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Health, Care and Sport Committee

Comataidh na Slàinte, Cùram agus Spòrs

Wednesday 2 September 2026

Session 7

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 2 September 2026

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HEALTH, CARE AND SPORT COMMITTEE
2nd Meeting 2026, Session 7

CONVENER

*Helen McDade (Mid Scotland and Fife) (Reform)

DEPUTY CONVENER

*Jack Middleton (Aberdeen Central) (SNP)

COMMITTEE MEMBERS

*Heather Anderson (Dundee City West) (SNP)
*Adam Harley (Strathkelvin and Bearsden) (LD)
*Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green)
*Joe Long (Mid Scotland and Fife) (Lab)
*Paul McLennan (East Lothian Coast and Lammermuirs) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Glenn Carter (Royal College of Speech and Language Therapists)
Caroline Hiscox (NHS Scotland Executive Group)
Paul Johnston (Public Health Scotland)
Kirstin Laing (Chronic Pain Group)
Lilian Macer (Unison)
Stuart McIver (Long Covid Scotland)
Eileen McKenna (Royal College of Nursing Scotland)
Dr Nóra Murray-Cavanagh (British Medical Association)
Jane Ormerod (Long Covid Scotland)
Sara Redmond (Health and Social Care Alliance Scotland)
Professor Sir Gregor Smith (Scottish Government)
Kenny Stewart (Scottish Action for Mental Health)
Janet Sylvester (#MEAction Scotland)
Charlotte Waite (British Dental Association Scotland)
Alison White (Health and Social Care Scotland)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health, Care and Sport Committee

Wednesday 2 September 2026

[The Convener opened the meeting at 09:02]

Key Issues in the Health Sector

The Convener (Helen McDade): Good morning and welcome to the second meeting of the Health, Care and Sport Committee in session 7. This is our first meeting after summer recess. I welcome our witnesses—thank you very much for coming. We look forward to hearing what you have to say. It is a very interesting time to hold this discussion.

We are joined by Alison White, chair of the chief officer group, Health and Social Care Scotland; Caroline Hiscox, chief executive of NHS Lothian and chair of the NHS Scotland executive group; Professor Sir Gregor Smith, chief medical officer, Scottish Government; and Paul Johnston, chief executive, Public Health Scotland. We are very pleased that you could all join us.

We are short of time, so we have asked you not to make opening statements. Most of you have sent us detailed background information. There is a lot to get through. We hope that our questions will allow you to tell us anything that you think we need to hear; if not, you can always write to the committee subsequent to the meeting.

Adam Harley (Strathkelvin and Bearsden) (LD): Thank you all for coming today. Ms White, we hear a lot about the impact of delayed discharge on our national health service, and we often hear about issues concerning care packages and communities. What needs to be done during this parliamentary session to begin really tackling the issues around delayed discharge and care packages?

Alison White (Health and Social Care Scotland): I suppose that it is about remembering that delayed discharge is one part of a much wider system, so we must ensure that we continue to work as a whole system. The number of people who are in delayed discharge is a small proportion of the total number of people to whom we deliver care at home or within the community, but the timing of that provision and the impact of how we do that matter.

There needs to be a real focus on social care in general. That was mentioned in the programme for government yesterday, which includes a commitment to a real redesign of social care and to considering what needs to happen. However, social care has been something of a Cinderella service for a long time. There has been a focus on small areas, but if we are to fix delayed discharge, we must address the wider problems, which often relate to staffing, pay equity and how we view people who deliver care compared with NHS staff. We need a much broader conversation about the importance of social care. We need to consider how we integrate services and ensure that we have good resources in our community in order to keep people safe and well in that environment.

Adam Harley: You mentioned the need to take an umbrella approach. What are the specific barriers to doing that? Issues have been ongoing for quite a long time. What specific measures do you want to be taken during this parliamentary session? What questions should the committee ask?

Alison White: A lot of it comes down to finance, and some of that relates to salaries. Although there is a commitment to ensure that front-line care staff are paid the real living wage, salaries remain significantly lower than those in the NHS and social work, for example. As a result, given the nature of the work, such positions are not always attractive to people. Someone can work in a supermarket for a similar salary but have a very different way of life.

Also, that level of investment in social care means that many integration joint boards and health and social care partnerships have to make decisions that reduce services and cap the level of care that they deliver because of the cost pressures and the scale of the financial challenge that they face. We are experiencing really significant pressures. Reserves have been depleted across all the IJBs. There really needs to be investment in social care, not just a conversation about social care. There must be investment in salaries, because that will attract carers into those roles. However, investment is also needed to enable us to design and redesign social care services properly and provide the right level of care and support in our communities.

Adam Harley: I have a final point. Crucially, part of the public sector reform agenda must be about investing in services, not stripping them back; it cannot only be about restructuring.

Alison White: I am not saying that redesign is not an important part of getting the best out of reform, but there are increasing demands due to demographic pressures and growing complexity. We are supporting people in the community who, at one time, would have been cared for only in healthcare settings. That means that we need a different conversation and a different level of investment.

The Convener: Joe Long has a follow-up question on social care.

Joe Long (Mid Scotland and Fife) (Lab): I note that my entry in the register of members' interests states that I was director of a third sector social care provider until 8 May.

I am very interested in the relationship between the health service and the social care sector, their interdependencies and how that relationship functions. One criticism of integration joint boards is that they are not always partnerships of equals between health and social care, and that they do not always function effectively. Given that, in his speech yesterday, the First Minister opened up the possibility of looking again at that relationship, I am interested in hearing witnesses' views on what would make a good and functional relationship, particularly in relation to social care, given the earlier discussion about its status.

Alison White: In my current role, I represent one of the interfaces between health and care, and I think that it often comes down to relationships, which can vary across the country. That is where you can end up with challenges. I recognise the point that it is perhaps not a relationship of equals. That extends to our relationships with the third sector and the independent sector, which deliver large amounts of care and support in our communities. We need to find a different way of balancing those relationships.

The governance arrangements make it complex. There is no lack of willingness to work together, and we often see a real commitment from our front-line staff and third sector providers to doing things differently. However, a really complex governance system has been created, which can, at times, create barriers to change at the pace that we would like. Also, because of the scale of the financial challenges that have been experienced across the sector, people can become very protective of their area of work rather than seeking to find new solutions, even if that might mean losing something. It is not only about giving the space and the commitment to make change but about finding a way for there to be less complex governance, which would allow some of those relationships to change.

Heather Anderson (Dundee City West) (SNP): I have three questions. First, could you say a bit more about how the current governance arrangements are restrictive and how you would recommend changing them? Secondly, could you speak about recruitment problems in the sector and the role of visas? Thirdly, how do we strengthen social care and prevention so that the focus is not only on supporting people when they come out of hospital but on preventing them from going into hospital in the first place?

Alison White: On what would help in relation to governance, part of the challenge is that many parts of the sector do not understand the governance, and that is where the challenges arise. As chief officers, we are familiar with working within those arrangements and understand the routes that we need to take to make things happen. However, it is complicated. When we try to explain the governance to others, we often get asked why it has been set up in that way.

People who are slightly more on the periphery of IJBs do not understand the governance processes. As a result, when we are asked questions or asked to do something, it can feel as though we are being a block or a barrier as we explain the process that needs to be undertaken. Therefore, part of the answer may simply be to broaden understanding of what IJBs are and what they can do.

The health and social care partnership element works well: staff work really well together and find solutions. However, I might find myself needing to go through the governance processes of the IJB, the council and the NHS, which can add additional steps and barriers.

On staffing and visas, there is a mixed picture across the country. I am in a fortunate position in that, at this time—I am now touching wood—we seem to have a good number of care staff, which allows us to create a level of flow. However, some of our local providers have relied heavily on the worker visa scheme, which might create a real risk as the rules change. It is certainly on our risk register as a threat. If foreign nationals choose to return home as the scheme changes, we are really worried about what that will mean for our care sector and our ability to deliver services, and also about what it will mean for unmet need in our communities. We might manage to continue providing care to those who already receive it, but others might face longer waits.

The position is very different across different parts of the country. Particularly in some of our rural and remote areas, there is a need to consider very different ways of working, including the use of technology and artificial intelligence, how we can recruit carers in different ways, and the use of direct payments, which can enable people to recruit their own carers. We are exploring all those options, but it is really challenging.

Social care has always had a role in prevention. However, when it comes to some of the cuts that we have needed to make over recent times because of financial pressures, the preventative element of social care is often the bit that goes. We all know that is where our focus should be but the prevention element often goes because the impact of that cut is not felt today but is felt in the future.

Social care, along with our health colleagues, has a critical role in delivering against social

isolation and in improving people's wellbeing and ensuring that they are engaged with their communities. We have a critical role to play in that.

The Convener: Thank you very much, Ms White. I think that other panellists might want to come in.

Paul Johnston (Public Health Scotland): Thank you for the opportunity to comment, convener. I also thank everyone on the committee for giving me the opportunity today to provide a Public Health Scotland perspective.

I strongly endorse the point that social care plays a vital role in preventing ill health and in enabling people to live good, independent lives for longer.

As I reviewed the papers that the committee has in front of it today, I noted that the centrality of prevention is a theme that runs through almost every submission. I know that the committee is taking evidence broadly, but I suggest that you dig into that theme in much more depth. I hope that the committee will be able to do that, because it is so important that we are specific about what we mean by a shift to prevention. We all recognise that such a shift is necessary, but we need to look at what that looks like in the NHS, where a lot of important preventative work is being done, what it looks like in social care and what partnerships must do to deepen their focus on prevention.

09:15

From our perspective, we think that the population health framework, which was again endorsed in the programme for government that was outlined yesterday, points to a range of specific actions that must be taken in this parliamentary session to shift our focus to prevention, including actions in relation to how we spend our money, how we hold our systems to account and much more. That is a theme that the committee could go into in more detail.

The Convener: Thank you. We will come back to that with other members of the panel. I think that Ms Hiscox has something to contribute on that point.

Caroline Hiscox (NHS Scotland Executive Group): Thank you for giving me the opportunity to present to—and, I hope, take part in a dialogue with—the committee.

As a health board chief executive and someone who, as you will have seen from my brief, holds the privileged position of chairing Scotland's NHS boards chief execs group, I fully endorse Alison White's description of the importance of social care and, indeed, integration. In saying that, I am referring not to the bureaucracy and the governance of integration but to the intention of integration and the interdependence not only of our social care colleagues but of communities themselves, the public sector more generally and third sector and charitable partners.

Mr Harley asked what specific issues we would like Parliament to address. I absolutely agree with what Alison White and Paul Johnston said about prevention, but prevention and improving population health somehow need to become the organising principle for how we do our governance and how committees conduct their scrutiny. Despite its best endeavours, the NHS cannot treat the country out of inequalities. We need to take a fundamentally different approach.

What we heard yesterday about that was really encouraging, but we need to take the opportunity to look at the funding model—not so much the amount of funding, but how it comes to us. I have mentioned the organising principle; we need to lean much further into an integration focus. We know from the evidence base that the strongest opportunity for us to have a healthy population is to grow that from communities up rather than from the NHS down. That must be the intention over the next five years.

The Convener: That leads us on to subnational planning, which Paul McLennan will ask about.

Paul McLennan (East Lothian Coast and Lammermuirs) (SNP): Thank you for your submission, Caroline. On the back of yesterday's announcement, I would like to ask about the impact of subnational planning. You have been moving towards regionalisation. In your submission, you said:

> "This collaborative work demonstrates that working at scale enables better use of resources, improved consistency, greater overall system impact and better value for the public purse."

Could you say a bit more about that? You mentioned that the planned care funding requirement has dropped from £61 million to £52.4 million and that planned activity has increased from 31,000 procedures to 39,000 procedures. If we move to having only two health boards, what lessons can we draw from the subnational planning work? For me, that is the key question.

Caroline Hiscox: NHS Scotland has always endeavoured to work collaboratively, but, as Alison White said, the fact that we are organised in such a way that we have 14 territorial boards—that is to say, 14 independent statutory bodies—as well as our national boards and the 31 integration joint boards, makes that difficult from the point of view of accountability flows and financial flows.

As I said, we endeavour to work collaboratively. We are particularly good at that when particular

areas are going through a short-term crisis. We are able to move people and colleagues to provide treatment.

The director's letter at the tail end of 2025 required us to build on that and start planning at a population level. That meant starting to think about how we would design our services and plan differently if we looked at things from the perspective not just of my geographical area but of east and west and, predominantly, of Scotland as a whole. That applies to everything from highly specialist tertiary services—the things that we need do only once, such as liver transplants—right down to the services that we should absolutely be delivering as close to people's homes as possible. That allowed us to think in a fundamentally different way. We used planned care—for our citizens who are having to wait more than 52 weeks—as a test for that, as well orthopaedics, the flow model that was published recently and the implementation of the MyCare.scot app.

Those are the elements that we focused on. We learned that there is an absolute willingness and determination to collaborate, and that there are definitely inequities with regard to capacity, workforce availability and funding. There is an interesting funding split between the east and the west in relation to the NHS Scotland national resource allocation committee formula. We have learned a lot about some of the constraints, but we have also learned about the opportunities, so that we can ensure that, as well as thinking about inner-city Edinburgh, we are planning for our most rural geographies and islands.

You quoted my submission. That relates to my point that the issue is not so much how much funding we receive as how we receive it. Every year, we rely on non-recurring funding to prop up our core planned care activity, predominantly surgery, although it supports other services as well. That does not allow us to appoint substantive full-time staff. Instead, we rely heavily on the independent sector and on locums, agency staff and others.

The usual practice is for each board to provide trajectories setting out what it will deliver over the year with the funding that is available. That work has enabled us to use the subnational structures to scrutinise performance and share best practice. In turn, that has allowed us to reduce the funding ask by the amounts that you quoted and to improve performance.

Moving to two subnational strategic health boards will allow us to think much more strategically as a country about the population's needs, ensure that we are addressing all of the population's needs, with a big focus on prevention, population health and addressing equality of access and outcomes—rather than sitting in NHS Lothian and thinking, "Actually, I don't have that much of a workforce problem in comparison with my colleagues in NHS Grampian, who have a significantly different situation." This approach provides much more flexibility and ensures that resources go to the right place for the population.

Paul McLennan: May I ask a quick supplementary question?

The Convener: Yes, but we all need to keep our questions and answers short.

Paul McLennan: Yes. Paul Johnston mentioned prevention, which is mentioned in all the submissions. What are the benefits of the subnational approach in relation to prevention? You touched on that in relation to where we go with the prevention agenda.

Caroline Hiscox: We as a delivery function have absolutely struggled to enact policy intent over the past 15 years, and we are now seeing the impact of that on our population's health. The benefit of the subnational approach is that, with improved governance and accountability and improved financial flows, the absolute intention would be to invest pre-emptively in prevention in a much more intentional way than we have been able to. At the moment, we are trying to do the transformation work and to balance 14 sets of annual accounts every year. If that work is reduced, we will have much more flexibility with regard to the money and we will be able to be much more intentional, not just on prevention but with regard to the funding that is required to support social care and primary and community services in a different way.

The Convener: I will follow up on that. First, you have taken an east and west approach. Do you think that that will probably be the model that will be used? I have heard that there can be problems with that. I point to the fact that Inverness is included in the west, which is a bit of an odd way to divide the map of Scotland, and that Aberdeen, which actually is in the east, is included in the east. Anybody who comes from those areas—I come from the north—knows that Inverness and Aberdeen are in the north and that the north is quite different from the central belt.

I have been told by senior doctors that there have been problems because of that arrangement. If the system of two health boards goes ahead, how will it address that issue?

Caroline Hiscox: Fortunately, I was the nurse director and the chief executive of NHS Grampian for a number of years, as well as having roles in NHS Tayside and now in NHS Lothian. I have lived experience of the challenges in the north, because

we worked closely with NHS Highland and with the islands.

In relation to my responsibilities for east and west planning, I have been incredibly conscious of the reality of, and perceptions of, centralisation. As to my previous response, the responsibility for planning has required me, as a leader, and chief executives from across Scotland not to take the easy option of thinking only about our own geographical patches.

There will always be risks and opportunities whichever way the system is divided up, whether that is by dividing healthcare and social care or by having territorial boards. We have to focus on intent, principles, trust, relationships and governance. If we can be clear about the intention that one outcome must be that there is parity of access for communities in the north of Scotland, we will be held to account for that.

As I said, I worked in the north for a number of years. There were previously three regions—north, east and west—and one challenge was that the north region definitely toiled for both workforce and financial resources, as well as dealing with the significance of rural geography.

As I said, there will always be risks and opportunities but, because of the planning that we have done and what we have learned from subnational work, I see the opportunity to provide equity of access and outcomes for the north as being at the root of what we are focusing on.

The Convener: Could we get more detail on that in writing?

Caroline Hiscox: Yes.

The Convener: The north has many problems with access.

Professor Smith, you advise the Government in general and have an overview. Would you like to comment?

Professor Sir Gregor Smith (Scottish Government): One really important aspect of what we are seeing as our healthcare system comes together is the ability to ensure not only that clinical care pathways are of high quality and safe but that they are resilient. We can take examples from how countries of a comparable size have begun to reform their healthcare systems—Denmark is the prime example.

Over the past year, the east and west partnerships have begun to use data much more strongly to get a sense of the outcomes that they are achieving for the population and to decide how best they can improve those outcomes. Certain types of clinical care, particularly in the planned care pathway, can be done at local level—I would call that general specialty care. Beyond that, there are far more specialist types of care—Ms Hiscox mentioned the example of liver transplants and there are many more, including some types of cancer care—that are done much better in consolidated centres with a volume of clinicians and a volume of cases annually that ensure that care is maximised.

The new approach to planning that has been introduced gives us the best opportunity to provide care to the population of Scotland in that way and to ensure that we improve outcomes, particularly in some difficult clinical specialty areas where there has been fragility in the services provided or where there has been a variation in outcomes across the country.

The Convener: Do any other witnesses want to come in?

09:30

Paul Johnston: Mr McLennan asked how subnational arrangements might support the shift to prevention that we have discussed. Much preventative activity is local, but there are enormous opportunities in the regional arrangements to learn from other areas and to scale up good practice. Vaccination and screening provide an example of an essential preventative intervention where rates vary from area to area. Similarly, pathways around tackling obesity and weight management can differ from area to area, and the same is true with regard to smoking cessation and drug and alcohol harm. Those are four areas that I hope that the committee will focus on as areas where an enormous amount of ill health can be prevented through scaling up our interventions.

Whatever structural changes we look at in this parliamentary session, it is vital that we bake in an enhanced focus on preventing harm through tried and tested interventions, such as vaccination and screening, and perhaps through ones that are still emerging, such as the weight management pathways that are available.

Professor Smith: It has been reassuring to hear so much discussion and questioning about prevention. It is critically important that we get out of the repair shop mentality that has developed around the healthcare system and make sure that we are focused on preventing ill health and maintaining good health for the future.

I want to make it clear that the health and social care system can go only so far by itself. Although it can do a significant amount of good in preventing ill health and maintaining good health in the population, it is really important that we focus, particularly through the population health framework that has been developed, on the cross-Government and cross-society responses that will

lead to good health or better health for the population of Scotland.

Healthcare will always shoulder its share of the burden in trying to improve health and pivoting towards prevention—Paul Johnston mentioned some of the key areas in which I would like to see that happen. However, the only way we are going to address some of the intractable inequalities that we have in our communities—remember that the issue is not just about the place where you live; it can be about the characteristics that you carry—is through a cross-Government and cross-sector response.

The Convener: Before we move on to another subject, does Heather Anderson want to come in again briefly?

Heather Anderson: I want to come in on loads of this.

The Convener: Restrain yourself.

Heather Anderson: First, I really appreciate the comments about specialist surgical interventions. People should go to the surgeon who is the best at a certain procedure, not to someone who has done that operation only twice.

I was interested in what all of you said about population-based planning, and I have two questions on that. All the submissions talk about a workforce plan. Will moving to the two subnational areas assist with workforce planning across the whole national health service and not just in specific specialties?

I also want to ask Mr Johnston and Sir Gregor Smith about the role of prevention. As a councillor—which I am this year, at the same time as being an MSP—I deal constantly with statutory services and discretionary services. Unfortunately, prevention is discretionary. What are your views about protecting funding for prevention? At the moment, as Alison White said, prevention is always the first area to be threatened. In Dundee, we were giving small sums of money to community groups that were keeping people going and preventing suicides and loneliness. The sums of money involved were tiny but, when the budget is tight, that is the area that is cut. What are your views on how we protect what we know is vital work and not let it be cut?

The Convener: I ask for a brief answer, so that we can move on to other topics.

Paul Johnston: I am happy to come in on prevention. I direct the committee again to the population health framework actions, which are exactly on point with regard to what you say. In particular, the very first action in that framework is about developing new approaches to resource allocation to support prevention across health and other public services. That recognises the risk that preventative interventions can be cut and points to the need for work that ensures that prevention expenditure is protected and that there is accountability for what is being spent in that space. It was encouraging to see that the programme for government has specific proposals to take forward that work in the period ahead.

The Convener: Thank you. Time is pressing, so we will move on. Kayleigh, I think that you want to ask a couple of questions.

Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green): Yes.

The Convener: Please say who you are directing them to.

Kayleigh Kinross-O'Neill: Yes, of course.

I thank you all for coming. It is nice to sit with you. I have a question on performance on mental health and neurodiversity in the context of yesterday's publication of the programme for government. Ms Hiscox, I do not remember reading much in the PFG about child and adolescent mental health services and the work that needs to happen there. What are your thoughts on how the Scottish Government is addressing children and young people's mental health? Was what we heard from the First Minister specific enough on tackling that issue? Do you have any other concerns?

Caroline Hiscox: I am not surprised that you have asked that question, and I welcome it. I will speak more broadly about mental health and then specifically about child and adolescent mental health services and our neurodevelopmental support for adults and children.

We are not where we would like to be for citizens and families who are experiencing such issues or for colleagues who work in those services. We have already spoken about inequality, the impact of poverty and parity. The board chief executives have been working on parity to give mental ill health the same focus and attention as we give to physical ill health. It is interesting that we group all of mental health under one heading, yet we have already spoken about several different physical ill-health presentations.

There is something really important about the attention that we pay to the increasing demand on our mental ill-health services. For me, there is a huge opportunity for us to genuinely work with the population on a whole-system basis, from communities and community planning partnerships to the police, the third sector and charitable organisations. There is a huge opportunity, particularly in education in relation to CAMHS.

In relation to the mental health space specifically, as chief executives, we have done a number of deep dives into that. Although it was not mentioned in the programme for government, it is most definitely the subject of a very live conversation with Scottish Government civil servants, advisers and ministers for us as chief execs and indeed for chief officers.

Most mental health and adult neurodevelopmental services are delegated to health and social care partnerships. Paediatrics tends to remain with health boards, although not in the west, interestingly. We know that there is rising mental health demand across Scotland. We want to focus on prevention, and that is what we are looking at. I have spoken about our neurodevelopmental services not being where they need to be.

Kayleigh Kinross-O'Neill: It will not surprise you that my next question is about autism and attention deficit hyperactivity disorder. I have written to you about a concern that is raised in everyone's inboxes, which is about the waiting times for ADHD assessment and the number of people who do not feel that they can wait so long and go into shared care agreements, which are a controversial subject. What are your thoughts on how we navigate that?

Caroline Hiscox: Again, I welcome the question and the scrutiny, because it will help us to be focused on the matter. I will speak specifically from a Lothian perspective. As I said—you will know this well—our adult neurodevelopmental services are delegated to the partnerships, but the NHS has a fundamental role.

You are absolutely right about the size, scale and length of the waiting list. In June 2026, we had more than 12,800 adults waiting for a neurodevelopmental assessment. Some of them are waiting for initial diagnosis, some are waiting for titration of their treatment and others are waiting for a review. I am happy to have a further conversation about that as I am conscious of time. I can give my position on it from a Lothian perspective. We have commenced a programme of improvement with our chief officers, but equally with our local authority colleagues, because we are not going to resolve this as the NHS alone—there are multiple opportunities for alternative treatments.

One of the key issues that we need to get past is the need for a diagnosis to access support. That is a big focus. The other piece is about shared care. You are right about the challenging situation for individuals who have a diagnosis and require that treatment. We are working closely with our primary care and specialist colleagues. I am happy to update you further, specifically on NHS Lothian, but that focus is absolutely shared across Scotland.

The Convener: Thank you.

Professor Smith, we are short of time and we have a couple of questions on other subjects, but you can give us a quick comment.

Professor Smith: I just want to say that the adoption of and commitment to implementing the Royal College of Psychiatrists route map for the four-level national model is really important in that context. I expect the route map to be published shortly.

Kayleigh Kinross-O'Neill: Thank you—I will look at that.

The Convener: Thank you very much, Professor Smith. We welcome further information on that when it comes forward.

We will move on, as we have not many minutes left. Jack, do you have a specific question to ask?

Jack Middleton (Aberdeen Central) (SNP): I do—thanks, convener.

Mr Johnston, thanks for being here today. I would like to explore issues you have raised to do with health inequalities, specifically in relation to alcohol harm. Your submission to the committee laid out in pretty stark terms that the health risks associated with alcohol cost the Scottish economy £10 billion a year. That far outstrips the cost associated with illegal drugs health risks, which is at £3.5 billion. Statistics published yesterday by Public Health Scotland show that the number of deaths that were partially attributable to alcohol dropped by 12 per cent between 2023 and 2024. However, what really stood out for me was the disproportionate effect that alcohol has on working-class men. Men were 40 per cent more likely to be hospitalised for alcohol harm and 56 per cent more likely to die from alcohol-related conditions. Those in the most deprived communities were almost three times more likely to die from alcohol-related conditions.

Is that glaring inequality recognised at a level that Public Health Scotland finds satisfactory? What work, if any, is specifically under way on that issue?

Paul Johnston: Thanks very much for the question. Our submission to the committee sets out five key asks, a number of which we have touched on today. Those are five areas where we, as Public Health Scotland, believe that Parliament could make a significant difference.

One of those asks is around the reduction of drug and alcohol deaths through a national approach. I am glad you have drawn attention to the figures that have been published most recently

and to the cost of both alcohol and drug harm. As you say, the figures in relation to alcohol harm are stark.

The international evidence is clear about what needs to be done to tackle alcohol harm and the glaring inequalities that are associated with it. That includes taking action on price, availability and affordability, alongside offering good treatment options. However, some of those actions on price, availability and affordability are in the prevention space, which we have already referred to.

In recent years, Public Health Scotland has conducted a significant review of the impact of minimum pricing for alcohol. I am sure that the committee will return to that topic in the years ahead, and I would be delighted, along with my expert colleagues, to present on that in further detail. We are clear that the evidence shows that that is one example of a policy that has had a material impact on reducing harm.

We have also been clear that no one policy on its own will deal with the severity of the issue that you have set out, and that is shown in those statistics. We must ensure that there is a co-ordinated approach to tackling the root causes of alcohol harm. Consistent with what others on the panel have said, our belief is that there is a role for the NHS, but it goes well beyond the NHS. It is vital that there is a focus on prevention, starting in our communities. There is also a role for Parliament in terms of national action, and there is absolutely a role for the NHS in taking forward action.

Jack Middleton: I will come back to those points in a minute, but I am after a specific point of clarity for the committee, given that this is our initial scoping session. The statistics I referred to were specifically on alcohol, but in your contributions you have referred to alcohol and drug deaths, and so did your submission and the Scottish Government's strategic plan. Why is that? Has it always been the case that they are referred to together? Would it be helpful to separate alcohol deaths and drugs deaths and communicate on them as two separate issues?

09:45

Paul Johnston: That issue has attracted a lot of discussion. In the previous parliamentary session, the Government's strategy on drug deaths attracted criticism for being focused on drugs alone and not on alcohol. I was part of many discussions during that period in which a range of parties were urging for a co-ordinated approach to be taken to the harms that are associated with drugs and alcohol.

As you said, the new Government strategy focuses on both and, to be honest, there are arguments for and against that. A similar approach applies to both drugs and alcohol in some areas of prevention and harm reduction, but different approaches are needed in other areas. Some of the actions around drugs are very particular to drugs, and some of the actions around alcohol as a legal product are different. That is perhaps worth exploring in further detail.

Jack Middleton: I read in the alcohol and drugs strategic plan that a specific alcohol harm prevention plan was on its way. It was not in the programme for government that was published yesterday, but I am sure that details will be forthcoming—the committee might want to ask the minister about it when she meets us. Do we need to look specifically at the points that I have raised about inequality in relation to the impact that alcohol has on working-class men? Does part of the prevention plan that you talked about involve a grown-up conversation about trusting people to take responsible choices in everyday settings rather than leaning specifically on alcohol minimum unit pricing alone?

Paul Johnston: You have raised important issues. As you drill into the data on inequalities, you will find that, in many settings, it is people in the poorest areas, and it is often men, who experience incredibly poor health outcomes and very low levels of healthy life expectancy. All the points that you have raised merit much further scrutiny.

I reiterate that we in Public Health Scotland believe that minimum unit pricing is one important tool in the toolkit but that we need to draw on a wide range of other tools in order to address the harms from alcohol and the sharp inequalities in relation to those people who are experiencing the greatest harm.

The Convener: In the few minutes that we have left, I would like to address issues in relation to ill health. We have heard a lot about, and received many submissions about, prevention, so it obviously will get a lot of discussion but, while we have the witnesses here, I would like to ask two things—to Caroline Hiscox, in the first instance.

The first is about long-term conditions, of which there are a lot. There is a long-term conditions framework, and 100,000 people live with either myalgic encephalomyelitis or long Covid in Scotland—that is a lot of people, who are getting very little help.

I would love to see some people preventing things that are not being prevented and that are not related to people changing their lifestyle. It is great to talk about and try to bring in prevention, but that will take 20 to 30 years; in the meantime, we have people—a lot of them of working age—who are costing the country billions. I know that there is some money for that—indeed, some of it

has come to Lothian. Could you share with us what is being done differently for those people, who are sometimes not patients but just sufferers?

Caroline Hiscox: You have raised a really important point around the impact of chronic disease and the broader impact not only on health but on people's ability to work and to live their best possible lives. You will have heard this multiple times already, but we are trying to do whole-pathway work, from prevention—although we recognise that that is not everything—all the way through to hospital treatment. That includes supporting independence and ensuring that we have primary and community care as well as the right specialist services wrapped around it.

The work on rehabilitation for long Covid and ME specifically sits with health and social care partnerships. We recognise that access to that treatment is not as consistent or as timely as we would like it to be. You have mentioned that some funding exists; however, access to workforce and financial constraints are parts of the challenge. That remains a focus of our attention for Lothian—you will see in our annual accounts and our annual meeting with the minister that we remain focused on improving access, particularly for rehabilitation of both those groups.

The Convener: There is £4.5 million for that for the whole of Scotland. Lothian is sitting with some of it. Forth Valley and Fife NHS boards have said that they cannot do anything, so they have given the money to a service in Lothian. I am interested in what that service is for those 100,000 people—or those who you can manage, which is obviously not all of them. What service is being provided for that extra money, which is ring fenced?

Caroline Hiscox: I do not know whether Alison White has any detail on that. If not, I am happy to get back to you in writing on that.

The Convener: That would be great—thanks.

I have one more question, which I think we have time for. It is about money for infrastructure, and specifically the Queen Elizabeth university hospital. An inquiry is ongoing, with £30 million having been spent on it. People have died, and the health board has now said that, on the balance of probabilities, the faults in the hospital contributed to that. Those faults are not solved. I was in the hospital at the weekend, and it is in a shocking state. There is scaffolding up, and cladding and fire doors are missing.

I know that you are not in NHS Greater Glasgow and Clyde, but there have been problems elsewhere as well. I ask you, in your capacity as chair of the executive group: what needs to be done urgently, and when will it be done? I do not think that there was anything in the programme for government on that, although I am happy to be corrected. If that is the case, what do the professional groups see as a responsibility in terms of doing something about that issue now? The issue is not about prevention; it is about people who are immunosuppressed going into that hospital—the parents are terrified to take those kids in.

There has not been enough talk about that issue, although it is something that the committee will, I hope, want to come back to. We have all this talk about prevention, but what are we going to do about the infrastructure? Are we suggesting that £X million or £X billion should be spent?

Caroline Hiscox: You touch on an incredibly important point about our inability at the moment to determine the capital investment for infrastructure, not just for our built infrastructure, but for our digital infrastructure—it would be remiss of me not to mention that, as it would come from a similar pot.

I will not comment on the Queen Elizabeth or on the work of the Scottish hospitals inquiry, but I am sure that the committee will follow that up.

From a more general perspective on the ability to build hospitals, it is indeed incredibly difficult and increasingly complex to commission and fund that work and to meet environmental standards. All that will come out, I am sure, through the Scottish hospitals inquiry. However, it would be fair to say that, as chief executives, we are very conscious of the difficulties of building new infrastructure. We are aware of the need for that but, equally, we are aware of the size, scale and cost.

As board chief execs, we have been discussing how we can share our capital infrastructure plan. Part of the subnational work will involve looking at how we plan for what the population needs. That goes from our most complex theatres and intensive care units to, importantly, our community assets. We need to consider what we could build that would be more straightforward, given that community assets do not need the same level of ventilation, water and so on.

The Convener: My question was quite specific, so we will put community assets aside. Can the hospitals be brought up to standard? Is that the conclusion that the chief executives have come to? If not, what is to be done? Do specialist things need to be built elsewhere? I suppose that my question is: do we need to build more hospitals, and do we need to build them more simply so that they comply with the recommendations and with what is needed?

Caroline Hiscox: I am definitely not trying to avoid answering your question. From a capital perspective—I will use Lothian as an example, as

I am more familiar with that—I currently have a potential £101.2 million bill for backlog maintenance. That is not for anything new; it is to maintain the current buildings.

Do we need to build more hospitals? We probably do, but not until we understand what the population planning looks like and how we could use all our current assets. We need to understand which ones can and cannot be brought up to current standards.

In Lothian, as you might be aware, there was a proposal for a cancer site at the Western general hospital site, but capital funding was not available for it. We are decommissioning and demolishing a significant proportion of that site, so we need a plan for cancer services. As, I am sure committee members are aware, a £2 million maintenance bill was required for the Princess Alexandra eye pavilion in Lothian before we reopened it.

I go back to my point about community, because these things are absolutely interlinked. If we can provide more diagnostic centres and more primary care and community infrastructure, we could reduce the need to build the number of hospitals that we would traditionally have built. We will need to build new hospitals, but that is not the only solution, although the simpler we can make them, the better, from a cost perspective and a build perspective. The intention of the population-level planning is to genuinely understand what we have and what we need as a country, rather than as 14 individual geographical areas, which should allow us to be more effective.

The Convener: I appreciate that, but the population of Scotland has gone up by 370,000 in 20 years, so it would have been good if we had been planning for that extra number. However, as the number of beds has gone down, we know enough to know that we will need more.

In the interim, can you reassure any parents who might still be wondering whether the Royal hospital for children and young people in Edinburgh is safe for use that it is not suffering the same problems that we still see at the Queen Elizabeth university hospital?

Caroline Hiscox: I notice that Gregor Smith wants to come in, but I can absolutely reassure you on the safety of the children's hospital in Lothian.

Professor Smith: We must be very thoughtful about how we think about hospital beds in the context of providing a sustainable health and care system for the future. It is clear that, if we are to sustain the type of care that we want to provide our population in the future, the keystone of that is a community-first approach by which we ensure that our primary care and community services across the country can do their jobs to the best of their abilities and optimise what they provide.

By far the majority of care that takes place in this country—90 per cent—takes place in a community setting, and we need to sustain that. Taking the prevention approach that we have discussed, allied with strengthening our major community assets, such as general practice and community nursing, gives us the best chance of managing our hospital estate in the future in a way that is sustainable for costs and that reduces the risks of harm that exist in any healthcare system in the world when people go into hospital.

The Convener: Your point about 90 per cent of care taking place in the community is a good one, and it brings me back to my first question. Most of the time, nobody much is caring for many of the chronically ill, so it does not cost the country visibly, because those people are cared for by their parents, their husbands or their wives. There is also the loss to the working world, as well as the effect on people as individuals. Therefore, I can see why it looks like that from your side, when you look at the figures that are being spent in the NHS, which is why we are interested in having more visibility of these invisible areas.

I was interested in Jack Middleton's point that we do not realise that it is mainly working-class men who have problems with addiction, but, of those who are affected by the conditions that I am talking about, 75 per cent are women, and I would suggest that there is not enough focus on them. I certainly hope that we will come back to that issue. I hope that, when you go home or go back to work, you will have a look at what is said in our later panel sessions.

We are running out of time. I am sorry that we do not have time for closing statements, but I know that you will send us any information that you think that we have missed, and I am sure that we will see you all again. Thank you very much for coming.

09:59

Meeting suspended.

10:05

On resuming—

The Convener: I welcome the next witnesses; thank you for coming in to give us your views and answer our questions on your various specialties. We have with us Lilian Macer, the Scottish secretary at Unison, Dr Nóra Murray-Cavanagh, the assistant director of the Royal College of Nursing—[*Interruption*.]

Dr Nóra Murray-Cavanagh (British Medical Association): I am the chair-elect of the Scottish council of the British Medical Association.

The Convener: My apologies—I slipped lines in my briefing. I need to drink my tea.

Dr Murray-Cavanagh is from the BMA. It is Eileen McKenna who is from the Royal College of Nursing Scotland. Charlotte Waite is from the British Dental Association Scotland and Glenn Carter is from the Royal College of Speech and Language Therapists and the Allied Health Professionals Federation Scotland. I got that bit right.

We are short of time so I will not ask witnesses to give opening statements. I hope that you will get across what you want to say in response to our general questions. If not, I hope that there will be time at the end of the session for you to put your points forward.

Jack Middleton: Ms Macer, I listened to a representative of Unison on the radio this morning and I thought that the points on social care were well made—as they were in the submission to the committee. Can you expand on what the current barriers are to social care and what you think the Government should prioritise first as we enter this great period of reform?

Lilian Macer (Unison): It is an important point that, when we talk about health, we cannot ignore social care. They are interlinked and dependent on each other. Over many years, Governments have starved one service to feed another and social care has been the poor relation. It is important that we recognise the value that social care brings to the population of Scotland.

One of the biggest barriers in social care is low pay, and low pay is one of the biggest issues that the Scottish Government can address. By addressing it, I mean looking at ensuring an effective voice in social care. A main issue in social care is the workforce's lack of voice. The Fair Work Convention published a report in 2019, which made recommendations to the Scottish Government about fair work in social care. That report was through the lens of the worker; it covered more than 200,000 workers, predominantly women and part-time workers on precarious contracts of employment, who said that they had no voice in the sector. The main recommendation from that was for sectoral bargaining. Sectoral bargaining would give that workforce that voice.

However, fixing low pay would be a significant resolution to the crisis in care. Let us be under no illusion: there is a significant crisis in care.

Heather Anderson: Lilian Macer, I know that you have been involved in the campaign about visas and the issue of visas being given to companies rather than to individuals or to a governing body. Can you speak about how an improved visa system would help the industry?

Lilian Macer: A lot of care and NHS systems in Scotland are predicated on migrant workers being able to work in our communities, hospitals, wards and departments. The main issue is that some of those migrant workers are placed with employers who treat them appallingly. We would like to see a fair visa system across the United Kingdom; Scotland could play a significant part in pressuring the UK Government to recognise our campaign for fair visas and to realise that fair system.

It is absolutely appalling that we ask people to come to this country but treat them the way we do and remove their right to remain. We want to ensure that the five-year period that was offered to people who are in this country now remains in place so that they can stay, work and contribute to Scotland's economy.

Heather Anderson: It reminds me of indentured labour in farming and the idea that someone belongs to their employer. We must change that.

The Convener: Joe Long, do you have a follow-up question on workforce planning?

Joe Long: I will save my question for later.

The Convener: In that case, we will move on to Kayleigh Kinross-O'Neill.

Kayleigh Kinross-O'Neill: My question is for Unison. The programme for government that we heard about yesterday includes ambitions to use new technology and artificial intelligence for streamlining and centralisation. What risks should the committee look out for?

Lilian Macer: Unison is not opposed to reform or change and we support using AI and new technologies in Scotland where those are put in place appropriately, particularly for use in diagnostic testing or in making sure that administration is more effective. However, those technologies must be there to support the workforce and the patient journey.

There are some issues. We have tried some new technologies, particularly in our admin processes, but some of that new technology does not pick up what you might call our "distinct" accents, which means that staff are required to double and triple check. We are concerned that the Scottish Government seems to think that AI and new technologies will be a panacea in removing workforce and we know that the Government has already announced that 20,000 jobs will be removed from Scotland's public sector.

Yesterday, the Government set out its stall to Parliament and to the population and said that it

would reduce 14 territorial health boards to two. It is now incumbent on me, as the Scottish secretary for Unison, to set out our stall. There must be the meaningful three months of negotiation and consultation that the First Minister pointed to yesterday and Unison will be part of that process. If that does not materialise, we are not taking off the table any appropriate action that we might need to take for our members, and that includes strike action.

The Convener: Dr Murray-Cavanagh, speaking on behalf of the doctors in your organisation, do you think that your members will think that the plan to improve flow is adequate? I have met doctors who feel quite desperate about the situation in accident and emergency. I know that the BMA has views about anaesthesia associates and physician associates, which may be part of any question about the number of doctors available and about what—other than money—will improve the situation of doctors and their working conditions. What should we do about educating more doctors?

10:15

Dr Murray-Cavanagh: I thank you for the invitation to the committee to represent the voice of doctors and medical students in Scotland—and for such an interesting question.

There have been a number of responses to the flow document. It was a surprise to general practice that there was not a greater emphasis on what we know about continuity of care preventing the need for flow in the first place. That is one big thing.

On workforce and skill mix, the core of what we want is patient safety. We want the right person with the right scope of practice—the right professional—to perform the care and be involved in the planning. Again, what was the stakeholder engagement in the production of the flow document?

The wider question is, where is the robust, long-term workforce plan? Why are we training doctors who are then unable to get higher specialty training posts? Why are we sending doctors abroad? Why are patients struggling to see, for example, a general practitioner? Seeing a GP helps someone to avoid hospital admissions and that engagement piece improves chronic disease management. There is lots of work on the GP funding package and the bolstering of general practice as underpinning what we want to see and deliver in our Scottish NHS, but not at the cost of stripping out a stretched secondary care.

In the first hour of the evidence this morning, we heard much about prevention and the public health piece, which is absolutely fundamental, and we are not going anywhere without it. However, for the 20 per cent of healthcare delivery that we can influence, let us have people who want to work here, training here, and working to the top of their licence in order to support our patients and the Scottish population to live full, healthy lives.

The Convener: Thank you very much.

Jack Middleton, does your question about band 5 nurses come in here?

Jack Middleton: Yes.

Ms McKenna, I noted in your submission a welcome to the commitment to improving pathways between band 5 and band 6 nursing. It was mentioned in the programme for government yesterday, but I do not think that we have the detail yet. How does the Government need to move that forward, and what would the priorities be to make it a reality?

Eileen McKenna (Royal College of Nursing Scotland): Thank you for your question. You have highlighted a good point. The RCN campaigned for a review of the agenda for change because our fundamental belief is that the impact of its current structure is to the disadvantage of nurses. It can be seen from the data that more than 50 per cent of registered nurses are at band 5, which is the entry level, and they stay there. Many stay at band 5 for their whole career. That does not recognise the knowledge and skills that registered nurses can bring across the whole system, so we campaigned, and the Scottish Government committed to the review of bands 5 and 6.

A significant proportion of band 5 nurses have engaged in the process, yet that process has been extremely slow in getting a resolution. However, the majority of those who have completed the whole process—more than 90 per cent—have achieved band 6. Our submission, therefore, is that registered nurses are a band 6 workforce and there should be, at registration, with some kind of preceptorship and support, an automatic transition from band 5 to band 6.

The review of bands 5 and 6 is the first step in the process. We believe that many nurses in other pay bands are wrongly banded. For example, qualified district nurses, who have done additional training, were predominantly in band 6, but you will know that, in one health board, we and the other trade unions achieved those nurses becoming band 7s. There is much variation across Scotland in how agenda for change has been applied to nursing roles.

Jack Middleton: That is helpful. Thank you.

The Convener: Joe Long, do you want to come in on workforce planning, if we are staying on that subject?

Joe Long: Yes. We could talk about workforce planning across the board; it seems like that might be a future session in itself.

I was struck by the fact that Dr Murray-Cavanagh's submission from the BMA says:

> "There is no long-term, evidence-based plan on how Scotland will make sure it has the workforce required to deliver care"

in the future. I was also particularly struck by the mention of "underemployed GPs". We hear all the time about people having difficulty accessing primary care. Could you tell us a bit more about what is causing that underemployment situation and how it is playing out for BMA members?

Dr Murray-Cavanagh: We are happy to provide a further written submission on that specific point. To answer your question today, I would highlight that the issue of underemployed GPs exists in some specific local areas, such as in Lothian, for example. However, as a result of the increase in funding in the past year, we are seeing a lot of turbulence, with a lot of GP practices changing the shape of their operations and some GPs moving around within the system. This is a time of change. That is probably what I want to say on that.

The Convener: Mr Carter, do you want to share your perspective on workforce planning?

Glenn Carter (Royal College of Speech and Language Therapists): As you said, I am representing the Royal College of Speech and Language Therapists today, but I also represent the Allied Health Professions Federation Scotland, which represents 14,000 allied health professions across 14 different professions.

On workforce planning in Scotland, we do not see that the allied health professions are in the right place to be able to meet the need here. We need high-quality workforce planning that covers the whole multidisciplinary team, not only doctors and nurses. AHPs are the third largest workforce in the service, but they are quite often left out of decision making. We have heard a lot today about prevention, which is in the DNA of the allied health professions—we have loads of fantastic examples of how we do that every day.

I will give an example of the lack of workforce planning in the speech and language therapy profession. In the past five years, the number of therapists has increased by 1 per cent compared with 19.6 per cent in England. As a result, the number of speech and language therapists per 100,000 of the population is far lower in Scotland than in the rest of the UK, and that is a significant concern for the large number of people with needs relating to communication or swallowing issues. We need workforce planning, and what would help in that regard would be to have AHPs at the most senior executive levels across Scotland. At present, there are no AHP executives in health boards; that is being replicated in subnational planning, and we are concerned that it will potentially be replicated across the strategic health boards. If we want to change the narrative in Scotland, we must have AHPs at the centre of decision making.

The Convener: Ms Waite, do you want to say something about workforce planning from your perspective?

Charlotte Waite (British Dental Association Scotland): Thank you, convener. The BDA welcomes the opportunity to speak to the committee about the key issues affecting NHS dentistry in Scotland. I echo what my colleagues have said; we are concerned that there is a lack of workforce planning for dentistry as well.

We have different cohorts of dentists. We have general dental services—the high-street practitioners—but we also have the public dental service and hospital dental services. We need the workforce plan to ensure that Scotland has the workforce that is required to meet population needs.

We know that workforce pressures are more significant in some areas of the country than in others. I will highlight some of the data. Over the past decade, the public dental service, in which dentists employed by health boards provide care for some of the most vulnerable patients in society and priority groups, has had a 22 per cent decline in head count; we have also seen a 17 per cent reduction in our hospital dentists, who support secondary care in the most specialised treatments. It is clear, therefore, that the head count is going down.

However, one of our significant concerns is that the data that is collected is only on head count, which does not provide the insight or the granularity that we need for workforce planning. In order to understand the capacity that is required to meet the population's needs, we need to know not just the head count but the whole-time equivalent figures. Within that space, some of our dentists will be providing only NHS care; we need to understand how much NHS dentistry is being delivered by those individuals, so that workforce planning is appropriate to meet the needs of the population.

We are very concerned by yesterday's announcement about the restructuring of health boards, and we really would urge the committee to forensically scrutinise those proposals.

There was a lack of detail in the proposals, and we will all want to engage constructively with the Government as the consultations move forward.

We cannot fault the objectives of joined-up delivery, improving access to care and reducing inequalities, but it is unclear how the proposals will achieve those aims. There really must be a fully funded, fully costed NHS dental workforce plan to ensure that we have the required number of dentists to meet population needs, as well as the whole dental team around them to support them.

On that point, I note that one of the significant pressures affecting NHS dentistry and the sustainability of funding is the rising cost of delivering care. Many high-street dentists are contractors to the NHS and have businesses to run, and we need the Government to bring forward full mitigation of the additional costs—in particular, the increases in employer national insurance contributions and the national living wage—to protect the viability of those dental practices and, therefore, protect patient access to NHS dental services.

The Convener: For information, what percentage of dental practices are now owned by what I would call conglomerates? We have seen that development with pharmacies and vet practices, for example, and it is now happening with dental practices. What percentage of Scottish dental practices are in that position?

Charlotte Waite: I can get that information and share it with the committee after the meeting. We call them dental groups or dental corporates. The majority of dentistry in Scotland is delivered by independent providers who are not part of such groups, but you are correct that a significant percentage of NHS dentistry is delivered by dental body corporates. I can look to get you the numbers, which I will submit in due course.

Lilian Macer: I want to pick up on points around workforce planning. It is important to recognise that, over a number of years, NHS staff have been asked to do more with less and the occupational groups have taken on more responsibilities—that is not being recognised. We have recently been involved in work around the band 5 and 6 nurses, and we have been involved in work on industrial action with some of our detailed occupational groups because of the job evaluation system that has already been mentioned and the work that needs to be done on that.

There needs to be an integrated workforce plan committee that is not solely on health; we need to bring in social care because that is part of how we deliver services to the population of Scotland. That workforce plan needs to be integrated. We have lacked a proper workforce plan in the NHS and social care for a number of years, and there needs to be a clear commitment to ensure that that becomes a reality.

An area of work that Unison and the other trade unions negotiated with the employers and the Scottish Government in the 2023-24 pay award was on the non-pay elements of pay. The work was to involve job evaluation and looking at the pay system and structures. However, none of that work has taken place—none of it has happened—and we are now moving into the 2027 pay award. We expect the Scottish Government to meet the anniversary date of April 2027 and for the non-pay elements around agenda for change and workforce planning to be actioned appropriately and at pace.

The Convener: We can perhaps come back to that with the minister.

Eileen McKenna: I would like to highlight the fact that at no point in the past few years has the NHS or social care had the number of required nurses. We publish a workforce report every year and, this year, we focused on community nursing, highlighting the lack of investment in community nursing across Scotland, which includes district nurses, health visitors and school nurses. We have heard a lot about prevention this morning, so we cannot understand why the number of health visitors and school nurses is reducing across Scotland and why there is a lack of investment in the additional qualification that district nurses, health visitors and school nurses require. Some boards have not put a single nurse forward for those specialist qualifications for five years. There is an ageing workforce, particularly in health visiting, yet there seems to be no plan to address that issue.

10:30

The Convener: Thank you. It is interesting to hear that there are sometimes no applicants for specialist jobs. I would like to ask Dr Murray-Cavanagh from the BMA what we could do about that problem. I have in mind a specific example, which relates to the allocation of money for a specialist to help people with long Covid and ME. According to NHS Fife, no one applied for that job, so it was a case of “job done.” There is an issue there to do with continuing professional development, but it also relates to the wider point that was made by Ms McKenna. How do we get specialists below doctor level, and how do we co-ordinate that?

Dr Murray-Cavanagh: With your permission, I will pick up on the issue of dental coverage, which strikes me as being an inequalities issue. We know that that is mirrored across the piece in healthcare through the inverse care law. In general practice, which is needed across the country, we know that there are not enough doctors in the places where general practice is needed most—the areas of highest deprivation.

In recent times, we have been sleepwalking into a two-tier health service, which has led to a rise in the number of people who try to fund private care for themselves. This morning, we have talked specifically about ADHD, but there is a wider piece around neurodivergence and accommodations. If someone needs a prescription for a medication, they need to be seen, assessed and treated. When we think about general practice as being the most financially efficient part of the NHS, and the amount of risk that is held in general practice, we would be foolish not to use the international data, which shows that it is good for patients to see their own GP, and we know that that is what they want to do.

You asked about emerging areas. Who is the long Covid specialist? What are we doing as regards academic medicine in Scotland? What are we doing with our research budget? How are we supporting people to do research? How are we funding innovation and novel treatments? How do we support that across the career piece?

There is the bottleneck in the middle that I mentioned earlier. We have had a great boost in the number of medical students, which is fantastic, but their educational experience is not as good as the one that I had when I moved to Scotland as a medical student. There are not enough doctors available to train them, and the doctors who are there are rushed off their feet in a service that is increasingly overwhelmed.

If we are not filling posts in that middle part of the system and are not doing the workforce planning piece and training people, how will we get the consultant specialists at the other end? How will we have strong general practice? How will we have GPs with special interests? That might be a very appropriate way of addressing the chronic disease management that is required for conditions such as long Covid and ADHD. We are not addressing that issue, and doctors and medical students are really keen to be involved in that discussion.

The Convener: That was very useful. Perhaps we should be talking to the educational establishments about how they are addressing the changing demographics and the increase in certain groups.

Dr Murray-Cavanagh: As doctors, it is part of our definition of ourselves that we should think about how we can develop, grow and learn in order to address the needs of our community.

The Convener: Thank you. We have had a good round of questions on workforce planning, but I see that Jack Middleton wants to come in.

Jack Middleton: I have a specific question on workforce planning to put to Ms Macer, on the back of what Unison says in its submission. It notes that one option would be a

"High cost area supplement (specifically for the north east)".

I would always support a pay uplift for my constituents, but I would like to know how that policy was arrived at. What would the intention behind such an uplift be? How would it be balanced with the Scottish Government's golden hello scheme that is in place across a few areas?

Lilian Macer: Over a number of years, through agenda for change, the Scottish terms and conditions committee looked at the recruitment and retention policy and how the recruitment and retention premium was paid. Historically, that retention premium was paid to male manual workers. We did an equality impact assessment on that. We wanted to ensure that, if there was a workforce shortage in a particular area that was associated with a high cost of living in that area, that was recognised.

One of the other areas is our distant islands allowance. Members will know that the distant islands allowance means that a health worker in Orkney, for example, will earn £1,300 per year less than a local government worker. Therefore, there is already a disparity for the population in the Highlands and Islands.

We are considering a high-cost premium, and the Scottish terms and conditions committee is considering how that could be applied. It could be that a premium applies for certain groups or for all groups living in certain areas. The premium would probably apply to all groups living in certain areas who are delivering high-quality health services to the population.

Adam Harley: My question is for Dr Murray-Cavanagh. I am aware that you are new to your role, so congratulations.

Dr Murray-Cavanagh: Thanks.

Adam Harley: Coming to the committee is quite the baptism of fire.

In your submission, you mentioned the need to foster a culture that prioritises staff wellbeing above reputation management, and we heard a bit about that from the former chair of the BMA. Could you speak on that, please? What would need to be in any new whistleblowing procedures to gain the confidence of staff?

Dr Murray-Cavanagh: There are a few parts to your questions. First, there is the health of doctors. It is unconscionable that this country would ask the people who are involved in the work of healing to be harmed by the work that they do, but that is what we see.

Surveys carried out among those in our profession show that a significant numbers of doctors' mental health is harmed by their work—sometimes the majority. Some very good things have happened in response to those surveys. The workforce specialist service is one, which builds on the work of the NHS practitioner health service in England. It is an important service and it must be protected. It is important to say that not all of the devolved nations have such services—there is not one in Northern Ireland.

I would like to have doctors not being harmed by doing their work. Actions on that can be taken through terms and conditions, pay and culture—you asked about culture. There could be engagement with those in our profession and involvement in planning what our structures look like. For example, where was the voice of the profession in the generational change that was announced yesterday? Trust us. We need to be involved in that change, because we know what works and we want to build a better system.

The final thing is that we should have a learn-not-blame culture, and we should not pay lip service—there should not be reform only for reform's sake.

Adam Harley: How do the cultural issues manifest at the minute? You talked about the mental health impact on doctors, and the BMA submission mentions patient safety. Do doctors feel that they are working in unsafe conditions for patients and that that is impacting their own mental health, but they do not feel that there is a mechanism in place to properly have their voice heard, or is it that they think that they are being shut down by the structures above?

Dr Murray-Cavanagh: There is a spectrum of issues. Many of us are working in what should be considered abnormal and unacceptable conditions, but we have come to accept the situation as normal—like that saying about boiling a frog.

There are situations that we consider safe, but what is the result if the situation becomes unsafe? Where are our voices heard? Who is responding to our concerns? Who is asking the questions? Who is reaching out to us? It is incumbent on the boards, as employers, and it is incumbent on the Government, as the overall employer, to consider all of that.

Culture comes from the top down. You will not hear me say "top down" in a positive way very often, but we have got to model it from the top. We have to say that we can hear hard things, accept them and do better to change them.

Adam Harley: Would it be fair to say that right now there is a lack of accountability and, ultimately, responsibility coming from the top?

Dr Murray-Cavanagh: That is a good and delicate question, is it not? BMA Scotland is really strong on collaborative discussion, and we see what good things can come out of that. The GP funding package has changed the atmosphere so much in Scottish general practice. We have GPs applying from England to come and work here, so we see what can be done when we collaborate and work together. That is what we are interested in. We are not interested in criticism and blame, but we want to see whose voices are and are not in the room and who needs to be there.

Eileen McKenna: I do not disagree with anything that Dr Murray-Cavanagh has just said. We have highlighted several times the poor working environments that nursing staff experience across the system and the impact that that has on their wellbeing. The nursing sickness absence rate across Scotland is double the target—it is more than 8 per cent—which increases the pressure on the staff who come to work. There is presenteeism: staff feel under pressure to come to work when they are unwell. When they are off sick, the employer's response is to give them targets and not to address the underlying issues that make their staff unwell.

It is a complex issue, but it was part of the reason why we pushed for the nursing and midwifery task force to take action to improve the working environment of nursing staff across Scotland. We are now two years down the line and none of the 44 recommendations that were made have been implemented, and our worry is that, in light of the programme for government and the planned restructuring of the NHS, none of them will be implemented. People will take their eye off the ball and focus on restructuring, rather than addressing the cultural and workplace pressures that nursing staff and other staff groups experience across the NHS.

Glenn Carter: It is a critical question because it goes to the core of what is required to deliver the reform that was recently outlined. AHPs should be at the forefront of the reform if it aligns with prevention, which we think that it does. However, if the foundation is not right and we ask staff to think radically about their core business, they need to feel safe and experience compassion in the system both for their own sake but also because we know from research that when professionals receive compassion, they have more capacity for compassion for the people in front of them. That, in turn, delivers huge benefits for people such as reduced hospital stays, improved outcomes and a reduction in the number of people coming back into hospital. It is an absolutely critically important

element to consider, because if the foundations are not right, the reform will be very challenging.

Charlotte Waite: We cannot underestimate the potential impact that yesterday's announcement will have had on staff throughout Scotland. I am sure that the Scottish Government is mindful of the impact that it will have on mental health and wellbeing and the uncertainty that change brings about. We hear that the reform will move at pace, but we really must consider the staff at the heart of this and ensure that their wellbeing is looked after throughout this period of change and through any transitions, because it is paramount that our workforce is supported. The Scottish Government really must ensure that that is at the core as we move through this period of reform.

Paul McLennan: I have a question for Glenn Carter. I will be up front about the fact that Glenn and I have been discussing an issue in East Lothian—it comes back to the paper that has been discussed here—which is about embedding nursery speech and language therapists, particularly external speech and language therapists, in every school and nursery. Some local authorities are not allowing that, which is creating a real issue for my constituents.

Will you talk briefly about the benefits of embedding speech and language therapy in every school, how each local authority is taking different positions on that and how we can get around that?

10:45

Glenn Carter: I suppose that that speaks to everything that we have talked about so far on prevention and how to deliver change. We have talked a lot about that, but we actually need to do it. The example that you have just cited is absolutely such an action. In Forth Valley, speech and language therapy children's services decided to listen to the population to hear what the need was. In partnership with all the councils, the service stopped to listen to what was important, including for families living in poverty, and then shifted pretty much all its resource into education in schools and nurseries. That has allowed the service to shift the care further upstream and prevent harm and other issues from happening in the first place.

That is a totally radical shift, and there is loads to learn from it. The teachers rate the service as the most effective one that they come across, and it has received two health awards, for tackling health inequalities and for innovation. The point is that, by taking that approach, the service has managed to reduce behavioural challenges, improve mental health and prevent long-term impact for people in terms of unemployment and contact with the justice sector. Teachers are experiencing support from health professionals to deal with the complex challenges that they face. That is what that approach is all about. If the committee is interested, we would be delighted for you to come and see it in action.

Mr McLennan made a point about the challenges of getting speech and language therapists into education. That sometimes comes down to funding being cut and independent practitioners not being able to get in there.

We see that as a really important approach, not just for children's services but for all of health and social care. We can learn about what it takes to deliver transformation, including in relation to healthy leadership and healthy cultures, which we have talked about already, and proper integration. That is a great example—it is real and it has absolutely worked.

The Convener: As a follow-up to that, and bearing in mind that you speak for the other organisations in the Allied Health Professions Federation Scotland, would you say that that point applies to a number of those other organisations as well? For instance, if people could self-refer to physiotherapists, that would take pressure off GPs and might mean that they do not have to go near a doctor. Obviously, there are other professions in your organisation for which that would be possible.

Glenn Carter: Absolutely. The concept of shifting professionals into the community or closer to the community is absolutely critical. Whether that involves physios in community centres, supermarkets or wherever, it is just about getting close. There are lots of examples of services providing community appointments where people can come and have challenges dealt with holistically, whether that is occupational therapy, physio, dietetics or podiatry—there is a huge raft of that.

One brilliant example is in Raigmore hospital, where physios and occupational therapists prevented 1,100 bed days just by being at the front door and managing support at that point. We also have art, music and drama therapy supporting people with mental health issues and preventing them from needing psychiatry support or admissions.

The principles that I have just described are absolutely applicable to allied health professionals.

The Convener: That is helpful—thank you.

Heather Anderson has a question about GPs.

Heather Anderson: I thank the witnesses for all the written submissions, which are very informative. My question is for Dr Murray-Cavanagh. We have heard a lot from allied health

professionals, dentists, district nursing and community nursing, and I really appreciate your comments on the impact that the increased award to GPs has made. What is your vision for GPs leading on the road to prevention in healthcare? How do you imagine GP practices innovating and working with allied health professionals, if that is part of the vision?

Dr Murray-Cavanagh: How long do we have?

Heather Anderson: I think 10 minutes.

Dr Murray-Cavanagh: From looking at healthcare systems internationally, we know that, when healthcare systems put general practice front and centre and value it—well, primary care more widely, but general practice specifically—there are benefits for patients, and so for the wider population, and for GPs. For example, as a GP, you are more likely to remain in your career if you have a better patient ratio. With regard to the money that was negotiated and how it will be used by individual practices, we are in a time of flux and are working out what that looks like in different places, but how it unfolds over time will shape how successful our NHS in Scotland is.

That is not an extreme thing to say; it is simply about having a frank understanding of how healthcare delivery works. There are rafts of evidence to show how it is not simply a moral case, a good idea or a nice thing to do; on a health economics basis, it frees up so many other things, with reduced admissions and better management of multimorbid conditions over time.

It is about thinking about the exceptional potential of general practice—that is, of episodic, longitudinal relationship-based care—and shedding the idea of care as a transaction. It is about deeply remembering that care is relational, and seeing how that impacts the health of the public. Once we unleash that exceptional potential, it frees up so much other space in the system for our incredible secondary care colleagues, and all of the people working in the system, to do their work. For example, nurses are less overwhelmed because there are fewer admissions that could have been avoided, and social care is better staffed, and so the whole system flows better.

We do not have a bottomless pot of money in this country, so we need to think about how our systems are structured such that funds go where the work is needed most, for example to practices in areas of incredibly high deprivation. As to how we do that, there is the idea of proportionate universalism: of there being a universal offer, while thinking about how we target things. It is about marrying that up with GPs being an incredibly efficient way to spend money, and then also more widely with what structure GPs appear into. A GP does not simply appear; they have been medical students and have worked in a variety of jobs, and it is about what that means for our colleagues who are in academia and research, or who are hospital-based, largely out-patient based, or who have more community specialties.

We also need to have fantastic A and E and trauma and cancer services. We will reap the benefits of all the work that we do on prevention years down the line—but, right now, cancer, vascular disease and dementia are big killers. We really need to keep those services solid and funded, and to build and grow the general practice offering that we have in Scotland, which is excellent and high quality and deserves some attention, in order to be able to provide the best care that it can for patients.

The Convener: I have heard it said that the GP model is outdated and that we are perhaps talking about multidisciplinary self-referring, to some extent: for example, a hub, such that people do not need to go through a GP if they think that they need to be referred. I met a cardiologist who works privately in Northern Ireland, and who took self-referrals, and they said that nobody had come in front of them who did not require to see a cardiologist; by the time they got there, that was what was needed. Often people think, “I really need to see a rheumatologist,” or whatever it might be, but it can be very difficult to get there; even if the GP is willing to refer them, they might not have the test for it.

I will ask two questions.

First, we have talked about maybe getting physios in there and so on, but is there a case for being more radical and thinking more about self-referral? As we are throwing the NHS up in the air, is that something that we might want to do?

Secondly, I am interested in why there seems to be a lot of resistance to assistant physician associates and anaesthesia associates. Will you comment on those concerns, because some of us have probably seen those associates and found them fine?

Dr Murray-Cavanagh: There was so much in your question

The Convener: I had to get in at the end.

Dr Murray-Cavanagh: Yes.

There is so much self-referral in the system already. All my patients can self-refer to a physio, for example. There are lots of bits of the systems across the country. With subnational planning, that might become more streamlined in some way; however, that is yet to be seen.

There is probably an underuse of digital. However, we should really be using digital to plan

services and support patients rather than forcing them into using it, because that would betray the relational bit of the care.

What we know about the system that we have is that the NHS really is the envy of the world, given how it is set up. What other countries are iterating to is something that looks like the NHS, with expert generalists at the front door—not the A and E front door but the community front door—and expert generalists working on the longer-term piece with patients. People are not going to see a cardiologist every time they need their blood pressure medicine tweaked. That would be a terrible use of public sector finance. People could do it with their own money if they wanted to, but that is a two-tier system that we are not supporting for the people of our country.

With the expert generalist piece, we have the GP at the front door. It is not about the GP being a jack-of-all-trades. Being a GP is a very specific thing. That is why there is specialist training to become one and not everybody can be one. We need to think about the expert generalist thing and the balance between private and public. As the stewards of public funding, how can we spend the money most efficiently? We know that having general practice at the front door is a very efficient way to do it.

Many things could be managed in secondary care. For example, lots of dermatology is managed in general practice and primary care, but if a patient does not know how the system is structured, they might of course think, “I need to see a dermatologist for this.” There is something about helping patients to navigate the system to get the best and most timely care from the right person. That leads on to your question about allied health professionals.

The BMA is interested in well-defined scope of practice with patient safety at the heart of it, and that is where we have been involved in the discussions up to this point. I hope that that answers your question.

The Convener: Thank you. We have a few minutes left. I invite our witnesses to take a minute or two to make some closing remarks, if they wish.

Lilian Macer: I will leave the committee with a couple of points about workforce shortages and the impact on staff wellbeing. It is critical to look at our skill mix reviews and make sure that we have the right people in the right places at the right time, because that is central to meeting the NHS performance challenges. The challenges of the NHS in Scotland will not be solved by structural reorganisation or efficiency savings alone, and we need to recognise that yesterday’s announcement will have a significant impact on the wellbeing of our members.

Unison represents over 60,000 NHS workers and huge numbers in social care, but the structural reforms and changes will not see a single extra nurse on a ward, paramedic in an ambulance, or domestic or porter on the wards or in the departments. The Scottish Government needs to sit down with the trade unions urgently to make sure that we are involved in the intense three-month consultation and engagement piece that it has set out.

It is critical to look at workforce planning and the skills mix in our workforce to meet the challenges, and Unison will play a significant part in that. However, our stall is already established and set out: Unison needs to be involved and engaged in that, but nothing is off the table at this stage, including industrial action—strike action.

Dr Murray-Cavanagh: An urgency has been introduced by the big announcement yesterday, and I want to add a note of caution. These are big decisions. Let us make them well, let us make them once, and let us make them with data and evidence and engagement from the stakeholders. BMA Scotland is very keen to be part of that. Thank you for inviting us to give evidence to the committee today.

Eileen McKenna: On the proposed structural reform, the RCN does not currently have a view on the number of health boards or their make-up. However, we highlight that major structural reform carries significant risk, including the diversion of resources and attention away from the immediate operational pressures that staff see on a daily basis. Any reform agenda must be adequately resourced and those who are delivering services must be appropriately supported.

There must be a no-detriment principle for staff, and I echo the other participants in calling for engagement. The Scottish Government has given a commitment to engage with the trade unions and other stakeholders, and that engagement must be meaningful and not just a tick-box exercise.

11:00

Charlotte Waite: Thanks again for the opportunity to address the committee. I think that the pressures that we have all talked about as affecting the NHS are increasingly being felt by patients. They feel them at first hand.

We hear of families travelling for long distances to access NHS dentistry. We know that children are facing unacceptably long waits for treatment under general anaesthetic. It is the most common reason for young children to be admitted to hospital in Scotland, and that remains a scandal, although there have been very good public health initiatives and much better children’s oral health over years; however, that is now plateauing out,

and we need to address those long waits. The situation is impacting on children's general health, oral health and ability to attend school.

Communities are struggling to obtain routine oral healthcare. In many areas, NHS dentistry is becoming particularly fragile.

Alongside sustainable funding, therefore, workforce planning must be a priority, as we have said. Too often, the discussions focus on recruitment, whereas retention is extremely important, and dentists and their dental teams must see the NHS as a place in which they feel that they can deliver care and will want to build their careers.

Our call is simple. We want sustainable funding for NHS dentistry, greater investment in prevention, and a focus on workforce retention and recruitment. Those measures are essential to protect patient access, reduce inequalities and secure NHS dental services in Scotland.

The Convener: I have a quick question on that. Should there be an increase in the numbers of students going into dental schools?

Charlotte Waite: We need the workforce plan to be brought forward, with evidence to support the number of undergraduate dental students that we need. That would be part of the overall workforce plan. We welcome the fact that there has been an increase in the number of undergraduate dental students in Scotland recently but, as I was saying, it is also about retention—about where those dental graduates are going to build their careers. We need to make sure that NHS dental services in Scotland are an attractive place in which they want to build their careers and be retained.

Glenn Carter: The reform that we have talked about today is all about prevention. AHPs need to be at the centre of that. It is part of their DNA; it is where they have the biggest impact; and AHPs save money. We need allied health professionals at the most senior level—executive level—across whatever structures we deliver in Scotland.

Let us consider what we measure. System measures can be important, but let us measure whether we are actually improving outcomes for the people of Scotland.

The reform that has been talked about is extremely complex. It has been delivered in pockets for AHPs, including speech language therapists, across a whole system. We need to learn from that; we can do so; and our suggestion is that we learn and spread that learning across Scotland.

The Convener: Thank you very much.

I thank all the witnesses for giving us their time. It has been very informative and I am sorry that there has not been more time. If the committee should have heard anything from you that you did not have time to bring forward, you are welcome to send it in.

11:03

Meeting suspended.

11:10

On resuming—

The Convener: Good morning—it is still morning, although it feels like we have been here a while. I thank our witnesses for coming. We have with us Janet Sylvester from #MEAction Scotland; Sara Redmond from the Health and Social Care Alliance Scotland; Kenny Stewart from Scottish Action for Mental Health; Stuart McIver and Jane Ormerod, who joins us remotely, from Long Covid Scotland; and Kirstin Laing from the chronic pain group.

I particularly thank those who are not well for joining us. I know that it takes a toll, so we are very appreciative of you for coming. Perhaps you can start by spending a few minutes saying what you want to put across to the committee before we ask our specific questions. We will start with Janet Sylvester, if that is okay, and then move to the long Covid reps, because we have a couple of questions on that. I will come to the others after that.

Janet Sylvester (#MEAction Scotland): Thank you, convener. We want to address the lack of services for people with ME in Scotland. Scottish Government funding is available to rectify the issue, but we are concerned about how health boards are currently spending that funding. I can discuss that in more detail, and we explain it in our briefing paper.

We also want to highlight that a long-term conditions framework, which has been in development for some time, is due to be published in March. To back up that framework, Long Covid Scotland and #MEAction Scotland spent a lot of time working as part of sub-group 5, on post-infectious and associated complex chronic syndromes, and we very much support its recommendations. Given the lack of support for people with ME, we would like those recommendations to be put in place straight away, before the framework is published next March.

Those are the two key issues relating to support for people with ME.

The Convener: Thank you. Stuart McIver and Jane Ormerod, you can decide who wants to lead off.

Stuart McIver (Long Covid Scotland): Scotland's problem with long Covid is that there is an accountability and implementation gap. We know what needs to be done—it is just not being done. The issue is not funding, because funding is available, but how the funding is being used to deliver a baseline of services that people need.

We have specific asks for the committee. Janet Sylvester spoke about the long-term conditions framework, which could be implemented now with the current funding. We need to establish a national baseline of care for everyone. That does not exist, so there is still a postcode lottery. We need to create accountability by setting out who is actually responsible, because there is a lot of passing of responsibility, with no implementation of the services that people need.

For children with long Covid, ME, chronic fatigue syndrome or Lyme disease, the situation remains dire. There are not really any services, despite there having been a long Covid inquiry. The recommendations of that inquiry, which I spoke at, have not been implemented. There is no public health messaging.

We have the solutions to hand, but we need to implement them and not be trapped in endless policy work. We need to take forward the recommendations now. Everything that Janet Sylvester said, which I support, is also the case for people with long Covid.

The Convener: Thank you—we will come back to that. Kirstin Laing, will you tell us about what you would like the committee to know?

11:15

Kirstin Laing (Chronic Pain Group): I would like the committee to know about the disparity in chronic pain management across Scotland. Working services and health boards throughout the country have been denying patients clinical interventions, removing lignocaine infusions and stopping life-changing steroid injections.

A patient's access to those interventions should not be denied based on whether they became ill at a certain point. In the Highlands, there are two classes of chronic pain patients. There are historical patients like myself—I receive an S1 nerve root injection and my husband receives lignocaine. Our procedures are safe at the moment in that they are continuing. However, if my husband and I were to be referred into the service with our conditions now, we would not be offered those procedures, because they have been stopped. Injections have been stopped for four years, and no new patients at all have been referred through the service for clinical interventions in those four years.

I have been in the service since 2009. I have never had to worry about whether I got my injection, and nor has my husband. However, for the past four years, each time that we have been up to use the service we do not know whether it will be secure. That is because it has not recruited someone to perform clinical intervention injections in the long term. The current clinical lead came back from retirement to run the service, but there has been no move to replace him. Since he returned from retirement four years ago, not a single new patient has been referred to see him—not one. Therefore, he is just working his way through patients like me.

Since 2009, there has always been about 900 to 1,000 people being referred into the service, and the clinical lead always had a waiting list of 300 to 400 patients for clinical interventions. Where have those patients gone? They have just disappeared. I am lucky that I have the service at the moment, but the clinical lead's contract is up in September—at the very end of this month—and there is no sign of it being renewed. That will send patients like me and my husband back to untold agony.

I just want the committee to know that I do not understand why our pain is not valid anymore, why it does not matter, why we are not being listened to, why decisions are being made without consulting patients and for what reasons, and why new patients all over Scotland—it is not just in the Highland area—are being moved around the chronic pain management system without being offered the full plethora of clinical interventions that are utterly life changing.

It is the difference between just existing and entering life. I was previously bedridden and on morphine, but I can now enter into life and have meaningful independence and mobility. However, if I were to be referred into the same service now, I would not be offered that life-changing injection. My question is, why is this being done throughout Scotland? Why are these services being removed from patients without any meaningful discussions?

The Convener: Thank you very much for sharing that, Kirstin—we will come back to that point. I believe that Jane Ormerod would also like to speak.

Jane Ormerod (Long Covid Scotland): I will follow on from what Kirstin was speaking about, which is particularly relevant given yesterday's announcement about health boards in Scotland. Variation between boards is not a harmless local flexibility, especially when it determines whether somebody gets appropriate care. Unfortunately, people with long Covid have had a similar experience, which is not appropriate. Moving forward, I hope that we will not see more of such

experiences and that the situation will improve—I would like to think that it will.

My second point is that patients have to be involved before decisions are made. There should not be consultation after the fact. We need meaningful involvement in the design, delivery, implementation and scrutiny of services. Although good strides have been made on that, certainly in relation to long Covid, we need more of it, and it needs to not just be lip service paid. Thank you.

The Convener: Thank you. Again, we will come back to that.

I ask Sara Redmond to make some opening remarks.

Sara Redmond (Health and Social Care Alliance Scotland): I thank you, convener, and the committee for this opportunity to speak about the issues. The Health and Social Care Alliance is Scotland's national collective voice for third sector health and social care organisations and for lived experience. The kind of issues that we regularly hear about are those that have already been described by Janet Sylvester, Stuart McIver, Jane Ormerod and Kirstin Laing.

We broadly welcome the Scottish Government's focus yesterday on radical change and on services that are person centred and prevention focused, but those commitments have been part of the rhetoric for a very long time now, and we and our members have been calling for them for a very long time. Our view is that we really need an unrelenting focus on implementation.

What we hear from people about their experiences of the healthcare system is that it is a very complicated system that is fragmented, that results in duplication of effort and missed opportunities and that feels very unresponsive. It can leave people feeling demoralised and demotivated to even try to access the support and services that they think are there, although sometimes they have to really battle to access them. A lot of people talk to us about the battle that they encounter in trying to access services and the burden of the health administration that they have to undertake, because there is no continuous flow of information for them through the system. People feel as though they constantly face reasons why they cannot access services and support.

Importantly, we hear about the postcode lottery. We hear that so often when people talk about challenges in accessing social care, and that is just as often the case with people's experiences of accessing healthcare. The integrated approach across health and social care is critical, so we cannot think about reforming one and leave the other one overlooked.

We hear from people that they are looking for a system that is much more person centred, and by that they mean personalised. One person's experience of a long-term condition or illness will not be the same as another person's. We need a recognition that people are not just symptoms but are people who have social and emotional needs and other needs and circumstances that need to be taken into consideration.

Importantly, we hear that people want a system that is much more co-ordinated and that recognises that they are an active partner in their own health and wellbeing. That is often the component that is missed—that bit about supporting a person's involvement in their health and wellbeing.

Another really important point that we hear is about the challenges with communication. The solutions that people talk about are not necessarily costly radical innovations; they are about getting the basics right.

Those are the really important points that we want to get across. This is not just about whether the announcements are broadly in line with what we hear people are looking for. It is about whether we are seeing the changes and the implementation.

The Convener: Kenny, would you like to make a few opening remarks or are you happy to go on to questions?

Kenny Stewart (Scottish Action for Mental Health): I will say a few words, if that is okay.

Thank you very much for having me. SAMH is Scotland's national mental health charity, and it is our view that, right now, Scotland is in a mental health crisis. The word "crisis" is quite serious and dramatic, but it is not something that we say lightly, and we took some time to get to that position. However, it is a fact that, in the most recent census, one in nine Scots said that they have a mental health condition. That is more than double that at the previous census, which was in 2011. At the same time, two people in Scotland die by suicide every day.

There is an opportunity in yesterday's programme for government. You heard a lot about prevention from the first panel of witnesses, certainly from an NHS perspective. Others have talked about where we are when it comes to policy and rhetoric. The commitment to prevention is in the population health framework and the health and social care service renewal framework. We now need to move to implementation.

For us, that means much more support in the community, and it means the commitment to reforming social care. The reform of territorial health boards is perhaps necessary, and the

reform of social care certainly is necessary. We struggled with that in the previous parliamentary session. However, what cannot happen is reform—that structural piece—becoming a barrier to the receipt of the kind of person-centred care that Sara Redmond talked about.

I will quickly mention that people with mental illness die, on average, 15 years earlier than people without, and the evidence shows that around two thirds of those deaths are from preventable causes. We probably all feel that mental health stigma has improved over the past 20 years or so. Certainly, there was a period during the pandemic when we were all very comfortable in talking about our wellbeing and the stresses that we were facing. That stigma has improved largely at the mild-to-moderate end of things. We probably need to redouble our focus and efforts on mental illness so that we can start preventing some of those unnecessary deaths.

The Convener: Thank you. I will get some committee input. Adam Harley, I think that you wanted to ask about long Covid. Will you start off?

Adam Harley: I thank everyone for coming along, and I echo what the convener said about those with lived experience and the toll that it takes to come to a session such as this one, so I thank you very much for that.

Mr McIver, you mentioned that there has been a lot of conversation about long Covid, and there have been policy recommendations et cetera, but that there is a real need for implementation. If you are comfortable doing so, will you talk about the experience—of yourself or the people you represent—of turning up at the GP and getting a diagnosis of long Covid? What happens then, and what is not happening?

Stuart McIver: Unfortunately, a lot of our members still cannot access care. We did a report, having surveyed our members. In 2026, we are still having long-Covid patients going to GPs and the GPs telling them that there is nothing for them from the health board.

It is very difficult. A lot of people with long Covid have had it since 2020. We have an issue with disconnect—people not getting access to care for long Covid because, if they have tried five times across five years, why would the sixth time be any different?

Building on that, there is now a lack of Covid testing, so people with long Covid are being diagnosed with ME, because there are no longer any Covid tests. We are therefore swapping a new problem for an old problem, and the provisions for people with ME are arguably even worse than they are for long Covid, with hardly any practitioners available to assist them or medical care across the boards.

To go back to your point, it is about luck: where you are, whether you have a good GP, and whether you are persistent, are willing to advocate for yourself and are able to do so—which many people with long Covid in Scotland are not. It is particularly bad for children and young people.

Adam Harley: Thank you. I will quickly follow up. This also relates to some of what we heard from Kirstin Laing. Having listened to you and Kirstin, I am very aware that, when it comes to the uncertainty of the treatment that you may or may not receive, there is a real mental health impact. Will you talk a little about that?

11:30

Stuart McIver: It is colossal. We hear that there is funding for services, but what are people supposed to do if they cannot access any help? What if someone is a parent with a child who has long Covid and they are left to cope? People with long Covid have had their lives absolutely devastated, and very little help is available for them. We have had a framework about a framework about a strategic network about an inquiry. Our patients—people with long Covid—and our community do not need more policy work. They need implementation of what already exists.

It is incredibly frustrating. Having done the work that Janet Sylvester spoke about with the long-term conditions framework sub-group 5, we have a document that points towards what is required and how we can address it within the current funding and budgets. Implementing those recommendations would go some way towards alleviating a lot of the mental stress that people are feeling, and the sheer hopelessness. I cannot overstate how desperate people are or how many have given up. They are looking to this committee for help.

Adam Harley: Thank you, Mr McIver. I appreciate your response.

The Convener: Janet Sylvester wants to comment.

Janet Sylvester: I want to pick up the point that Stuart McIver made, because people with ME face exactly the same problems that he talked about. Someone told us:

> "I don't go to my GP any more as the advice wasn't good, so I just try to manage myself".

Someone else said:

> "My daughter was told she needed to get out more often and try going for walks outside."

Now, exercise is a particular issue for people with ME because one of its cardinal symptoms is

post-exertional malaise. That means that any sort of exercise, whether it is emotional, cognitive or physical, can exacerbate the symptoms and there is a delayed response to that. For a person with ME to be told to exercise in any form is almost certainly going to make them worse. My daughter was told to exercise and ended up in a wheelchair as a result. For GPs not to be aware of the harm that exercise can do is hugely damaging.

Also, people with severe and very severe ME are often unable to get to a GP or do an online consultation. They have real physical issues in accessing GPs.

The Convener: Thank you, Janet. If you want to take a minute, we will come back to you.

Joe, do you want to follow up on the long Covid point?

Joe Long: Yes. In fact, my question relates to all long-term conditions. This week, we have had a proposal from the Scottish Government on the flow of care, and a plan for that. I am mindful that the independent review of social care a few years ago talked about the relational rather than the transactional elements of support. I am really interested in how crucial those relationships are, particularly for the continuity of care for people with long-term conditions. I would like to hear more about how those are working, or not working, in providing long-term support. Perhaps Jane Ormerod could respond to that in the first instance.

Jane Ormerod: I go back to the point that it is a postcode lottery. It is very variable. Some people have good experiences. We know from our members that some people develop good relationships with healthcare professionals if they can get to see them. However, some people do not have that opportunity. Even when they do, the difficulty is that there is often an associated stigma. There is a stigma associated with, certainly, long Covid, and with many other long-term conditions. That is about the media and people in general not understanding people being unwell with long-term conditions and being unable to work, access healthcare and all those things. The conditions make life very difficult for people, which then affects their relationships with healthcare professionals and their ability to access the care that they need. I am not sure whether that answers your question.

Joe Long: It does—thank you.

Janet, if you feel ready to answer, will you comment on the continuity of care and how that looks for your members?

Janet Sylvester: Could you come back to me on that?

Joe Long: Yes—I am sorry. My question is about continuity of care and the relationships for those who are supporting people over the long term. I was just wondering how that experience was for your members and those with lived experience.

Janet Sylvester: Yes, I understand, but could you come back to me on that?

Joe Long: Oh, I beg your pardon. I did not realise what you were asking.

The Convener: Sara Redmond, did you want to come in?

Sara Redmond: Continuity definitely comes out as one of the things that people are looking for. Continuity is not just about having one particular person, but is about the nature of the relationship with the service, too. In other words, although we might say, “We have a predefined response about what you can get and you can take or leave it”, what is actually more important is having that particular conversation and how it plays out. To what extent do you involve the person in understanding who they are and what matters to them?

It is also about co-ordination. I think that people understand that different healthcare professionals have different expertise to offer, but what they do not want to be is the only person who has to navigate the system. The system is so complicated to navigate, and no one is really there to help you do it. Therefore, we would cautiously welcome some of the proposals that are about trying to have a single point of co-ordination.

What worries me is that we were not very much involved at all in the flow improvement plan, and I would go back to Jane Ormerod’s point about those who are on waiting lists for accessing services and those living with long-term conditions having invaluable insight into how the system is or is not working. The frustration is that the Government is willing to involve people at the consultation phase but then does not involve them when it comes to implementation and making sure that the solutions are the right ones. That is immensely demoralising for people.

I think that continuity of care is really important, and the evidence is that we need to target it at people who are facing the highest barriers to accessing what they need. It is also important to understand who is in a good position to do some of that work; it will often be healthcare professionals, but often it will be third sector professionals whom people are working with, whether they are community links workers, mental health practitioners or whoever. The responsibility has to be much more on the system to ensure that any such response is much more compassionate

and respectful of people's health and wellbeing, instead of the system constantly just trying to manage demand and giving you a reason why you should not be accessing a service.

Janet Sylvester: Can I come back on the question now?

Joe Long: Yes.

Janet Sylvester: With regard to lived experience, what Sara Redmond and Jane Ormerod have described is very much the case. For many people with ME, continuity of care is almost a dream—it simply does not exist at the moment. I am afraid to say that I have not actually read the plan that came out yesterday, but as Stuart McIver points out in his submission, the fact is that people have to become the expert patient. They have to negotiate their way through the system as individuals; I am sure that those with ME are not alone in this, but there is no co-ordinator of it all to help people co-ordinate their care.

With something like ME, GPs quite often do not know what to do, because there is no pathway for people with ME to follow. They are completely at a loss as to how to co-ordinate their care. If the new plan tackles any of those issues, that would be good.

The Convener: Thank you, Janet. I think that Jane Ormerod wanted to come in.

Jane Ormerod: We have already heard quite a lot about prevention both in the earlier evidence sessions and in this session, and what has, I think, been particularly striking is the fact that if we could improve some of these issues—even solve them, dare I say?-—we would save people with long-term conditions having to access secondary care, which is what we all want. Such care might well be appropriate for them, and they might need it, but if there are other primary care health professionals who can help with and solve matters, and if people with long-term conditions can get access to them, we might be able to stop people going into secondary care.

Another thing that I will mention is around education. We heard a lot about workforce planning and education from the earlier witnesses, and some good work has been done, certainly on long Covid and ME, but it only scratches the surface when it comes to educating health professionals. We really need to work more on that and involve people who have lived experience when developing and evaluating those educational sessions. If we do so, we will see health professionals in a better place to support and help people with long-term conditions.

The Convener: Thank you, Jane. To give a bit of background, 30,000 people in Scotland have ME and 70,000 have long Covid—those are the figures that I have seen as registered with GPs, and they seem to be about right, if not an underestimate, because I certainly know from personal experience that you do not go near your GP after a while, and they probably do not know that you exist. Although it is probably an underestimate, that is still 100,000 people.

Figures have been produced previously that show the billions of pounds that that costs the country, and that the people who are affected are often young. Seventy-five per cent of people with ME are women. Is that also the case for long Covid?

Stuart McIver: Yes.

The Convener: That point will be interesting for when the committee considers inequalities. I think that people with chronic pain are also often women due to their having various conditions such as arthritis.

Kirstin Laing, I do not know whether you want to come in on that point. You made a specific point about getting the pain treatment: there are very few pain clinics, and as you have said, they have now, for some reason, rolled back on helping people get treatment. Most of the chronic conditions that we are talking about are not curable as such. Some people might improve, or even get better in the case of ME, but a lot of the time it is ongoing and treatment is about what you can do to manage it.

There is a phrase in the Government's paper called "waiting well", which I presume means "while you wait for care", but in this case, we could talk about living as well as you can. Kirstin, I know that you were on the cross-party group on chronic pain and you talked about how you and your husband get treatment, but I understand that many people do not get it. Could you explain the effect that that has had on some of them?

Kirstin Laing: I know from being involved in the cross-party group that it is not an isolated issue. The continuity of care in chronic pain is abysmal—there is none. It is much more of a postcode lottery based on where you live, and its impact on people who have had injections removed or delayed is very difficult to put into words.

Most people who enter the chronic pain management service have exhausted all the possibilities that are available to them. They are at the end of their tether and, to be fair, probably almost suicidal, because there is no escape from chronic pain, which impacts every single part of a person's life: their ability to function, ability to think straight and ability to get out of their bed.

Yes, a multidisciplinary approach to chronic pain does help, and self-management has its place. However, patients need to be evaluated by experts

in chronic pain management because the GP can only go so far, whereas the lead clinicians who are in charge of chronic pain management have seen it and know what works for different patients. Part of that might involve clinical intervention.

Surely a patient should be able to exhaust all the possibilities that are available to them before they are just sent home to "live well" with pain. For many patients, "living well" is not living, whereas having the option of a chronic pain management specialist even looking at them, and the option of some clinical intervention, can be life changing. It can make somebody who is unable to work be able to work. It can make somebody who is unable to have any time with their family whatsoever be able to be present with their family.

11:45

Decisions about our pain are being made by those in health board management, and even in the Scottish Government, who do not regard us as people. I do not see why my pain is not as valid as that of a new patient coming into NHS Highland or any of the other health board areas where people are not being triaged correctly and are just hanging around in the system, being told to do yoga and exercise. Why is my pain not as valid as theirs?

Why is my pain not as valid as that of somebody who has just had, say, spinal surgery? The severity of their pain might be the same as mine, but I am without an injection. On the ward, their pain is controlled. They are not told by a doctor or a nurse, "I'm sorry, but you'll have to go home and live well with your pain." Their pain is controlled, so why is my pain not controlled? Why are the options for patients who come into services in Scotland being completely dismantled, rearranged and denied, with their pain not being controlled?

We are not talking about pain management that removes pain altogether. We have an incurable condition. It is chronic pain. However, through chronic pain management, it is possible to get relief from pain—relief to the point at which people can enter society and be people again, instead of being waking zombies who lie crying, waiting for the medication to kick in, because they have reached their limit. Their tolerance of the morphine is so high; they are on levels of morphine that people who are dying are given, but it is not enough because their tolerance has reached such a point and so they lie crying in a corner.

That is the difference between chronic pain management being consistent and well managed and patients being denied it altogether.

The Convener: Thank you very much for sharing that. You mentioned the mental toll, too. Kenny Stewart, in your experience, do a lot of people who have mental ill health also have underlying chronic illnesses, as well as dealing with their life circumstances and perhaps depression? Do you find that quite a proportion of people are in that position?

Kenny Stewart: Absolutely. I do not have stats to hand on that, but we operate more than 70 services across the country, and people certainly come to us with comorbid conditions. There can be a bi-directional relationship between mental health and other conditions. Conditions such as chronic pain can lead to poorer mental health, and sometimes it can go the other way, too.

When we talk about continuity of care, our mantra for some time has been that people with mental health problems should be able to ask once and get help fast. Obviously, I have not had much time to read the flow plan yet, but it talks about having one conversation. As Sara Redmond rightly said, that does not necessarily mean talking to one person, but it does mean explaining your circumstances and then not having to tell your story over and over again. There is certainly a role for community link workers in that regard.

There is also a role for independent advocacy, whether for people in the system or for those in community care. In relation to continuity of care, we need a shift into the community, with care being available for people where they are. We have heard a lot about the challenges of accessing services, so there needs to be support at home and across community services.

Kayleigh Kinross-O'Neill: Some witnesses have mentioned that the timing of access to treatment is really important. Have you any advice for the Government—or for us, as committee members and scrutineers of the Government—on how best to involve and include disabled people, people with mental health issues and folks with chronic conditions in that scrutiny and decision making?

I do not know who wants to answer first.

Jane Ormerod: I will, please.

In many instances, systems are in place. There are policies aplenty about co-productive work: what it looks like, the detail of it, how patients should and could be involved, and reimbursement for patients who are involved. There are systems in place in many health board areas—I am not saying all, albeit that that should be the case.

We are not going to reinvent the wheel. It comes back to that. We have strategy systems aplenty; let us get them implemented, working properly and engaging in a way that makes patients feel that their input is valued, because, as we have heard today, that does not always happen.

By and large, if patients are asked for their realistic and truthful input, they will give it. However, we get fed up of telling our stories, that is for sure. We are more than our stories. Very often, people in such groups have a set of skills and previous experience that can be of real benefit. Those need to be utilised. I say that we should use the systems that we already have in place, make them work and let patients be involved in the whole thing.

The Convener: Thank you, Jane. I think that Kirstin Laing wants to comment.

Kirstin Laing: Yes, but on a previous little point about mental health as well as on the current question.

From my perspective, I have attended numerous meetings and have listened to lots of patients from all over Scotland talk about the impact on their mental health of not having their pain managed. The thing is that, pre-Covid, 40,000 returning patients and 20,000 new patients came into chronic pain management services in Scotland. However, only new patient waiting times are published, so boards do not have to publish how long patients wait for treatment—and patients are left waiting.

One patient spoke eloquently about her struggles with contemplating suicide. From 2021, NHS Lanarkshire left her for three years without an injection, despite MSPs campaigning and lobbying to try to get her something that she had previously had for many years.

Another difficulty is that some of the language used around patients and meaningful discussion is not helpful. When practitioners make decisions about our interventions and injections, and remove the choices that patients had before, or even just the menu of options, the new patients do not know that those procedures are being removed. They do not know that those decisions are being made.

I was on NHS Highland's pain network. We sat and talked with everyone in the network about what we thought the vision should be for moving forward. I and the other patient rep were patiently listened to, but nothing was implemented and nothing that we said was used. The whole thing has been stopped and disbanded because, unfortunately, a lot of the things that were brought to the table were not used by NHS Highland.

The language that boards use to talk about their decisions is downright insulting. This week, *The Press and Journal* is running an article on concerns about NHS Highland. I will give an example of the language that the board used. When it was asked why new patients are not being referred and offered clinical interventions—why that has been stopped for four years—it said that existing patients continue to receive their injections but that the

"Chronic Pain Management Service does not accept referrals for new injection interventions. Patients are triaged against referral criteria and prioritised accordingly within respective Services … Our focus in the pain team is to support and coach patients to understand their condition and develop skills to live well with pain. This is similar to other Boards the same size as Highland. Injection interventions are not a cure and do not promote long term change. Clinical opinion was there was limited evidence for offering injections."

According to that, I am obviously not living well enough with my pain. What long-term change would the board like patients like me to make? Should I stop having injections and go back to being bedridden and on morphine because having an injection does not cause long-term change? The change is about being a human being as opposed to being bedridden. The phrase

"Clinical opinion was there was limited evidence"

makes me wonder what chronic pain management as a specialty has been doing for all these years and decades. The answer is that it has been changing people's lives. Patients are the clinical evidence—hey should task us what difference it makes.

The Convener: Kirstin, we are going to switch you to audio only, because the connection is not that good. We heard everything that you said there, and I appreciate your sharing that. We are not turning you off, but you will move to audio only.

Kirstin Laing: Okay.

The Convener: Paul McLennan wants to ask a question.

Paul McLennan: My question is for Kenny Stewart. Your submission made several points. One of them, which you also mentioned in your opening remarks, relates to achieving a meaningful shift towards prevention. We have heard about prevention throughout our evidence sessions today, but will you say a bit more about how you see that happening? I suppose it is about having a more systemic approach, because this is not just a health issue. The question is where health fits into that, because—as we heard this morning in the earlier evidence sessions—the issue is much more systemic.

Kenny Stewart: It is about more than health; it is about social care as well. We heard yesterday that change is coming. The strategic policy building blocks are in place. One of the big challenges relates to the kinds of positive, progressive national ambitions in the population health framework and the service renewal framework. There is nothing to disagree with in those frameworks—there is actually much to commend. However, there is a huge disconnect

between decisions that are made locally and what actually happens on the ground—

Paul McLennan: Sorry for interjecting, but my second question was going to be about local procurement and commissioning. Maybe you can take that question as well when you are answering the first one, because that is almost the same—I would be asking the same thing.

Kenny Stewart: Sure. In the session with the first panel, Heather Anderson asked about statutory and discretionary obligations. The truth is that, at the moment, prevention is discretionary, but IJBs naturally tend towards their statutory obligations—they need to.

Yesterday, there was stuff in the programme for government about a prevention investment framework. That is an interesting idea, and I will be fascinated to see what it is about. I hope that, as stakeholders, we around this table will be involved in that.

Fundamentally, prevention and the type of participation that Kayleigh Kinross-O'Neill was talking about are what the third sector does incredibly well, and we do those across communities. When it comes to that kind of participation, I should also mention the Scottish Recovery Network, VOX Scotland and other organisations in that space. We can innovate, we can take chances and we can try to do things a bit differently—we have that agility.

From SAMH's perspective, we have recently rolled out what we call the nook, which is our national network of walk-in, no-referral community mental health hubs with no waiting lists. So far, more than 8,000 people have visited our hubs, although the first one opened only 10 months ago. Yesterday, in the programme for government, we heard that the Government will provide support for the nook network, which is really welcome.

If we can get Government support for initiatives such as the nook, as well as for the services offered by Chest Heart & Stroke Scotland and others, we can make a dent in achieving our goal of prevention. If we can move there, that will lead to improvements in individual health outcomes as well as a reduction in the pressure that statutory services and the NHS face.

If we look at how reorganisation might work over the next three months, we can see that we will need to ensure that local government and IJBs, whichever form they might take in the future, are able to tailor support to their areas. However, we will also need to be able to turn those national ambitions and desired outcomes into reality and spending decisions on the ground, which we have not achieved so far.

Paul McLennan: Kenny, just one thing—

The Convener: Sorry, Mr McLennan. You can have just a quick follow-up question.

12:00

Paul McLennan: What is the most appropriate way to access mental health triage, initially? Some people are referred, for example. I am not just talking about CAMHS; the issue is much broader than that. What are the key points on triage? Someone might seek help from their GP or from you. What is the most efficient way to access triage?

Kenny Stewart: Mental health services have argued for a long time that we need to see multi-agency responses. GPs need to be a significant part of that and, if we are talking about young people, CAMHS obviously needs to be involved as well. That is particularly important given that, yesterday, we had new data on waiting times for CAMHS and adult psychological therapies. The adult psychological therapies waiting time target has never been hit in our history, and almost four in 10 CAMHS referrals are being rejected.

If we were to have a multi-agency response to a CAMHS referral, it would be much easier for a young person to be signposted somewhere else. Often, CAMHS is not the right place for young people. However, it is the only thing that a concerned teacher or GP is aware of, and so it gets all these referrals, which are often not appropriate. Young people need to be able to go somewhere else, and that is made much harder if the right people are not in the room.

The Convener: Heather Anderson might have a specific question about the nook.

Heather Anderson: Yes. However, first, I want to thank Jane Ormerod, Kirstin Laing, Stuart McIver and Janet Sylvester for their very powerful testimony on long-term conditions. We will not forget that.

My question is for Kenny Stewart. In Dundee, we have Hope Point, which is a 24/7 walk-in service for people with mental health issues. We want to make a shift to prevention, and your report mentions that you are beginning to think about evaluating that. We know that the numbers at Hope Point at 3 o'clock in the morning are lower than they are at 9 o'clock at night, but the people there at 3 o'clock in the morning really need support.

Will you share your thinking on how we measure the impact of prevention? If people go away and you do not see them again or follow them up, how do you know that you have helped?

Kenny Stewart: Absolutely. There are obviously things that we need to do at the national

level. An outcomes framework was promised in the first year for the SRF, but I do not think that we have seen that yet; it is late. I hope that it will be considered an urgent piece of work that will be taken forward in this new session.

Before I get to the nook network, I note that we do not really know the extent to which a lot of our statutory services help with people's mental health at the population level. Back in 2023, Audit Scotland published a report on adult mental health that said that we do not really know the efficacy of much of what we are doing.

In evaluating the nook, we try to gather a whole range of data points with the people who come to visit. Obviously, we make that proportionate to the relationship that we have with them: if someone is coming in for just a brief chat, we do not want to hit them with a barrage of questions, because we do not want to create any further barriers. However, we are trying to establish the extent to which we are, in fact, improving the mental health and wellbeing of the people who come in to see us, as well as what they might have done had they not come to us; for example, might they have gone to a GP, and so we have diverted them away from that?

We have engaged the University of York to support us on a piece of work on health economics to consider the impact of the nook. That should help to make the case for it and to demonstrate its efficacy, as well as that of community support in general. There will be lessons that we can use to evidence the importance of having such walk-in community support across the country.

The Convener: We have a question from Jack, and then I will ask one or two.

Jack Middleton: A thread that I have pulled upon with the last two panels of witnesses is around tackling wealth inequality in Scotland, which I am deeply passionate about. Will you each reflect on how poverty, access to cash and living in a deprived community, where we know that people have significantly poorer health outcomes, impacts and exacerbates the conditions of the people you represent?

Stuart McIver: We are really blind on how long Covid and ME affect elderly people. We do not know what is happening there, because we do not have the data. We also do not know how they are affecting ethnic minorities. Efforts have been made, but we just do not know. My concern is that a lot of elderly people have just been left to suffer and are not accessing help at all.

Long Covid and ME affect people's ability to work. I have only just come back to work part time. They are greatly impacting people at the thin end of the wedge in society. People who were already affected by poverty have been greatly and further impacted by long Covid. A lot of health workers are from different ethnicities and have been disproportionately affected.

People have been catapulted into poverty as a result of their illness. People who were making valid contributions to our society are now economically inactive, but we are not looking at the costs of the lost economic activity of those people. We are blind on that.

Of course it is having an effect. Why would it not have an effect? However, no work has been done on that, and I do not know why. It is very troubling to hear content about disabled people being a burden on society. They are not receiving the support that they need to get themselves out of poverty.

Jack Middleton: Would it be an ask from you for the Scottish Government, through Public Health Scotland, to do much more work on the subject so that we actually know the impact?

Stuart McIver: Yes. We need to have consistent data across everything, but we are not looking for it. The long Covid inquiry spoke about the need for data. Where is it?

The Convener: Would it be fair to say that people might think of this as a middle-class disease because middle-class people are the only ones who can fight their way through the system, or even get into the system?

Stuart McIver: Yes.

The Convener: There must be a lot of people who have no idea what is wrong with them. Not everybody with long Covid knew that they had Covid before they developed the symptoms of long Covid, and people may not have been particularly ill, although some were. It is the same with ME—it takes a lot to get a diagnosis, although it may be getting a bit easier.

Janet Sylvester: That is a very good point. People have to be articulate and, as I said earlier, be their own expert patient in order to get help through the current healthcare system. People who are facing complex problems in their lives in low-income areas and throughout Scotland are going to see GPs, but those GPs may not be aware of how they can be helped. Without having the required knowledge and being the expert patient, it is very, very hard for people to get help.

Where GPs diagnose ME, they may not know how people can be helped and supported. Where they do not diagnose it, they may give people the wrong treatment, as I said earlier—they may tell them to do things that will actually make them worse. There are real issues in that regard across the board.

Jane Ormerod: At Long Covid Scotland, we have had three messages in our mailbox in the past three weeks—two from youngish people with young families and one from someone who was not, I suppose, on a lower income—who have been, as Stuart McIver said, catapulted into economic difficulties because of long Covid.

One of those people was told by their GP, "Well, I can't do anything for you." That was it—full stop. They have asked us for pointers on what to do. The second person has similar issues. The third person has a hugely complex issue to do with social security. They had got well into the system, but they are facing complex difficulties to do with Motability and everything around that, and they were not sure where to go for help.

Those are just three people that we have heard from in the past fortnight. I am sure that there are a whole load of other people out there.

The Convener: Are GPs telling people, "You might find help from these organisations," and are you, as a result, finding yourself further burdened? I see that you are saying no—people do not get referred.

Jane Ormerod: No.

The Convener: I take it that that means that you are not recognised enough for that to be a recognised route.

Anyway, I imagine that you do not have the ability to take on referrals. You are a volunteer organisation, and I presume that nearly all of you have long Covid. I know that it is a similar case in #MEAction.

Sara, did you want to say something?

Sara Redmond: You raise a very important point. The current structure of the health and social care system risks widening inequalities, because it is so complicated to find the support that you need and there are so many barriers to accessing it. In addition, there is an organisational culture that, at times, operates a system of bias, so people often describe feeling a sense of stigma, of not being listened to or of being gaslighted when they try to raise the issues that they are encountering. As a result, they need quite a lot of resilience and self-advocacy if they really want to find the support that they are looking for.

You will probably have seen the diagram that shows that only 20 per cent of a person's health outcomes will be influenced by our healthcare system. Considering how much public investment goes into that system, it is absolutely vital that it is tasked with addressing health inequalities, not widening them. We feel that a really high priority for Government and the Scottish Parliament is to ensure that the reforms that are taken forward focus on addressing the barriers that people encounter. Therefore, your question is really important.

Public Health Scotland, public health practitioners, GPs and others have been doing work to inform the healthcare inequalities action plan, which is about the barriers that people encounter in trying to access healthcare. That plan needs to have much more prominence, as it forms an important connection between the population health framework and the work that Scotland's health and social care services can be doing. It is really important that that equity argument lies at the heart of all of this.

Another point that has continued to come up is about data and the fact that we are not actually monitoring who is or is not receiving the services and support that are available, and we are not tracking unmet need. That leadership is just not there, and monitoring is an important action that needs to be taken forward as part of the approach to healthcare inequalities.

The Convener: I am going to round up, but first I will give Kenny Stewart a chance to say what he wants to say, and then I will ask the lived experience people for their thoughts.

Kenny Stewart: With regard to mental health, there are lots of areas where we do not have enough data, but this is actually an area where there is quite a lot of data available. You are much more likely to die by suicide, live with mental illness or be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 if you are from a more deprived area.

That points to three things in particular, the first of which is ensuring that support is available to people where they are in those communities. It is also about social security; I know that that issue is not part of this committee's remit, but I point out that, towards the end of last year, we had an independent review of the adult disability payment. The Scottish Government put out a bit of a holding response to the review, saying that there was too much in it to do before the election. However, I note that there was no sign of social security in yesterday's programme for government, and certainly nothing about the adult disability payment, so we need to see that picked up in this parliamentary session.

Something else that was talked about last session, and possibly the previous session, was the abolition of non-residential social care charges, which is another real barrier for people experiencing poverty when it comes to accessing care services.

The Convener: Thank you, Kenny.

I will give Janet Sylvester a chance to give a closing statement, but I hope that she does not mind if I give a bit of background about the ME community, given that we did not really go there.

For the benefit of the committee, and those members who might not know, I point out that ME has been known about, under different names, for several decades now. Many people, some of whom are in #MEAction, have been ill for decades. Those with long Covid, which is appalling, are unfortunately looking at the ME community, which is already there, and thinking, "That could be us."

12:15

There is a lot of talk about prevention, but we do not know how to prevent anybody from getting these conditions. They are mostly post-viral conditions—that is the general conclusion nowadays—and there is general acceptance that they are neurological, among other things, and not psychological, but GPs do not necessarily know that. Janet Sylvester referred to people being given advice to exercise, and we know that many people have been badly affected by that. There is data on that from survey work.

Is there evidence that doctors are getting better at dealing with people with ME? I will not ask you whether the numbers are increasing, because there are people with long Covid now. There is a spectrum. I am not saying that everybody is the same—it depends on what they had originally. For both groups, is there any evidence that doctors are dealing with the conditions any better, or are people still struggling to find somebody who is sympathetic and gives the right advice?

Are the National Institute for Health and Care Excellence guidelines being followed in Scotland? It took several years for us to get the NICE guideline for ME, which was introduced in England in 2021, adopted in Scotland—I declare an interest, as I was involved in that work—and for doctors to be educated about the condition.

Janet Sylvester: The NICE guideline for ME and CFS was adopted by the Scottish Government in 2025. There is anecdotal evidence that that has been very helpful, because patients are able to tell their doctor that a NICE guideline exists and that the Scottish Government says that it should be followed. It is not necessarily the case that doctors know a great deal more about the condition until a patient tells them that they need to refer to the NICE guideline, but we have certainly heard anecdotal evidence that the adoption of the guideline has been positive.

We are very concerned that some of the services that are being developed using the £4.5 million of funding are not following the NICE guideline. It is critical to us that the services that cover long Covid, ME and similar conditions use their funding in a way that helps people with all those conditions and do not focus only on specific ones.

One of our key asks is that the services employ trained staff. We know that the issues with recruitment and training, which were discussed earlier, are really problematic in relation to finding an ME specialist. Courses, training and continuous professional development on ME exist, so it is a case of promoting that and making people, particularly healthcare professionals, much more aware of it.

To answer your question, I think that anecdotal evidence suggests that there has been a slight improvement, but people can still face complete ignorance when they go to see their GP or another healthcare professional. As I said, our concern is that the services that are currently being developed are not really addressing the issues.

The Convener: I am sorry to hear that.

Stuart McIver: The problem is that there has to be something for a GP to refer people to. For example, NHS Highland has just opened—today, I think—new referrals for long Covid. That option has been closed for a year, so what do the GPs do up there? I do not really understand why that is the case, because there are doctors there. That is why the report on post-infectious and associated complex chronic syndromes, which we have spoken about, is so important. It will set a baseline.

Education is key. Last week, I spoke to a doctor who told me that another doctor had said, "Long Covid—it's not real, though, is it?" It is real, and ME is real. There are cultural issues that need to be addressed through training. That is why we need the framework for people to refer to.

Separately, I noted from yesterday's discussions that members are specifically concerned about the flow stuff and whether it will be more of the same with regard to the "once for Scotland" approach and care for people in their areas. What is different?

The approach is not working now. It is great if support is centred on your area, but if the area is not giving you the care, you are stuck, which is why so many people have given up. GPs have given up—if I were a GP, I would give up, because they keep referring people to nothing. There is a huge unmet need, and a huge percentage of people have given up. We need to find those people and reach them, which is why I have spoken consistently about public health information. Covid is inconvenient, but it is even more inconvenient for people with long Covid and ME.

The Convener: Thank you, Stuart. Do you want to add anything, Jane?

Jane Ormerod: Being here today has felt like groundhog day. In 2024, Stuart and I gave evidence to the Scottish Parliament's long Covid inquiry. I also gave evidence to the UK Covid inquiry. Many of the issues that were spoken about then are absolutely the same today. We do not want further strategy development; people need service delivery and action now. We do not want a gap before whatever comes next. Services do not want to stop. If they are in place, let them continue. Let us see something that reflects all the information that has been provided by service users. We need to be given some respect, really, and seeing such action would signify that.

The Convener: Thank you, Jane. I am sorry to hear that the situation has not improved.

Kirstin, do you want to give a closing comment?

Kirstin Laing: I want to respond to the question about deprived areas and chronic pain. If you look at the data on that, you see that it shows a higher percentage of patients in those areas because people injure themselves in manual jobs. A lot of people who come through chronic pain management are nurses or home carers who are injured in work. Your ability to navigate and advocate for yourself through the service is affected by your education and where you live. People who are in deprived areas are at a disadvantage.

My closing point is that, although I echo everything that everybody has said about chronic pain management, it is a little bit simpler for patients like me because it is a question of what works for us. Just protect what works, because it has a profound effect on people's lives, and we are not taking up more NHS resources because our pain has been adequately managed. We must examine the inequality between patients and, as I brought to your attention, the disparity between old and new patients. We must insist on patient involvement from the start, keep people informed and listen to what is being said because, after all, our lives are affected.

The Convener: Thank you, Kirstin.

I am afraid that we have run out of time. We are very grateful to the witnesses, especially to those with conditions—Stuart McIver, Jane Ormerod and Kirstin Laing—and Janet Sylvester for telling her story. I could not agree more with the point about having to go out and tell your story to encourage action.

I am sorry to those who say that the situation has not improved. Based on what Janet Sylvester said, perhaps there is a glimmer of hope, but a key point that has emerged is the need to find out what has happened to the £4.5 million, how it is being spent and what education—if that is what specialists require—will be undertaken so that the money can be spent as it should be. I hope that we will all see an improvement in that area.

I also thank Sara Redmond and Kenny Stewart for giving broader perspectives and representing people with other conditions.

Decision on Taking Business in Private

12:24

The Convener: Before we close, do members agree to take our review of evidence in private?

Members *indicated agreement*.

The Convener: I should have asked that question at the beginning of the meeting.

12:24

Meeting continued in private until 12:39.

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Room T2.20
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Email: official.report@parliament.scot
Telephone: 0131 348 5447

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