Health and Care Improving Flow Plan 2026 - 2031

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Scottish Government
Riaghaltas na h-Alba

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1. Foreword

Every one of us will rely on our precious health or care services at some point in our lives.

Whether you are a parent seeking help for a sick child, needing support to remain independent in your community, experiencing a mental health crisis, or waiting to bring a loved one home from hospital, you rightly expect services that are responsive, joined up and easy to access.

Our services have been under sustained pressure since the Covid-19 pandemic and not everyone in Scotland has the same experiences of care.

You may have found services difficult to navigate, waited too long for urgent care, or spent longer than necessary in hospital because the support you need in your local community is not in place. Our staff work incredibly hard to provide the best possible care but are doing so in a system facing rising demand, increasing complexity and significant pressure.

That is why improving how you move through the system, from your first contact through to recovery, is an opportunity to improve health and care outcomes for all.

At its heart, improving hospital flow is not about targets, processes or organisational structures, it is about people. Ensuring you can access the care you need, when and where you need it. Ensuring you move through services safely, quickly and with dignity.

Our ambition is clear, **one connected system, simple routes to care, ensuring every person receives the most appropriate response as quickly as possible.**

This is our contract with the people of Scotland.

You will no longer be expected to navigate complex services yourself. We will take responsibility for understanding your needs as individuals and connecting you to the right care, in the right place, at the right time. Your care team will not be confined by geographical or organisational boundaries but be empowered to join your support together in one seamless, connected experience. This means improved access, a smoother journey through hospital and returning home sooner with the right support to remain independent in your community.

You will be supported by the right people to get the help you need, accessing more care at your fingertips, in your home and in your community. We will ensure there are visible hubs in your local area to provide safe, consolidated contact points for the vast majority of your care needs.

If you experience a life-threatening emergency, or require highly specialised acute care, you will be cared for in a hospital setting which prioritises your dignity, privacy and experience. We agree that corridor care and long waits in A&E are unacceptable and should be eradicated. This plan aims to tackle these issues, creating the conditions for staff to deliver the high-quality care they are trained to provide.

Put simply, we are planning for unplanned care.

In return, we ask you to use services appropriately and take an active role in maintaining your health and wellbeing wherever possible. While we are committed to providing more care closer to home,

you may be asked to travel further to receive the most highly specialised care, in the most appropriate setting.

Delivering this change will require partnership at every level, transforming services nationally, regionally and locally. You, your family and your carers will remain at the heart of everything we do.

We recognise the extraordinary pressures that many of our hard-working health and social care staff face every day. Their expertise, commitment and experience will be essential to success. We will therefore work closely with our staff and their representatives to drive the improvements needed.

Across Scotland, there are already inspiring examples demonstrating what is possible: more care delivered at home, fewer unnecessary admissions to hospital, earlier discharge and better outcomes for patients and families. We are building on that progress and setting a clear national direction for the future.

You rightly expect improvement to be visible and measurable. We will be transparent about progress towards this vision, monitor the outcomes that matter most and act wherever improvement is needed. Where services are performing well, we will support learning and spread good practice. Where performance falls short, we will provide support, step in where necessary and take decisive action to improve outcomes for patients and communities.

The prize is significant: a Scotland where it is easier to get help, where more care is delivered closer to home, where you spend less time waiting and more time receiving care, and where health and social care services work together as one connected system, coordinated around your needs. A system that fits around you, rather than expecting you to fit around the system.

Together, we can build a rebalanced system that is simpler, fairer and more sustainable. A system that supports staff, strengthens communities and delivers better outcomes for everyone. Above all, a system that gives you confidence that when you need care, the right help will be there, in the right place, at the right time. Working with you, we can make this happen.

Angela Constance
Cabinet Secretary for Health and Care
Scottish Government

2. What will be Different for You

One conversation. One coordinated journey. We'll help you find the right support without the frustration of being passed between services.

Fast access to the care you need. Every decision will be guided by professionals involved in your care plan, ensuring you receive the right care, in the right place, at the right time.

Hospitals will focus on emergencies and the most acute specialist care. Hospitals will focus on specialised treatment, recovery and returning you home safely and sooner. If you can be treated elsewhere, you will be redirected to access the right services, without unnecessary waits.

Care closer to home will become the norm. You will be supported to live well, stay independent and remain connected to your family and community.

Supporting recovery where people thrive best. More people will recover at home or in community settings, with personalised support to help them regain confidence and independence.

And for those who deliver our health and care services every day:

You'll see the impact of your work more clearly. By supporting people earlier and closer to home, you'll help prevent crises and improve outcomes for the communities you serve.

You'll have the time and tools to provide the care you're trained to deliver. Modern technology, interconnectivity, and simpler processes will reduce duplication and administrative burden, with less time navigating systems and more time helping people.

You'll work as part of one joined-up team around the person. Health, social care and community services will work together seamlessly, giving you easier access to the expertise and support you need.

You'll spend less time managing avoidable pressures and more time delivering meaningful care. Earlier intervention and stronger community services will help reduce demand on acute and crisis services.

You'll feel part of a system that works with you, not against you. Services will be designed around the needs of people and professionals, enabling you to do your best work every day.

3. Executive Summary

Right Care. Right Place. Right Time.

Scotland's health and social care services are among our most valued public services. Every day, staff across the NHS, social care, local government, the third sector and local communities provide high-quality care and support that saves and changes lives.

However, demand for services is growing. People are living longer in ill-health, and too many continue to experience delays, difficulty navigating services and longer stays in hospital than necessary. Staff work under sustained pressure in systems that can feel fragmented and difficult to coordinate.

The current model of care is increasingly unsustainable. While hospitals remain essential for life-threatening emergencies, the most acute care and highly specialised interventions, not all your specialist care needs to be delivered in hospital settings. In many cases you can achieve better outcomes when supported at home or in your community. Specialist care is already provided in communities across Scotland. For example, you can already receive free eye tests and support for eyecare on your local high street. We want to build on this by expanding access to high quality support closer to your home wherever it is safe, effective and beneficial for you.

The Improving Flow Plan sets out how Scotland will respond. Our ambition is simple:

One connected system, simple routes to care, ensuring every person receives the most appropriate response as quickly as possible.

At its heart, this Plan is about improving how people experience care. It is about ensuring that you receive the right support, in the right place, at the right time and move safely, effectively and compassionately through health and care services from the moment you seek help through to recovery. Achieving the best possible quality of life, wellbeing and autonomy for your circumstances.

Continuity of Care

Your route to care is clear:

- Call your GP practice, or where appropriate, attend your local pharmacy or walk-in service, in hours.
- Call 999 for any life-threatening critical emergency such as a suspected heart attack, stroke or excessive bleeding.
- If you think you need A&E but it's not immediately life-threatening, call 111, day or night.

We are committed to providing continuity of care through a local multi-disciplinary team who understands your health, circumstances and what matters most to you. Your GP Practice, supported by a multidisciplinary team, will coordinate your care and help you navigate services. Particular emphasis will be placed on strengthening continuity for people with complex needs, including those with mental health conditions, dementia, frailty or those approaching the end of life.

No one should have to navigate health and care services alone. Through a "Team Around the Person" approach, professionals will work together to provide you joined-up, person-centred care, supporting major life transitions and addressing barriers that prevent access to services.

We will improve coordination between community, hospital and urgent care services, including named consultants during hospital treatment and earlier access to senior professionals who can make decisions about your care and treatment. New Integrated Navigation Centres will bring together expertise across NHS 24, the Scottish Ambulance Service and wider system partners to provide coordinated triage, advice and access to the right service first time.

Alongside this, MyCare.scot, Scotland's new health and care app, will be your online front door to health and care services, giving you easier access to appointments, information and support while continuing to provide telephone and face-to-face access for those who need it.

Home Care

We will ensure more care is delivered in your home whenever it is safe, clinically appropriate and aligned with your wishes.

Hospital at Home, virtual care, online and phone consultations, remote monitoring and care at home services will continue to expand, enabling you to receive high quality care in your own home. Better self-management support and digital services will help you remain independent and manage your health and wellbeing more effectively.

Community Care

A new Community First approach will strengthen local multidisciplinary services and shift more care into communities, supporting you earlier and preventing your health from getting worse.

Health, social care, wider public services and the third sector will work together more effectively through local teams, making it easier for people to access high-quality support and care when and where they need it, in person within your community or virtually, where appropriate and better for you.

We will also strengthen links with housing, welfare and other community services to provide you more joined-up support which meets your whole life needs.

Hospital Care

Hospitals will be reserved for life-threatening emergencies and highly specialised treatment.
We will improve patient flow through acute hospitals by strengthening same-day emergency care, assessment pathways, operational management and use of real-time data. Put simply, where care does not need to happen immediately, we will organise it better. This will create a more responsive and resilient system for you, our staff and our communities.

Corridor care is unacceptable and we are clear it should be eradicated. Recognising that this is a complex issue with no single solution, the broad range of actions outlined in this plan will work collectively to improve flow, reduce pressures across the system, to ensure you receive safer, more dignified care. This will also ensure our staff can deliver the high-quality care they are trained to provide.

Discharge planning will begin on day one of a hospital stay. Through the Discharge Without Delay approach, health and social care teams will work together to ensure you can return home, or move to the most appropriate setting, as soon as your treatment is complete.

Greater use of discharge-to-assess models, community rehabilitation, frailty pathways and discharge teams will reduce delays and support you to regain independence more quickly.

What Will Be Different for You

This Plan is built around a series of transformational changes that will make care simpler, faster and more connected.

You will find it easier to get help through clearer access routes and better navigation across services. You will tell your story once, with professionals working together through coordinated teams and shared information.

More care will be provided at home and in local communities through expanded community services, Hospital at Home, virtual care and digital support. Hospitals will focus on delivering emergency and specialist care for those who need it most.

You will spend less time waiting, less time in hospital and more time recovering in your own home and community whenever it is safe to do so. Staff will benefit from better-connected services, reduced duplication and improved conditions in which to deliver high-quality care.

Accountability and Improvement

We will celebrate success and spread good practice wherever improvements are delivering better outcomes.

However, we will also be honest when performance falls short. Where we identify persistent challenges, unwarranted variation or poor performance, we will step in, working with local services and partners to understand the underlying causes, provide support and take decisive action to improve outcomes ensuring every community experiences first class services and care.

Improvement, accountability and support will go hand in hand.

Our Vision for Scotland

This Plan is more than a programme of reform.

It is a commitment to create a health and care system that is easier to access, better connected and designed around people's needs.

A Scotland where it is easier to get help.

A Scotland where more care is delivered closer to home.

A Scotland where people spend less time waiting and more time receiving care.

A Scotland where hospitals focus on those who need them most.

A Scotland where health and care services work together as one connected system.

And a Scotland where people live healthier, more independent and fulfilling lives.

This is our contract with the people of Scotland. And together, we will deliver it.

4. Why Change is Needed

Scotland's health and care services are a source of national pride. Every day, staff, carers, volunteers, communities and partner organisations provide compassionate, high-quality support to people across the country. However, the environment in which services operate is changing rapidly, and reform is essential to ensure they can continue to meet your needs in the future.

Changing Needs and Growing Demand

Scotland's population is ageing, and more people are living longer with multiple long-term conditions, frailty, mental health needs and increasingly complex care requirements. As demand grows, people need help from an increasing range of services in their lives. At the same time, you rightly expect care that is timely, coordinated and centred around your needs.

Yet too often services are organised around organisations rather than people. This can result in delays, fragmented care, repeated assessments and you moving between different parts of the system before you receive the support you need.

A Different Model of Care

Hospitals will always play a vital role in responding to life-threatening emergencies, treating serious illness and complex conditions, but they cannot meet rising demand on their own. Many people can safely receive care closer to home, in their communities, or through digital services. For older people, those living with long-term conditions, complex needs or frailty, this often leads to better outcomes and a better experience of care.

Reform is therefore about creating a more connected system that supports you earlier, prevents avoidable crises and ensures care is delivered in the right place, at the right time.

Pressures on the Current System

The need for change can be seen across the health and care system today:

- People are waiting too long for urgent and unscheduled care.
- Emergency Departments and ambulance services are under significant pressure.
- Hospitals often operate at very high occupancy levels.
- Too many people remain in hospital after they are clinically ready to leave.
- Staff spend valuable time managing system pressures rather than providing direct care.
- Access, experience and outcomes can vary according to people's circumstances and where they live.

These challenges affect patients, families, carers and staff every day and the current way of delivering care is not sustainable without reform.

Building a Sustainable Future

Health and social care services also face significant financial, workforce and operational pressures. Meeting future demand will require a greater focus on prevention, early intervention, community-based support, digital innovation and new models of care that help you access support sooner and in the right place.

Across Scotland, examples such as Hospital at Home services, integrated community teams and improved discharge planning are already demonstrating that better, more person-centred care is possible. We must now work to make these improvements available consistently across the country.

Improving flow is about creating a health and care system that is easier to access, better connected, more equitable and sustainable, and capable of delivering high-quality care for future generations.

Whole-System Collaboration

Improving flow cannot be achieved solely through changes within hospitals but requires a whole-system response that supports you earlier, closer to your home and in more appropriate settings.

We recognise that transforming urgent and unscheduled care will require sustained collaboration across health, social care, local government, emergency services, the third sector, independent providers, professional bodies, staff representatives and people who use services.

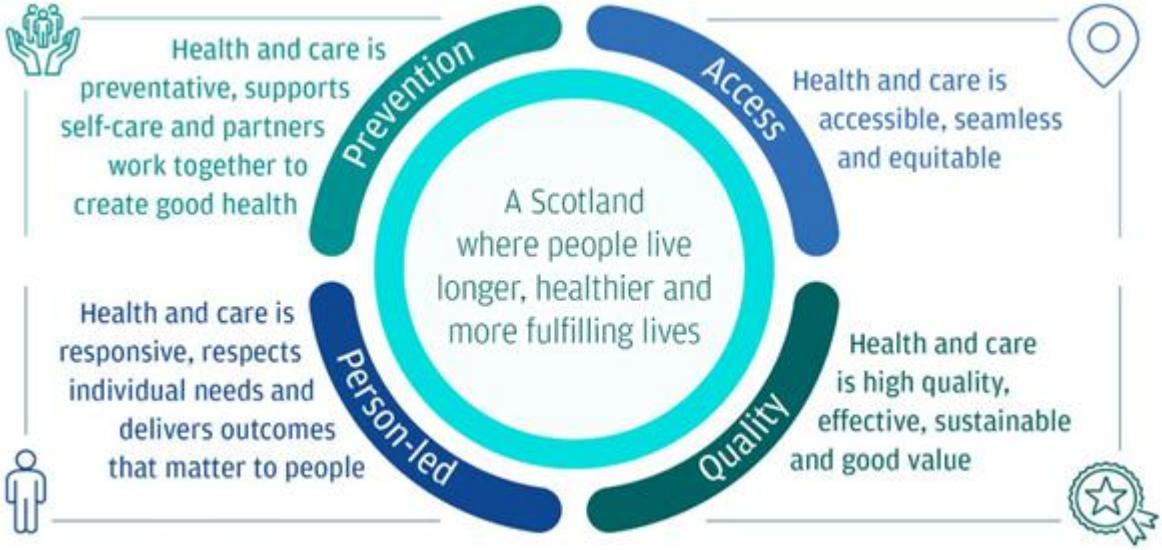
We will therefore continue to engage widely with stakeholders as we implement this Plan, using evidence, learning and lived experience to further develop our approach. Through this ongoing partnership, we will refine and strengthen our plans, ensuring that future actions reflect your needs, the needs of our staff and of our communities, while supporting the delivery of a more sustainable, person-centred and responsive urgent and unscheduled care system.

5. Our Ambition

Our ambition is simple:

One connected system, simple routes to care, ensuring every person receives the most appropriate response as quickly as possible.

At its heart, improving flow is about people. Our ambition will deliver on our Health and Social Care Vision and its core values, building on our Service Renewal Framework and Population Health Framework.



Source: Scottish Government, Health and Social Care Service Renewal Framework.

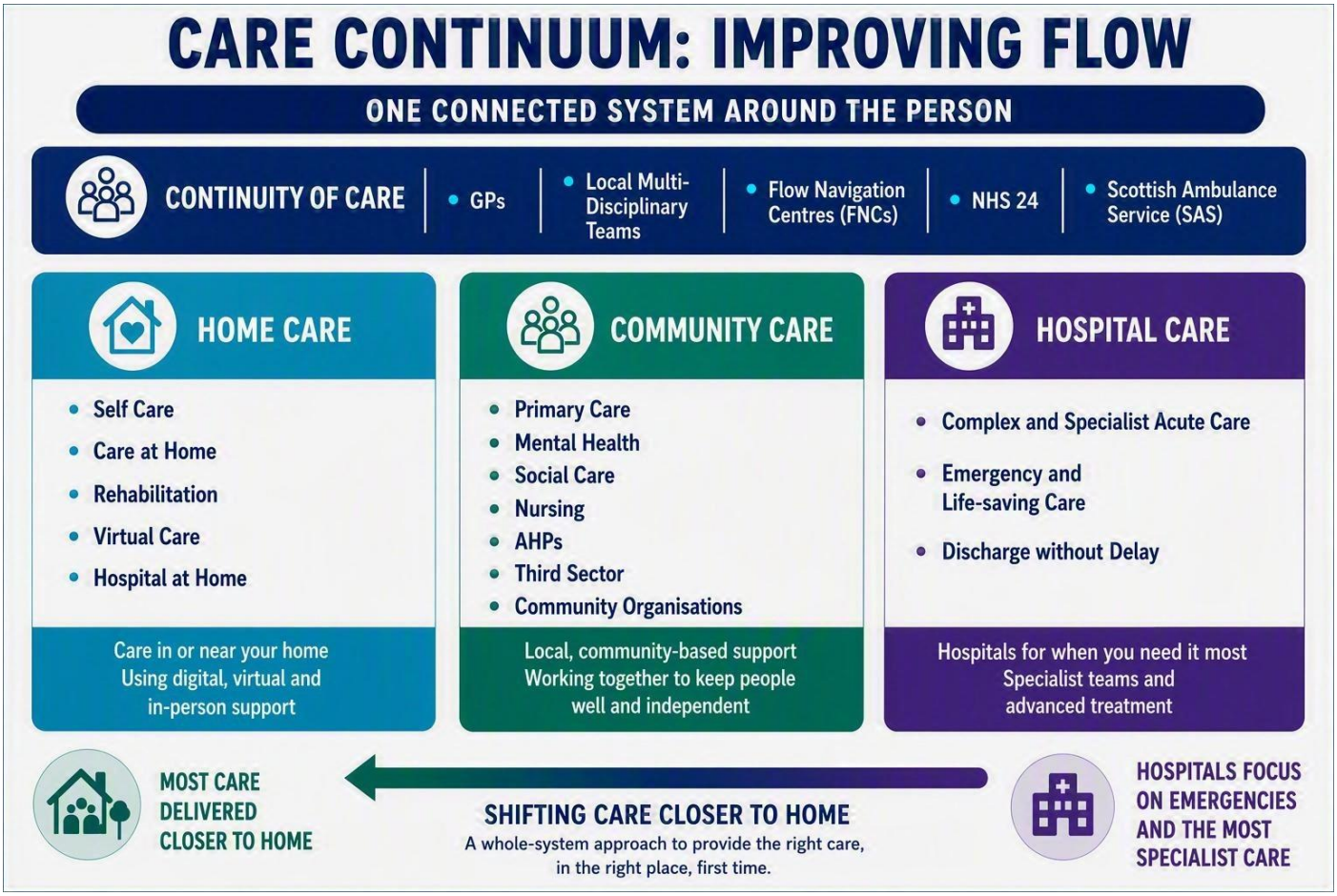
Prevention – You will be supported to manage your health and care earlier and in the most appropriate setting, with more care delivered in your home and community. This means wherever possible you will recover in your own bed or in your local area, more connected to your own support network, preventing further ill-health. By developing one connected system, with simple routes to care we will better manage the complexities inherent in everyday life, provide holistic support and tackle the inequalities in our society, anticipating and preventing further health needs.

Person Led – Your time is your most precious resource, let's not waste it. This plan will reduce your time waiting for care, support you to navigate the system and get you back to your home, loved ones and community as soon as possible. It will get you the care you need, when you need it and build the wraparound support to be healthier, happier and more independent.

Access – No one wants to be bounced from pillar to post, telling their story repeatedly. This plan will direct you to the care you need seamlessly, connecting the system more efficiently and removing the need for you to navigate disparate services yourself.

Quality – Health and social care services are among Scotland's most valued public services, delivering high quality care for those that need it most. This plan will build on that legacy, strengthening the continuity of care you receive, putting patient safety at the heart and working whole system to deliver changes that ensure you receive the highest quality of care at every stage.

6. Delivery Plan



Source: Scottish Government.

6.1 Continuity of Care

A single navigation point nationally, that connects seamlessly with coordinated community care with appropriate connections to relevant non-health and care support.

Continuity of care is critical for good health outcomes, particularly when you are most at need. Your GP practice is the best coordinator of your overall health and care needs, supported by a wider local multi-disciplinary team. We are committed that this local team knows you, your circumstances and what matters to you. They will see the entirety of your health and care journey, supporting you to understand and navigate the system.

Continuity of care improves your quality of life and prevents the deterioration of your health. This continuity of care is particularly valuable if you have complex mental health needs, dementia, frailty or are approaching the end of life. We are therefore committed to strengthening the pathways that deliver this continuity for these individuals.

We are committed that no person should have to navigate services alone. When you require hospital care, you will have a named consultant throughout your journey. You will know who this individual is and how you can contact them. They will be accountable for your journey through hospital, responsible for managing any transitions and will ensure you have continuity in your care journey. This coordination will feed through into your local multi-disciplinary team.

Coordination will follow the principles of the 'Getting It Right For Everyone' (GIRFE) practice model and you will be supported through a 'Team Around the Person' approach. This will ensure that you receive clear and accessible information, to decide what options suit you, and that these choices will be respected. Practitioners will take the time to listen to you, understand you as a person and your entire life situation, rather than treating isolated conditions. Your care team will work together to deliver proactive early intervention and support you through critical life transitions such as moving from child to adult services, discharge from hospital or moving into residential care be that social care, dependency support, palliative or end of life support.

We understand that life is complex. Creating a system that works for everyone requires a deep understanding of individual needs. This includes recognising the barriers and challenges that people face in accessing and navigating care, and understanding how wider structural, social and economic inequalities can shape health outcomes and experiences of services. The system must adapt to meet your needs, not the other way around. We should understand who is accessing care, who is not; who is experiencing difficulties in getting access and why; and then make the system work for them. That is why we are piloting a network of new GP-led walk-in services that allow you to access the help you need without needing to book an appointment.

We are committed to empowering local decision makers to work with you and those who support you to understand your needs, tailor their systems and processes to respond to these needs and ensuring that flow improves for everyone.

The principles of coordination outlined are intended to build trust and support you as a whole person. We understand that missed appointments are often an indicator of unmet need rather than a personal failing. We are therefore committed to shifting how missed appointments are seen in the system, using the connection with your local multi-disciplinary team, as the coordinator of your care, to explore where additional support may be needed for you to access health and care. Where more intensive support is required, the local multi-disciplinary team will be able to connect you to support for your wider non-health and social care needs, removing any barriers.

6.1.1 Navigation

Your route to care is clear:

- Call your GP practice, or where appropriate, attend your local pharmacy or walk-in service, in hours.
- Call 999 for any life-threatening critical emergency such as a suspected heart attack, stroke or excessive bleeding.
- If you think you need A&E but it's not immediately life-threatening, call 111, day or night.

Improving flow depends on making better decisions about your care earlier in your journey. Access to senior professionals, in charge of making decisions about your care, such as A&E consultants, will be embedded in navigation, urgent assessment, ambulance support, acute assessment, same-day care and discharge pathways. Strengthening access to senior clinicians will improve outcomes, particularly for complex cases, ensuring a whole system response to your individual needs, creating a more seamless response. It may be that an Emergency Department is not the most appropriate place for you, when your needs can be safely met elsewhere you will be supported to access this support quickly.

Public Health Scotland data show that around half of all A&E attendances are self-referrals, highlighting the critical role of effective navigation within the urgent and unscheduled care system. Citizens' Panels have told us that you want a system that provides rapid access when care is urgent, while also maintaining continuity and personalised support where this is most important.

We heard that you value services that are simple to navigate, make effective use of NHS resources and involve you in decisions about your care.

We will build on the progress already made through the expansion of NHS 24's capabilities by establishing new Integrated Navigation Centres and Co-ordination Hubs, ensuring NHS 24, the Scottish Ambulance Service and existing flow navigation functions work together seamlessly for the benefit of patients. This will provide 24/7 access to a senior clinician, smoother triage with fewer touch points and a journey that helps you access the right care, in the right place, first time. This model will continue to evolve over the next five years.

We will implement digital access routes, including for example e-triage, while maintaining phone-based and in-person access. We will harness innovation, and new and emerging technologies, to optimise clinical expertise, directing you quickly to the most appropriate care pathway to meet your needs.

We will continue to build on our new health and care app MyCare.scot to deliver the single biggest digital innovation in Scotland's health and care system. This will give you a single point of access to manage your health and care journey. Over time this will enable you to book and reschedule appointments, review your records and access self-management and remote monitoring tools. This will give you greater control to arrange appointments at a time that suits you, removing barriers to healthcare, preventing missed appointments and making your health and care journey work for you. For those unable to go online, in person and telephone services will still be available.

In the last Parliament we delivered the Care Reform (Scotland) Act 2025, which places a duty on Scottish Ministers to ensure those who receive health and care services in Scotland can have a digital health and care record. This record will be available through the MyCare.Scot service, building on the personal information that is already available.

The digital health and care record will be a major infrastructure change that will be delivered incrementally, giving those that work in our health and care system an integrated, interoperable means for data sharing and real time updating of your record, reducing the administrative burden they experience. This will make you safer, reduce errors and improve your experience by reducing duplication and supporting more of your care to be delivered earlier and closer to home. It will also mean that your care team can follow your entire journey and adapt it to meet your needs, providing clarity and understanding where needed.

Case Study – Flow Navigation

Following a 999 call for worsening breathlessness, a patient living with heart failure was assessed by the Scottish Ambulance Service. Rather than being conveyed automatically to an Emergency Department, clinicians sought advice through the Flow Navigation Centre. Working together across hospital departments, health professionals reviewed the patient's needs and agreed that a direct referral to the Hospital at Home service was most appropriate. The patient received timely assessment and treatment without a prolonged wait in hospital. This journey demonstrates how integrated navigation and early clinical decision-making from a senior clinician can connect people to the most appropriate service first time, improving outcomes while supporting hospital flow.

6.1.2 Pathways

It may be that dedicated mental health services can better support you and we will therefore make sure mental health crisis pathways are available consistently across Scotland with stronger connections into community-based recovery and support services. This will build on existing good practice already underway such as ensuring mental health clinicians are available in every board to receive referrals from NHS 24 and that they are available to front line services such as Police Scotland and the Scottish Ambulance Service. We will build on emerging innovations such as mental health triage cars based across the country, where there is demonstrated benefit, expand NHS 24's mental health hub to include psychological therapies, and promote the use of Safe Spaces offering more therapeutic environments such as Hope Point, the Neuk and the Lighthouse.

These models can offer a more suitable response when experiencing mental health crisis, including those affected by substance use, while reducing pressure on Emergency Departments. In some areas they also provide a place where Police Scotland can safely bring or refer individuals, allowing officers to transfer care and return to frontline duties more quickly.

Our Distress Brief Intervention (DBI) programme is providing a non-clinical intervention, which is a consistent, compassionate and personalised for people experiencing distress. Professionals working in frontline services, including NHS services, Police Scotland and the Scottish Ambulance Service can refer you to trained staff. If you require a DBI Level 2 service, a trained DBI practitioner will make contact within 24 hours and provide short-term, community-based support focused on problem solving, distress management, wellbeing planning and connect you to ongoing sources of help. This ensures when you are in distress you receive timely support that is responsive to your needs and circumstances.

There is also work taking place to improve mental health crisis support in clinical settings. Examples include dedicated quieter spaces and peer support workers embedded in Emergency Departments, and specialist mental health assessment areas.

To support consistent improvement, NHS Boards have been asked to develop local blueprints for unscheduled care. Mental health should be a core component of these plans, ensuring that prevention, crisis alternatives, community support, discharge pathways and follow-up care are considered alongside traditional urgent and emergency care measures. This will help create a system that not only responds effectively if you are in crisis, but also ensures you are cared for in the best place, accounts for your preferences and gets you home as soon as possible.

The Coming Home Action Plan 2026 reaffirmed our commitment that if you have learning disabilities and complex support needs you will be able to live in your community with the right support at the right time, close to family and friends. You will not be delayed in hospital or placed in other care settings, you have not chosen, for long periods of time.

If you, or someone you love, are receiving palliative care or approaching the end of life, we appreciate that urgent and unscheduled care can be complex, unpredictable and highly distressing. Care pathways must direct you to the most appropriate setting for your care, regardless of the time of day or night. Through our integrated approach we will strengthen collaboration between partners, to improve access to advice, medication and equipment. Providing compassionate, rapid, community-based support in line with Scotland's Palliative Care Matters for All strategy.

6.2 Home Care

A significant expansion of home-based care.

We must stop thinking of hospital as the default response to urgent care. Improving flow requires a fundamental shift in the way care is delivered across the system. While hospitals remain essential when you require specialist, complex, or intensive treatment, they are not always the best place for you to receive care. Extended stays in hospital can lead to physical or cognitive decline, loss of independence, increased risk of hospital-acquired infections, and poorer patient experience, particularly for older people, those living with frailty and people with complex health needs. For most people, you can achieve better outcomes, recover more quickly, and maintain greater independence when supported in your own home and community.

As part of the Community-First programme we will expand home-based care significantly, creating a continuum of support ranging from self-care and digital enablement through to intensive Hospital at Home and Care at Home services. Our ambition is to make community and home the default place of care whenever it is safe, clinically appropriate to do so, and aligned with your individual preferences**.**

If you have been assessed to not require an immediate response, we will adopt a stronger "wait well" approach. While you await a call back, clinical review, diagnostic test, planned appointment or treatment you will receive clear information on what you can do while you wait, including self-care guidance, symptom monitoring advice and signposting to local support services. NHS Inform and community pharmacy services will play a central role in providing this support, helping you to manage your symptoms safely, access advice and medicines where appropriate, and understand when and how to seek further help if your condition changes.

Wherever possible, you should be supported to live independently in your own home and community for as long as it is safe and appropriate to do so. Care at Home can help to keep you well, avoiding the need for hospital treatment; enable earlier discharge, supporting your recovery following illness and reduce the need for long-term residential care. This enables you to remain connected to your family, community and what matters most to you.

If you require social care, Self-Directed Support (SDS) can support you to live more independently, pursue your passions and participate in your community. SDS gives you a real choice and control over the care and support you receive, shaping that support around you and your family. We are committed to working with SDS delivery partners across statutory, third and independent sectors to build on the improvements to the delivery of SDS that we have achieved through the Self-Directed Support Improvement Plan 2023-27, which was developed jointly with COSLA and the National SDS Collaboration. We will also work closely with local authorities and Health and Social Care Partnerships to ensure appropriate services to meet local needs are commissioned enabling more people to receive care in their own homes.

The provision of equipment and adaptations supports you to participate fully in daily life and to live safely within your home environment for longer. By working with our national equipment and adaptations Network we will seek opportunities to create an efficient service that promotes a consistent, integrated and person-centred approach to provision of equipment and adaptations.

We will provide clear information online and implement consistent, credible and clinically proven digital interventions. This is to help you to get the information and support you need when you need it, from trusted public services.

Our ambition is for remote and technologically enabled health and care to become a mainstream component of a digitally enabled health and social care system, empowering you to manage your health and care and providing safe and effective solutions at home. This will give you greater independence, an ability to manage your own care in a way that suits you and helps you prevent ill-health. This means you will receive more personalised care, helping to prevent conditions from becoming more serious and reducing the need for hospital stays or residential care.

We will also build on emerging innovation in virtual models of care, including learning from the NHS Greater Glasgow and Clyde and NHS Lanarkshire Virtual Hospital approach, evaluating and expanding these where there is demonstrated benefit. This will include exploring how technology-enabled care can support you to receive monitoring, review and treatment at home, rather than waiting in hospital for investigations, diagnostics or clinical review.

Alongside this, we will explore opportunities through Healthcare Improvement Scotland's recent assessments of remote monitoring and technology-enabled care, to increase the number of patients who can safely undergo diagnostic testing, monitoring and clinical observation at home. By reducing avoidable hospital occupancy and enabling more people to receive hospital-level care in their own homes, these developments have the potential to improve patient flow, increase capacity in hospitals and deliver a more person-centred model of care across Scotland.

We will build on the progress made through our Hospital at Home Programme. The recently published Hospital at Home National Programme Report 2025/26 demonstrates the significant contribution these services are making to reducing hospital pressures, with more than 17,000 people aged over 65 receiving care in a more appropriate non-hospital setting during 2025/26, and admissions increasing by 27% over the year. This has delivered substantial estimated savings while also allowing people to stay in the comfort of their own homes while receiving treatment.

Hospital at Home is not just for older people, it is our ambition that over the next 5 years everyone in Scotland will have access to a Hospital at Home service so you can receive treatment at home, where it is clinically appropriate and if you choose to. We have already expanded services in some areas to include paediatrics. Recent data shows that 340 babies and children avoided time in hospital between November 2025 and April 2026 due to Hospital at Home services.

Between February and April 2026, more than 7,500 people across Scotland received hospital-level care at home through Hospital at Home services, enabling them to remain in familiar surroundings while receiving the treatment and support they needed. Building on this progress, we will work with NHS Boards to increase capacity so that more than 10,000 people can benefit from Hospital at Home services this winter making Hospital at Home a core component of Scotland's approach to improving urgent and unscheduled care flow.

Case Study – Home Care

An individual developed a serious chest infection. Instead of a lengthy stay in hospital, they were referred to the Hospital at Home service, where a multidisciplinary team provided hospital-level care in their home. Regular clinical visits, medication management and direct access to specialist advice allowed them to receive treatment safely while remaining close to their family and community. The individual was then discharged to a remote respiratory care pathway, and now receives ongoing monitoring and support at home, allowing changes in their condition to be identified and managed earlier. This experience demonstrates how Hospital at Home and remote monitoring can deliver high-quality acute care while maintaining independence, reducing disruption to family life and improving flow across the wider health and care system. The individual reports greater confidence in managing their health and reassurance that specialist support is available when needed.

6.3 Community Care

Enhancing community services and creating the conditions for more care closer to home, including by delivering a National, Regional and Local model of delivery which supports coordinated and high-quality local care. Ensuring hubs exist in every community providing easy access to health and care services.

Improving flow cannot be achieved solely through changes within hospitals but requires a whole-system response that supports you earlier, closer to your home and in more appropriate settings. The Collaborative Response and Assurance Group (CRAG), co-chaired by the Cabinet Secretary for Health and Social Care and COSLA's Health and Social Care Spokesperson, currently provides assurance and accountability on delayed discharge performance. Going forward, its remit will expand to cover whole-system flow, including unscheduled care and delayed discharge, with a focus on addressing barriers to improving flow and supporting national solutions. CRAG will provide strategic oversight of flow across health and social care, promote collaborative problem-solving and sharing of good practice, and strengthen accountability.

We will therefore be using Community First approach to drive the transition of care to your community, towards earlier interventions and prevention, and deliver better care closer to your home. Together this approach, Improving Flow Programme and Planned Care Programme will deliver a more integrated and coordinated system. More detail will be set out shortly with the publication of the Primary Care and Community Health Routemap later this year.

Local multi-disciplinary teams already deliver the majority of the care you need, we will invest in local leadership and upskilling, as well as expand these teams, enabling them to support local populations, tailoring responses to your local area and your community's needs. Care will be based on clear assessment of population need and will mean that any care you need, that is not already at your fingertips or in your home, will be visible and accessible in your local community. This matters especially for rural and island communities.

We recognise that life is complicated, and your needs don't neatly fit into boxes. It is therefore vital that local multi-disciplinary teams are connected beyond health and care to support you to access what you need to remain healthy, happy and independent. We will therefore reinforce the connections nationally, regionally and locally with wider public services.

Unpaid carers are essential partners in delivering care closer to home and supporting people to live independently in their communities. As we shift the balance of care towards prevention and community-based support, we will strengthen support for carers, including implementing the right to breaks from caring, helping to protect their wellbeing and sustain caring relationships.

We are already delivering greater access to services in your local community through walk-in GP clinics, mental health hubs and one stop shops, which we will continue to build on. However, over the next five years we will go a step further, exploring how we best coordinate this support, with local partners, including through new health and care hubs, collocating support in every community, so that you know, wherever you live in Scotland there is place close by where you will be seen, heard and supported to access the care you need.

We will develop a national vision for community infrastructure, including the potential role of assets such as community hospitals or GP surgeries, as flexible Community Health and Care Hubs, maximising and adding to existing local assets to provide integrated care, rehabilitation, prevention and support closer to home while retaining the flexibility to meet your needs.

Our communities in Scotland are diverse, with varied needs and the delivery of services must be tailored to these unique contexts. Within our Once for Scotland ethos of national consistency we will deliver in a unified, streamlined way across the country, while supporting local planners, workforce and community groups to maximise opportunities for innovative approaches and transformation tailored to their local populations needs. We will coordinate nationally so innovation can be scaled, so that you will benefit from the innovation and experiences across Scotland and be able to access services you expect, no matter where you are in the country.

Shifting the balance of care towards prevention and community care is a long-standing commitment and is critical for improving the flow of the entire health and care system. In line with the ambition for hospitals to be focused on emergency and highly specialised acute services, we will explore opportunities to move more services from hospital settings into local communities where it is safe and appropriate to do so. This may include greater access to specialist outpatient clinics locally, building on the success of Community Appointment Days, which provide multiple support services, face to face, in a single visit in your community. We will utilise the whole health and care workforce and the community assets available to deliver preventative care, while reducing your wait for assessment. We will also work closely with practitioners who deliver care to strengthen support for older people and those living with frailty. By providing more coordinated care at an earlier stage of your journey, we can help you to maintain your independence, reduce the time you wait, prevent your conditions from worsening, and help you to stay well for longer.

If we are to shift the balance of care into the community, support needs to be available to you in the places you need it. Access to social care support in our communities is key to this. We will work with Local Government and social care providers, to strengthen social care provision and reduce the instability within this critical area of support.

We recognise that moving more care into the community requires broader changes across the whole of health and care, from rebalancing investment towards community care workforce and premises, supporting self-management and prevention (including through digital tools), and easier information sharing through an integrated health and care record. First steps towards the shift to the community, prevention and early intervention will be set out shortly.

We are already expanding community-based services so that more people can access the care they need closer to home. This includes a broader range of services through NHS dental practices, improved access to hearing aid and low vision services, and greater availability of community-based glaucoma care.

Working with providers and partners, we are also moving the diagnosis and treatment of uncomplicated age-related hearing loss into community settings, reducing the need for hospital visits and improving access to care.

Prevention and early detection are central to improving health outcomes. We will expand the range of community diagnostic and screening services, including introducing heart and lung MOTs, helping you stay healthier for longer and receive support at the earliest opportunity.

While significant progress has been made in improving services for people living with frailty across Scotland, the next phase must focus on preventing people from reaching a crisis point that results in urgent or emergency care.

This will require earlier identification of frailty and dementia, alongside a comprehensive assessment of a person's health, wellbeing and future support needs. This includes care planning, support from a range of health and care professionals, regular medication reviews, and ensuring people receive recommended vaccinations.

Taking this proactive approach will help people stay healthier for longer, maintain their wellbeing, and continue to live well in their communities. It will also ensure that planning ahead for future care becomes a routine part of supporting those at greatest risk of deterioration.

Case Study – Community Care
A person waiting for musculoskeletal support attended a Community Appointment Day where a range of clinical and support services were available in a single community setting. Rather than navigating multiple appointments across different locations, they received assessments, advice and an agreed care plan on the same day. Their needs were addressed quickly, and they were able to continue managing their condition closer to home with the option of further support if required. This approach reduced waiting times, improved their experience and demonstrated how coordinated community services can provide prompt, accessible and personalised care.

6.4 Hospital Care

Hospitals are focused on providing lifesaving, highly specialised or inpatient care, while more people receive support through community-based services and closer to home.

We will ensure that acute hospitals are reserved for when you require lifesaving, highly specialised or inpatient care. By making better use of alternative pathways and community-based models of care, we will create capacity within hospitals to provide safe, timely and high-quality treatment for those with the greatest clinical need.

Using real-time data and intelligence, across the system, will help us improve decision making and identify pressures earlier meaning we can take action before you experience delays. Moving from reactive pressure management to a proactive system response, we will improve patient flow through acute hospitals and tackle overcrowding, ambulance handover delays and prolonged waits in Emergency Departments. These challenges affect safety, experience and outcomes for you and our staff, requiring coordinated action across the whole health and social care system. We will support this through stronger operational management and clear accountability. For you this means you will be directed to services who can see you sooner and better meet your needs.

You should never receive care in an environment that compromises your dignity, privacy or experience. We are clear that corridor care is unacceptable and must be eradicated. Health Boards will be expected to take sustained action to tackle corridor care through the delivery of this plan. We will work with Health Boards and our improvement teams to share best-practice so that you can be confident you will receive the best care possible in hospitals.

Hospital admission is not always the best option for your needs. Long stays in hospital can lead to physical and cognitive decline which can leave you less able to manage at home. Therefore, where admission is needed, we will ensure you do not remain in hospital for longer than necessary. Each day in hospital should add value. The staff organising your care will have a realistic and honest conversation with you about how to achieve the best outcome for you and planning for discharge will begin with your family and others delivering your care, on day one. We want to personalise your care and avoid over investigating and over treating you. These are conversations that are in line with what you have told us that you expect.

When hospital care is necessary, we will:

- Manage more people in units designed to deliver care on the same day, without admission.
- Ensure you are assessed and discharged within 3 days in the vast majority of cases.
- Ensure that if you experience frailty, you will be managed by staff who specialise in delivering coordinated and tailored specialist frailty care.
- Develop services for adults living with multiple comorbidity and multiple disadvantage so that you benefit from continuity and multidisciplinary coordination.

This will mean you are not admitted for longer than required and it will ensure space is available when you need admission, tackling corridor care and reducing ambulance handover delays.

For same-day and short stay admissions, we will ensure that an appropriate area is identified, a senior clinician is involved at an early point in your admission, key investigations are available and that you have the information about you care that gives you clarity and confidence when discharged. We will ensure where appropriate you can be referred directly into these services to avoid delays in the Emergency Department.

Recognising that we are seeing more adults who live with multiple comorbidities and disadvantage we will expand the pathways to provide continuity of care and multidisciplinary team working and develop General Medical services to support them. This group have seen the largest proportional increase in admissions in recent years and principles of practice have been developed to guide the establishment of new services.

Through a coordinated focus on prevention, continuity of care, timely assessment, efficient flow and safe discharge, we will work with NHS Boards and national partners to reduce avoidable delays, tackle corridor care, improve patient experience and ensure that acute hospital services can respond safely, effectively and sustainably when you need them most.

6.4.1 Discharge

Planning for discharge starts on day one, involving a wide multi-disciplinary team in acute settings and in the community. Discharge efficiency and partnership working will drive down delays and shorten length of stay.

If you receive specialist hospital care, our Discharge without Delay model will support you to recover at home once your treatment is complete. The model works across health and care, with a multi-disciplinary team supporting you to transition back into the community.

Discharge Without Delay works through four simple elements working together to improve your experience in the hospital and of returning home:

Acute Frailty Units – If you are identified as having frailty you may be admitted to a specialised unit where staff are trained in delivering frailty care. This ensures the right team are supporting you while in the hospital and that they are better prepared to anticipate what your journey home should look like.

Planned Date of Discharge and Integrated Discharge Teams – On your first day in hospital you will be given a Planned Date of Discharge, this may change based on clinical assessments, but this will help to prevent you staying in hospital longer than clinically necessary, by facilitating early and effective planning for discharge at the earliest safe opportunity. This means early discharge conversations at or soon after the point of admission involving you, your family, and others who are providing you support. Unpaid carers will be involved in discharge planning wherever appropriate, recognising their vital role in supporting recovery and a successful return home. You

will be supported through this transition by an Integrated Discharge Team, who will manage your journey home.

Community Hospital and Step-Down Rehabilitation – This plan will work towards as many of you as possible being supported to recover in your own bed at home. However, sometimes you will require some support to rebuild your independence before going home. Community hospitals are typically better able to provide you with the necessary rehabilitation or reablement support, than an acute hospital. This interim support ensures you can return home more ready to manage your regular routine, therefore part of your transition home may require support at a step-down facility in a local community hospital.

Discharge to Assess (sometimes called Home First or Home Assessment) – Assessments of your care needs are best conducted where you live to ensure the long-term care you receive, matches your needs and is deliverable in your home. You may therefore be discharged home with your short-term care needs provided for a period of up to 21 days.

These approaches mean that you will be seen by the right staff to manage your needs; can access step-down care and will be supported to rebuild independence before returning home where appropriate.

This approach also reduces the risk of administrative delay by planning ahead for your discharge and assigning dedicated resource to manage this transition, reducing the likelihood of remaining in hospital once you are ready to return home.

These commitments apply to adults of all ages living with frailty, multimorbidity or complex needs, including younger adults with disadvantage, mental health need, substance use or recurrent crisis.

Over the next two years, we will ensure that the frailty services, which exist in every Emergency Department, fully embed frailty expertise early in urgent and emergency pathways, with rapid transfer to the most appropriate service to support you. We will increase the number of patients being discharged from frailty units within 72 hours through early identification of frailty and initiation of comprehensive geriatric assessment. If you experience frailty, you will receive prompt, specialist support from the moment you arrive, reducing the delays you experience and your length of stay, discharging you efficiently through integration between community and hospital teams.

Case Study – Discharge
An older person required urgent hospital care following a fall. The hospital team began planning their return home from day one, working with community professionals to understand their likely support requirements. They were assessed as potentially requiring long-term residential care. Rather than remaining in hospital while decisions were made, they were supported through a Discharge to Assess pathway. They returned home with short-term support and assessment delivered in their own home. As their needs became clearer, they regained confidence and independence and were supported to continue living at home. Their experience demonstrates the benefits of Home First principles, allowing people to recover in familiar surroundings while ensuring assessments are based on how they function in everyday life.

6.4.2 Leadership & Accountability

Alongside existing national standards, we will develop a consistent process for escalation moving from a reactive to a more proactive joined-up approach. This will help you receive timely care, with NHS boards coordinating support across traditional boundaries when needed, working together to make the best use of all available capacity and reduce delays in care.

Healthcare Improvement Scotland is developing standards for urgent and unscheduled care. The standards will support more consistent, safe and person-centred care across Scotland. For you, this means services will be designed around quality, safety and timely access to care, regardless of where you live. We will monitor improvements and use this data to ensure that we are addressing health inequalities through the changes. The standards will also help NHS boards identify where services can be improved, supporting a more consistent experience no matter where you are in the country.

People rightly expect improvement to be visible and measurable. Accountability will be defined across national, regional and local levels, with clear ownership of outcomes, escalation routes for persistent variation, and mechanisms for resolving cross-boundary issues between organisations. We will monitor performance against clear national and local measures, publish progress transparently and work with NHS Boards and partners to support improvement, reduce variation and ensure people receive safe, timely and high-quality care regardless of where they live.

We recognise that improving flow through acute hospitals depends on improving flow throughout the wider health and care system, and we are committed that frontline leaders will have a prominent role in this improvement journey. Working closely with our local government partners to ensure the right support is available through Health and Social Care partnerships.

We will continue to prioritise efforts to reduce long waits for planned care, building on the progress seen so far. Evidence suggests that prolonged waits for planned assessment and treatment can lead to deterioration in physical and mental health and increase demand on primary care, NHS 24, urgent care services and Emergency Departments. It is therefore important that waiting times are managed carefully and transparently, with individuals at the centre of decision-making, to ensure you receive appropriate support while waiting and to reduce the risk of your condition worsening.

7. Immediate Priorities

While this Plan sets out a five-year vision for transforming health and social care, people should begin to see improvements much sooner.

Over the next 12 months we will focus on practical changes that make it easier for you to access support, reduce delays, tackle corridor care and help you receive more care closer to home. These include:

- Launching a national campaign, in Autumn 2026, to help people access the right care, in the right place, at the right time.
- Expanding access to senior clinical advice through NHS 24 and Navigation Centres and improve triage in Emergency Departments.
- We will strengthen direct referral pathways from our navigation centres into alternative services.
- Increasing Hospital at Home capacity so more people can receive treatment and monitoring at home.
- Reducing conveyance to hospital through enhanced community pathways
- Expanding mental health crisis support.
- Introducing earlier discharge planning and increasing use of Home First and Discharge to Assess approaches to reduce the time people need to spend in hospital.
- Expanding access to Same Day Emergency Care services, increasing the number of people who can receive timely assessment and treatment without requiring admission.
- Supporting younger people who are admitted to hospital with multiple comorbidity and multiple disadvantage through multidisciplinary care and continuity between community and hospital settings.
- Improve the care of the older person living with frailty through properly tailored care in line with best practice identified by Healthcare Improvement Scotland and the Discharge without Delay principles.
- Ensure robust escalation procedures that anticipate pressures and optimise capacity across the whole system, recognising that A&E performance is not solely an Emergency Department issue but reflects the effectiveness of flow across the entire health and care pathway.
- We will deliver earlier identification of frailty, improve uptake of anticipatory care planning, and promote coordinated multidisciplinary support for people living with frailty and dementia.
- Remove barriers to weekend discharge by implementing effective seven-day working models, ensuring patients do not remain in hospital longer than necessary due to service availability.

7.1.1 Preparing for Winter Surge

In the coming months, urgent action is required to prepare for the period of surge over winter. Systems are already experiencing significant pressure, and we cannot wait for longer-term reforms to take effect before delivering improvements.

Improving delayed discharge is one of the most effective actions available to increase capacity, reduce overcrowding, improve patient experience and prepare services for winter demand. Ahead of this winter, we are asking all Health Boards to make improving discharge and reducing delays in acute hospitals an immediate priority. By winter 2026/27, every Board is expected to have implemented the core principles of a Discharge Without Delay approach and established improvement trajectories for discharge performance and average length of stay. This will include ensuring discharge planning begins at the point of admission, identifying likely discharge needs as early as possible, supporting clinical decision-making within the first 72 hours of a hospital stay, reducing avoidable delays within hospitals, and increasing the use of criteria-led discharge where appropriate. Ministers will have direct oversight of this improvement activity through our Collaborative Response and Assurance Group.

To ensure improvements are sustainable, we will strengthen collaboration between hospital, community, primary care, social care and third-sector services to support timely discharge and recovery at home, including expanding discharge-to-assess, step-down and community-based support pathways. Together, these actions will help ensure you spend only as long in hospital as is clinically necessary and can return home sooner, where it is safe to do so.

Vaccination also remains a key part of our approach to winter preparedness. Alongside the delivery of new and expanded vaccination programmes, we are working with Health Boards and partners to strengthen this year's winter vaccination programme and maximise uptake among eligible groups. A national public information campaign will support this effort, encouraging people to come forward for vaccination when invited, helping to reduce serious illness, protect vulnerable people and ease pressure on health and care services during the winter period.

7.1.2 Next Steps

This Plan sets out a clear direction for the future of health and care in Scotland. By improving flow across the whole system, strengthening community and home-based care, enhancing continuity of care, and ensuring hospitals focus on those who need them most, we will create a more sustainable, connected and personalised system of care. Delivering this vision will require collaboration, commitment and a relentless focus on improvement, but the prize is significant: better outcomes, better experiences and a health and care system that works seamlessly around your needs. Together, we will build one connected system, with simple routes to care, ensuring you receive the most appropriate response as quickly as possible.

Following the publication of this plan, our NHS Sub-National Planning and Delivery Committees will develop detailed delivery plans working with a wide range of partners, to deliver practical improvements at pace. This will align with the ambitions outlined in our Programme for Government; our existing reform activity outlined in the Service Renewal Framework and Population Health Framework; and the new Community First approach, to deliver a stronger, more accessible and more integrated service. We will monitor progress against this plan, reporting annually, working with Audit Scotland, and in line with our other reform publications.

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