Prevention-Focused Lothian Health and Care System

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1. Acknowledgements

The prevention plan, and the wider approach to embedding prevention, has been developed collaboratively across the Lothian health and care system. We are grateful to colleagues for their valuable input to engagement sessions, impact assessments, logic modelling, and feedback on the draft plan.

2. Introduction

The Lothian health and care system has reinforced its commitment to improving population health and tackling inequalities through the Lothian Strategic Development Framework (LSDF), the Prevention Framework approved by the NHS Lothian Board in April 2024 and, more recently, commitment to becoming a Population Health Organisation and embedding prevention through its core business. The Prevention Framework set out the case for strengthening prevention and identified opportunities to embed it more fully across the system.

The population is ageing, and people are living longer with multiple long-term conditions, while overall health is declining, ill health is starting earlier, and inequalities are widening. Together, these trends increase pressure on health and care services at a time of limited resources, making the current approach to service delivery unsustainable. Prevention remains one of the most cost-effective actions available to the NHS and the wider health and care system to improve population health and reduce health inequalities. Sustained focus on prevention is essential to achieving long term system sustainability and reducing future demand for services.

Evidence increasingly demonstrates the economic value of public health interventions. Primary prevention - actions that stop problems arising in the first place - offers particularly strong returns, with a median return on investment greater than 14:1 and typically being three to four times more cost effective than treatment. Audit Scotland has also emphasised the need to invest in tackling the root causes of ill health to reduce long term pressures on the NHS. Investment in primary prevention provides the greatest opportunity to improve population health, manage future service demand and create a sustainable health service for the future.

Health is shaped by a wide range of social and economic factors, including our living environment, employment conditions, housing, and education. While healthcare plays an important role, these wider determinants have a stronger influence on overall health and wellbeing. This requires the health and care system to act across the full set of building blocks of health rather than focusing narrowly on healthcare alone. In support of this, the NHS Lothian Board agreed three high level priority areas for strengthening prevention work: the building blocks of health; maternal, children and young people’s health; and reducing the burden of disease.

This paper describes the progress being made towards a prevention-focused system and identifies the key outcomes and actions required to embed prevention across the Lothian health and care system, aligned to the three priority areas, and support the Lothian health and care system's ambition towards becoming a Population Health Organisation.

Not everything in the prevention plan is new, however, this approach marks a shift from short-term, programme-specific activity to a sustained, system-wide commitment to prevention based on population health principles. It embeds prevention as a core organisational responsibility, supported by a focused and consistent set of indicators that allow progress to be tracked over time. Preventative activity will be routinely integrated into programme boards and decision-making structures, rather than treated as an add-on, ensuring alignment with delivery and accountability frameworks. Greater emphasis will be placed on preventative spend and longer-term investment decisions, recognising that improvements in outcomes and inequalities require time to realise benefits. Consistency and continuity in priorities, measures and governance will support cumulative impact and create the conditions for prevention to be embedded as standard practice across the system.

3. Understanding Our Population: Demographics and Health Needs

Understanding the demographic characteristics of our population such as sex, age, ethnicity, and deprivation is a crucial first step in shaping policy and practice to support health and wellbeing. As of mid-2024 the total population of Lothian was estimated to be 932,180 people (52% female, 48% male). The largest five-year age group in Lothian is 20–24-year-olds, comprising 8% of the total population. The largest ethnic group in Lothian are those who identify as white Scottish or white British (79.4%), with 10.1% identifying as another white ethnicity and 10.5% identifying as being from a black and minority ethnic background. Although most people in Lothian live in less deprived areas, 34,620 residents are in Scotland's most deprived 10%. Deprivation is unevenly distributed: only 5% of East Lothian and 7.3% of Midlothian live in the most deprived quintile (SIMD 1), compared with 11.8% in Edinburgh and 14.3% in West Lothian.

Our health is shaped by a combination of social, economic, and environmental factors. Where we live, our work conditions, our housing and education are fundamental building blocks and the primary drivers of our health and wellbeing. According to data gathered by the 2023 Lothian Public Health Survey[1], younger respondents experience more negative outcomes and situations such as food poverty, loneliness, and less stable employment status. Additionally, people in deprived areas experienced worse health outcomes such as mental health conditions, mobility issues, and pain/discomfort compared to those in affluent areas.

[1] Public Health Reports – Public Health and Health Policy

When these building blocks are unequally distributed, it is harder for our population to live healthy lives.

Growth in life expectancy is stalling, and people are spending more of their life in ill health. It is estimated that one in four deaths in Lothian are avoidable, 68.3% of which could be prevented through effective public health and prevention interventions. This trend is patterned by deprivation, where those in the most deprived areas had four times the avoidable death rate as those in the least deprived areas. The Scottish Burden of Disease Study forecasts the national burden of disease to increase by 21% by 2043. Increases are projected to be largest for cardiovascular diseases, cancers, and neurological diseases, accounting for 68% of the total increase in forecasted disease burden. Alongside a growing disease burden, population projections estimate that the population served by NHS Lothian will grow by 9.6% between 2022 and 2032, for which the largest increase is estimated to be amongst those aged 65 and older. Taken together, these trends point to increasing and potentially unsustainable pressure on health and social care services unless a stronger focus on prevention is adopted.

There is a need for sustained focus and investment in prevention and early intervention, addressing the conditions in which people live, work, and grow, through both whole-population approaches and targeted action for those at greatest risk.

4. Policy Context

4.1. Population Health Organisation: Enabling Prevention

A strong population health approach is essential to delivering a prevention-focused health and care system that advances equality and realises people's rights to the highest attainable standard of health. This requires the right organisational enablers to support informed decision-making, collaborative action, and sustained improvement across the system, ensuring that resources and effort are targeted in ways that reduce unjust and avoidable health inequalities. The Population Health Organisation framework sets out how the system should be organised to drive population health improvement, and the system change required to implement national policy commitments as set out in the Population Health Framework and Health and Care Service Renewal Framework, aligned with equality and human rights duties.

Understanding population needs through ***data and intelligence*** is foundational to prevention and addressing inequality. High-quality, disaggregated population health intelligence enables partners to identify differential outcomes across communities and populations, understand structural and systemic drivers of inequality, identify emerging risks, and target action where it is most needed. This supports proportionate, rights-based decision-making, ensures prevention efforts are

evidence-led, and enables transparent tracking of progress in improving population health and reducing health inequalities over time.

Workforce and culture are critical to embedding prevention, equality, and human rights in everyday practice. Visible system leadership and collaborative working across the whole system support a shift from reactive care to upstream prevention, grounded in an understanding of social justice and the social determinants of health. Prevention is embedded as a pan-system priority through the Lothian Strategic Development Framework (LSDF), promoting shared responsibility, learning, and consistent approaches that respect diversity, reduce discrimination, and enable meaningful participation of staff and partner agencies.

Leadership, governance, and accountability provide the structure needed to drive and sustain change. The Population Health Programme Board will act as a central forum for the prevention approach, enabling coordinated working across programme boards and maintaining a clear focus on tackling inequalities and improving outcomes for populations experiencing disadvantage. Clear governance and reporting lines, alongside the integration of population health, equality and human rights considerations into Board assurance mechanisms will ensure prevention remains a priority and aligns with wider organisational and policy commitments.

A ***prevention-focused system*** grounded in the social determinants of health recognises that health is shaped by the conditions in which people live, work, and grow, and that these conditions are not equally distributed. The development of a prevention logic model and associated actions supports coordinated, cross-system delivery through LSDF programme boards, enabling collective action on the root causes of inequality. This is reinforced through efforts to increase, align, and prioritise preventative spend in ways that are proportionate to need and transparent in their impact on equity.

Service design and delivery play a key role in enabling prevention and advancing equity, with a strong emphasis on accessible, culturally appropriate primary and community healthcare. Shifting care closer to home supports early intervention, reduces avoidable hospital use, and helps address health inequalities by improving access for people and communities who experience barriers to services. Designing services around people's needs and rights strengthens dignity, choice and fairness in the health and care system.

Finally, a ***value-based approach to health and care*** ensures that resources are used in ways that deliver the greatest benefit for population health, including narrowing health inequalities. By focusing on outcomes that matter to people and communities, than activity alone, value-based approaches reinforce investment in prevention, support sustainability, and help ensure services are effective, equitable and responsive to current and future population needs.

4.2. Population Health Framework[2]

Published in June 2025, the Scottish Government and COSLA sponsored Population Health Framework sets out Scotland's 10-year, whole-system approach to improving population health and reducing persistent and widening health inequalities. It is explicitly focused on primary prevention and addressing the root causes of poor health, recognising that most determinants of health lie outside the health and care system. By 2035, the Framework aims to improve overall life expectancy and reduce the life expectancy gap between the most deprived 20% of areas and the national average.

The Population Health Framework is underpinned by five key drivers of health:

- **Prevention-Focused System** – Strengthen collective accountability for population health outcomes and reduce inequalities.
- **Social and Economic Factors** – Improve the social and economic conditions that support better health and reduce inequalities.
- **Places and Communities** – Create healthy and sustainable places by working with and within communities.
- **Enabling Healthy Living** – Develop supportive environments that promote health and wellbeing and reduce health-harming activities.
- **Equitable Health and Care** – Foster a health and social care system that delivers equity, prevention, and early intervention.

Initial action focuses on embedding prevention and equity into planning, budgeting, and accountability; strengthening local delivery through Community Planning Partnerships; and targeted action on healthy weight and food environments.

4.3. Health and Care Service Renewal Framework[3]

Published alongside the Population Health Framework, the Service Renewal Framework sets out the medium to long term strategic direction for reforming health and care services so that they remain sustainable, high-quality, accessible, and affordable. While the Population Health Framework focuses on improving health and preventing illness, the Service Renewal Framework focuses on how service must change to support prevention and early intervention, deliver care in the right place at the right time, and shift resources away from avoidable hospital-based care.

The Service Renewal Framework is structured around five principles that guide service planning:

- **Prevention** – prioritising proactive and preventative care
- **People** – person-centred, outcomes focused services

[2] Scotland's Population Health Framework - gov.scot

[3] Health and Social Care Service Renewal Framework - gov.scot

- **Community** – care closer to home and community-based delivery
- **Population** – population-based planning rather than organisational silos
- **Digital** – modern, digital-first services and data-enabled improvement

The Prevention Plan presented in this paper articulates how the Lothian Health and Care System contributes to the delivery of these two important policy documents.

5. Aims and Objectives

5.1. Aim

The aim of the prevention plan is to build a prevention-focused health and care system that improves population health, reduces health inequalities, and secures sustainable services for the future, by lowering premature mortality (under 75 years) and narrowing the gap in life expectancy between the most and least deprived communities.

5.2. Objectives

Building a prevention-focused health and care system requires a shift in how the whole system thinks, plans, invests, and measures success. The objectives below are critical enablers of that shift, ensuring prevention is not treated as an add-on, but as a core function of the system.

5.2.1. Make prevention a system-wide priority

Prevention must be embedded across the entire health and care system, not limited to specific services or programmes, to achieve lasting improvements in population health. Making prevention a system-wide priority helps address the root causes of poor health, such as social, economic, and environmental factors, before illness develops. This approach reduces avoidable demand on services, improves quality of life, and supports earlier, more effective action to reduce health inequalities and premature mortality.

5.2.2. Support local partners to embed prevention in strategic planning and service delivery

Local partners (both within the health and care system, and wider community planning partners) are best placed to understand the needs, assets, and challenges of their communities. Supporting them to integrate prevention into planning and delivery ensures interventions are relevant, targeted, and equitable. Strong local ownership of prevention strengthens collaboration across sectors, aligns resources around shared outcomes, and helps close the gap in health and life expectancy between the most and least deprived communities.

5.2.3. Embed prevention within performance frameworks

What is measured shapes what becomes prioritised. Embedding prevention within performance and accountability frameworks ensures long-term health improvement is valued alongside activity and treatment targets. This helps shift focus from short-term outputs to outcomes that matter most, such as reduced risk factors, improved wellbeing, and delayed onset of ill health, supporting sustained progress on population health and inequalities.

5.2.4. Maximise investment in prevention

Sustained investment in prevention is essential to break the cycle of rising demand and constrained resources. By directing funding towards evidence-based preventive actions, the system can reduce future costs associated with avoidable illness and inequality. Investment in prevention improves value for money, supports financial sustainability, and enables services to better meet the needs of the population now and in the future.

5.2.5. Establish a robust learning and accountability system

A strong learning and accountability system ensures prevention efforts are informed by evidence, adapted over time, and deliver impact. By tracking progress, sharing learning, and holding the system accountable for outcomes, the health and care system can continuously improve what works for different populations. This supports transparency, strengthens decision-making, and ensures that prevention efforts contribute meaningfully to reducing premature mortality and narrowing health inequalities.

6. Progressing a Prevention-Focused Approach

6.1. Make prevention a system-wide priority (Objective 1)

Making the case

NHS Lothian has demonstrated a clear commitment to strengthening its approach to population health improvement and reducing inequalities, initially through the Lothian Strategic Development Framework (LSDF) and more recently through the Prevention Framework[4] approved by the NHS Lothian Board in April 2024. The Prevention Framework set out a clear rationale for prioritising prevention and identified opportunities to further embed preventative approaches across the Lothian health and care system.

[4] NHS Lothian Public Health and Health Policy - A strengthened approach to prevention across the Lothian health and care system

Equality and Children's Rights Impact Assessment

Stakeholders from across the system worked collaboratively to undertake an Equality and Children's Rights Impact Assessment (ECRIA) on a whole-system approach to prevention. This process resulted in five key recommendations:

- **Adopt a whole-system, collaborative approach to prevention** to improve efficiency and effectiveness and reduce duplication. A clear, consistent approach to prevention should be embedded across the system.
- **Clearly define the different levels of prevention** within the strategic plan, including their expected impact on health inequalities. This will provide greater clarity on how prevention activities influence inequalities and help identify any unintended negative impacts, particularly from secondary and tertiary prevention.
- **Strengthen general practice within primary care** by improving infrastructure and capacity to deliver timely, high-quality prevention and early intervention in local communities. This includes building on existing work to deliver more services locally and strengthening the interface between primary and secondary care.
- **Enhance data and intelligence** to improve understanding of key population health issues and enable more effective planning and targeting of prevention activity towards those most in need. This includes people at greatest risk of poverty, multimorbidity, and poor access to housing, as well as consideration of the wider determinants of health affecting children and young people. Improved data will also support assessment of impact and return on investment.
- **Ensure preventative spend is visible within organisational finances**, establishing a baseline for current investment and enabling a managed, gradual shift towards prevention over time, with consideration of both short- and long-term impacts.

The prevention plan outlines high-level outcomes and actions, with subsequent development and delivery likely to require further impact assessment to strengthen understanding of differential effects across equality groups and to inform the specific, proportionate actions needed to address any identified inequalities.

System-wide engagement

Engagement was undertaken with stakeholders across the health and care system through Senior Leadership Teams and LSDF programme board structures to strengthen the system's approach to prevention and develop a shared language. Definitions of prevention were informed by Public Health Scotland's work but adapted into more accessible, user-friendly language.

There was strong agreement to retain the modified terminology of prevention, early intervention, and mitigation (rather than primary, secondary, and tertiary prevention),

as feedback from engagement sessions indicated these terms were easier to understand and supported clearer interpretation.

System-wide stakeholders also collaborated to develop a prevention logic model. LSDF programme boards and other cross-system groups have since been consulted on the proposed outcomes and actions.

Definitions

The agreed prevention definitions are set out in Table 1 below.

Table 1: Prevention definitions

Prevention	**Early intervention**	**Mitigation**
Invest in the building blocks of health to stop problems happening in the first place.	Focusing on early detection of a problem to support early intervention and treatment or reducing the level of harm.	Minimising the negative consequences (harm) of a health issue through careful management.

The prevention plan set out in objective 2 (below) uses these definitions and prioritises prevention and early intervention to deliver meaningful improvements in population health. Engagement sessions confirmed that, while prevention and early intervention should be central to the plan, mitigating action remains necessary at this stage to support effective condition management, reduce avoidable deterioration, and limit the need for crisis intervention and should therefore be included e.g., action to increase uptake of diabetic eye screening.

6.2. Support local partners to embed prevention in strategic planning and service delivery (Objective 2)

The prevention logic model and associated actions are presented below across three priority areas. Actions are focused on the shorter term (1–2-year period). They have been developed through engagement with a wide range of stakeholders from across the Lothian health and care system, alongside consideration of the available evidence. This approach has enabled the identification and prioritisation of short-, medium-, and longer-term outcomes, which align closely with the priorities and actions set out in the Population Health Framework.

The relationships shown within the logic model (for example, between medium- and longer-term outcomes) represent contributory pathways rather than standalone activities that are sufficient on their own to achieve subsequent outcomes. These anticipated contributions are informed by the best available evidence and theoretical

foundations and require coordinated action at both national and local levels, particularly in relation to the building blocks of health.

The logic model is complemented by a series of topic-based links signposting to relevant evidence and theory, illustrating how progress against specific outcomes is expected to contribute to subsequent outcomes within each priority area (paper available on request).

Through embedding the outcomes and actions within cross-system programme board implementation plans, we will create an integrated, collaborative, and sustainable approach to prevention across the system, for greatest population health benefit. The relevant programme board(s) are noted in each section of the logic model below.

6.2.1. Building Blocks of Health (Priority 1)

People's health is strongly influenced by their income, housing, work, transport, neighbourhood environment, and social connections. When these basic building blocks are lacking, it becomes much harder for communities to live healthy lives. As a major local employer and purchaser, and key partner in community planning, the Lothian health and care system is an *anchor institution*, with huge potential to use its influence to improve social, economic, and environmental conditions for the population it serves. All services have the responsibility to consider the social determinants of health in both service design and in supporting individuals to manage their health and wellbeing.

6.2.1.1. Employment

What we want to achieve

	By 2027	By 2030	By 2035
Population Health	Recruitment, employment and career progression practices and systems support and attract diversity in the workplace, provide secure, well-paid, quality employment, and support people to retain and return to work.	There is increased recruitment and employment experience from local populations under-represented in HSC[5] workforce.	More people from under-represented groups experience the benefits of LHCS[6] fair work policies and practices because the workforce reflects the Lothian population as closely as possible with respect to age, sex, ethnicity, and disability.

How we'll achieve it

- Maintain an Anchor Institution focus on accessible, inclusive recruitment and retention to deliver on our role as a Good Employer[7]:

  - Continue focused work on co-ordinated recruitment; flexible working; improving access to recruitment; and employability work with Local Employability Partnerships
  - Update and implement the NHS Lothian Work Well Strategy (and Employability Strategy) to maximise staff health and wellbeing through evidence-based interventions and healthy working environments
  - Work with the Centre for Local Economic Strategies (CLES) on in-work progression/reducing in-work poverty pilot.

- Monitor workforce to ensure it is representative of the population, and track and seek to increase employability and other supported recruitment cohorts e.g., young people and child poverty priority populations.

[5] Health and Social Care
[6] Lothian Health and Care System
[7] https://org.nhslothian.scot/anchorinstitution/

6.2.1.2. Income

What we want to achieve

	By 2027	By 2030	By 2035
Population Health	LHCS has expanded access to specialist welfare, debt and housing advice for staff, patients, and visitors, resulting in more people securing their financial entitlements, including increased financial gain for pregnant women and families. A growing proportion of frontline staff are trained and confident in addressing financial wellbeing, enabling them to effectively identify needs and connect people to appropriate sources of support. Health and care services minimise any unintentional financial burden on patients by ensuring policies, pathways and service delivery are designed and delivered in ways that reduce the risk of deepening poverty. LHCS procurement practices increasingly prioritise local economic development and social value, demonstrated by a sustained upward trend in the proportion of spend directed to local suppliers.	More people successfully access financial support and advice, with measurable increases in financial gains and reduced barriers or stigma to seeking help.	People experiencing the impact of money worries have increased agency with household finances. Local communities and businesses experience increased social and economic benefit, demonstrated by a year-on-year rise in local spend and socially responsible procurement within the LHCS supply chain.

How we'll achieve it

- Continue monitoring of hospital income maximisation services and monitor and report on the 2026-27 early years pathway income maximisation funded programme.
- Building on funding provided by the Lothian Charity, investigate options for sustainable income maximisation service funding and explore other areas of the LHCS which would benefit from a focus on income maximisation.
- Embed money worries question and referral pathway to income maximisation support in the child health pathway.
- Explore the cost of a clinical appointment/day for the patient (based on work in Manchester).
- Explore options for improving proportion of procurement classified as local spend by investing in a fixed-term Anchors funded project officer post in Procurement.

6.2.1.3. Housing and Environment

What we want to achieve

	By 2027	**By 2030**	**By 2035**
Population Health	Appropriate frontline staff are equipped with the skills and confidence to discuss individuals' housing situations and take early action when there is a risk of homelessness. Implementation of the Good Food Nation plan and supporting infrastructure improves reliable access to nutritious, affordable, and sustainable food across the LHCS. LHCS collaborates effectively with local spatial planning systems to shape environments that support health. Local policies or procedures addressing the Commercial Determinants of Health are strengthened through LHCS influence, contributing to healthier community environments	More people can access timely, appropriate housing advice, resulting in reduced stigma, simpler pathways to help, and improved connections to support. LHCS land and assets are used in ways that support and benefit local communities, improving access to opportunities and contributing to reduced inequalities. The LHCS food system is more sustainable, resilient, and higher quality, supporting healthier diets and reducing environmental impacts. LHCS is progressing locally tailored action on alcohol, tobacco, high fat, salt and sugar foods and drinks, gambling, and the sexual entertainment industry	LHCS land, assets and environments contribute to healthy places for local populations. LHCS has developed healthier food and retail environments across healthcare settings, aligned with Good Food Nation principles.

How we'll achieve it

- Use learning from the Edinburgh HSCP Primary Care Ask & Act pilot to inform a wider LHCS approach to the Ask & Act duty, promote wider understanding of the impact of housing on health, and continue to facilitate existing hospital in-reach support for those most in need.
- Develop and deliver actions from the Good Food Nation Local Plan.
- Public Health Partnership and Place teams work in partnership with Local Authority Spatial Planning to develop Local Development Plan (LDP2) ensuring the built environment contributes positively to healthy, sustainable communities.
- Draft and agree LHCS position statement around Commercial Determinants of Health (CDoH) factoring in emerging conversations/wider professional positions.

6.2.1.4. Climate and Sustainability

What we want to achieve

	By 2027	By 2030	By 2035
Climate and Sustainability/ Scheduled Care	Environmental impact and value are fully embedded in NHS Lothian's decision-making processes, influencing how physical assets are used, managed, and disposed of. LHCS has a clear understanding of the climate adaptations required now and, in the future, to protect services, infrastructure and populations. LHCS works collaboratively with local planning systems to shape healthy places, including progressing joint initiatives that reduce emissions such as District Heating Systems and shared premises. The NHS Lothian estate becomes more climate-resilient, more biodiverse, and better able to support local food growing, as well as increased use of greenspace by staff and patients. A sustainable travel plan is established, providing clear, accessible information across all HSC sites to	LHCS staff, patients and visitors rely less on private car travel, leading to lower vehicle emissions and a reduction in transport-related environmental impacts. LHCS delivers digitally enabled, integrated, co-located, and environmentally friendly services, reducing the need for travel, and lowering carbon output, pollution, and biodiversity loss. Use of greenspace across the LHCS increases, supporting wellbeing, connection with nature and healthier behaviours. LHCS has positively influenced the protection and enhancement of natural, green and play spaces in local communities. LHCS strengthens its ability to anticipate, withstand and adapt to emerging climate-related threats.	LHCS is more resilient to the impacts of climate change because of its adaptation plans and partnership working. LHCS contributes to improvements in the natural environment e.g., air and water quality.

	increase staff, patient and visitor awareness and use of active travel and public transport options.		

How we'll achieve it

- Embed climate emergency and environmental sustainability in NHS Lothian decision-making processes.
- Each major site conducts adaptation needs assessment (with action plans to respond to needs assessments developed in subsequent years).
- Continue to develop joint initiatives to reduce emissions, such as District Heating Systems, and the need for patient travel, including, use of shared premises, and increased use of online appointments and patient-initiated follow up.
- Develop greenspace management plans that include climate change adaptation as well as further opportunities for staff, patients, and visitors to make use of green space, including through existing green health projects.
- Develop NHS Lothian Sustainable Travel Plan and staff travel survey.

6.2.2. Maternal, Children and Young People's Health (Priority 2)

The foundations of lifelong health and wellbeing are shaped from the earliest stages of life, beginning even before conception. Effective primary prevention that supports women pre-conception and children in their early years creates the strongest platform for future health and upholds the UN Convention on the Rights of the Child, which affirms every child's right to the highest attainable standard of health and development. This period is also the most impactful window for reducing inequalities, as interventions in early childhood have the greatest and most lasting effect.

Addressing adverse childhood experiences is central to this rights-based approach, helping prevent the lifelong impacts of trauma on physical and mental health, reducing the risk of chronic illness, poor mental wellbeing, and harmful behaviours. Over time, this reduces avoidable demand for NHS services by preventing ill health, limiting crisis presentations, and improving long-term outcomes.

Evidence consistently shows that early-years interventions are highly cost-effective, delivering substantial long-term social and economic benefits. Given this, protecting and strengthening maternal and children's services must remain a central priority in future decision-making. This includes working collaboratively with community planning partners to embed a system-wide, children's rights focus on giving every child the best start in life.

6.2.2.1. Preconception and Pregnancy

What we want to achieve

	By 2027	By 2030	By 2035
Children and Young People/ Primary Care/Women's Health Group/ Tobacco Control Board	Knowledge and awareness of the importance of preconception health and care increase among all people of reproductive age. Use of long-acting reversible contraception (LARC) and other effective contraceptive methods increases. More pregnant people participate in the smoking-cessation incentive scheme, supporting smoke-free pregnancies. Antenatal and postnatal continuity of care is maximised for individuals experiencing complex social factors, and those experiencing racialised inequalities in maternal health, ensuring more consistent and responsive care.	People planning a pregnancy can access the support and information they need to make informed, healthy choices. Uptake of NHS-provided folic acid supplements before and early in pregnancy increases, supporting healthier conception and early foetal development. The number of unplanned pregnancies and terminations decreases because of improved access to contraception, preconception support and reproductive health services. Rates of smoking during pregnancy fall, contributing to improved maternal and infant health outcomes. Clear multi-agency pathways are in place to provide enhanced support for individuals who require more intensive help during pregnancy.	Rates of maternal obesity decrease, supporting healthier pregnancies and improved long-term health for mothers and babies. Fewer people experience harmful pregnancy and birth outcomes associated with alcohol or substance use, because of effective prevention and support. Pregnancy and birth outcomes improve for individuals with protected characteristics and for those facing complex social circumstances, reducing inequalities in early life.

How we'll achieve it

- Undertake a health needs assessment on the preconception health and care needs of the Lothian population and co-produce (with relevant services and stakeholders) an action plan which responds to its recommendations.
- Increase awareness and availability of contraception by embedding contraception counselling in antenatal and postnatal pathways, improving the LARC offer in general practice and redesigning the postnatal LARC delivery model.
- Implement the maternity incentives scheme and increase the number of pregnant people supported to stop smoking.
- Improve antenatal and postnatal continuity of care using quality improvement methodology and learning from successful local and national delivery models.

6.2.2.2. Perinatal, Infant, Children and Young People Mental Health and Wellbeing

What we want to achieve

	By 2027	By 2030	By 2035
Children and Young People	LHCS develops a clear and comprehensive understanding of how the determinants of child and adolescent mental health and wellbeing vary across Lothian, enabling better-targeted action. Trauma-informed and rights-based practice is increasingly embedded across children's services, improving the quality and responsiveness of support. Tier 1 and 2 perinatal, infant, children and young people's mental health services are realigned to meet changing population needs more effectively.	Access to neurodevelopmental (ND) support is improved at the point of need, ensuring people receive timely help regardless of diagnosis. CAMHS waiting times are reduced to meet the national 18-week standard, ensuring children and young people access support more quickly.	Perinatal, infant, children and young people's mental health, wellbeing and resilience are improved.

How we'll achieve it

- Undertake a population mental health needs assessment and use findings to rebalance provision towards prevention and early intervention.
- Deliver organisational approaches to support staff and strengthen trauma-informed practice across universal services e.g., TRUST passport for staff and managers, senior leaders training, review of organisational policies, champions network, trauma walk-throughs. *[TRUST = Trauma-Responsive, UNCRC-informed, Supportive Training]*

- Develop and deliver with partners a shared framework for prevention and early intervention interventions to improve clarity and consistency of access routes, advice, and support at Tiers 1 and 2, including advice and consultation models for universal services.

6.2.2.3. Infant Feeding and Child Healthy Weight

What we want to achieve

	By 2027	By 2030	By 2035
Children and Young People	The Delivering Early Breastfeeding Support (DEBS) programme continues to be expanded, ensuring more families receive timely, high-quality early breastfeeding support. UNICEF Baby Friendly accreditation is sustained, with ongoing progress toward achieving Gold (Sustainability) status. Strengths-based, whole-family support for families with young children continues to be targeted and expanded, with approaches further tested and adapted for school-aged children.	Breastfeeding drop-off reduced to 18.1% by 2030 in line with the national target, with focused improvement in communities where early breastfeeding drop-off is currently highest. The gap in breastfeeding rates between the most and least deprived areas (SIMD 1 and SIMD 10) narrows, contributing to greater equity in early years nutrition. Tier 2 and Tier 3 healthy weight interventions for children are effective, accessible, and well-targeted, providing appropriate support for families who need it.	Hospital admissions for babies with feeding-related issues (such as faltering weight gain and hypoglycaemia) decrease. A higher proportion of children achieve and maintain a healthy weight.

How we'll achieve it

- Strengthen whole system approach to healthy weight by expanding DEBS to three further areas of low breastfeeding and maximising uptake and developing a programme to increase staff confidence in having good conversations with families on healthy weight and other health-related issues.
- Maintain UNICEF Baby Friendly Accreditation in Maternity and Neonatal Services, Health Visting, and Family Nurse Partnership and work towards UNICEF Baby Friendly Gold status to sustain and embed good practice.
- Achieve UNICEF Baby Friendly Stage 2 Accreditation in Children's Services.

6.2.2.4. Child Development

What we want to achieve

	By 2027	By 2030	By 2035
Children and Young People	Comprehensive anticipatory care pathways for families with children under five are in place, delivered through a proportionate universalism approach. Improved continuity and information flow between health visiting and Primary 1, ensuring more seamless transitions.	Developmental concerns at 27-30 months reduced to 13.5% by 2030, with targeted improvements in speech, language and communication and emotional and behavioural development.	The gap in children's developmental progress between the most and least deprived areas (SIMD 1–10) narrows at 13-15 months, 27-30 months, and 4-5 years. Improved school readiness among children entering primary education.

How we'll achieve it

- Continue to deliver systematic developmental screening at key milestones and take an intelligence-led approach to inform universal and targeted approaches to support all children to reach their developmental milestones, through strengthened collaborative working between Allied Health Professions, universal early years services, and the Third Sector.
- Ensure all children identified as having wellbeing or child protection concerns are transitioned seamlessly to the School Nursing Service through a structured and multi-agency process.
- Develop a collaborative and enhanced Named Person transition framework from pre-school to Primary 1 to optimise Named Person transition arrangements to ensure continuity of care for children and families and strengthen accountability across life stages.

6.2.2.5. Corporate Parenting

What we want to achieve

	By 2027	**By 2030**	**By 2035**
Children and Young People	Care experienced children and young people have routine access to high-quality health assessments that support their individual health needs and reduce inequalities by minimising barriers to universal services such as GP care, dental services, and vaccinations. A non-stigmatising, supportive approach to missed healthcare appointments for children and families is consistently embedded in practice.	More care experienced children and families, including those on the edges of care, can access the support they need at the right time. Improved engagement with healthcare services, resulting in fewer missed appointments for care experienced children.	More families remain together through strengthened nurturing relationships and intensive support that interrupts intergenerational trauma.

How we'll achieve it

- Proactively engage care experienced children and young people through regular health reviews and integrated children's plans, ensuring their healthcare appointments are prioritised across all relevant services.
- Ensure Corporate Parenting responsibilities are understood, across both paediatric and adult services.
- Develop a shared language of care and consistent ways of working across services and professionals, so families experience coordinated support rather than navigating conflicting systems, processes, standards, or expectations.
- Use insights from the 'Was Not Brought' pilot in paediatric services to update staff training, practice guidance, and IT systems, and implement these improvements across all children's services to better address how inequalities and trauma influence access to care.

6.2.3. Tackling the Burden of Disease (Priority 3)

Healthcare settings should continue to prioritise interventions that address modifiable risk factors - such as smoking, alcohol use, and obesity - while maintaining a strong focus on services that manage non-communicable disease, such as, respiratory disease, cancer, diabetes, and cardiovascular conditions. These efforts should be delivered alongside screening and immunisation programmes as part of a coherent and effective prevention approach. Delivering these efforts alongside screening and immunisation programmes ensures prevention is coordinated, efficient and person-centred. Screening and immunisation provide established, high-impact opportunities to identify risk early, prevent avoidable disease, and engage people with wider preventive support. Aligning interventions in this way maximises population reach, reduces duplication, and strengthens the overall impact of prevention activity across the life course.

A wide range of universal and targeted public health programmes already exist across Lothian. However, we would strengthen their impact by better connecting these programmes to the scheduled and unscheduled care touchpoints that people already experience. This is especially important for population groups who may present more often through unscheduled routes, as well as those supported by specialist services, to ensure equity of access and improved outcomes for all.

6.2.3.1. Common Non-communicable Disease

What we want to achieve

	By 2027	By 2030	By 2035
Primary Care/ Healthy Weight and Type 2 Diabetes Prevention	Enhanced early intervention for at-risk populations through systematic identification and management of modifiable risk factors, including blood pressure, lipids, obesity, blood glucose and smoking status. Planned and well-governed introduction of weight-loss medication, supported by a robust economic case and comprehensive evaluation framework. Increased proactive case-finding to identify individuals with pre-diabetes and enable earlier intervention to prevent progression to type 2 diabetes.	Reduced proportion of the population at elevated risk of CVD, type 2 diabetes, COPD, and selected cancers.	Reduced inequity in non-communicable disease outcomes between the most and least deprived SIMD groups.

How we'll achieve it

- Continue to deliver and monitor the national Cardiovascular Disease Directed Enhanced Service in local practices, to inform future system-wide action for other long-term conditions.
- Progress obesity treatment pathways in Lothian, including digital pathways and the managed introduction of weight loss medication, and implement appropriate monitoring and evaluation.

- Introduce Point of Care testing pilot within community pharmacy, which aims to identify patients at risk of developing type 2 diabetes and refer directly into the weight management programme.

6.2.3.2. Inequalities in Access and Outcomes

What we want to achieve

	By 2027	By 2030	By 2035
Primary Care/Scheduled Care/ Mental Health and Wellbeing	The underlying factors contributing to low or poor engagement with healthcare services, including mental health services, are identified, and clearly understood. Trauma-informed practice is increasingly embedded and consistently applied across services. A non-stigmatising, supportive approach to patients who miss healthcare appointments is established and routinely implemented.	Greater equity in access to care and continuity of care across population groups. A measurable narrowing of the gap in 'did not attend' and 'was not brought' rates between SIMD 1–10 groups and people with protected characteristics. Enhanced patient experience across services.	Improved access to timely and appropriate care for population groups that currently face barriers or delays.

How we'll achieve it

- Quantitative and qualitative analyses of DNAs used to inform system-wide approaches to support those who miss healthcare appointments, joining up and building on initiatives such as Bridge Builders and primary and secondary care interface models, and making changes to the system which help support attendance.
- Use learning from the 'was not brought' pilot project in children's services to consider how such a pilot could be adapted in adult settings, which understands and addresses how inequalities and/or a history of trauma can impact on one's ability to access services.

- Take forward recommendations from the Equality and Children's Rights Impact Assessment (ECRIA) of the implementation of Scottish Government Waiting Times Guidance to minimise any potential discriminatory impact and help to achieve equity of access across different population groups.

6.2.3.3. Waiting Well

What we want to achieve

	By 2027	By 2030	By 2035
Scheduled Care/ Tobacco Control Board	A comprehensive package of universal and targeted support is in place to enable effective prehabilitation for individuals awaiting surgery or treatment, including those on cancer pathways. The Waiting Well framework is fully embedded across services to support people's health and wellbeing while they await treatment.	Greater numbers of people accessing evidence-based support to improve health outcomes, including income maximisation, smoking cessation, nutrition and physical activity programmes, and participation in screening and immunisation.	Shorter recovery periods and better clinical outcomes following treatment or surgery.

How we'll achieve it

- Implement prehabilitation toolkit and resources developed for cancer and non-cancer pathways.
- Develop Waiting Well offer, using toolkit and learning from prehabilitation work to support a range of social and behavioural factors.
- Improve access to, and uptake of, smoking cessation support in those waiting for surgery or other treatment.

6.2.3.4. Supported Self-management

What we want to achieve

	By 2027	By 2030	By 2035
Strategic Change Group/Children and Young People/Primary Care/Digital	Health literacy is improved, and everyone has equitable access to high-quality, reliable health information. Use of digital tools to support self-management increases, while the risk of digital exclusion is actively minimised. Opportunities for community-based support outside traditional health and care settings are explored to enhance people's health and wellbeing.	More people with long-term conditions are supported and enabled to self-care effectively. Primary and community care routinely supports people to benefit from local assets that promote good health and wellbeing. Realigned models of care optimise holistic, multidisciplinary team support for people living with long-term conditions.	Increased numbers of people are supported to manage their long-term conditions and maintain a good quality of life.

How we'll achieve it

- Explore ways to support health literacy through the work of the LSDF programme boards.
- Improve digital resources and optimise the use of AI and digital technology to enhance support for neurodiverse children, young people, and adults.
- Provide support for neurodiverse children, young people and adults at point of identification of need, regardless of diagnosis.
- Explore the role of Digital Front Door in supporting self-management and access to wider community support.

6.2.3.5. Mental Health and Wellbeing

What we want to achieve

	By 2027	By 2030	By 2035
Mental Health and Wellbeing	The projected burden of mental ill health, and its implications for future service demand and provision, is clearly understood. Mental health and wellbeing support, including digital resources, is readily accessible to local populations.	More people with mental health conditions are engaging with and accessing healthcare services. Community mental health support is strengthened and optimised to better meet people's needs.	People with mental ill health experience better overall health, including improved physical health outcomes.

How we'll achieve it

- Undertake a population mental health needs assessment.
- Review use and accessibility, and explore future opportunities for use, of digital tools to support mental health and wellbeing.
- Expand early intervention and urgent community support and shift from reactive to planned care through timely triage and proactive follow-up in the community.

6.2.3.6. Inclusion Health (Drugs and Alcohol, Sexual Health and Blood Borne Viruses)

What we want to achieve

	By 2027	**By 2030**	**By 2035**
Drug and Alcohol Harms Oversight Group/ SHBBV Co-ordination Group	People can access substance use support, treatment, and harm-reduction services in line with the Medication Assisted Treatment (MAT) Standards. More people are tested and started on treatment for HIV and Hepatitis C, in line with national commitments to eliminate Hepatitis C and end HIV transmission.	Access to high-quality treatment and care is improved for all who require it.	Decreased rates of non-fatal overdoses, drug-related deaths, and alcohol-related morbidity and mortality.

How we'll achieve it

- Continue to deliver the work set out within Lothian's three Alcohol and Drug Partnership Strategies and Plans, including prevention activity and continued implementation and maintenance of the Medication Assisted Treatment Standards.
- Implement any additional recommendations from the new national Alcohol and Drugs Plan, once published in 2026, and apply the Charter of Rights for People Affected by Substance Use.

- Strengthen the consistency of offer and improve uptake of blood borne virus testing in vulnerable populations, including those who use substances (target 80% test uptake by 2027/28), those in the prison setting (target 75% test uptake by 2027/28), and roll out of BBV testing in Emergency Departments.

6.2.3.7. Dental Health

What we want to achieve

	By 2027	**By 2030**	**By 2035**
Primary Care	Priority populations experience improved access to oral health services, including, young children (0–2 years), dependent older adults, those with experience of the justice system, those experiencing homelessness, and adults with additional care needs. Target populations benefit from well-implemented and effective Childsmile supervised toothbrushing programmes.	The number of children requiring dental extractions under general anaesthetic is reduced.	Improved dental health outcomes at P1 and P7, with a measurable reduction in the gap between children living in SIMD 1 and SIMD 10 areas.

How we'll achieve it

- Continue to deliver oral health improvement programmes to help reduce oral health inequalities, particularly for vulnerable groups, including: Childsmile in nurseries and schools, and the Caring for Smiles adult oral health programmes.

6.2.3.8. Immunisation

What we want to achieve

	By 2027	By 2030	By 2035
Immunisation Oversight Board	Clear identification and understanding of factors limiting immunisation uptake in targeted populations. Evidence-informed immunisation services delivered effectively through a skilled and adaptable workforce. Efficient, user-friendly digital consent systems implemented across immunisation programmes.	Strengthened public confidence in the safety and effectiveness of vaccines. All immunisation programmes achieve maximised uptake and equitable participation across population groups.	Improved equity in childhood and adult immunisation uptake, with a demonstrable reduction in the SIMD 1-10 gap.

How we'll achieve it

- Development of child and adult based Assurance Frameworks which include priorities on workforce and inclusion.
- Strengthen partnerships with community and voluntary sector partners and trusted messengers to enhance understanding of communities' needs and barriers to take up.
- Identification of clear digital objectives and continue to influence digital developments to embed immunisations in the digital roadmap e.g., digital consent.
- Explore ways to increase flexibility of vaccination service delivery.
- Explore Making Every Contact Count (MECC) in vaccination appointments and share learning for wider roll out across services.

6.2.3.9. Screening

What we want to achieve

	By 2027	By 2030	By 2035
Screening Governance Groups/ Scheduled Care	Clear identification of screening inequalities followed by coordinated action across partners to resolve identified barriers.	All screening programmes achieve maximised uptake and equitable participation across population groups.	Improved equity in screening participation, with a demonstrable reduction in the SIMD 1-10 uptake gap.

How we'll achieve it

- Apply data-driven demand forecasting and continuous monitoring of screening uptake to identify underserved populations and guide targeted interventions.
- Introduce and evaluate national pilots and local improvement efforts to ensure services meet the needs of eligible populations and improve reach to those not currently engaging with screening.
- Develop readiness for lung cancer screening implementation in selected populations.

6.2.3.10. Frailty and Falls Prevention

What we want to achieve

	By 2027	By 2030	By 2035
Primary Care/ Unscheduled Care	Frailty is recognised and addressed at an earlier stage, with a greater proportion of management taking place in primary care through the GP Enhanced Service. Delivery of Phases 1 and 2 of the Lothian Falls Prevention and Management Framework, contributing to fewer fall-related ED attendances and admissions.	Shifting frailty management away from secondary care, with more needs met through proactive community-based approaches. Delivery of Phases 2 and 3 of the Lothian Falls Prevention and Management Framework, leading to better identification of those at risk of falling and enhanced prevention measures across services.	Ongoing reduction in hospital attendance and admissions related to frailty, reflecting improved prevention and community-based management. Sustained reductions in avoidable harms from falls, enabled by reliable identification of people at risk and consistent delivery of prevention interventions.

How we'll achieve it

- Maintain and further embed the GP Enhanced Service for frailty to support earlier identification and management in primary care.
- Implement the five pillars of the Lothian Falls Prevention and Management Framework: Person-Centred; Collaborative; Prevention; Data Informed; and Knowledge and Education.

6.3. Embed prevention within performance frameworks (Objective 3)

The proposed suite of prevention outcome measures, aligned with the logic model, is outlined below in Table 2.

Outcome indicators have been selected based on the following principles:

- They are meaningful and relevant to Programme Boards and the wider Lothian health and social care system.
- They are sensitive to intervention, such that change can reasonably be attributed to preventative action.
- There is sufficient scope for change over time, avoiding indicators that may be subject to floor or ceiling effects.
- They are feasible to collect and can be captured routinely in a sustainable way.
- They are clear, easy to interpret, and make sense within the context of the prevention logic model.

The Appendix provides further detail on these measures by priority area, including the proposed measure type (quantitative or qualitative) and data source (noting that some indicators, whilst feasible, are not presently measurable without investment in new data collection and/or analysis endeavours).

The measures represent a selected set of indicators that demonstrate progress towards a more prevention-focused system and improved population health outcomes; they do not capture all outcomes within the logic model.

The focus is on medium- to longer-term measures, suitable for annual reporting to the NHS Lothian Board and relevant groups and committees. Progress against short-term actions and outcomes will be reported through the relevant Programme Boards, via their implementation plans, with relevant measures agreed by those groups.

Alongside this work, a wider set of indicators is being developed nationally to support the programme of reform and a stronger focus on population health. It is important that local arrangements for board assurance align with these emerging national measures to ensure coherence, comparability, and clarity of accountability. As national indicators are refined and implemented, local approaches will be reviewed and adapted as necessary to maintain consistency while remaining responsive to local priorities and learning.

Table 2: Proposed outcome measures

Overarching outcomes
• Trends over time in death rate (European age standardised rate per 100,000) of those aged under 75 • Inequalities in life expectancy by sex (using Relative Index of Inequality (RII))[8]

Building blocks of health	
Medium term	• Total client financial gain (£) annually through NHS Lothian Hospital Welfare Advice Services • Proportion of emergency department attendees who are of no fixed abode ***(NB this is proposed as an aspirational indicator. Data Loch have been exploring the inclusion of a homelessness flag on electronic health records which will likely be a necessary enabler. If this is successful, measurement would be possible)*** • Narrative summary of work undertaken across LHCS that is likely to have influenced the impact of commercial determinants of health on the local population • Percentage of a representative sample of staff, patients and visitors that use a range of transport methods (car, bus, cycle, walk/wheel, train, tram, taxi) to travel to NHS Lothian sites ***(NB this is contingent on data being collected via a staff survey)*** • Narrative summary of LHCS adaptation to emerging climate threats, e.g., description of local progress against the "NHS and Social Care" actions of Scottish National Adaptation Plan (2024-2029)
Long term	• Distribution of employees of NHS Lothian by protected characteristics (age, sex, disability status, ethnicity, religion, sexual orientation, transgender status) and SIMD, compared against Lothian's known distribution of these characteristics as per census estimates • Narrative summary of contributions of LHCS land, assets, and environments to healthy places for local populations, e.g., drawing on land and asset metrics reported annually to Scottish Government

[8] Relative Index of Inequality (RII) is used to quantify the socioeconomic gradient in health outcomes, in relative terms rather than reflecting the absolute gap between most and least deprived. A RII of 1.0 indicates no degree of inequality and typically ranges between -2 and +2.

Maternal, children and young people's health	
Medium term	• Annual rate of pregnancy terminations (per 10,000 population) • Total annual rate (per 1,000 women aged 15-49) of LARC prescriptions (Implant, IUS, IUD) • Percentage of people identified as smoking at antenatal booking appointment • Percentage of CAMHS patients waiting over 18 weeks • Percentage drop-off in breastfeeding between initiation and 6-8 week follow up by SIMD quintile • Narrative summary of evidence-based interventions in place locally to support child healthy weight (including information from ongoing evaluation of these programs locally) • Percentage of child health reviews at 27-30 months identifying a concern in speech/language developmental domain by SIMD • 'Was not brought' rate for care experienced children (aged under 18 years) in outpatient services.
Long term	• Percentage of people that have a BMI of 30 or more at antenatal booking appointment • Percentage of people identifying depression and/or anhedonia during the past month at antenatal booking appointment • Percentage of children in primary 1 recorded as having a healthy weight

Tackling the burden of disease	
Medium term	• Percentage of local delivery plan annual smoking cessation target achieved • Rate of newly diagnosed cases of type 2 diabetes annually (per 100,000 population) • Annual "did not attend" rate across all outpatient specialties • Narrative summary of policy and practice implemented by LHCS to identify and reduce missingness • Percentage of eligible (18+) population uptaking influenza vaccination by SIMD quintile (as at end of influenza season) • Percentage uptake of HPV vaccine for S1 pupils • Percentage uptake of 6 in 1 vaccine for children aged 12 months • Percentage of eligible population who have been successfully screened for diabetic retinopathy • Overall uptake of bowel screening within eligible population • Coverage (%) of eligible women who have attended cervical screening
Long term	• Inequalities in early deaths from cancer, aged <75 years (using RII) • Inequalities in coronary heart disease hospitalisations (using RII) • Inequalities in chronic obstructive pulmonary disease (COPD) hospitalisations (using RII) • Age-standardised rate (per 100,000 population) of drug deaths • Age/sex standardised rate (per 100,000 population) of alcohol-related hospital admissions • Inequalities in the percentage of children in primary 1 with no obvious tooth decay (using RII) • Rate per 1,000 population of A&E admissions due to falls

6.4. Maximise investment in prevention (Objective 4)

Phase 1: Baselining preventative spend

The Scottish Government Prevention Project team is working with Health Board Directors of Finance on an initiative to identify preventative spend across NHS Boards.

In December 2025, NHS Lothian Finance, in partnership with Public Health, agreed to work with the Scottish Government and a small number of other Health Boards to participate in a pilot programme on preventative spend budget tagging. The purpose of the pilot was to identify and classify preventative spend within NHS Boards and forms part of a wider programme to estimate preventative spend across the Scottish Government budget by summer 2026. This work will support delivery of commitments set out in the Public Service Reform Strategy and the Population Health Framework.

NHS Lothian Finance has completed the initial stages of this work and is contributing through a Directors of Finance Short-Life Working Group (SLWG). This includes reviewing Scottish Government financial guidance on preventative spend and developing a consistent approach to budget and expenditure tagging. The tagging process requires a review of the full financial ledger and the application of preventative spend classifications, including categories of preventative activity and levels of prevention.

The next steps are to share and refine this work with local stakeholders to ensure application of the guidance and resultant classifications are reasonable and consistent. Learning will be shared with the Scottish Government and the SLWG.

Phase 2: Guiding future investment in prevention

A national strategic group on preventative spend has been established, co-chaired by a Director of Public Health and a Director of Finance. The focus of this phase is to develop a clearer understanding of the key drivers of demand within the health and care system, alongside the evidence-based interventions that can best address this demand. This will support informed investment decisions by identifying preventative approaches that deliver the greatest return on investment and contribute to the long-term sustainability of the health and care system.

6.5. Establish a robust learning and accountability system (Objective 5)

Governance

A central aim of the prevention approach is the establishment of a robust learning and accountability system. Governance arrangements must be firmly embedded within the Lothian Strategic Development Framework (LSDF) to ensure appropriate oversight by the Corporate Management Team (CMT) and assurance to the NHS Lothian Board and relevant sub-committee(s).

CMT will provide oversight to the delivery of the prevention plan and wider prevention approach.

The Population Health Programme Board's primary role is to provide leadership and strategic direction to improving population health, including programmes to embed prevention and tackle health inequalities. The Population Health Programme Board will provide strategic direction to a portfolio of workstreams, including prevention, health equity, and placed-based work through our Anchors and community planning work, ensuring coordination and coherence for population health activity across the Lothian health and care system.

The Population Health Programme Board will work collaboratively with relevant programme and parameter boards and other cross-system groups to ensure the system-wide prevention plan and wider preventive approach are being delivered. It is proposed that the refreshed Population Health Programme Board supports and monitors progress with delivery of the prevention plan set out in this paper.

The Population Health Programme Board will operate in line with established LSDF governance arrangements, reporting to and receiving oversight from the CMT.

Reporting

Two levels of reporting are proposed.

1. Routine programme reporting:

All Programme and Parameter Boards will report on prevention actions and short-term outcomes through the established bi-annual reporting process for LSDF implementation plans to the CMT, Strategic Planning and Performance Committee (SPPC), and the NHS Lothian Board, as part of the Corporate Objectives reporting process. The Healthy Weight and Type 2 Diabetes Prevention Oversight Group also reports bi-annually to CMT.

2. Annual prevention reporting:

An annual system-level prevention report will monitor progress towards medium- and longer-term outcomes, using the outcome measures outlined in this paper. This will provide assurance on progress towards longer-term objectives, support assessment of impact, and inform adaptation of programmes of work where required.

7.0. Summary

This paper outlines progress towards a prevention-focused system and sets out the outcomes and actions required to embed prevention across the Lothian health and care system. It aligns activity to three priority areas – building blocks of health; maternal, children, and young people's health; and tackling the burden of disease – and supports the ambition for Lothian to become a Population Health Organisation.

The paper describes the case for change and the approach to embedding prevention through five core objectives. It sets out the expected outcomes, actions and measures needed to assess progress and impact, alongside work to establish a baseline for preventative spend and the steps required to increase this over time. It also outlines the arrangements for effective system-wide governance, monitoring and oversight of the prevention approach and delivery plan.