decarbonisation Plans for large acute sites • Identify opportunities for renewable power generation at major sites • Progress installation of renewable technologies to reduce carbon emissions • Deliver on carbon reduction target for 25/26 (target to be set once 24/25 carbon data available in APR 25)
Greenspace & Biodiversity	• Utilise previous years mapping exercise of greenspace resource to identify opportunities to expand provision, maximising beneficial use. Widen the scope of the estate mapping exercise so data can used to address strategic aims and objectives such as climate change mitigation and to promote more informed targeting of funding. • Allocate £250,000 block grant funding to appropriate greenspace & biodiversity projects. To increase impact, funding criteria will be expanded beyond mandatory requirements to include consideration of how a project contributes to strategic aims and objectives such as climate change mitigation and resilience and strengthening community links.
Environmental Management System (EMS)	• Develop strategic intent documents, with focus on Waste Management key requirements and Statutory Combustion Permitting to effectively manage environmental risk through centralised and controlled documentation.

12.1 Climate Change & Sustainability Strategy

The delivery plan objectives are woven throughout our Climate Change & Sustainability Strategy 2023-28. The strategy breaks down the long term 2038 & 2040 national targets into a five-year mobilisation period. This is underpinned by a comprehensive governance framework which has been established to deliver national outcomes and targets in line with the NHS Scotland Climate Change and Sustainability Policy (DL38) ambitions. It also supports the growing statutory auditing and reporting requirements required as part of our wider corporate governance obligations. The governance structure can be seen below:

Figure 13: Sustainability Governance Structure



Each of the working groups above has developed a charter which details their 5-year plan and contributes to the overall ambition of the strategy. A summary of the relevant sections is detailed below:

12.2 Sustainable Transport & Active Travel

Management of our leased, hire and owned vehicles, and the promotion of active and sustainable public and/or private transport options, is overseen by the Transport and Active Travel Group. As part of their remit, the group has exceeded targets for fleet decarbonisation of small and medium vehicles, supported by installation of decarbonisation software in 2024/25. We will continue to work towards Scottish Government targets for 'net zero' including further transition towards alternatively fuelled vehicles delivered in line with available resource, however this could be accelerated with additional funding. Further development of fleet telematics will allow increased monitoring of mileage and CO2

emissions. Promotion of public transport networks and the cycle to work scheme will continue.

12.3 Waste Management

Waste minimisation and the enactment of circular economy principles, across all waste streams will continue to be a priority in 2025/26. The main objectives will include increasing existing Dry Mixed Recycling (DMR) across all facilities and the enhancement of clinical waste segregation through Pre-Acceptance Audit (PAA) process to minimise clinical waste disposal, resulting in cost containment and emissions associated with clinical waste treatment. We will continue to facilitate collaboration and exploration of new avenues for financial and non-financial savings related to waste management.

12.4 National Green Theatres Programme (NGTP)

NGTP is a key component of our NHSGGC Delivery Plan. Our Clinical Sustainability Group oversees implementation of actions released by the Centre for Sustainable Development (CfSD) from the NGTP. These actions have been designed by clinicians and multi-disciplinary professionals to reduce any negative impact on the environment, whilst leading to significant financial and carbon savings. The key actions of the NGTP include reducing use of potent anaesthetic gases, sterile gloves and battery-operated appliances, and getting the best efficiency out of heating, air-conditioning and ventilation systems, whilst making carbon savings.

12.5 Energy in the Built Environment

The Energy and Built Environment Group collaborates with Estates and Facilities and Capital Planning and sets policy, benchmarks, and annual carbon reduction targets. Sustainability & Value (S&V) Net Zero initiatives are supported providing both carbon and financial savings. In 2025/26 decarbonisation pans will be completed for major sites and installation of renewable technologies will reduce carbon emissions. Further opportunities to develop large multi-stakeholder capital schemes to deliver heat and power decarbonisation will be explored within available resource.

12.6 Greenspace & Biodiversity

The Greenspace and Biodiversity Group, governs initiatives designed to support and contribute to enhanced biodiversity, climate change adaptation/mitigation and a reduction in air and noise pollution, in line with our Climate Change & Sustainability Strategy, Scottish Government's climate change targets, and the Scottish Biodiversity Strategy. High quality greenspace complements and enhances our built envirnment by supporting improved physical, and mental health and wellbeing for patients, staff and visitors, offering wider community wealth building and socio-economic benefits. These spaces also present opportunities for species diversity, climate change mitigation and a reduction in the effects of extreme weather events. All these factors have a direct or indirect bearing on the utilisation of our services and facilities through their relationship with public health, service resilience and building design and maintenance. In 2024/25 a greenspace resources

mapping exercise was completed and this will be utilised to identify opportunities of maximum benefit. Block Grant funding will be allocated to optimal greenspace and biodiversity projects.

12.7 The Environmental Management System (EMS)

The EMS continues to be implemented within the scope of the Estates & Facilities Directorate, as part of a broader compliance-based, integrated management system approach, to underpin corporate governance for the Directorates activities. A hierarchical structure was established to support a top-down and bottom-up approach, incorporating the creation of documents that outline the organisation's strategic intent and governance arrangements.

A methodology has been introduced to identify significant environmental and associated organisational risks, which will be recorded as part of the Management System. Pilot implementation will focus on Waste Management compliance key requirements, to ensure that the plan, do, check and act ethos of International Organisation for Standardisation (ISO) standards is reflective and suitable and sufficient in its wider roll out. This is expected to build compliance with environmental legislation, reduce impacts to the environment and reduce resource use, minimising the financial and reputational exposure to non-compliance, and over consumption of resources.

13.0 Summary & Conclusion

Our Delivery Plan sets out how we will deliver both our priorities in 2025-26 and our vision to transform how we deliver care over the next 3 years.

2025/26 will be an exciting and challenging period for us as we continue to implement our programme of transformation and harness the opportunities of the NHS Scotland Reform programme.

We remain indebted to all our staff across our health and social care system and their continued hard work to deliver excellent care within the context of increasing patient demand and service pressures.

14.0 Glossary of Abbreviations

ACH	Ambulatory Care Hospital
ADHD	Attention Deficit Hyperactivity Disorder
ACRT	Active Clinical Referral Triage
ADRS	Alcohol and Drug Recovery Services
ADP	Alcohol and Drug Partnerships
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
ANIA	Accelerated National Innovation Adoption
APP	Advanced Practice Provider
ASD	Autism Spectrum Disorder
AWI	Adults With Incapacity
BCEIIP	Business Continuity & Essential Investment Infrastructure Plan
BI	Business Intelligence
BAME	Black and Minority Ethnic
CAMHS	Child & Adolescent Mental Health Services
CAPTND	Child & Adolescent Psychological Therapies National Dataset
CAR-T	Chimeric Antigen Receptor Therapy
CBYC	Call Before You Convey
CLD	Criteria Led Discharge
CPD	Continuous Professional Development
CPP	Community Planning Partnership
CfSD	Centre for Sustainable Delivery
CTAC	Community Treatment and Care
CVD	Cardiovascular disease
D2A	Discharge to Assess
DFD	Digital Front Door
DL	Director's Letter
DMA	Data Maturity Assessment
DMR	Dry Mixed Recycling
DNA	Did Not Attend
DPH	Department of Public Health
DR	Digital Radiology
DwD	Discharge without Delay
ED	Emergency Department
ENT	Ear, Nose and Throat
EMS	Environmental Management System
EQIA	Equality Impact Assessment
F/HEI	Further/Higher Education Institutions
FMH	Forensic Mental Health
FNC	Flow Navigation Centre
GDS	General Dental Services
GIRFE	Getting It Right for Everyone
GJUNH	Golden Jubilee University National Hospital

GP	General Practitioner
GP OOH	General Practice Out of Hours
GRI	Glasgow Royal Infirmary
H@H	Hospital at Home
HCID	High Consequence Infectious Diseases
HCSS	Health and Care (Staffing) (Scotland) Act 2019
HIS	Health Improvement Scotland
H&N	Head & Neck
HR	Human Resources
HSCP	Health and Social Care Partnership
HVC	High-Volume Cataract
HWB	Health and Wellbeing
IiP	Investors in People
IJB	Integration Joint Board
INS	Institute of Neurological Sciences
ISO	International Organisation for Standardisation
ISBC	Immediate Sequential Bilateral Cataracts
IP	Independent Prescriber
IPCU	Intensive Psychiatric Care Unit
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LARC	Long-Acting Reversible Contraception
LCPAR	Local Poverty Actions Report
LDP	Local Delivery Plan
LEPs	Local Employability Partnerships
LoS	Length of Stay
MAT	Medication Assisted Treatment
MDT	Multidisciplinary Team
MFT	Moving Forward Together
MHAU	Mental Health Assessment Unit
MSK	Musculoskeletal
MVP	Maternity Voices Partnership
NES	NHS Education for Scotland
NGTP	National Green Theatres Programme
NMAHP	Nursing Midwifery and Allied Health Professionals
NTC	National Treatment Centre
ODP	Operating Department Practitioner
OH	Occupational Health
OPAT	Outpatient Parenteral Antimicrobial Therapy
PAA	Pre-Acceptance Audit
PCIP	Primary Care Improvement Plan
PDD	Planned Date of Discharge
PDS	Public Dental Services
PET-CT	positron emission tomography-computed tomography
PF	Pharmacy First

PHS	Public Health Scotland
PIFU	Patient Initiated Follow-Up
PIR	Patient Initiated Review
PNET	Pancreatic Neuroendocrine Tumors
PoA	Power of Attorney
PPE	Personal Protective Equipment
QEUH	Queen Elizabeth University Hospital
RAaC	Rapid Assessment and Care
RAH	Royal Alexandra Hospital
RM	Realistic Medicine
RPA	Robotic Process Automation
RTT	Referral to Treatment
S&V	Sustainability and Value
SACT	Systemic Anti-Cancer Therapy
SAS	Scottish Ambulance Service
SCIN	Scottish Clinical Imaging Network
SDG	Specialty Delivery Group
SG	Scottish Government
SGCIG	Scottish Government Capital Investment Group
SHaW	Safety Health and Wellbeing
SHBBV	Sexual Health & Blood Borne Virus
SIMD	Scottish Index of Multiple Deprivation
SLWG	Short Life Working Group
SPA	Single Point of Access
SSTS	NHS Scotland payroll system
SRA	Standard Rate Agency
SW	Social Work
T2DM	Type 2 Diabetes
TNE	Transnasal Endoscopy
TSI	Third Sector Interface
TTG	Treatment Time Guarantee
UP	Universal Pathway
USOC	Urgent Suspicion Of Cancer
VBHaC	Value Based Health and Care
WHP	Women's Health Plan
WMS	Weight Management Services
WoS	West of Scotland