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Name of health board	Ayrshire and Arran
General description of the proposed service within your health board.	Current service People with a diagnosis of Long Covid diagnosed since March 2020. The funding for this service finishes in end March 2026, so without current funding the staff involved will be re-deployed within our organisation, losing the skilled level of knowledge they bring to this complex group of patients. **£187554 cost of existing service model** The A&A Long Covid service sits within our HARP service (Healthy and Active Rehab Programme) and this wider aspect of our service targets people with multiple long-term conditions like diabetes, angina, stroke, cancer, COPD. The proposed additional service would benefit from have a tiered approach to scaling up the existing Multidisciplinary (SG funded) Long Covid service to incorporate the clinical conditions of ME/ CFS to our HARP criteria. The additionality would incorporate medical support for those more with more severe energy limiting symptoms; expansion of assessments and interventions provided via Group delivery and as well as supported self-management groups for those with mild to moderate symptoms. AHP additionality can widen options for all people with multiple long-term conditions as well as people with an energy limiting diagnosis, it will increase capacity and location choice for clinics/ classes/ support across all our conditions. Taking a broader long term condition approach makes jobs attractive, broadens experience and allows services to flex and respond to a variety of demands and yet to be determined referral patterns. Children and Young People (CYP) Current scoping has not determined whether these young people are having their needs met, and this may need further exploration. To date, there have been no CYP have been referrals or a request for assistance made. There is a suggestion that there may be complexity surrounding an energy limiting diagnosis and it is important to be safe/ get it right/ and that the professionals surrounding that child have the correct skill set. This proposal would aim to have time spent on scoping need formally to determine what intervention and staff resource is required.

Changes to expand and widen access existing services	Additionality would consist of: Medical lead clinic Group supported self-management sessions In Reach and Outreach to Peer support groups to ensure patients with lived experience are collaboratively included. Scoping of need within Children and Young People (CYP) for scale of need and the appropriate mechanism/ skill set to support that. Widening of access to people with Long term conditions to our wider multimorbidity programmes Evaluation of the service and its outcomes would be essential. Additional opportunities for class developments/ expansion and facilitated support groups. Volunteer with lived experience support within classes.
Engagement activity	Consultation has included : HARP, Long Covid Steering Group, South Ayrshire HSCP GP Partnership Lead, CYP Comm paediatric lead Ayrshire, CHSS GP, Psychology & AHP Leads, AHP Consultant Rehab Medicine, Ayrshire CAHMS Service Lead, Lived experience HARP Steering group representatives. In addition, Smart survey results – patients with lived experience within A&A have indicated gaps in care including missing medical support, investigations and understanding of their condition therefore this expansion would address these gaps.
Additional posts	1. New Assistant Psychologist post Band 5 (1.0wte) to scope CYP needs in Ayrshire, in reach and outreach role to support groups to scope what is important to those living with ME/CFS type conditions, deliver education sessions, audit and QI role for service and psychology intervention groups across multiple conditions 2025/2026- non recurring role 2. Named medical support (GP) sessions 2 sessions per week that support the clinicians within the team and those people in Ayrshire who have complex and or severely limiting symptoms (0.2wte). 2026/2027 3. Increase OT provision with 1 band 6 (1.0wte) to facilitate and deliver rolling programme group self-management and peer support sessions.

	4. Increase NAHP provision @band 6 totalling 0.3WTE to support an Ayrshire wide delivery of local clinics, classes and expertise to people with long term conditions. 2026/2027 5. Admin Support Band 3 (0.3wte) supporting new post holders and service deliverables (Assistant Psychology, AHP, Peer Support admin requirements) 2026/2027

Vision and ambition	All people within Ayrshire will have an accessible service to people with ME/CFS that has in-reach and out-reach to local support groups and the third sector. Optimised tiered levels of support with a variety of skilled team members who have blurred role boundaries to enable 1 to 1 support to those that would benefit when required. In addition, an improved group and enhanced peer support model for self-management. We recognise the need for robust evaluation of any new service and the assistant psychologist would bring that skill set. We need to address the CYP provision by looking at scale of need/ skill set required. We would like to enhance all our multi morbidity long term condition provision HARP service of which ME/CFS is part of. Governance is provided by HARP steering group and membership of appropriate NSD groups.
Existing capacity & skill mix	Temporary funded posts of 0.5 wte Nurse,0.6 Occupational Therapist, 0.6 wte Physiotherapist, 0.5 8A Clinical Psychology
Optimal capacity & skill mix	Initially in this financial year and 1.0 B5 assistant psychologist Then current staffing with additional 1wte Occupational therapist, 0.2wte GP with extended role or equivalent, 1wte band 6 OT, 0.3 WTE NAHP@B6 with 0.3 B3 admin support.
Timeframe for achieving optimal capacity & skill mix	There is uncertainty on the time required for local vacancy processes which includes assessment of risk and sign off by several internal scrutiny panels. CEL letter may be of use for supporting risk. As a guide the timeframes could be 3 months for assistant psychologist recruitment and 6 months for NAHP recruitment and upskilling to include additional conditions. Medical recruitment – uncertain time frame and could possibly be limited with time frame of proposal opportunity. Staggered training needs over first 3 to 6 months but pre-existing team will be able to support and facilitate that timeously. To manage this we would like to be able to offer a minimum of a year fixed term contract to maximise the chance of

	recruitment/ secondment options. This could mean looking for contracts beginning in the new financial year.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	We would expect an additional OT would be able to increase capacity by 200+ patient sessions per year when established Medical capacity would be determined by job plan but would increase sessional capacity at expert level,safety of the service as well as the patient experience. It would increase opportunity for prescribing and necessary interpretation of investigations. Nurse/ Physio recruitment would support HARP provision, develop rural clinics targeting Girvan and Kilbirnie and expand access to Breathe Easy class. Assistant psychologist could support the QI, CYP scoping, research and audit of the service whilst practically supporting the organisation and delivery of groups (including peer support groups).
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	2 weeks
	Average time from referral to first assessment/intervention.	4 to 6 weeks, but this will vary according to demand which at this point is not yet known.
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	DCAQ, CORE 10, EQ5D, FACIT, smart survey pt experience, pt stories

Name of health board	NHS Borders
General description of the proposed service within your health board.	NHS Borders is developing a locality based approach to support patients with Long Covid, ME, CFS, and similar conditions. This multidisciplinary and multi-agency locality based approach provides symptom management support from a range of professions and services using an asset based approach in our communities. An Advanced Practitioner Occupational Therapist (APOT) would continue to be the Board subject matter expert, carrying a clinical caseload, but also providing training, education and professional support across locality teams. Medical input will be maintained by the referring General Practitioner alongside the ongoing upskilling and education of Allied Health Professional (AHP) colleagues and third sector organisations. A Regional approach to support a cohort of individuals requiring complex intervention from a rehabilitation medicine consultant alongside clinical psychology intervention has been outlined in the NHS Lothian Board return.
Changes to expand and widen access existing services	The development of locality teams improves access through more timely identification of symptoms, with access available locally. Enhancing peer support groups and offering greater assistance to individuals with symptoms will enable them to access community resources and activities more effectively. This initiative will also provide opportunities to bolster rehabilitation services for ongoing symptom management. Current referral processes and use of electronic system will be required as part of this change.
Engagement activity	Extensive local engagement around locality working and community based services is ongoing in conjunction with Board Clinical Strategy development which will support and influence this work.
Additional posts	Band 7 Advanced Occupational Therapist (1wte) Band 4 Rehab Assistant (0.6wte)

Vision and ambition	The similarities in symptoms across various conditions present an opportunity to apply the same client-centred approach used for Long Covid within NHS Borders. Integrating Long Covid, ME/CFS, and other conditions with similar symptoms, while expanding access to rehabilitative support, can enhance patient care and resource efficiency, benefiting a broader patient population. Streamlining the referral process could reduce service duplication across different services improving access and reducing waiting times. Delivering services close to home for patients enhances the opportunity to build upon peer support, which has already shown positive outcomes. This approach fosters a supportive community environment, contributing to better patient experiences and outcomes. Signposting to national services such as CHSS and online resources.
Existing capacity & skill mix	**Current Long Covid Support:** <u>Funded through non-recurring SG long covid funding:</u> • **Advanced Practitioner Occupational Therapist (AP OT):** 30 hours per week <u>Funded through core budgets:</u> • **Upskilled OT Band 6 in Localities and LD Physio:** Supported by AP OT • **Respiratory Physio Access:** Available through the existing Long Covid pathway, currently requires waiting list • **Well-being Advisor:** Provides virtual consultations for patients with less severe symptoms
Optimal capacity & skill mix	Additionality of Band 4 HCSW to ensure appropriate clinical skillmix and to release leadership capacity within advanced practice role (as per section above). Please see above section in relation to proposed regional approach to rehabilitation medicine and clinical psychology.
Timeframe for achieving optimal capacity & skill mix	Funding dependant. Recruitment to posts unlikely to be challenging.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	60 referrals per annum for specialist Long Covid Support. This does not include patients with ME/ CFS/ long covid who's symptoms were managed through core services. At present there is no mechanism for capturing this data. All were offered an appointment
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Specialist long covid assessment waiting time less than 8 weeks.
	Average time from referral to first assessment/intervention.	2 to 4 weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	The 5-level EQ-5D version (EQ-5D-5L) Patient Satisfaction Questionnaire

Name of health board	NHS Dumfries and Galloway

General description of the proposed service within your health board.	Dumfries and Galloway Health and Social Care partnership have developed a combined Energy Limiting Condition pathway. It was agreed at the start of the Long Covid funding that D&G would develop a combined pathway and not one exclusive for Long Covid, this was an important step that recognised the gap in this essential service and assured an inclusive pathway. Despite being in the early stages of development there are some key foundations that have already been developed. These include a single access point from primary care at the point of diagnosis, this is essential to ensure timely and streamlined process. The pathway is hosted in the regional rehabilitation team, with a focus on proactive approaches that promoted realistic medicine principles with self management at the core. All patients receive a holistic assessment, thus ensuring that right level and professional input is provided first time. The proposed model would build on these core foundations, further enhancing the holistic and self management approach. The enhanced model will include a dedicated psychology practitioner, which will strengthen the MDT. Additionally the introduction of a self management programme starting Oct 25 will further support people to live well in our communities. The fixed term until March 26, will focus on establishing and building community connections and capacity. These elements are essential in the creation of a delivery model for all long term conditions in D&G that focuses on de-medicalising and is proactive, with self management at the core. The team will also focus on ensuring alignment to the NICE guidelines. The focus has previously been on an adult pathway and more scoping is required to understand needs of a paediatric pathway. This requires to include exploring regional models to support specialist access in D&G. Dedicated project support is needed to robustly explore this. The additional fixed term money until March 26 will be utilised to ensure robust scoping, data collection, planning and promotion can be undertaken. This will also include development of a training plan to increase awareness across the whole system and delivery of a universal access for all.
Changes to expand and widen access existing services	The expansion of the service would involve dedicated psychology support.

<table>
<tr><td></td><td>Psychology has a crucial role to play in supporting people living with Long Covid and energy limiting conditions including ME and CFS. It can be useful to view these at three levels, the individual, the team and the wider workforce.

For people living with ELCs, dedicated psychology input will be available to support people to live well with symptoms and their impact on mood. The additional burden of anxiety, low mood, panic and loss risks increasing suffering and struggle if unaddressed. Psychological therapy will aim to address this through dedicated treatments focusing on acceptance and compassion. As this is practitioner level this will be targeted and if more specialist input is needed this will be out with this dedicated pathway.

The psychology practitioner input will be able to provide MDT input and will provide support a team level. This will promote the tasks associated with setting the narratives around ELCs, including the biopsychosocial nature and the aim to live well with the condition. Work will be undertaking to how dedicated education as well as the sensitive framing of these narratives can be built into the service so they land in a way that is supportive, compassionate and heard.

By introducing a self management programme this will further enhance the support for people to manage their own conditions and to reduce the reliance on medical models. This will be developed alongside local community groups and will work with partners to build community capacity. This aligns to the vision of management of long term conditions, the Renewal Framework and supporting people to live well in their own communities.</td></tr>
<tr><td>Engagement activity</td><td>The current team have good links with the local support and peer groups. Regular engagement occurs and is sought through this forum.

Promotion of the pathway has occurred with primary care cluster leads, this will be enhanced as the pathway progresses.</td></tr>
<tr><td>Additional posts</td><td><table>
<tr><th></th><th>WTE</th><th>£</th></tr>
<tr><td>Band 6 (ftc to 31/3/26)</td><td>0.5</td><td>29,505</td></tr>
<tr><td>Band 5 - Psychology</td><td>1.0</td><td>51,175</td></tr>
<tr><td>Band 5 - Community Development post (ftc 31/03/26)</td><td>1.0</td><td>48,121</td></tr>
<tr><td>Pays Total</td><td></td><td>128,801</td></tr>
</table></td></tr>
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Non Pays 2%		2,662
Non Pays Balance		1,613
Allocation		133,076

Note: pays are costed at mid point of scale 25/26 + 3.25%

2026/27 & 2027/28

	WTE	£
Band 7 (top of scale)	0.43	36,503
Band 5 (mid point of scale)	1.00	51,175
Band 4 (bottom of scale)	0.40	17,679
Pays Total		105,357
Chest, Heart & Stroke SLA		24,000
Non Pays 2%		2,662
Non Pays Balance		1,057
Allocation		133,076

Note: pays include 3.25%
26/27 pay award + 3% assumed pay award 27/28

Vision and ambition	Dumfries and Galloway Health and Social Care Partnership aims to create a model that supports people to receive the right care at the right time. The vision is a model that supports people to live well in their local communities. It has strength and assets based approach focused on maximising independence and supporting people to manage their own conditions. The ambition is a full MDT that work together to ensure people receive timely access to the care and information they require. A MDT that communicate effectively to reduce duplication and delays for patients. In partnership with the health MDT is a community led team, focused on building capacity within local communities, supporting community led activities and self management. For paediatrics exploratory work is required and an understanding of regional models is required.
Existing capacity & skill mix	The service is currently being delivered with a combination of band 7 Physiotherapy and Occupational Therapy and a band 4 OT/PT Assistant Practitioner.

	Work has been undertaken to enhance knowledge of those in the regional rehab team directly involved and also the wider rehab team to enhance overall awareness. Alongside clinical knowledge, good conversation training has been essential and has supported enhancing and changing the delivery model to one that is strength and asset based
Optimal capacity & skill mix	The proposed psychology input would add meaningful value to the people in Dumfries and Galloway living with ELCs, and to the existing team. Focused predominantly on cognitive behavioural therapy. Due to financial constraints this has required to be a practitioner rather than a clinical psychologist. This will allow targeted input with the clinical supervision of a clinical psychologist. This is modified from our previous proposal due to level of current funding The self management programme would be run in partnership with Chest heart and Stroke Scotland they supply the health care support workers who run the programmes within local communities. Combined with fixed term community development worker who, would work directly with service users, 3rd sector and local communities to develop capacity and capability within local communities to provide ongoing support and maximising local assets. The fixed term project manager will provide dedicated project support to ensure pathways are developed that can embedded and to scope paediatrics and regional working. This approach will support the sustainability of this model and provide a vision for all long term conditions in D&G. Further good conversation training would be undertaken for the full MDT.
Timeframe for achieving optimal capacity & skill mix	Recruitment could take around 3 months. Training needs analysis would be required to be completed for the wider team. This could take around 6 months to build required levels across the MDT. Service user coproduction on the self-management programme and community capacity building is expected to take around 6 -9 months. This time is required to ensure this model is region wide, and not limited to postcode areas.

How much do you expect to do (activity/process)	Number of individuals referred to services.	Annual new referrals of approx 500 to 750

	Number of individuals offered an appointment.	All referred patients will be offered a level of input this will vary depending on need and required professional input.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Aim is for 2-4 week to initial contact. This may involve completion of questionnaire
	Average time from referral to first assessment/ intervention.	Routine seen within 8 weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	European Quality of Life – 5 Dimension scores (EQ-5D). – Measure quality of life, activity, mobility, anxiety etc) UCAL 3-item loneliness scale – Measure of loneliness/social isolation ONS - (Life satisfaction/worthwhile/happiness) Referrals by SIMD (deprivation levels) Number of contacts with Primary Care

Name of health board	NHS Fife
General description of the proposed service within your health board.	In the past we have provided a limited stand-alone service for CFS/ME; however, this was a single-handed service (only 1 nurse and no Multi-disciplinary Team (MDT)). We no longer have this service and have been unable to recruit to the vacant nursing post, although we still have this post , and will utilise it within our new service alongside the additional posts. With the SG temporary funding in relation to Long Covid provision, we took the opportunity to provide this service using a long-term condition (LTC) management approach supplementing staffing into exiting teams, mainly community rehabilitation teams and our pain management service. This allowed us to build knowledge and experience within our existing staff and teams to build sustainability.
Changes to expand and widen access existing services	Therefore, moving forward our vision would be to house this Long Covid/CFS/ME service alongside our other community rehabilitation teams and pain management service; taking the same approach we used previously to supplement our existing teams and services, with appropriate skilled and expert practitioners to support this patient cohort through a MDT and LTC management approach, which would be best practice and builds sustainability for the service. We also plan to work with neighbouring boards NHS Lothian, NHS Forth Valley and NHS Borders) to provide a regional offer for our more complex patients. this allows us to provide medical and senior clinical leadership across the boards. NHS Lothian have successfully trialled a comprehensive MDT approach to their most complex patients after securing input from a Consultant in Rehabilitation Medicine. Planned expansion will allow us to meet the needs of our most complex patients, on a Regional basis for patients across NHS Lothian, Fife, Forth Valley and Borders. All boards will offer their own local rehabilitation services however due to capacity and expertise required will be challenged to offer a comprehensive MDT approach that includes appropriate medical and psychology input in each board independently. Instead, this will be offered Regionally with each board contributing their NRAC share to the Regional aspect; access will be supported through both outreach where appropriate and / or remote access fully utilising digital approaches. Our regional approach will also offer educational opportunities for local staff in all four boards, enhancing sustainability of services going forward.

Additional posts	NRAC Share to support Regional Approach with NHS Lothian, Forth Valley and Borders. £89,226 Band 8a 0.5 wte Clinical Co-ordinator Service Lead (Nurse or AHP) Band 8a 0.31 wte Psychology Band 7 0.5 wte Advanced Practice AHP Band 6 1.5wte AHP's and Nurse NHS Fife Service Total £218,269 Grand Total (Fife and Regional) £307,495.

Vision and ambition	Our vision for this service is to empower individuals living with Long Covid, ME and CFS to achieve optimal health, independence, and quality of life through compassionate, evidence-based, and person-centred multidisciplinary care.
	• We aim to establish an integrated multidisciplinary service that:
	  • **Delivers holistic care** tailored to the complex and fluctuating needs of people with Long COVID and CFS/ME.
	  • **Bridges primary, secondary, and community care**, ensuring seamless support across the patient journey.
	  • **Empowers patients** through shared decision-making, self-management education, and personalised planning with a personal outcome focus
	  • **Utilises the differing skills and expertise** of a diverse team—including medical, nursing, physiotherapy, occupational therapy, psychology, and peer support—to address the physical, psychological, and social dimensions of these conditions.
	  • **Drives innovation and research**, contributing to the evolving evidence base and best practices in managing post-viral and fatigue-related syndromes.
	  • **Reduces health inequalities** by ensuring equitable access to care for all individuals, regardless of background or circumstance.
	  • **Builds resilience across the health and social care system** by promoting sustainable, proactive, and preventative approaches to long-term condition management.

Existing capacity & skill mix	Currently the only substantive post we have for CFS/ME services is 1.0 wte Band 7 Nurse. The SG Long Covid funding is non-recurring/temporary and is in the final year; but we have utilised this to build capacity within our existing teams and services to support all patients who require rehabilitation and psychology interventions.
Optimal capacity & skill mix	NHS Lothian have successfully trialled a comprehensive MDT approach to their most complex patients after securing input from a Consultant in Rehabilitation Medicine. Planned expansion will allow us to meet the needs of our most complex patients, on a Regional basis for patients across NHS Lothian,

	Fife, Forth Valley and Borders. All boards will offer their own local rehabilitation services however due to capacity and expertise required will be challenged to offer a comprehensive MDT approach that includes appropriate medical and psychology input in each board independently. Instead, this will be offered Regionally with each board contributing their NRAC share to the Regional aspect; access will be supported through both outreach where appropriate and / or remote access fully utilising digital approaches. Our regional approach will also offer educational opportunities for local staff in all four boards, enhancing sustainability of services going forward. A well-rounded MDT should include professionals with complementary expertise to address the multifaceted nature of these conditions: • Medical • AHP's including Physiotherapy, Occupational Therapy, Dietitian, Speech and Language Therapy • Psychology • Nursing • Underpinned with a Clinical Lead to provide co-ordination and case management as well as leadership and professional expertise This service model would be able to provide flexible access (in-person, virtual, home visits), promoting shared care and joint working with primary, secondary and community care. It would provide patient centred care with a focus on personal outcomes and goal setting; supported with regular MDT reviews and use of appropriate PROMS. I do not have exact information, however using available prevalence data; Fife has a population of approx. 375,000; long covid prevalence of 2-3% would be 7,500-11,250 people and CFS/ME prevalence is 0.2-0.4% therefore 750-1,500 people. So, a combined patient population of 8,250-12,750.
Timeframe for achieving optimal capacity & skill mix	Over the course of year one, with initial focus on getting the Clinical Lead/Cor-ordination role and senior clinical posts. With all other recruitment following quickly to ensure we can provide the full service offer as soon as possible. This includes supporting the regional model and recruitment.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	We understand that patients with this diagnosis do seek our appropriate healthcare; therefore if we estimate that 60% of this patient population engage with

		services that would provide a range of 4,350-7,650. Not all patients will require a full assessment and intervention package; and we would take a stratified approach to our offer e.g. Universal, Targeted and Specialist.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Following good practice guidance, we would expect; **Referral to First Contact** 2-4 weeks and this could be a triage call, screening questionnaire or virtual consultation regarding need to MDT input.
	Average time from referral to first assessment/intervention.	**Referral to First Full Assessment** 6-8 weeks. This would be a comprehensive MDT assessment, with a co-produced intervention and care plan initiated.
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	We would look to develop a suite of appropriate outcome measures to consider a number of domains e.g. **Quality of Life;** EQ 5D-5L, PROMIS 29 **Fatigue;**Chalder Fatigue Scale, DSQ-PEM **Functional Capacity;** 6MWT, FIM, WSAS **Mental and Cognitive Health;** PHQ 9, GAD 7, MoCA/ACE III **Patient Centred Goals;** GAS, PAM.

Name of health board	Forth Valley
General description of the proposed service within your health board.	As part of the one stop clinic, all patients would be offered a face to face 1st clinic appointment, followed by either face to face, telephone or near me support as required. (This will be dependent on any further face to face assessments/treatments required) to support patients to independently self manage. We would continue PoTS investigation and non pharmacological treatment with inclusion of pharmacological treatment as part of the new regional service. Virtual group sessions 3-6 months after discharge by way of reinforcing the self management tools needed. These will be run by a facilitator from the team and videos covering the 9 most relevant topics will be used to refresh each symptom management support.
Changes to expand and widen access existing services	In order to expand the current Forth Valley Long Covid service to provide integrated, multidisciplinary rehabilitation for assessing physical and mental health support which incorporates Long Covid ME/CFS the following would be required: For existing staff • The existing team would need relevant further education on ME/CFS and prescribing qualification. • Forth Valley Long Covid Psychology staff to work within the regional team – base to be determined. For new staff • This would be provided within the regional centre - Lothian, Fife, Boarders and Forth Valley. System development. • Website updated • Referral Pathways updated. • Referral pathways built for secondary care support of all conditions at regional centre. • Service structure redesign. • Digital referral update • Review of IT systems to identify/implement appropriate patient management systems • Health board communication and education on new service. • Access to relevant investigations by regional centre. • Review and reprint of NHS Scotland workbook. • Group Video nationally or regionally. • Statistician to collate national data from Elaros.

Engagement activity	Local long covid lived experience group and current long covid caseload patients would be consulted and feedback gained. ME/CFS patients identified in Forth Valley would also be consulted and feedback gained. This engagement would be by postal/digital evaluation and face to face / near me focus groups.
Additional posts	• Regional team. Lothian, Fife, Borders and Forth Valley.

Vision and ambition	**Vision**. A one stop post viral/chronic fatigue clinic provided by specialist highly skilled multidisciplinary team. Patients will be investigated, diagnosed and treated by the same team. This service will cover but not be limited to PoTS, breathlessness, fatigue, health psychology, gastric/dietary changes etc. **Ambition** This clinic will alleviate the burden on primary care by reducing/limiting the need for appointments out with this specialised clinic. The service will reduce the number of secondary care advice requests and referrals needed by using the multidisciplinary recourses available within the team. This patient groups will live well, independently managing their conditions through periods of both relapse and remittance and where relevant, maintaining a fulfilling working life.
Existing capacity & skill mix	The current Forth Valley Long Covid service has the following skill mix: 1x WTE band 7 nurse/Long Covid Coordinator 1x 0.7 WTE band 7 physio 1x 0.4 band 8a Psychologist. Current capacity for physical input over the last 12 months has been approximately 200 pts seen over 800+ appointments. Current capacity for mental health input over the last 12 months has been approximately 43 pts seen over 265 appointments.
Optimal capacity & skill mix	The optimal skill mix would be: 1x WTE band 7 nurse prescriber/ Coordinator 1x 0.7 WTE band 7 Physio 1x 0.4 WTE band 8a psychologist 1x 0.4 WTE GP

	1x 0.4 WTE band 7 psychologist 1x 0.4 WTE band 5/6 O.T 1x 0.2 WTE paediatric O.T or funding to access Lothian service. 1x 0.4 WTE band 3 admin Optimal capacity for physical input is hard to estimate as the number of referrals/demand from conditions other than Long Covid is not known to me at this time. Forth Valley do not have a specialist ME/CFS service to take these figures from. Optimal capacity for mental health input is hard to estimate as the number of referrals/demand from conditions other than Long Covid is not known to me at this time. Forth Valley do not have a specialist ME/CFS service to take these figures from.
Timeframe for achieving optimal capacity & skill mix	The proposed service will take 12-24 months to establish depending on recruitment.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	The number of individuals expected for for physical and or mental health input is hard to estimate as the number of referrals/demand from conditions other than Long Covid is not known to me at this time. Forth Valley do not have a separate ME/CFS service to take these figures from, however widely accepted estimate for ME/CFS prevalence in Scotland is 0.2-0.4% of the population, so we would expect to see around

		9000 patients who already have a diagnosis. In Long Covid the number is fairly similar at around 3.5% of the population. I don't have figures for the other related conditions. Diagnosis is complex however and these numbers may be higher. All patients with symptom burden matching that of the WHO long covid diagnosis criteria and those with existing or potential ME/CFS would be offered an appointment with the service.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	The additional staff requested is just short of double our current provision. This should keep our staff to patient ratio similar to that of our current service. This will allow us to see all patients from referral to first app within 14 week.

	Average time from referral to first assessment/intervention.	First face to face clinic app will be within 14 weeks of the referral date if the referral is accepted. If further information is required at the point of triage this waiting time may increase.
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	For the last 6 months FV have collected data on PoTs, this will continue as it helps shape / tailor the service needs for this condition. 1:1 clinic satisfaction / service evaluation survey. Mental and physical Health improvement patient survey. Group satisfaction survey. All current Morse / patient management system data will continue. Proms we would also collect are: Nijamgan C19yrs EQ5DL

		Any other relavant symptom specific prom. It is Forth Valleys intention to discontinue onboarding to Elaros.

Name of health board	NHS Grampian

General description of the proposed service within your health board.	Continue to develop an effective, adult and paediatric Long Covid pathway including transition from the child to adult pathway. Sustain and augment these pathways to include ME/CFS and other similar long term conditions, enabling equitable access to a wider population who experience similar presentations and challenges in managing their condition. The augmented pathways would continue to deliver clinical support and clinical advice through patients being assessed or through provision of information and signposting. This also includes training and support for clinicians who are delivering care to those with these conditions.
Changes to expand and widen access existing services	Through development of the long Covid pathway we have identified limitations and capacity issues within existing services to help manage the complexity and variety of symptoms people with Long Covid experience. We recognise the similar challenges that people with ME/CFS and other long term conditions experience. There is an opportunity to build on the experience from our Long Covid service to develop an inclusive needs/symptom led pathway approach, while still ensuring those requiring access to medical assessment and specialist care are enabled to do so. It is recognised, through feedback from our lived experience group, that accessing support can be challenging with many having journeyed through multiple services and specialities. The current model is a multi-disciplinary one ensuring a person's condition and needs are matched with the treatment offered. The long covid practitioners as part of the multi-disciplinary team act as a single point of contact for patients making it easier for them to navigate and access the support they require. While conditions differ, there are cross over symptoms that impact on people's daily life. The practitioners within the existing service can build upon and widen their breadth of knowledge to include the nuances of different conditions such as MS/CFS with similar symptoms. Enhancing the current model with clinicians trained and experienced in; psychological therapy, breathing pattern disorder management, fatigue management, physical rehabilitation, chronic pain, POTS and/or vestibular assessment and management, MCAS will support a wider group of people in managing their symptoms.

	Maintaining or securing employment can be particularly challenging for people with long term conditions. In developing the pathway we will explore options for support with the existing vocational rehabilitation service. Within the adult LC service there is a 22-week waiting list due to vacancies which we have been unable to fill due to uncertainties around continuation of funding. Previously the waiting list averaged 12 weeks. There is no children's and young persons (CYP) waiting list currently. Expansion of the pathway would increase capacity to maintain an average waiting list of 12 weeks while expanding the service to include ME/CFS and other long term conditions.
Engagement activity	While discussions have taken place with some key colleagues, timescales to complete this bid have limited the opportunity for broader engagement around the future service model. Further discussion to be had with adult and paediatric stakeholders including those with lived experience to finalise the detail of the model(s). Work on associated conditions with common symptomology, specifically supporting people presenting with functional disorders, is being taken forward through a 2.5 year NHS Grampian Charities grant to explore patient need, educational requirements and service impact through a managed service network model. This will involve extensive collaboration and consultation with service users and offers context for continuing of service for patient with long COVID with expansion to ME/ CFS and other conditions. The current service would look to collaborate with this work to identify shared opportunities for learning and future service models. We will also explore with neighbouring boards in the North of Scotland any regional opportunities for collaboration. Further development of our local pathways will also be explored with our third sector partners.
Additional posts	0.5WTE Clinical psychologist 1.5 WTE practitioners who are AHP’s with a range of relevant backgrounds. 0.2 WTE Medical 0.5 WTE administrator

Vision and ambition	We propose a vision with 3 stages towards our ambition that people with lived experience of long COVID, ME/ CFS and similar conditions feel 'heard, held and empowered' and that patients experience a holistic pathway with professionals knowledgeable in their range of symptoms vs referrals to multiple specialties where symptoms are 'standalone'. 1. Build on the good practice of the long COVID adult and paediatric service which has evidenced high patient acceptability and excellent clinical outcomes. ***Priority 1: Ensure ongoing provision through this service.*** 2. Build on the learning from the long COVID service in particular areas needing additional resource (POTS assessment and management; Sleep apnoea; Psychological functioning; medical screening at point of access). 3. Explore opportunities for collaboration with locally planned development of a functional disorders service. 4. Explore with NoS Boards any opportunities for regional collaboration ***Priority 2: Provide additional resource for augmenting current long COVID service to provide wider clinical service and wider scope of patient groups (including ME/ CFS and similar conditions)*** 3. Consider service development consistent with COVID-19 SIGN guideline 188 and ME/ CFS SIGN 206 recommendations, our long term vision would be to develop a service which supports self-management (5.1 SIGN 188); Uses a multidisciplinary approach to rehabilitation including a personalised rehab plan (5.2 SIGN 188) and provides access and care and support planning by an ME/ CFS specialist team (1.5 SIGN 206). ***Priority 3: Expansion of current long COVID-19 service to include wider scope of conditions (including ME/ CFS and similar conditions) and provide access to specialist MDT for care and support.***
Existing capacity & skill mix	Current Service Model: 2.5 WTE Adult Long Covid practitioners who are AHP's with a range of relevant backgrounds. 1 session/4 hours Rehabilitation Medicine consultant. 0.5 WTE administrator 0.2 WTE Adult clinical lead. 0.5 WTE CYP Long Covid Practitioner 0.1 WTE CYP clinical lead
Optimal capacity & skill mix	The adult LC pathway waiting times are longer than desired, currently at 22 weeks due to vacancies which we have been unable to fill due to uncertainties around continuation of funding. Previously the waiting list averaged 12 weeks. Additional capacity to the core service would broaden the

	pathway to include a wider cohort of patients while helping to reduce waiting times to access the service. Evidence supports that access to a wider range of specialities/professions are beneficial to improve patient outcomes therefore skill mix to include professions with training in breathing pattern disorder management, fatigue management, physical rehabilitation, vestibular assessment and management; POTS, and psychological therapies to assist with psychological care and signposting.
Timeframe for achieving optimal capacity & skill mix	6- 9 months from confirmation of funding. Anticipating recruitment of Clinical Psychology will be through additional hours reducing the time lag to recruitment. See note below re use of some of the 25/26 funding for Project management capacity*

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	35 new patients per month* 35 per month, mix of new and return* *Based on current long covid activity figures. Further collaboration with colleagues to be undertaken to fully understand patient numbers with extended provision
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	12 weeks
	Average time from referral to first assessment/intervention.	12 weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	Use of minimum data set for LC agreed at National level. MECFS assessment toolkit Symptom specific outcome measures e.g. FACIT

		Qualitative and quantitative service evaluation Service user feedback

Name of health board	NHS Greater Glasgow and Clyde
General description of the proposed service within your health board.	This bid fits very well with the Long Term Conditions Strategy recognising that people with long term conditions are often managing a multitude of conditions which are unlikely to be fully resolved with medical management alone, the model proposed is aligned to the House of Care Model, putting the person firmly at the centre of any care plan , ensuring connections with local community and peer resources. As such this is a non-medical model of condition and symptom management, building a non-diagnostic pathway for Long Term Conditions within GGC. The service model adopts key principles from the evidenced Long COVID Service established within GGC over the last 3 years. This service proposal will expand access to Long-Term Conditions where a collaborative supported self-management model is the preferred approach, conditions are likely to include ME and Chronic Fatigue Syndrome, fibromyalgia, and long covid as well as other syndromes which result in fatigue and other symptoms such as psychological distress that respond well to a focussed brief interventions. This will deliver equitable access and an increased offer of interventions to a wider patient population. This proposed model is AHP led and enables individuals to self-manage symptoms associated with long term conditions, enabling maximisation of quality of life and societal engagement through programmes of physical and psychological rehabilitation. By offering people with Long Term Conditions, a service which encourages supported self-management and self-care through early intervention and prevention, a realistic medicine approach is achieved; delivering value-based healthcare, which optimises the use of digital resources, and contributes towards a more sustainable health and care system. This modelling supports the Scottish Government and Reform Framework, National and GGC Digital Strategy and the National Long Term Conditions Framework. In addition to this, our vision is that this health board wide model will support NHSGGC reform agenda, offering a board wide alternative to traditional medical models. Ensuring that where possible patients are being managed at home, with the confidence and self management tools they need. Decreasing

	frequency of repeat appointments at GP surgeries and attendance at ER. This service proposed would mirror the GGC Long COVID delivery model access via GP referral and advanced practitioner clinical triage. The service model will adopt a digital first approach through online Educational Group Programmes supporting presenting symptomology including Dysautonomia, PoTS, Activity, Fatigue, Breathlessness, Cognitive Dysfunction, Wellbeing and Planning for the future, including goal setting and vocational rehabilitation. Within the service model, evidence indicates 60% of referrals will be effectively supported within the digital programme. Where required additional interventions will be facilitated via onward referral to either a statutory or non-statutory service, for example Centre for Integrative Care (CIC), Pain Management services, CHS Foundation or HSCP/ community resources. Depending on individual need, 40% of referrals will require individual short-term intervention from the Long-Term Condition advanced practitioners and specialist occupational and physiotherapists. Individuals accepted into the programme may also require referral and escalation for longer term intervention which the augmented CIC pathway will provide. Those identified as requiring further medical/specific diagnostic management, will be referred back to their GP as RMO and coordinated onward referral to secondary care specialist services and mental health services. To promote individual resilience and community connections, opportunity is given for people to informally interact within the group setting space, providing peer support which has evaluated positively. Within long covid this has seen the development of ongoing peer support, that has endured following the end of the formal treatment intervention. As year 1 funding for the expanded Long Term Conditions service will not be available to September, it is unlikely that NHSGGC will be able to recruit to posts, engage with the patient population, revise existing long covid group programme/resources to meet broader long term condition needs before spring of 2026. Our estimation is that we will have recruited to new posts and started the service transition by January 2026.
Changes to expand and widen access existing services	The service model adopts key principles from the evidenced Long COVID Service established within GGC over the last 3 years.

	This service proposal will expand access to Long-Term Conditions that benefit from symptom management including ME and Chronic Fatigue Syndrome, fibromyalgia, long covid etc. This will enable equitable access and intervention to a wider patient population. This delivery plan will combine the expert holistic services provided by Centre for Integrative Care (CIC). The Centre for Integrative Care (CIC) has recognised expertise with patients with long term conditions and post viral illness, and the CIC's whole person (holistic) approach addresses mental and physical health along with emotional and spiritual wellbeing.
Engagement activity	The Long COVID service has engaged with service users and can provide robust quantitative and qualitative evaluation and service user feedback from individual and group engagement. As part of the development of a Long-Term Conditions Service we would work with PEPI to reach out to this patient population to seek their views on our service model and associated resources. This work is already underway. In collaboration with GGC Public Health lead we are developing an innovative digital Wellbeing Hub, long terms condition self-management is a key part of this. We have had an excellent response from the population and are testing our AHP LTC digital resources with this population. The first phase of this project will go live in September 2025.
Additional posts	The service profile for delivery is outlined below. This is an augmented staff team. Tier 1 Long Term Condition Advanced Practitioners from the Long COVID service with additionality to support the breadthening of access through the non-diagnostic pathway. The Tier 2 CIC pathway is supported by additionality for that MDT including medicine and psychology. **Financial Risk to Board** It is important to note that the majority of existing staff in the Long covid Service have been on fixed term contracts since the service was established. As such they will have permanency. As well as this multi-year funding (for up to three years) would mean that any staff employed under fixed term contracts would also achieve permanency. If the SGovt did not then baseline services, the health board would need to re-deploy these staff. Furthermore, we have feedback from

	staff that FTC extension year on year is very unsettling and may result in staff leaving for permanent contracts. There needs to agreement and clarity around annual pay uplifts for LTC staff. There was no agreement for the Long Covid team, therefore annual lay uplifts have been funded from salary budget. This was seen a loss of advanced practitioner posts, this was further compounded by a lack of a ringfenced non pays budget. As staff assess for and prescribe a range of assistive equipment.

Staffing Profile and costs

Component 1

The current Long COVID Service

		2025
Current Long COVID Service Staffing Profile	**Contracted WTE**	**Annual Costs**
Band 8a Occupation Ther Serv	0.93	79,456
Band 7 Occupational Ther Serv	1.00	71,856
Band 7 Occupational Ther Serv	1.00	71,856
Band 7 Occupational Ther Serv	1.00	71,856
Band 7 Occupational Ther Serv	1.00	71,856
Band 7 Physiotherapy Services	0.88	63,233
Band 7 Physiotherapy Services	0.86	61,796
Band 4 Occupational Ther Serv	1.00	44,647
Band 3 Office Services	1.00	40,817
Band 3 Office Services	1.00	40,817
	9.67	618,190
Non-Pay Estimate		**No budget identified. Finance**

Component 2

Additionality for the current Long COVID Service to expand to long term conditions

Component 3

<table>
<tr><td>Centre for Integrated Care</td><td>
<table>
<tr><td></td><td></td><td>taken from salary budget</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

<table>
<tr><td>0.07wte 8A Team Lead (to increase post to fulltime</td><td>£5,981</td></tr>
<tr><td>3 wte band 6 AHP</td><td>£176,944</td></tr>
<tr><td>1wte band 4 Support worker</td><td>£44,647</td></tr>
<tr><td>1 wte band 3 Admin support</td><td>£40,817</td></tr>
<tr><td>Non pays budget for staff training, laptops, phones, ADL equipment for compensatory strategies, travel expenses, other non pays spend that supports clinical interventions.</td><td>£40,000</td></tr>
<tr><td>Total cost for multi-year proposal</td><td>£308,389</td></tr>
</table>

<table>
<tr><td>Speciality Doctor</td><td>£24,470.40</td></tr>
<tr><td>Band 6 Registered Nurse/AHP</td><td>£10,483.20</td></tr>
<tr><td>Band 7 Psychologist</td><td>£14,614.08</td></tr>
<tr><td>Band 4 Admin support</td><td>£12,378.66</td></tr>
<tr><td>Total proposal cost for 12 months</td><td>£61,946.34</td></tr>
</table>

Total Service Annual Spend

£ 988,525
</td></tr>
<tr><td>Vision and ambition</td><td>A contemporary service delivery model, enabling General Practitioners and Secondary Care Consultants a centralised referral pathway for patients experiencing symptoms from Long Term Conditions. This service will move alongside the medical treatment of individuals, and offer support to enable people to adjust, manage and live well with symptoms of their condition.

This will be a notable service improvement for the population of GGC who currently experience multiple referrals to multiple services, by offering a single point of contact for symptom management. This specialist support, evidences the improved individual resilience and the resulting reduction in ongoing healthcare usage, by this population group. This offers a much-improved patient experience and outcome.

Anticipating in our service plan, individuals may need longer term individual intervention including medical and psychology</td></tr>
</table>

	assessment and treatment, this model has escalation / referral pathway to the Centre For Integrated Care. The additional staffing funding will enable this specialist unit to respond timeously, through a medically led MDT.
Existing capacity & skill mix	The existing capacity is the developed expert staffing from Long COVID service. This includes 6 Advanced OT and PT Practitioners in long term condition management. This is a highly skilled AHP team, which are an exemplary model of Transforming Roles across Scotland. (see page 10 GGC Long COVID service report) Key to this service development has been collaborative and compassionate leadership role and the support from HCSW and administrative staff.
Optimal capacity & skill mix	The proposal for this non diagnostic service includes skill mix and succession planning with Level 5 and 6 staff. This creates a test and educational bed for a wider staff group with rotational opportunities, and defined career pathway in this clinical area. This delivery model aligns with our National Service Reform Framework, and therefore it will be vital to programme this service with undergraduate staff practice learning.
Timeframe for achieving optimal capacity & skill mix	As reflected in the funding proposal, the current staff are at a juncture in their employment as all are on short term contracts. By securing their employment we will secure these expert staff and harness their expertise which we have invested in. The required recruitment to the additional workforce will direct the timeframe for launch, with Board governance approval processes and communication strategy running in parallel. Our project plan predicts a 12-week lead in to positioning staff in post from the date of funding confirmation. The project plan aims that induction and preceptorship for new staff will be led by current expert staff group and the AHP education lead.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	The evidence from long COVID service is that in 2024 an average of 70 referrals per month. By expanding this service to a non-diagnostic pathway, predicting referral numbers is challenging, but a 100% increase is planned for. This is based on the Scottish

		Government Long-Term Conditions Framework public health data suggesting approx. 30% of the population have a long-term condition, for GGC this equates to ~400,000 individuals.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Individuals and referrers will receive contact of referral confirmation, initial service information and self-management resources within 10 working days.
	Average time from referral to first assessment/intervention.	Utilising the digital first approach will enable triage and access to LTC management resources and classes within 8-12 weeks of referral.
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	The service will triangulate quantitative and qualitative data to evaluate the service based on specific clinical outcome measure, Patient reported experience measures and Patient reported outcome measures. These include but not exclusively, the Modified C19, EQ5D5L, GAD-7 ,Medical Research Council (MRC) dyspnoea scale and Modified Fatigue Impact Scale. Pre and post intervention data will be collected. Clinical outcome data includes profession specific standardised outcome measures, which will cover ADL, function, Vocational rehabilitation needs as well as psychological measures where required. Postural tachycardia syndrome

		(PoTS) symptom severity management.

Name of health board	NHS Highland (including consultation with NHS Shetland, NHS Orkney)

General description of the proposed service within your health board.	NHS Highland will establish an integrated "Long-Term Conditions (LTC) Recovery Service" covering Long COVID, ME/CFS, PTLDS, and similar post-infection or chronic fatigue conditions. This service will build on our existing Highland COVID Recovery Service (which currently provides rehabilitation support for Long COVID patients via Medical review, Occupational Therapy, Physiotherapy and Psychology), and will expand its remit and capacity to include ME/CFS and related conditions. The service will function as a "one-stop" multidisciplinary clinic model, led by a doctor (e.g. a GP/Physician with specialty interest) to ensure robust medical assessment. It will provide holistic assessment, diagnosis (or exclusion of other causes), and coordinated rehabilitation for individuals suffering persistent symptoms such as pathological fatigue, post-exertional malaise, cognitive difficulties, palindromic arthropathy, breathlessness, and autonomic dysfunction. By unifying Long COVID ME/CFS, PTLDS, and similar post-infection or chronic fatigue conditions, we will leverage synergies in management approaches (for example, fatigue strategies) while tailoring care to individual needs. Services will be delivered virtually and in-person as appropriate, ensuring accessibility for our widespread rural and island population. Patients will be able to access the service via referral from primary care and the team will maintain close links with GPs and community services to enhance the patient journey.[1–3]
Changes to expand and widen access existing services	With the new funding, we will expand capacity and widen access in several ways. First, we will liaise with existing ME/CFS clinics in our professional network and lived experience volunteers with both ME/CSF and PTLD from the NHS Highland area to determine a co-created pathway for this patient group. This is likely to be similar, but not identical to the existing long COVID strategy. Thereby opening the service to a wider patient group who previously may not have benefited from a dedicated service. Second, we will increase staffing (detailed below) to handle greater referral volumes and to offer more intensive support (including one-to-one and group interventions) without long

	waits. This will improve coverage across our region – for example, through virtual clinics that patients from remote areas (including the Island boards) can attend, supplemented by in-person assessments/outreach on a case-by-case basis. Third, we will strengthen medical input to the service (adding a GP and some specialist consultant sessions), which will allow more thorough evaluation (e.g. ordering investigations to rule out other diagnoses) and management of complex cases together with collaboration with secondary care clinics. By doing so, we aim to reduce inappropriate referrals and ensure each patient "feels listened to and heard" through a comprehensive assessment process. Fourth, we aim to establish a defined paediatric component: scope with stakeholders in 2025/26 and commence delivery in 2026/27 (e.g. paediatric consultant sessions or liaison model).[4–5] This paediatric aspect is being scoped collaboratively during 2025/26 (working with paediatric specialists and patient families) with a view to implementing the agreed model in 2026/27, in line with engagement outcomes. This will likely involve dedicated paediatric consultant input or a liaison arrangement, as NICE guidance emphasises that children with suspected ME/CFS (and similar conditions) should be referred for *paediatric* assessment and management. We are committing in 2025/26 to determine the best mechanism of paediatric support so that it can be rolled out the following year. Fifth, we aim to redevelop a co-created POTS pathway (NASA lean test at home, AHP management, and physician prescribing where indicated. Finally, we plan targeted outreach and education for primary care teams and the public to raise awareness of the service – for example, providing referrers with clear referral guidelines and promoting self-management resources. These steps will help identify patients sooner and improve equity of access (including for vulnerable groups who might not engage without proactive support). Additionally: Create clear, common entry points and consistent triage when extending the remit to ME/CFS, PTLD and other similar conditions. Increase capacity with additional clinical posts and leadership oversight to stabilise delivery.

	Strengthen digital access for remote communities; standardise use of PROMS/clinical metrics (e.g. C19-YRS, DePaul PEM score, FAS, EQ5DL, etc) to prioritise care, and track outcomes.
Engagement activity	Since 2023, NHSH have been in consultation with NHS Orkney & NHS Shetland. We have built a working relationship and all parties are open to having a collaborative service moving forwards. We are also hoping to further strengthen our working relationship with NHS Western Isles board – a board with whom NHSH already share several services. Co-creation and stakeholder engagement are central to our approach. We will organize two North of Scotland Long-Term Conditions Conferences to bring together all relevant stakeholders in a collaborative planning forum: • Event 1: Inverness (late 2025) – two days; ~20 attendees (GPs, hospital specialists, AHPs, managers, third sector, patient reps; Highland and the Island Boards mentioned above). • Event 2: Island location (early 2026) – follow-up to finalise cross-board model, governance and shared learning. This will facilitate shared learning on best practices for managing Long COVID and ME/CFS, and allow us to co-design future service improvements (for 2026/27 and beyond) with input from all parties. A follow-up conference (in early 2026, hosted in one of the Island board locations for equity) will reconvene the group to finalise the regional service model, solidify partnership arrangements between boards, and ensure lessons from the initial implementation are applied. Budget has been allocated for travel, accommodation and meals for attendees for both events. In addition to these events, ongoing engagement will include regular meetings with primary and secondary care staff to gain their buy-in and feedback, as well as consultations with patient advisory groups (leveraging existing networks such as Chest Heart & Stroke Scotland's Long COVID support group and local ME charities). This collaborative approach will ensure the service is truly responsive to patient needs and is supported by clinicians across the region. Through our consultation with NHS Orkney and NHS Shetland, we have an agreement in principle that a small percentage of their NRAC budget share will be allocated to NHSH for specialist input and strategic oversight should the stakeholder engagements result in a cross-board service.
Additional posts	From October 2025 (pro-rata to March 2026)

	GP 0.8 WTE (salaried GP) – medical oversight, complex case management. Programme/Service Lead 8b/c 0.4 WTE Occupational Therapist Band 7 fatigue/vocational rehab, holistic assessment 1.0 WTE; Clinical Psychologist Band 8b 0.6 WTE Physiotherapist 0.6 WTE (Band 7) – breathing rehab, orthostatic tolerance, activity within tolerance. • Consultant Physician 0.25 WTE (Oct–Mar) – POTS pathway prescribing/complex advice. • Admin (Business Support) Band 4 0.6 WTE – referral, scheduling, data support. • Data and audit: Statistician 0.2 WTE (junior doctor grade), Consultant oversight 0.1 WTE, Band 8b/c 0.1 WTE – build internal outcomes and reporting system. These additional posts are in line with the recommended multidisciplinary skill mix (doctor, OT, physio, psychology, etc.) for Long COVID/ME/ CFS/PTLD services. If budget allows after covering the above priorities, we may also bring in sessional clinicians on a temporary basis to further boost capacity during the initial surge – notably when taking on Island Board patients (for example, additional GP or physician sessions to clear any backlog, or extra AHP hours). We anticipate that approximately 4.0 WTE of staff time is being added in 2025/26 through this funding. Recruitment for these roles will begin as soon as funding is confirmed (with an aim to have staff in post by Q4 2025/Q1 2026).

Vision and ambition	Our vision is to develop a gold-standard, person-centred service for Long COVID, ME/CFS, PTLD and similar conditions, that allows patients to feel truly listened to, supported, and guided towards improved health and quality of life. “Good” means that every patient in Highland (and our partner Island Boards) with these conditions can access timely assessment and coordinated multidisciplinary care without having to navigate fragmented services. As Peter Homa, foundation chair of the NHS leadership academy says: *“Always do what is right for patients and staff. Avoid short-term answers to long-term questions. Often, it’s only when we pursue radical goals that we discover dramatically better ways to care for those we serve”* In practical terms, this means a service where: patients are heard and believed regarding their symptoms; comprehensive medical assessments are done to rule out other causes and confirm the diagnosis (fulfilling the guideline that services be led by an experienced doctor[]); each patient has a personalized care plan (covering physical, psychological, and social aspects) co-created with them; and a core team of

	therapists provides integrated rehabilitation tailored to the patient's goals (consistent with NICE NG188 and NG206 recommendations). Our ambition is for an optimal service that not only treats symptoms but also helps people rebuild their lives – supporting return to work or education where possible, aiding self-management, and connecting patients to community resources. We also aspire to be a center of excellence in the North of Scotland, sharing expertise across boards - so that even those in remote island communities receive the same standard of care as mainland patients, and contributing to emerging research or guideline development (e.g. through our POTS pathway pilot and collaboration with the national Long COVID Strategic Network). **Summary:** A multidisciplinary service, inclusive of a core medical component, delivering timely, empathetic assessment and integrated rehabilitation, ensuring people feel listened to, receive continuity of care, and progress against goals (function, participation, wellbeing). Consistent pathways for Long COVID, ME/CFS and PTLD, with a regional equitable network model to provide a true partnership beyond the traditional hub and spoke model between boards and to provide equality of access that transcends geography. Further we aspire to provide a defined paediatric component in place from 2026/27 following 2025/26 scoping.[1–5]
Existing capacity & skill mix	Small MDT with limited medical capacity; psychology input available but constrained; rurality limits in-person access. Various MDT members' secondments have ended or will move back to substantive posts by March 2026. This highlights the need for further recruitment (and retention).
Optimal capacity & skill mix	GP (or specialty doctor) providing clinical leadership in the MDT; Service/Programme lead providing overall oversight and cross-board cooperation, strategy and sustainability. OT (senior and core), physio, clinical psychology, admin/data; defined paediatric component; access to consultant-level advice for complex cases/POTS.[1–5] With the new funding, our optimal model (by the end of 2027/28) will have a fully staffed multidisciplinary team: a GP or specialty doctor (~1.0 WTE), supported by at least 0.4 WTE Service lead, 1.0 WTE Occupational Therapist, 1.0 WTE Physiotherapist (we anticipate eventually increasing physio from 0.6 to 1.0 as demand grows), 0.6 WTE Clinical Psychologist (to provide robust coverage for psychological assessment and therapy needs - (we anticipate increasing psychology input from 0.6 to 1.0 as demand grows), and access to specialist medical input (e.g. a consultant in rehabilitation or cardiology at ~0.1–0.2 WTE for complex case review and mentorship of the GP). We will also maintain

	administrative and data support. This skill mix maps to the recommended core team for LC rehab (OT, PT, psychology, medical, etc.) and to the ME/CFS guideline's call for a coordinated multidisciplinary approach including medical, therapy, psychological, social expertise. Additionally, our optimal service will cultivate links with wider services: for example, readily referring to social services or welfare advisors (for benefits and social support), linking with vocational rehabilitation services to help patients return to work, and engaging specialist services (respiratory, cardiology, neurology, pain management, etc.) through clear referral pathways for any investigations or treatments beyond our team's scope. By having this rich skill mix, we can manage most patients effectively within our service, while those few who need secondary care referral will be identified and supported through that process by our team.
Timeframe for achieving optimal capacity & skill mix	We plan a phased approach over the funding period. In 2025/26 (by March 2026), we aim to establish the foundational team (GP, OTs, physio psychology, admin) and to then launch the expanded service following stakeholder consultations. This immediately brings us much closer to the optimal model. In 2026/27, with a full year of recurring funding, we will evaluate service demand and outcomes from the initial phase. By mid-2026 we expect to recruit any additional hours needed (for instance, increasing the physio to 1.0 WTE if waiting times are long, or adding more psychology time if the case complexity demands it). We also aim to formalize network agreements with three Island Boards by 2026. We hope to avoid a top down, "Hub and Spoke" approach, rather developing a network of equal professionals: whilst NHS Highland might provide specialist input (e.g. the GP or consultant can do virtual consultations for island patients) while local island teams provide expertise on rural medicine, throughout the highlands and islands and provide hands-on elements of rehabilitation care. By 2027/28, we anticipate the service will reach a steady state at the optimal capacity described. Summary: • 2025/26 (Oct–Mar): Leadership oversight; recruit GP; expand AHPs & consultant sessions; launch data system; conferences and stakeholder sessions. • 2026/27: GP in post; defined paediatric input commenced; refine capacity to meet demand. • 2027/28: steady-state optimal MDT, sustained regional model, robust outcome reporting

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	2025/26 (half-year ramp-up): ~ 60–80 new referrals.

		From 2026/27: ~200–250 referrals per year (plus group contacts), all appropriate referrals offered an appointment
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Referral to initial contact within two weeks; referral to first assessment/intervention within four to six weeks; care plans shared with patients/GPs; MDT case reviews for complex cases; continuity via named coordinator.
	Average time from referral to first assessment/intervention.	Referral to first assessment/intervention within four to six weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	We plan to collect a range of outcome and experience data to measure the impact of the service. Key clinical outcome measures will include patient-reported outcome measures (PROMs) such as the COVID-19 Yorkshire Rehabilitation Scale (C19-YRS) or similar symptom severity scores, which the ELAROS app facilitates tracking digitally. We will use these at baseline and follow-up to quantify changes in symptom burden (fatigue levels, breathlessness scores, cognitive function, etc.). For ME/CFS patients, we may use the DePaul Symptom Questionnaire or functional scales like the Karnofsky Performance Scale to track functional improvement. Patient experience will be captured via feedback questionnaires (e.g. a tailored survey asking about satisfaction with access, whether they felt heard, and whether their needs were met). We also intend to

		capture objective measures where possible: for example, 1-minute sit-to-stand test or 10-minute NASA Lean Test results for those with suspected POTS as recommended by NSS LC guidelines (improvement in these over time could be an outcome), and employment status or activity levels at start and end of intervention (to see if people return to work or increase daily activities). We will record the average length of intervention (how many sessions, over how many weeks, is a typical patient involved) and track discharge outcomes (e.g. number of patients discharged with self-management only, number referred onward to other specialist services, etc.). Importantly, we will collect data to contribute to national reporting: number of referrals, number assessed, waiting times, etc., as required by the funding governance. Our service database (potentially using the ELAROS platform or a local spreadsheet) will be set up to capture all these data points. This data will be reviewed monthly within the team and reported quarterly to the Board and Scottish Government. If possible, we will also collaborate with Public Health Scotland's Long COVID data efforts to ensure we are contributing to the understanding of prevalence and needs (for example, sharing anonymized data on patient demographics and outcomes). By developing a robust dataset, we aim to demonstrate the effectiveness

		of the service (e.g. showing improvements in patient-reported fatigue or function after intervention) which will support any case for longer-term mainstream funding. Finally, In addition to clinical outcome and patient experience data, we will collect and develop data on staff wellbeing, using the Areas of Worklife Scale (AWLS) as a structured framework. This will allow us to track how the team experiences their workload, control, reward, community, fairness, and value alignment over time. These domains are known predictors of burnout and turnover, and systematically monitoring them will provide early warning of pressure points that could undermine recruitment and retention. Strong leadership is needed to prioritise this data collection, not as an “add-on,” but as a core component of service sustainability: if staff wellbeing is safeguarded, the service can maintain stability and provide high-quality, compassionate care for patients. Embedding AWLS monitoring into regular audits will ensure that leadership decisions are informed by evidence about the working environment, reinforcing the link between staff experience and patient outcomes.

Name of health board	NHS Lanarkshire

General description of the proposed service within your health board.	**Aim:** Develop a Post-Viral Conditions and Chronic Fatigue Specialist Team within NHS Lanarkshire. The service will provide evidence-based, person-centred assessment and rehabilitation for people living with the symptoms associated with conditions such as Long COVID, ME/CFS, and other related post-viral fatigue syndromes in line with NICE 209 and NICE Covid-19 rapid guideline. The team will address a gap in coordinated care for this population and reduce pressures on primary and acute services. **Background:** NHS Lanarkshire serves a population of approximately 655,000 people, with areas of high deprivation and long-term health inequality. As of recent Public Health Scotland estimates, more than 10,000 people in Lanarkshire are likely to be experiencing ongoing symptoms of Long Covid. Many of these patients report prolonged fatigue, cognitive symptoms, post-exertional symptoms, and significant reductions in functional ability. In addition, it is estimated that 1 in 250 people in Scotland live with ME/CFS, a condition shown to be historically underserved by specialist services (Scottish Government 2023). There is currently no dedicated multi-disciplinary team in NHS Lanarkshire to support people with non-Covid related post-viral fatigue syndromes, resulting in fragmented care, inappropriate referrals, and avoidable hospital presentations. Covid specialist services within NHSL are also time limited due to non-recurring funding. Due to time limited funding, the intent of the NHSL Covid Rehabilitation pathway has always been to provide temporary support, allowing time to develop a clear plan for Long Covid clinical activity to be managed throughout existing Lanarkshire services. From October 2024, the Covid pathway progressed to mainstream provision for new presentations, and the pathway access point has been replaced by a rehabilitation coordination tool, helping referrers to navigate existing mainstream pathways, with guidance towards the most appropriate interventions based on presenting symptoms. This transition period has been supported by ongoing learning and development opportunities, ensuring that clinical expertise, best practice, skills and knowledge within

	the temporary covid specialty workforce is widely shared with the work force in mainstream services. The additional year of 25/26 funding has retained a reduced Covid workforce, and has offered the opportunity to strengthen the mainstream integration process ensuring: • The remaining covid workforce will see all patients currently on the Covid Pathway waiting list. • Retaining and further developing expert CRT clinical knowledge in Lanarkshire, to support the flow of patients through integrated mainstream services • Clinical expertise, best practice, skills and knowledge within the covid specialty workforce is widely shared with the workforce in mainstream services via comprehensive education programmes. • Supporting a leadership role to continue working alongside the Long Covid Strategic Network providing assurances that equitable, safe, effective and person centred care for people with long term effects of COVID are being delivered within Lanarkshire. This would include ensuring resources are implemented effectively and that evaluation of effectiveness of service developments and patient interventions continue to be collated. **Proposal:** NHSL's proposal will expand the current Covid rehab team, who have the skillset to treat the symptoms associated with conditions such as ME/CFS, and other related post-viral fatigue syndromes. The new pathway will focus on symptom rather than condition based referral pathways. Service provision will be provided by an interdisciplinary team focus delivering specialist advice and complex case assessment where self-management or first line advice via a primary care pathway is not having the desired impact. The service will provide support to individuals over the age of 16. Specialist paediatric skills will remain within paediatrics services, as this is the most appropriate model for NHSL. The service will link and collaborate with paediatric services to ensure learning/education and support is available for all Children and Young People's pathways as required.

	Objectives: • Develop a dedicated specialist team within NHS Lanarkshire to support adults with post-viral fatigue syndromes (LC, ME/CFS) by supporting this with recurring resource. • Provide specialist holistic assessments and patient centred goals/treatment plans. • Promote safe and tailored symptom-led specialist rehabilitation. • Reduce pressure on GPs, ED/USC by improving single point of access to specialist services. • Support return to work, education, and social roles where appropriate. • Support/educate NHSL workforce within mainstream pathways, raising awareness of the complexities of symptoms and facilitate support/self-management advice. • Develop NHSL self-management/digital based resources and promote use of within all services who have contact with this patient group. **Service Delivery:** • Referral pathway from primary care services, community rehab teams, hospital discharge, and explore future self-referral options and self-initiated reviews. • Based in community health hubs across Lanarkshire giving equality of access. • AHP led service, with collaboration and consultation with GPs as the key medical care provider, and with specialists within secondary care as appropriate e.g. Cardiologists, Rheumatologists. • Hybrid delivery using NHS Near Me for virtual consultations alongside in-person assessments as appropriate. • Integration/partnership working with existing services such as: • Primary care occupational therapy services • Lanarkshire Mental Health & Wellbeing Services • Community Rehabilitation Teams • Employability services and social prescribing networks/3rd sector.
Changes to expand and widen access existing services	**Service Expansion and Pathway Development Update:** In 2025/26, the Covid Rehab Team is focused on strengthening integration with mainstream rehabilitation pathways. Alongside this, the team is actively scoping demand for symptom-focused referral pathways to support the expansion of services beyond Covid rehabilitation. This work aims to ensure appropriate support for individuals with

	post-viral long-term conditions such as ME/CFS, through clearly defined referral routes from primary care, MSK services, and acute and community teams. A new test-of-change referral pathway was launched in July 2025 via Primary Care Occupational Therapy (PCOT), targeting patients with moderate to severe presentations that exceed the scope of standard PCOT provision. This pathway is co-produced across services and is subject to ongoing evaluation to ensure effectiveness and sustainability. **Next Steps – From August 2025:** **Recruitment:** With financial support from the Scottish Government, recruitment for additional team members will begin in September 2025. **Service delivery plan:** A comprehensive service delivery plan has been developed to define the purpose, scope, and structure of the evolving service. **Pathway Renaming:** The referral pathway will be renamed the Specialist Long-Term Conditions Rehabilitation Pathway, reflecting its broader remit. **Tiered Service Model:** The pathway will be implemented in a tiered approach, prioritising support for individuals with the most complex presentations to PCOT. Patients with mild to moderate symptoms will continue to be supported through mainstream services. Planned implementation of other pathways via MSK, rheumatology and cardiology will are in the exploration stages. **Mainstream Support:** The specialist team will provide ongoing education and guidance to mainstream services to enhance their capacity to manage less complex cases effectively. **Stakeholder Engagement:** Engagement with key stakeholders is underway to ensure alignment, collaboration, and shared ownership of the pathway development. **Measurement:** Robust reporting and measurement using those PROMS, Data and patient/staff experience set out in page 10. Lived experience: Patient evaluation questionnaires have been sent to in excess of 70 patients who have completed Covid Rehab. Patient experience interviews will take place in September 2025 with those who have volunteered to give further feedback. This will inform service redesign in the co-production of the service. **Coms:** Engage in consultation with NHSL and HSCP leadership to develop a communications strategy, ready for implementation once funding confirmed.

	POTS: Scoping work is underway to develop a POTS (Postural Orthostatic Tachycardia Syndrome) pathway and clinical guideline within NHS Lanarkshire, in consultation with NSS. We are also engaging with neighbouring health boards to explore opportunities for collaborative working. **Peer support network:** Continue to share and collaborate with national colleagues and peers to share service design ideas.
Engagement activity	There is ongoing engagement and strong commitment from the NHS Lanarkshire Long Covid Steering Group, with representation across the board. NHS Lanarkshire is currently developing a comprehensive Long-Term Conditions (LTC) Strategy. This strategy encompasses all long-term conditions, not reduced to those detailed above. It aligns with the corporate objectives outlined in Our Health Together, Lanarkshire's overarching healthcare strategy, and is being shaped through extensive stakeholder consultation. The NHS Lanarkshire Rehabilitation Strategy emphasises the importance of timely access to information and services that support effective rehabilitation with ongoing stakeholder engagement. Work is actively underway using the CEIM framework to gather patient feedback on Long Covid rehabilitation services. This feedback will continue to inform future service development through co-production with individuals who have lived experience. Patient interviews are scheduled for September 2025. Care Opinion remains a valuable platform for gathering service user feedback to drive continuous improvement. The NHS Lanarkshire Long Covid workbook has been successfully adapted for use nationally, in collaboration with ALLIANCE. We also maintain active participation and collaborative working with the NSS network.
Additional posts	NHSL have staff in post until March 2026 with current Long Covid funding. These will be extended until March 2028 using 26/27 and 27/28 NRAC share: • 1.0 WTE Leadership 8a • 3.0 WTE Band 7 Physiotherapists (currently 1.53 WTE funded NHSL at cost pressure)

	• 1.0 WTE Band 7 Occupational Therapist • 1.0 WTE Band 3 Administrator In addition to these posts we will use our NRAC share for 25/26 to recruit the following positions fixed term until March 2028: • 1 WTE additional Band 7 Occupational Therapist • 0.5 WTE Band 8a Clinical Psychologist • 0.11 WTE Band 7 Speech and language Therapist or Dietitian (assessed on greatest need). In addition, we will temporarily increase psychology to 0.6 and SALT/Dietetics to 0.5 by offering additional sessions during 25/26.

Vision and ambition	**Pathways:** A person-centred approach with consistent clinical governance across all areas. Provide holistic, symptom based pathways which encourage early intervention and self-management advice and resources across every sector, with direct access to specialist input for the most complex of patients. **Digital focus:** Data sharing across health and social care including patient access to personal information. Use of digital solutions across all pathways to help communicate, monitor and engage patients in their own health and care and support staff in best/appropriate pathway choices, giving access to resources and education. **Education:** Information, education and supported self-management across the whole patient journey is crucial to empowering patients to actively engage in their own health and care. Use of 3rd Sector support utilised to their full potential. Access to this interdisciplinary team as a source of expertise within NHSL. Resources and 'workbook' access to all. **Partnership working:** Collaboration with partner organisations and 3rd Sector Community Groups should be encouraged throughout the full pathway. This will involve significant increase in awareness of opportunities and links within each of the different sectors. Coproduction of service and development of services with those with lived experience.
Existing capacity & skill mix	• 1.0 Leadership 8a - Fixed term March 26 • 3.0 Band 7 Physio - Fixed term March 26 • 1.0 Band 7 OT – Fixed term March 26 • 1.0 Band 3 Admin – Fixed term March 26
Optimal capacity & skill mix	Our ideal service provision would require the skill level of: • 1.0 Leadership 8a • 1.0 Band 8a Psychologist • 3.0 Band 7 Physio

	• 2.0 Band 7 OT • 1.0 Band 4 Therapy support practitioner • 0.2 Dietitian • 0.2 SALT • 1.0 Band 4 Admin However to remain within budget with multi- year funding 26/27 and 27/28 we can financially support a team comprising of: • 1.0 WTE Leadership 8a • 3.0 WTE Band 7 Physiotherapists • 2.0 WTE Band 7 Occupational Therapists • 1.0 WTE Band 3 Administrator • 0.5 WTE Band 8a Clinical Psychologist • 0.11 WTE Band 7 Speech and language Therapist or Dietitian
Timeframe for achieving optimal capacity & skill mix	As soon as recruitment concluded – there are currently appropriately OT skilled staff within health board to increase staffing. Existing core team in post can be extended (fixed term). Psychology post will go out to advert. This may be more challenging to recruit to due to fixed term and part time financial constraints. Scoping exercise has already commenced from July 25 with proposals for immediate graded expansion.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	May 2022 – June 2024 CRT accepted 1376 referrals for patients with Long Covid needing rehabilitation. A scoping exercise is ongoing to predict demand for conditions presenting with similar symptoms. On average with a full interdisciplinary team in post (similar to the **optimal** WTE proposed) 400 appointments were offered per month to patients referred to CRT. This included new and return slots.
How well do you expect to do it	Average time from referral to initial contact.	1 week

(Quality of activity/process)	Average time from referral to first assessment/intervention.	12 weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	**<u>PROMS – pre and post</u>** GAD-7 PH-9 EQ-5D-5L, Therapy Outcome measure (TOMs) FACIT fatigue Patient experience – Post Interviewing. Staff evaluation. **<u>Data – Quarterly reporting</u>** Numbers referred, numbers seen, diagnosis groups (to determine staff education needs, demands – POTs etc). Referral pathways utilised. Impact on GP attends pre and post – (timescales post treatment to be determined)

Name of health board	NHS Lothian
General description of the proposed service within your health board.	NHS Lothian recognised early the complexity and heterogenous nature of Long Covid. Rather than a single standalone service, we plan to continue with our stratified approach which we believe will best meet the needs of our population. Our approach therefore is threefold, stratified on need rather than diagnostic criteria: 1. Supported self-management across a range of rehabilitation services in partnership with CHSS 2. Enhanced individual clinical services that offer support to those with the most commonly presenting symptoms of LC / ME/ CFS and other post viral conditions. This includes a range of therapeutic and rehabilitation services, including vocational rehabilitation, breathlessness and fatigue management 3. A full MDT, including a Rehabilitation Medicine consultant for those individuals who have particularly complex needs offering comprehensive assessment, including linking with other medical services.
Changes to expand and widen access existing services	Whilst we have a range of rehabilitation services within Lothian, much of our current Long Covid offer is based on non-recurring funding which will cease in March 2026. We have a well-established, but small ME/CFS service which has seen an exponential growth in demand since 2020. Our proposal is to expand the existing ME/ CFS service to allow capacity to meet demand. In addition to establishing our other rehabilitation offer on a recurring basis. Through the non recuring funding received to date we have successful trialled a comprehensive MDT approach in Lothian to our most complex patients after securing input from a Consultant in Rehabilitation Medicine. Planned expansion from 2026 / 2027 will allow us to meet the needs of our most complex patients, on a Regional basis for patients across NHS Lothian, Fife, Forth Valley and Borders. All boards will offer their own local rehabilitation services however due to capacity and expertise required will be challenged to offer a comprehensive MDT approach that includes appropriate medical and psychology input in each board independently. Instead this will be offered Regionally with each board contributing their NRAC share to the Regional aspect; access will be supported through both outreach where appropriate and / or remote access fully utilising digital approaches.

	Our regional approach will also offer educational opportunities for local staff in all four boards, enhancing sustainability of services going forward. For Children and Young People we believe that their needs will continue to be met best through the wrap around model already provided using a GIRFEC approach however we will enhance our offer to Children and Young people through increased Occupational therapy input plus close collaboration with ME/CFS service.
Engagement activity	Service User engagement has been a key factor throughout the development of our Long Covid service developments, with our clinical lead chairing our Long Covid Patient Representative Group. We plan to expand membership of this group to those with other LTCs.
Additional posts	NHS Lothian: 3.6 Occupational Therapist (ME/CFS, Vocational Rehabilitation, CYP) 1.0 Physiotherapist (ME/CFS) 1.0 Speech and Language Therapist (breathlessness/ respiratory) 1.0 Clinical / Service Lead Regional for South East Scotland: 1. Medical consultant (likely Rehabilitation Medicine however may split across specialty) 1.0 Medical secretary / admin support 0.5 wte Psychologist 1.0 AHP Clinical Lead

Vision and ambition	NHS Lothian will provide, individualised, accessible, flexible, compassionate, trauma-informed, responsive, high quality, nationally recognised specialist multidisciplinary services for patients and their families. We will provide timely access to a range of evidence-based interventions and resources, (consistent with NICE guidelines) for patients experiencing the range of severity of ME/CFS, Post Covid or PVFS symptoms. We will ensure that service users are involved throughout in decisions relating to their physical, emotional and social care needs. We will offer specialist resources for colleagues working in primary care, and hospital services on both a local and regional basis, providing support, guidance, information, training and consultation. Our services will support individuals to develop self-management strategies of their long term condition, enhancing

	their potential for improved functioning, maintenance of independent living and education/training/work, enhanced mental health, and quality of life.
Existing capacity & skill mix	Other than general rehabilitation services, ME/CFS is currently the only specifically funded pre-existing service: 1.0 WTE Applied Psychology 0.5 WTE Specialist Physiotherapist 1.1 Occupational therapy (nonrecurring LC funding ceasing March 26)
Optimal capacity & skill mix	See additional posts section above
Timeframe for achieving optimal capacity & skill mix	We are confident that the skills, knowledge and expertise required are available within the workforce available for recruitment as the non-recurring funding has allowed a number of secondments / temporary posts. Early confirmation of recurring funding would allow us to make a seamless progression of our existing offer through recruitment on a permanent basis. For optimal capacity / skill mix implementation we would be confident of this being in place within 4 – 6 months of funding confirmation. We would plan to commence our Regional model from April 2026.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	Estimated numbers based on historical and projected data: 1200 - 1500 / year All individuals will be triaged and offered an appointment with appropriate clinician / service / pathway. This may be single clinician or MDT review. Depending on patient need or choice, individuals may receive 1:1 or group sessions.
How well do you expect to do it	Average time from referral to initial contact.	Maximum 18 weeks; individual AHP services have 12 week target RTT

(Quality of activity/process)	Average time from referral to first assessment/intervention.	As above, intervention typically starts with initial appointment
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	Our services use a range of outcome measures, including but not limited to: • Chalder Fatigue measure • Physical Functioning Measure (SF36) • Mood and Anxiety (PHQ-9/GAD-)7 • EQ5D • Epworth Sleepiness Scale • PGI and CGI • Patient Satisfaction measure Work status

Name of health board	NHS Orkney
General description of the proposed service within your health board.	From 2026/27, NHS Orkney proposes to collaborate with NHS Highland, NHS Shetland, and the Western Isles to deliver a regional Long Covid and ME/CFS service. This model will allow NHS Orkney to allocate its funding to NHS Highland, who will act as the lead provider for specialist assessment, clinical oversight, and multidisciplinary rehabilitation. NHS Orkney will retain local delivery of face-to-face care through existing staff, supported by remote clinical advice and shared protocols. This approach addresses current limitations in our local service model, including fragmented provision and limited access to specialist medical input. It will enable a more sustainable and equitable service for our population, aligned with NICE guidelines NG188 and NG206
Changes to expand and widen access existing services	The collaborative model will significantly expand access to specialist services for people with Long Covid and ME/CFS in Orkney. It will provide: • Access to a multidisciplinary team led by appropriately skilled clinicians • Shared care pathways and protocols across boards • Remote access to specialist advice and virtual clinics • Enhanced support for local clinicians delivering face-to-face care
Engagement activity	Engagement with NHS Highland and other island boards is ongoing to co-design the regional model. Local clinicians and service leads have contributed to shaping the proposed pathways and identifying workforce and digital enablers. There are specific engagement activities planned by nHS highland – see below two North of Scotland Long-Term Conditions Conferences to bring together all relevant stakeholders in a collaborative planning forum: • Event 1: Inverness (late 2025) – two days; ~20 attendees (GPs, hospital specialists, AHPs, managers, third sector, patient reps; representatives from the island boards and highland • Event 2: Island location (early 2026) – follow-up to finalise cross-board model, governance and shared learning. This will facilitate shared learning on best practices for managing Long COVID and ME/CFS, and allow us to co-design future service improvements (for 2026/27 and beyond) with input from all parties. A follow-up conference (in early 2026, hosted in one of the Island board locations for equity) will reconvene the group to finalise the regional service model, solidify partnership arrangements between boards, and ensure lessons from the initial implementation are applied. Budget has

	been allocated for travel, accommodation and meals for attendees for both events. In addition to these events, ongoing engagement will include regular meetings with primary and secondary care staff to gain their buy-in and feedback, as well as consultations with patient advisory groups (leveraging existing networks such as Chest Heart & Stroke Scotland's Long COVID support group and local ME charities). This collaborative approach will ensure the service is truly responsive to patient needs and is supported by clinicians across the region. Through our consultation with NHS Orkney and NHS Shetland, we have an agreement in principle that their NRAC budget share will be allocated to NHSH for specialist input and strategic oversight should the stakeholder engagements result in a cross-board service.
Additional posts	No additional posts are proposed locally. NHS Orkney will continue to utilise its existing 8a Advanced Practitioner in respiratory care and other local teams (Eg Occupational Therapy), supported by NHS Highland's multidisciplinary team. Providing our funding to a pool enable NHS Highland to add additional practitioners to their model – a specialist nurse and additional hours of GP and psychology cover. Our share of the funding would not enable any additional capacity locally realistically as we historically have found it very challenging to recruit practitioners for small contracts

Vision and ambition	• Our vision is that all individuals with Long Covid or ME/CFS in Orkney have timely access to high-quality, evidence-based care, regardless of geography. By collaborating regionally, we aim to overcome workforce and resource constraints, ensuring that even complex cases receive appropriate specialist input. • This model supports sustainability, avoids duplication of scarce specialist roles, and ensures alignment with national guidance.
Existing capacity & skill mix	• **Existing**: Limited local capacity, with limited input from a specialist advanced practitioner in respiratory care and other services working in an adhoc way accepting long covid and CFS/ME and other diagnosis as identified without formal pathways or resource
Optimal capacity & skill mix	Access to a multidisciplinary team including medical oversight (GP and consultant), OT, physiotherapy, psychology, and specialist nursing – with a hub and spoke model
Timeframe for achieving optimal capacity & skill mix	WE anticipate regional model to be operational from April 2026

How much do you expect to do	Number of individuals referred to services.	2025/26 (half-year ramp-up): ~5-10 new referrals.

(activity/process)	Number of individuals offered an appointment.	From 2026/27: ~200–250 referrals per year across the whole of hosted area(plus group contacts), all appropriate referrals offered an appointment
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Referral to initial contact within two weeks; referral to first assessment/intervention within four to six weeks; care plans shared with patients/GPs; MDT case reviews for complex cases; continuity via named coordinator.
	Average time from referral to first assessment/intervention.	referral to first assessment/intervention within four to six weeks
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	We plan to utilise the outcome and data metrics developed by our partners in NHS Highland and other collaborating boards. This includes clinical outcome measures, patient experience feedback, and staff wellbeing indicators, ensuring consistency and alignment across the regional service.

Name of health board	NHS Shetland

General description of the proposed service within your health board.	NHS Shetland will develop a partnership approach. NHS Highland can provide specialist input (e.g., virtual consultations with a GP or consultant), while local island teams contribute their expertise in rural medicine and deliver hands-on elements of rehabilitation care.
Changes to expand and widen access existing services	The Shetland access will widen to incorporate the elements of the service delivered in Highland that are unable to be delivered locally. This will be done in partnership with Highland and Island Colleagues. Specifically, this will include access to specialist diagnostic, Psychology and AHP.
Engagement activity	We will begin stakeholder engagement sessions in areas in partnership as a Highlands and Islands Team.

Vision and ambition	Our vision is to develop a gold-standard, person-centred service for Long COVID, ME/CFS, PTLD, and similar conditions—one where patients feel listened to, supported, and guided toward improved health and quality of life across the Highlands and Islands
Existing capacity & skill mix	NHS Shetland has a Generalist Specialist Workforce
Optimal capacity & skill mix	A Highlands and Islands approach will aspire to share expertise across boards so that patients in remote island communities receive the same standard of care as those on the mainland, while contributing to emerging research and guideline development. This will ensure a balance of remote access expertise with local generalist specialist skills and knowledge to enable people in communities to live well and maximise their outcomes.
Timeframe for achieving optimal capacity & skill mix	TBC

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	This is still to be confirmed as we establish our Highlands

		and Islands partnership and cost per referral.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	This will align with NHS Highland performance metrics.
	Average time from referral to first assessment/intervention.	This will align with NHS Highland data
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	Shetland AHP experience measure to be developed to understand the impact of partnership working.

Name of health board	NHS Tayside

General description of the proposed service within your health board.	NHS Tayside has adopted an integrated, person-centred model for managing Long Covid and proposes to expand this model, enhancing our AHP led model of symptom and condition management to include Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and other energy-limiting, post-viral conditions. This approach enables individuals to recognise and self-manage the symptoms and impacting functional limitations associated with their long term condition, enabling the maximisation of their quality of life and societal programmes through a rehab focused approach. This service would offer the specialist and targeted models of intervention required by individuals to enable them to then engage with ongoing community based resources and universal offers. The service will work alongside the ongoing development of health and wellbeing hubs with local leisure provides to encourage joint working and shared skills to maximise long term positive self-management behaviours. This approach is aligned with the Scottish Government's Long-Term Conditions Strategic Framework consultation document, the ME/CFS Oversight Group Report, the Scottish renewal framework and value based healthcare. It also reflects the guidance from NICE NG188 (Long Covid) and NG206 (ME/CFS), emphasising early access, coordinated multidisciplinary care, and holistic, needs-led planning. The GP remains the responsible medical officer for these patients and the model builds in GP capacity for MDT weekly discussions. The AHP rehabilitation and symptom management service will be embedded in HSCP structures and led by Allied Health Professionals, with secondary care advice and treatment where applicable using well embedded models of consultant connect MDT support. Optimising the use of digital resources the service would continue and further expand the links with online self-management support, near me, digital tools, NHS Inform, Chest Heart & Stroke Scotland (CHSS) Advice Line, and third-sector collaboration. It provides symptom and function-based access rather than relying solely on a formal diagnosis. Key elements of the service model include:

	• Primary care-led initial investigations and management planning • Care co-ordination and support provided by the AHP service • Weekly MDTs for case discussion • Supported self-management and early intervention • The use of digital self-management programmes may enable regional working and support and planning discussions are in place across the North region. • Multidisciplinary assessment and individualised rehabilitation • Group education and rehabilitation programmes • Peer and lived experience support • Integration of psychological and spiritual care, where appropriate • Support for vocational rehabilitation and return to work. This inclusive model is designed to offer equitable access to care regardless of diagnosis and enables tailored support across different severity levels of fatigue-related conditions. The Tayside Long Covid rehab model received positive feedback from the population and offered a responsive service for the often relapsing, remitting nature of the individuals needs. The service proposal is directed at adults but discussions have been held with Paediatric AHP managers and agreed that where required support and advice can be offered and peer development and networking can be supported.
Changes to expand and widen access existing services	• Eligibility criteria broadened from Long Covid to be inclusive for those experiencing symptoms associated with conditions such as ME/CFS and post-viral fatigue syndromes based on symptoms and needs. • Embed a single structure across Tayside, linking regionally to maximise the use of resource. • Embed new clinical roles of an AHP rehab consultant for case co-ordination and expert clinical intervention. This addresses a recognised shortcoming of the existing Tayside model in meeting the national guidance with specialist care co-ordination.

	• Continued partnership with CHSS, Live Active, and other peer-led support organisations. • Embed and ensure PROMS, PREMS and other outcome measures are robust and align to national data collection plans as the C19-YRS tool stops. • Rebranding of the current Long Covid service to reflect its broader remit across energy-limiting conditions. • Establishment of local long-term conditions (LTC) networks, incorporating primary care and AHP leadership. • Introduction of a "hub-and-spoke" multidisciplinary outreach model to support those in rural or underserved areas. • Local network to support paediatric teams with condition specific guidance and professional support. • Shared planning for online fatigue management and other resource delivery with regional partners and neighbouring boards.
Engagement activity	• Development of a Lived Experience Network in collaboration with The ALLIANCE. • Regular feedback from patients via surveys (latest: Jan–Feb 2025) and Care Opinion submissions. • Active participation in national programme boards for Long Covid and ME/CFS.
Additional posts	The future service will consist of: • OT Rehabilitation Consultant (LTC). This role will lead the team, offer clinical co-ordination for the population and provide expert OT intervention including vocational rehabilitation and fatigue management. **(Band 8B, 1.0 WTE) – £89k** • Advanced Practitioner Physiotherapist. This role will provide respiratory, breathing pattern, mobility, balance and other clinical specialisms. **(Band 7, 0.8 WTE) – £51k** • Specialist Physiotherapist . This role provides direct rehab & respiratory interventions and supports the self-management programme • **(Band 6, 0.8 WTE:) – £42k**

	• Specialist Occupational Therapist. This role provides direct intervention including fatigue and vocational rehabilitation and supports the self-management programme. **(Band 6, 0.8 WTE:) – £42k** • Healthcare Support Worker Assistant Practitioners **(Band 4, 2.0 WTE) – £72k** • Specialist Speech & Language Therapist **(Band 6, 0.4 WTE) – £21k** • Specialist Dietitian **(Band 6, 0.2 WTE) – £10k** • GP or Consultant input –weekly MDT **(0.05 WTE sessional support) – £7.5k** • Administrative support for group and vocational programmes **(Band 3, 0.4 WTE) – £13k** It is likely that we will be able to recruit existing Long Covid staff to some but not all of these posts as their contracts end. Given the timing for recruitment, the following is our planned additionality spend for year 1: • (Jan – March) AHP Rehabilitation Consultant (LTC) (Band 8B, 1.0 WTE) – **£23k** • (Oct – March) Advanced Practitioner (Band 7, 0.8 WTE) – **£26k** • (Jan – March) Specialist Physiotherapist (Band 6, 1.0 WTE: rehab & respiratory) – **£13k** • (Jan – March) Specialist Occupational Therapists (Band 6, 1.0 WTE: vocational & fatigue) – £**13k** • (Oct – March) Healthcare Support Worker Assistant Practitioners (Band 4, 2.0 WTE) – £**36k** • (Oct – March) Specialist Speech & Language Therapist (Band 6, 0.2 WTE) – £**10k** • (Oct – March) Specialist Dietitian (Band 6, 0.2 WTE) – **£5k** • (Oct – March) GP or Consultant input (1 WTE sessional support) – **£4K**

	• (Jan – March) Administrative support for group and vocational programmes (Band 3, 0.4 WTE) – **£3.5k** Total Planned expenditure: **£134K** If recruitment processes allow we would recruit earlier and this amount would increase but not exceed the total allocation. Challenges anticipated: -Recruiting with multi-year funding for 3 years requires a significant risk appetite for boards as recruitment will be to permanent posts. - The time lines for recruitment in year one limit the planned expenditure and impact for the population. As per national discussions Tayside would support a plan to enable any draw down in this financial year but plan for year one officially to be from April 2026.

Vision and ambition	NHS Tayside's vision is to deliver an equitable, sustainable, and multidisciplinary service that improves functional outcomes and quality of life for individuals with Long Covid, ME/CFS, and other energy-limiting conditions. Our ambition is closely aligned with the Scottish Long-Term Conditions Strategic Framework, focusing on personalised care, early intervention, and integrated self-management and psychological support.
Existing capacity & skill mix	• Experienced AHPs within community rehabilitation teams • Limited access to Dietetics, SLT, and Psychology • Peer support via CHSS and third-sector partners • Structured education and rehab programmes in place • Primary care coordination using Consultant Connect and peer networks The proposed AHP Rehabilitation Consultant will assume the coordination role, drawing on the successful model developed in neurorehabilitation and stroke care.
Optimal capacity & skill mix	• MDT including Physiotherapy, Occupational Therapy, Dietetics, SLT, Psychology, and GP/Consultant input • Vocational rehabilitation and peer support integration • Administrative and digital infrastructure (C19-YRS, ELAROS) • Outreach and digital access support for rural and low-mobility populations

Timeframe for achieving optimal capacity & skill mix	• Core MDT roles established by Q4 2025/26 • Enhanced digital and rehabilitation medicine integration by mid-2026/27 • Full MDT and pathway implementation by end of 2027
Risks / constraints / challenges to achieving vision	• Variability in coding of ME/CFS and fatigue syndromes limits activity modelling • Recruitment and retention challenges for short-term posts; need for sustainable staffing • Gaps in vocational rehab provision for working-age adults Pressure on GP continuity; mitigated through AHP care coordination • Digital equity barriers; local delivery via community rehab teams will reduce access inequality

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	1. Long Covid • Estimated prevalence: UK data suggests 2%–3% of the population may experience Long Covid symptoms beyond 12 weeks. Applying 2.5% to Tayside: • 416,000 × 2.5% = ~10,400 individuals • Not all of these will require referral: • If 5%of those seek MDT rehab services: 520 referrals/year 2. ME/CFS • Estimated prevalence: ~0.2%–0.4% of the general population • 416,000 × 0.3% (midpoint) = ~1,250 individuals living with ME/CFS

		• Assuming 10%–20% might be actively referred in a given year: • 125–250 referrals/year 3. Other Post-viral / Fatigue Syndromes • Harder to estimate precisely, but potentially another 100–200 referrals/year, especially with widened eligibility criteria.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	10 – 14 days
	Average time from referral to first assessment/intervention.	21 – 28 days
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	• Patient-reported outcome measures (PROMs), including EQ-5D and Fatigue Impact Scale • C19-YRS data (where implemented) for symptom tracking and service evaluation • Patient experience feedback through surveys and Care Opinion • Tracking of vocational and functional status improvements (return to work/education, ADLs) • Equality monitoring for access and digital inclusion

Name of health board	NHS Western Isles
General description of the proposed service within your health board.	The local proposal is to employ a Long Covid/ME/CFS practitioner for approximately 2 days per week on a substantive contract. This practitioner will act as a clinical resource as well as providing co-ordination of a virtual MDT for this cohort of patients spread across the Island chain on NHSWI. The practitioner will work both as clinician and also link worker/social prescriber. The role has been written to appeal to nursing or AHP colleagues and awaits final approval and sign off.
Changes to expand and widen access existing services	NHSWI are conscious of the geography and population size. We aim to work with third sector partners who already provide input into this area. Specifically there is an offer from Pain Association Scotland to help support the biopsychosocial needs of this group with their regular monthly sessions. In addition we have linked with CHSS who provide on line support specifically aimed at Long Covid.
Engagement activity	The local NHSWI Intranet provides access to resources for Long Covid/ME/CFS for all clinicians. Once we have a practitioner in post we will aim to engage with the community and publicise much wider.
Additional posts	NHSWI feel the above model working as a virtual MDT with OT/Physio/Mental Health/GP/General Medicine and Respiratory specialities/Primary Care/Community resources and the third sector will allow sufficient coverage for the Island chain.

Vision and ambition	The vision is a single point of contact for all suffering from Long Covid/ME/CFS. This will allow self referral as well as professional referral. The SPOC will act as a co-ordinator and champion/advocate for this patient group. Geography makes an MDT clinic approach less attractive due to capacity and the need to avoid unnecessary travel for patients both from a social point of view and also bearing in mind the carbon footprint of such a model. We will use Near Me technology as appropriate as well as other digital means where this suits the patient.
Existing capacity & skill mix	Over the last four years we have developed a virtual group of interested clinicians and support workers. This has been co-ordinated by a short term secondment (B6 nurse) to develop a network of staff and resources. In particular we have linked with and supported: • Primary Care Occupational Therapy. This group, as well as the wider OT team have taken a lead for the service

	providing access to holistic care for individuals referred by the Primary Care team. Whilst this would be an option for a standalone service, which has been considered, problems with recruitment and retention have prevented progress in this area. • Physiotherapy. Linking in with OT the Physio department have provided input with pacing and aspects of movement and pain management. • Respiratory Consultant. Link for patients whose primary issues relate to breathing with access to respiratory physio and specialist nursing. • General Medicine. Interested lead locum Gen Med consultant providing support and clinic review as required • Mental Health. We provide a range of face to face and virtual resources to support this cohort. There is a general shortage of psychology due to issues of recruitment and retention in a small Island health board. We use virtual support wherever possible and have a cross island agreement with colleagues in NHS Orkney to help support this area. • Public Health. Provide resources that can be signposted too for graded activity including walking groups. • Council. Local scheme providing support for monitored and graded activity • Third Sector. Pain Association Scotland and CHSS both provide on line video support sessions including pacing, fatigue management, medication, pain management etc. The former being funded directly by NHSWI.
Optimal capacity & skill mix	As stated above, we believe that a single resource of co-ordinator is optimal. This based on population but also on resource allocation which would preclude funding a much wider team directly. As is often the case the Island health boards need to work differently to accommodate the challenges of geography, demographic and NRAC formulation.
Timeframe for achieving optimal capacity & skill mix	We believe with successful recruitment into post we will be able to achieve the above within the next twelve months.

How much do you expect to do (activity/process)	Number of individuals referred to services. Number of individuals offered an appointment.	Access to accurately coded diagnoses is an ongoing challenge to allow a prediction. Anecdotal work at primary care level suggests that there are circa. 20 patients per 5000 population actively seeking support at any one time. This would equate to approximately 100 for the Western Isles population.

		At present we are not coding appointments as these happen out with a single point of contact. We are aware anecdotally of activity across all the specialities identified above.
How well do you expect to do it (Quality of activity/process)	Average time from referral to initial contact.	Our target is 14 days from referral to contact.
	Average time from referral to first assessment/intervention.	This will depend on triage at initial contact. An expectation is for this to be within 28 days to first assessment by the single point of contact.
What other data will be collected/developed?	Any other data / patient experience and outcome measures.	We aim to collect data through the single point of contact including: initial diagnosis, reason for referral, time to first contact, time to first assessment, referral locations, time in service, outcomes, patient satisfaction/experience, and patient reported improvement in presenting symptoms.