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Aithisg Oifigeil

Health, Care and Sport Committee

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Wednesday 16 September 2026

Session 7

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HEALTH, CARE AND SPORT COMMITTEE
4th 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:

Angela Constance (Cabinet Secretary for Health and Care)
Alison Thewliss (Minister for Community Care)
Maree Todd (Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health, Care and Sport Committee

Wednesday 16 September 2026

[The Convener opened the meeting at 09:30]

Scottish Government Priorities

The Convener (Helen McDade): Good morning, and welcome to the fourth meeting in 2026 of the new Health, Care and Sport Committee. We have received no apologies.

This meeting is part of a series to enable members to gain an overview of the key issues. Today, we are focusing on the priorities of the Scottish Government, and our witnesses have kindly given us up to two hours. We welcome the Cabinet Secretary for Health and Care, Angela Constance; the Minister for Community Care, Alison Thewliss; and the Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs, Maree Todd, as well as their officials—I hope they will excuse my not introducing them all by name.

We will have an opening statement from the cabinet secretary, and we received a written submission before the meeting.

The Cabinet Secretary for Health and Care (Angela Constance): Good morning. Thank you for the opportunity to appear before the committee, convener. This is my first appearance at committee since my appointment as the new Cabinet Secretary for Health and Care. All ministers very much welcome the opportunity to discuss the Government's priorities directly with committees. No doubt, this will be the first of many appearances.

The committee will be aware that at the very heart of the programme for government is a clear commitment to protect, renew and reform our health and care system. We have a national health service that is founded on the principles of publicly funded healthcare that is free at the point of use and supported by dedicated staff to provide high-quality care each and every day. My responsibility, and that of the Government, is to ensure that those principles remain sustainable for future generations.

There is clear progress in a number of areas, to which I will quickly draw the committee's attention. We set a target to deliver 150,000 extra appointments and procedures in 2025-26, and we have gone beyond that, delivering more than 168,000. Since we opened our first general practitioner walk-in service in February, we now have 11, and our plans for 15 were so popular that we have now more than doubled that to 40. The numbers of GPs, nurses, midwives and dentists are all up. The number of new out-patients waiting longer than 52 weeks is 76.7 per cent lower than it was in July 2025. Finally, the risk of dying from cancer in Scotland is at the lowest rate on record.

However, we continue to face significant challenges. Demand for health and care services continues to grow as our population ages, and financial pressures require us to ensure that every pound of public investment delivers the greatest value. I am also aware that we still have people waiting far too long for the care that they need, which I find simply unacceptable.

I want an NHS that ensures that everyone, regardless of where they live, gets the right care in the right place at the right time. I want a focus on earlier intervention and a simplification of our national health service. To do that, we need to break down the barriers that lead to slow decision making.

I will give the committee some quick examples of such barriers. Queen Elizabeth university hospital in Glasgow must work with six different health and social care partnerships to discharge patients. Across the country, we have 84 accountable officers all taking different decisions. It just does not make sense that, with the current barriers between health boards, neighbouring health boards such as Tayside and Fife require multiple layers of approval before patients can access care in the board next door.

That means that we have slow decision making and delays in transferring care short distances down the road or to other parts of the country. That is why public service reform is central to the programme for government. Fundamentally, public service reform is about improving services for people, not structures. Our focus is on simplifying systems, reducing variation and supporting our hard-working staff to deliver on the ground. It also demands that we look at the system as a whole.

We cannot reform the NHS in isolation. We must also reform how social care is delivered, but that is not entirely in the gift of the Scottish Government. We will require partners from local government, the third sector and, most importantly, the people who use social care services to agree the next phase of social care reform. That is why we have committed to a three-month period of engagement with the aim of agreeing some solutions to deliver services that are more person centred, sustainable and easier to navigate. We are clear that no option is off the table and that success will require partnership across the board.

Alongside the longer reform programme, we remain absolutely focused on delivering improvement in the areas that matter most to patients and the public. The committee will be aware that the Government recently published the national flow navigation centre and hospital flow action plan, which includes important measures, such as: increasing the number of people being treated through hospital at home, including within paediatric care; implementing discharge without delay, so that conversations about a patient's discharge are held on day 1; increasing activity; and reducing the longest waits.

I will draw my remarks to a close. The task ahead of us is undoubtedly significant, but so, too, are the opportunities. My focus as cabinet secretary will be on delivering practical improvements for patients, supporting our workforce and building on the strong foundations that we have. I very much look forward to working with the committee and discussing all those matters further, as the three of us do as a health and care team.

The Convener: That leads on nicely to our questions. I was thinking that the best way to structure this is that we will address questions primarily to you, cabinet secretary, to begin with, for around 20 to 25 minutes, then move on to the ministers. That way, the questions will not spread across portfolios too much. Of course, committee members are welcome to ask supplementary questions, and you are welcome to interject during someone else's question.

The plan for major reform is a good place to start. I ask committee members and witnesses to keep questions and answers short as we have a lot to get through. We obviously want you to have the time to say what you want to say.

Jack Middleton (Aberdeen Central) (SNP): Good morning. Thanks for coming to the committee this morning.

Cabinet secretary, your submission to the committee confirms that it is the Government's intention to move to two health boards, east and west. Will you please unpack the rationale behind that for the committee and specifically—I ask this as the most northerly MSP on the committee—how you think that will work in the north of Scotland, which has unique needs as a region? Will you also confirm that that region will not be split in half and that those unique needs will be accounted for in that east-west system?

Angela Constance: Thanks very much, Mr Middleton. I start by saying to you and to colleagues that what we seek is transformational—not marginal—change.

On the arrangements that will serve the people in the north of Scotland, my rhetorical question to you and to other MSPs is, how are current arrangements working for you just now? From the questions posed to me in chamber, the correspondence that I receive from members of the Parliament, and written parliamentary questions, I hear dissatisfaction with the status quo. That applies in the north of Scotland as it does elsewhere.

Let me be candid; change and public sector reform are not optional. We are making changes because we want to protect services in the north and elsewhere. Our national health service is our most precious service, and we need to protect it for the future, as there is rising demand. I am acutely aware of the uniqueness of different parts of Scotland, including the north, the more rural parts and our island communities.

Let me be straightforward and say that this is not about centralisation. In fact, it is the opposite. I have been very clear with my officials, the chief executives and the chairs of boards that we must not confuse a move towards removing boundaries, removing bureaucracy and a simplification of decision making and governance structures with local service delivery. I want to do more to boost fragile services in all parts of Scotland, because there is an issue of equity, despite Scotland being a relatively small country. If we want to do that, we have to make better use of our resources, and in some areas that requires us to work on a once-for-Scotland basis.

We do not need 14 different ways of doing things. We need to reduce unwarranted variation—I choose those words carefully, because this is not a one-size-fits-all approach. I hear about unwarranted variation a lot from MSPs, who, at the end of the day, represent the people that we seek to serve.

I will endeavour to continue to reassure people in all parts of Scotland that PSR is about serving all parts of Scotland.

Jack Middleton: I want to challenge some of that, and I would like more clarification about how we have landed on having one board for the east and one for the west. Perhaps we will have information on that at the end of the consultation period, but can you provide more information to the committee on that today?

Angela Constance: Important foundations have been laid, but I stress that it was not guaranteed that we would land on having two strategic boards. There was an inquiry process, and any Government has to balance pace and deliverability issues. There are always other options available in such processes. Having one

board was an option, but that would take longer to pursue and would require primary legislation.

I noticed in Labour's manifesto that it supports having three health boards, but that is the only place that I have seen that suggestion—I say that with respect. That suggestion has not been made through the system or through the engagement that I have had.

We have an important platform to build on, which is the structures around what we call subnational population planning. Forgive me—we have lots of titles, language and jargon in the health service, which at times might feel impenetrable. In essence, subnational population planning was about enabling health boards to work together. For pragmatic reasons, it took an east-west approach, because there needs to be both a balance in the range of services provided and sustainability. I am not telling any tales out of class, but there are particular challenges in NHS Highland and in NHS Grampian—NHS Grampian has been escalated to stage 4. Any structure has to be sustainable. We need the breadth and depth of services if we are going to get people to work together to improve equity.

I also stress that the reform is not only about vertical co-operation; irrespective of the east-west structures, we will expect people to work in a once-for-Scotland way and across the east-west provision. I apologise for the length of that answer.

09:45

The Convener: No need—there was a lot to discuss there, and I will follow up on two aspects of it.

Was subnational planning almost a trial of the proposal, given that it was set out on an east-west basis? You referred to NHS Highland and NHS Grampian, where I know there have been problems with some things. We could have a fight about who comes from furthest north—I come from Thurso—but, in any case, we know the problems with health services up there. Inverness, Raigmore and Aberdeen have always worked together, for example. I take your point that people can work across those areas, but there have been problems with dividing things into such large areas across that east-west border. Some areas have done well, while others have not really managed under those arrangements. If subnational planning was really a trial of what you are thinking about now, is there evidence from it that we can look at that shows improved structures?

You said that those in the NHS are the people to do this but, in many places, the NHS is not in a good place. Are they really the right people to turn things around? I absolutely agree with you that change is not optional but, in handing things over, should you not perhaps be thinking about new management coming in? Perhaps you are. I suppose that that is my question. What has been trialled on this proposal through subnational planning? What have we learned from it, and can that be shared with us?

Angela Constance: I would not necessarily describe subnational planning as a trial, and I certainly would not describe the move from subnational planning to two strategic health boards as a fait accompli.

You are absolutely right that there is some very valuable learning here. Subnational planning has taught us about the potential for co-operation, particularly around planned care. I will not repeat what I said in my opening remarks, but I referred to the progress that has been made on the longest waits. That work has taken us so far, and it has involved the subnational planning taking to heart the population health framework and being focused on co-operation as people do what they can to work together and remove boundaries. Ultimately, however, it is a voluntary arrangement.

In developing the approach further, we now need to remove some of the legal and structural boundaries between health boards. There is really important learning there, and I will have a discussion with officials about what we could share with the committee. The best example may concern orthopaedics and the work that the east and west subnational planning structures have done around understanding trajectories and how they can work together to meet the overall aim by the end of this parliamentary session, so that no one waits longer than 26 weeks for their treatment. There is definitely information that we can share.

The Convener: That would be great—we would appreciate that.

On another point related to the plan, have you been speaking to the unions about it? The First Minister has said that there will be no compulsory redundancies, but money has to be saved somewhere, and you are looking to streamline things. How much engagement have you had with clinical experts, among others, and how much have you had with interested parties such as the unions? When does the three-month consultation end?

Angela Constance: You raise a crucial point. I am very clear that I will not be setting out further measures over and above what we have announced in the programme for government until we have completed thorough engagement and partnership working with stakeholders, the workforce and those who represent them. We are currently agreeing a process with trade unions.

Let me be clear that the starting point for all this work is to improve patient care. It is not about structures per se, and it is certainly not about spreadsheets. My perspective is that, over the past 20 years, staffing in the NHS has increased by 29 per cent, and an increase in investment is projected over the next spending review period. I consider that to be positive.

However, we have to recognise that that increase in investment and workforce has not kept up with the increase in demand across the entire service. Therefore, the reforms must be about working better and differently, and about doing so together. I will be engaging hand in glove with our trade unions, because we are doing this with the workforce, not to the workforce. We are relying on the workforce to achieve high-quality services, so it will need to be involved in the design phase and have input into the full business case. I am currently interrogating timescales, and we will also need workforce input on those. There will, of course, be impact assessments, and I am committed to a rigorous programme of engagement.

The Convener: You mentioned the increase in workforce. Since 2019, £3 billion extra has been allocated to the health service, and there are now 20,000 more full-time equivalent or working-time equivalent staff. That is quite a big increase, even over that period, yet we are not seeing the expected outcomes. I ask again, is the NHS the organisation to sort this out, or should it be approached from a completely different angle? Local authorities are already in charge of social care, which we will come on to shortly. There is concern about the management that there has been of many aspects of the NHS. That is the point that I am making.

Angela Constance: As I outlined in my opening remarks, we are seeing improvements, and that is down to our hard-working staff. There is no doubt that we need to do things differently, but let me be crystal clear, for the avoidance of doubt, that the Government is committed to a national health service that is within the public realm. It is our most precious public service. We are not going to hand it over to anybody else to oversee or organise, and we are committed to the founding principle that its services are free at the point of need. It is important that we are clear about that, so that we are not setting hares running and so that we provide stability. We need to work with the trade unions and the workforce so that we get the reforms right.

We are not handing the NHS over to anybody and we will not move away from the founding principles of our national health service—only over my dead body. Our NHS was a hard-won gain of the post-war era. We just have to make sure that it is fit for the future.

The Convener: Do you agree that the local authorities, which are elected bodies, have an important role in the discussion?

Angela Constance: Local authorities clearly have an important role in discussions. They are legally and electorally accountable, and are a separate tier of government. They will be crucial in the discussions on social care.

There is also a discussion about the future of local government, as laid out in the programme for government. There are interdependencies here—we are all well aware of the interdependencies among the NHS, social care and local government. The raison d'être of public service reform is to deliver excellent public services that are not fragmented and to provide a continuum of care for our people.

The Convener: Paul McLennan has a question that follows on from that point.

Paul McLennan (East Lothian Coast and Lammermuirs) (SNP): In one of our previous sessions, we took evidence from the chief executive of NHS Lothian, who talked about subnational planning. She focused on a couple of issues relating to that, including the number of procedures and financial savings. What lessons were learned from the work on subnational planning, and how will those be taken forward in discussions on moving to two health boards?

Another point that came up in our previous evidence session was prevention. I know that this is a broad question, but how do we measure prevention, and what are the timescales for doing so? We cannot move from acute services to a more preventative approach overnight.

Angela Constance: There has been increased activity as a result of subnational procedures and the service delivery that they have enabled. Annual in-patient day care activity from July to July was up by 8.5 per cent, which is very positive. There has been a similar increase in out-patient activity, which is up by 4 per cent to 1.3 million out-patient activities. That means more operations and procedures, as well as strong volumes of diagnostic activity, which is crucial for early diagnosis. There has also been good progress in relation to the eight key diagnostic tests.

I spoke in my opening remarks—I will not repeat them—about how the subnational work is helping to drive down the longest waits. From what I read of her evidence to the committee, I know that Caroline Hiscox spoke about the flow of decision making and resources. However, subnational planning can take that only so far, because there will still be 84 accountable officers, all of whom

understandably make decisions in the best interest of the part of the system or the geographic area for which they are responsible, as they are required to do. We need to find ways to overcome that issue, hence my focus on NHS simplification.

On the question of prevention, a new unit on preventative budgeting is being established in the Scottish Government so that we can better demonstrate the impact of our budget on preventative spend. This Government has undertaken many preventative interventions in health over the years, such as the family nurse partnership programme, minimum unit pricing and, arguably, concessionary travel. Our work on tobacco and vaping is another example.

However, we need to follow the money better and ensure that prevention is knitted into the budget process. That is not just for the health and care portfolio, because 80 per cent of the determinants of good health lie outside the health system. We need to bring healthcare upstream into people's homes, giving them access to services at their fingertips, as well as within communities, whether that is through primary care or community health services. Good health is also shaped by other public services, including education and efforts to tackle poverty.

Paul McLennan: Can I ask a quick supplementary question?

The Convener: Very quickly.

Paul McLennan: I understand the direction of travel towards preventative spending in the budget, and the establishment of that budgeting team is great, but what metrics should we use? I am not expecting you to answer that here and now, but, going forward, the Health, Care and Sport Committee will be asking which preventative metrics it needs to consider. How we, and the Government, assess and track those metrics is a key question for us all.

Angela Constance: That endeavour will be over the medium to longer term. The challenge in shifting the balance of care upstream to preventative care is in managing the transition, given the immediate challenges here and now. I agree that the metrics in the immediate, medium and longer term are important, but we also need to have the courage to do the longer-term work.

The Convener: I ask people to keep questions and answers short. I realise that we are halfway through an hour and have not got through a lot yet, but I welcome the broader background.

10:00

Heather Anderson (Dundee City West) (SNP): I want to cover three aspects of social care: consultation, workforce and legal duties. Cabinet secretary, will you clarify whether there will be one consultation for local authorities and health boards? It is clear that there has been ongoing work with the health boards through subnational planning, but we have been asked by the social care sector when the consultation will start, who it will be with and who will be involved. I would like to get some sense of whether there will be a single consultation covering health and social care, or whether separate consultations will be undertaken simultaneously.

Angela Constance: There will be a range of overlapping discussions. In my engagement with health stakeholders when I came into post just before the summer recess, people were saying to me, "What do you want to do? Can you just tell us what you want to do?" Discussions on public sector reform can be very circular; because of those interdependencies between health, social care and local government, we can all go round in circles. I was really keen to put a stake in the ground and say, "This is where it starts." It starts with NHS simplification, but that will not be the end of the journey.

The issues around social care most certainly do not all lie in the hands of the Government, so we have to work with our partners. Of course, there is also the broader discussion around local government.

I am happy to share this, because I am just working through the final details of what will be my programme of engagement. Obviously, other partners across Government are involved in this, but I will lead on NHS simplification and social care reform, supported by Mr McKee and the Deputy First Minister, given their interests in public sector reform and local government, as well as by the two ministers sitting next to me.

There will be lots of discussion and exploration. Nothing is off the table. There are no blank sheets, but there are no tablets of stone, either. You will have heard the First Minister say that. The endeavour to put some structure and limits around this is something that we have been talking about for a long time. Let us bring social care reform to a shared point of fruition, because social care is an essential service, and its reform is essential.

Heather Anderson: We have heard very clearly from the social care sector concerns about the workforce. It represents 6 per cent of the workforce in Scotland. Lilian Macer of Unison told us that the visa system is causing enormous problems in the sector. They want reform. Last week, Donald Macaskill told us that toxic immigration policies are affecting recruitment in the sector.

If you are speaking with the unions, are you engaging with them on the issues around

immigration, visas and greater devolved powers to help the sector?

Angela Constance: I will bring in Ms Thewliss in a few seconds, because she has been working very hard and very closely on the issues in and around immigration and the adult social care displaced workers scheme.

For brevity, I will simply say that we need to value caring work and the role of carers more. I do not want to revisit any past trauma around debates and votes on the national care service. There is much to learn from that. Speaking very personally, I believe that we, as a country, have some unfinished business from the pandemic. How do we, as a nation, value the role of caring and the people who do it, whether they are paid or unpaid carers?

The Minister for Community Care (Alison Thewliss): I thank the committee for inviting me today; it is lovely to see you all.

I very much support the campaign that Unison has embarked on regarding visas for care workers. Care workers are a crucial part of the care system, they are valued and they are important. However, the rhetoric from the United Kingdom Government on the issue has caused significant damage to the visa system and our ability to recruit in the sector. I understand that, in 2023, 108,000 people came to the UK on a care worker visa but that the most recent figures show that that has fallen to just 1,400. That is a huge reduction in the number of available workers in a sector that very much needs them. It is hugely damaging, particularly in more rural and remote areas, where it is challenging to recruit people. Yes, we need to ensure that we are recruiting and training people from Scotland, but we also need those other workers to come and supplement the work that is being done.

The displaced workers scheme, which we reopened on 31 July, has been able to bring in additional people who would otherwise have lost their ability to work in the UK. I know, having spoken to some of those displaced workers and listened to their stories, how much they valued the opportunity to come here to work, to serve and to do their bit. They really value that caring role, and we are very glad to have them.

The Convener: On the point about training in Scotland, there is obviously a shortage in many areas, particularly, as you say, in rural areas. The University of the Highlands and Islands is an example of a place where people could train more locally. Is there any plan for the Government to expand the social care training that is currently ongoing at further education colleges in particular?

Alison Thewliss: Yes, we can certainly look at that. We want to see more people coming through the sector. One of the things that I have seen reflected in previous reports is that, because the workforce in Scotland is more qualified, people value the ability to work in Scotland and to go through the processes that we have here to deliver that very high-quality care. It is really important that we have people who are qualified but who also have a real passion to work in the care sector.

The Convener: I am sure there are lots of them out there.

Alison Thewliss: There are.

Heather Anderson: I have a final question about consultation. Cabinet secretary, as you mentioned, local authorities have statutory responsibilities in terms of social care and looked-after children. There has been some alarm within the sector because the First Minister said that health would take the lead. That is not in the programme for government, and I am very relieved that you have said that nothing is off the table. I just want to check your thinking at the moment about how we deal with the legal responsibilities of local authorities in the midst of this quite complicated debate.

Angela Constance: Nobody is disputing the legal responsibilities of local authorities. I am a former social worker, so I am well aware of the legal responsibilities that local authorities have and for which they are accountable in relation to social care, social work, vulnerable adult legislation and looked-after children.

However, we all have a shared interest in delivering for our people. We have a fragmented care system in terms of health and social care, and we have to start somewhere. We can start with NHS simplification. There is a lot of work to be done on that, as I have outlined, but we also recognise the role of local government and the accountability that it has. We will keep that in mind as we embark on our discussions.

The Convener: Kayleigh Kinross-O'Neill has a question on the health framework.

Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green): Yes, and it links to prevention as well.

Following on from Paul McLennan's question, I note that a priority in the population health framework was that resource allocation should be weighted towards prevention, and you have already spoken about how the Government has a team targeting that, which is fantastic. In that context, one of the strongest points in favour of general practitioner walk-in centres was the suggestion that they would reduce the strain that is brought about by the 8 am phone rush. That has worked to varying degrees across the country, as we have heard from doctors. The committee met a

doctor in Wester Hailes who told us about a guy who came in with a headache. He would never have phoned his GP normally, but had been told to go to the walk-in clinic by his work. The doctor said that it turned out that the guy had really high blood pressure and other symptoms and would probably have fallen ill at work if he had not gone to the clinic. In a crude way, that saved the NHS a lot of money.

How can we capture that kind of prevention more effectively? How can we protect prevention efforts in this time of crisis, when so many issues are competing for our attention? We know that prevention efforts are needed right now for the future.

Angela Constance: We know without a shadow of a doubt that investing in prevention is cost effective. The challenge is dealing with the here and now while also increasing investment activity upstream. That is why we need to be laser focused on tracking where resources go.

You talked about GP walk-in services, but I think that your point is broader than that. Quick or same-day access to care—wherever it is, and whether it is through pharmacy first, GP walk-ins or NHS 24—is preventative, and it can save a life, because things are being picked up.

The GP walk-in programme will be evaluated extensively for its value for money and the impact it has on other parts of the system. A benefit of that programme is that it is trialling different models, as experiences are quite different in different parts of the country. In the Western Isles, for example, the walk-in programme was focused on the visitors to that area, and that helped to ease pressure on the local GP services. The programme is about complementing our fundamental primary care provision and our 900 GP practices the length and breadth of the country.

Some GP walk-in centres have been busier than others. The centres in Cardonald and Wester Hailes have been busy. It is interesting that there are different patterns of attendance in different areas. The Lochee centre is a really interesting example, because initially the focus there was on a particular practice. There are now plans to extend the programme to all of Dundee or an even bigger catchment area, but originally in Lochee, the focus was on a particular GP practice in an area where there were a lot of health inequalities and therefore a higher rate of attendance at accident and emergency.

It is really important that we have space for innovation, but the fundamental point is that quick or same-day access to care, advice and treatment has the potential to save lives. We have to treat it very seriously and not as an add-on.

The Convener: Thank you very much, cabinet secretary. Adam Harley has a follow-up question. I ask everybody to keep it short. We have a long list of questions, and unless people want us to be running on, we need to be brief.

Adam Harley (Strathkelvin and Bearsden) (LD): Thank you, convener. I will go as quickly as I can. Thank you to the witnesses for coming today.

Cabinet secretary, in your opening statement you described the GP walk-in clinics as “popular”, but in July, they had only about 120 appointments a day, compared with about 136,000 GP contacts. Can that really be described as a popular uptick?

Angela Constance: I know by my mailbag and the representations that I have had from numerous MSPs and my own constituents that it is a popular option.

Let me be clear: we have 900 GP practices up and down the country, and this programme is there to complement GP practices. A simple example, which I will give for brevity, is that my mother will always want to see her own family doctor. I—as with many other people like me with busy working lives—will happily go elsewhere if it fits in the diary and I can be seen quickly and sent on my way.

Adam Harley: The Royal College of General Practitioners has said that the walk-in centres are not the solution. You talk about them being complementary to GP practices. Would you describe how the walk-in centres are removing pressure from GPs?

Angela Constance: Fundamentally, I would describe GP walk-in services as an additional service for people to access things such as information, advice, help, signposting and a prescription quickly. That is the fundamental point for me.

To respond to Adam Harley’s very valid point about supporting GPs, there is an additional three-year investment of more than £500 million, which is over and above core primary care funding. I hope that that speaks to the value and importance that the Government and I place on GP practices.

10:15

Adam Harley: The Government plans to spend £36 million on GP walk-in clinics, as I understand it. How else could that money be spent in primary care to support GPs more directly?

Angela Constance: We have to invest in all parts of the system. The £531 million is on top of the core investment for GPs, which, from memory, is about £1.3 billion. Primary care funding is in excess of £2 billion, so the level of investment is substantial.

We are all wrestling not only with the level of resource that is available, but also with how the system can work differently to meet the needs of both an ageing population and a busy working population.

Jack Middleton: I want to build on Adam Harley's point and reflect on what you have said about the varying needs and demands across the country. I have a GP walk-in centre in my Aberdeen Central constituency. It has been incredibly busy and popular. I think that it opened slightly after the 10 initial centres were opened. The problem is that it is not yet up to full scale: the demand is there and it is incredibly popular, but it is not yet open from 12 until 8, seven days a week.

What work is going on in Aberdeen and across Scotland to scale up the centres? How long do you think it will take for the centres to have opening hours of 12 to 8?

Angela Constance: I will happily correspond with Mr Middleton on the detail, but it is important to put on record that many of the projects are opening on a phased basis. That is so that we do not destabilise the system, which could cause everybody to compete for staff, for example.

Regarding the point about meeting need, the feedback that I have heard from Ms Todd is that, in Shetland, despite some local scepticism, the centre has been working very well. An apposite point, given some of the discussions about men's health this week, is that the location of the Shetland GP centre means that men who are taking the kids to sport or football on a Saturday, or whatever day of the week, can raise health concerns while they are there that they perhaps would not otherwise have pursued.

Joe Long (Mid Scotland and Fife) (Lab): Thank you all for coming this morning. I will zoom back out a bit to look at the bigger picture. Cabinet Secretary, you alluded to the fact that this might be our first meeting of many during the parliamentary session. We have heard a bold plan for reform, and there is a clear direction of travel on prevention, which there is cross-party consensus around. What are the measures for success on which this committee and others should hold you to account in the coming parliamentary session?

Angela Constance: There will be many measures. We are not short of statistics or reporting in the health and care system—that is for sure. We release a plethora of data reports every month and, usually, several in any one week. It is important that we get the right measures.

The issue that occupies much of my time is activity. Are we using all our current capacity in NHS estates? Tracking activity levels is therefore really important.

Ultimately, waiting times are an important measure. How long are people waiting for planned care?

Another measure is progress around the national hospital flow plan, which is essentially about the movement of patients through the system. That plan includes immediate actions around the expansion of hospital at home, the roll-out of discharge without delay and tackling issues in and around corridor care. However, it is also a five-year plan.

The plan is pragmatic, action-focused and strategic in trying to get one continuous journey for patients. It looks at the interdependencies. For example, people are waiting too long in accident and emergency departments, because those become very busy, due to demand, until they become full and congested. That happens because hospital occupancy levels are high and people cannot be moved on through the hospital. Delayed discharge is part of that. When our A and E departments are congested and too full, we see an increase in ambulance handover times. That takes us back to the activity levels and performance of primary and community care as well as the issues with same-day access and the preventative metrics that we spoke about earlier.

Joe Long: The population health framework is mentioned in your plans but we have not heard much lately about the national performance framework, which has more of a focus on wellbeing outcomes for the people of Scotland and is not just about the remediation of difficulty. Where will the revised national performance framework sit within the plans that you are setting out for us?

Angela Constance: That is an important point because the framework does need to be refreshed. My Cabinet colleagues are engaged in that work, which is being led by Mr McKee. As I said earlier, 80 per cent of the determinants of good health sit outside the health and care portfolio, so you make an important point.

The Convener: The cabinet secretary has kindly given us almost an hour, which we appreciate, and we have one final question to put to her before we move on to her colleagues.

Cabinet secretary, the NHS estate is also part of your portfolio. What work is being done to remediate the Queen Elizabeth university hospital, which does not seem to be fit for purpose? Fire doors are missing and building materials are lying around. Those do not seem to be temporary issues, so is there some kind of recovery programme?

Angela Constance: I will begin by speaking more broadly about the NHS estate and our capital

resources before coming to the subject of the Queen Elizabeth hospital.

In the next decade or so, we will invest £10 billion of capital in NHS infrastructure. It is important to recognise that, by 2029-30, Scotland's capital departmental expenditure limit block grant will reduce by 5.7 per cent in real terms in comparison with 2026-27. That has been compounded by historical real-terms cuts to the block grant by the UK Government, so there is a lot of pressure on capital investment. That makes it more important than ever to develop a whole-system NHS infrastructure plan. There are various projects in the infrastructure development pipeline, including both hospital and community health projects that have been committed to. Over and above that, we have asked boards to complete risk assessment reviews and there will then be a strategic needs assessment of the whole NHS estate. We must deliver as much as we can for all of Scotland.

A risk assessment will have been carried out for the Queen Elizabeth, as for other hospitals, and any new priorities will be considered. If members will forgive me, I will be quite judicious in my comments because I am conscious that there is still an inquiry going on and I do not want to say anything that could be perceived as interfering with that process.

Where there are infrastructure needs, we are working hard to address those. When I engaged with families recently, I spoke about our commitment to having a new bone marrow transplant unit. I know for a fact that remedial work is ongoing at the Queen Elizabeth hospital and that my officials take a keen interest in that and have close oversight.

My officials may want to add something.

The Convener: We are short of time, but I will just come back on that topic—and then Jack Middleton has a follow-up point as well.

I appreciate the overview of the estate. My question is about the here and now at the Queen Elizabeth university hospital, because people are coming in now—parents are taking their children into the chemotherapy unit, and other things are happening generally as well. It is astonishing that there is building material inside the hospital. It is not a temporary thing; it was there a month ago and it will be there in a month's time. There are fire doors that are not in place. What happens if there is a fire? I take your point that there will have been a risk assessment, but I have seen the risk assessment, and there are a lot of risks. What is the Scottish Government is doing about the here and now for the people who have to use the hospital now?

Angela Constance: As I said, convener, a range of works is currently under way in the Queen Elizabeth university hospital. My officials have oversight of that, and there are various assurance processes, but it is clear that the people of Scotland did not get the hospital that the country paid for. I have no doubt that the Scottish hospitals inquiry will shed crucial light on a range of issues. However, I assure you that we are actively engaged in addressing the here and now.

The Convener: Let us hope that there is not a fire in the meantime.

Jack Middleton has a follow-up question.

Jack Middleton: Very briefly, cabinet secretary, you will be aware that, in NHS Grampian, we have the Baird family hospital and the Aberdeen and north centre for haematology, oncology and radiotherapy—ANCHOR—which is also delayed and over budget. Can I have some assurances for the people of the north-east of Scotland that the doors to these units will be open as quickly as possible—and remain open—that the units will be safe, and that, in the meantime, patients are getting quality of care elsewhere on the campus?

Angela Constance: The Baird and ANCHOR facilities are much needed, and we absolutely must proceed with them. It is regrettable that there needed to be changes. I accept that they were needed for patient safety and I am not going to argue with that, but it is always regrettable when changes need to be made once construction starts. That is a source of frustration for me, and no doubt for Mr Middleton as the local MSP, but the facilities are much needed and we absolutely want to get them over the line. Again, there are oversight procedures that involve the chief operating officer, in the same way as with Queen Elizabeth university hospital, because patient safety is always paramount.

The Convener: Thank you very much, cabinet secretary, for your extensive time with us—that is much appreciated.

We move now to some questions for the Minister for Community Care on her particular area. Paul McLennan will kick us off.

Paul McLennan: I have two questions, minister. The first, which is on an issue that we have already touched on briefly, is about dementia care pathways and where we tend to see them. I speak from personal experience, because my dad passed away with dementia.

As you will be aware, in the previous parliamentary session, there was a lot of discussion about the Assisted Dying for Terminally Ill Adults (Scotland) Bill. My second question is about what the Government is considering in relation to palliative care.

Alison Thewliss: I appreciate your experience around dementia. I also have experience of that in my family, so I am personally committed to making sure that we make improvements. I was very grateful for the recent opportunity to meet representatives from Alzheimer Scotland's lived and living experience groups, who were clear about what they would like to see and about their ambitions and priorities. I am listening carefully to those voices to make sure that we get this right. They reflected that Scotland has been a leader in Europe and across the world in the work that has been done on Alzheimer's and dementia. We need to keep up that pace, because other countries are now moving ahead.

The next stage of the delivery plan will look at brain health and improvements to post-diagnostic support, on which we have made great progress, although there is still a lot more to do. That support must be available to everybody, and we are making some progress on that. There are also issues around transitions within care. When someone's condition worsens or gets more complicated, transitions should be made in the best possible way for people.

Work is under way on women's health as it relates to dementia, to understand how that affects women more or in different ways than it does men.

10:30

Work is continuing in relation to hospice care, too. Recently, I was happy to meet Children's Hospices Across Scotland. I looked at the CHAS facilities that are available at Robin house and at the developments that it is making to improve the conditions in that centre. When I visited, I was struck by the care that was being provided not just in the hospice but out in the community. That speaks to the community aspect of care.

At the reception that CHAS held recently, people spoke powerfully about the fact that more young people are now able to die in the safety, comfort and warmth of their own homes, rather than in a clinical hospital location. That was really important to those families. In the hospice sector, there is a lot of talk about how to make that real for people. Whenever possible, people should have the death that they wish and that they choose, and the hospice sector is a huge part of that. I have a massive amount of respect for what those in the sector are doing, and we will work closely with them.

Paul McLennan: I have two remarks. One is about post-diagnostic support. I recently met a dementia group, and the biggest issue for those people was that post-diagnostic support was mixed. For example, it might depend on who their doctor was.

My second point is about not only children's hospices but about general hospices and, as you said, the move towards people dying at home. That is a good point—it will be a key issue in the next few years because it is projected that more people who die will die at home.

The Convener: Joe Long has some questions.

Joe Long: I am sure that we will have a few discussions in the coming months about social care governance and structures—as we have been having for several years.

I want to flag up something that has come up in evidence and discussion with local care providers in my region, which is the collaborative and ethical commissioning that was envisaged by the Feeley review, back in 2021. Care providers are still in a market system in which there is sometimes a race to the bottom on price and providers are pushed to lower their prices. At times, not-for-profit providers have to wait on payment for services for months or years on end. We do not have the ethical and collaborative commissioning that we need in social care. Whatever structure we arrive at, how do we change that culture to ensure that we get a collaborative commissioning process?

Alison Thewliss: That is an important question, particularly for those who work in social care and for those who receive it. It cannot be people on the lowest possible wages who deliver that service, because people will not get the devotion and care that they need and that they would get from a well-paid and engaged workforce.

I have seen that change over the years. In the distant past, when I was a councillor, we moved significantly from getting the cheapest contract to looking at best value in the broadest sense and what value we were getting for the service. That has been a journey. We are not quite where we should be yet, but we are certainly moving in that direction.

An important part of that is the move towards sectoral bargaining. Progress has been made on that—things have been moving quite quickly—and there is hope that we have almost reached the final stages. Officials will be meeting providers and trade unions next week to discuss that. Sectoral bargaining can make a difference by providing real benefits to the 110,000 workers in the sector in Scotland. Those workers already receive the real living wage—which is a significant step—but improvements can be made for them over time. Sectoral bargaining is a huge part of that picture.

Joe Long: On the point about the workforce and sectoral bargaining, you mentioned the real living wage. Something that has been flagged up in evidence in the past few weeks—I have talked about it previously—is the differential between, for

example, the pay of someone at band 3 in the NHS and that of someone working in a commissioned social care service. That can be as much as £3,500, not to mention the different pension arrangements, the unsocial hours and so on. Does the Scottish Government have an ambition to create parity between the NHS and social care in that regard?

Alison Thewliss: That sort of thing will certainly be addressed through sectoral bargaining. As people will appreciate, it is not for me to sit here and set wages for the sector. Bringing the workers, trade unions and providers together is the most important way of ensuring better wages and more certainty for people in the sector, which can often have a high turnover of staff.

The Convener: There is a lot of talk about getting people out of hospital beds and into social care, whatever they require at home. I have spoken to a couple of organisations—including the Scottish Huntington's Association, which had spoken to Jenni Minto about this when she was the minister—that are talking about getting national collaboration instead of having to negotiate individual contracts with different NHS boards. That might fit in with your plans. I believe that the Red Cross is delivering similar care on a pilot basis in the Aberdeen area. Will you talk about that?

Alison Thewliss: Absolutely. The work that the Red Cross is doing is really interesting: the pilot is making sure that people's houses are ready for them to go into. If you live on your own and are coming to the end of your hospital care, you do not want to go back to a cold, empty and dark house; you want to go home to a house that is warm, that has food in the fridge and that is ready for you, because that makes the transition all the easier.

The great opportunity from the reforms that we are embarking on is that we will make pockets of good practice common practice by ensuring that more people know about the good bits of work that are going on, sometimes in isolation. Instead of a small organisation having to go around the 32 local authorities to let them know about the work that it is doing, we will have a better way of organising that to ensure that people who have conditions such as Huntington's are able to get equity across Scotland, rather than there being really good services in some places but poor services elsewhere.

Kayleigh Kinross-O'Neill: Could we hear more about where we are with the national social prescribing framework and other work that you are doing on social prescribing?

Alison Thewliss: That is more in Ms Todd's area than in mine.

The Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs (Maree Todd): We have been working on that for a period of time, and it is a major ambition in Scotland. Again, there are great pockets of work—in Badenoch and Strathspey, which, of course, has the natural asset of the amazing environment, they are really good at including options for social prescribing in their healthcare. However, that is not happening consistently around Scotland. I have had exciting conversations with representatives of our culture sector and our sport and physical activity sector, and we are pretty keen to bring social prescribing into a proper framework that means that it is accessible for everyone in Scotland.

Social prescribing is an amazing opportunity. On physical activity, for example, if we could get people moving more, that would be like a magic pill, except that you could not overdose on it. Physical activity is a phenomenal intervention, but it is quite hard to fit it into the health service, because we are very focused on medical interventions. However, we are working on that, because we recognise that we could make enormous progress through social prescribing.

Kayleigh Kinross-O'Neill: May I follow up on that, convener? That will then be me for the morning.

The Convener: Sure.

Kayleigh Kinross-O'Neill: You brought up physical activity and sport, minister. When I speak to folk at Edinburgh Leisure, one of the things that they say is that physical activity is sometimes missed out of sport strategies, but it is really important as a preventative measure. For example, Edinburgh Leisure runs—or ran—programmes on frailty in order to make older people less likely to be hospitalised if they have a fall. It is fantastic work that should definitely be supported. Is there scope for a physical activity strategy or other work that separates physical activity from sport? Will you talk a wee bit about that divide?

Maree Todd: We have that divide, because physical activity and sport are not the same. Although they go hand in hand, they are not the same, and the word "sport" puts a lot of people off. I cannot understand why myself, but that is the reality.

We have a strong physical activity strategy, which is in line with the World Health Organization's work. We have been working on it for many years, with solid success, aided by a phenomenal academic sector that has helped us to make sure that everyone in Scotland has more opportunities to move more often.

You are right about Edinburgh Leisure. I have been to one of its falls classes, and it was absolutely phenomenal. It was led by an absolutely outstanding, incredibly talented physical instructor—I think that his name was Michael McIntyre, but I might have got that wrong—who has the power to get people moving, even when they are really quite incapacitated, and to give them confidence to continue living in their own homes, even when they have had difficult experiences.

I spoke to some of the individuals at that class. One elderly gentleman, who was very tall, had fallen into the bath and his wife could not get him out. There had been trauma associated with getting him help and support, but there they were at that class, working out how they would cope if they got into that situation again, what they would need to have close at hand so that they could call for help, and how not to panic but instead to move on to their front and get safely back up on to their feet. The class was full of simple but clever stuff, and it was delivered in a way that absolutely boosted people's confidence. A lot of the class was about giving people confidence, after traumatic experiences, so that they could continue living independently and be confident that support would be provided if they needed it. It was great.

Kayleigh Kinross-O'Neill: Thank you for sharing that.

The Convener: Members have a couple of other questions for the Minister for Community Care. Heather, do you have a question?

Heather Anderson: Yes. I was lucky to get a briefing from staff at Specsavers in Dundee, who explained that 94 per cent of hearing loss is age related and that they can deal with that. I know that I should not be advertising Specsavers; other services are available.

The Convener: I hope that they do not clip our video.

Heather Anderson: Basically, they can deal with the bulk of hearing loss cases, which frees up the hospital waiting list for children who are experiencing hearing loss or for people who have had accidents and actually need to be seen by a specialist.

I would like to hear more about your plans to move audiology and optometry services into community settings. We have heard about MOTs and our meeting papers also mention "integrated navigation centres". Will you tell us more about those?

Alison Thewliss: I was really pleased to have a recent round-table meeting with audiology experts, and I think that you have received a letter updating you on the significant work that is under way to ensure that we have a comprehensive audiology service across Scotland. Tayside is an excellent example—

Heather Anderson: I know.

Alison Thewliss: Audiology services are working well there, and I think that, in time, we will be able to roll out that experience across the country.

There is often a stigma around seeking help for hearing loss or getting a hearing aid. That should be no different from going to the dentist or the optician. It should simply be part of what people do, and the preventative step of going for a hearing check is really important.

On community services, we are funding the Royal National Institute for Deaf People's "Near You" programme in various places across Scotland, where volunteers support hearing checks in the community. I went to see some of those recently. It is a simple test, and we could all do it online right now if we wanted to. It helps people who think that something may not be quite right with their hearing and who want to check that. If you do not get your hearing checked, that could have implications for other parts of your life. For example, hearing loss is a contributory factor in dementia, which is something that I have seen in my own family. It is important to think about hearing and how we can maintain healthy hearing throughout our lives. Therefore, if we have any issues, it is important to have them checked.

Heather Anderson: Can you tell us about the integrated navigation centres?

Angela Constance: That may be a question for me, because they deal with an important part of the national health and care improving flow plan.

In essence, it is about having far closer collaboration between NHS 24, the Scottish Ambulance Service and health boards and about taking a whole-system approach. For example, the Scottish Ambulance Service has become good at identifying people who do not need to be conveyed to accident and emergency—53 per cent of their engagement now involves people being treated on site or directed to another source of help. That will help us to take a grip of the flow through hospital front doors and of patient movement, but there is also work to do at the back door to deal with delayed discharge.

The Convener: Thank you, cabinet secretary. I think that Jack Middleton has another couple of questions for Ms Thewliss.

10:45

Jack Middleton: Minister, it is obvious that social care has limitations when it is delivered by

local government, especially in the realms of delayed discharge, which the convener touched on. Will you outline how wide-scale healthcare reform will alleviate the issue and make the system more joined up? Right now, I do not believe that it is.

Alison Thewliss: It is really about partnership working. I do not want to sit here and blame local government, because that is neither constructive nor helpful. It is also not really true to say that those in local government are at fault in any way. At the moment, the system is complex, and individuals and those who support them do their best to navigate a system that perhaps does not work as well as it could.

As the cabinet secretary laid out, it is important to ensure that, as soon as someone goes into hospital, there is a plan in place for their discharge, including what support will look like at that point. During some of the visits that I have made across the country, I have heard that, when people go into hospital, their care package stops after a time, which makes it more difficult to restart when they leave hospital and can therefore delay discharge.

We also need to look at the front end of the system. Before people get to hospital, do they get the support that they need? Ms Todd talked about services around frailty. Is there a way to prevent people from having those falls in the first place, prevent them from going into hospital, which might not be the best place for them, and therefore prevent delays when they are ready to leave hospital?

We need to look at the whole journey that somebody goes on, including the reasons that people go into hospital. There is really good work in some local authorities to look at the whole person and ensure that the whole system is wrapped around them, that we understand who they are and what their needs are, and that we identify what can keep them well for longer and prevent them from moving into longer-term care.

Jack Middleton: Thanks, minister.

Joe Long: I absolutely recognise the flow-of-care aspiration and the need to address the needs of people coming out of hospital. Do you also recognise that there is some concern in the social care community about the idea that commissioning from the NHS, as was hinted at, might result in the overmedicalisation of people's needs, and that there are people with lifelong support needs whose aspirations are not about delayed discharge from hospital or medical treatment, but about having a meaningful life in the community, and that the role of social care is not only to serve the NHS or facilitate that flow of care for the people who need it?

Alison Thewliss: Yes, absolutely. I agree with that, and I noted a comment from Donald Macaskill in his evidence to this committee about social care not being simply a mechanism

"to support the NHS"

but existing to

"enable people to live"—[*Official Report, Health, Care and Sport Committee*, 9 September 2026; c 5.]

full and independent lives. That is a key point, because social care is a very wide spectrum. Often, social care is narrowed to older people, but it is much wider than that, as the committee knows, so we need to think about how best to support people during their lives.

Angela Constance: I know that some of the discourse on delayed discharge is about the whole system and the NHS, but we have to remember that, fundamentally, delayed discharge is not good for patients. it is absolutely detrimental to anyone who remains in hospital longer than their clinical needs require. That is reflected in the evidence on the effect of lack of movement, lack of socialisation, loss of independence and a decrease in mental wellbeing. That is the primary reason why we want to address delayed discharge, notwithstanding the important system-wide issues.

The Convener: Thank you very much. We now move on to the Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs. We have questions on all those remits, so I ask everybody to keep the questions quite short.

Paul McLennan: You will be aware that, in the previous parliamentary session, this committee, as well as the Equalities, Human Rights and Civil Justice Committee, looked at the issue of neurodiversity and that there was discussion about the proposed learning disabilities, autism and neurodivergence bill. Various summits were held, too. Where is neurodiversity in the Government's priorities? I want to hear your thoughts on what comes next. We all get lots of casework on the issue, so what can we tell constituents in that regard?

Maree Todd: I welcome the opportunity to be here and to talk about my very broad-ranging portfolio.

With regard to neurodiversity, you are absolutely correct. There has been an increased level of demand for services, which has caused a real challenge within the system. That has happened not just in Scotland, but all over the UK and, in fact, all over the world. We find our system overwhelmed.

We have committed to improving the system. We have committed to adopting a four-tier system

for adults, as recommended by the Royal College of Psychiatrists in Scotland. The work started on that some time ago and, over the summer, I had a round-table meeting with a wide range of stakeholders to consider how we can implement the four-tier system. We have not quite decided what to call it—there is talk of a four-tier, four-level or four-phase model. It provides a number of ways for people to access care. The important thing is that individuals with neurodivergence need to be able to access support when and where they need it.

At the moment, we are very much focused on diagnosis, but although that is important, diagnosis is not the be-all and end-all. What people really need is support, and we are building a system of support for both adults and children.

The picture is slightly different for children than it is for adults, because of the work that we are doing with the education system. A number of pieces of work are under way, including the implementation of the recommendations of the McManus review, which will make a difference. However, the principle is the same: people should be able to access the right support, at the right time, where they need it and when they ask for it. Of course, we have an overarching system for children—getting it right for every child, or GIRFEC—which makes clear that there is no need to wait for a diagnosis in order to provide support. A child's needs should be assessed. Every child has a right to access education, and any adaptations that need to be made can be put in place as soon as they are required.

Paul McLennan: I have a follow-up question. When I was on the Equalities, Human Rights and Civil Justice Committee in the previous parliamentary session, a key issue that emerged concerned teachers and others in the system, such as GPs. It came across clearly that there was a mixed level of training on how to deal with neurodivergence issues, and that variation could be seen from school to school, never mind from teacher to teacher. Diagnosis is one part of the process, but there is also the need to recognise and make the reasonable adjustments that are required. What is the Government doing to expand that training so that we can be confident that professionals are aware of the issues affecting neurodivergent children?

Maree Todd: A number of strategies are under way. Core training is available to those on undergraduate courses, and there is access to continuing professional development for regulated professions, which helps them to support individuals with neurodivergence.

I visited Windygoul primary school last week—I think it might be in your constituency.

Paul McLennan: It used to be; the constituency borders have moved.

Maree Todd: Well, it is nearby. A unit within the mainstream school supports children with additional support needs, and the work that it is doing is phenomenal. When I asked the teachers specifically about how supported they felt in their training and in their ability to support those young learners, they told me that one of the most important things for them was their access to the full multidisciplinary team, which visits the school. When those specialists come in, they sometimes support individual children, but they also often help staff to support learners in their learning. Staff are clearly supporting parents to do that, too.

I want that to happen everywhere. One of the reasons that I visited that school was that we had announced £7.6 million of funding to support community interventions for neurodivergence, and I would like to see the quality of care and learning that happens there to take place everywhere.

Paul McLennan: Windygoul is a great example.

The Convener: Joe wishes to follow up on this issue.

Joe Long: I make my now-customary note of my entry in the members' register of interests showing that I was employed as the director of Scottish Autism until May.

Thank you for that answer, minister. I recognise exactly the picture that you have painted, but none of it is news. Neurodevelopmental assessment and support pathways were trialled as part of the strategy for autism, which ended in 2021. There were promises regarding post-diagnostic support as part of the Covid mental health transition and recovery plan, and we were also promised action within 100 days of the Scottish National Party returning to power.

What concrete resource can we expect to see in the coming months for all of the people who have been waiting years for assessment and support? That resource is urgent, because people have been waiting a long time and there have been years of discussions about neurodevelopmental assessment and support.

Maree Todd: That is a fair summary, but you did not mention the increase in the number of people who are seeking support. Ten years ago, when we first considered an LDAN bill, there was a low level of awareness, particularly in relation to neurodivergence—people did not know about it or understand what it was. Since then awareness has greatly increased, and many more people—the number has sometimes increased by several hundred percent—are seeking diagnosis, assessment and support in many parts of our country. We cannot fix the problem overnight, as

much as we would all wish to. There will need to be a process to ensure that people get support. People will, to an extent, need to be triaged, and we will need to build a system that can respond to the level of need.

That will not happen overnight, but I am committed to it happening, because I agree with you. I know that you were focused on the LDAN bill and that you did a lot of work to ensure that it became a commitment of the Scottish Government. Yesterday, I met a lived experience advisory panel, and I share its disappointment at the change of direction. However, at this time, I need to focus on improving service delivery, not on creating legislation that gives people expectations and rights that cannot be upheld unless there is a system that has been built to respond to those needs. We are not for a second deprioritising that work; we are just shifting our focus to practical improvements, policy reform and targeted investment to get a more rapid impact, which is what we all want to see.

Joe Long: A consultation on social care was pledged and then there was a five-year consultation on the national care service, which did not end up in there being a national care service. People also gave months and years of their lives to supporting the LDAN bill. You will recognise, in a context in which there is waning faith in the ability of politics to deliver for people, that there is some consternation in the community at the abandonment of the bill and scepticism about whether the Government will deliver, particularly for groups that were not explicitly mentioned in the programme for government.

Maree Todd: I recognise that point, and we spoke about that a great deal when I met the lived experience advisory panel yesterday. I hope that I was able to reassure it that all its work has not gone to waste. We have absorbed the lived experience and now better understand how it feels to try to navigate the system and where we need to work harder to deliver better. Individual experiences are very useful in that respect. As a Government, we have also learned a great deal about how to use lived experience from population groups that are often considered heard to reach and to make sure that that experience is heard and acted on in Government. Therefore, none of the work that people have done to help us understand their situation has been wasted.

I was able to point to some tangible differences that have been made with regard to policy reform, service improvement and targeted investment. For example, there is the coming home work for individuals with learning disabilities. It is a devastating situation; so many individuals have been cared for far from home in institutions, and it has taken some time to build a system that is now delivering an impact. We are making a difference: we now have a dynamic support register, which means that we know who those people are and where they are in the system. That gives us good visibility at both the national and local levels.

11:00

We now have the targeted investment into the independent living fund that was announced earlier this year. I am absolutely confident that that will bear fruit and support people to come home from institutions and live in their communities. Ms Thewliss leads on that work, which is undoubtedly having an impact. I see signs of progress where we have been able to take that approach.

People's human rights are at the core of that work, including the rights to be supported to live a healthy and fulfilling life and to maintain a family life. I am absolutely delighted and am confident that we can make progress. It is not a case of those needs being deprioritised; rather, we are just approaching them in a different way. Legislation is hard to implement and takes a long time to bear fruit. We saw that in England with the Down Syndrome Act 2022, which was passed a number of years ago but has yet to be implemented and is not yet making a difference. The urgency is so acute that we must make a difference right now, and I am determined to do that.

The Convener: Thank you, minister. We have a theme running, because my next point follows on seamlessly from that. You and I sat, possibly in this very room, and talked about this six years ago, and I also sat here about 20 years ago. My history is well known: my daughter had ME from the age of 6 to the age of 19, which very much shaped my view of long-term conditions, as did my training as a veterinary surgeon.

My questions are about the long-term conditions framework. To pick up what Joe Long said, I know people who gave up their time to commit to joining the discussion about that and, as is often the way, good progress appeared to have been made. Where has that progress gone? A promise was made and people are looking for answers. Witnesses came here and gave evidence, which you may have read, which affected the committee very much. They spoke about ME, long Covid and chronic pain, which are connected to health inequalities. The stark percentage of men and women who have chronic ill health has gone up quite severely.

What has happened to the £4.5 million for people in Scotland who have ME and long Covid? I have asked several NHS boards about this, and the answer that I have got is that it is now estimated that the number of people with those conditions is 100,000. That £4.5 million is not a lot

of money for 100,000 people, many of whom will never get better unless something changes. You know that, because you have been here before. The £4.5 million was ring fenced and has now been handed out. The NHS boards that I asked about this told me that they advertised for specialists but nobody applied. Of course nobody applied: nobody is trained to specialise in those conditions, so that is the first problem—that is not the way to do it. I understand that three NHS boards have put their money into Lothian, so has that money just gone into the Astley Ainslie hospital, which was already doing something, rather than being used as the patients requested? That takes us back to the issue of lived experience.

Maree Todd: We made a commitment in our manifesto to publish the long-term conditions framework next year, and it will be published early next year. I am grateful for all the work that has been done by people with lived experience and other stakeholders. There has been lots of third sector involvement and I think we will come up with a really good framework that everyone will be satisfied with and will be able to work to.

On the issue of ME, as you said, we have put £4.5 million into health boards and they have now received that money. My experience of asking my local health board—NHS Highland—what it had done with the money was slightly different from yours, convener, because I found out that it is setting up and building a service.

As is sometimes the case, its communication with individuals who had been involved in developing the service was not great, so the feedback loop to people with lived experience who had helped to shape the service was not great, but I am hoping that that will improve. I am very happy to go back and see what is happening to that money nationally, then come back to the committee in future with details on what the service is shaping up to look like around the country.

The Convener: I would very much appreciate that, minister. We look forward to hearing from you on that.

Angela Constance: Convener, you have given an example of unwarranted variation. We have heard about two experiences at two different health boards, which, in a country of this size, should not be the case. At the core, our reforms are about a once-for-Scotland approach and equity of treatment and access.

The Convener: That is a good point and, on that, I think that many of us would welcome a round-table meeting with the medical profession, too. If there is to be a national viewpoint, we need to know that it is delivering on the latest research and not giving the wrong advice. I would welcome a follow-up meeting on that issue with Ms Todd.

There are a few further specific points to cover. I think that Jack Middleton wants to ask about alcohol.

Jack Middleton: Of course—alcohol is a theme that I have pulled out at all previous evidence sessions.

The Convener: I assumed that you would ask about it; I thought that you had gone to sleep.

Jack Middleton: Paul Johnston and I spoke at a previous meeting about the issues that working-class men face. They are far more likely to be hospitalised from or die from alcohol-related conditions, with those in deprived communities almost three times more likely to die from such conditions. When is the alcohol harm prevention plan likely to be published, and will that specific inequality be part of that work?

Maree Todd: Thank you very much for that question. I expect the alcohol harm prevention plan to be published pretty soon; I cannot give you a specific date, but we are working hard on it at the moment and I expect it to appear in the next couple of months.

Inequality is at the heart of all that work. There is a clear inequality in mortality and morbidity for individuals experiencing harm from alcohol, and a similar but wider inequality exists for drugs. It is really important that all our work on substance use disorders takes those inequalities into account. We spoke earlier about work that is going on in prevention, and the cabinet secretary has mentioned a couple of times that 80 per cent of people's health is influenced by factors other than healthcare, which we see very starkly with alcohol and substance use. You are absolutely correct, including on gender inequality: it is men who are dying, and men from more socioeconomically deprived backgrounds.

Population health measures work very well for those men. Minimum unit pricing for alcohol is the most significant policy that we have introduced to tackle alcohol harm over the past decade or so, and the modelling suggests that it has saved hundreds of lives. It has prevented hundreds of deaths and averted hundreds of alcohol-attributable hospital admissions, and its impact has been greatest in the areas of highest deprivation, with the largest impact for those living in the 40 per cent most deprived communities. Sometimes, instead of thinking that we have to target individuals, we find that population-level measures work best in the areas where the harm is worst.

Jack Middleton: Can we expect to see more pragmatic regulation of that nature in the alcohol harm prevention plan? As you have indicated, minimum unit pricing has been hugely successful.

I want to ask a specific question that I also asked Paul Johnston. He alluded to the fact that there was a wider conversation in Government and with other organisations about this. We seem to couple alcohol and drugs together now. They are often separated out in statistics, but, when we talk about the issue, they are put together as being one and the same. Why is that? Is it helpful or would it be more helpful to separate them out in our communications?

Maree Todd: First, yes, you can expect to see population-level measures in the alcohol harm prevention plan. We have made great progress in recent years, but we have not gone far enough. In fact, the most recent statistics showed that approximately 1,200 people died of directly alcohol-attributable causes last year. That is only the tip of the iceberg—those are, largely, the people who are dying of liver disease. The number is higher than the number of those who are dying of drug-related causes, and the issue affects every community in Scotland.

We are not very good at identifying alcohol-related deaths in which alcohol is only one factor. About one in 10 breast cancer cases include alcohol as an attributable factor. Alcohol contributes to several cancers, cardiovascular disease and a range of ill health issues that we do not accurately measure. What we do accurately measure are directly alcohol-attributable deaths.

When it comes to lumping alcohol and drugs together, there is a lot of commonality across the broad spectrum of substance use. You are talking to a pharmacist—I think of all those individual drugs, and I think of alcohol as a drug. The substantial difference with alcohol is that it is legal and culturally condoned. It is not only a legal drug; it has a particular status in Scotland, which means that you need to take a different approach to tackling alcohol harm. There is a level of alcohol consumption that can be considered safe, but the medical evidence suggests that alcohol is a health-harming substance.

It is not wrong to consider alcohol and drugs together, but there is no doubt that there are times when different approaches need to be taken, simply because alcohol is a legal drug and drugs are largely illegal and drug use is largely illicit.

Jack Middleton: Thanks, minister.

The Convener: We have an appalling drug death rate in Scotland, and that issue sometimes gets lumped with alcohol use but, as you said, it is very different.

I have two points on that. The first is about safe consumption rooms—I think that that is what they are called. I might be wrong, but I think that I saw that you plan to open another one, this time in Edinburgh. As a pharmacist, you might agree with me on this. Figures have been published that suggest that the rooms save lives, but there is a big argument that if somebody comes in and takes drugs—they might be sitting around taking naloxone—that does not really mean that you have saved their life, because they might not have done so otherwise. You cannot know.

Putting that to one side, I want to ask about the cost of the safe consumption room, the response from people who live near it and whether there might be a better way of spending that money, such as on rehabilitation. The Right to Addiction Recovery (Scotland) Bill failed, but many people want to see far more resources go in that direction because, even though drugs are illegal, we condone drug use by providing users with a safe room and giving them methadone. What is your informed opinion on that?

Maree Todd: How do I unpick all that? We need to be very careful in how we talk about drugs and harm reduction. It is not an either/or when it comes to rehab and harm reduction strategies, which might cover opioid substitution therapy, right up to facilities like the Thistle, which are safe injection rooms.

This week, published statistics showed that we not only met our target of increasing the number of publicly funded placements in residential rehab to 1,000, but actually exceeded the number this year. That means that, during the national mission period—from 2020 to 2026—there has been a 60 per cent increase in access to residential rehab.

It is a really vexing, difficult problem. More than 1,000 people die of drug harm every year, with all of the tragedy and cost that that causes in our communities. We need to take many measures and many steps in order to tackle drug harm.

11:15

With regard to opioid substitution therapy, it is important that we look at the evidence. You are a vet, so you will be used to evidence-based medicine. The evidence would suggest that opioid substitution reduces the risk of death by around 70 per cent for individuals. In a country that is facing a huge level of drug-related deaths, we must not rule out evidence-based approaches to tackling that harm. Opioid substitution therapy is not the be-all and end-all, and it is not the end of treatment for people; very often, it is the start.

I would say that the Thistle has been a life-saving intervention. We get regular data around it. There is zero evidence to support your claim that it encourages drug use.

The Convener: It was not a claim. I was asking a question to clarify the matter.

Maree Todd: There is no evidence to support that hypothesis. What we see is that people who are very vulnerable and are using in the street—which is highly risky; they are likely to die taking drugs—are able to take drugs in a safe environment. They are able to access not just naloxone to reverse overdoses, but advice on safe injection technique. It is a sterile environment. A lot of harm, including amputations as well as deaths, is occurring because of injection site reactions and infections. There is also public health harm that comes from sharing needles and using drugs in unsanitary conditions. The Thistle is intended to reduce the risks associated with all those harms.

In the Thistle's first year and a half, up to the end of August, it has registered more than 800 people. It has overseen more than 15,000 injecting episodes, and I would wager that that is 15,000 injections that could have happened outdoors, in the street. That is 15,000 needles not on the street, because the needles are safely disposed of after use. It has responded to 195 medical emergencies. Those will range from probably requiring just a bit of support with breathing and monitoring to full-blown resuscitation. We have absolutely no doubt that the facility has prevented deaths. In a country that is experiencing such a high level of drug-related deaths, that is absolutely something that we should continue to explore, study and scrutinise, and we should make decisions about whether it might be useful elsewhere.

A facility like the Thistle is being explored for Edinburgh. The effort on that has been led largely from the ground up. There are many people in the community who, because of the level of harm that they are seeing, are keen to explore a safe drug consumption room. I think that the consultation on that has now concluded. We will work with the City of Edinburgh Council to find out what we can do to bring that facility into being, should the council and the citizens of Edinburgh decide that that should be done. That is not a straightforward process, because the UK's Misuse of Drugs Act 1971 prevents us from having safe drug consumption rooms. We have to work with the Lord Advocate very carefully to ensure that we meet the legal needs—the laws of the land need to literally be lifted in a particular geographical area in order for that harm reduction to proceed.

The Convener: Thank you for that explanation.

I do not want to take up a lot of time but, on a different note, I was appalled by an example that I saw recently, which related to ketamine use. A specialist bladder clinic is being opened in Aberdeen because people's bladders and ability to be continent are being ruined by such drug use when they are young. I worked with ketamine as a vet. Might the Government consider having a public information campaign on that? If people are going to do drugs—we have just had that discussion, and we may agree or disagree about it—it would be quite nice if they were not doing ketamine and having their bladders destroyed by the age of 20 or so. People might not know about that risk. If they are going to choose a drug anyway, perhaps we should publicise the dangers of choosing that one.

I am not being facetious—I genuinely think that that would be a good thing. I suggest that something should be done about that, in the same way as the harm reduction approach taken at the Thistle, because the idea of all those people having another 50 years in the state that they are in is just appalling.

Maree Todd: That highlights the tension and the real area of challenge for politics, politicians and people who are involved in the public debate about those issues. Should we provide people with information that might help them to make choices that reduce harm, and should we support them to take drugs in a less harmful way, or to choose less harmful drugs, which is the question that you put to me, or does that simply encourage drug taking? That is the real tension at the heart of this.

As a public health minister, and as a health professional, I am very focused on approaching the issue from a public health perspective and reducing the harm that I see happening across Scotland right now.

You are absolutely correct to point to the harm resulting from ketamine use. It is one of several drugs that have burst on to our scene. One of the challenges that we face in tackling drug harm is that it involves an ever-changing scene and an ever-changing market. As a pharmacist, I was astonished to hear that people are using ketamine recreationally, but it is being used widely, and its chronic use can undoubtedly cause irreversible bladder harm. As you pointed to, in the north-east, a whole new service has had to be built to respond to that level of harm.

Some public health initiatives to inform people are happening. One of the challenges is that we need to be agile. I talked about the ever-changing market. Over the past few years, we have invested in a system that has brought strong benefits to Scotland: the rapid action drug alerts and response—RADAR—system, which picks up on changes in drug use and the drug market. It very quickly highlights to people on the front line—those who are working in substance use services and those who are using drugs—the associated harms. We do not see that information because we are not on that scene, so you and I will miss out on that very rapid response that comes out to the

population, but the people who need to see it are aware of it.

Young people are just amazing. I have met individuals who have experienced irreversible harm from ketamine use but, through TikTok and other means that young people use to communicate, they are explaining to the population what happened to them. They are bravely saying, “Here is my experience, and here is why you need to avoid this happening to you.” That peer-to-peer education is one of our most powerful means of raising awareness and reducing harm.

The Convener: Yes, certainly.

We have 10 minutes and four questions left. If the questions and answers are very quick, we will get them all in. Jack Middleton has a follow-up question.

Jack Middleton: Returning to the conversation we had about drug policy, minister, I put it to you that the need for the Thistle centre is a result of decades of failed drug policy. Speaking as someone who has experience of addiction and, sadly, death in their family, I feel that pushing people with addictions further into the shadows and out of sight of the general public only exacerbates those issues and leads to an increased likelihood of death.

I welcome the fact that we are moving to create more facilities for people with drug addictions in Edinburgh, but there are clear limitations. As a Government minister, you will know that more than anyone.

Andy Burnham, the Prime Minister, has challenged the devolved Governments to put forward a list of laws that they would like to be devolved to their Parliaments. I ask for an assurance from the Scottish Government that the devolution of drug policy, which used to have cross-party support—I am not sure whether it still does—will be at the top of its list.

Angela Constance: As a former justice secretary, I will step in for a moment to respond to that and will then hand back to Ms Todd.

The Misuse of Drugs Act 1971, which is almost as old as I am, was written for a different age. As you heard from Ms Todd, the substances that are now on our streets, such as synthetic benzodiazepines and opioids, pose a greater risk than others, given their toxicity, and they are becoming more novel in form. In contrast, the legislation is old and outdated.

To be clear, in the context of discussions about the Thistle centre and services like it, there is nothing that the Scottish Government—or, indeed, any Lord Advocate—can do to overturn primary legislation that has been passed by the Westminster Parliament. We do not have scope not to follow the 1971 act, which comes with great limitations, particularly regarding harm reduction, such as using equipment for treating injuries, whether it be tourniquets or other equipment to prevent wounds that result from people smoking substances. Those are practical limitations that we cannot contravene. I need to be clear about this point: there is nothing that any Lord Advocate or the Scottish Government can do to contravene the law of the United Kingdom. Instead, the Lord Advocate can, in discrete circumstances, using powers that are independent from the Government, issue statements about prosecution policy.

As the first ever Minister for Drugs Policy, I was very involved in the debate—as was Ms Thewliss, who was then an MP for Glasgow—about the excruciating journey to find, in effect, a way to land a jumbo jet on a postage stamp within our narrow powers. The framework for the Thistle centre is narrow in scope and based on evidence and extremely detailed work.

The Government’s position in support of the devolution of drug legislation is not new—it has been our position since about 2023. The legal context is important, and our eyes are wide open about what we can and cannot do, which is why we support the devolution of drug policy.

Maree Todd: I was probably being a bit too broad in my statement about lifting the law of the land, but it helps people to understand that it is not a straightforward case of Edinburgh just being able to do what Glasgow did. The Thistle project involved a careful process of working with the Lord Advocate and the community to assure ourselves about the limited circumstances in which we can change how prosecution policy applies in a specific geographical area.

The top of my list of ways to fully take a harm reduction approach would be to devolve drug laws, because the Misuse of Drugs Act 1971 prevents us from taking such an approach. Examples of the challenges that exist are the creation of safe consumption rooms and the provision of tourniquets, because the law prevents us from providing sterile tourniquets and paraphernalia, which is the category that tourniquets come under. The Thistle has an exceptionally sterile environment, but people need to, for example, tie shoelaces around their arms to pop their veins up so that they can inject. Even a layperson can see the risks that are associated with that; if a person were to go into a hospital environment to get an injection, they would expect a sterile tourniquet to be used.

The law also prevents us from providing inhalation pipes. One of the greatest harms that we face in Scotland at the moment is the injection of cocaine. One reason that that is so harmful is that people take cocaine in bursts and, as the day progresses, they become intoxicated and their injection technique becomes poorer, so they face more harm in relation to the injection site. Cocaine is also a local anaesthetic, so people do not feel pain if they get it wrong. Therefore, encouraging people to smoke cocaine rather than inject it, and providing them with the tools to do so safely, would be a reasonable harm reduction strategy, but we are prevented from doing that.

There are strong reasons why we want to take a different approach, overarching all of which is the devastating level of drug deaths in Scotland. I sometimes wonder whether my colleagues in England quite appreciate the level of harm that we are facing—we are having different conversations in Scotland than those that are happening in England. If my colleagues in England do not want to take the approaches that we do, the most straightforward way to solve that problem would be to devolve the power to us so that we can take those harm reduction approaches.

11:30

The Convener: Thank you, minister. We appreciate the time that all of you have given us. We have a few questions left, but perhaps we could submit those in writing as I understand that the ministers need to leave. You have given us two hours and provided detailed answers, which we appreciate. I apologise to committee members who could not get more questions in.

Next week, we will continue taking evidence on sport. I apologise that we did not even approach the subject of sport in today's evidence session, but I am sure that we will see the ministers here again, and in the meantime perhaps we could submit key questions to you in writing.

Angela Constance: Thank you, convener. I ask any members who did not have time to ask their questions to follow up in writing and we will ensure that they get timeous answers.

The Convener: Thank you. That concludes the public part of today's meeting.

11:31

Meeting continued in private until 12:09.

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