OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 10 February 2026

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
6th Meeting 2026, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lucy Gibbons (Scottish Government)
Neil Gray (Cabinet Secretary for Health and Social Care)
Phillip McLean (Scottish Government)
Wendy Rayner (Scottish Government)
Professor Sir Gregor Smith (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 10 February 2026

[The Convener opened the meeting at 09:20]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the sixth meeting in 2026 of the Health, Social Care and Sport Committee. I have received no apologies.

The first item on our agenda is for the committee to decide whether to take items 5 to 8 in private. Do members agree to take those items in private?

Members *indicated agreement*.

Draft Climate Change Plan

09:20

The Convener: The second item on our agenda is a further evidence-taking session on the Scottish Government's draft climate change plan, "Scotland's Climate Change Plan: 2026-2040". The committee previously took oral evidence on the draft plan at its meetings on 13 and 20 January.

I welcome to the committee Professor Sir Gregor Smith, the chief medical officer; Phillip McLean, the Scottish Government's head of national health service facilities and environmental sustainability; and Wendy Rayner, the Government's lead NHS Scotland circular economy adviser. We will move straight to questions.

Emma Harper (South Scotland) (SNP): Good morning to you all, and thanks for being here today.

After I have asked my questions, I will probably come back further down the line to discuss green theatres, as well as propellants from inhalers and so on, which I am interested in because I am the convener of the cross-party group on lung health.

I am interested in hearing about what discussions are happening around emissions reduction, following the Government-wide health in all policies approach. How closely involved are you in taking emissions reduction or net zero approaches in healthcare?

Professor Sir Gregor Smith (Scottish Government): First, thank you for the opportunity to come and give evidence on this subject. As you know, I have outlined the situation in several of my annual reports. I see it as one of the biggest population health challenges that we currently face, not just in Scotland but around the globe. Ensuring that we take an approach that addresses some of the human effects of the planetary health crisis is critical. It is particularly important that we do that in an integrated way, so that we do not miss the opportunity also to tackle the other population health challenges that I have outlined previously. Having a balanced approach across those four population health challenges is really important.

I am delighted that I have been able to be involved with other clinicians across the country in beginning to shape our approach in NHS Scotland to tackling the issue of emissions across our estate. Although much of that work involves the infrastructure of the estate, there has also been an incredibly important workstream on reducing the healthcare and care impacts of emissions.

This is my starting point: the type of care that is the most harmful to the environment is care that is not necessary. Taking a much more balanced approach to prevention in the first place and treating that as our priority is the very first step that we have to take. Taking a national approach to improving prevention will not only help us with the impacts on planetary health, as it will clearly have an impact on human health as well.

Secondly, we need to identify the healthcare that is provided that does not significantly improve the health of our population or of those patients who receive it. The Organisation for Economic Co-operation and Development suggests that, in most healthcare systems, about 20 per cent of the resources that are utilised in providing care do not actually improve health. Using a value-based approach to health and care to ensure that the kind of care that is provided is materially improving people's health is the second element that I would outline.

On the healthcare that is provided, the next step is to develop practices and make choices to minimise our impact through emissions—whether in relation to volatile gases or the propellants in inhalers that you mentioned, or by considering greener healthcare pathways and alternatives to what we might think of as traditional healthcare to improve health and help people with their healthcare. I am delighted that, through the realistic medicine programme of work, through value-based health and care and through my work with colleagues across the country, clinicians have been fully involved in identifying new ways of working that can help to improve our emissions profile in Scotland.

Emma Harper: You mentioned prevention—obviously, it is not only the health portfolio that looks at prevention. Last week, I asked the Cabinet Secretary for Health and Social Care, Neil Gray, about how, for instance, housing can impact on and improve health. How can we work across portfolios to look at what we can do to support the national health service with emissions reductions? It is a cross-portfolio thing.

Professor Smith: It absolutely has to be a cross-portfolio thing. Everyone on the committee will be familiar with the Marmot review's model of health. At the base of that model is the fact that about 80 per cent of the contribution to improving the population's health comes from outside the direct provision of healthcare. It comes from our socioeconomic policies, education and a variety of different aspects. Health in all policies—ensuring that there is cross-portfolio working and mission-style government to improve health—is a critical part of the prevention strategy.

Committee members will be familiar with the population health framework, which looks at primary prevention to make sure that that approach is embedded across Government and across all sectors, to improve the health of the population. That has to be the starting point for the benefits that it will have on healthcare utilisation and for the sustainable healthcare system of the future. If we make our population healthier and more resilient, less resource will be utilised in providing care, which will have beneficial net impacts on how we manage the planetary health crisis.

Emma Harper: Does the climate change plan reflect how we can tackle health inequalities? A lot of the approaches to challenges in the population health framework—I am thinking about the good food nation plan—come under the processes of the climate change plan. I will be succinct: does the draft climate change plan support the health equity outcomes?

Professor Smith: In my view, it does. I apologise for going back over this territory again—this is the key part that I want to reiterate. I will quickly run through the four population health challenges that we face. First, there are the on-going threats caused by infectious disease, which remains a global threat. There is the need to improve healthy life expectancy and to close the health inequalities gap around the country. We need to create a sustainable health and care system in the face of demographic change that puts additional pressure on it. Finally, there is the planetary health crisis. Those four elements are intertwined.

The point that I was trying to make at the beginning was that if we choose to concentrate too much of our efforts on only one of those streams, that will have a negative impact on the other streams. As we approach the planetary health crisis, try to improve the impact of healthcare on it and prepare for the different threats that it will cause in healthcare, if we do not make that transition in a just way and recognise that it is those in our communities who suffer from inequalities who will suffer the most from the planetary health crisis, we will only compound the problem and make it worse.

Brian Whittle (South Scotland) (Con): Good morning, Professor Smith. I was interested to hear you talk about the preventative agenda, which is something that is close to my heart. It has been much talked about in the time that I have been in the Parliament—I have talked about it the whole time—yet outcomes continually slide, so I am pleased to hear that it is at the top of your agenda.

What we have been doing so far has not worked. What is different now?

Professor Smith: I could talk all day about prevention. It has to be at the core of our response if we are to create a more resilient society for the future and make sure that we are in a socioeconomic position to prepare for the future, too. Our prevention agenda is one of the most important things that we can try to do nationally to ensure that we have a sustainable health and care system for the future. What has changed is that we have a much better understanding of the need to make interventions for our population as far upstream as possible, and of the type of interventions that have a beneficial impact.

09:30

To go back to the previous question, one of the biggest changes that I have seen has been about ensuring that we have an all-Government, all-sector approach to prevention, and that we are making that coalition ready to act in a mission-style way. There is a strong evidence base that we have been able to play into the work of the population health framework, which tells us where we have to intervene. In the conversations that I have with the organisations that will be charged with delivering progress on the issue, I now see and hear about a much greater degree of understanding and willingness to become fully involved in that agenda for the future.

A good example of that would be the move in our health boards to become public health organisations. That might sound strange, but our NHS in Scotland, for a long time now, has concentrated very hard on fixing things, and I think that it has done so very well. The need to ensure that we get upstream and use institutions to promote the prevention agenda and to take steps that act with our communities to reduce the burden of disease in future is now a much greater priority on the agenda of all the meetings that I am involved in with those institutions than certainly it has been in the 13 years for which I have been in the Government.

Brian Whittle: You and I have had quite a few conversations on the issue. My point is that we have always known—well, we have known for a long time—what would be impactful in moving the work upstream. It makes logical sense to prevent things from happening in the first place, and we have always talked about that. Politically, what do we need to do in the Parliament to promote and support that agenda?

Professor Smith: Thank you for that important question. Having the support of this committee in ensuring that prevention is at the forefront of everything that we do is really important.

In the metrics and measurements that we use to assess how our ecosystem is performing, I would like much greater emphasis on some of the prevention work. That is really important. Tracking exactly where our spend is through some of the proposed mechanisms, such as budget tagging and so forth, is another important aspect.

It is also about the degree of scrutiny that we have all placed on the NHS in its role as a body to fix ill health. We need to flip that to challenge and scrutinise the NHS and the other organisations that are involved, such as local government, on their contribution to the prevention agenda. Ensuring that we have the right measurement framework to do that is one of the most important things that this committee can contribute to in future.

Brian Whittle: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner.

Good morning, Sir Gregor. Before I ask the questions that I was going to ask, I want to go back a bit. You spoke about, in essence, giving health boards more power and greater responsibility and budget in the community. I have a lot of concern about that, and the scandal that has arisen due to contaminated water at the Queen Elizabeth university hospital is a prime example of why that is. In that case, the board covered things up. There is also the former chief nursing officer, Ms McQueen, who basically bribed a patient. Are those the type of people and organisations that should be given more power, money and responsibility?

Professor Smith: I do not think that I said anything in my evidence this morning about giving health boards more power. That has not been any part of the conversations that I have had. I said—I will recount it so that there is no mistake—that NHS organisations are invested in and contributing in a much greater way to the prevention agenda. They realise that the benefits of the prevention agenda for the populations that they serve will reduce the burden of disease and therefore produce a more sustainable model for the care that they will be able to provide in the future.

I see health boards accepting their role as public health organisations in the promotion of health and wellbeing alongside the delivery of healthcare, which will allow them to remedy what they can in relation to the problems that people present with in hospitals.

I want to be clear: at no point in the evidence that I have given today did I say that health boards should be given any more power.

Sandesh Gulhane: If health boards are being given the ability to do more in communities to fulfil

the agenda that you are talking about, they will presumably be given more money. Does that not essentially equate to being given more power?

Professor Smith: I again disagree with your assertion. We are talking about health boards using the resources that they have in a more focused and perhaps—some would say—precise way to try to improve the health of the communities that they serve. They are using data to identify the exact needs of those communities and then pivoting to ensure that the interventions that they are supporting in the community, through their own work and in partnership with local government and health and social care partnerships, are promoting more cohesive and healthier communities.

Sandesh Gulhane: Taking that point alongside the inverse care law, let us consider a facility in Drumchapel that serves a community that needs as much intervention and help as we could possibly give. It serves a community that has a lot of asylum seekers in it. Let us stay away from the politics of that, but those are people who need triple appointments, because of the issues that they come in with, because they do not speak English and because of the healthcare systems that they have come from. That all requires more time for doctors to deal with their issues. However, the condition of the facility is not acceptable; it cannot expand and it is old. Essentially, the GPs and doctors in the Drumchapel health centre are working in a facility that has been left to rot. Is your idea to use resources from the health board to tackle such problems?

Professor Smith: One of the most important aspects of the prevention agenda just now is to identify, through the precise use of data, the exact needs of the different communities that are being served, and then services should be focused on how to best serve those communities. Whether that is through the processes of budget tagging or community planning, we should identify exactly how the resources that are being given can be used in the best way to improve the health of a specific population.

You are right that our populations and communities are not homogeneous. As an independent adviser to the Government, I have advocated for a long time now for the greater use of proportionate universalism in how resources are identified and then used in the healthcare system. That approach has been used effectively, most recently with the production of directed enhanced services in GP practices for the prevention of cardiovascular disease. GP practices that serve communities that are more socioeconomically disadvantaged have been given disproportionately more funding to allow us to reach those communities in a better way than we have been able to do in the past.

We need to have new techniques for engaging with communities. We would all recognise that one of the biggest barriers to improving health in Scotland relates to engaging with some of our communities in a way that is meaningful and starts to improve people's health.

Wendy Rayner and Phillip McLean, who are attending with me today, will be able to say a bit about the estate and how it is developing across the country. We are using available capital funding cleverly to ensure that we develop the NHS estate from which services are delivered in a way that serves community needs much better. As the committee will know, that might not be in the form of a facility purely for healthcare; it might be about making the best use of a building for community purposes by bringing in other services, with a view to ensuring that the estate has a net zero effect in terms of its carbon emissions. I will invite Wendy and Phillip to say more about the estate.

Sandesh Gulhane: I have some questions about the estate—my next question is about that.

First, on the point that you made, we have seen GP funding going up in Bearsden, because it has a slightly older population, so both a very wealthy area and a deprived area are getting a bit more funding, but the money really needs to go to the deprived area.

On the NHS estate, what is the estimated cost of bringing it up to scratch and achieving net zero in line with the plan?

Phillip McLean (Scottish Government): I am happy to answer that question. Our low-confidence estimate is £700 million of capital. We do not have a great deal of confidence in the methodology that was used to develop that estimate, because it is based on high-level net zero road maps that were prepared for health boards some years ago. To improve our estimate, we are supporting health boards to prepare detailed site-level decarbonisation plans.

Although there are 900 sites across the NHS estate in Scotland, 20 of them account for more than 60 per cent of the estate's heat and power emissions. They are our priority sites. For example, the Foresterhill health site in Aberdeen produces 13 per cent of the NHS's heat and power emissions, and a site decarbonisation plan is being prepared for it.

The estimate that I provided also does not take into account the planned measures' effect on the revenue budget. Many of those measures will lead to lower costs because they will result in savings to the revenue budget. Such measures include the installation of LED lights and upgrades to building management systems, both of which have short periods in relation to the return on investment,

which means that, within a few years, investing in that change will have been cheaper than not doing so.

Sandesh Gulhane: How much does it cost to change an NHS light bulb?

Phillip McLean: I am afraid that I cannot provide you with that level of detail. However, moving from fluorescent tubes to LED lighting in a hospital environment is not straightforward. Rewiring is needed. It is not simply a case of changing the light fittings or a light bulb. In a healthcare environment, there are also design requirements for lighting that need to be taken into account. There are things that people perhaps would not have thought of, such as positioning. For example, you cannot have lighting running up the middle of a hospital corridor, because patients are pushed around in trolleys and beds, and you do not want them to be staring up into the lights. Therefore, it is not as straightforward as switching one light bulb for another.

Sandesh Gulhane: Sorry, you were in the middle of speaking about other things.

Phillip McLean: Yes, I was talking about the capital cost. The estimate also does not take into account how much of the cost will need to be paid for by the public sector. Part of our strategy is for health boards to connect large hospitals into district heat networks, which will be paid for by the developers of those heat networks. Another, related, part of the strategy is to seek opportunities for health boards to secure power purchase agreements, which are agreements with generators of renewable electricity whereby electricity is supplied directly to the NHS estate. In that scenario, the health board pays for the cost of development through its electricity bills, but the capital costs are funded by the developer of the solar farm.

We are working to improve the estimate and develop a financial model that will give us a better understanding of the true financial effects of decarbonisation on the NHS.

09:45

Sandesh Gulhane: My final question is about the fact that we have an estimated £1.5 billion maintenance backlog. Does that need to be addressed urgently, and do buildings need to be maintained and brought up to standard?

I go back to Drumchapel health centre, where the GPs were told that they could not create another room because it would not meet current health standards. However, it is okay for them to be in their current rooms, which do not meet health standards currently, because they are considered historical.

Phillip McLean: To give overall context, patient safety is our number 1 priority. This financial year, the Scottish Government is providing £114 million of additional investment for priority maintenance and equipment replacement in the NHS, which is on top of the health board's delegated capital budgets of £156 million. It is certainly the largest increase for maintenance and equipment that I am aware of.

Sandesh Gulhane: Previously, there were cuts, were there not?

Phillip McLean: No, there have not previously been cuts to maintenance and equipment replacement.

Sandesh Gulhane: Cuts to the capital budget.

Phillip McLean: The delegated capital budget has stayed roughly at the same level for a number of years, but the allocation is now starting to increase. The capital budget funds more than maintenance and equipment replacement; it also funds new developments, such as the ambulance replacement programme and technical elements, including health research and budget cover for leases.

On the question about the relationship between decarbonisation and backlogged maintenance, it is important to appreciate that those are not separate categories. One of the main risks in the NHS estate is the continued use of steam heating systems. They are expensive, inefficient and difficult to maintain. Moving to modern heating systems that use medium-temperature hot water is an important part of addressing the maintenance backlog. It is also a very important step in preparing a hospital to use renewable heating, because although renewable heating systems can produce steam, it is more expensive to do so and they operate much more efficiently with lower water temperatures. Those two things—decarbonisation and modernising the estate—are connected.

Sandesh Gulhane: Thank you.

Gillian Mackay (Central Scotland) (Green): To follow up on Sandesh Gulhane's question, one of the things that we do not talk about is electrical waste in hospitals. The nature of how healthcare is now delivered means that a number of big machines do a lot of work across hospitals, but they often come to the end of their lives either because patient safety issues mean that they are no longer considered safe to keep doing their job or because companies make software updates and machines become redundant as a result of those updates.

What work is being done to reduce the level of electronic waste across the NHS, and how do we ensure that anything that has to go, for patient

safety reasons or any other reason, is recycled or repurposed, so that we do not put loads of stuff into landfill?

Wendy Rayner (Scottish Government): There is a national waste management steering group that oversees all the activities of all health boards. It co-ordinates its activities via the waste management action plan. There is also a national framework contract in place for waste management services, of which electrical goods are one component.

With regard to reducing the amount of electrical waste that is generated, a large part of that falls within the circular economy work programme, and we are working closely with suppliers to try to change the format of those contracts. We are looking more at access contracts or the possibility of leasing, allowing that equipment to be upgraded during its time on our sites.

Gillian Mackay: That is useful. Thank you.

I turn now to transport and how people get to and from the NHS estate. We know that there is now a great number of electric vehicles in the fleet, which allow staff to go from site to site. However, with regard to staff getting to hospitals and arriving at work, what are we doing to ensure that people are able to make alternative choices in getting to health and social care settings and to enable a shift to low-carbon travel, especially in remote and rural areas?

I am sure that folk around the table will be very much aware of the parking issues at hospitals across the country. The committee has previously discussed the letters that go out in many health boards telling people to arrive 10 minutes before an appointment if they are arriving by car because of the issues with parking.

Professor Smith: Phillip McLean has been involved in quite a bit of work on that.

Phillip McLean: It is, without a doubt, an area where further work is required. There has been some progress by health boards—for example, in assisting staff in taking more sustainable travel options. Boards have put in place initiatives such as cycle-to-work schemes and discounted bus travel through arrangements with local bus companies. There have also been improvements on NHS sites to the infrastructure for active travel—for example, the installation of secure cycle lockers.

However, NHS sites are ultimately either a destination or a starting point for a journey, and collaboration with local authorities, regional transport partnerships and transport companies is therefore essential. That collaboration is happening, but it is fair to say that there is still more to be done. At a national level, NHS Scotland Assure engages with all seven regional transport partnerships, and, at a local level, health boards meet with their local regional transport partnership.

You mentioned patient letters as an example. That issue was raised last week by NHS Scotland Assure at the national travel and fleet meeting, and the transport leads will be taking a look at what their own particular health board says in its appointment letters, because practice undoubtedly varies across the country. It is an area where work is being done on the NHS side, but there is more to be done, and collaboration with local authorities and others is absolutely essential.

Emma Harper: NHS Dumfries and Galloway has advised people to arrive 15 minutes early for appointments, so that they can find a parking space. When I wrote to the board to say, “Can ye no give some information about active travel, getting buses and cycle routes?”, it came back with a very positive reply and said that it is working to improve measures such as engaging with public transport and community transport initiatives.

When I worked in Los Angeles, we had a car pool scheme whereby we got points—and points made prizes—if we shared a car, rode a bike or even walked. Should we be pursuing that sort of thing in Scotland? Wee car pool initiatives could encourage car sharing, so that the car parks are not full.

Professor Smith: There is a good car sharing initiative that has been widely publicised across Scotland. Phillip McLean and Wendy Rayner might know a little bit more about it, but I know that it is already in place and has led to quite a significant reduction in mileage.

If we look at NHS usage in terms of overall business miles, we see that it has fallen substantially, as have the carbon emissions associated with it. Perhaps my colleagues will have some of the detail on the figures, but I know that the scheme is in place.

Phillip McLean: On the point about NHS business mileage, in 2024-25, claims for business mileage represented a total distance of 45 million miles. That is for car travel. Oh no—my apologies; my figures are the wrong way round. In 2024-25, business mileage was 42 million miles, and the year before it was 45 million miles, so that is a decrease of 3 million miles in business mileage claims.

With regard to car sharing, that would both assist with reducing emissions and provide a way for staff to reduce their travel expenses. It is promoted across the NHS, but it is marketed principally on the basis that it is a way to reduce costs and emissions.

I am told that, although car sharing is being promoted, it has been difficult over the past few years since it was prohibited during the Covid-19 pandemic. There was definitely a drop-off then, although it is now starting to recover.

Emma Harper: Okay. Thank you.

Brian Whittle: I am going to sneak in a wee supplementary on the previous question, if I can.

We always hear about people being told to arrive 10 or 15 minutes early, so that they can get a car parking space. Are we just being completely unrealistic in our expectations when we are delivering healthcare, especially at hospitals? With regard to the hospital in Glasgow, it was understood that, in the future, there would be much more active travel and people arriving by public transport, but that is just unrealistic, given the nature of what hospitals deliver.

Professor Smith: It goes back to my earlier point, that all our healthcare systems need to be very aware of all the communities that they are serving—not only the geography of their local community, but how that community works, the patterns of travel and the challenges that it faces. When we are planning services, it is important that we factor all of that in.

There is no doubt in my mind that one of the most important aspects of reform of the healthcare system, now and in the future, has to be a greater proportion of care taking place in communities themselves. That means using the hospital not as the default for care, but as a way of escalating care and, importantly, de-escalating care thereafter when that is necessary.

The future has to be about moving to a thought process whereby people see their hospital as the cathedral of care in the system, recognising the huge contribution and the foundation that community services provide. Some of that might involve examining the way in which we provide services in the future and thinking about which specialties can take the care that they traditionally provide in a hospital out-patient setting much closer to communities. We are already starting to see that taking shape in our communities just now, and I want to see more of it in the future.

Ensuring that we have the infrastructure in a community setting to enable that to happen, and preventing those journeys to the huge cathedrals—the hospitals themselves—by ensuring that we provide care in other places, closer to where people come from, has to be, as I said, one of the most important and critical outcomes of future service reform.

10:00

Brian Whittle: I do not disagree with you—the issue is how you get to that position.

I had better move on to what I am supposed to be talking about, which is goods and services—specifically procurement. Food, food procurement and food waste are bugbears of mine. I do not know whether this is still the case, but the last time that I looked, the food that the Queen Elizabeth university hospital was serving was prepared in Cardiff and driven up the M6 every day, and 55 per cent of it was being thrown out. I know that the position is similar in Edinburgh. That must stop. How is the Government tackling the issue?

Professor Smith: I am aware that there are a number of different workstreams on procurement, and food sits right at the heart of that. I think that procurement is split into nine different subject headings. It has been shown that the majority of food procurement is provided by local suppliers. The situation with pre-prepared meals and delivered meals is different, as no Scottish supplier is able to supply those to the required specification currently.

However, as I said, there is good evidence that food is procured as locally as possible. That is good for the environment, because there is no travel cost. It also makes sense that it is provided as close to the hospitals as possible from the point of view of supporting local communities and socioeconomic development.

Again, my colleagues might want to say more on that. I note that the issue has come to the oversight board, and that reassures me.

Phillip McLean: That is correct. Nine NHS national procurement food contracts are in place, and the suppliers of eight of the framework contracts are based in Scotland. As Gregor Smith says, one supplier, which is for the direct meal service framework, is based in England. That framework provides special diets and texture-modified food, and no supplier in Scotland can provide that service.

The amount of food that is produced in Scotland varies from framework to framework. However, 100 per cent of milk and dairy products, 80 per cent of butcher meat and meat sundries and 70 per cent of potatoes and veg are produced in Scotland. In addition, on the direct meal service contract, 20 per cent of the food is produced in Scotland, although the supplier is based in England.

Of course, food waste continues to be an issue in NHS hospitals, although there has been some progress. In 2023, Zero Waste Scotland assessed 14 health boards and found that all had reduced their food wastage compared with the baseline year, which varied for each health board but was

in the period 2015 to 2017. Zero Waste Scotland assessed that six health boards had reduced their food wastage by more than 33 per cent.

Work aimed at making improvements continues. There are various reasons for food wastage in hospitals, some of which can be due to the quality of the food. However, unserved meals play a part, and we see examples of overordering by wards on a just-in-case basis. One of the actions that have resulted in a reduction in food waste is the introduction of electronic bedside ordering. Health boards that have brought that in have seen their food waste go down. Unfortunately, that is not in place everywhere yet.

Brian Whittle: That points to what we were talking about before, Professor Smith, in relation to the prevention agenda. Surely it is obvious that serving the highest-quality food possible would benefit patients' recuperation. As I said, 55 per cent of food is being thrown out because people are not eating it. That is a problem. The idea that we would build hospitals without kitchens is surely a false economy, as the best meals are prepared fresh on site. Is any consideration given to how and where we produce food, and the quality of the food that we deliver?

Professor Smith: I am certainly not involved in those discussions, as that is not my area of expertise or specialty. As I said, my colleagues may want to come in if they are aware of any work that is being done on that.

We need to remember that the provision of nutrition in hospital is overseen by experts in that field—nutritionists. They ensure that the dietary requirements of each individual patient are assessed where that is necessary. That may involve changes in the texture or type of food, or looking at how to establish a proper protein or overall calorie intake in order to meet the particular health needs of the patient. That is key—it is why we have healthcare nutritionists doing that work across the NHS in Scotland.

I am not aware, from direct involvement, of any specific work in relation to infrastructure such as kitchens. However, as I said, I will pass the question over to my colleagues, in case they are aware of anything.

Phillip McLean: There is a national catering strategy, but Mr Whittle is correct in saying that different models of food production have developed in different parts of the country. We see a variety of models, including cook-freeze models, cook-chill models and hospitals with kitchens for on-site production.

As part of a review of the national catering strategy, there needs to be an assessment or analysis of what the best model is for the production of NHS food. Mr Whittle makes very good points about the need for on-site kitchens, and that has to be considered as part of a more cohesive and unified approach, recognising that geography varies across the country and it is possible that the same model of food production will not fit each area. That needs to be taken into account.

On the question of the quality of food, there is a specification for food in hospitals. That was last issued in 2016, but it has recently been reviewed and the new draft version is intended to be published very soon. NHS Scotland Assure has led the production of that updated specification, working with dieticians, Public Health Scotland and catering leads from the health boards. The specification sets out standards and advice on how to prepare meals and develop menus for hospital catering, taking into account the different needs of the patient population across NHS Scotland.

Professor Smith: In my view, there is an added advantage to ensuring that there are good kitchens in a healthcare facility. It is not just about food preparation and what that does for people—the kitchen is an important place, and learning life skills around the kitchen is important for our communities. There is some fascinating work led by David Eisenberg at Harvard University, among other people, looking at the role of community kitchens and how they can be used to improve health. That approach relies on our anchor institutions and community facilities having well-equipped kitchens so that we can begin to teach people about food and its preparation, and about the connection that people experience when they come together to eat food. We can equip people with life skills that will allow them to go away and take a healthier approach in their behaviours throughout life.

We sometimes have to look beyond the immediate practical aspect of what having a kitchen in a hospital provides. When we start to think about the kitchen as a place for improving health, we see that there is an added benefit that we have yet to fully explore and utilise across our estate. That is one thing that I suggest we should look at in the future.

Brian Whittle: It is interesting that you talk about nutrition—that is one thing, but the food has to be edible. If 55 per cent of food is being thrown out, it might be because it is inedible despite having nutritional value.

I have a final question on the point that you made, Mr McLean, about the various models that exist across the country. Is there a problem in that respect? We have 14 different health boards that do things in 14 different ways, and they can each

say no to a question, all of which means that it is difficult to deliver a universal approach.

Phillip McLean: It is a very interesting question. That is absolutely one of the factors that leads to variation at a local level. Sometimes variation is a good thing, as it takes account of local needs and the resources that are available in a particular area, but it also can act as a barrier to having a standard specification or a common approach. There are always costs and benefits to these different models of service provision.

Emma Harper: I have a supplementary question, which goes back to the issue of cross-portfolio working. The Natural Environment (Scotland) Bill, which was passed just last week, contains provisions for increasing the use of venison in public sector settings such as hospitals and schools. We know that we have an abundance of venison. If we are going to promote it as being sustainable, healthy and locally sourced, what should be the practice for communicating the need for such action? If we pass a bill that says that we need to promote venison and get it into hospitals, how should that information be communicated and disseminated to different health boards?

I see that Wendy Rayner is leaning forward.

Wendy Rayner: Would you like me to try to answer that? I am afraid that I do not have full details, but I had a conversation only recently with the lead procurer for food across Scotland, who works for NHS National Procurement, and she was talking to me about the opportunities for adding venison. She frequently meets the expert catering group and she corresponds with all the health boards, enabling those products to be on contract. That approach is then supported by the boards being able to pull those products off contract and, with the use of standardised recipes and menus throughout Scotland, venison could be added.

Emma Harper: There is a school in Lockerbie where one of the teachers brings in venison and has the young people make burgers. Eating venison is not just about steaks—it can be made into burgers, meatballs and sausages. It is about changing our attitude to venison, because it is a good source of protein.

Professor Smith: I am going to come in on food in general, because I think that we all realise that, in order to ensure that we have food security for the future, we have to educate our population and diversify their behaviours as much as possible.

It is generally accepted that 60 per cent of our calories globally come from four crops: rice, maize, wheat and soya. In my view, the situation needs to be addressed at a global level, because those four crops are produced by only a small number of countries. As we see global changes to the climate and the impacts of those changes, it is clear that food security has the potential to become a real problem. We need to diversify the food that we eat, and change attitudes to agriculture so that we are not using it solely to feed the animals that we then choose to eat. Those are all important parts of how we ensure that we have better food security for the future. I would be very much in favour of looking at how we begin to educate people in a much more systematic way, at a very young age, about food and nutrition, and health in general, through the school curriculum. That would be beneficial for us in the future.

Emma Harper: That reminds me of the work of Dr Stuart Gillespie on ultra-high-processed foods and other such things that I am interested in, but I will leave that for another day.

10:15

David Torrance (Kirkcaldy) (SNP): Good morning. To what extent are health boards addressing the need to reduce the use of single-use plastics in personal protective equipment, and what are you doing to promote and facilitate any cultural change and education required in both clinical and procurement practices?

Professor Smith: Quite a significant amount of work is being done on that, and my colleagues will be able to say a bit about it. Wendy, do you want to start?

Wendy Rayner: Absolutely. It is an area that is very close to my heart.

Plastics is a key material stream for us and one that we feel should be valued. That is particularly pertinent, given that the NHS is in possession of very high-quality polymers in the products that we buy.

A large percentage of medical devices that we purchase are single use, and we are aware that a large number of them contain or comprise relatively large quantities of plastic. In addition to the environmental sustainability impacts associated with raw material extraction and manufacturing, plastic waste has a significant impact and will add to future cost pressures via increased taxation from the emissions trading scheme that is on the horizon. Therefore, it is important that we address plastic waste and value plastics as a material stream.

The Scottish Government and NHS Scotland have undertaken a number of pieces of work focusing on plastics, including one that was started more than seven years ago with Zero Waste Scotland on supporting the extraction and processing of plastics from our treated clinical waste stream to create high-quality recycled polymers suitable for use in future manufacturing.

A position statement on plastics, which went to a formal consultation managed by national procurement, was undertaken about 18 months ago, and a trial of source-segregated high-value polymers from clinical settings that was undertaken last year was deemed to have been so successful that it was then included within the national contract—that is, the national framework for waste management services.

As part of a larger circular economy data project, we have worked with suppliers to identify the types of plastics as well as other materials used in products, and we are linking that data to procurement system data to support future segregation as well as demand modelling. That will support the waste and resources industry in putting in place plastic collections as well as increasing the recovery of high-grade plastics in the future.

Finally, at United Kingdom level, we have co-commissioned a project that brings together people with expertise to assess opportunities and requirements for a move away from single-use items, where appropriate, ensuring at all times that patient safety and the quality of care come first and that such a move can be compatible with resilient, sustainable and cost-effective healthcare.

Earlier, there was mention of our green theatre programme. That has been expanded into what is called green healthcare Scotland; it covers a number of different areas, not just theatres. It has been involved in a number of pilots and projects that aim to reduce our reliance on single-use plastics, including some PPE items, and to work with clinicians to embed more sustainable practices. For example, in one particular trial, single-use textiles were removed from an operating theatre, and we employed a company to provide textiles as an alternative service; the trial was successful, and we have now employed a project manager to explore opportunities to implement the same approach across Scotland.

David Torrance: Thank you for that. In addition to the green theatre programme, which you have just touched on, what specialties are being considered for action by the centre for sustainable delivery? Secondly—and this is really important—how are you engaging with clinicians on being innovative in reducing emissions, and what challenges are you facing in that respect?

Professor Smith: Quite a significant amount of work is under way on that. First of all, though, I want to recognise the work of what was the green theatre programme, what it achieved in Scotland and its international prominence. The thing that I loved about the programme was that it came from a group of clinicians who were incredibly invested in making changes at a local level and were then able to spread their practice across the country with the support of the centre for sustainable delivery. That was one of the programme's key characteristics: change had been identified at a local level and was then spread out across the country.

Since then, we have seen that good news story, and the enthusiasm of the clinicians leading the initiative, attracting more and more specialties into getting involved. Renal medicine, for example, is an area of intense resource utilisation, because of the types of medicine and care that people get, but ways of trying to make that process much more efficient are being established. Again, that work is very much being led by clinicians on the ground.

The national green theatre programme has been expanded into the green healthcare Scotland programme, which is beginning to bring those other specialties into the fold. I would expect, certainly from the conversations in which I have been involved and the people whom I see, and the eagerness and enthusiasm that those specialties are showing, that we will begin to see some of the same success that we saw through the green theatre programme being broadened out with those other specialties.

It would not be fair to single out certain specialties, because things are much more broadly based than that. In the conversations that I have, I am constantly pleased—and reassured—by the breadth of specialties and geographies that are represented. People come to me and say, "Can you come and see this? I think we're doing something here that's important." As I have said, it all starts at a local level and, with a bit of success and some encouragement, then begins to make an impact.

We need look only at the small-scale projects that we are beginning in, say, general practice or renal medicine. We know that about 20 per cent of the emissions that the NHS contributes come from prescribing, medicines and so forth. If we take a much more proactive approach to our use of such substances, we will not only help with the environmental impact of our resources in terms of emissions but practise a much more sustainable form of medicine with regard to the costs incurred. It is also less likely to be harmful to the environment from a biodiversity perspective; indeed, we have had groups examining the impacts of medicines that have been disposed of inappropriately, the impacts of the by-products of the consumption of those medicines on local waterways and so forth. It is a full-ecosystem approach that we are taking.

David Torrance: Thank you. I have no further questions, convener.

Gillian Mackay: One of the ideas that we have been talking about for a very long time now is electronic prescribing, which is one of the most basic ways in which we could save something as simple as paper within the NHS, as well as time and all those sorts of things. It is one little idea among a whole load of others that we could be progressing more quickly. What are the barriers to our doing some of those simple things such as electronic prescribing, sustainable medicine disposal and moving to better, greener ways of giving people their medicines through blister packs? Is it a lack of resource? Is it about expertise? Is it because these things need to be done better at a global level? Is it a bit of everything?

Professor Smith: That is a really good question. I know that my colleagues will want to come in on it, too, but I will start off with my own views.

Electronic prescribing is really important, but we have to put it in context, do we not? It is going to make a contribution, but not as big a contribution as some of the other things that we can do with medicines. For me, the biggest prize will be ensuring that we are much more careful in the way that we prescribe, continue and review medicines. Indeed, the Scottish prescribing guidelines that have been produced on polypharmacy, respiratory medicine and the use of medicines such as benzodiazepines will be one of the most important starting points in that respect. A medicine that has been prescribed and continued, but which actually is not improving things or is not having its intended purpose—or, even worse, might be having harmful effects—is the worst type of medicine for the environment, because of the knock-on effect.

For me, then, the absolute starting point is value-based health and care and ensuring that we take that approach when we consider, and share with people, decisions about their medicines, so that we are properly addressing their own preferences for their care. Yes, I agree that electronic prescribing will help, too, as will optimising medicines management and stewardship, but for me the starting point is ensuring that medicine prescribing is as good as it can be.

Gillian Mackay: I think that I was using electronic prescribing as an example of a quite basic thing that we have not achieved yet. Where, in your mind, is the blockage in that respect? Is it a lack of money to do these things? Is it a matter of prioritisation and getting the bigger things rather than the smaller ones over the line? Is it about the cumulative impact?

Professor Smith: Again, I will pass over to my colleagues, but what I am seeing is a very crowded landscape with regard to investment in digital technologies, and we have to prioritise that and ensure that those digital approaches have the biggest impact, while also keeping in mind the technical solutions that already exist. We should always remember that technical solutions in a digital sense are only part of the problem; we also have to ensure that they are properly adopted and that people understand how they can be used properly, safely and efficiently. All of that needs to be taken in hand, but much of this is about the technical solutions themselves and prioritisation, too.

The guys who are with me might want to say a bit more about that.

Phillip McLean: In general, one of the things that we are trying to do, certainly when it comes to sustainability, is to bridge the gap between the publication of guidance or the running of a successful pilot project and its implementation. Sometimes the change that we are looking for is actually behavioural change; more support is required for that, and that is the way in which we are treating those projects. We are putting in place support for health boards so that they can implement the changes that have been piloted and then reap their benefits.

I cannot really talk about the particular issue of digital prescribing, although I appreciate that you are using it as an example. However, one aspect of our approach to sustainability is that we are bringing together different services to recognise the dependencies that they have on one another. One of the great—and, indeed, less obvious—successes of the green theatre programme is that it has increased communication and collaboration between theatre teams and the teams responsible for running decontamination services, which are the services that sterilise surgical instruments. Each of those teams now has a better understanding of what the other requires, with fewer assumptions being made.

In that respect, I would also highlight the example of the lean trays project. Although it is being led very much by theatre teams, it is having great benefits not only environmentally and financially but for decontamination services, too. For me, this is about resourcing our projects properly, implementing things in a planned way and bringing together the services that need to be involved in order to make that change successfully.

Wendy Rayner: I can say a little bit about pharmacy waste, but not about electronic prescribing, I am afraid.

Gillian Mackay: Thank you.

Emma Harper: I am really enjoying this morning's discussion, because there is a lot going on in the NHS, and, as a former theatre nurse, I am really keen to hear about changes in operating theatres.

As I mentioned earlier, I am also the convener of the cross-party group on lung health, and we have had some evidence-taking sessions on low-global-warming-potential propellants and inhalers. I am a wee bit worried that any blanket switching in the transition to such inhalers from multidose inhalers—that is, the relievers—will put people in danger. I see you nodding already. I guess that my concern is about ensuring that we have the right inhaler for the right person and that we check their technique instead of just blanket switching. We also need to do this in a way that helps with the transition while ensuring that people do not end up having asthma events and then having to be admitted and so on.

I would point out that, although some dry powder inhalers might have low or no emissions, they are full of bits of plastic that cannae be recycled very well, whereas the current salbutamol inhalers, for instance, have bits of plastic that can be recycled. It is complicated, but I am concerned about how we make that transition while keeping patients safe.

10:30

Professor Smith: I will say a little bit about the clinical aspects of this, because I think that they are really important. I will start off by trying to answer your question about respiratory care, and then I will perhaps go on to talk about some of the green theatre programme's work.

What really attracted me to focusing work on inhaler usage in Scotland was that, when we began to look at international data and compare Scotland with demographically similar countries, particularly across Scandinavia, with regard to the utilisation of particular devices and health outcomes, there was certainly evidence of much greater usage of short-acting beta-2 therapy inhalers—which, for those on the committee who are not familiar with the terms, are generally what we call reliever inhalers. In Scotland, there seemed to be a disproportionate use of those inhalers compared with preventer inhalers, which form the absolute bedrock and keystone of ensuring good asthma care over a long period of time.

The high usage of short-acting beta-2 agonists, in particular, was leading to significant increases in the amount of emissions; people were going through so many more inhalers because they were not actually using the preventer inhalers. Work that has been led around the country—for example, in Glasgow and so forth—is giving us a better understanding of what has been happening there.

I do not think this comes down to simply switching from some of the gas-propellant inhalers to the dry powder inhalers; it is about making sure that we optimise the care of patients. The 2024 British Thoracic Society guidelines set out a slightly different approach to modifying drugs usage and take us down a slightly different route in terms of how we use inhalers to improve asthma care. It is all about taking a holistic approach with a patient to see exactly what works for them, given their stage and current experience of asthma. That is certainly what is being advocated in the Scottish prescribing guidelines on respiratory care. This is not just about blanket switching to dry powder inhalers; it is about optimising the care of patients, with the side benefit of an impact on emissions, too.

That is a really important point to underline. Emissions have been falling in, I think, quite a striking way. Indeed, the data that I have suggests an 18 per cent fall in emissions, even from 2022-23 to 2024-25, as a result of some of the work that has been going on. All of that is a benefit.

We also have to recognise that other medicines that we are using are having a harmful effect on the environment, none more so than the volatile anaesthetic gases that you would have been used to, Ms Harper, when you worked in theatres. Again, extensive work has been carried out in Scotland on how we make best use of those gases, where their use is appropriate, and we have begun to stop using those that are most harmful, such as desflurane. Through the work of national procurement and engagement with clinical teams, we have seen changes to the whole approach to using those volatile gases.

Likewise, we need to examine the broader use across our estate of gases such as nitrous oxide, or Entonox, which is often used as a pain-modifying therapy. We must ensure that we are making best use of the infrastructure that sits round about that, in order to reduce the amount of leakage across the system and to make sure that such gases are being used appropriately. We are beginning to see a great reduction in that respect, too.

Therefore, side by side with some of the equipment in theatres being used in a completely different way is the different use of the medicines that support those theatres and, indeed, care across our hospitals, and I am really encouraged by that. It is fair to say that, certainly among the community of people across Europe with whom I am involved, Scotland is seen as a leader in this. In the past couple of years, I have had the pleasure of signing a memorandum of understanding with

the regional Government in Galicia, as we choose to work together on these types of approaches to ensure that we embed sustainable care in our healthcare systems.

Emma Harper: Is there still a place for nitrous oxide in maternity services, ambulances and emergency departments?

Professor Smith: Absolutely. We are not removing it as an option; we are just making sure that it is being used appropriately and that, when it is used, the infrastructure that sits behind it does not lead to leakage. It became evident that some of the impacts of nitrous oxide were arising not from patient use, but from leakage in the system during its delivery.

Emma Harper: Thanks.

Brian Whittle: There is so much to unpick here. Like Emma Harper, I am really enjoying this conversation; indeed, I think that we are starting to get to the nub of it just as we are reaching the end of it.

Gillian Mackay asked about the impact of technology. In Scotland, we are way behind the curve when it comes to what technology can deliver. I just do not think that we have quite recognised what it can deliver with regard to, for example, the climate change agenda. Indeed, you have talked about overprescribing or wrong prescribing in that respect. We have 14 health boards, and we need the ability to adopt and apply technology to best effect. Where are we with that? How do we overcome the inertia that seems to be a major drag on how the health service has been able to move forward on this agenda?

Professor Smith: I want to be clear about what we are talking about when you ask about technology. Are we talking about machines and systems that support care, or are we talking about the data that sits behind that, for planning care?

Brian Whittle: It is all interlinked, to be fair. The fact is that we have data coming out of our ears in Scotland, but there is no way of interrogating it. A starting point would be having some universality in collecting and interrogating the data and applying it in a real-time workplace.

Professor Smith: I am glad that you have said that, because, for me, data is the key starting point in all of this. We must have systems and approaches in Scotland that support the use of data across the country, not only to guide our provision of care, but to give us an assessment of the quality of the care that is provided. That is the absolutely critical starting point.

In that respect, the way in which our national organisations such as Public Health Scotland, NHS National Services Scotland and NHS Education for Scotland hold and use data becomes really important. Indeed, we see how Public Health Scotland analyses such data in the regular reports that it produces, which give us an assessment of care. It also informs our data modelling, which, in turn, informs research reports such as the Scottish burden of disease study, giving us a sense of not only where we are just now, but what is coming in the future. That use of data is absolutely critical to a precision public health approach to the way in which we provide care or improve the health of the population for the future.

Data is king, but we still have a bit to go before I am comfortable with how we use it in this country. I would like to see much more availability of data from general practice, in particular, but also from community care, and I would like it to be fed into our overall system, to support our understanding of how the system itself is functioning. There is also the opportunity for it to be used appropriately to inform research. As I have said, data is the starting point here.

In my view, the approach to planning that is being taken through the sub-national planning groups, which you will all be aware of, gives us an opportunity that we have perhaps not had before to ensure that, instead of having 14 different flavours of technology adoption, that sort of thing can happen much more consistently across the country—whether it be adoption of particular strategies or technologies or just ensuring that they are being used in an appropriate way at a local level. That is one of the key things that the sub-national planning groups will eventually assist us with in the future.

Brian Whittle: I am not against having 14 different health boards, but do you accept that the lack of universality and the lack of a basic information technology infrastructure applied across all 14 boards are a drag on our ability to deliver on this agenda?

Professor Smith: As a simple clinician, I want to see consistency across the country in everything that we do, but particularly in governance. Whether it be in the protocols that we use for providing care or those that underpin the quality assurance of our lab services and the systems in that respect, consistency is important.

We have a very fluid workforce that moves around the country, and it is reasonable to expect that, wherever they move to, they will be familiar with the systems that they are using and will not have to move away from them. Therefore, consistency across the country in the adoption of our patient management systems, our point-of-care testing and all the systems that underpin how

we provide care across Scotland is beneficial and is something that I have always wanted to see.

Phillip McLean: In our sustainability programme, data is very important—indeed, central—and we have a workstream dedicated to it. I appreciate that much of the discussion has been about clinical data systems, but that workstream is looking at energy management systems and waste management and waste data.

We also have some very exciting projects that combine data from suppliers on particular products with NHS data on how those products are used, and those projects will help with the planning of circular economy initiatives. One particular project is being taken forward with an Edinburgh-based company as a CivTech digital innovation project.

You are absolutely right that data is very important; indeed, it is essential to this agenda. We are trying to take a data-led approach, wherever possible, and we have a number of projects that are looking to join up data systems not just across the NHS but with the supply chain.

My colleague Wendy Rayner will be able to say more about that particular CivTech project, if that is of interest.

Wendy Rayner: The CivTech project is really quite interesting, because it will enable suppliers to provide us with information while maintaining their commercial security. It will also provide in under four minutes—or so it is claimed; let us say five minutes—a full life-cycle assessment, which will give us a carbon footprint for individual products. That is work in progress at the moment.

It is also worth noting that we have just secured €7.2 million of European Union horizon funding for a data programme that will support the remanufacturing and reprocessing of medical devices on a pan-European level. Scotland has received €1.7 million of that directly.

Brian Whittle: There is so much to get into, but I will leave it there, convener.

The Convener: Thank you very much, Mr Whittle, for doing that. I also thank our panel of witnesses for their evidence this morning.

Before I suspend the meeting, I would just like to formally acknowledge the passing of the former Cabinet Secretary for Health and Social Care, Jeane Freeman, at the weekend. She was a dear friend and colleague to many of us sitting around the table this morning, and I pass on my condolences and the condolences of the committee to Susan, Jeane's wider family and those who loved her.

10:45

Meeting suspended.

10:54

On resuming—

Medical Training (Prioritisation) Bill

The Convener: The next item is an evidence session with the Cabinet Secretary for Health and Social Care and supporting officials on the Medical Training (Prioritisation) Bill legislative consent memorandum, LCM-S6-72, which was introduced in the Scottish Parliament by the cabinet secretary on 21 January 2026. The legislative consent process that is set out in chapter 9B of standing orders requires the Scottish Government to notify the Parliament by means of a legislative consent memorandum whenever a UK Parliament bill includes provision on devolved matters. Each LCM is referred to a lead committee to scrutinise and report on it before the Parliament decides whether to give its consent to the UK Parliament legislating in the manner proposed.

The Medical Training (Prioritisation) Bill was introduced in the House of Commons on 13 January 2026. The purpose of the bill is to introduce a system that gives graduates from UK medical schools and certain other groups priority for training places to become doctors. The bill has been introduced as emergency legislation, subject to an expedited timescale, to allow prioritisation to be implemented for live training programme recruitment rounds, and it would affect those receiving offers for training posts starting in August 2026.

I welcome to the committee Neil Gray, Cabinet Secretary for Health and Social Care, Lucy Gibbons, head of the health skills development and delivery unit, and Lucy McMichael, head of the branch social care legal services unit, Scottish Government. I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Convener, colleagues, thank you for inviting me to speak with you today. The committee will be aware that the bill passed through the House of Commons unamended on 27 January. Across the UK and here in Scotland, the dedication of our NHS staff continues to be remarkable, but we must be honest about the challenges that are facing our medical workforce. I thank those doctors who took part in phase 1 of the future medical workforce project and who shared their views on those challenges candidly.

We cannot ignore the increasing pressures within the UK medical training pipeline that are affecting our resident doctors. Demand for the foundation programme and specialty training posts has grown sharply. In 2025, 12,000 UK-trained and 21,000 internationally trained doctors competed for 9,500 specialty training places. That bottleneck threatens the progression and retention of doctors who have trained in the UK and who are most likely to stay and build their careers here.

To match the increase in the number of undergraduate places, the Scottish Government has created 252 foundation-year places since 2021 and will add a further 72 in 2026. Furthermore, in line with anticipated future workforce needs, approximately 850 additional specialty training posts across multiple specialties have been added since 2014. To address concerns about training bottlenecks this year, the draft Scottish budget provides an additional £14 million for specialty training posts. That will increase the number of available posts in 2026 by approximately 10 per cent.

Although the Scottish Government can take action in Scotland, the impact of that on the UK-wide pool of posts and, ultimately, the experience of resident doctors in Scotland is influenced by the actions of other Governments in the UK. It is against that backdrop that the Medical Training (Prioritisation) Bill is being enacted. It is right that training posts are determined by future workforce needs, but we cannot risk losing those whom we have trained in our world-class universities. Although Scotland experiences those pressures to a lesser extent than other parts of the UK, the reality is that we operate within a UK-wide recruitment system, so moving together on a four-nations basis is the only way to ensure that Scotland is not negatively impacted. If prioritisation were to apply without Scotland, we would experience displacement effects.

The bill provides a lawful and proportionate mechanism to prioritise UK medical graduates alongside other priority groups where limits are required. It also ensures that, from 2027 onwards, we can recognise and value internationally trained doctors who have made significant contributions within the NHS by enabling them to be prioritised through future regulations. The concurrent regulation-making powers with safeguards around Scottish ministers' consent provide the necessary assurances that our devolved responsibilities are fully respected.

I stress that the bill will not prevent international recruitment. Indeed, international students will always be welcome in Scotland for their positive contribution to our campuses, our economy, our NHS and our local communities. The bill will support a sustainable and reliable future supply of doctors and ensure that those who have trained here have the opportunity to progress their careers. On that basis, and having considered the legal, financial and operational implications, the Scottish Government recommends that the

Scottish Parliament grants legislative consent to the bill.

11:00

The Convener: Thank you, cabinet secretary. We will move to questions.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

On 14 June 2025, at the Scottish Conservative conference, I announced that we would introduce pretty much the same policy as we are talking about here, so I obviously support the bill. However, given how quickly the bill passed through the House of Commons unamended, should we spend a bit more time considering it and taking evidence from, say, international medical graduates?

Neil Gray: I recognise that there has been an expedited timetable, particularly in the House of Commons—as the convener set out, that was needed in order to meet this year's recruitment rounds—but the Scottish Government has been discussing these matters with the UK Government for quite some time. As I said in my opening statement, we believe that the bill contains the most proportionate legal proposals that the UK Government has made and, critically, that the proposals are workable.

It is for the committee to determine its work programme—I cannot direct it—but I believe that the bill is balanced and the right course of action to take. That is why we recommend that the Parliament should give its legislative consent.

Sandesh Gulhane: As I said, I very much support the bill and think that it is key. Graduates in Australia, for example, get the training places that they need, and then the places that are left go to people who have emigrated from, say, this country, so that they can get that experience.

I know that other members will ask about recruitment into roles that are harder to fill, so I will not touch on that. However, does the bill cover dentists?

Neil Gray: No.

Sandesh Gulhane: GPs have to go through specialty training programmes, so does the bill cover GP training?

Neil Gray: Yes, it covers GPs.

Sandesh Gulhane: Does the way in which the bill has been constructed mean that a number of people from, say, England will want to come up to Scotland to practise?

Neil Gray: That opportunity will remain, and there might be expanded opportunities as a result of the prioritisation being on a four-nations basis. There will be reduced competition for UK-based medical graduates, and it will be proportionately harder for international medical graduates.

However, I reiterate that, given the issue that you mentioned relating to places that are harder to fill, international medical graduates will still be required and will still be very much valued by the Scottish Government. In our discussions with the UK Government, we were not comfortable with previous iterations of the policy because we felt that they would impinge on our ability to recruit internationally. I want to leave the committee in no doubt that the Scottish Government's position is that we will still require international medical graduates, even under this policy.

Sandesh Gulhane: It is important to state that, under the system, an international student who has come to study at, say, the University of Glasgow will be given the same prioritisation as anyone from this country who went to that university. Is that correct?

Neil Gray: That is correct. Anyone who has started their medical education at a UK university will be treated as a UK-domiciled graduate. Anyone who has carried out their foundation year programme in the UK will be prioritised as a UK medical graduate, but the prioritisation will start in relation to those who are entering for the first time to take up a specialty position. That is where the difference lies.

Sandesh Gulhane: Given that this is a UK-wide recruitment that prioritises people who have graduated in the UK over those who have graduated internationally, if a graduate of a Scottish university or a Welsh university chose to go to England for specialty training, they would not be ranked below somebody who graduated from an English university, or vice versa. Is that right?

Neil Gray: That is correct.

Emma Harper: Will what the bill proposes affect the allocation of graduates on the Scottish graduate entry medicine programme to foundation year 1 and 2 posts? As you know, I am interested in how successful ScotGEM has been in recruiting doctors for rural practice in NHS Dumfries and Galloway. Will the bill affect ScotGEM students?

Neil Gray: I recognise Emma Harper's long-standing interest in and advocacy for ScotGEM, so I understand her desire to ensure that ScotGEM is not impacted by the process that is proposed by the bill. I can confirm that ScotGEM will not be impacted by it.

Brian Whittle: Good morning, cabinet secretary. We all agree on the positive impact that international graduates, GPs and medical staff have on our NHS. At the moment in Scotland, we

have a cap on home-based medical graduates. Will what the bill proposes necessitate a raising of that cap to allow more Scotland-domiciled graduates to get a training place? Will it change the perspective in that regard?

Neil Gray: Are you asking about specialty training places?

Brian Whittle: Yes.

Neil Gray: As I said in my opening statement, we have provided additional specialty training places, in recognition of the fact that it is a competitive landscape. I put on record that I think that it is right that it is competitive, as that serves to ensure that the best come through. People who receive their medical education and training in Scotland and the rest of the UK are held in very high esteem internationally. Therefore, we have incredibly high standards to ensure that the best come through into our system.

We review annually the number of specialty training places that are available. As I said in my opening remarks, we have allocated an additional £14 million to increase the number of specialty training places by 10 per cent. That matches proportionately what the UK Government is delivering. Obviously, we will keep under review the impact that the bill has on the delivery of the workforce supply that is required and whether we need to move that up or down in future years.

Brian Whittle: You said that you are increasing the number of specialty training posts in Scotland. How will you ensure that that increase reflects the demand that will be there now that the bill has been introduced?

Neil Gray: That will be part of the discussions about recruitment that we have on a four-nations basis. NHS Education for Scotland has representatives in those discussions, which help us to determine what our need will be as regards specialty training and how many people should be recruited to that. As I said, there is a fine judgment to be made to ensure not only that the process is competitive but that it delivers the number of specialty training places that will allow us to fill the gaps in our supply that we need to fill.

Brian Whittle: The competitive nature of the process is totally understandable. It is right that it is so competitive. From a completely selfish point of view, we want people who emerge from that competitive process to choose to be here. How are you ensuring, in a four-nations context, that Scotland sits at the forefront in that regard and that access to specialty training is such that it makes it easy for people to make the choice to stay here?

Neil Gray: A number of factors determine the attractiveness of Scotland, or any other part of the UK, as a place for people to live and work. There are a number of reasons why people should want to choose to live in Scotland and to work in the NHS in Scotland, which I am more than happy to put on the record. Through NES, we look to set out a competitive and supportive education programme and specialty programme. I have certainly not had any feedback to the contrary in discussions with either the British Medical Association resident doctors committee or the medical students committee.

There is concern from the BMA, which is why it has set out its support for the bill, although in some places that is qualified support. The bill will make it easier for UK-domiciled medical graduates to access specialty places. Everybody is aware of the issues that exist between the BMA and the UK Government at the moment. The bill is an attempt to resolve some of those issues.

David Torrance: Good morning. What impact could the bill have on vacancy gaps in areas such as rural Scotland, where places are hard to fill?

Neil Gray: We are taking a number of measures to try to improve recruitment in rural and island areas. Emma Harper mentioned ScotGEM, which is an example of that. We have taken forward a number of programmes to provide rural and island communities with people to serve those services. The bill will not necessarily directly change the perspectives in that regard but, taken alongside some of those programmes, it has the potential to help us to meet the skills gaps in our rural and island communities.

David Torrance: What evaluation has been undertaken of the impact that the bill might have on specialist programmes that have historically had higher levels of non-UK graduates, such as general practice and psychiatry?

Neil Gray: That relates partly to Dr Gulhane's questioning. There will still be a need for international medical graduates for some specialties, where there is not the same popularity among UK-domiciled medical graduates. That will not change—I expect that we will still have that.

The dynamic that might change is that the more popular specialty places among UK-domiciled students might be harder for international medical graduates to come into. However, if those graduates continue to have a determination, as I hope that they will, to live and work in the UK—I want that to be in Scotland, but it could be other parts of the UK—they might have to choose other specialties to practise.

Emma Harper: We talked about ScotGEM. Specialty training means that a GP could spend part of their time in a GP practice and part as a diabetes or rheumatoid specialist or something like that. Does the bill enable the continuation of

supporting rural practice by allowing doctors to split their time between in-hospital specialties, following training, and a GP practice?

Neil Gray: I will bring in Ms Gibbons in a second on the dynamic that is at play and the impact that the bill will have on the ability to have a mixture of practice and to diversify. In rural communities such as the one that Ms Harper is from and the one that I am originally from, it is incredibly important to have medical professionals with diversity in their practice. We understand the need for rural practitioners, whether they be medical practitioners or part of the wider multidisciplinary team, to have diversity in their portfolios. They need to be able to deliver a wider variety of services. I have seen evidence of that in my visits to rural and island communities where, because of capacity and what needs to be responded to, people are stepping into areas of specialism that would be delivered by specialists in the central belt.

It is important for us to consider the crux of the point that you are making and I will bring in Ms Gibbons to talk about the dynamic in the context of the bill.

11:15

Lucy Gibbons (Scottish Government): The bill will not affect the curriculum or the way in which people undertake training in general practice or any other specialty, which will remain the same, but it will affect their eligibility to be prioritised at the point of initial application.

Carol Mochan (South Scotland) (Lab): I am interested in the international medical graduates and how we are going to manage. You outlined that in your opening speech so, to follow up, I wondered whether we know how many locum appointments for training—I think that they call them LATs—and clinical fellow posts in Scotland are filled by international medical graduates. Was that group considered when you looked at how to implement the legislation?

Neil Gray: I will need to write to the committee to give numbers, but I understand Ms Mochan's point about the wider impact that international medical graduates have across the whole system, which is why I talk about the importance that I place on us being a welcoming nation not just to international medical graduates but international workers in our health and social care system in general. Ms Mochan and I have corresponded on that on a number of occasions. I will write back to the committee with the numbers that Ms Mochan is asking for, because I do not have them to hand.

Carol Mochan: Thank you. I think that you have addressed my next point. I know that we both think about making sure that Scotland continues to be an inclusive workplace for our international students, that we value them and that the bill continues to mean that we are fair and consistent in our approach. I do not know whether you want to add anything to what you said in your opening statement.

Neil Gray: I very much share the concern that Ms Mochan puts on the record, which is why the Scottish Government is content with this approach as opposed to others that we discussed with the UK Government before this legislation was mooted. In my view, it achieves the inclusive and welcoming approach that we want to take and the legal and workable element that I mentioned in my opening remarks. From our perspective, the UK Government's previous attempts to address the issue, which we heard about in our private discussions with it, did not pass that test. We are now in a much better place with the bill.

Carol Mochan: That is great. I have one last wee question. A couple of people have raised the issue of Ukrainian doctors. Have we got Ukrainian doctors working here, and is it easy enough for them to be part of the system?

Neil Gray: Ms Mochan will recognise my ministerial background in that regard and my determination to do all that we can to ensure that we support displaced Ukrainians in the health and social care system and those who bring with them skills and qualifications that are much in demand across the public sector and wider economy. Discussions continue to be had about the sharing of qualifications and qualifications standards. I will need to provide Ms Mochan with the status of that. Because it is to do with regulation, some of it lies outwith our control here in Scotland.

In principle, I will say now what I have been saying for four years: we expect our Ukrainians who have been displaced to be able to work to their qualifications, because we need their skills and experience, and we can offer them an opportunity to rebuild their lives here in Scotland. I care deeply about that, and I will make sure that I provide a more formal update to the committee on the progress of those discussions.

Gillian Mackay: Other committee members have covered most of the issues that I wanted to cover. Others have mentioned concerns relating to the need for international medical graduates, because they go into specialties that are not usually preferred by UK graduates. The British Association of Physicians of Indian Origin has raised concerns about the potential limitations for career development. What equality monitoring is the Government planning to undertake to detect any adverse consequences that the bill might have for international medical graduates working in the NHS in Scotland?

Neil Gray: Such monitoring is carried out routinely through discussions among the four nations on the recruitment that is required. Given that I will be writing to the committee in response to Ms Mochan's questions, I am happy to add a paragraph to provide the assurances that Ms Mackay is looking for.

Gillian Mackay: Beyond the bill, what can be done to ensure that international graduates feel welcome here? There has been a lot of anti-migrant rhetoric across the UK recently, and the bill could be seen as adding to the idea of not wanting people to come to this country to work. I appreciate from what the cabinet secretary has said that that is very much not the Scottish Government's position, so what softer measures can it put in place to ensure that international medical graduates are aware that they are still welcome and that the bill should not put them off coming to Scotland?

Neil Gray: I very much recognise Ms Mackay's concern. We wanted to ensure that the proposals were workable and legal and would not have an unfair detrimental effect on international medical graduates. That was our first point, and we fiercely guarded that principle. To be fair, other devolved Governments were in a similar position in wanting to ensure that that basic principle was adhered to.

The second point is about the culture and rhetoric in Scotland. We have heard from committee members that there is a welcome consensus on the need for us to recruit internationally and the value that we place on our international medical graduates. It is to our credit that that position has been expressed on a cross-party basis in the committee. I hope that that view will extend to the wider body politic and that our political discourse can return to one in which greater dignity is shown to our migrant workers in Scotland than has been shown of late, as Ms Mackay referenced.

Gillian Mackay: Thank you.

The Convener: A number of clauses in the bill confer powers on UK ministers that might be exercised in areas of devolved competence. Will you expand on how the regulation-making powers that are set out in the bill were decided? To what extent does the approach respect the devolution settlement?

Neil Gray: I will bring in Ms Gibbons in a second to provide a bit more detail. In our negotiations, we secured a number of conditions, including Scottish ministerial consent, that will ensure that the devolution settlement is respected. For all the reasons that I set out in my opening statement, we recognise that operating on a four-nations basis on the issue is advantageous to us, because that will avoid unintended consequences and detriment to the Scottish system. I ask Ms Gibbons to provide additional information on how that was achieved.

Lucy Gibbons: The committee might wish to refer to the recent letter that Mr Gray sent to the Delegated Powers and Law Reform Committee, which details the four powers in the bill. Three of them are treated in the same way—that relates to the consent element to which Mr Gray referred. There is also an option for those powers to be concurrent, so Scottish ministers could exercise them by themselves if they wished to do so. The final power is slightly different and reflects the UK Government's international trade obligations. In certain circumstances, that is a reserved power, so our involvement would not be required.

The Convener: I thank the cabinet secretary and his officials for their attendance.

Petitions

Women's Health Services (Caithness and Sutherland) (PE1924)

Access to ADHD Diagnosis and Treatment (PE2156)

11:25

The Convener: The fourth item on our agenda is consideration of two public petitions that have been referred to this committee: PE1924, which calls for an emergency in-depth review of women's health services in Caithness and Sutherland, and PE2156, which calls for access to diagnosis and treatment for attention deficit hyperactivity disorder to be improved.

The Citizen Participation and Public Petitions Committee referred PE1924 to this committee on 15 June 2022, in the context of the committee's wider consideration of health inequalities. It referred PE2156 to this committee on 18 June 2025, and the committee agreed to consider that petition as part of its inquiry into ADHD and autism pathways and support. The committee completed that inquiry by publishing a report on 2 February 2026. We will address each of the petitions in turn.

How do members wish to proceed in relation to PE1924?

Brian Whittle: This petition is of considerable importance. Given that we do not have time to go into it in the depth that it requires, I think that it should be carried forward into the next session.

Gillian Mackay: This petition should be left open, with something put into our legacy document about how the next committee could take it forward. I do not think that the issue that it concerns has concluded yet, and a new iteration of this committee should definitely look at it.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

We should keep this petition open as we certainly do not have time to do justice to it. I agree with Gillian Mackay that we should put it into our legacy report, but my feeling is that we should ask for the issue to be considered in a wider context than just Caithness and Sutherland.

Emma Harper: In my work, I have been involved quite heavily with the Galloway community hospital action group, looking at maternity services in the south-west of Scotland—that links with a previous petition about maternity services in Caithness. I know that a Scottish maternity and neonatal task force has been created to consider maternity issues overall, so I would be happy to keep the petition open and mention it in the legacy report, because there is on-going work concerning maternity services, especially in rural areas.

Carol Mochan: I agree with what has been said. Members have made good points about the work that is going on in relation to the issue that the petition concerns. It is important to make our successor committee aware of the petition, so we should include it in our legacy report.

The Convener: Does the committee agree with those recommendations?

Members *indicated agreement*.

The Convener: How do members wish to proceed in relation to PE2156?

Gillian Mackay: Given that the committee has concluded a large piece of work on this topic, I would be content to close the petition. However, as there is on-going work in relation to the issue that the petition concerns, we could recommend in our legacy report that, a couple of years into the next session of Parliament, the issue should be looked at again to consider whether any further improvements need to be made.

Emma Harper: I agree with Gillian Mackay. We have done a substantial bit of work, but because of the significant delays in assessment and diagnosis that we uncovered, which we addressed in our report, we need to keep an eye on progress.

Brian Whittle: As others have said, we have done a significant amount of work on this topic and have produced a report addressing the issues. We should close the petition, but we know that the issue will be raised again in the next session of Parliament.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I agree with my colleagues. We have fulfilled the petitioner's request to look into the issue in depth. Given what is contained in the petition about the lack of a diagnosis and the consequences that that can have on somebody's life, the next committee should have an on-going look at the issue. However, as I say, we have fulfilled the petitioner's request.

The Convener: Do we agree to close the petition, and to mention the committee's work on the issue in our legacy report?

Members *indicated agreement*.

The Convener: At our next meeting, we will undertake periodic scrutiny of the work of Food Standards Scotland and the now-finalised national good food nation plan. That concludes the public part of our meeting.

11:31

Meeting continued in private until 12:02.

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