

NHS Grampian

Meeting:	NHS Grampian Board
Meeting date:	8 October 2026
Item Number:	9.12
Title:	Planned Care Performance and Improvement
Responsible Executive:	Geraldine Fraser, Chief Officer, Acute Services
Report Author:	Matthew Toms, Head of Performance Governance

1 Purpose and recommendations

This is presented to the Board for:

- Assurance

Recommendations

The Board is asked to:

- Review and scrutinise the planned care position, the priority improvement areas, principal delivery risks and the proposed assurance framework.
- Confirm that the report provides limited assurance at this stage, recognising stronger delivery controls but ongoing work required to achieve a sustainable path to the national target ambitions.
- Agree the approach to planned care recovery as detailed in the report, following discussion and outputs from the Board Seminar deep dive on 10th September 2026
- Endorse the evidence set for future reporting: performance against trajectory and national standard, backlog flow, quantified action impact, finance-to-activity reconciliation, milestones, risks and accountable owners.

This report relates to:

- NHS Grampian Strategy: Plan for the Future - Pathways, including timely, equitable and sustainable access to planned care.
- Board Annual Delivery Plan and NHS Grampian Delivery Priorities 2026/27 - Planned Care.
- Service Operational Plan and national planned care expectations.

This aligns to the following NHS Scotland quality ambitions:

Safe
Effective
Person centred

This subject matter of this report is relevant to the mitigation of the following strategic risks

- Inability to meet population demand for Planned Care

2 Report summary

2.1 Situation

Overall assessment: LIMITED ASSURANCE

Delivery control has been strengthened, specialty-level scrutiny is more frequent and targeted support is in place. However, current trajectories do not yet demonstrate a credible route to eliminate all waits over 52 weeks within 2026/27 or to sustain achievement of the cancer standards. Assurance should remain limited until the delivery plan is fully quantified, implementation is evidenced and recurring service constraints are addressed.

At its meeting on 22 July 2026, PAFIC escalated an unassured planned care position to the Board. The concerns were the absence of a forecast to eliminate New Outpatient and Treatment Time Guarantee waits over 52 weeks by the end of March 2027, the absence of a forecast to achieve or materially improve the 62-day cancer standard, and insufficient evidence that actions were adequate to deliver the required improvement.

The subsequent Board discussion sought a clearer line of sight from specialty and tumour-group delivery to the aggregate position. A Board Seminar planned care deep dive session took place on 10 September 2026.

2.2 Background

National expectations cover 12-week waits for new outpatients and treatment, a 6-week diagnostic standard with 95% compliance, and 95% compliance with the 31-day and 62-day cancer standards. In-year planning is focused particularly on eliminating waits over 52 weeks and improving 62-day cancer performance. The current local trajectories do not provide a path to all of these expectations by year-end.

Pathway	Current assurance position	Key interpretation
New outpatients	Limited	Performance is ahead of the local 52-week trajectory, but the trajectory does not reach zero by year-end. Weekly review has also identified continuing divergence in some 78- and 104-week cohorts, with Dermatology the largest outpatient backlog.
Treatment Time Guarantee	Limited	Performance is ahead of trajectory across the reported long-wait bands, but earlier outpatient recovery creates treatment demand and recurring capacity gaps remain.
Diagnostics	Limited	Radiology is on or better than trajectory across the reported modalities. Endoscopy is better than trajectory for upper and lower endoscopy, while colonoscopy and cystoscopy remain slightly above

Pathway	Current assurance position	Key interpretation
		trajectory. There is no current route to 95% six-week compliance.
Cancer 31-day	Limited	Current performance is at local trajectory but remains below the 95% standard.
Cancer 62-day	Limited	Current performance is at local trajectory but below the national standard and the 80% in-year expectation, with diagnostic, workforce, theatre and oncology constraints.
Theatre cancellations	High	Short-notice cancellations remain within the recent Scottish comparison range; repeat cancellations for the same patient were found to be rare and not increasing. Continued monitoring is required.

2.3 Assessment

The control environment has strengthened since July. Weekly specialty trajectory review, booking-in-turn review, a single action tracker, monthly Programme Board oversight and Executive Team weekly reporting are now established internally. These are complemented by weekly sub-national performance reporting through the Chief Operating Officers Performance Support and Oversight Group and the Sub-national East Board Chief Executive Performance meeting. The most recent weekly review reported performance for new outpatients ahead of the 52-week trajectory but continued divergence in 78- and 104-week cohorts. The principal assurance gap is not the absence of oversight; it is whether actions are sufficiently quantified and sustainable to close the gap between the local trajectory and the national ambition.

Assurance question	Assessment	Evidence and remaining gap
Are delivery controls stronger?	Yes, with caveats	Weekly specialty review, booking-in-turn, action tracking and escalation are in place. The route from specialty evidence to Board level assurance still requires strengthening.
Is performance improving at the required pace?	Not yet demonstrated	Several measures are delivering to or ahead of local trajectory, but trajectory delivery is not equivalent to national standard compliance or a path to zero long waits.
Are actions sufficiently quantified?	Partly	Funded projects are quantified and monitored. The residual contribution from wider service and improvement actions is not consistently quantified.

Assurance question	Assessment	Evidence and remaining gap
Is delivery sustainable?	Limited evidence	Material gains depend on non-recurring funding, waiting-list initiatives, regional delivery, insourcing or locum capacity. Recurring workforce, demand-capacity and infrastructure constraints remain and require service planning, workforce redesign and infrastructure investment.
Can assurance improve?	Potentially	Improvement requires an agreed implementation plan, clearer demand-capacity understanding and evidence of delivery and impact, supported by regional and national partners. #

2.3.a Planned care recovery approach and development of the recovery strategy

The next phase will bring the existing recovery programme, specialty delivery plans and longer-term redesign work into a single Planned Care Recovery Strategy. The strategy will be owned by NHS Grampian and developed with clinical, operational, finance, workforce, infrastructure, digital, analytical and improvement colleagues. External partners will add dedicated capacity, challenge, benchmarking and implementation support. Accountability for delivery will remain with NHS Grampian.

The approach will comprise five connected elements:

Deliver: maintain grip on the current funded and agreed recovery plan for 26/27, focusing on ongoing improvement in reducing the longest-wait cohorts and diagnostic improvements, with operational ownership and executive oversight.

Improve: use transparent national and local benchmarking to target demonstrable productivity opportunities, including booking in turn and list pooling, waiting-list validation, clinically appropriate prioritisation, ACRT and Patient Initiated Review, clinic and theatre utilisation, patient-focused booking, one-stop models and advanced-practice roles.

Redesign: prioritise pathways where incremental productivity will not create sufficient core capacity. Initial areas include Dermatology, ENT and Urology, alongside community discharge pathways for coeliac and glaucoma patients. Redesign will consider demand management, digital and community models, workforce roles, diagnostic dependencies and the most appropriate location of care.

Collaborate: secure realistic East of Scotland and national capacity where it is clinically appropriate and deliverable. This will include testing specialty and sub-specialty fit, patient suitability, willingness and ability to travel, follow-up arrangements, equity and the sustainability of local services.

Escalate: identify the residual capacity, workforce, infrastructure and funding gap that cannot be mitigated through confirmed local, regional or national action, so that choices on investment, prioritisation, service configuration or risk acceptance are explicit.

2.3.b MCK improvement support

MCK is engaged until March 2027 and will provide dedicated on-site specialist support to prepare the Planned Care Recovery Strategy by October 2026 and support its delivery. The work will begin with specialty and sub-specialty analysis of the 52-week position and will be undertaken directly with clinical and operational teams so that the baseline, causes of delay and proposed actions reflect what is realistic and deliverable in each service.

For each priority specialty, MCK will support the development of an agreed set of actions to reduce demand, increase capacity and improve productivity. Each action will specify its cost, expected impact on the number of patients waiting over 52 weeks, anticipated timing of benefit, accountable owner, milestones and dependencies. These contributions will then be modelled into specialty trajectories and aggregated to show the NHS Grampian position, making visible any residual gap that confirmed actions cannot close.

The intended sequence is: specialty and sub-specialty data breakdown by 18 September 2026; remedial actions by 9 October; initial draft trajectories and delivery plans by 16 October; and final trajectories, with formal delivery of remedial actions, by 23 October 2026. Activity that is already agreed or can safely commence earlier will continue rather than waiting for completion of the strategy. The resulting delivery plans will become the core documents for operational oversight and will set out who will do what, by when, and how additionality and impact will be evidenced.

2.3.c Centre for Sustainable Delivery support

The renewed partnership with the Centre for Sustainable Delivery will complement the MCK work by supporting improvement, benchmarking, adoption and spread of proven pathways. CfSD contributed to the Board planned care deep dive on 10 September and will support the Urology workshop on 18 September. Local engagement with CfSD Specialty Delivery Groups will be used to test specialty-level variation and support implementation of the national productivity framework rather than applying blanket assumptions across services.

CfSD support will focus on opportunities such as booking in turn and list pooling; scheduled administrative, patient and clinical validation; consistent clinical prioritisation; ACRT and Patient Initiated Review; patient-focused booking; clinic utilisation and extended days; one-stop pathways and diagnostic hubs; appropriate movement of local-anaesthetic activity from main theatres; standardised session expectations; job-planned versus delivered activity; and advanced practitioners for high-volume, high-flow work. These opportunities will be considered alongside workforce, infrastructure and pathway redesign because productivity alone cannot resolve insufficient staffed or physical capacity, infrastructure constraints or the most complex long-wait cohorts.

2.3.d. Prioritisation and implementation

The strategy will prioritise a smaller number of high-impact pathways where there is a material long-wait contribution, a credible opportunity to improve or redesign, and sufficient clinical and operational leadership to implement change. The work will distinguish between interventions that maintain existing capacity and those that create sustainable additional capacity. It will also recognise that clearing one stage of an

interconnected pathway can create pressure downstream across diagnostics, decision to treat, treatment and follow-up; therefore, demand and capacity will be modelled across the whole pathway rather than considered in isolation.

Clinically led redesign will be supported by dedicated analytical, transformation and implementation capacity. This reflects the Board seminar conclusion that the organisation often understands the available opportunities but requires greater capacity and pace to convert clinical direction and proof-of-concept work into scaled, sustainable delivery. Proposals will therefore include the enabling investment, recurring workforce, infrastructure, digital, information-governance and organisational decisions required to move successful change into business as usual.

2.3.e Infrastructure as an enabler of recovery

Infrastructure will be treated as a core component of the Planned Care Recovery Strategy, rather than solely as an estates or compliance issue, because theatre and procedural capacity depends on facilities with limited redundancy and little headroom for planned downtime. The developing Theatre Infrastructure Plan will apply a staged, risk-based and demand-led approach: protecting current capacity by addressing critical defects and maintenance risk; creating sufficient headroom to enable rotating closures, refurbishment and replacement of ageing systems; and defining the longer-term theatre estate required to meet population need, case complexity, workforce availability and future service models. Near-term options, including the Yellow Zone, short-stay theatres, Woodend and compliant modular capacity, will be appraised for cost, timescale, capacity impact and alignment with the preferred longer-term direction, so that urgent action reduces immediate risk without creating abortive expenditure. The strategy will therefore make explicit the infrastructure dependencies, investment choices and sequencing required to maintain activity, strengthen resilience and create sustainable additional capacity.

2.3.f Governance, grip and Board assurance

The strengthened governance model will connect weekly specialty delivery oversight to the Planned Care Delivery Group, Planned Care Programme Board, Executive Team, PAFIC and the Board, with corresponding reporting through East of Scotland performance and recovery arrangements. The aim is to reduce duplication and variation in reporting and provide a transparent flow of information from operational teams to local, regional and national oversight.

Future assurance reporting will show, for each priority specialty and for the aggregate programme: actual performance against local trajectory and national ambition; movement in 52-, 78- and 104-week cohorts; delivery milestones; patient and quality impacts; delivery confidence; escalation triggers; and the residual gap requiring a decision. This will allow the Board to assess not only whether agreed actions are being delivered, but whether the combined response is sufficient and sustainable.

2.3.g Patient benefit, equity and sustainability

The strategy will retain a clear focus on patient benefit and clinical need. Options involving regional or national delivery, digital access, validation or pathway change will explicitly consider travel, access, equity, patient choice, follow-up arrangements and

the sustainability of local services. The long-term aim is not temporary backlog reduction, but a planned care system in which demand, capacity, workforce, infrastructure and pathway design are aligned sufficiently to provide more timely and equitable access and prevent recurrence of very long waits.

2.3.1 Quality / patient care

Long waits can lead to deterioration in quality of life, including social, financial and relationship impacts, increased medication use, inactivity and deterioration in mental health. Clinical delay can also mean that longer or more invasive treatment is required because of disease progression. Existing monitoring of health gain foregone and causal mortality remains reassuring, but this does not remove the need to reduce delay and variation.

Booking-in-turn review and weekly scrutiny of the longest waiting cohorts are intended to support fairness and clinical prioritisation. The continued gap to national standards means that the Board cannot yet be assured that timely access is consistently achieved across pathways.

2.3.2 Workforce

Workforce constraints remain a principal sustainability risk. Current pressures include breast radiology, oncology, anaesthetic and other specialist skills. Mitigations include recruitment, locum capacity, nurse-led and advanced-practice models, and national or regional support. These measures provide short-term capacity but do not yet establish a fully recurring model.

In the breast cancer pathway, workforce and diagnostic capacity are the dominant risks. Radiology gaps increased the wait to first appointment from around two weeks to up to nine weeks by June 2026, and around 80% of patients require ultrasound. Local waiting-list initiative clinics and mutual aid provide short-term relief, while recruitment challenges continue across breast radiology, surgery and oncology.

2.3.3 Financial

NHS Grampian has received £15.7 million of additional funding in 2026/27 to support planned care activity. This comprises £12.6 million non-recurring funding for outpatient, TTG and diagnostic activity and £3.1 million recurring diagnostic funding. The funding is aligned to 59 projects that are monitored monthly for activity realisation, spend to date and forecast spend.

The most recent formal status report, dated 17 August 2026, recorded projects as green or amber. Amber status related to risks around recruitment and contract start dates. Funding cannot be moved outside agreed projects without national agreement, which limits flexibility in responding to slippage. Targeted investments approved by the Executive Team include clinical validation linked to Golden Jubilee capacity, disposable endoscopy scopes and elective recovery improvement support.

2.3.4 Risk assessment / management

Risk	Current evidence	Mitigation / control	Residual risk
Recurring demand-capacity gaps	Several specialties rely on non-recurring funding, WLI, insourcing or mutual aid.	Integrated service, workforce and financial planning; demand-capacity modelling; prioritisation; service redesign; and focused support from CfSD and other partners.	High until a recurring model is agreed.
Workforce	Specialist shortages constrain breast, oncology, anaesthetic and other pathways.	Recruitment, locums, advanced practice and national support.	High because of national shortages and fixed-term funding.
Infrastructure	Endoscopy decontamination, short-stay theatre and ventilation or air-handling failures reduce usable capacity.	Business continuity, disposable scopes and prioritised infrastructure planning.	High; mitigations reduce disruption but not underlying fragility.
Unscheduled care displacement	Beds and theatres can be diverted during operational pressure.	Capacity oversight, prioritisation and delivery of the unscheduled care plan.	High – risk increases as we enter winter
Patient travel and uptake	Use of national capacity depends on suitability and willingness or ability to travel.	Consent clinics, ready-to-book cohorts and patient support arrangements.	Medium.
Competing priorities	Prioritising cancer, diagnostics or long waits may displace another pathway.	Whole-system prioritisation and transparent reporting of trade-offs.	High.

2.3.5 Equality and diversity, including health inequalities

A quasi-independent review of the operation of the local access policy has been commissioned from Public Health and Health Intelligence. The NHS Grampian Equalities Officer has been asked to complete an Equality Impact Assessment of the local access policy. Previous work has not identified inequity as a direct consequence of planned care policies, but the review should specifically test whether travel expectations, digital access, waiting-list validation and the use of regional capacity create differential barriers.

2.3.6 Other impacts

Focused delivery examples

Area	Position	Immediate evidence required
Urology	Limited assurance. The service remains behind trajectory, although recovery to trajectory by the end of quarter 2 has been forecast. Systemic cancer, TTG and outpatient pressures remain.	Agreed demand-capacity model, service design, workforce plan, productivity opportunities, quantified milestones and measured benefit from cystoscopy and biopsy capacity.
Breast cancer	Limited assurance. The pathway has defined mitigations, but workforce and diagnostic constraints remain dominant and current actions are not yet a sustainable baseline.	Completed pathways from mutual aid and WLI, secured nursing and radiology capacity, recruitment progress, theatre and oncology impact, and a recurring pathway model.
Orthopaedics	External diagnostic assessment identifies a recognisable governance route and detailed operational information, including specialty reports, booking-in-turn, trajectories, cancellation information and theatre utilisation review.	Final external conclusions and action plan, clear ownership, quantified impact, and evidence that improvement activity changes long-wait delivery and recurring capacity.

Minimum evidence required to strengthen assurance

Domain	Minimum evidence for partial assurance
Outcome	Actual performance improves in line with an agreed and credible trajectory; breach and backlog cohorts reduce; and there is no unexplained deterioration in related standards.
Sustainability	A credible plan demonstrates how recurring demand and capacity will be balanced, with explicit workforce, infrastructure and financial assumptions.
Implementation	A single overarching action plan sets out owners, milestones, quantified impact and escalation.
Finance and benefits	Monthly activity and expenditure are reconciled by project, with slippage, mitigations and forecast benefit transparent.
Risk	Dependencies, trigger points, contingency and escalation routes are explicit.
Governance	Exceptions are traceable from specialty review through Programme Board and Executive decision to PAFIC and Board outcome monitoring.

2.3.7 Communication, involvement, engagement and consultation

The report has been developed from operational specialty review, the Planned Care Programme Board, Executive Team consideration, PAFIC feedback, external planned care support and the Board deep dive. A detailed discussion summary from the seminar will be considered by the Planned Care Programme Board on 29 September 2026 to inform programme priorities, delivery plans and future assurance reporting.

2.3.8 Route to the meeting

- PAFIC, 22 July 2026 - planned care position escalated to the Board because assurance was not demonstrated.
- NHS Grampian Board, August 2026 - requested clearer specialty and tumour-group line of sight.
- Planned Care Board Deep Dive, 10 September 2026 - strategic discussion of opportunities, risks, challenges, assurance requirements and how the Board can support delivery.
- Weekly Planned Care Performance Meeting, 8 September 2026 - reviewed specialty trajectories, action tracker, capacity, staffing and recruitment.

2.4. Recommendation(s)

The Board is asked to:

- Review and scrutinise the planned care position, the priority improvement areas, principal delivery risks and the proposed assurance framework.
- Confirm that the report provides limited assurance at this stage, recognising stronger delivery controls but ongoing work required to achieve a sustainable path to the national target ambitions.
- Agree the approach to planned care recovery as detailed in the report, following discussion and outputs from the Board Seminar deep dive on 10th September 2026
- Endorse the evidence set for future reporting: performance against trajectory and national standard, backlog flow, quantified action impact, finance-to-activity reconciliation, milestones, risks and accountable owners.

3 Appendix/List of appendices

- None.