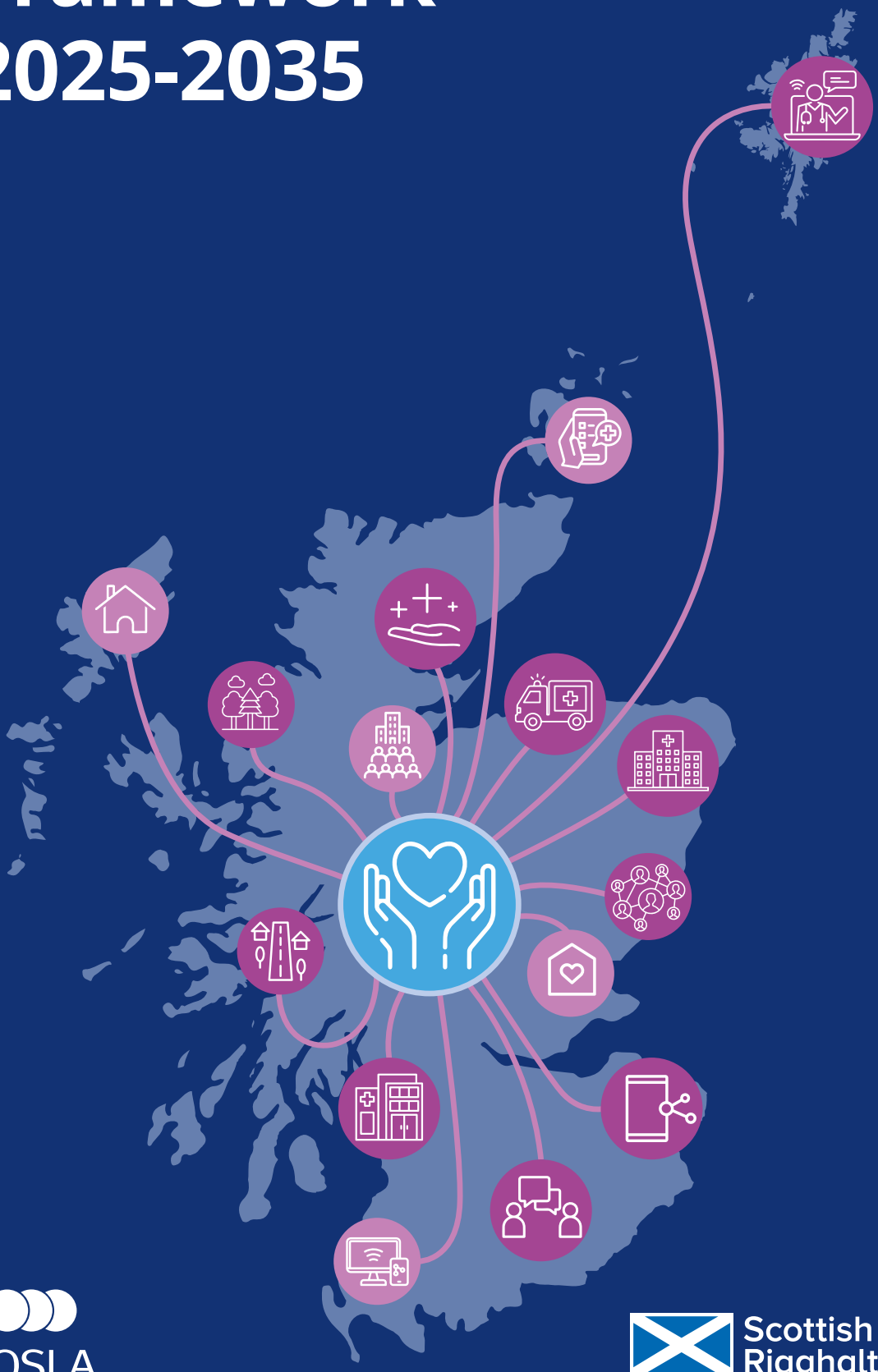
Health & Social Care Service Renewal Framework 2025-2035



COSLA

Scottish Government
Riaghaltas na h-Alba

Contents

List of Acronyms

AI - Artificial Intelligence
ARC – Alarm Receiving Centre
cCBT – computerised Cognitive Behavioural Therapy treatments
CHI – Community Health Index
COSLA – Convention of Scottish Local Authorities
CPP – Community Planning Partnership
GIRFE – Getting it Right for Everyone
GP – General Practitioner
HSCPs – Health and Social Care Partnerships
IJBs – Integration Joint Boards
IT – Information Technology
IV – Intra-Venous
MDT – Multi-Disciplinary Team
MSK – Musculoskeletal
NCS – National Care Service
NHS – National Health Service
NHSEG – NHS Scotland Executive Group
NSS – National Services Scotland
OIP – Operational Improvement Plan
PCSPs – Pharmaceutical Care Service Plans
PHF – Population Health Framework
PHS – Public Health Scotland
PPC – Preventative and Proactive Care
SLIF – Scottish Learning and Improvement Framework
SRF – Health and Social Care Service Renewal Framework

Foreword

Our health and social care system is at a critical juncture. The challenges are well known, including shifting demographics, growing demand, the impacts of a changing climate on people's health, and increasing financial pressures. We must respond strongly to these challenges and see them as introducing both necessities and opportunities to transform how the health and social care system works for the people of Scotland. We are grasping this opportunity through bold reform to health and social care.

Our shared ambition between Scottish Government and Local Government is to ensure people of all ages are able to live well, with the right support, and to lead healthier and more fulfilling lives. National and Local Government have a shared responsibility to create the conditions for this to happen, and this Health and Social Care Service Renewal Framework (SRF) is a step towards setting out how we will work together to achieve this. This Framework sets out how we will shift the balance to enable a community-orientated approach to health and social care which, in turn, will contribute to better integration of services to meet individuals' and families' needs.

Together, the changes set out in this Framework will deliver our vision for health and social care. They will progress reform to ensure long-term financial sustainability, reduce health and care inequalities, further harness the benefits of digital technology, and improve health outcomes for people in Scotland.

The impact of this reform for the people of Scotland will be significant. The system will be reshaped to focus on delivering the outcomes that matter to the people we support and care for, and empowering people to be more in in charge of the care they receive. Building the capacity of, and access to, primary and community care means access to high quality care will be easier and more equitable.[1] At the same time, we will further develop centres of excellence, building on the success of our National Treatment Centres, and ensuring that those who need more acute and complex treatment can access this more quickly.

This will have significant implications and opportunities for the health and social care workforce. Our staff comprise the very fabric of our health and social care system and are our greatest asset. Our commitment is to work collaboratively with them to build capacity and rebalance resources to enable this shift to the community. This will require new ways of thinking and planning, as well as working together in different ways. This Framework provides the guidance and authority for system and service leaders, as well as staff, to plan and deliver the key transformations needed to realise our vision for health and social care in Scotland.

[1] WHO (2018). Building the economic case for Primary Care.

The changes we are setting out will help us seize the opportunities presented by the rise of innovation, digital, and treatment advances, helping to shape a health and social care system that is efficient, high quality, and good value for money. This approach will also rely on Scotland's excellent public research institutions who are producing world leading research and development that offer the opportunity of new clinical insights and ways of working. Critically, the changes must respond to the challenging financial environment and achieve sustainability for the health and social care system.

Now is the time for courage and a shared commitment to change. The time for organisations, the people who deliver health and social care and, of course, the people of Scotland themselves, to come together and collectively design and deliver the transformation required. Only by collective action can we build a system that supports longer, healthier and more fulfilling lives for all.

Neil Gray, Cabinet Secretary for Health and Social Care, Scottish Government

Councillor Paul Kelly, Spokesperson for Health and Social Care, COSLA

Executive Summary

The Health and Social Care Service Renewal Framework (SRF) will help us achieve our vision for health and social care - a '**Scotland where people live longer, healthier, and more fulfilling lives**'. It comes at a time of significant financial challenges for health and social care, and at a time when we expect demand for services to continue to increase, driven in part by Scotland's changing demography.[2]

This Framework provides a high-level guide for change, to ensure the sustainability, efficiency, quality, and accessibility of health and social care services in Scotland. Importantly, the SRF builds on the Operational Improvement Plan (OIP) and Population Health Framework (PHF). The SRF sustains and builds on the immediate improvements set out in the OIP, and it maximises the contribution health and social care services can make to improve population health as described in the PHF.

What the Service Renewal Framework means for people

Implementing the changes set out in this Framework will bring significant, positive improvements to how people in Scotland experience health and social care. Over the next ten years, people can expect faster and fairer access to care, with a particular focus on reducing long waits for planned treatment. By expanding capacity in primary and community healthcare, the SRF will help ensure that more people receive the right care, in the right place, at the right time.

Care will be more 'people-led', with greater emphasis on choice and control. Timely access will be more firmly embedded across care and support services. People will be empowered to be more in charge of their care, and they will be supported to manage their self-care. More 'specialist' clinical care, such as optometry, will be available in local settings, helping to reduce pressure on hospitals and shorten waiting times for more complex care. People will also have improved digital access to information about their own health and care, be able to record information that matters to them, and be able to use digital tools to manage how they interact with the services they use (such as booking appointments). This will further streamline their care journey and reduce some of the frustrations we know people have around how their care is coordinated.

What the Service Renewal Framework means for the workforce

For the workforce, the transformation outlined in this Framework will bring new opportunities to deliver care more effectively and efficiently. Staff will be supported to work in more collaborative, flexible ways across territorial and organisational boundaries. It will mean working more with people as partners in their care and

[2] Scottish Fiscal Commission. (2025) Fiscal Sustainability Report.

having improved access to information about the people they support. Staff and their representatives will play a key role in shaping and developing services and to support individuals to manage their own care, which in turn will reduce demand on acute services.

Our NHS Boards and Integration Authorities will be empowered and held accountable for collaborating on planning and delivering services within the principles of this Framework. That will mean planning at a national, sub-national[3] and local level, working closely with the Scottish Government, partners in Local Government, wider stakeholders and service providers to make change. This work will be progressed by optimising the use of data and drawing on the evidence of what improves outcomes for people. The Framework will also promote an environment in which health and social care system leaders will be authorised and supported to help create the changes necessary to realise our vision.

Principles and Changes

This Framework sets out five key principles for renewal:

1. **Prevention Principle:** Prevention across the continuum of care
2. **People Principle:** Care designed around people rather than the 'system' or 'services'
3. **Community Principle:** More care in the community rather than a hospital-focused model
4. **Population Principle:** Population planning, rather than along boundaries
5. **Digital Principle:** Reflecting societal expectations and system needs

These principles provide an evidence-based and value-driven foundation from which to plan, make decisions, and deliver change.

The Framework also sets out major areas for change, which will deliver on the intentions behind these principles so that they become a reality. These include:

- Enhancing services that prevent disease, enable early detection and effectively manage long-term conditions.
- Delivering health and social care that is people-led and 'Value Based'.[4]
- Strengthening integration across the system.
- Improving access to services and treatments in the community.

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[3] Existing or occurring below a national level, but not necessarily according to Health Board or Local Authority regional boundaries.

[4] Value Based Health and Care delivers better outcomes through the equitable, sustainable, appropriate and transparent use of available resources. Value Based Health and Care in Scotland is based on the primary principle of person centred care that is not only high in quality but also delivers the outcomes and experiences that really matter to people, defined by and reported by them.

- Redesigning our hospitals as we deliver more care within communities.
- Delivering services which are accessible through digital technologies, with people and our workforce able to access and make use of the right information.

To support service renewal, we will need to adapt how we use our resources. Our focus will remain on enhancing efficiency and productivity, applying the Once for Scotland approach—an ethos of national consistency in policy and practice that ensures services are designed and delivered in a unified, streamlined way across the country. This helps avoid duplication, reduce variation, and maximise value across people, finances, and infrastructure. Improving access to services and treatments in communities will also mean using those resources differently, with more of them deployed over time in primary care and community settings.

We acknowledge Audit Scotland's recent report on governance of NHS Scotland and will continue to build robust and clear governance arrangements to support the scale of reform required. We are committed to ensuring that NHS Scotland remains sustainable, accountable, and fit for the future. This Framework is a central part of our response to the challenges highlighted in the report.

We will work collaboratively with system leaders to progress the development of national, sub-national and local population plans, which will reflect the Population principle set out in this Framework.[5] We will maximise the use of existing mechanisms such as Community Planning Partnerships to drive collaborative leadership and planning. We will review current accountability frameworks to ensure transparent, effective governance and decision-making. This will lead to more responsive services, better use of resources, and improved outcomes for people. In doing so, we will deliver care that is safer, fairer and more aligned with people's needs.

We will develop performance management systems with an increasing focus on outcomes, place[6], and person-centred and whole system views.

Recognising the mixed market of providers for health and social care, we will also work with partners across the public, third and independent sectors to strengthen strategic, financial and workforce planning. This is to ensure the workforce is shaped to deliver services that are planned and designed in accordance with this Framework.

[5] A Renewed Approach to Population Based Planning Across NHS Scotland
[6] The Place Principle | Our Place

A Phased Approach to Delivering Long-term Change

This Framework sets out a long-term strategic intent to renew health and social care services, supported by a series of milestones structured around a ‘three horizon’ model. These horizons provide a roadmap for achieving the Year 10 objectives.

We have identified a set of **specific, realistic actions for the first five years**, with a particular focus on Year 1, where detailed planning has already been completed. These early actions lay the groundwork for transformation and allow us to make tangible progress.

For the period beyond Year 5, we have not yet defined detailed actions. This is deliberate. Further changes will be shaped by:

- Evidence of progress made in the early years,
- Ongoing engagement with delivery partners, and
- Evolving population needs and system pressures.

This approach ensures the Framework remains **flexible, evidence-informed, and responsive**, while keeping a clear focus on long-term outcomes we aim to achieve by Year 10.

Key steps to delivering change

Year 1

Foundations for Transformation

Within the first six months, we will:

- Collaborate across Scottish Government, NHS Boards and Integration Authorities to develop **population-level strategic needs assessments**. This foundational analysis will provide a clear understanding of current and future health and care needs, supporting evidence-based decision making and local strategic planning, including workforce planning.

Following this, we will:

- develop collaborative multi-year service change plans at **national, sub-national and local levels**. These plans will translate the insights from the needs assessments into prioritised actions – identifying what needs to change, where and how – alongside the infrastructure, finance and workforce requirements to support delivery;
- agree a **joint programme of ongoing population planning**. This will build on the initial assessments and ensure a consistent, system-wide approach to planning and delivery as more care is delivered in community settings. It will also help embed population-based planning as a continuous, adaptive process across the system;
- support the social care sector, including Health and Social Care Partnerships (HSCPs) and third sector and independent care providers, to **draw upon the evidence base of the population level strategic needs assessments** to inform workforce planning at a local and employer level;
- progress the **work of the Adult Social Care Ethical Commissioning Group**, ensuring the care and support we commission is high quality, person-led, and achieves best value;
- develop a **shared Outcomes Framework** to support implementation – translating the strategic priorities in this document into measurable outcomes that guide delivery, align efforts across the system, and enable transparent reporting on progress;
- publish a **Primary Care Route Map**. This will be a delivery plan for how we will enhance our core front door health services alongside wider community health improvement to support a shift to prevention and community-based care;
- initiate a comprehensive **review of existing NHS accountability mechanisms** to strengthen performance oversight and foster a culture of collaboration, continuous improvement and public trust;
- task NHS Boards and Integration Authorities to actively involve **communities in improving accessibility to services**;
- actively involve the **workforce and their representatives in designing and implementing** the changes we need to see locally and nationally;
- set out a new approach to how national organisations will support local health and social care systems to **deliver digital transformation**;
- introduce a forward-looking approach to **identifying new and promising medicines earlier**. This will help bring the most effective treatments to patients faster.

Year 2-5: **System Integration and Innovation**

- Scottish Government will publish a renewed planning framework that integrates health and social care systems to support coordinated, system-wide delivery.
- Scottish Government and Local Government will develop a **new approach** to commissioning and allocating resources across the health and social care system, that focuses on outcomes rather than organisational boundaries. This will support more flexible and collaborative working, enabling the system to plan and deliver services together where it makes sense to do so, especially in relation to specialist services, so that people receive more consistent, joined-up care, regardless of where they live.
- NHS Scotland and partners will move from initial population needs assessment and early planning into the **delivery phase**, by developing and implementing detailed **integrated service and workforce plans**. These plans will ensure that the right services and staff are in place to meet the specific needs of different communities, linking population data with practical delivery models and workforce capacity.
- The Scottish Government, NHS Scotland, independent contractors and wider partners will continue to drive forward the outcomes and actions to be set out in the forthcoming **Primary Care Route Map**.
- NHS Scotland will develop a **future Hospitals Plan** that clearly defines the evolving role of hospitals, within an integrated health and care system. This Plan will set out which services should continue to be delivered in hospital settings, and which can be safely and effectively shifted into community settings. It will also guide how hospital infrastructure, staffing and service models need to adapt to support this shift.
- Scottish Government and NHS Boards will continue to fast track **proven innovations** to the healthcare frontline through the Accelerated National Innovation Adoption pathway.
- NHS Scotland and its partners will complete the roll out of our Digital Front Door service and the associated online app, and be tasked with further developing and enhancing the service to **transform how people interact with health and social care services in a nationally consistent manner**.

Objectives by year 10: **A renewed health and social care system**

- People will receive more of their care closer to home through our stronger focus on primary and community settings.
- Individuals will be empowered to live well, with improved choice and control over the care and support they receive, resulting in better outcomes.
- Everyone will have the choice and the ability to manage their health and wellbeing online.
- Hospital sites across Scotland will be redesigned to reflect the evolving healthcare needs of the population.
- Rural and island populations will consistently experience care that meets quality standards and delivers effective outcomes.
- Services will be commissioned on an outcomes basis, with resources allocated to drive value and impact across the whole system.
- A refreshed approach to education and training will prepare the future workforce to deliver care in a population-based, community-orientated and integrated system.
- Planning of health and care services will be informed by population needs and priorities.

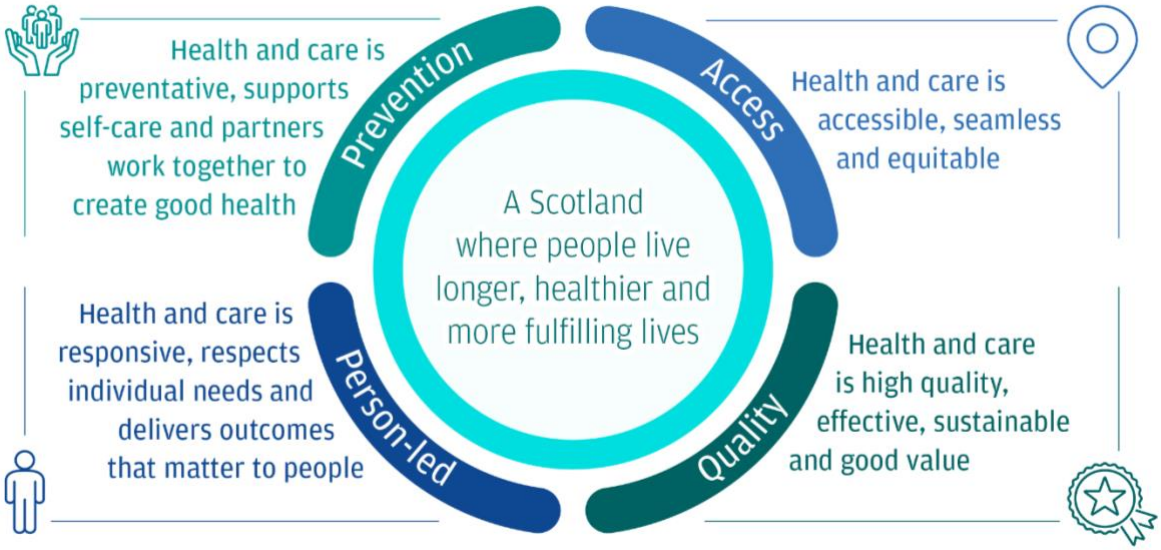
1. Introduction

In June 2024 the Cabinet Secretary for Health and Social Care set out a new vision for health and social care in Scotland:

"A Scotland where people live longer, healthier and more fulfilling lives"

To achieve our vision, we need to focus on improving population health – including mental health – and preventing and reducing inequalities. The vision (see Figure 1) depends on improving prevention and ensuring that health and care services are accessible, high quality, and person-led.

Figure 1: Vision for health and social care



To realise this vision, the Scottish Government has published three interconnected products: an NHS Scotland Operational Improvement Plan (OIP), a Population Health Framework (PHF), and a Health and Social Care Service Renewal Framework (SRF - this document). The OIP describes short-term commitments and actions across NHS Scotland that are needed to improve the experiences of patients. The PHF provides a long-term, cross-government and cross-sector approach to improving health in Scotland.

The SRF sets out the framework within which our system and service leaders, and staff, alongside the wider population, will plan services for the future, building on what we already know works well.

People's experience and priorities will be key in shaping the future of our health and care services. Over recent years there has been extensive engagement with the

public about their experiences of health and care, and they have already told us what matters most to them. We have listened, and we are taking bold steps in this Framework to deliver.

We are publishing the SRF at a point where the fiscal climate is as challenging as it has ever been and with all parts of the health and social care system facing sustainability challenges. Therefore change must be delivered within the existing financial envelope of health and social care.

The financial sustainability of the health and social care system is integral to this Framework, to ensure our resources are used efficiently, effectively and transparently within the context of wider Public Service Reform. The work National and Local Government are undertaking to ensure the viability and sustainability of social care seeks to address these pressures, and close, collaborative work is ongoing. Activity such as this contributes to our vision of a Scotland in which everyone will have access to integrated health and social care services that are efficient, good quality and effective.

The SRF builds on work already underway to fulfil the aims of the Christie Commission, and existing strategies and reform programmes.[7] It will also guide ongoing work on integration of health and social care, which will be a key focus of the new National Care Service (NCS) Advisory Board.

The SRF is designed in line with the principles of Value Based Health and Care. This delivers better outcomes through equitable, sustainable, appropriate and transparent use of resources, delivered through the practice of Realistic Medicine.

The Local Government Best Value themes have also been embedded in our approach to renewal, including: vision and leadership; governance and accountability; effective use of resources; partnerships and collaborative working; working with communities; sustainability; and fairness and equality.

[7] For example: Care in the Digital Age: delivery plan 2024 to 2025; Community Health and Social Care Integrated Services Framework; Mental Health and Wellbeing Strategy 2023; A National Clinical Strategy for Scotland 2016; Health and Social Care: National Workforce Strategy 2022; Healthcare quality strategy for NHSScotland 2020; and work of Primary and Community Health Steering Group on primary care reform.

2. Impact of Service Renewal for People and the Workforce

Our key priority in implementing this Framework is to have a positive impact on people and on the workforce.

Impact for People

A shared aim of the Population Health Framework (PHF) and this Framework is to reduce health inequalities by ensuring that services are designed and delivered in ways that are inclusive, equitable, and responsive to the needs of all communities. This includes targeted support for those who face the greatest barriers to accessing care, whether due to geography, socio-economic status, disability, ethnicity, or other factors. Success in these Frameworks will result in people accessing care more quickly and on a more equitable basis.

People will experience more joined up, integrated care with a greater focus on prevention and early intervention. They will also be more in charge of how this care is delivered, participating in shared decision-making to make informed choices about the treatment and care that is right for them. The public will also inform the wider design and delivery of the reforms presented in this Framework.

In the future, more treatment and care will be available in local communities or, through better use of technology, including through supported care at home. Our acute hospitals will still play a vital role, but this means fewer people will need to go to hospital, unless it is for something that cannot be treated elsewhere, like major surgery or complex treatment and care. Thanks to new ways of working, including mobile healthcare teams and digital tools, treatments like intra-venous (IV) antibiotics can now be safely given at home or in nearby community clinics - whether you live in a town, a rural village, or an island. If someone does need to go into hospital, they will be supported to get home as soon as they are ready, with strong follow-up care and rehabilitation to help them recover well in familiar surroundings.

If someone needs to go to hospital, the type of hospital they attend will depend on the kind of care they need. Most routine treatments can be provided at a local hospital, close to home. But for more complex or specialist care, they might need to go to a hospital that is a bit further away to make sure they get the right support. This is already how many specialist services are delivered, ensuring people receive the best possible care from the most experienced teams. While this may mean some changes in how people access services, they can feel confident that their care will be delivered in the right place, by the right team, to give them the best possible outcome.

People's 'core front door' in-person health services, such as their GP and community pharmacy, will have increased capacity and a strengthened role in the system. People can therefore expect greater access to these services when they need them. Furthermore, multi-disciplinary health and social care teams from hospital to home will work together to wrap around the person and their needs, removing the need for people to navigate multiple teams.

Defined core services and delivery models will ensure equitable access for people living in remote, rural, and island areas. Planning will reflect local needs and ensure consistency in service availability.

People will be offered the choice to access information and services digitally, where appropriate, in an inclusive manner. As our digital and data transformation becomes embedded, digital engagement with health and social care services will increase. This will include, for example, a growing proportion of interactions being via digital services where appropriate. This will include people being able to use their health and care record on their own phone, record their preferences, request checks, manage their condition, coordinate their appointments, access their prescriptions, see diagnostic results, access personalised preventative support and share information with their healthcare professional via our Digital Front Door service.

Those professionals supporting the person will have all the right digital access and information they need to do the best job. Digital and data technologies will enable significant change in our services with personalised and individual shared care plans being accessed and used by staff as the norm. Changes in artificial intelligence (AI), genomics, diagnostic testing and personalised medicine will further accelerate these changes with earlier and faster diagnosis of conditions. We will also aim to share data beyond the health and social care sector, supporting wider public sector reform (for example, to make sure people can easily access benefits they are entitled to).

Impact for the Workforce

The greatest asset of our health and social care system is our dedicated, diverse and highly skilled workforce. The changes that we need to make cannot happen without them. Positive working cultures and excellent staff wellbeing are crucial to the delivery of sustainable change. We want our health and social care services to be a working environment where everyone has the opportunity for an engaging and rewarding career, and where our teams are encouraged to break down boundaries, contribute ideas and drive innovative solutions to improve our health and social care system. As we take forward implementation of this Framework, we will work closely with the workforce and their supporting structures and representative bodies, including professional, regulatory and trade unions, to shape our approach.

As employers and contract holders with primary care providers, NHS Boards will work through their partnership structures and with partner employers to ensure that

the workforce are ready for these changes and feel confident in their skills and ability to work in new ways.

We also recognise the invaluable role of the workforce that is employed through Local Government, the third sector, and independent care sector. All have distinct but vital roles in supporting people to live healthy, fulfilling lives. We will continue to work with partners to improve the experience of the workforce, including through progressing and embedding fair work principles across the health and social care sector.

Knowledge, skills and development will be considered to ensure that the current and future workforce are equipped for the new ways of working needed for the renewal of health and social care services.

Aligned with the People Principle (see Section 3), we want all of our workforce to work with people and patients as partners in their care, with people increasingly leading their own care plan. This requires a rebalancing of power, and a shift for how the workforce and people and patients work together. A larger proportion of the health workforce will work in community settings alongside existing community-based health and social care services. Our health, social work and social care workforce will more often work in multi-disciplinary teams, aiming to meet most care needs in the community, wherever possible and appropriate. Whole system education and training will be developed to support these changes, including developing awareness of the different roles which support people's health and care across the system.

Our workforce will be deployed differently in the future to achieve improved outcomes for the people of Scotland. We will work with partners to strengthen workforce planning to deliver services that are planned and designed based on population needs, aligned with the Population principle. We will ensure the workforce is at the heart of this decision making and is consulted throughout planning. The workforce will continue to be able to make their career choices based on their individual aspirations and we will seek to facilitate choices to work in different settings and across geographic and service boundaries. This includes increasing the supply of affordable homes in our rural and island communities through our Rural and islands housing action plan, and the £25 million Rural Affordable Homes for Key Workers Fund, a five year initiative (2023-2028) to support Local Authorities and registered social landlords acquire suitable properties for key workers where there is identified need. We will continue to invest in our workforce as roles change, and ensure they have the skills and development opportunities in the future to carry out those roles.

The day-to-day experience of the workforce will improve through better use of digital systems to streamline support and reduce the administrative workload, freeing up capacity so staff can spend more time with individual patients and people. This will include making the most of digital care and treatment options. We will also focus on

increasing the digital skills and leadership required, including in developing the specialist digital workforce and further enhancing the Digital and Data Capability Framework.

In all settings, our workforce will be supported to deliver Value Based Health and Care. Careful and kind care sits at the heart of delivering Value Based Health and Care, as set out in Chief Medical Officer annual reports.[8]

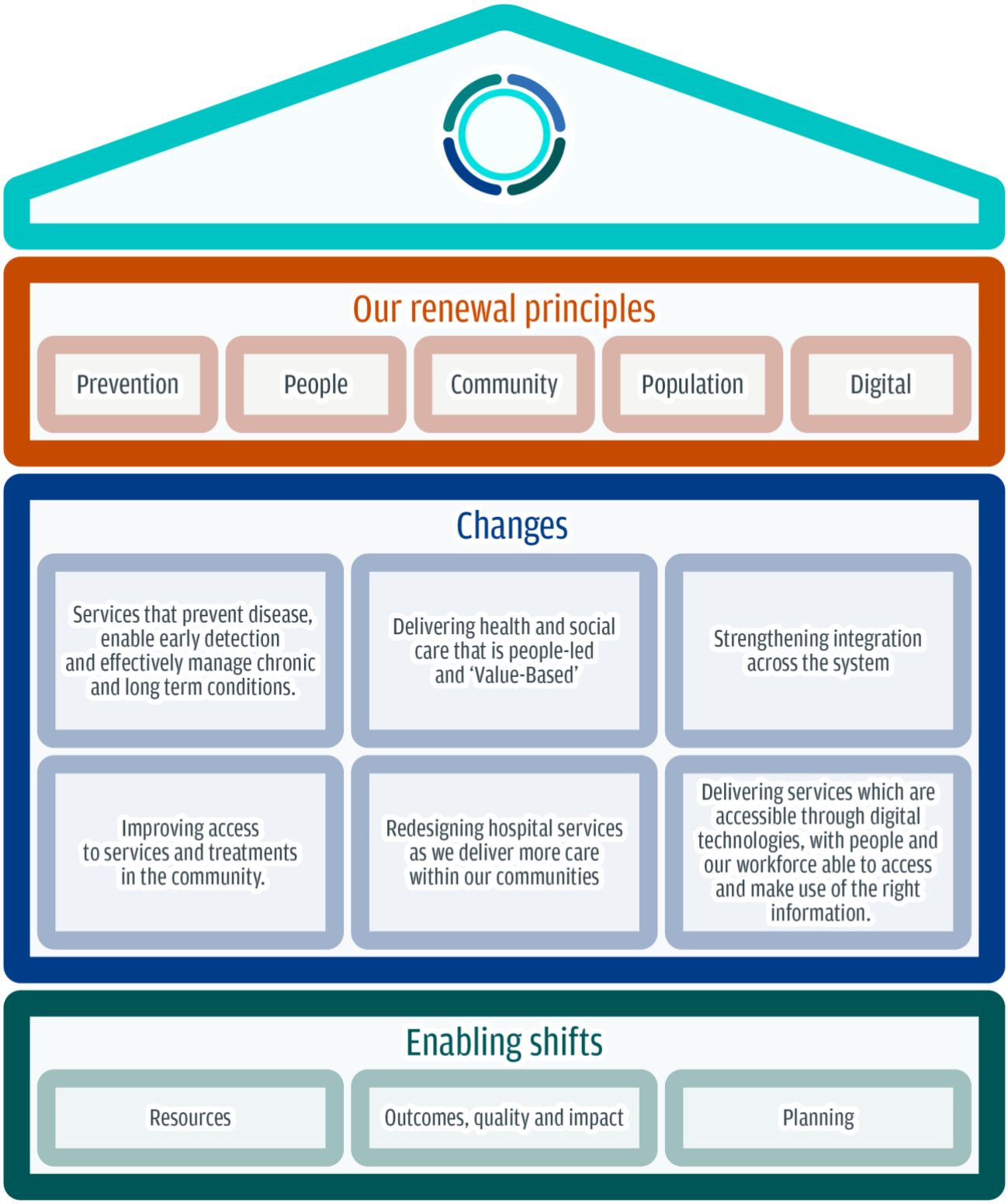
[8] Chief Medical Officer Annual Report 2024-25; Annual Report 2023-24

3. Service Renewal Framework

This Framework is comprised of a set of principles, changes, and 'enabling shifts' which will ensure it supports the delivery of our vision for health and social care. The **principles** focus on prevention, people, community, population planning, and digital. They capture the values that we consider must be at the core of a thriving, sustainable health and social care system. Each principle is intended to guide the design, planning and delivery of services nationally, sub-nationally and locally. This means we will use the principles to, for example, guide resourcing decisions about workforce, finances, and infrastructure that focuses on achieving the best outcomes. These principles also all recognise the links between people's physical, mental and social needs.

To enable the principles to become a reality, we have identified major **changes** that we will implement. To make all these changes possible, we set out three required '**enabling shifts'** in the way we work, plan, and make decisions. The following section describes the principles and changes. The shifts are described in Section 4.

Figure 2: Health and Social Care Service Renewal Framework



Renewal Principles

Prevention Principle: Prevention across the continuum of care

Health and care is focused on prevention and proactive early intervention to realise long term wellbeing and reduce the burden of disease. All parts of the community and health and social care system will work together to maintain better population health, and reduce inequalities and stigma.

Our current model of health and social care focuses most of its resources (workforce, finance, infrastructure) on caring for established sickness or care needs. Shifting towards a focus on the drivers of health - a good start in life including eliminating child poverty[9]; access to education; good jobs and income; good quality, well-designed housing; sustainable places that enable healthy living, and contact with nature; and equitable access to good public services - is critical to achieving our vision for health and social care.

Prevention and early intervention activities seek to improve health and wellbeing by increasing the years people live in good health, enhancing their quality of life, and promoting independence[10] (e.g. through housing adaptations). These activities are amongst the most cost-effective interventions the health and social care system can make, leading to improved outcomes, reduced inequalities, and less pressure on acute services. With growing demand for services, increasing health challenges, and financial pressures across the system, investing in prevention and early support has never been more important.[11]

Taking a preventative approach to health and wellbeing in Scotland is a shared responsibility of the whole system. This is reflected in the connection between this Framework's 'Prevention' principle and the Population Health Framework's (PHF) Driver 4: Equitable Health and Care.

The PHF is focused on '**primary prevention'** – action that is designed to stop problems from emerging in the first instance. Health and social care services – the focus of the SRF – also have a role in primary prevention by enabling healthy living, ensuring equitable access to services, and helping people maintain good health.

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[9] Addressing child poverty is crucial to enabling healthier lives and breaking the cycle of ill health that perpetuates inequalities. The PHF and this SRF seek to complement and build upon ongoing and planned action described in the Best Start, Bright Futures: tackling child poverty delivery plan. This includes action by the NHS in Scotland to reduce child poverty through the NHS Anchors programme.

[10] The Independent Living Fund enables people with complex disabilities to access the support they need to live more independent lives in their communities. The Fund reopened to new applicants in 2024 and we are continuing to grow the Fund in 2025/26.

[11] Scottish Fiscal Commission. (2025). Fiscal Sustainability Report.

The SRF builds on primary prevention by setting a framework for a health and social care system which supports and promotes **secondary** and **tertiary prevention**. Secondary prevention is action which focuses on early detection of a problem to support early intervention and treatment or reduce the level of harm. Tertiary prevention is action that attempts to minimise the harm of a problem through careful management. Both are critical components of a sustainable health and social care system – one that not only promotes good health but also responds quickly when risks or early signs of illness or crisis emerge.

Spotlight on Current Services: A Prevention-Based System in Practice

The Preventative and Proactive Care (PPC) programme provides an example of how we can continue to build a primary and prevention-based health and care system with a community focus, in line with the vision for health and social care. The programme, which ran until March 2025, had the core aim of increasing and improving preventative and proactive ways of working together, to support Scotland's citizens and communities to have more control over their health and be able to access and benefit from preventative and proactive resources and services. This aim was achieved through delivery of initiatives including the GIRFE National Practice Model, Waiting Well supporting those waiting for health or social care intervention, and a Cardiovascular Disease (CVD) National Toolkit and Directed Enhanced Service.

Primary Care reform, through general practice, dentistry, optometry, community pharmacy and community urgent care, are all critical aspects of this and are already making impacts in prevention and access.

For example, in dentistry, as part of our ambitious payment reform programme dentists are now directly remunerated for providing preventative advice, adding primary and secondary prevention into appointment times. According to official statistics reporting annual treatment activity in 2024/25, nearly 2 million instances of preventative advice were delivered in the first full year of dental payment reform[12], supporting patients to better manage and improve their own oral health between appointments. This approach is further supplemented by changes to examinations, also introduced by reform, which ensure that patients are seen at a check-up recall interval which aligns to their own oral health need. We have also introduced a system of adult oral heath metric data collection for the first time, based on key data points routinely charted during enhanced dental examinations, and this will empower clinicians to track and monitor long-term improvements to their local patient cohort's population oral health over time, including the impact of enhanced prevention.

A further example is community pharmacy, where the team play a key role in preventative care, informing and empowering individuals to manage their own health, and increasingly playing a key role in secondary prevention of cardiovascular

[12] Public Health Scotland. (2025). NHS dental data monitoring report. Quarter ending March 2025.

disease and diabetes. Delivery of some women's health services are now undertaken by community pharmacists, including advice on and access to emergency and bridging contraception and treatment of some urinary tract infections, thereby avoiding the need for a GP appointment. Access for treatment under NHS Pharmacy First increased 86% from June 2021 to June 2024 with a 93% increase in treatment for urinary tract infections over the same period. In the areas of highest deprivation, access and treatment similarly increased 77% and 73% over the same period for treatment under NHS Pharmacy First and urinary tract infections.[13]

Major Change: Services that prevent disease, enable early detection and effectively manage chronic and long-term conditions

We are committed to improving health and wellbeing across Scotland by focusing on prevention at every stage – from helping people stay well, to detecting problems early, to supporting those living with long-term conditions.

- In delivering the SRF, we will **continue to align with the Population Health Framework**, including on its commitment to develop and implement a new Healthcare Inequalities Action Plan to help us tackle the root causes of poor health, and reduce unfair differences in health outcomes across communities.

- **We are supporting national efforts to improve healthy weight**, not only through promoting healthier lifestyles, but also by treating the physical and mental health impacts of overweight and obesity. This includes early intervention and tailored support for those already affected.

- **We are implementing the Mental Health and Wellbeing Strategy and updating our delivery plan**, recognising how inequalities can affect mental health and understanding the connection between mental and physical health needs. Our approach includes prevention, early support, and ongoing care for those living with mental health conditions.

- **We will further enable** innovative and inclusive rehabilitation across settings and sectors.

- **Our new Long Term Conditions Framework**[14], to be published by end of 2025 will improve the quality of care and support for people living with long-term conditions. This includes helping people manage their conditions well, avoid complications, and maintain their independence and quality of life.

[13] Public Health Scotland. (2025). NHS Pharmacy First Scotland, 1 April 2021 to 30 September 2024.
[14] Scottish Government (2025). Long term conditions - framework: consultation paper.

- We are also supporting efforts within the PHF to publish a Health and Work Action Plan, which will include improving support for people with ill health[15] who wish to return to work. This Framework will **deliver enhanced and cross-organisation services that deliver tailored, employment-focused care and support**.

- We are **shifting funding and workforce capacity into primary and community care**, ensuring that prevention is embedded across the full spectrum of care.

We will also improve how we use and analyse data, allowing us to identify key risk factors and make targeted interventions for high-risk subsets of the population. People with long term conditions or other health issues interact with multiple parts of the health and social care system, so we will continue to improve sharing of information so that, where possible, people do not have to repeat their stories.

Spotlight on Current Services: Community Appointment Day

Some NHS Boards in Scotland have now implemented the community appointment day model for people living with musculoskeletal (MSK) and pain conditions. These appointment days, hosted in local leisure facilities, bring together physiotherapy services, health and third sector partners to combine specialist MSK assessment with holistic care needs assessment to understand what matters most to people living with these conditions. This approach provides the opportunity to provide preventative and proactive care to individuals. The focus of these days is to understand what matters most to the patient in relation to living with their condition and providing multiple options to support them to improve their condition or live well with it. In this evolving method of service delivery, colleagues are collaborating across traditional boundaries to learn and evolve the model building on user experience.

For example, in Lanarkshire, over 500 people attended the first community appointment day at a local sports centre in East Kilbride. It provided same-day access for people from across the community to a range of support including rehabilitation, advice on self-care and health promotion. Feedback from both staff and patients were very positive.[16] A recent scientific journal article noted that community appointment days allowed for more than three times as many patients to be booked in compared to routine outpatient clinics.[17] Further, these events had positive outcomes for patients and were successful in reducing waiting times.

[15] Scottish Government (n.d.). Illnesses and long-term conditions.
[16] NHS Lanarkshire (2024). Pioneering Community Appointment Days.
[17] Alexander, H., Sinclair, A., Dover, L., et al. (2025). A New Model of Care: Community Appointment Day Outcomes and Impact on Musculoskeletal Physiotherapy Waiting Times. *Journal of Primary Care and Community Health,* 16, ePub 2025.

In Moray, a community appointment day session was held in a local sports hall for 200 people who are on the MSK waiting list. When people arrived, there was an 'about me' conversation, and they completed their 'personal health passport' which helps staff understand the person's care needs and what matters to them. They then had a physiotherapy or podiatry appointment, followed by visits to other relevant services that were located within the sports centre for the day. People therefore had access to a range of relevant professionals in the same place, without requiring referrals or additional waiting time. Further, various professionals were enabled to work collaboratively around people's needs and provide them with the required support in one place.

People Principle: Care designed around people rather than the 'system' or 'services'

Health and care is responsive, respects individual needs and delivers outcomes that matter to people. People will be more in charge of their own health and wellbeing as we enable self-care. People will have the information they need to share decision-making about their own physical health, mental health and social care, and services will trust their choices. Services will be equitable (i.e. proportionate to need).

We will place the individual at the centre of our decision making. In doing so, we will more proactively apply the principle of participation in health and social care, supporting people to be in charge of their own health and wellbeing and empowered to make decisions about the care they receive.[18] We will ensure that the principles of Planning with People underpin our approach to service changes, along with ensuring people's voices are heard[19] and they are able to realise their rights and responsibilities.[20] Services and support will be designed with the people that access them, aiming to better meet their needs, and leading to greater effectiveness and efficiency in the system overall.

To help achieve this, we will ensure easier access to information about individual's own health and care, and about the services they can access. We will implement innovations to help people self-care, such as remote monitoring of specific conditions, which give people flexibility and a different way of living their lives. We recognise that people have different levels of need and so levels and types of support will vary - but always with the aim of being proportionate and equitable.

[18] Evidence suggests awareness of the right to get involved in service design has been low. For example, see Ninth Citizens' Panel Report (2022).
[19] National Care Service – Making sure my voice is heard: regional forums. Findings Summary. (2023)
[20] National Care Service – Realising rights and responsibilities: regional forums. Findings Summary. (2023)

Major Change: Delivering health and social care that is people-led and 'Value Based'

Getting it Right for Everyone (GIRFE) is a model of delivering health and social care support that puts the recipient front and centre, based around a series of GIRFE principles. The approach has been co-designed with people who have direct experience of care, together with several local partnerships.

The GIRFE model allows people to make an informed choice about the care options that are right for them. However, we also know that if people are fully informed about and involved in decisions about their care, they often choose less treatment or consider a more conservative approach. They are also far more likely to value the treatment they choose, and this reduces waste and potential harm. This approach therefore leads to appropriate use of available resources while delivering care that really matters to people – the key objective of Valued Based Health and Care. Implementation of the GIRFE practice model is already showing tangible results for people (see case study below) and for the workforce. We will now roll out the use of the GIRFE practice model to all areas of Scotland, ensuring that the core GIRFE principles are part of all of health and social care delivery, enabling people to fully participate in their own care.

Case Study: Using a GIRFE Approach to Support People in Alcohol and Drugs Services

An individual known as 'S' had a history of drug and alcohol dependency, self-harm, and seizures which resulted in 15 admissions to hospital between May 2023 – May 2024. When discharged from hospital, S was deemed to be at risk in terms of his social care and health needs as he had no tenancy, clothes, furniture or access to funds; was socially isolated; and was not receiving relevant community support.

The relevant Local Authority team then applied the GIRFE 'Team Around the Person Toolkit' to its care and support for S. This included involving S in conversations with those supporting him and allocating him a designated care co-ordinator. S and the professionals involved were able to share information and develop a clear understanding of how S would like to be supported, enabling collective decision making. Weekly meetings co-chaired and facilitated by the Clinical Nurse Manager and Principal Social worker brought together all the professionals involved in the care of S, from multiple agencies and organisations.

The Toolkit provided a framework for the professionals to have conversations with S and develop a robust and preventative plan of care and support. As a result, S only had one 24 hr stay in hospital in the following three months. This admission wasn't for self-harm or seizures, but was related to another acute health condition. S now actively engages with his plan of support and substance use support programme. When S was asked about the support he has around him, he said, "I have got my life back and never felt so safe".

As another example of people-led services, Whole Family Support is our approach to integrating services, supporting local partners to use the resources they have in the way they find most effective to support families in their area to thrive.

Whole Family Support enables services at a local level to wrap around families, prioritising their needs and delivering integrated, responsive and preventative services. We know this type of support can help families to thrive and prevent future crises (see case study).

Our expectation is that all partners will work collaboratively with each other and with people to transform services to deliver whole family support through better coordination, alignment, integration and local control of resources. We have already seen excellent partnership working across health, social care, housing, the third sector and employability services.

Case Study: A holistic support project for families in General Practice (Glasgow Health and Social Care Partnership together with Includem)

A GP referred a mother and baby to the Family Wellbeing Worker in the new "Whole Family Support through General Practice" programme, part of innovative healthcare inequalities reform work in primary care in partnership with Includem, a third sector organisation. The GP had cumulative concerns about the impact on the mother's health of her financial debt, being pregnant with her second child, and her partner being in prison due to domestic violence. The mother was due to attend court to give evidence, which was impacting her mental health. The baby was not sleeping, impacting further on the mother's mental health.

The Family Wellbeing Worker supported the mother by listening to her and offering her emotional support. Once their relationship had been established, the mother was empowered to consider the support she needed. The Family Wellbeing Worker was able to: facilitate housing support in the mother's preferred area where she had family support; make several referrals including to a welfare adviser, 'Thrive Under 5' and Livewell; and connect with the baby's nursery to secure additional support for the mother. The Family Wellbeing Worker also quickly identified the cause of the baby's poor sleep, which related to their bedding, and applied to the Young Person's fund to access a cot bed.

Positive outcomes from this referral have helped to improve the mother's mental health and the baby's wellbeing. The mother reports feeling 'stable', less emotional, and has commented that her relationship with her family has improved. She has engaged with the welfare adviser and her benefits have been maximized, helping to control her debt. Whilst she declined the Livewell support (due to a move away from the area), she has accessed the Pantry support, including vouchers for cooking essentials. Her housing support has continued although the family has moved on from the service.

To enable the overall shift to people-led and value based health and care, we will:

- Enable local areas to **embed the GIRFE principles** and the Team Around the Person Toolkit and, integrated with Getting it Right for Every Child, develop the model to one which can fully support families.
- Help people have their voices heard and participate fully in decisions about their care by **enhancing independent advocacy provision**.
- Ensure people's own health and care information will be more readily available to them so they know more about their own care, through the creation of a **digital health and care record**.
- Make it easier for people to access the tools and support they need to manage their wellbeing and be informed of their rights and access to services.
- Drive **improvements to the complaints process in adult social care**, by building upon the 'codesign' used to develop the National Care Service Programme, where people were supported to participate in planning and decision-making.

Community Principle: More care in the community rather than a hospital focused model

Health and care is accessible, seamless, and equitable across settings. People will be able to access more services and support in the community – and hospitals will focus on the most acute and complex procedures or levels of care.

This principle is about bringing more healthcare closer to home—whether that is a local General Practice, pharmacy, or wider primary and community health teams, or treatment from hospital-based specialists. We will make this possible by moving more staff, funding, and services into local areas, as well as building on the core skills and capacity we have in our community. This will mean people can get the care they need in the places they know and feel comfortable, within their own communities. It will also mean they are further supported to 'live well locally', having more of their needs met within a reasonable distance of their home.[21]

Primary care, community health and social care services (including those provided by the third and independent sectors) already play a vital role in keeping people well, treating and managing health conditions and supporting people to live well locally. We have made significant progress in integrating primary and community health and social care since the enactment of the Public Bodies (Joint Working) (Scotland) Act 2014, but further whole system integration is still required.

[21] This 'Local living' is one of the six spatial principles set out in the fourth National Planning Framework (NPF4) to inform how we should plan our places.

Our model of care is still overly specialist, organised around hospital-based care settings rather than person-centred pathways and approaches. This means it often feels like hospitals are at the centre of our healthcare system, rather than primary care, community health and social care services.

We have therefore set out two major changes within this section on Community, building on our learning from what people have told us about their experiences of accessing and receiving support.[22,23,24,25,26] First, to strengthen integration across the system, and second, to improve access to services and a wider range of treatments in the community.

In doing so, we must ensure distribution of resources is equitable and transparent so that different health conditions, for example diabetes or musculoskeletal problems, are supported fairly and in line with the needs of our communities. This means allocating resources not only based on population size, but also on the specific health challenges faced by different areas, including rural and island communities, where access to care can be more limited.

Major Change: Strengthening system-wide integration

Reform of Social Care

Building on the work of the Independent Review of Adult Social Care and the two joint statements of intent between COSLA and the Scottish Government, we will continue to improve the Social Care Support and Social Work sectors in Scotland. Scottish Government and COSLA have worked closely with key partners and stakeholders in recent months to understand the challenges within the current adult social care support and social work system.

The National Care Service Advisory Board is now in place and will provide an opportunity for partners to work to deepen integration, putting people at the heart of that work; support a collaborative culture of improvement, improve quality and consistency of support and services, understand performance; and ensure the workforce is supported to deliver. The work programme for the Advisory Board is in development and will be published in the coming months.

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[22] National Care Service - keeping care support local part 1 – local services: regional forums - findings summary. (2023)
[23] National Care Service - keeping care support local part 2 – community health care: regional forums - findings summary. (2023)
[24] Thirteenth Citizens' Panel survey. (2024)
[25] Scottish Government (2025) Socioeconomic inequality and barriers to primary care in Scotland: A literature review. Social Research.
[26] Scottish Government (2024). Health and Care Experience Survey 2023/24: National Results.

Working Together to Plan Better Care

We will make sure that leaders across the NHS, Local Authorities, and other services, including third sector and independent commissioned social care services work together to plan care that meets the needs of people and communities — not just based on current organisational, or territorial practice and boundaries. We recognise the important role that Community Planning Partnerships play in supporting this collaboration across partners at local level, and will seek to strengthen these partnerships to drive forward joint working. By planning at national, sub national, and local levels, and focusing on what communities really need, we can make better decisions that support more care being delivered closer to home. This means more focus on prevention, early support, and joined-up services that help people stay well and live independently for longer.

We will enhance whole system cohesion, centred around our shared Vision and these principles, building on the GIRFE approach. This includes developing seamless, person-centred pathways that span services (e.g. primary and secondary healthcare and social care) and settings (e.g. within communities and between community and hospital care).

We will focus on fostering leadership, nurturing a culture of continuous improvement, and creating the space and time needed to support quality improvement. We will also promote joint working across sectors, with active involvement from service users and the third sector.

Working with partners, we will explore avenues for more coordinated and integrated inspection regimes, building on recommendations to date on patient safety and the Independent Review of Inspection, Scrutiny and Regulation.

Spotlight on Current Services: Enhanced Mental Health Pathway

Since November 2023 the Mental Health Hub, within the NHS 24 111 service, has responded to over 180,000 calls[27], ensuring anyone in mental health crisis or distress can quickly and easily connect with professionals who are experts in that field. The award winning Enhanced Mental Health Pathway enables emergency calls received by Police Scotland or Scottish Ambulance Service, where callers are identified as requiring mental health advice, to be directed to the Hub. This ensures people in distress can access support from an appropriate mental health professional more quickly while also removing pressure from other emergency services. Work is also underway to establish a new self-referral pathway to respond to increasing demand and provide access to digital therapies and psychological treatments without the need for a referral from local GPs, protecting primary care and unscheduled care services.

[27] NHS 24 (n.d.) Previous NHS 24 111 operational statistics.

Case Study: Care from multi-disciplinary teams

"M" is an older female with a long term neurological condition. She uses a power chair full time, and requires moving and handling equipment to transfer between seated surfaces. M lives on a ferry link island in the north of Scotland. She was attending the mainland for a routine follow-up appointment, but travel to the mainland involved a journey of more than one and a half hours each way – overall she was out of her house for more than 10 hours each time.

The local ferry service does not have wheelchair access to the passenger lounges, cafeteria or toilets, therefore M's self-care, personal care and privacy and dignity were at risk. Flying for the journey was not an option because small airplanes have no, or very limited, wheelchair access. There was a risk that M's health and mobility would deteriorate further with prolonged periods of sitting while undertaking this journey, and the trip created emotional stress, with negative impacts to M's wellbeing and mental health.

A multi-disciplinary team (MDT) was stood up to support M, based on the GIRFE principles and 'Team Around the Person' toolkit. The team involved M in planning and decision-making processes about her care and identified an island wellbeing coordinator for her care. The coordinator looked at other possible ways in which M could attend appointments, and as a result virtual meetings were established with her consultant (who was on the mainland) for her routine appointments. The coordinator also supported M to ensure she had appropriate equipment (and was comfortable using it) for attending these virtual appointments.

This approach enabled health and social care professionals to involve M in decisions around coordination of her support, and gave her the opportunity to have her wishes and views heard. Collaborative working between professionals and M using the My Plan and Virtual Meeting GIRFE tools reduced the physical and emotional stress of attending in-person routine appointments. Utilising the GIRFE co-ordinator tool enabled M to have a point of contact to have support to attend Team Around The Person meetings and to be able to use digital technology to attend routine healthcare appointments.

Major Change: Improving access to services and treatments in the community

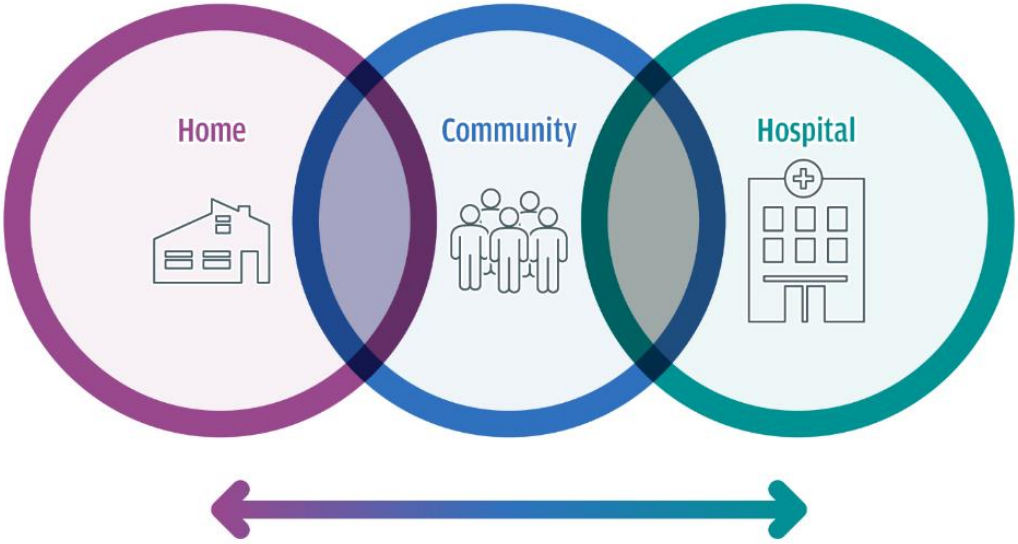
We will increase access to health and social care services and treatments in the community. Hospitals will focus on the most complex and acute areas of care and treatment that cannot be delivered at home or in the community.

To achieve this, we must ensure a strong and thriving primary care and community-based health system – this is most people's first point of contact with the health service. Most health and care needs are already managed entirely in the community, without being escalated to a more 'acute' level or needing hospital-based treatment. There is a growing body of evidence and experience that shows that many of these

health needs can be managed safely in people's own homes with more intensive multi-disciplinary or specialist support.[28]

This is not about shifting demand and responsibilities to community teams, but a rebalancing of the overall health and care system, and a greater proportion of our resources (workforce, finance and infrastructure) being moved towards our community settings. This is covered more in section 4 on Enabling Shifts.

Figure 3: Health and Social Care settings for care delivery



Specifically, we will set out a clearer model of care that will work across three care settings - **home, community and hospital**. This will enable a more preventative approach, as well as contribute to closer integration of health and social care services so that they are delivered and communicate with each other seamlessly around the person. As we implement this approach, people and the workforce can expect to see:

- Specialists delivering more care in the community, allowing them to develop expertise with better technology and national clinical support.
- Community services providing more generalist and specialist care as close to home as possible, building on the capacity, role and strengths of primary and community healthcare teams.
- Seamless transitions between care settings being facilitated as part of a coordinated care plan, supported by multi-disciplinary teams with staff working across settings in structured networks.
- Unpaid carers receiving the recognition and support they deserve.

[28] Scottish Government. (2016). A National Clinical Strategy for Scotland.

- The same high-quality care being provided, no matter where someone lives. including planning for the unique needs of rural and island communities.
- All people (and the staff providing them with care) having access to relevant key information about themselves, regardless of organisational boundaries, through the digital health and care record.
- The individual and their care needs being at the heart of all decision-making, with and for them, reflecting GIRFE principles.

To achieve these ambitions, we will:

- Enable NHS Boards and wider system leaders to take the lead in national, sub-national, and local planning and decision making, and ensure that planning guidance issued to them reflects the Community principle set out in this Framework.
- Build on the work of the Primary and Community Health Steering Group[29] to ensure primary care outcomes, such as sustainable, equitable and timely access to healthcare in the community, are realised and the capacity of this critical part of the health and care system is progressively improved and supports wider changes to specialist care.
- Set out in the detailed Primary Care Route Map the actions and enablers required for this shift (workforce, infrastructure, systems), clarify the role and services to be delivered in the community, and support leadership and cohesion in our health services in the community.
- Maximise flexibility and cohesion across the primary and community health workforce to increase access, building on core General Practice capacity and wider primary care professionals across the MDT and beyond.
- Help GP practices to improve their appointment systems by supporting the implementation of digital telephony by January 2027, which will enable practices to enhance access via more modern and higher capacity patient communication tools.
- Ensure the future planning and delivery of community hubs considers opportunities for infrastructure co-location to further develop person-led approaches for access to seamless and coordinated care.
- Continue to implement the Once for Scotland rehabilitation approach as part of population planning, drawing on our existing Rehabilitation and Recovery Framework[30], and ensure service change plans enable patients to be treated as close to home as possible and recover more effectively.

[29] The Steering Group was convened by Scottish Government in May 2024. It brings together Primary Care and Community Health independent contractors, stakeholders and partners. The Steering Group is collaborative and has led work on Primary Care reform, including the development of a Primary Care Route Map (see above).
[30] Scottish Government. (2022). Rehabilitation and Recovery: A Once for Scotland Person-Centred Approach to Rehabilitation in a Post-COVID Era.

- Build on our existing work in relation to follow up outpatient appointments, where they are necessary, ensuring that where possible these are delivered in the community and are patient initiated.
- Build on work established as part of the Delayed Discharge Mission to ensure that stays are minimised for those who have to be admitted to hospital.
- Take advantage of changing technology, meaning that tests which are currently only possible in hospital settings will be able to be delivered in the community or at home.
- Increase collaboration between NHS 24 and the Scottish Ambulance Service, building on highly successful joint working to date to improve the patient journey – including developing an annual Collaboration Plan focused on urgent care service improvement.

Spotlight on Current Services: Hospital at Home

Scotland's first Hospital at Home service began in Lanarkshire in 2011 and this approach has since grown and developed across every area of Scotland. While services might look different depending on the needs of the local population, all share the core ambition of helping people stay at home during a period of acute illness rather than being admitted to a hospital setting.

From the densely populated central belt to our island populations, Hospital at Home provides acute, hospital-level care by healthcare professionals for a condition that would otherwise require a stay in hospital. Hospital at Home services prevented almost 16,000 people spending time in hospital during April 2024 to March 2025.[31] These people were able to stay with their families and loved ones in familiar surroundings throughout their treatment, instead of spending this time in a hospital, and this relieved pressure on A&E and Scottish Ambulance Service. This avoids the risks of infection and deconditioning or dependence that can occur in hospitals.

This programme has high satisfaction and patient preference, reduces pressure on hospitals by avoiding admissions and accelerating discharge, and has consistent evidence of lower costs compared to inpatient care.[32]

Spotlight on Current Services: Keeping people safe in their own homes - National Support for Local Services

All 32 Local Authorities in Scotland, in a number of cases in partnership with the housing sector, use a range of sensors, falls detectors and community alarm pendants to support people to remain safely in their own homes. This service is usually referred to as 'telecare' and collectively around 132,000 people currently

[31] Healthcare Improvement Scotland (2025). Hospital at Home Programme. Progress update March 2025.
[32] Healthcare Improvement Scotland (2025). Hospital at Home Programme. Progress update March 2025.

benefit from this core social care support service.[33] By 2027, everyone will have had the technology in their homes upgraded to newer digital technology, away from the traditional landline-connected analogue systems currently in use.

To support this, the core systems used by Local Authorities to manage the alerts and receive calls from individuals needing help - known as the Alarm Receiving Centre - also needed to be replaced. Working with COSLA, the Scottish Government asked the Local Government Digital Office to explore national options for embracing modern cloud-based digital solutions in a way that allowed individual Local Authorities to manage their own services, but with stronger national support. Stakeholders recognised that digital enabled new ways of working in a more collective, collaborative manner that also allowed for a reduction in the number of systems purchased by the public sector, creating greater efficiencies and improved resilience.

The result of this work was a shared procurement via Scotland Excel for a single Alarm Receiving Centre platform (a 'Shared ARC') that all service providers can use. To date, 18 Local Authorities, along with several housing providers, have signed up to use this single digital platform. Having a single national platform that all Local Authorities can use significantly reduces the technical burden of individual organisations, increases the cyber resilience of our services, allows different Local Authorities to support each other for service resilience purposes, improves data sharing, makes it easier to integrate into health services and offers up far greater potential for data-driven personalised predictions to be made for the people supported at home.

Population Principle: Population planning, rather than along boundaries

Our planning of services will be based on evidence-based, strategic assessments of population needs across Scotland, at national, sub-national and local level.

Planning on a population basis, rather than planning along geographical boundaries, means we will analyse the changing needs of the population at a macro level, and use that data and information to provide the right services, in the right places to meet these needs. For example, we will look across Scotland at the demand and need for particular services and treatments, and plan the provision of our services according to that need and how we can achieve the best outcomes for the population.

There is overwhelming evidence[34], especially for surgical treatments, that patient safety and surgical outcomes are better when the surgeon is doing that particular surgery more frequently.[35] By concentrating certain surgical treatments in fewer

[33] Public Health Scotland (2025). Technology enabled care; support provided or funded by local authorities in Scotland 2023/24.
[34] See, for example, Morris et al. (2024). Implementing A 10-Year Health Plan: International Examples, The King's Fund.
[35] Scottish Government (2016). A National Clinical Strategy for Scotland.

centres (with number and place informed by evidence of population need), the surgeons within them can be very practised and highly experienced in that particular procedure, and we can improve patient outcomes as well as improve efficiency. As a result, we will see hospitals which each treat a greater number of patients for the intervention they are specialised in, ensuring they can take advantage of specialist teams, attracting and developing a world class workforce, and equipment and infrastructure.

This is just one example. We will apply this population planning principle across a much wider range of clinical services and treatments to better understand where care is best delivered and by whom. As demonstrated in the surgical example, this will involve careful balancing of evidence of population need (e.g. demand, demographics, geography), with evidence of what delivers the best outcomes for people and for the population (e.g. clinical quality, safety, efficiency).

We are already doing this in some hospitals and this has been at the core of the development of our five National Treatment Centres, which are a network of healthcare facilities across Scotland that provide extra capacity for planned inpatient care, day case treatment and diagnostic services, and which have already generated positive feedback from patients. They support regional working across territorial NHS health boards, helping to improve people's access to treatment, and support them to do so more flexibly.

We will apply a population level planning approach across the entire health and care system – engaging with partners in acute care, primary care, community healthcare and social care. This joined up approach will support both national and local services to make more informed and sustainable decisions that are tailored to the needs of their populations. For example, this could include:

- Designing services for people with specific needs, such as older adults or those requiring highly specialised care home provision
- Planning for early identification and intervention in conditions with known risk factors, helping to prevent illness and reduce long-term demand on services.
- Deliberately targeting opportunities to collaborate across traditional organisational boundaries and deliver more seamless services. Service providers will use this approach to consider how to better share resources and improve efficiencies.

By taking this whole-system view, we can ensure that care is better coordinated, more proactive and aligned with what people and communities truly need.

Spotlight on Current Services: Pharmaceutical Care Service Plans

Health Boards define their pharmaceutical care needs within an area through Pharmaceutical Care Service Plans (PCSPs), and are a good example of population based planning in primary care led by NHS Boards. PCSPs provide information to

the public, community pharmacy providers and wider NHS services on the pharmaceutical care services currently available from the network of community pharmacies within a Health Board's area and take into account evidence of local need - this helps decision-makers map where there are possible service gaps or wider issues. PCSPs also recommend improvements to help the Board ensure patients have reasonable access to pharmaceutical care services. PCSPs has been fundamental to improving service provision. We will continue to develop PCSPs through wider reform of the pharmacy contractual planning framework.

Across health and social care, there is a relatively small but significant group of individuals with multiple, complex needs who require intensive and specialised care support in their communities. Evidence shows that a coordinated, population-based approach to planning for this support can be beneficial to those who need that support – both for those receiving care and for the systems that provide it.[36] As part of this approach, it is important to also recognise and address the needs unpaid carers who play a vital role in supporting these individuals.

More broadly we will use data and other sources of evidence to guide decisions on where and how we deliver health and social care services. This will support a strategic shift to greater provision in community settings. Our planning will include consideration of remote care models, centres of expertise for specialist acute services and innovative approaches to commissioning highly specialised social care support.

In taking this approach, we will consider the impact on health inequalities, ensure that care models are appropriate to the needs of different populations and pay particular attention to the unique challenges faced by rural and island communities.

At the national level, this approach will require strengthened collaboration between the Scottish Government, NHS Boards, IJBs, Local Authorities and wider delivery partners. Together these partners will need to make strategic decisions about the redesign of services – determining what is best delivered, how it should be delivered, and where it should be located to ensure equitable and effective access.

We also recognise that this type of population planning approach for the health and social care system means that, in some cases, people may have to travel further for treatment. Encouragingly, the results of the latest survey (June-September 2024) of the Citizen's Panel for health and social care showed that 84% of respondents agreed they were willing to travel further for specialist services such as surgery if it resulted in better outcomes for them.[37] However, as we implement, we will seek to ensure that making it easy to access services is an integral part of NHS Boards' service planning and decision-making, including travel and transport needs.

[36] Scottish Government (2016). A National Clinical Strategy for Scotland.
[37] Citizen's Panel. Fourteenth Panel Report.

In parallel, we will encourage NHS Boards to work collaboratively with Regional Transport Partnerships and other partners to co-design and implement transport options which support people to access treatment, guided by the Scottish Government's Transport to Health Delivery Plan (2024).

To support a population planning approach where certain care and treatment may be concentrated in fewer specialist centres, whilst a broader range of care is also being shifted out of hospitals and into communities, we will need to ensure our hospitals and staff within them are prepared and supported for this fundamental shift.

Major Change: Redesigning our hospitals as we deliver more care within our communities

This Framework recognises that some of what happens in our current hospital sites will, over time, move to community settings. However, there will always be a requirement for the most acute and complex treatments, and these must be delivered from modern hospital sites with the highest quality equipment and infrastructure, and able to attract world class workforce, expertise and innovation.

The Scottish Government has started to work with stakeholders on future service models across our health services, drawing from our primary and community care enhancement work and in partnership with those delivering and receiving care.
In the first year after this plan is published, we will begin a major review of hospital care. This will be part of a bigger, long-term plan to improve the whole health system, based on what people and communities need. This long-term 10-year programme will be delivered in close collaboration with NHS Boards, clinical leaders, and system partners. Key priorities include:

- Development of a clear strategic assessment of population needs both now and, in the future, to inform planning and investment decisions.

- Working with NHS Boards to co-develop a future hospital model and improved care pathways that integrate care across settings and strengthen the interface with primary and community care. This will be implemented on a phased basis and supported by redesigned care pathways.

- Working with NHS Boards to ensure that easy access to services is an integral part of their service planning and decision-making, including travel and transport needs.

- Setting out a clear offering of core services for every area that are consistently applied according to population need. This will include development of core service specifications to guide planning and delivery, helping communities to understand what local services are available, and when travel to another area for care may be required.

- Creating national referral guidance to make it easier for people to move through the health and care system when they need treatment or are ill. This guidance will help ensure that care is well coordinated and easy to navigate, co-designed across primary and secondary care (including through interface groups). These clearer, more consistent pathways will help reduce waiting times and make sure people get the right care at the right time, especially when they are most in need.

- Developing clear guidance to define the roles of different types of hospital to ensure services are future-proofed, evidence-based and aligned with population needs.

- Aligning workforce planning with population-based service delivery, and reviewing national infrastructure planning processes, with a strategic approach to estates and capital investment to support this direction.

This programme of work will lay the foundation for a more integrated, equitable, and sustainable hospital system – one that is responsive to the evolving needs of Scotland's population and supported by the right infrastructure and investment.

Digital Principle: Reflecting societal expectations and system needs

Using technology and innovation to change people's experiences of how they interact with services and better manage their own wellbeing, whilst simultaneously maximising the use of data and technology to make services as modern, joined up and efficient as possible.

We have a population which is increasingly comfortable with using digital tools within their daily lives, and increasingly expectant of having digital ways of engaging with health and social care services. In support of this, our existing commitment to ethical, transparent uses of people's data[38], coupled with the desire to enable people to fully access their own data, remains fundamental. Our ability to deliver health and social care services in line with the objectives in this Framework depends on how effectively we use digital tools and data insights. We know that our current model of care does not yet do this consistently, as evidenced by multiple different consultations and engagements with the public and professional bodies on a wide range of subjects.

In reforming our health and care systems for the future, we need to create a 'digital first' mindset, taking into account issues with digital exclusion.[39] Across the system we need to think how we can reshape our services by making greater use of digital to support people – delivering improved outcomes and helping people take

[38] Scottish Government. (2023). Health and social care: data strategy.
[39] Audit Scotland (2024) Tackling digital exclusion.

ownership of their own wellbeing. This is not just about technology. It requires leadership and investment in core digital and data infrastructure, skills, and governance, including the knowledge, tools and resource to support digital inclusion to ensure equity and choice for the people of Scotland in accessing and engaging with health and care services using digital.

At the moment, information for social work, social care, and health is often held in silos and in systems that are unable to share information. Poor information sharing can impact adversely on a person's "journey" across health and social care services and can also result in an inability to properly collate, use and share datasets for service planning and delivery purposes and to help inform strategic direction. The Scottish Government, Local Government and NHS are already working together to better manage how to share information more effectively and are using systems like Microsoft 365 to help them work better as a team.

Improving our digital capabilities will contribute to the reform of our services, improving productivity and efficiency, and releasing money and time to help us invest in the changes we have set out elsewhere in this Framework. It will also enable our workforce to focus on care and relationships. Our approach will be progressive, seeking first to maximise the use of technologies and innovations that we know are successful so that these are as widely available and familiar to people as possible. We will then build on these foundations, developing new services and the data-sharing capabilities that underpin them, and look forward to fully utilising rapidly emerging technologies such as AI for the public good.

In doing so, we recognise the need for individuals and clinicians to have choice around what approach works best for them. Ultimately, everyone should have the opportunity to be offered the choice to use digital, where appropriate, in an environment where they are supported to be digitally included.

Major Change: Services which are accessible through digital technologies, with people and our workforce able to access the right information.

Taking a digital approach is not simply about moving from paper to electronic systems. It's about reimagining how we deliver care and how people interact with the care system — empowering people to take control of their own health, enabling professionals to work more efficiently and collaboratively, and creating data-driven systems that are proactive rather than reactive. This will be enabled via a renewed approach to digital delivery and change management, with an expectation of national by default, local by exception for major digital delivery initiatives.

We must also be conscious of inequalities as we develop digital-focused approaches. Embedding and mainstreaming digital inclusion support across health and social care as part of 'business-as-usual' processes in service delivery is vital for long term sustainability and progress in ensuring digital equality.

- We will speed up delivery and improve our digital services by bringing together teams and resources from different national boards to work in a more joined-up and efficient way.

- We will deliver the first iteration of the Digital Front Door and progressively enhance the services available, making it easier for people to: manage their interactions with health and social care services; access and update their own data; and to find health and care information they can trust.

- We will embed the learning from the Digital Inclusion Programme across health and social care to equip providers with the tools and resources to develop local approaches to digital inclusion as part of person-centred care.

- We will work with partners across Local Government and more widely to adopt the use of CHI in Local Government, ensuring that there is a common identifier for verification and data matching to support better information sharing across organisations.

- We will strengthen Primary and community healthcare and social care data and digital infrastructure to ensure a relentless focus on outcomes.

- We will implement Digital Prescribing and Dispensing initially in General Practice and then across all primary and community settings, bringing benefits in relation to safety, efficiency and experience.

- We will establish a Primary Care Data and Intelligence Platform which will enable controlled access to data for Boards to support service delivery, planning, monitoring and research.

- We will continue the ongoing rollout of digital telecare to enable a far greater range of equipment than is currently used and support better use of data to make earlier and more effective interventions, thereby improving outcomes and potentially reducing hospital admissions and delayed discharges.

- We will continue to accelerate the embedding of digital therapies within mental health pathways.

- We will use data and AI to help predict people’s needs and provide more personalised services, like spotting who might be at risk of falling and offering support through digital telecare.

- We will redesign NHS Inform to make it easier for people to find and use trusted health information and services that supports them to better manage their health.

- We will introduce an AI framework for the safe, efficient and ethical application of AI across our services.

Spotlight on Current Services: Remote Monitoring of High Blood Pressure

High blood pressure affects an estimated 1.3 million Scots and is the leading preventable risk factor for heart and circulatory disease, associated with around half of all strokes and heart attacks. Since 2019, we have had a digital-first blood pressure remote monitoring service that to date has empowered well over 100,000 patients to take control of their blood pressure, reducing the risk of heart attacks and strokes while easing the burden on the NHS.[40]

This uses the 'Connect Me' service which enables primary care patients to share their blood pressure readings with healthcare professionals without attending General Practice appointments and promotes self-management to help control the condition. As well as prioritising a digital approach, this programme delivers on the SRF principles related to people, community, and prevention. It allows clinicians to monitor patient trends and change medication as required, whether levels improve from healthy habits or start increasing over time.

The service is estimated to have saved over 400,000 unnecessary appointments for blood pressure alone using simple technology. For every 50,000 people who routinely monitor blood pressure up to 745 strokes and 500 heart attacks could be avoided over a five year period. One of the largest programmes of its kind globally, through this framework we aim to expand this approach to a greater range of conditions supporting more people than ever be in greater control of their health and wellbeing.

Spotlight on Current Services: Computerised Cognitive Behavioural Therapy

Digital mental health therapies offer the option of instant and free access to evidence-based 24/7 support. Thirty-five computerised Cognitive Behavioural Therapy treatments (cCBT) are now available in Scotland, spanning programs referred to and supported by local NHS staff who check in during the online programme, to apps that are free to download and help with anxiety or insomnia. Additionally, our wellbeing website Mind to Mind offers short videos on how people living with mental health conditions manage them and signposts to support services. This is an innovative and rapidly expanding space. Over 70,000 referrals to digital therapies are now processed annually, with scope to provide even more proven options for the right care, in the right place, at the right time in future.[41]

Case Study: Digital and data enabling multi-agency support

A young woman in supported housing, Sophie has schizophrenia and gets support with alcohol addiction. Like many people, she gets care support from more than one service. Sophie's social worker has overall responsibility for ensuring she remains

[40] Scottish Government. (2024) Supporting people with high blood pressure.
[41] Scottish Government. (2024) Care in the Digital Age: Delivery Plan 2024-25.

safe, well, and independent. Sophie is additionally supported by a Multi-Disciplinary Team (MDT):

- A psychiatrist who prescribes medication and recommends the most appropriate form of treatment
- Community psychiatric nurses who give medication and manage community-based care and support
- An occupational therapist, recommending activities to help maintain independence
- An alcohol support worker helping Sophie manage her alcohol addiction.

They support Sophie through integrated use of digital technologies, co-ordinating their engagement through enhanced use of Microsoft Teams and Microsoft 365 collaboration tools. The National GP IT System, hosted online, means the information they record and share is accurate and up to date, enabling them to work more closely and collaboratively.

Sophie is anxious about leaving her home, but engages through video consultation using Near Me, and gets information through NHS inform. Sophie was recently in hospital and was prescribed medication through the Hospital Electronic Prescribing and Medicines Administration system. In future, Sophie's information will be entered directly into her Integrated Social Care and Record, alerting professionals to changes in her medication and treatment. Sophie will also communicate using the Digital Front Door, meaning she only needs to tell her story once. These digital systems and processes allow staff to deliver person-centred care, ultimately addressing social and health inequalities.

4. Enabling Shifts Required

Rebalancing of Resources - Finance

In the 2025-26 Scottish Government Budget, funding of £21.7 billion was allocated to the Health and Social Care Portfolio with resource funding having more than doubled since 2006-07 in cash terms. However, growing demand means that our health and care services are having to stretch further than ever before. This Service Renewal Framework must enable us to make the very best use of the resources that are available to us to meet the needs of the population. In line with the principle of allocative/population value, the way we use these resources should be equitable and transparent, and distributed across the pathway of care, including prevention.

We will do this through the following measures:

- A **continuous focus on efficiency and productivity and promoting clinical and operational excellence** regardless of health setting. This will help us meet increases in demand more efficiently, reduce pressure on staff and facilities, and free up capacity to dedicate to health and care provision.

- Supporting more **open, collaborative communication across statutory partners**. This is critical to ensure widespread understanding across all partners of the pressures, cultures and drivers being experienced in different parts of the system, and opportunities to meaningfully shift resources.

- **Maximising national collaboration for greater efficiency.** We will make the most of opportunities to deliver services **on a Once for Scotland[42] basis –** doing things once, nationally, rather than repeating across multiple organisations. This means building on the strengths of our National NHS Boards, ensuring they have the clear remit and authorising environment to lead and deliver on behalf of all NHS Boards. We also expect closer working between National Boards, with greater alignment of priorities, shared planning and, where appropriate, joint delivery of services. This collaborative approach will reduce duplication, improve consistency and make better use of national expertise and resources.

- **Investing in digital, data and AI technologies** to improve the delivery of services and enhance patient access and outcomes.

- **Enacting a long-term shift in the balance of care** by ensuring key resources (workforce, digital capital and training) and new investment

[42] Scottish Government (2024). NHS Scotland 'Once for Scotland' workforce policies: consultation.

proposals are focused on capacity building and service improvement in primary and community care. By building this capacity at a system level, with a focus on evidence, primary and community services will receive an increasing share of total health funding, ensuring our health and care system is adequately resourced to improve population health outcomes in the longer-term. We will monitor this balance as part of wider outcomes frameworks.

- Working with our NHS Chief Executives and accountable officers (i.e. Chief Officers) to **understand and address barriers to re-focusing and rebalancing resources** on preventative services and primary and community healthcare.

- Working collaboratively to **further embed integration**, including across integrated health and social care budgets. We will engage openly with our local populations and partners in the third and independent sector about the opportunities and challenges for reform.

- Prioritise **long term strategic investment cases** that align with this Framework, ensuring decisions on capital, workforce, infrastructure, etc. are drawn from robust population and planning data, are objective and are focused on and shaped around the health and social care system.

Outcomes, Quality and Impact: Renewed Systems Performance and Outcome Measures

No matter what setting, health and care must be high quality, effective, sustainable, and, as emphasised above, good value. Implementation of this SRF will contribute to increased effectiveness, quality and value for money within our health and social care services. This will happen not only through clear prioritisation, innovation and reform but through how we monitor performance and outcomes.

Understanding the performance, outcomes, and effectiveness of the health and social care system as it is now, and as it transforms, is critical. Our data, research and analysis must support delivery of the Major Changes set out in this Framework, ensuring not just that we are delivering on the actions identified, but that they are driving the change we need to see. To achieve this, our approach must be anchored in whole-system outcome frameworks, with updated performance metrics and clearly defined outcome measures for all parts of our system. To support implementation, an initial outcomes framework will be developed within the first year following publication of the SRF. This will translate the strategic priorities in this document into measurable outcomes that guide delivery, align efforts across the system, and enable transparent reporting on progress.

This work will build on the Health and Social Care Data Strategy which aims to get insights from data that allow us to improve services and inform policy; inform communities; monitor outcomes, experiences and access to services for different

population groups; target interventions and support; and improve services and partnership working.

Performance, outcome, financial and experience data need be further developed, and data needs to be accessible and understandable to support improvement activity across the system. The principle of shifting of care into the community also requires a rebalancing of our funding, data and analysis towards primary care, community health and social care.

Going forward we will build on the work already undertaken to identify gaps in our data landscape and make improvements. This will include:

- Working with Local Authorities, NHS Boards and National Records for Scotland to better understand population need, including by determining how the changing burden of disease and demographic profile of the population will impact future service provision.

- Implementing the 'Scottish Learning and Improvement Framework for Social Care Support and Community Health' (SLIF) which been developed jointly by Scottish Government and COSLA, in partnership with key stakeholders and those with lived experience of care.

- Continuing work with National Services Scotland (NSS) and Public Health Scotland (PHS) to drive improvements in data, data gaps and administrative data, which includes exploring the automation of data collection, analysis and use of AI.

- Driving alignment between official statistics relating to performance and SRF priorities, following the outcome of the PHS statistics consultation

- Working with Research Data Scotland to continue to improve safe access to health and social care data for research and innovation. This includes expanding the availability of data which can be accessed via the Researcher Access Service, streamlining approvals processes for accessing data and continuing to engage the public on the safe use of data for research.

- Introducing secondary legislation, subject to the passing of the Care Reform (Scotland) Bill, that supports information sharing and the setting of information standards to help make better use of data to inform national and local insights, planning and developments.

- Developing a nationally coordinated approach to the capture and use of patient reported outcomes and experiences to drive improved services.

- Working to explore how we measure the preventative and early interventions undertaken in the health and social care system.

In addition to our work on performance and outcomes measures, we know research and innovation are essential to delivering safe, high quality and sustainable health care services. Embedding health research and innovation throughout the NHS, supporting our dedicated research and innovation professionals, and working in collaboration with the academic and life sciences sector are fundamental to transforming our NHS and bringing the benefits of scientific advances to the people of Scotland. We will continue to support and promote health research and innovation through maintaining the national research and innovation platforms within our NHS; continuing our support and fellowship offerings to future generations of research and innovation leaders; and by supporting the delivery of impactful research and innovation through grant funding and ensuring access to UK-wide funding opportunities.

Coordinated Planning and Delivery

Population Level Strategic Needs assessment

To plan and deliver effectively, the Health and Social Care system requires strategic needs assessment across the range of areas that will impact service provision in the short, medium and long term. This marks a significant shift from traditional service-based planning to a **population level model** that considers the full spectrum of health and wellbeing needs—now and into the future. It will enable a more proactive, preventative, and equitable approach to service design and resource allocation.

There is already excellent work in place on the Burden of Disease and related products and further development is planned. This must now be applied and further developed at a national, sub national, Community Planning Partnership (CPP), Integration Authority and locality level to enable a firmly evidence-based approach to planning in the immediate, medium and long term. This will be a single source of truth available to all, allowing the public to see how the system plans to meet need.

Planning and delivery

Planning and delivery will be nationally coordinated but locally led. The Population Principle in this Framework prioritises planning for our population's needs at a national, sub-national and local level, above organisational interest and beyond the constraints of organisational boundaries. It seeks to deliver Value Based Health and Care, and it recognises that greater central vision is needed to make that behaviour and philosophy a reality in the NHS.

In recognition of the need to work differently and more collaboratively across the NHS, a revised Scottish Government governance structure has been introduced to support the DG Health and Social Care and Chief Executive NHS Scotland. The NHS Scotland Executive Group (NHSEG) is a key lever to deliver transformation at a national level. The group will make decisions and recommendations on what should

be delivered at a national or sub-national level across relevant Health Boards. The Executive Group is supported by a sub structure, which includes the NHS Scotland Planning and Delivery Board and Strategic Planning Board, who have a role in providing leadership and oversight of population level planning.

We will continue to work collaboratively between Scottish Government and COSLA through our joint governance structures, including the Collaborative Response and Assurance Group, to support and drive forward local improvement through use of whole system data.

NHS Boards, Integration Authorities, Local Authorities, and wider delivery partners will collaborate to ensure planning and delivery is responsive to the needs of their communities and has local ownership. Community Planning Partnerships and Local Outcome Improvement Plans will play a vital role in aligning this local planning with national priorities. Planning structures will also reflect the priority given to primary care and community health, working with independent contractors through groups such as the Primary and Community Health Steering Group and embedding a shift toward preventative, community-based care.

These priorities mirror and are intended to drive forward the ambitions set out within the Public Bodies (Joint Working) (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015. Both pieces of legislation clearly emphasised the need to shift the balance towards integrated, preventative community care.

We will significantly transform the capability of our National NHS Boards by the creation of a new single body called 'NHS Delivery'. That new body will bring together the existing functions of NHS National Services Scotland and NHS Education for Scotland, and will allow us to review and consolidate other cross-cutting delivery functions. This will provide a single point of accountability and delivery for a wide range of support, training and digital services to the Health and Care system in Scotland and will underpin the concept of Once for Scotland services across the public sector. The Scottish Ambulance Service and NHS 24 will be tasked to develop a complementary Collaboration Plan to enable transformational improvement in the delivery of urgent care services.

In addition, we acknowledge Audit Scotland's report and continue to build robust and clear governance arrangements to support the scale of reform required across NHS Scotland. We are committed to ensuring that NHS Scotland remains sustainable, accountable, and fit for the future. This Framework is a central part of our response to the challenges highlighted in the report. We will:

- **Clarify Governance Structures**: Building on the existing blueprint for good governance, we will look across the range of duties and guidance that is in place for Boards and work with them to ensure that those legal duties and relevant guidance are fully met in our work on reform.

- **Strengthen the governance of NHS Boards**: We are updating guidance to more explicitly align board governance with the demands of service reform. This will include clearer expectations for performance oversight, risk management, and collaborative leadership.

- **Support Collaborative Planning**: The Service Renewal Framework introduces a more integrated NHS planning model that encourages NHS Boards to work together and with wider public service partners. This will help deliver more consistent and equitable healthcare across Scotland.

- **Ensure Strategic Alignment**: The Framework has been designed to ensure that governance improvements are embedded within a broader vision for transformation.

- Significantly **transform the capability** of our National NHS Boards by the creation of a new single body called 'NHS Delivery'.

We recognise that reform is challenging, but it is essential. We are working closely with NHS Boards and stakeholders to implement these changes effectively and transparently.

Recognising the central role of primary care and community health within the NHS and across the wider system, we will strengthen their integration into whole-system planning and governance. This includes drawing on the expertise of existing mechanisms such as the Primary and Community Health Steering Group and the Mental Health and Wellbeing Strategic Leadership Board.[43]

All planning must be complementary and demonstrate meaningful partnership working across NHS Boards, Integration Authorities, Local Authorities, and other key stakeholders. This includes the third and independent sectors, whose contributions are essential to delivering holistic, person-centred care.

Single Authority Models are an opportunity to explore the role of alternative local governance arrangements in delivering service renewal, with a particular focus on health and social care. We are working with three geographies (Argyll and Bute, Orkney and the Western Isles) to develop local decision-making arrangements which can best respond to the unique challenges faced by these communities.

This document does not change any responsibilities on NHS Boards, Local Authorities or Integration Authorities regarding their planning and delivery responsibilities as set out in the Primary Medical Services (Scotland) Act 2004, The National Health Service (Scotland) Act 1978 and the Public Bodies (Joint Working) (Scotland) Act 2014. Our approach, with its emphasis on collaboration at a national,

[43] The Mental health and wellbeing strategy leadership board was established in August 2024 to support and oversee the ten priorities and related actions set out in the mental health strategy, delivery plan and workforce action plan.

sub-national and local level, driven by population needs, complements these legislative frameworks and will help to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in planning and delivery of services.

5. Delivering Change and Conclusion

Delivering Change

This Framework outlines the important changes needed to improve health and social care for people across Scotland. It creates a clear and supportive environment that encourages collaboration and strong, accountable leadership – so that all partners can deliver better outcomes for individuals and communities.

We will actively support accountable and collective leadership through NHS Board Chairs and Chief Executives, alongside the NCS Advisory Board. Working in partnership with Local Government, Integration Authorities and other partners, this leadership will be central to drive meaningful, system-wide change.

We have already set out our expectations for collaboration across NHS Board boundaries. Building on this, we will undertake a comprehensive NHS Accountability Review to ensure clarity in relation to national priorities, strengthening of performance oversight, and enable leaders to act with confidence. This review will help create an environment that encourages innovation, responsible risk-taking, better information and data sharing, and cross-organisational working. This will foster a culture where collaboration, testing, learning and continuous improvement are the norm, and ensure alignment with national priorities and measurable impact on health outcomes.

Overall, this Framework indicates a shift in how change is led and delivered. Leaders across the health and social care system will directly shape and implement the next phase of transformation, focusing planning at the population level and delivering modern digitally enabled and community focused services.

Conclusion

The Service Renewal Framework sets out a bold and necessary vision for the future of health and social care in Scotland—one that is person-led, prevention-focused, digitally enabled, and rooted in the needs of our communities and population. It provides a clear and actionable roadmap for transformation, grounded in five core principles: **Prevention, People, Community, Population, and Digital**.

This transformation will be underpinned by strengthened governance and accountability arrangements across NHS Scotland. The SRF reinforces the importance of clear accountability, robust oversight, and empowered leadership. We are clarifying decision-making structures and ensuring our governance structures

guarantee that the NHS in Scotland is equipped to lead and deliver reform effectively.

These principles will:

- underpin population-level planning at both national and sub-national levels, such as supporting local areas with local planning, including Strategic Commissioning Plans, ensuring Scotland's care and support services can meet the changing needs of our communities. This will be driven by high-quality data, robust evidence, and our collective analytical capabilities, enabling more informed and responsive decision-making.

- be applied and informed by clinical and professional advice, data, and evidence to support the redefinition of existing clinical pathways. This work will be clinically led, with strong engagement from the Chief Medical Officer and senior clinical leaders.

- address and support our existing work on health inequalities and underpin service design to reduce disparities in access, experience, and outcomes across the population of Scotland.

- build on existing work in areas such as oncology and vascular care to inform the redesign of hospital-based services, improving sustainability, reducing unwarranted variation and waste, and supporting a population approach to planning. This will contribute to the development of a leaner, more modern hospital estate across Scotland.

- prioritise investment in and support to our core first point of contact primary care services – such as general practice and community pharmacy – to provide a resilient foundation for a community-oriented model of health care.

- enhance community services so that they are person-led and embed the wider intentions of the SRF, in particular effective prevention and early intervention.

- guide the design of enablers such as education, training, digital and physical infrastructure so they support the changes we want to see, ensuring our plans are both realistic and deliverable.

This will be a collective endeavour. The success of the SRF will depend on shared leadership, clear accountability for delivery, sustained collaboration, and a relentless focus on what matters most: improving the health and wellbeing of the people of Scotland. Together, we can build a health and social care system that is fit for the future—one that delivers longer, healthier, and more fulfilling lives for all.

Summary: A Health and Care System for the Future

Scotland's health and social care system is changing to better meet the needs of people today and in the future. This Health and Social Care Service Renewal Framework is a long-term plan to make care more local, more personal, and more effective. It is designed to complement the Operational Improvement Plan, which focuses on reducing long waits for planned care and improving access across the system and sits alongside the Population Health Framework (PHF), which prioritises primary prevention. While the PHF aims to prevent illness before it starts, the Service Renewal Framework focuses on secondary and tertiary prevention – ensuring timely diagnosis, treatment and ongoing care. The vision is simple: to help everyone in Scotland live longer, healthier, and more fulfilling lives.

What is Changing?

- **More care in communities**: You will have easier access to care in your community, and have access to more types of treatment and support closer to home, not just in hospitals.
- **Focus on prevention**: Services will help you stay well, and keep you from getting sicker, not just treat you when you are at your most unwell.
- **Better use of technology**: You will have easier access to your health information and services online.
- **Joined-up care**: Health and social care services will work more closely together, so you do not have to repeat your story.
- **Person-centred, quality care:** Services will be designed around your needs and what evidence tells us works best, and you'll have more choice and control over your treatment.
- **Support for staff**: The people who care for you will be supported to work in new, different ways.

This is a big change, and it won't happen overnight. But over the next 10 years, the aim is to build a health and care system that works better for everyone—wherever you live in Scotland.

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