



Official Report
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Health, Care and Sport Committee

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Slàinte, Cùram agus Spòrs**

Wednesday 7 October 2026

Session 7



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HEALTH, CARE AND SPORT COMMITTEE **7th 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:

Professor Linda Bauld (University of Edinburgh)

Alison Payne (Enlighten)

Robbie Pearson (Healthcare Improvement Scotland)

Richard Robinson (Audit Scotland)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health, Care and Sport Committee

Wednesday 7 October 2026

[The Convener opened the meeting at 09:30]

Pre-budget Scrutiny 2027-28

The Convener (Helen McDade): Good morning, and welcome to the seventh meeting in this session of the Health, Care and Sport Committee. We have no apologies. Today, we will start our pre-budget scrutiny for 2027-28. The committee has agreed to examine how the Scottish Government is preparing for future challenges in the health, care and sport sectors. Today's evidence session will focus on health, although there will be some crossover. We have up to two hours for discussion.

I am pleased to welcome Richard Robinson, senior manager at Audit Scotland; Professor Linda Bauld, professor of public health and co-head of population health sciences at the University of Edinburgh; Robbie Pearson, chief executive of Health Improvement Scotland; and Alison Payne, research director at Enlighten. Thank you all very much for coming. I thank those who submitted concise summaries—it is much appreciated. We have further background information, and we have taken evidence over several weeks. We want to take a fairly general look at the issue, but we will sometimes direct questions specifically. However, others are welcome to chip in—just flag up that you wish to speak in the usual way.

We have read the papers so, rather than ask you to give an introduction, we will kick off with issues that have come to the fore for us. Kayleigh Kinross-O'Neill will start.

Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green): Thank you all for being here. I feel like I am on the panel, too, as I am sitting very close to you, so I feel quite nervous. I will jump in at the deep end with a question for Audit Scotland, although I welcome comments on this from other witnesses. It is about the news of social care potentially coming into the national health service. How will that impact on sustainable financial planning? What concerns, if any, do you have about that proposal?

Richard Robinson (Audit Scotland): Today, I will speak about some of the evidence that we have given on long-standing pressures and issues that the committee might want to consider in its pre-budget scrutiny. Obviously, we are in a period of notable reform following the programme for

government, both in terms of NHS structural reform and proposed local government reforms.

Although we have not done any specific work on the impact of moving staff between parts of the public sector, the management and alignment of workforce with what the Scottish Government wants to achieve over the medium term through its reforms will be important. We know that the workforce is essential to delivering services, and that workforce costs are one of the main areas of cost pressure in the health sector. That means that it will be important for the Scottish Government to be clear about the cost implications of potential changes, as well as the implications for regulation.

I am sorry that I cannot be more specific, as we have not done any particular work on that, but I hope that that is helpful.

Kayleigh Kinross-O'Neill: That is fair enough.

The Convener: I do not know whether any of the other witnesses wishes to comment now. The issues might come up later in the session. If no one wants to come in, we will move on to Heather Anderson.

Heather Anderson (Dundee City West) (SNP): My question is for all the witnesses. Richard Robinson's written submission is clear that we are continually spending more money but not improving performance. We have evidence about integration joint boards being in trouble and health and social care partnerships facing challenges. How could we use the money better? Is there a governance issue about how the money is spent, or is the issue simply the overwhelming increase in costs? How do you explain the fact that much more money is going in but we are not getting the performance results?

Richard Robinson: I will briefly mention three things. First, it is correct that spending on the NHS has increased over the years. As we reported in "NHS in Scotland 2025—Finance and Performance", that is alongside additional staff and additional costs, but some activity and productivity measures are still below pre-Covid levels.

One thing that we recommended in that report was for the Scottish Government to get a better understanding of the drivers or reasons for that. It can sometimes be difficult to draw correct lines between additional spending and the impact on activity. For example, in the report, we mention NHS Grampian's work with KPMG to try to understand how additional spending was leading to additional productivity. There could be several reasons for the situation, such as demographic variations between areas, the extent of long-term health issues and the impact of backlogs, which

have been an issue for various boards since Covid.

That leads to my second point, which is about how well the Scottish Government understands how those drivers affect NHS boards across Scotland. That will be particularly important as we come to a period of reform and potential structural reorganisation. It will be important to consider how to benchmark and monitor the situation as we go through changes in arrangements that might affect reporting.

The third point is about the effect on how we spend money. We have raised challenges to do with the financial sustainability of the budget. This year is the first year in which we have moved away from brokerage arrangements towards more up-front additional support. That support is due to be removed in the coming years as an additional, as opposed to a baseline amount. However, further clarity is needed about the extent of the funding envelope for reform and prevention. Prevention is one of the things that we are here to talk about today. To what extent will primary, secondary or tertiary prevention help to alleviate costs, alongside the impact of service framework renewal measures such as national treatment centres and hospital at home?

There is a lot in the strategies that have been produced over the past year or so. The next step is to set out what that means for the sustainability of the NHS over the medium term and how the costs and benefits will be realised over that term.

Alison Payne (Enlighten): It is important to note that, although NHS spending has increased, local government spending and local authority budgets have been cut. Much of the important work that is done on prevention is in the local government sphere. Too often, key organisations, often in the third sector, are first in line for cuts. Although spending on the NHS and dealing with illness has increased, we have not been effective in our spending on prevention. It is good that the Scottish Government is considering structural reform, but it is also important that it considers what is happening in local authorities, because spending elsewhere in the Scottish budget, whether on housing, education or a range of other things, impacts on health. Often, the most effective spending is on work by third sector organisations in our communities. If budgets are cut there, that will lead to increased demand elsewhere.

The Convener: Adam Harley wants to add something, but I will come back to the other witnesses.

Adam Harley (Strathkelvin and Bearsden) (LD): I want to pick up on the point about where money is spent most effectively, and this also follows on from Kayleigh Kinross-O'Neill's

question about social care. We are spending about £1.2 million every day as a result of delayed discharge, which has an enormous impact on the health service and, in particular, on emergency care. Is there an argument for investing more in social care to save in the long term? We hear a lot about how we can save money in the budget. Have any calculations been done on that?

Perhaps Mr Pearson could come in, on the broader point initially.

Robbie Pearson (Healthcare Improvement Scotland): I will go back to the broader point that others have touched on. We have talked a great deal, certainly in my 34 years in the health service, about shifting the balance of care. Social care is obviously a fundamental part of supporting people to lead longer and more independent lives at home.

However, the system is structurally and financially driven towards hospitals. There are several reasons for that, such as the immediacy of need and the pressures in hospitals with regard to emergency departments and corridor care. That contrasts with the fact that there are fewer visible services for social care in the community and in primary care. There is a drive to adjust that and make a fundamental shift to support more preventative measures and more people to lead longer and healthier lives at home.

When I was born, something like 13 per cent of adults were aged over 65. Today, it is around 20 per cent, so there has been a fundamental shift. When I was born, the ratio of working-age adults to pensioners over 65 was around seven to one, and now it is three to one. We know that there has been a fundamental shift in Scotland's population. It is ageing and there are demographic shifts between the west and the east.

However, that does not take away from the point about how we ensure that the system of care is orientated to supporting more people to lead longer lives at home and how we make appropriate choices in that regard across the portfolios and the budgets in a more holistic way. I am sure that my colleagues will want to say more about that in the context of the national performance framework.

Professor Linda Bauld (University of Edinburgh): I will go back to the original question. The other witnesses have mapped this out. If you look at the evidence, you will see that the pressures that we face are not unique to Scotland; many countries are in a similar situation. The reason for that is those population drivers. There are demographic shifts. The burden of disease is projected to increase by 20 per cent up to 2040, so there is a fundamental change in our population.

We looked at social security spend, which is, of course, another major area of Government expenditure. That rise is driven by disability payments, for example, demographic shifts and the burden of disease. Those are the main pressures.

The challenge is how the system adjusts. That is why there is a move towards prevention, which we will come on to. We have a lot of evidence that primary prevention in particular—those building blocks of health—is highly cost effective. The commitments in the public service reform strategy and the population health framework are built on that.

To come back to the point about looking at the whole system, the Health Foundation's 2023 report on Scotland's health and health inequalities points to local government and the other parts of the system, such as the voluntary sector, and explains why we have seen those pressures and why investment in different parts of the system needs to be strengthened. Those are important points.

Richard Robinson: We have written a report on delayed discharges fairly recently that is pertinent to your question, Mr Harley. There are issues around prevention and people needing services in the future, but we know that there are issues with delayed discharges now, and they are not cost neutral. We estimate in our report that it costs around £440 million a year to keep people in beds when they are technically ready to leave the hospital, so there is a financial cost attached to that.

Some of the reasons why people are delayed in being discharged can include that they are awaiting availability in a care home or awaiting a community care assessment. That emphasises the point that for the NHS to succeed, it needs to succeed within a broader system that is able to adapt and respond and is properly funded to do so.

That is why the Scottish Government's work on flow, which was announced recently, is going to be important. Unpicking those blocks in the system to make sure that you are getting the most effective and efficient use of your funds will be central. Monitoring how new initiatives such as flow navigation pathways and national treatment centres are helping to unblock those issues will also be central.

The Convener: I will pick up on a couple of things that have come up, and perhaps you can bring them back in. We have heard a lot about bed blocking and issues around shifting things to social care, but we have not heard a lot about healthy years lived. We have heard a lot about inequality, but, across the board in Scotland, the average figure for healthy years lived has decreased. I think

that the figure that I saw was that it had decreased by five years, from 64 to 59, for one of the cohorts. If that is wrong, I am happy to be corrected.

Interestingly, we had a meeting with a delegation from the Bavarian health committee yesterday. We met around a table like this, and I asked them whether healthy years lived was an issue for them. To be honest, they looked like they did not really understand the question, and then they said, "No. Our population lives longer healthier. It is just that they are living until later life." They have the same problem with care for the elderly, but they did not recognise that issue.

What evidence is there about other countries and other parts of the United Kingdom? Does anybody have any suggestions as to why they might be different?

09:45

Professor Bauld: The two main indicators that we use to measure life and healthy life are life expectancy—that is, mortality—through National Records of Scotland and healthy life expectancy, which is a composite measure that is made up of how people self-report their health and those mortality statistics.

Improvements in life expectancy started to stall around 2012, 2013 and 2014, and there has been a slight increase in the past couple of years. That has been because things were really bad during the pandemic and have picked up slightly. However, healthy life expectancy continues to decline. We are at odds with a number of comparator countries on that front, although there are issues with the self-report part of the measure.

Why has that occurred? It comes back to the points that other witnesses made about thinking about how we support all the different aspects of a whole system, particularly the preventative aspects of people's health. We have some particularly acute issues in Scotland, such as drug deaths and alcohol harms. We have had big successes, such as reductions in smoking, increases in breastfeeding and reductions in teenage pregnancy, but we have all those other issues that we still need to deal with.

I will be repetitive on this because I am a public health person, but we need to think about turning off the tap earlier in the system. We need to try to support people to be healthier early in life and during their working life. That will prevent some of the declines later in life that have happened in recent years.

Heather Anderson: I assume that you have all seen the Scottish Parliament information centre paper. The graph that kept me up at night is on page 6. It is figure 3, which is health care costs per

person. It basically shows that we have put in a lot at the beginning, as you say, through our investment in early years and then there is an incredibly steep curve when people get to 60. The biggest spending is, obviously, at the end of life. In some ways, we are the victims of our own success, because people are living longer.

All prevention is good and some prevention is more effective than other prevention. On what age group do we need to focus the preventative actions? Looking at the graph, I wondered whether it was 50 to 60-year-olds. Should we increase activity on some kind of health MOT or capture people in that age group before they go into decline? We have unhealthy life expectancy starting at 47 in Scotland. If you were going to put extra money in, what age group would you put it into? I know that it all counts.

Professor Bauld: If you want the biggest return on investment, you still invest in the early years. That evidence is absolutely irrefutable. Giving children and babies a good start in life sets them up for their future educational attainment and ability to participate in the workforce, for example. That is why addressing child poverty is fundamental.

However, you also need to focus on midlife. I will not say that you should just focus on health behaviours, but we have an overweight and obesity epidemic in Scotland and many conditions—musculoskeletal conditions, mental health conditions, diabetes, cardiovascular disease and respiratory conditions—are linked to a series of problems of which that is one. If we can do more for people in their 20s, 30s and 40s or even, as you point out, people in their 50s, who might exit the workforce because they are dealing with health challenges, they will be healthier in their 60s and 70s when they have those healthcare needs.

We need to have a twin-track approach: we need to focus on older people and their quality of care, but Scotland needs to focus a lot of its attention on the early years plus preventative interventions in the working-age and midlife population. You see a lot of that in the commitments that the Government has made, but I am sure that more could be done.

The Convener: Your point about the early years is interesting, and I thank you for it. What figures do you have for how that money is going to be transferred, given the constraints that the country is operating under? Many people talk about it as if, within five years or at most 10 years, we will see that change and improvement in the population if we stop spending money in one area and find a way to spend it in another area. That is what I was asking about: why is Scotland facing the situation

that I mentioned, and what needs to be done about it? Is there evidence that we could use to consider that issue? You have pointed us to a lot of documents, but has the specific question of how we get money into the early years been addressed? This might not be in your bailiwick, but is there evidence that early nursery care or childcare is better than having parents look after their own children? Is there a way to support parents?

That might be too wide a question for you, but I am just thinking about those issues.

Professor Bauld: When the cabinet secretary comes to you in November, that is an important point to raise in terms of the population health framework and the early years focus. However, on the point about evidence, Heckman and others have drawn a curve that shows what you get in terms of return on investment in not only childcare but all the factors around early life—I do not have the figures in front of me, but I can submit them subsequently.

One of the major outcomes from the evaluation of the expansion of childcare and the early years support in Scotland was that they increased maternal employability, giving women an opportunity to be more active in the workforce. There are health and wellbeing benefits to the infant, but there are also benefits to the family. We can certainly come back to you with more evidence of that, if that is helpful.

The Convener: On that point, perhaps we can ask why there are so many children going to school at five who are not potty trained. Again, that is beyond your remit, but I am putting that up against the assertion that children are all developing so well.

I see that Ms Payne would like to come in.

Alison Payne: I want to add a couple of things relating to what you said previously. Not everything requires additional investment. For example, alcohol advertising, which has been discussed in Parliament a lot, is still aimed at young people and children, and there are interventions that we can put in place in that regard. We can also do more in terms of vaccination take-up—we have been told several times that there will be a re-examination of the specific case of take-up in the Highlands, where there is an issue with the way that they are being delivered. A lot of stuff needs to be done in the early years. We have known for years that the participation of teenage girls in sport and exercise drops off at a certain point. There are interventions that can be put in place in relation to all of those issues, and not everything is about having to invest and spend money.

Having looked across the party manifestos, I see that there is agreement on the need to look at vape usage among young people, and bold action could be taken because of that. Although vapes have a place with regard to helping people stop smoking, figures that were released yesterday show that 1 million people across the United Kingdom are vaping who have never smoked. We can get ahead of that problem instead of waiting to find out what the issue is, because there is party-political agreement on the need to act.

We do not always need to wait for a health problem to arise before we act. For example, we can think about what interventions such as public education programmes we can put in place so that issues such as obesity, alcohol and drug issues can be addressed when people are younger.

Professor Bauld: I would like to reassure the committee that there is a raft of evidence about youth vaping—I want to come in on that issue because nicotine and tobacco are my main areas of research. We have been concerned about youth vaping for a number of years, and we are seeing rises in the rates of people vaping, which is concerning, although it is true that it is far less harmful than smoking.

The Tobacco and Vapes Act 2026, which was passed in the UK Parliament, is four-nations legislation. It is being implemented in stages, starting with the smoke-free generation provisions. There is a raft of very ambitious measures to deal with novel nicotine products, addressing the marketing, the availability, the point-of-sale displays, the attractiveness, the appeal and, through an excise tax, the price.

Again, I am sure that there is more that we can do, but I feel relatively confident that there is a huge amount of action in that area.

Alison Payne: I would just slightly challenge that, as I do not think that enough work has been done on the long-term harms of vaping or on whether it is a gateway to smoking among teenagers. Anecdotally, most parents will tell you that, in their children's peer groups, smoking has been picked up among the generation that was not doing it previously. Further, because of vape shops and the way that they are regulated, there have been two huge fires that have ground two of our major cities to a halt. There is a massive load of problems there that we are sitting on our hands about. We could be taking more action, given that there is political agreement on the issue. If there is something that could be done, I think that we should be bold.

The Convener: Those were good and interesting points. Mr Pearson, do you want to comment on that issue?

Robbie Pearson: No—not on that particular point.

Richard Robinson: It is clear that the spending decisions that are made in the budget sit alongside other things that can be done in relation to communication, culture, legislation and so on.

The original question was about what evidence we have, where the spending will go and what impact it will have. On the money that is being spent, it is easier to pick out the big things that have a long-term effect on health outcomes. For example, people talk about the Scottish child payment and additional hours of funded childcare—the point about childcare has been raised. The Scottish Government needs to get a better understanding of all its current preventative spending in its budget, and it is encouraging that it is starting to do that. Before it thinks about future preventative spending, it should be certain on where all the preventative spending is going now.

The SPICE paper talks about the ongoing work in relation to the pilots and so on. That will probably be quite subjective—judgments will need to be made on what is and is not prevention—but that will at least give a better benchmark against which people can judge how we spend money on or utilise preventative measures across the public sector to help with health outcomes.

It is correct to ask when, where and how we will see the benefits from preventative measures. That is where tracking, monitoring and reporting against the population health framework intentions come into their own. Over time, that should, I hope, sit alongside scrutiny of the finances so that we know whether we are on the right track and whether the preventative spending is delivering the results that we want.

The Convener: We all agree that evidence is essential if we are making major changes. Joe Long wants to come in on that point.

Joe Long (Mid Scotland and Fife) (Lab): I will park my question on capital spending—we might come back to that issue—because it seems as though we are moving towards the issue of budget tagging, which a few of us want to ask about. It is striking that a slightly more comprehensive model for tagging preventative spending is emerging, which will allow us to work out how much of notionally preventative spending is tertiary spending on, for example, people who are already in the system.

I have two questions. First, a lot of preventative spend will be outside the health system and hard to evidence. Has Audit Scotland, Professor Bauld or anyone else thought about how we evidence more community-based wellbeing spending that might have health benefits but might not be

covered by the tagging system? Secondly, how do we prevent people from tagging as preventative spending things that are already happening and that fit quite neatly into the tertiary category? I am just throwing out those two questions.

Professor Bauld: I have some of the figures in front of me. I will provide a bit of background information, some of which is in the SPICe paper. A prevention unit has been set up—the work on preventative spending covers the public service reform strategy and the population health framework—and a pilot was conducted. If you look at the planned preventative spending by level of prevention for 2025-26, you will see that 40 per cent of the spending was on tertiary prevention. You are right that the tagging shows that, in the vast majority of cases, the preventative spending was on either secondary or tertiary prevention. The really important question for me, as a researcher, and for Audit Scotland in its tracking, is how the spending can be shifted more towards primary prevention. *[Interruption.]*

Your other question was about spending outside the health system. As you will have seen, the pilot was done on the Scottish budget, but NHS boards and local government were pilot sites, and work is ongoing in that regard. It would be really interesting for the committee to look at the local government element of budget tagging.

It is right to say that it is subjective. I have not been involved in the process, but, if I were finding articles to do a literature review, I would not decide myself whether an article was relevant and could be included; I would have a group of people deciding that with me. In its preventative spending exercise, the Government seems to be getting a number of people to make independent judgments about whether they think that the prevention is primary, secondary or tertiary, before coming to a consensus. That is good practice.

As I understand it, the aspiration is to set up a preventative investment framework in a future programme for government—Audit Scotland's role will be key there. With my researcher hat on, I will be interested to find out whether that can be achieved—it has been done in other countries, for example in the state of Victoria in Australia—and whether we can put money into some of the interventions that we have talked about while still managing the huge pressures associated with the acute need in the system.

I hope that that was helpful.

Joe Long: It was—thank you.

The Convener: I must apologise for my phone going off as you were speaking.

10:00

Richard Robinson: I would like to add to what has been said, because I think that it is an important point. Given that health is delivered across the board, is it right that we should look only at health prevention spending in the NHS territorial boards?

In our community health and social care report, we raised the issue of the difficulty that the Scottish Government and local government have in getting together all the information that tells them what makes a difference to people collectively. We know that the Scottish Government wants to do more on, and to expand the use of, whole family support models, which involve understanding the role that the police, health services and schools play in relation to families. That work is really important. In our report on community healthcare, we mentioned the fact that the Scottish Government said that it would work with partners across local government to adopt the use of community health index numbers in local government. Basically, the more data that it can get about how different parts of the public sector are working together towards a health outcome, the better.

What we refer to as primary, secondary and tertiary levels of prevention are important, but they are just categories, and they will remain just categories unless they influence decisions. We will need detail to establish whether we are comfortable that we have the right levels of primary, secondary and tertiary care, how those levels are changing over time and how we feel about that—when I say “we”, I mean the Scottish Government. Those are the types of questions and challenges that it will have to put to itself in consecutive budgets over the medium and long term.

The Convener: Paul McLennan has an issue that he wants to bring up

Paul McLennan (East Lothian Coast and Lammermuirs) (SNP): I want to explore that point a bit more. You are right in what you said about primary, secondary and tertiary care, but we have all touched on the need for a whole-system approach. How do we embed a preventative approach across the whole system? Given that some parts might work better than others, that is a particular challenge. We are almost talking about a one-size-fits-all model, but how do we ensure that it fits the mix of urban and rural areas that we have in Scotland? That is complex.

Have you done any work on that? You have looked back at what has happened, but we need to think about what could happen in the future. How do we ensure that a whole-system approach that takes account of regional differences is

embedded in what we do in relation to the preventative agenda? We could do good work in some areas, but that will fall by the wayside if we do not take a whole-system approach. That is the crux of the challenge. We need to ensure that that is embedded across the sector.

Richard Robinson: Others will undoubtedly have more to say on this. Briefly, different areas all have different levels of rurality as well as different age and poverty demographics. All areas of Scotland are unique. For auditors, that begs the question: who is best placed to lead and understand what is right for a particular area of Scotland? One of the submissions discussed that question. That is a decision for the Scottish Government and local government to make together. Some of the whole family support work has been carried out quite locally, so we need to ask how that has been supported by the Scottish Government and how it feeds into other work. In other areas, a more systematic approach has been taken. For example, child payments, which support poverty and health outcomes, are delivered more centrally.

As structural changes take place during the period of reform, it will be important to keep an eye on the extent to which the approach taken reflects what is best for local communities that may differ in need across the country.

Professor Bauld: I have a couple of points to make in response to that question. In relation to the pathfinders and pilots—we can use whole family support as an example, but there are others—it will be very important that we evidence whether they are successful. We need to have adequate evidence on the extent to which they work in different parts of the country. If a scheme is successful, it should be rolled out nationally, if local people agree and it is wanted by local communities.

We spent about 18 months doing a lot of consultation on what should be in the population health framework and its different elements. One of the key objectives in the first two years is a prevention-focused system, which requires a national approach. You are right that there are different views on how achievable some of that is in the islands and in rural and remote areas. However, in the governance, we have tried to make it a national approach, and we will track how it is being embedded through the evidence and evaluation.

The point about looking at what happens in small areas and making sure that things work before we roll them out is an important one.

Paul McLennan: The system design at the start is important, but so is how we monitor it going forward. We can say, “Okay—this is the system

and this is what we’re doing”, but how do we monitor that? We do not want to be here in five or 10 years’ time saying, “We looked at this years ago when we redesigned it.” What are the fundamentals? Richard, this question may be for you. Where are the key metrics that we need to look at? It is not simple, so how do we ensure that the whole-system approach is working? A year after the reforms come in, what will the committee need to do to see whether they have worked? Will we need to look at it regularly? How will that feed in? I know that this discussion is a bit like asking, “How long is a piece of string?”, but will you comment on that?

Richard Robinson: Professor Bauld might also want to respond to the question. Over the past year, the Scottish Government has set out a number of frameworks and strategies whose success it plans to judge, and they have different timelines. The service renewal framework and the population health framework have slightly longer ones. To enable parliamentary scrutiny, it will be important for the Scottish Government to set out what you can reasonably expect to see next year, in five years’ time and in 10 years’ time. That is important because it will enable you to scrutinise whether the money that is being spent is working as the Government intends. It will be for the Scottish Government to pull that together, but it is really important that those milestones and the measures of success are set out. Professor Bauld may want to say more about that.

We may come on to discuss this, but we are awaiting the refreshed national performance framework. In the past, we have commented that the previous NPF was not really a decision-making tool and that the monitoring and measuring of some of the indicators was inconsistent. If the refreshed framework is to enable you to scrutinise whether the spending decisions are making the expected difference in relation to health, poverty, contributions to the economy and so on, it will be really important to have a clear line of sight on how budgetary decisions, and spending decisions within that, are linked to those outcomes.

Professor Bauld: The population health framework has an overall aspiration to reduce the decline in healthy life expectancy and reduce inequality. It contains some figures on that, and it will be really important for the committee to track the extent to which that is achieved. The other thing to look out for is the evaluation of the population health framework, which contains further measures of progress. Again, having a good look at that will be important.

The refreshed NPF will be very important for the population health framework, the public service reform strategy and other things. Essentially, it has three levels. There are high-level indicators related

to health and wellbeing and a bunch of other outcomes that we wish to see for the people of Scotland, and they are connected to how the Scottish Government will track performance on them. There are also intermediate indicators. Most of the NPF indicators are annual. I hope that the committee will be able to look carefully at that and ask challenging questions as the work progresses.

The Convener: That is helpful.

Heather, I am sorry—I forgot to come back to you.

Heather Anderson: It is great to hear this evidence. So many plates are spinning at the same time, but I think that there is complete agreement that this is the right direction of travel. What we are trying to do—to move towards prevention—is completely sound. There is a big implementation gap, but it is becoming clearer and clearer that a lot of the spend that helps with prevention is done at local authority level and we do not have enough evidence to inform what we are doing.

The Government's prevention unit has done a lot of work on a methodology, on tagging and on trying to make sense of what the Scottish budget is doing. I presume that it is incredibly important that that methodology is carried through to local government level, so that we are all talking about the same numbers, data and indicators. Do you agree? Is that happening? How quickly are local authorities evaluating their spending? How soon can we expect to hear from them about their analysis? I know that that is a complicated question.

Professor Bauld, you mentioned in your written submission a health and social care reform preventative investment advisory group. That sounds like an important group, and I think that we should hear from it. I want to find out a bit more about what you know about that group and what it is looking at. Part of the stress is that the budget is coming at us immediately, and we are trying to assess it in terms of prevention. We are asking you to help us to work out how we evaluate that over the next four years. We want to know, for example, if we move a certain amount in year 2 and a certain amount in year 3, where we will spend it.

The first question was about methodology, indicators and the work at local government level. I would also like to hear a bit more about that advisory group.

Richard Robinson: That covers a lot of important areas. As we have discussed, to achieve prevention and better outcomes, it is important for different parts of the public sector to work together. The Scottish Government produced a leadership statement in September, which was useful in

setting out its expectation that its leaders will work across different parts of the public sector. That is encouraging.

Local government is a separate tier of government. With previous national performance frameworks and outcomes, there has been mutual agreement on how local government and Scottish Government outcomes could work together. There are opportunities for the Scottish Government, working with local government, to agree how that will work with regard to the new national performance framework indicators.

I can say something about how the Scottish Government and local government build on, improve and amend their current ways of working together. We have community planning partnerships, local outcomes improvement plans and various forums where NHS boards, councils and others can come together, and we have made various comments about regional discrepancies in how effective those arrangements are. The Scottish Government and local government might want to look again at how they gather data and work together towards those goals.

The other point is that some of the ambitions that will lead to the hoped-for long-term improvements are not new. As you will have seen from the committee papers, the focus on prevention goes back to the Christie report in 2011 and before that. The intention to shift the balance of healthcare towards communities has also been a long-term commitment and ambition. That is why the Auditor General has said that there can be an implementation gap between ambitions and reality. The key challenge for the Scottish Government and local government is to explain what is different now. What will make it a success this time and enable the Government to deliver what was wanted in the past?

Professor Bauld: The health and social care reform preventative investment advisory group is working with the economists and others who are involved in the prevention unit to provide advice. The group's membership includes NHS directors of finance, directors of public health, Public Health Scotland and, importantly, the Convention of Scottish Local Authorities and the Scottish Government. Local government is feeding in to that.

To respond to the other question, the pilots have involved local government. My understanding is that the advisory group will continue to be involved in how the preventative spend work is rolled out and in ensuring that it is appropriate for different parts of the sector.

The Convener: Thank you. Those are interesting pointers to things that we can come

back to later. That leads us neatly on to concentrate more on preventative spend.

Jack Middleton (Aberdeen Central) (SNP): We have covered a fair bit of ground on preventative spend, but I have a question on the metrics that Richard Robinson mentioned. How do the metrics that we use to calculate whether preventative spend has been successful five or 10 years down the line fit with the annual budget process that we are in right now? I recognise that we are a devolved nation and that those are the cards that we have, but what changes can the Scottish Government make to respect preventative spending and acknowledge that the successes or the metrics that we want will not be realised in a 10 to 12-month period?

10:15

Richard Robinson: Again, others might want to come in on this. The challenge of preventative spending, which the Auditor General highlighted as a real challenge in last year's NHS in Scotland report, is that there is a limited financial envelope, there is immediate need and, alongside that, there is long-term need. The question is how to ensure that prevention receives the space and priority that it requires in that environment.

That environment will not change immediately. Based on Scottish Fiscal Commission projections, the financial pressures in the Scottish budget are likely to continue in the coming years. We have spoken about the ability to name and point to preventative spending, which is a positive development. One issue that we have raised in the past is that, apart from the bigger announcements, it is not always clear where preventative spending is or what it is. Understanding where it is in the budget and the difference that it is making will help.

It will be important for the Scottish Government to continue to produce information and evidence to show whether the spending is meeting its milestones, even if those are intermediate milestones. That could involve setting out the difference that the spending has made so far, towards those end goals. It is tricky to justify spending that might not deliver a financial or population health return for 10 years, but regular reporting, the justification of spending, and clarity and transparency on that in the budget will be important in helping that along.

Paul McLennan: Jack Middleton makes a good point in saying that it might take five or 10 years for benefits to emerge. When the cabinet secretary appeared before us, one of the key issues that we discussed was the success of subnational planning. In the interim, before we go from 14 health boards down to two, what do we need to do on subnational planning? That is about resource

but it is also about more procedures taking place. This is an open question. What can we do to have that focus before we move to two health boards and before we see the benefits of preventative spending in five or 10 years?

Richard Robinson: Could I ask you to rephrase the question? Are you asking how we should scrutinise the interim arrangements?

Paul McLennan: Yes—it is about the interim arrangements. We have heard about the success of subnational planning and the difference that it has made. What focus do we need in the five to 10 years before the benefits of preventative spend start to kick in?

Richard Robinson: As things stand, some details about the timescales for the new arrangements have still to be provided. In the meantime, subnational arrangements are in place. The accountable bodies are still the NHS boards, which we presume will be different under the new arrangements. The purpose of the subnational arrangements is, in effect, to allow the better flow of treatment and patients between areas of Scotland to alleviate pressures in some parts of the country. It is reasonable to ask the Scottish Government what success has flowed from that arrangement to date, and how that will be reflected in future budgets.

For us, the important point is that, although the new arrangements are expected to differ from the current subnational planning arrangements, lessons should be learned from the subnational arrangements on accountability, decision making and the challenges of managing services on a regional rather than a board basis. It will be useful to see those lessons reflected in the new arrangements when they come along. We need to have an understanding of what difference the new arrangements will make on savings, efficiencies and so on.

The Convener: On the point that you just made about subnational planning, does anyone have any evidence that they can send us about what it has achieved so far? We are all aware of it. There are issues with it. Some things have been pointed to us as a great example of where we might go. Others who work in the field pointed out that there is little evidence on some aspects. If any of the witnesses has any detail on the analysis of what has happened so far, the committee would welcome that.

Richard Robinson: Audit Scotland is currently working on its NHS in Scotland 2026 report, which will come out on 1 December. That will have some information about subnational planning in it.

Alison Payne: I will respond to Mr Middleton's question about the five to 10-year metrics.

In preparation for the committee meeting, I looked back at the Kerr report from 2005. It was designed to be a 20-year plan for the NHS. I think that it said that the status quo could simply not carry on. It turns out that we can carry on with the status quo. We get into circles of knowing what we need to do but the right decision is not always the politically expedient one. That is a problem.

We did not implement the Kerr report or the Christie report. We know what needs to be done, but trying to deliver preventative reform might take five, 10 or 20 years. We have talked about the importance of early years. It will take a long time. We need more cross-party working to develop and enable some of the reforms that are required because that preventative agenda does not work on an electoral timetable. In a number of areas, not just in health but across the public sector, we have failed to deliver reform because of that. If we really want to deliver prevention and not keep having the questions as to why the Christie report was not implemented, we need to think about how we enable greater cross-party working.

Jack Middleton: How do we make that a reality? What are the mechanisms for the committee and politicians in the chamber to hold the Government to account on it and ensure that prevention happens and is in action in five or 10 years?

Alison Payne: We need to be honest with the public about what can be achieved and the difficult decisions that lie ahead. If we always try to pretend that things can be fixed easily, we will not bring the public with us.

However, there is also an opportunity. Enlighten recently published a report by Alex Neil and Richard Simpson. It was not an all-encompassing health report but it tried to find the political common ground between a former Scottish National Party health secretary and a former Labour health minister. There are areas of mutual ground and I suggest that the committee hear from a panel that includes Andy Kerr, Michael Matheson and Alex Neil—people who have tried to implement reform but are no longer part of party politics—to have an honest conversation about where the obstacles are, how we can overcome them and how we work together to find common ground and deliver the change that is needed.

The Convener: Okay. We will take that under advisement. It is interesting.

Heather Anderson: I go back to my first question. It is about impact. I completely agree with everything that we are doing on child poverty, early learning and child care and I know that that is a long game, but my first question was: if we had another key strand of work, what age group would it focus on?

I come back to the idea about MOTs for people when they are 50 or 60, about to leave the workforce and perhaps taking their health more seriously than they did when they were 25. If you get people to stop smoking when they are 60, that has a massive impact on what is next, even if they might have smoked up until then. All prevention is good but some prevention has a bigger return than other prevention. If you had to pick another age group, what would you do? Would it be an MOT of some sort for the population at 55 or 60? Would that just generate more demand or would it help us to plan?

Professor Bauld: I am not an expert on the evidence on routine health checks, but I know that the evidence on the English system is mixed, so I am not going to advocate a single MOT. However, we need to ramp up a series of things that we can do when people are in midlife in relation to the preventable risk factors for non-communicable diseases.

Your point about smoking cessation is excellent and spot on. We must not disinvest from stop smoking services, even though, as we saw yesterday, the prevalence of smoking among the population is down to 9 per cent. That is not the figure for the age group between 45 and 64, and about one in five people in the most deprived communities still smoke.

Another risk factor is diabetes, which I have talked about previously. We can prevent type 2 diabetes, the number of cases of which is rising exponentially across Scotland, particularly in the age groups that you mentioned.

Cancer prevention is another example. We know that dietary changes and physical activity are important not just in the primary prevention of cancer but in the prevention of cancer recurrence.

We need to consider what is being done not just by the NHS but by the voluntary sector. An excellent point was made earlier about whether we are giving the sector enough support. Maintaining vital local authority services that make preventative interventions for those in midlife will also make a big difference. There is no single answer, but we should ensure that the preventative measures on which there is huge evidence are taken in Scotland.

Adam Harley: Ms Payne, on your important point about trying to remove the party-political barriers to reform, it would be helpful to hear how we should balance the need for longer-term reform with the alarm bells that are ringing now in the NHS. People who are dealing with the emergency on the front line of the NHS feel that, if anything, they need more attention in order to deal with the current issues relating to corridor care and so on. Equally, we are dealing with those issues only

because we have not addressed the need for reform, particularly the need for prevention, over the past few years. How do we find the right balance? I do not want to put you on the spot, Ms Payne—other witnesses might want to answer—but do you want to say anything about finding that balance?

Alison Payne: We have to look more widely and work with partners. In relation to prevention, we held an event recently at which Jane-Claire Judson from Chest Heart & Stroke Scotland, Rami Okasha from Children's Hospices Across Scotland and Tejesh Mistry from Voluntary Health Scotland talked about how we can deliver front-line services while trying to manage a budget and how we can restructure while counting the coins. Those in the third sector who are delivering on the front line can bring their skills to such conversations, because they have to make difficult decisions day in, day out.

One of the issues that came through from that conversation was the diversity of experience on the boards of those organisations. The boards include people from the business community, and from a range of backgrounds, who are helping to shape how the organisations operate. We can learn an awful lot from those organisations.

Equally, in the public sector, we are not doing enough work across silos and across the different sectors. For example, we know that an awful lot of people who are homeless also have an addiction problem, but our services are designed around the needs of those services, not the needs of the individual. How can we design services around individuals so that we can best deal with their acute needs and be preventative at the same time? The Kerr report, the Christie commission and all the other reviews that we keep doing are about how we design systems around individuals. Recently, somebody said something to me that really stuck with me: our health systems are designed by healthy people, so how can we address those problems?

We should stop trying to do everything ourselves, to reinvent the wheel and to centralise. We should learn from partners who are trying to juggle those issues. As you said, there is firefighting and there is prevention, but many incredible organisations in our communities are doing just that.

Joe Long: I am loth to leave the prevention agenda—

The Convener: Oh, we are not leaving it.

Joe Long:—because there is a good deal of consensus on it, but, as has been alluded to, we are riding two horses in trying to shift to prevention and reform the health service at the same time.

I want to pick up Paul McLennan's point about the potential massive restructuring of the NHS by asking Robbie Pearson a question. Healthcare Improvement Scotland's briefing talks about the needs of the health service, and I was struck that you identified governance, culture and leadership as areas in which work is needed. Governance relates to structure, but leadership and culture do not necessarily relate to structure. In relation to reforming what we have, can you unpack what you have found around those phenomena and tell us what you think might be needed?

10:30

Robbie Pearson: On the shift in the focus of Healthcare Improvement Scotland over the past decade, we have moved from looking exclusively at direct patient care, which is very important in the context of infection prevention and control, for instance, to looking at matters that are more relevant to the system as a whole. What I mean by that is matters of leadership, culture and behaviour, and the extent to which staff feel supported when they raise an incident and know that it will be acted on.

Those matters are of increasing importance, because we know that they are critical in the system to ensuring the safety and quality of care. Maternity inspections is a good example. Over the past 18 months, in around 15 out of the 18 acute units that we have looked at so far, we have identified matters that relate to leadership and culture, matters that relate to direct patient care with regard to triage of mums and other matters in relation to infection prevention and control.

Leadership and culture are absolutely central to that. Structures get you so far, but at the end of the day, however you define the unit of currency—whether it is 14 health boards or two strategic boards—it is about behaviours, how people are incentivised to give their best and how organisations provide an environment for staff to give their best and be supported to deliver high-quality and safe care.

Joe Long: Can you unpack some of the issues that you unearthed around leadership and culture? What does that look like on the ground?

Robbie Pearson: In relation to maternity, one of the big messages is about the connection between the top of the organisation and the front line. Does the board and the most senior leadership in the organisation understand the pressures and the incidents that are happening on the ground?

For example, an inspector will go into a maternity unit and asks a midwife, "What happened the last time that you reported an incident? What was the feedback and what assurance did you get that there was learning and

that there would be mitigation to prevent that from happening in future?" It is a simple question that our inspectors would ask. In a number of instances, we did not have confidence in relation to the feedback that was received about the extent to which there was an understanding of staffing levels or the handling and management of adverse events, for instance. That forms a picture of the importance of culture and leadership in organisations.

Joe Long: That is interesting. When you identify such issues and, I presume, make recommendations, where does the accountability come from? Do bodies such as yours have enough teeth to ensure that that that culture change happens?

Robbie Pearson: We do our inspections against two things, one of which is standards. When we make a determination against a failure to meet a standard, that becomes a requirement—it becomes a must. The board must do that. In relation to responding on good practice, it is a matter of saying, "You should do this."

In all our inspections, we review improvement plans within 18 weeks, and we are back within a year. Boards will be at different levels of concern arising from our inspections. For some boards, we may well escalate to the Scottish Government according to our ability to do that in our operating framework. We can escalate, in the first instance, to the chief executive and, secondly, to the Scottish Government. In extremis, if there is not sufficient progress, the chair of Healthcare Improvement Scotland will speak directly to the cabinet secretary.

Remembering that health boards, as constituted at the moment, are under the direction and control of the Scottish ministers—that is what the National Health Service (Scotland) Act 1978 states—it is important that the powers that we have to exercise requirements and escalation are clear and explicit.

Joe Long: What would you need to maintain your role in a big restructure? What do you need to ensure stays in place in order for you to be able to make those recommendations?

Robbie Pearson: At the moment, we relate to 31 health and social care partnerships, jointly with the Care Inspectorate, and 14 territorial boards. If we were to move to a situation in which there were two strategic boards—the key operative word is "strategic", I guess—we would need to determine what the overall landscape looks like in the context of the operating currency at a sub-strategic board level. That will be important.

In relation to reform of the system, wherever you look across the United Kingdom, one of the critical things in the learning and evidence is how the eye

can come off the ball during structural change. What we cannot afford to happen is for there to be any deviation from the fundamental purpose of why Healthcare Improvement Scotland exists and why boards exist, which is to deliver high-quality, safe care to patients who come into contact with the NHS and the independent sector.

The Convener: Heather Anderson has a follow-up question.

Heather Anderson: I am a local councillor, so I know that, as Alison Payne said, balancing the council budget is a stressful nightmare that involves months of going through lines in minute detail and saying that, for example, you cannot afford to give a group £600 even though it is doing enormously good work in the community in stopping people committing suicide. There is huge pressure on statutory services, which are protected, and discretionary services, which are always the ones that do all the prevention. I would like to hear the panel's views on whether we should have some category that protects prevention in the delivery of care. Should we pass legislation to say that services that are involved in prevention work have some status whereby their funding is not able to be reduced as easily as it is at the moment, because they are discretionary?

My second question is about targets, which are mentioned in the HIS report. Robbie Pearson, you talked about how the entire infrastructure is built around health as the focal point, which means that we have a set of health targets that drive behaviour and feed into a culture of people trying to hit those targets at any cost. Do you think that we should introduce a different range of targets that are more directed towards prevention? How might that change behaviour?

Robbie Pearson: I will start on that, and perhaps hand over to Professor Bauld in relation to the national performance framework and how that is evolving.

Around a decade ago, Professor Sir Harry Burns carried out a review of targets, which raised a number of interesting questions about what targets we need and the balance between having more immediate hospital-based targets, such as those around the four-hour waiting time in accident and emergency units, and longer-term targets in relation to prevention, which we have discussed this morning. There is a balance to be struck in relation to the immediate things that matter to patients in relation to the safety of their care and so on. Those things should not be traded for the other things that are just as important. That is a really important point.

Others might wish to discuss the point about starting to insert must-dos into statute and the extent to which doing that constrains and fetters

accountable bodies and democratically elected bodies with regard to what they should do. That is a different matter that would have to be considered, because whatever you write down will be open to interpretation.

Nonetheless, coming back to the broader point about wellbeing and the national performance framework, if we are going to get the approach right, as accountable leaders, we have to ensure ownership of the measures in it. What I mean by that is that we cannot underestimate the extent to which the jagged nature of accountability and the pointed need to do something today in relation to responding to pressure can crowd out the longer-term achievement of broader cross-sectoral ambitions and objectives.

Heather Anderson: I never underestimate that pressure.

Richard Robinson: We have been asked whether we should have targets. The Scottish Government made the choice to have the targets, and it could make the choice to have different targets. I understand the argument that the existence of targets can skew resources or time towards meeting them, but, as we have reported, there have been several targets that the Scottish Government has missed. Targets can also be of use in enabling you to target what intervention you need to put in place to correct that. For example, the operational improvement framework—the Scottish Government’s set of short-term one-year plans, which we commented on in last year’s report—was able to set out the view that there are some waiting times that are too long, and say that attention and resources would be targeted towards resolving the issue. Targets can have a use, so there is a baby-and-bathwater point in relation to whether we should stop having them.

On the NPF, as we were saying earlier, there is a question about the extent to which the NPF is the decision-making tool for budget decisions. As we have said, this has not previously been the case in the past, but if there are issues with how you balance, explain and scrutinise what you are spending on immediate issues and what you are spending on preventing issues that might arise, having an NPF front and centre that sets out how you are making decisions about how to spend money and how to balance the levels of funding that go to the NHS, local government or whomever helps the cause by ensuring a greater degree of ownership and visibility.

The Convener: Mr Pearson, I have a couple of questions on prevention and on your role. You explained quite a bit about your role. How does the patient safety commissioner interact with it? Do you have any comments on how that is going?

Robbie Pearson: The patient safety commissioner has been in place for a year, and has just produced an annual report. We are building a very constructive working relationship with her. The patient safety commissioner is in statute and is accountable to Parliament. The post has a role in relation not to the advocacy of individual patients but to the patient experience and how that may reflect systemic matters of concern across the NHS. In the coming week, we will sign off a memorandum of understanding. A key aspect of that will be about how we work together and how we share our collective knowledge and intelligence.

The Convener: Great—that sounds good. I look forward to reading that.

I have a specific question on prevention, which I think is quite interesting. We only had an hour with the Bavarians, and they spoke German and we spoke English. Nevertheless, some interesting things came out of the discussion. I asked whether long Covid was a problem for them, as it is in this country, and what they were doing about it if so. They told me that they have estimated that, in the years between 2020 and 2025, it has cost the German economy €318 billion and that they are spending €500 million over 10 years on research.

That was interesting to me, because I would like to know what has been done in this country about the issue. We are talking about prevention, but let us talk about trying to help people not to be ill for the rest of their lives because they have not been given adequate help. Do any of the witnesses have any data on that? All I know about it is that the Government has given £4.5 million a year for an unknown number of years to address ME and long Covid, which are estimated to affect 100,000 people in Scotland, many of whom are unlikely to get better unless something changes. Can anybody comment on that?

Professor Bauld: I can say something about the research, but not about the practice in Scotland. You could get back to me with a request about how the evolution of care for people with long Covid has developed in Scotland since that immediate post-pandemic period, because I am not up to speed with that at the moment.

UK Research and Innovation is funding an extensive research programme, through the Medical Research Council and others, that aims to better understand the condition—which, as you know, is multifactorial—and to follow up on people who have received a diagnosis or who have a condition that a clinician is relatively confident is long Covid. I am aware that a lot of research is being done, but I am not up to speed with what is happening in the NHS to best support people with long Covid.

10:45

The Convener: That is interesting. Can you tell us who is doing that research? Where could we look that up? Could you send it on to us?

Professor Bauld: We can send it on. UKRI's website is searchable, but I will take that away. I am happy to send information about that to the clerks and to speak to colleagues who I know are active in the area.

The Convener: That is great—thank you.

I will perhaps ask Mr Pearson the question about the provision of medical support. Do you have any understanding of where the medical profession is in that regard?

Robbie Pearson: I would need to come back to the committee in relation to what the current practice is.

The Convener: It would be great if you could do that.

Adam Harley has a follow-up question.

Adam Harley: I would like to know how much long Covid and other chronic long-term conditions are costing Scotland's economy as a result of people not being able to return to work. Obviously, that has a huge impact on them personally, but there is also a knock-on effect on the economy. Are you able to say how that impacts the budget?

Robbie Pearson: Mr Robinson might be best placed to answer that.

Richard Robinson: I am not aware of Audit Scotland having done any specific work on the particular issue of how conditions such as long Covid affect the budget. It is clear from what has been said that they affect a lot of people. How that translates to an impact on the delivery of services by health boards and the nature of that impact seems like a slightly different issue—I am speaking outside of my areas of expertise here—from that of more preventative work. It is a question of how people can be supported to manage the issues that they have over time. I am afraid that we have not done any specific work on that.

One issue that the Scottish Government has had has been to do with the length of waiting lists and the number of waits every year. The cabinet secretary has spoken about how the length of time that people on some of those waiting lists are having to wait is coming down. Someone might not be able to work while they are waiting, it might be more difficult for them to do so, or the waiting might be affecting their quality of life. For scrutiny purposes, it is legitimate to ask about the impacts on people of such longer-term or lifelong conditions, alongside the impact of longer waits for

treatment that they may require, whether that is in orthopaedics or cancer services.

Adam Harley: It sounds as though there is a bit of a gap there and that some work needs to be done to look at the long-term conditions and the knock-on effect that they are having in Scotland. The committee should press the Government on that.

Richard Robinson: I think that it is for the committee to decide how it would like to do such work. It sounds reasonable to try to set out the difference that the issue makes to people's lives and how much money it costs for budget purposes.

The Convener: I will come to Alison Payne in a minute. We have been talking about how we can take money off the NHS to do preventative work. I am asking about work of the kind that the Germans have done to establish how much it costs for many people to be inactive. Putting aside the social care costs, the loss of working people for decades is a major cost to the economy. Work has been done on that in relation to ME. It was done some years ago, and I cannot remember the figures offhand. I would have thought that Audit Scotland might find it of interest to look at that work. I was interested to learn that the Germans have identified the issue as a problem. They have identified that the impact is quite large—it is in the billions. That was also the case in the UK, a number of years ago, for ME, and that was before another 70,000 people were diagnosed.

If people were to look into such conditions, we might find a way of dealing with them. I am not saying that they are curable at the moment, but there is no doubt that they can be made worse by bad advice. Until somebody focuses on the issue, the people affected will not get the help that they deserve. That is just a thought. I would be happy to hear back from people on that.

Alison Payne: Organisations such as Chest Heart & Stroke Scotland, which I have mentioned, and the Scottish Huntington's Association deliver the specialist care that many of these conditions require. It is not just the NHS that delivers the care. A lot of individuals need financial support and guidance to address some of their problems. There is also a point about education in relation to how such organisations access schools and address various elements of employability.

We should look to organisations that are delivering cross-sectoral support. Often, we focus too much on the state, which might treat the condition, but there could be impacts on someone's housing and so on, so we should look to the specialists in helping individuals by delivering that support in our communities, because they are the experts. We do not need to keep reinventing the wheel centrally.

The Convener: That is a good point about looking outside the medical sphere, but we need those inside it to look at the issue, too.

Robbie Pearson: On Mr Harley's point about chronic conditions, musculoskeletal problems, such as back pain, can be debilitating over the long term and can result in people missing out not just socially but economically. We seek the views of the just over 1,000 individuals on our citizens panel, and we have received strong feedback that individuals want to be active, not passive, recipients of their care, especially when it comes to chronic conditions.

One example of our work to better join things up is our community appointment days. That is an initiative whereby people who might be on a waiting list after having been referred to the NHS for a musculoskeletal condition are seen in a large arena—that is the best way to describe it. They are seen by physiotherapy and counselling support services, for example, which means that their needs are met in a more holistic way, as opposed to the traditional NHS referral involving an outpatient appointment at a clinic. That example from NHS Lanarkshire is a good one. In that forum, about 400 individuals who were on a pathway for a musculoskeletal condition were seen through a multidisciplinary approach. Subsequently, through appropriate interventions as opposed to being seen in a medical sense, a number of those people were able to come off a waiting list, be rehabilitated and go back to active lives.

That is an example of the joined-up thinking that the other witnesses have described in relation to prevention. It takes us away from a medicine-dominated approach to one that genuinely relates to the intent around realistic medicine and one that supports people, especially those with musculoskeletal conditions, to get back to being physically and economically active.

The Convener: That is a very interesting example.

Paul McLennan: I know that we have limited time left in this evidence session, but one of our key themes is drug and alcohol deaths, so I want to ask about that issue. The key statistic, which is really scary, is that the rate of drug deaths in the most deprived areas is 15 times higher than the rate in the least deprived areas.

There are a couple of key issues for me. The first relates to the role of national frameworks, such as the population health framework, and the second relates to the effectiveness of the current delivery framework that we have in place, with drug and alcohol partnerships. My question is about the national approach versus the local approach. As is mentioned in the committee's papers, the use of drugs is higher in areas such as Glasgow, Dundee,

North Ayrshire and Inverclyde. My question is about the population health framework and local delivery versus national delivery. This is still a key issue for us, given that the statistics from last month showed that there had been another rise in the number of deaths. What are your views on that? The committee will be doing more work on the subject, but can you give a broad overview?

Professor Bauld: That issue is an important component of the population health framework. The framework works in practice by bringing together key overarching strands, including the building blocks of health and behavioural and environmental factors. Nested within that is a series of delivery plans and strategies. The specific actions on alcohol and drugs are in the alcohol and drugs strategic plan for 2026 to 2035, which was published recently. Alison Payne has an interest in alcohol issues, so she might wish to speak about that. On the Enlighten website, there is commentary from Alastair MacGilchrist, the chair of Scottish Health Action on Alcohol Problems, who has strong views on the changes that should occur.

That is all that I can say on that. That local/national issue is an active focus in the consideration of the consistency of delivery locally, and there are new investments in alcohol treatment teams in hospitals and so on. I come back to the point that, when the minister comes to the committee again, you might wish to raise challenges and explore some of those points in more detail.

Alison Payne: I highly recommend Alastair MacGilchrist's post, and I am happy to send the link to it, if anyone would like to read it. He makes interesting points about alcohol and drugs being classed as one thing and whether we need to address the two separately. There is an awful lot of focus on the drugs side, and there is perhaps a cultural issue in Scotland about how we address alcohol. As a liver doctor, he points out that, by the time that he addresses individuals who require his help, there have been many missed opportunities to address alcohol behaviour, the harm that is caused and the broader issues around that.

There are a number of issues that we need to grapple with, including the cultural one. Alcohol advertising was touched on in the previous session of Parliament, but we moved away from that. There are difficult conversations that we need to have about alcohol, and SHAAP has made an interesting point about separating alcohol and drugs.

The Convener: That is something that we have considered, and we will certainly look at that. I just want to clarify for anyone who is watching that, of course, not everybody with liver cancer or liver

disease has an alcohol problem. Some people have received contaminated blood, for instance—that is a well-known group. No one wants to imply that everyone has an own-fault illness, as I call them.

Alison Payne: I apologise, convener—you are quite right.

The Convener: I know that you did not mean that, but I would not like anyone to be left with that impression.

Heather Anderson: We have focused a lot on the structure of health boards. What we have heard about the national performance framework is helpful, and we need to look into that in more detail. I have asked whether we can have a study day on the report “Learning from 25 years of Preventative Interventions in Scotland.”

However, I want to ask about the role of general practitioners, because they are the primary contacts. I know that GPs already focus on preventative measures, but what could we do to support them to focus even more on those?

Robbie Pearson: That is absolutely essential. Professor Bauld made a point about the midlife population and cardiovascular disease. The provision of statins and the monitoring of blood pressure and cholesterol are all critical in relation to the preventative agenda.

I will not go into the general medical services contract, but I come back to the point that I made at the start of this conversation about ensuring that we genuinely have a system that is in balance and one in which primary care, community health services and the hospital sector, as well as the range of non-statutory bodies, are engaged in supporting people to lead healthier lives for as long as possible, with at least 90 per cent of the care delivered in general practice. There are 900 general practices in Scotland, and they are absolutely essential to the mission that we are discussing.

Heather Anderson: Do we need to do more on training GPs? Do we need to spend more to incentivise particular interventions? We used to make payments to GPs to ask specific questions. What mechanisms would make that more proactive?

Robbie Pearson: Convener, if I may, I will sidestep that question. Professor Bauld might want to talk about some interventions.

11:00

Professor Bauld: Again, we are slightly straying beyond, I think, all our areas of expertise. Professor Carey Lunan and others have produced excellent work on the Scottish GPs at the deep end

project, which is very much worth looking at, so I commend that to you. We also had the quality assurance framework model, whereby there was incentivisation for preventative interventions, but that does not exist any more, if I recall correctly.

There is a debate about whether incentivisation helps or not. Sticking to the areas that I know about, I note that part of the actions in the population health framework is to have primary care and the boards committing to becoming public health organisations, so work is under way. I refer again to Carey Lunan’s work. Primary care is under so much pressure given what it is asked to deliver. I know from my research that it is important that we ask GPs to do what is appropriate in that setting—on, for example, weight management and smoking cessation—but also that they have a referral mechanism so that they can refer their patients to specialist support on cessation, weight management, alcohol treatment and so on, rather than us expecting it all to happen in primary care, which is often unrealistic.

The Convener: I wonder whether that raises a question. It has been suggested that having the GP model alone is not correct and that we need a multidisciplinary approach. I know that GPs are bringing in physios and some have pharmacists involved, but I am thinking more broadly about the point that you have just made, Professor Bauld. The specialists do not need to be consultants—they could be specialist nurses, such as diabetes nurses. Has medicine become complicated enough that it would be better if there was a hub so that people did not have to wait for referral and, for example, a specialist nurse could pick up a difficult case instead of the person having to see their GP continually until they are sent to an appointment somewhere else. Has that model been considered?

Richard Robinson: I wonder whether the issues that we are talking about are the same issues that we see in secondary healthcare, but they are just packaged slightly differently. The issues with waiting times at accident and emergency departments might be the same as the issues with the workload that is placed on GPs in primary care. The Scottish Government has done work on understanding flow, alternative models of care and having hubs or centres, and the Scottish Ambulance Service has done some work on triaging. It is likely to be a multipronged approach that will make a difference in alleviating pressure on capacity.

The typical audit will say that a lot of this comes down to the quality of the data that the Scottish Government gets to understand the problem that it is faced with. When we produced our report on community health and social care, we noted that

the Auditor General had said in his report on general practice that the data that the Scottish Government had to make decisions on planning and investment in general practice was inadequate. Robust information was needed about demand, workload, the workforce and the quality of care.

It is important for the Government to have a better understanding of the issues that it is facing in those broader areas, and then to consider how some of the alternative models can help to alleviate that pressure and free up GPs and their multidisciplinary teams to deliver the best care in an affordable way.

Heather Anderson: May I ask make specific comment on that, convener?

The Convener: Yes.

Heather Anderson: Lochee medical practice, which is one of the walk-in GP clinics, is doing a lot of work with Ninewells hospital, because it knows that many people who turn up at the accident and emergency department there would be better served if they went to their GP clinic. It is important to make sure that the data that it is gathering will feed into consideration of the issues, because it is about alleviating waiting times at A and E and getting people better treatment.

The Convener: Thank you, Heather. We will circle back to drug and alcohol deaths. Paul, I believe that you wanted to ask about that.

Paul McLennan: I think that I have already asked the question, convener.

The Convener: Okay. Does anyone else want to come in on that? It is a big issue for us. I will kick off, then, as everyone seems nonplussed.

This question is about drugs—I am not talking about the alcohol issue. When the figures came out the other week, we learned that there were 1,133 drug deaths in Scotland in 2025, which is a sobering thought. It has been suggested that expanding the provision of safe injection facilities such as those that are provided by the Thistle would help. Others might say that we should have much more focus on rehabilitation. Although some more funding has been put into that, increasing the funding from very little to a little does not amount to grappling with the issue. There is also the underlying question of why we have a worse problem than other parts of the UK and elsewhere.

Professor Bauld: The response that I gave to Mr McLennan might be relevant here. I do not think that those of us who are here today are specialists in alcohol and drugs. I encourage the committee to look at that issue in depth and to make sure that it hears from the right experts. You made some

excellent points on alcohol policy, but I think that some of the queries that you posed are for others.

The Convener: Okay. I will take that on board.

Jack Middleton: Ms Payne, will you expand on your view that alcohol advertising is targeted towards children? Could you provide some examples?

Alison Payne: SHAAP has previously done work on alcohol advertising in football and the links with sport. In the previous session, we did an event with Maree Todd and Scottish Women's Football, which does not take alcohol sponsoring. We can say that children's strips are not sponsored, but the adult ones are. The issue is the mindset and what kids are being exposed to.

A debate needs to be had, and we should look into the issue. On a number of occasions, we have started to have the discussion, but it has got a bit difficult. I think that we can talk about alcohol in such a way that we recognise that it is an important industry in Scotland, while recognising the harms that it causes, just as we recognise that the food industry is a hugely important industry in Scotland, while recognising the obesity angle. We need to separate out the different aspects and to look at the potential harms and what is being done in that area.

To follow up on Professor Bauld's point, I am not an expert. The committee should hear from SHAAP. Given that we have a problem with alcohol and alcohol deaths, we need to ask whether there is a cultural problem, and if there is, whether it is right that we have the level of advertising that we have. What messages are we sending to young people? I am not saying that I have the answer, but we should have that discussion.

Jack Middleton: Alcohol is intrinsically connected to society in Scotland. Every cultural event somehow has a link to alcohol. Policy wise, do you think that the fact that the Government and the statistics consider drugs and alcohol together is to the detriment of having a grown-up conversation about alcohol? Do you think that, if we separated the two issues, we would be able to have a grown-up conversation about alcohol, to move our culture on and to evolve our relationship with it?

Alison Payne: Yes. We all reflect on our own experiences when we talk about obesity and exercise, and we need to do that with alcohol as well. That is perhaps a bit uncomfortable for us to do, which means that we tend to shy away from it. We should address the uncomfortable relationship that people in Scotland have with alcohol. If we really want to address some of the failure demands, we need to look at our association with

alcohol. It is not the case that it is not a good industry or one that does not bring economic value to the country, but we need to look at the problems and behaviours—including our own—that are associated with alcohol. That is a difficult conversation to have. I am not saying that there is an easy answer; I am simply saying that we need to have that conversation.

I think that we should separate alcohol from drugs, given that the illegality of drugs and the other issues that are associated with drugs make them two different conversations. They are similar, but we need to have separate conversations about them. I highly recommend that the committee should hear from actual experts, such as SHAAP, on the issue.

The Convener: We could start in the Parliament. We could say, for example, that there was to be no alcohol in the Parliament. Every night, there is a reception, with wine and a bar. That is just a thought.

Heather Anderson: There are also soft drinks available.

The Convener: I agree that there are also soft drinks available, but there are always soft drinks available. It is an interesting subject and one that we will come back to.

We are nearly out of time, but we have one more thing to address, which is about whether there is learning to be gained from models elsewhere. Joe Long is going to ask about that.

Joe Long: I think that it is Jack Middleton who has a question on that.

The Convener: It was about Marmot.

Joe Long: That was an earlier question.

The Convener: Oh right—that has been and gone.

Jack Middleton: I want to offer the witnesses the opportunity to reflect on other states or nations that have entered into healthcare reforms that are similar to the ones that we are looking at here. Denmark, which is a country of broadly similar size to Scotland that faces broadly similar demographic challenges, has invested significantly in digitisation. Are there examples of best practice on healthcare reform that Scotland and the committee could reflect on, from Europe or perhaps further afield? I put that to any of the witnesses who wishes to come in.

Richard Robinson: Audit Scotland has not done specific work on international comparisons, although I am aware of the Denmark example. Speaking personally, and having read a couple of blogs on the issue, there appear to be direct

comparisons there that would be good to learn from.

From the point of view of the budget, it is important to be aware of the rest of the UK position. The NHS in England has a 10-year plan, too, which it brought out last year and which includes measures that are similar to those that are taking place in Scotland, such as digitisation and closer-to-home treatment. I raise that not just from the point of view of learning, but because of the budget implications. Spending in the rest of the UK is reflected in Barnett consequentials. Should the reforms there be geared towards more efficient services and perhaps changes in the levels of spending required on health compared to other areas of the public sector, that will have a direct impact on the funds that are available to the Scottish Government.

Although we have not done anything on the breadth of international comparisons, we often highlight the importance of the rest of the UK's spending decisions when it comes to Scottish budget decisions.

Professor Bauld: I will comment on population health specifically, rather than on the health service. An interesting review article from last year looked at multiple countries' population health frameworks. We have a number of strengths in Scotland. Many countries sit prevention and population health in their health service framework. That is the case with the English 10-year plan for the NHS, for example, in which there are very few mentions of prevention and public health. That area is a strength of ours.

We have had interesting conversations with the Irish Government in informing its refreshed healthy Ireland initiative, which is something to look out for.

I always look at the Finnish example, because Finland has amazing data sets that it can use to set indicators and directly track progress. It has a separate implementation plan for its population health framework. That is a really interesting example.

If you are interested in international approaches to prevention and preventative spend, Carnegie UK has produced an interesting report on the approach of Victoria in Australia and some of the other examples that I mentioned earlier. I am sure that we can learn from that.

The Convener: That sounds like excellent bedtime reading for us, so we will go back to that. Thank you for those suggestions.

We have run through pretty much all of our questions, but I want to come back to something that was said earlier and leave a comment as food for thought—just to be controversial, perhaps. A suggestion was made about putting money

towards people having their children in childcare so that they can get better opportunities to work. Where is the evidence that children who come through that system perform better than, say, children who are looked after by their families? Could the Government spend some of the money for prevention on families so that they can look after their children for longer before they go back to work?

There was research in Italy on how obesity in children has increased significantly as mothers have gone back to work and so have not made so much homemade food. That might be a sweeping statement, but the issue is definitely out there and nobody discusses it. Does anyone have anything on that that they can send us, either to refute or support it?

Alison Payne: On the educational side of the work that we have been doing, we have been calling on the Scottish Government to develop a longitudinal study of children that follows them from the early years right the way through. That sort of study happens in England. It considers outcomes so that you can begin to see the impact and the differences.

I also add the point that fathers go back to work, too.

11:15

The Convener: I said “families”. In fact, my family was an example of that. When I said “families”, I was including grandparents, because an awful lot of grandparents are expected to step up and take that place. They do not get any financial support for that whereas, if the children were put into an official nursery, some support would be available. I am just pointing out that there is an interesting inequality in that.

Alison Payne: If we could have a longitudinal study, we would be able to get some records on that.

Heather Anderson: We have done work in Dundee on improved literacy from early learning and childcare. There is also a lot of evidence about weight loss and weight gain when children are in school and out of school.

My question is always, “What would Harry Burns say?” What percentage of the budget should we shift to make a significant impact? Just think that you are Harry Burns; you do not have to say it as yourself and take responsibility. Is it 5 per cent, 10 per cent or 20 per cent? How much of a financial shift do we need to make to make a significant difference?

Robbie Pearson: I caution against arriving at an arbitrary percentage this morning. In all that we do,

the committee’s focus should be on the impact of what we are delivering as opposed to necessarily on a percentage. If we are to make a fundamental shift away from episodic care to much more longitudinal care and supporting people to lead longer, healthier lives, there has to be a fundamental shift in our thinking, but I would not want to arrive at a percentage today. It is about our impact.

Professor Bauld: The Australians set a target of 5 per cent for their NHS to invest in prevention. That is not local government. Australia was the only one of the multiple countries in the analysis that had a target for that.

The preventative spend work that is going on at the moment quantifies what is preventative spend across the Scottish budget and other budgets. If we know that it is a certain amount, it is reasonable to ask where we want it to get to while recognising that having a target might not be helpful. However, we want to see the change being tracked over years and want the interventions that we invest in through the prevention framework that is an aspiration for the next programme for government to be evidence based.

Richard Robinson: I echo that. The bar chart in the committee papers that shows what amount is spent on primary level, secondary level and tertiary level preventative spend raises the question: is that the right amount? Is it the right balance? How much should it be? It is a completely legitimate question. The Scottish Government will have to ask itself not just whether that is the right proportion but what that proportion is and what difference it makes. It will also have to use that as the evidence baseline to say that we need more in one area or not as much in another based on the difference that it makes. That takes you away from an arbitrary target, albeit that it can be useful in setting the direction of travel, as Professor Bauld says.

You also mentioned in relation to councils, Ms Anderson, that, sometimes, we can have a small spend with a big difference. Looking purely at proportions may miss the point that smaller interventions may make big differences and bigger interventions may make smaller differences. It is not just about the quantum of money but about the Scottish Government understanding the best way to use it.

The Convener: It has been an in-depth, wide-ranging evidence session. I thank all the witnesses for taking the time to come to the committee. We will continue with the pre-budget scrutiny, considering specifically care—and, indeed, sport, not forgetting its impact on health as well as on wellbeing. We will do those sectors as we go along and will hear from the Scottish Government in

early November. We will certainly reflect on what the witnesses have told us and will look up some of the directions that they have put us in. I thank them again for their time.

We now move into private for the next three agenda items. The committee will return in public at 12 o'clock.

11:19

Meeting continued in private.

12:00

Meeting continued in public.

Subordinate Legislation

Mental Health (Care and Treatment) (Scotland) Act 2003 Remedial Order 2026 [Draft]

The Convener: The next item on our agenda is an evidence session with Maree Todd, Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs, on the Mental Health (Care and Treatment) (Scotland) Act 2003 Remedial Order 2026.

The Minister is joined by the following Scottish Government officials: Joanne Farrow, deputy director, complex care and rights division; and Ivan Boemer, solicitor, mental health, adults with incapacity, palliative care and digital health branch, legal directorate—quite a few titles there.

I welcome you all to the meeting and invite the minister to make a short opening statement.

The Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs (Maree Todd): Thank you for the opportunity to speak to the committee about the order.

The order removes an unjustified difference between the rights of civil and forensic mental health patients. It will allow the Mental Health Tribunal for Scotland to specify, review and modify recorded matters for patients subject to compulsion orders, compulsion orders with restriction orders, hospital directions and transfer-for-treatment directions.

A recorded matter is a treatment, care or a service that the tribunal considers appropriate to specify formally. It may relate to medical treatment, rehabilitation, communication support or discharge planning. That provision is already available to patients who are subject to civil compulsory treatment orders.

In October 2022, the Court of Session held that the absence of an equivalent power for patients subject to a compulsion order amounted to unjustified discrimination under article 14 of the European convention on human rights, and the Scottish Government accepted that legislation was needed to remedy that.

The order extends the remedy across the main relevant forensic orders. We consider that fair, coherent and proportionate, as limiting it to compulsion orders would leave patients on other forensic orders without equivalent access.

The order will integrate recorded matters into existing review and tribunal processes. It will

enable patients and named persons to seek modifications, place duties on relevant professionals and Scottish ministers, and provide a route back to the tribunal where a recorded matter is not delivered.

Our consultation received 23 responses, which broadly supported the policy intention. Respondents highlighted the need for clear guidance, accessible information, advocacy and legal support, alongside concerns about capacity and service availability. We are working with delivery partners to address those points.

This is a targeted change. Around 635 people were subject to the relevant forensic orders on 1 January 2025, based on the most recent data available from the Mental Welfare Commission. The estimated number of recorded matter cases is around 19 to 64 each year. The additional activity should be modest and largely accommodated through existing processes.

We acknowledge that progressing the remedy has taken some time. However, the work required careful legal development across several forensic orders and completion of the statutory remedial order process. Subject to Parliament's approval, the changes will take effect from 13 November 2026.

This is a necessary, rights-based and proportionate reform. It addresses the incompatibility that was identified by the court and supports parity between civil and forensic patients. I invite the committee to recommend that the order be approved.

The Convener: Does anyone have any questions that they wish to put to the minister?

As everyone appears to be content, I invite the minister to speak to and move the motion.

Motion moved,

That the Health, Care and Sport Committee recommends that the Mental Health (Care and Treatment) (Scotland) Act 2003 Remedial Order 2026 [draft] be approved.—[Maree Todd]

Motion agreed to.

The Convener: We will publish a short report to the Parliament setting out our decision. I thank the minister and her officials for attending.

That is the last item on our agenda. The Parliament will be in recess for the next two weeks, and our next meeting will be on Wednesday 28 October.

Meeting closed at 12:05.

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