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Health, Care and Sport Committee

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Wednesday 4 November 2026

Session 7

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HEALTH, CARE AND SPORT COMMITTEE
9th Meeting 2026, Session 7

CONVENER

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

DEPUTY CONVENER

*Jack Middleton (Aberdeen Central) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Cabinet Secretary for Health and Care)
Richard Foggo (Scottish Government)
Christine McLaughlin (Scottish Government)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health, Care and Sport Committee

Wednesday 4 November 2026

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Helen McDade): Good morning, and welcome to the ninth meeting of the Health, Care and Sport Committee. We have no apologies. Our first item is to consider taking agenda item 6 in private. Do members agree to do so?

Members *indicated agreement*.

Pre-budget Scrutiny 2027-28

09:30

The Convener: Today, we complete our evidence taking on the pre-budget scrutiny, and we are joined by the Cabinet Secretary for Health and Care and her officials. We have up to two hours, and I refer members to papers 1 and 2.

I am pleased to welcome the Cabinet Secretary for Health and Care, Angela Constance and her officials from the Scottish Government: Christine McLaughlin, director general for health and social care; Richard Foggo, director of population health; and Fiona Bennett, chief finance officer, health and social care finance.

I thank everyone for attending, and I invite the cabinet secretary to make some short opening remarks.

The Cabinet Secretary for Health and Care (Angela Constance): Good morning. I am grateful for the opportunity to join you all and to give pre-budget evidence. I very much recognise the importance of Parliament's pre-budget scrutiny and the impact that it has on the draft budget.

It would at this stage be helpful for me to lay out the context of our pre-budget discussions alongside our approach to this year's budget. Through the programme for government, we have set out a five-year vision that is focused on eradicating child poverty, growing the economy, tackling climate change and delivering stronger public services. The 2027-28 budget will be the first opportunity to translate those ambitions into funded action and to set the course for delivery over this parliamentary term.

The budget must therefore balance delivering the ambitions that are set out in the programme for government and investing in long-term outcomes and prevention, while at the same time responding to immediate pressures and growing demand. Our commitment to pass on all front-line health consequentials in full has been delivered, with an investment of £22.5 billion in health and care in the 2026-27 Scottish budget. That provided a real-terms uplift to enable more sustainable and resilient services, with £17.6 billion for health boards, which is an uplift of 1.8 per cent.

The 2026-27 published budget also included more than £2.3 billion for social care, delivering our commitment to increase funding by 25 per cent. Within that budget, we have also provided £2.4 billion for primary care; a £100 million investment to deliver further reductions in waiting times, supplemented by a further £90 million in-year; and an additional £40 million investment in sport and physical activity.

We are also investing in prevention, the improvement of access in our communities and the reduction of waiting times. However, as we look to the decisions ahead of us, we recognise that we operate in a landscape of increased pressure on public finances and growing demand for public services. Achieving fiscal sustainability for future years will be critical, and public sector reform and productivity is a core part of that approach.

The PSR strategy sets out our commitment to save £1 billion by 2030 to improve service delivery and outcomes while reducing costs associated with duplication, clutter and administrative overheads. That includes, crucially, reducing long-term demand for high-cost acute services through a sustained focus on prevention.

I am focused on transforming health and care services so that the people of Scotland receive the very best of treatment and care, as well as the support that they need to stay healthy, independent and connected to their communities for as long as possible. That is why our plans for prevention, service renewal and national health service simplification will be so crucial to the health and care portfolio in the coming years.

Thank you very much, convener. I am delighted to be here to answer questions.

The Convener: To start, Adam Harley will ask a question about current issues.

Adam Harley (Strathkelvin and Bearsden) (LD): Thank you, convener, and thank you to all the witnesses for coming to see us. My question is for you, cabinet secretary. I quote the Royal College of Emergency Medicine, which said this week:

> "We are … now in a worse state than this time last year. … We once again call on the government to urgently send support our way in the form of improvements to the 'back door' of our hospitals. Lives are at stake, and without immediate intervention, emergency departments are at risk of collapse."

What immediate support will the Government provide? As we look ahead to the budget, how will we ensure that that situation does not happen again next winter?

Angela Constance: Thank you very much for that topical question, Mr Harley. It is no secret that our accident and emergency services continue to be under extreme pressure. The people on the front line, whether they be clinicians or other support staff, are, as always, providing a heroic effort.

I met the Royal College of Emergency Medicine a few weeks ago, and it made a particular ask of Government; it also wrote to the Scottish Government yesterday. Our published activity very much centres around the national "Health and Care Improving Flow Plan 2026-2031", which is about ensuring that we have as connected a system as possible.

We know that relieving those pressures at the front door cannot be achieved through one intervention; it must involve a series of comprehensive and meaningful interventions right across the system. That, of course, will start with robust and repeated public messaging to people that accident and emergency is for accidents and emergencies and that a range of other services, including pharmacy, can be approached for primary and community care.

I have had extensive discussion with the Royal College of Emergency Medicine about the flow through the hospital, too. We are all well acquainted with the challenges around delayed discharge and, although that issue is not completely in my gift—indeed, it requires us to continue to work with our partners and local government and beyond—it is serious. The Royal College of Emergency Medicine spoke to what more could be done in our hospitals to get that movement of patients through other specialities and services. The RCEM also wants increased accountability for health boards. In our ongoing engagement with the RCEM, my officials and I will endeavour to work on additional solutions over and above the hospital flow plan.

The national health and care improving flow plan is the baseline of a wide range of activity to get movement across the system. I will not go through it all, because time is precious, but we will work intensively with the Royal College of Emergency Medicine to improve that accountability in Government and at board level and to consider what more we can do to provide direct support.

Adam Harley: The Government has already spent £220 million to improve flow but that has clearly not worked. Why is that and what will be different this time? Crucially, we know that a lot of the issues in delayed discharge link directly to social care—a lot of that is about attracting people into the profession and keeping them when they are there. What will the Government do to attract more staff to make social care a profession of choice again?

Angela Constance: The national "Health and Care Improving Flow Plan 2026-2031" was published just a few months ago—an announcement was made at the time. The plan has a renewed focus on the movement of patients throughout our system.

It is important to focus on delayed discharge, but I think that you were intimating that issues in and around social care go beyond that. Within the hospital flow plan, there is a renewed focus on

things such as rolling out frailty units and delivering an improvement in ambulatory care.

It is also imperative to focus on interventions such as discharge without delay, and we have a renewed focus on that. I have seen and heard that, in particular areas of the country, there have been improvements in relation to the discharge of patients due to an approach that involves planning for someone's discharge as soon as they are admitted to hospital. The plans might change, depending on somebody's clinical presentation, but that planning starts at the point of admission. Where that approach has been adopted, the length of stay in hospital has reduced.

My challenge is, if we have interventions that are evidenced and that work, why are we not implementing them across the country? I am determined to do everything that I can to ensure that such interventions are more broadly adopted. That is part of the purpose of the hospital flow plan.

On the broader issue of social care, I am clear that social care, by necessity, needs to be reformed. That is a significant undertaking. I respectfully remind the member that the Government is not a social care employer. However, we provide substantial funding for the sector. Some £2.3 billion of the health and social care budget goes into social care, and the funding routes for that involve health boards and integration joint boards.

The Convener: I want to circle back to your comments about the emergency medicine issue, which issues such as delayed discharge touch on. You mentioned that social care is not directly under your remit, but, at the same time, we are looking to what is happening in relation to local authorities, and the budget is presumably looking to that, as well. Local authority budgets have been constrained for a number of years, and people have seen the effect of that in the social care that is provided to get people out of hospital—we all know of cases where somebody could not get a care package in time.

You have pointed out that some areas are managing to do that better than others. I visited NHS Borders and was impressed with what it has done—I was shown the figures and the metrics on that. I also note that it is working closely with the local authority. Of course, it has the advantage that its area is the same as that of the local authority, so there are no arguments about whether their budgets are meant to cover the same area.

Obviously, you are looking towards what is to come later on—we will come back to the major issues around the reorganisation of health boards—but I would like to hear your thoughts about how social care can step up. I take the point about staff, but a lot of that is to do with people not getting paid enough or only getting paid when they are actually at a house, rather than when they are travelling to the house. Everybody agrees that we need to treat staff better so that we retain them—and so that we can ensure that we have them in rural areas, which is another issue. Obviously, that involves working across health boards, local authorities and the IJBs, which exist for that purpose. Can you tell us something about what the intentions are for IJBs in the reorganisation?

Angela Constance: Your point about coterminous boundaries is interesting. Coterminous boundaries tend to support a simplification of approach. That is a point that is worth bearing in mind, particularly as we proceed with public sector reform more widely. I am sure that we will come to NHS reform, but I would say that there is a huge interdependency between NHS reform, social care reform and local government reform. Of course, in terms of social care, we are in a period of intensive discussions with our partners, and it is important that we have timely, intensive discussions in good faith.

09:45

No decisions have been made about the future of IJBs. However, the frustration that I hear from members representing their communities—and, indeed, from those who are working hard in our services—is about the fragmentation of care. I hope that addressing that will be a significant objective of reform. Irrespective of the structures that will be negotiated and agreed for the future, we should have a single, co-ordinated care journey across the health and social care system.

We have—I will be brief, convener—always set a budget that has recognised the priority that not only parliamentarians but the people of Scotland place on health and social care. The annual budget uplift for the health and care portfolio has been between £0.7 billion and £0.9 billion, and £10 billion of additional funding has been provided at the top level of the health and care budget over the past decade or so. Some of that is due to our investment in improving social care terms and conditions and in funding the real living wage.

I am very cognisant of the 2025 Audit Scotland report that spoke about the importance of data. Data is important for transparency, for scrutiny and for holding people to account. If it is used in the right way, it can invigorate and motivate change. The report also spoke about the need to continuously focus on the resilience of the workforce, and I acknowledge that the workforce is key.

The Convener: We might come back to that issue, but Heather Anderson wishes to ask a question on health and social care funding.

Heather Anderson (Dundee City West) (SNP): Cabinet secretary, I echo your comments about the Government having absolutely no reluctance to commit huge sums to health and social care in the budget. However, we are struggling with the fact that, although we continually provide more money, we do not necessarily get the performance that is required.

I have questions on two areas. First, how effective has the massive investment of between £90 million and £100 million been in reducing waiting times? How might you change that funding?

Secondly, I have questions about the investment in general practitioners. Would you like me to ask those now, convener?

The Convener: Yes.

Heather Anderson: The Government has also provided a record-breaking settlement for GPs. What difference has that made? In relation to the investment in the innovation of GP walk-in clinics, Dundee has the Lochee health centre, which is a deep-end clinic, but every walk-in clinic takes a different approach. I know that all the pilots will be evaluated, but have you any insight on how they are going?

My questions are about waiting times, GP investment and new models of general practice.

Angela Constance: Do you want me to answer all those questions at once, convener?

The Convener: I would like us to try to stick to the funding aspects at the moment. However, as Heather Anderson has said, a lot of money has gone into trying to reduce waiting times. How has that work gone, and how will it be carried forward in the budget?

Angela Constance: As has been well documented, funding has substantially increased—I can talk more about that, if required.

There has been clear progress on waiting times performance because of targeted investment. For example, the number of new out-patients who are waiting for longer than 52 weeks is nearly 78 per cent lower than it was in September 2025.

We are also seeing real progress in diagnostics. The total number of people on waiting lists for the eight key diagnostic tests is the lowest that it has been since May 2021.

You will see that productivity is up. The Golden Jubilee hospital is the United Kingdom's largest hip and knee centre. The number of procedures completed there in the past year has increased by 30 per cent, which is a demonstrable improvement.

On in-patient and day-case treatment, more than 90 per cent of people on the waiting list have been waiting for less than a year. Again, that is demonstrable progress. I contend that that is down not only to targeted investment but to collaboration at subnational planning level.

That investment alone will not be enough for the future of our national health service, which is why we must redouble our efforts and have a laser-like focus on prevention and public sector reform.

The member is right about funding. There will be £530 million over a three-year period for general practitioners, in recognition of their role in prevention and their need for stability. That will support not only their capacity to increase recruitment but their day-to-day operations. That investment was much welcomed by the British Medical Association.

We now have 12 GP walk-in centres. There has to be a place for innovation—we can talk more about that later.

The Convener: I am sure that somebody will want to ask what you think about the relative cost of GP walk-in clinics. You talked about data. People are asking what we would have got if that money had gone straight into GP practices.

Jack Middleton (Aberdeen Central) (SNP): There has been a lot of discussion about funding and an increase in year-on-year investment in health and social care, but it would be remiss of me not to point out that, in recent days, the Deputy First Minister and Cabinet Secretary for Finance and Local Government has been extremely vocal about her belief that there was a £650 million real-terms cut to the Scottish budget in the UK budget that was announced last week. Does that put the Scottish Government's plans at risk? What will be the impact of that on health and social care? Will it limit your ambitions for investment?

Angela Constance: I echo the Deputy First Minister's sentiment when she said that that budget represented a missed opportunity. We all know that rising demand for health and care services outstrips the increase in front-line staff and in the resource that we have made available.

We will feel the pressure of various issues as we go into this budget period. The block grant is projected to fall by around £450 million in 2027-28, and I have real concerns about capital over the spending review period in relation to that real-terms reduction. The increase in employer national insurance contributions continues to present a challenge. We all continue to live with the consequences of Scotland being dragged out of the European Union against our will. It has been well established that the hit to Scotland's revenues has been about £3.3 billion. I would not

underestimate or underplay the financial challenges in future. Those challenges are not going away any time soon. It will be for the Deputy First Minister to lay out to Parliament, in the draft budget, the detail of what we will do.

The Convener: On metrics, in Scotland we spend considerably more money per person on health than happens in England. I do not know if this is still the case—perhaps you can tell me: following the Covid pandemic, we found that the English waiting list numbers went down more quickly. How do we compare with England on the metrics for waiting lists and so on, noting the fact that we are spending more per person?

Angela Constance: The national health service in Scotland has taken a different road to that taken by our counterparts in England and Wales. I would argue that we have trodden a truer path in terms of our founding principle of services being free at the point of delivery, rather than going down the route of marketisation. Further changes have taken place and are planned for the health service in England, and I have followed some of that situation.

Of course, Scotland's rurality and our many island communities pose an additional challenge, and that partly explains the level of our funding per head of population. I would contend that, because of the actions taken in Scotland, our national health service is the cornerstone of our society, and it is an extraordinary force for good in this country.

I do not have up-to-date figures on waiting times in England and Wales. People will always make comparisons between ourselves and our nearest friends and neighbours. That is fine; we just have to be clear that we are comparing like with like. I sometimes think, however, that we need to broaden our horizons and compare ourselves with other European counterparts. I am always open to learning from other jurisdictions.

The Convener: And learning from ourselves. I was concerned when I discovered how many fewer healthy years lived that Scots have now compared with the figure from 10 or 20 years ago. There is a pretty significant difference of about five years on average. To explain the phrase for those who are not used to it, "healthy years lived" means the average age that people are expected to get to without having major health issues. That figure has dropped considerably in Scotland over the past 20 years. What research do you have on that? What are your thoughts on it?

Going back to the prevention aspect, what can we do to address it? The Bavarian health committee visited us, and we asked their members what the situation was in Germany. They did not really understand our question at first but, when they did, they replied, "Our people live more healthily and for longer." They have the same problems as we have with looking after frail people. I wonder what research there is on that and what we can look at in the prevention area.

Angela Constance: We are not short of research on health inequalities in Scotland, or indeed in other jurisdictions. The issue is always about delivery and what we are going to do to address it. A decade or more of austerity has not helped, and there is a lasting legacy from the pandemic that must be addressed, too.

We need to have a focus on preventative spend. As I am sure you will be aware, the Scottish Government has established the prevention unit, which is in essence about tagging what our investment is delivering by way of prevention. That involves being able to tag and identify preventative spend so that we can all hold ourselves to account and work towards using the resource that we have to make an impact on preventative interventions.

Are you looking for something more specific, convener?

The Convener: Not on the budget: we will come back to those points as we consider a number of issues affecting women's health and long-term conditions, for instance. If your officials find anything of interest, though, that would be welcome.

10:00

Joe Long (Mid Scotland and Fife) (Lab): We probably need to come back to a few questions about NHS reform. However, while we are on the topic of prevention, in the Parliament there has been quite a lot of cross-party consensus that a preventative agenda is both welcome and needed. There is good support for that. A few questions come out of that aspect.

I will ask about budget tagging. Much of the spend that is indicated as being preventative is about tertiary prevention—that is, how we prevent people with significant challenges who are already in the system from having further and more complex challenges. We are interested in seeing a shift to secondary and primary prevention, and what that would look like in the budget. I suppose that there are risks around that. Will we end up tagging as "preventative" things that are already happening, or will there be a shift in the budget towards prevention? How would we achieve such a shift while meeting the immediate pressures that you have laid out for us?

Angela Constance: In addressing the convener's points, I started off by talking about the prevention unit and the work that is being done to identify and track preventative spend. We need

clarity on the methodology when it comes to primary, secondary and tertiary prevention. Work on that is ongoing. It is not that we do not want to invest in tertiary prevention, which is about preventing problems from getting worse. Secondary prevention is also important, because that is about responding to early signs. However, we also want to shift towards primary prevention, which is about preventing problems from arising in the first place.

The Government's prevention unit did an interesting pilot that looked across seven portfolios, and health and care was part of that. The pilot did not cut across all budget lines—and it did not deal with all Government spend, but it did cover a sizeable chunk of it. When it came to what was tagged as "preventative" in the 2025-26 health and care spend, we found that 22 per cent was for primary prevention, 46 per cent was for secondary and 32 per cent was for tertiary.

Obviously, when it comes to NHS boards, that proportion of the spend is different: about 11 per cent is preventative, but much more—55 per cent—is acute responsive. Last week, I met chairs of health boards about that aspect. As part of the population health framework process, we want to move towards having public health organisations. Health boards are working on that: they are putting action plans in place and will provide returns by the turn of the year.

Clearly, our health boards that have responsibility for hospitals are very much in the acute space. Nonetheless, we ask what they can do, given that they also have a key role in primary and community care. A lot of work is going on in that area to untangle what is preventative spend and what is enabling, as well as what is in that acute responsive space.

Joe Long: How might we expect to see that laid out in the forthcoming budget for the coming years?

Angela Constance: That learning needs to be built on. The pilot covered a selection of Government spend; the plan for the prevention unit is to broaden that out across the whole budget and for the pilot work to really inform the budget process as regards both how we understand things and what choices have been made. There are difficult spending choices to make about what we need to do now to make things better for the future, and in particular on winter pressures, which relates to Mr Harley's questions.

The Convener: We still want to bring a couple of things in before we move to public sector reform. Do you have a follow-up question, Jack?

Jack Middleton: Yes. I want to bring things back to funding before we move on. You will know, cabinet secretary, that NHS Grampian is one of Scotland's worst-performing health boards financially and that the Government has had to step in. How is the Scottish Government helping to get NHS Grampian's finances back on track? What strain does that put on this coming budget and what strain has it put on previous budgets?

Angela Constance: I flag that the annual reviews of NHS Grampian and NHS Highland take place next Friday and this Friday respectively, and that I will chair both those reviews. As the member has said, it is no secret that NHS Grampian has been escalated for financial reasons. There is considerable oversight of the matter, which involves senior officials—indeed, Christine McLaughlin had a big part in that process in her previous role.

The board moved to stage 4 escalation, which is very high, to ensure that it has the support not only to mitigate the financial and associated operational pressures but to stabilise the system. In addition, an assurance board will strengthen the measures that are already in place. You will be conscious that several changes have taken place, including some new leadership in NHS Grampian.

This budget received nearly £1.5 billion in baseline funding, so scrutiny and oversight by the Scottish Government is crucial, because we want to be assured that that substantial slug of public money is used effectively to serve the good people of the north-east. Do you want to add anything about the assurance process, Christine?

Christine McLaughlin (Scottish Government): I would make the point that in all such escalations, you are not dealing with only one issue. In the NHS Grampian situation, the financial position is a consequence of decisions that were taken over many years, so in looking at how to improve the financial position through the assurance process, it is important that we do not cause detriment to other parts of the system, that quality and safety remain absolutely critical and that in managing performance, as you have said, we consider not only the unscheduled care performance but the waiting times. For example, NHS Grampian has been an outlier on longest waits and on cancer performance.

Many things are really good in NHS Grampian, too. When we focus on escalation, we always look at things where a board has become an outlier, but the role of the assurance board is quite broad and looks to bring in support from across the country around those performance elements. Just last month, the chief executive outlined that just under £9 million of benefit came from working across the east subnational network to get mutual aid from other boards to reduce waiting times. The Government intervention is not just about scrutiny

and challenge; it is about bringing support into the system to get it to reduce the overall deficit in a balanced way and to move from outlier to median performance on all those key priorities for Government.

The Convener: Adam Harley has a quick follow-up question. I ask everyone to keep their contributions short, as we still have a lot to get through.

Adam Harley: Cabinet secretary, earlier, you mentioned that the NHS in Scotland is staying more true to the principle of services being delivered free at the point of delivery than is the case with the NHS in other parts of the UK. You will be aware that many people are being forced to pay privately for treatment. For example, I have met constituents who have been forced to use their life savings to pay thousands of pounds for hip operations. Heather Anderson and I recently had a meeting in the Parliament with a group of women who had to pay privately for surgery for ovarian cancer. One woman had to pay £30,000, and she does not expect to be compensated. Are you and the Government aware of that dynamic? Do you think that the woman who had to pay £30,000 should be compensated? Will the Government look at that?

Angela Constance: I have perhaps had some engagement with constituents of yours on this issue—certainly, I recently met women who were involved with ovarian cancer strategies, and I think that one of them was one of your constituents.

Metrics from the Private Healthcare Information Network, which publishes figures quarterly, continue to show that Scotland still has a lower rate of take-up of private healthcare than England, and that the numbers are comparatively small. Nonetheless, I accept that people being forced or feeling compelled to use life savings is less than desirable, and that is why we remain focused on addressing the root cause, which is to reduce waiting times and improve access to care.

The latest figures that I have to hand show that there are about 241 private admissions in Scotland per 100,000 of the population. However, we would point to the fact that thousands more NHS operations are taking place now because we have been focused on increasing activity. I can double-check this figure, but I think that the number of operations has increased by 7 per cent over the year. That represents a lot more procedures being carried out.

The Convener: I will circle back to a slightly related point. There are several areas that need urgent support. In Grampian, one that comes up is maternity care, as it does in Highland and many other areas. We have already mentioned the depth of concern that there is about emergency medicine, so are you putting aside money to help get through what is considered to be the huge risk that those services will be overloaded this winter? Various services have been temporarily stopped. You have assured us that Perth royal infirmary is not going to remove emergency medicine, but there are other services that are affected. We understand the wish to move to a prevention strategy, and the fact that money needs to be shifted towards that, but can you assure people who are concerned about what will happen this winter that there is an acceptance that there are urgent needs?

Angela Constance: I hope that my letter to the committee on the continued provision of accident and emergency at Perth royal infirmary was very clear and put paid to any speculation in that regard. I have had assurances on that matter from the chair of the board.

On winter resilience, we have not kept money back in this year's budget for winter. All of the budget allocations are already with health boards, because we wanted to support all-year-round planning for preparedness and resilience.

The Convener: Thank you; that seems clear. Joe Long has a question.

Joe Long: I have a question about neurology. Last week, in Dundee, a few of us here today met people living with Parkinson's, and I recently met the Neurological Alliance of Scotland. I was struck by the fact that, in the UK, we have something like 1.1 consultant neurologists per 100,000 people whereas, in western Europe, the average is 1 per 12,000. Given that that area includes the treatment of people living with Parkinson's and multiple sclerosis and, increasingly—with an ageing population—forms of dementia and Alzheimer's, there seems to be an issue around the scale of our specialist neurology workforce. That is particularly the case given that people sometimes feel that, when they are of an older age, they do not get a specialist referral to a neurologist, but simply get referred to older people's services. Is that issue on your radar? Has there been an assessment of our neurology capacity, given the changing demographic that we see?

10:15

Angela Constance: Mr Long makes an important point. We often think of workforce planning in terms of quantum, but it should be about people and the specialisms in place, and not just around the structures and nuts and bolts of services. That is where the population health framework and the service renewal framework help.

With regard to workforce planning at the national, more strategic level, there is cognisance

and consideration of demographic changes. We are all living longer, but that means that there is heightened acuity and complexity. People are living longer with particular conditions. It is about ensuring that people are on the right pathway, that we have clinical pathways, and that decisions are not made based on age by default.

I do not have any specific figures around neurology services to hand, but I would be happy to write to the member. I do not know whether officials have anything further to add on that.

Christine McLaughlin: Mr Long's point is also generally relevant in relation to other specialties where there is a combination of growing demand and very specialist skills, with a number of years required in order to train people into those posts. That is one of the reasons why, in our reform propositions, we are looking at ensuring that people have access to those specialist skills when they need them, if not necessarily at having those skills in every single geographical area.

As the cabinet secretary said, we can look at the detail on that. However, the same point would be relevant to a number of specialties. It is also about looking at the multidisciplinary team in relation to broadening out the range of support at different stages for people in the pathway.

Joe Long: I will follow up on that with a question about a different area, which is the learning disabilities, autism and neurodivergence agenda. As usual, I refer members to my entry in the register of members' interests, as a former director of Scottish Autism.

There is some difference of opinion between the Parliament and the Government about whether changes to support people with learning disabilities, autism and neurodivergence need to be on a statutory footing. However, there is consensus that we need better support now. That has absolutely been recognised across the board.

We have had a ministerial statement about extra spend that has come in this year, particularly for children and young people. However, as Adam Harley pointed out in his earlier question, there is continued concern about the fact that a lot of people are accessing and spending money on private diagnosis, and the funding package that was announced earlier this year did not contain a huge amount for adult support.

Given both the Government's statement of ambition in relation to supporting these communities, and the consensus around the need for action, what will the commitment in this coming budget look like in relation to improving support for people with learning disabilities, autism and neurodivergence?

Angela Constance: I acknowledge the strength of feeling, and that there are some differences of opinion. I will not restate the Government's position in full, other than to say that I am probably less idealistic about legislation, in that it does not address waiting times in the here and now. Having said that, we are not closed to legislation in the future.

I do not want to annoy Parliament in any way, but a request has been made for a further ministerial statement on the matter and—subject to that request being approved by the Parliamentary Bureau—the Government is content to make another statement to Parliament. You will have heard the First Minister say that we would reflect on the debate and the wide range of contributions to it, many of which were excellent.

Your point about support for adults is interesting. This year, £2.5 million of support is being provided for the autistic adult support fund. The year before, 15 organisations benefited from the provision of around £1 million, which supported 1,800 autistic adults and 470 families. Therefore, there has been investment in adult support. However, we all know that there is growing demand for support in this area, for children and young people and for adults and people in mid-life. We will reflect on that in preparing for the up-and-coming statement.

One of the frustrating things about pre-budget scrutiny is that I cannot tell you anything definitive about the budget—

The Convener: We find that frustrating, too.

Angela Constance: —because the process is still ongoing. In fact, I am to meet the Deputy First Minister later today. The draft budget will be announced to Parliament on 3 December, but the committee has an opportunity to hear a range of views about what it should contain.

The Convener: Paul McLennan wants to come in.

Paul McLennan (East Lothian Coast and Lammermuirs) (SNP): A commitment was made in last year's budget to giving hospice staff pay parity with NHS staff. As you will know, there are particular challenges in the NHS Lothian area. Yesterday, I visited St Columba's Hospice Care. Are you able to say a bit more about how you will ensure that that is implemented on the ground for the likes of St Columba's Hospice Care for the next budget year? Outwith pay parity, will you say a bit more about the sustainable funding model?

Angela Constance: Members will be aware that in excess of £9 million was allocated for hospice care to address the disparity in pay. Having engaged with party spokespeople and those with an interest in the matter, I know that, irrespective of people's views on the Assisted Dying for

Terminally Ill Adults (Scotland) Bill, which was debated extensively in Parliament at the end of last session, there is unanimity on the need to do more on hospice care, end-of-life care and palliative care. I am very alert to that.

I add that, when there has been significant debate in Parliament that the Government has responded to and acted on by taking decisions to provide funding for specific causes—this applies to other issues as well as hospice care and palliative care—I am always very keen to follow the money. That is not always easy, but I have beaten that drum for many years. I am somewhat intolerant of money being allocated for specific purposes, only to find that that journey has been a bit convoluted or delayed or interrupted. I say, for the record, that my views on that matter apply equally to drug and alcohol investment.

Paul McLennan: I have a brief supplementary question. I welcome your comments on hospices. The other issue relating to what you said about the need to follow the money is about money going to local government in relation to prevention. Can you say more about how to follow that money through? I think that local authorities have had some challenges in terms of feeding that money through to where it should go.

Angela Constance: In general terms, I want to be able to see the impact of Scottish Government investment, irrespective of where it lands, whether it is going to health boards, IJBs or local government.

I have to acknowledge and respect that local government is a separate tier of government. Local authorities are independent and are democratically elected. It is the job of councillors, as the local elected members, to scrutinise spending and follow the money at a local level. However, there are issues around data and transparency in relation to the ability to follow the money and investment. It is important to be able to evaluate outcomes, and that approach and philosophy should apply across all public services.

The Convener: Kayleigh Kinross-O'Neill has a question.

Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green): Thank you, convener. I know that it looks like I am on the panel of witnesses, but I am not.

I thank our witnesses for their time and for coming to see us. My question touches on data gathering and research and development. Last night, I attended the cross-party group on cancer, at which there was a lot of discussion of the importance of research as part of prevention and early intervention.

As we have already said, we are in a time of tight budgets, but I want to understand the extent to which this budget will be able to prioritise research and development and data gathering. It might be a wee bit early to describe this in detail, but are there geographic or condition priorities? Can you say anything at the moment about research and development?

Angela Constance: Research and development and the close links and collaboration between that area and healthcare are absolutely crucial. The links between our universities and the research community and the NHS are important in terms of things such as the development of new equipment, prosthetics, clinical treatments, medicines and different ways of working. The role of innovation, research and development is absolutely crucial to our public service reform journey.

Research and development also plays a big role in prevention. In that regard, I point to the work of the University of Strathclyde's centre for sustainable development, which is housed at the Golden Jubilee hospital. I also draw your attention to ANIA. We love an acronym in health, and I am probably not pronouncing this right, but it stands for the accelerated national—what is it, again?

Christine McLaughlin: Innovation and adoption.

Angela Constance: Yes, the accelerated national innovation and adoption pathway, which, again, involves a once for Scotland approach and is extremely connected to the research community.

The issue of public sector reform has already been flagged, and one of the many reasons why I want to see a simplification in our structures is due to the engagement that I have had with the research community and the frustration that it has expressed about having to deal with 14 different health boards—I can think of a particular example around the work on brain cancer research at the BioQuarter in Edinburgh. Rightly, there is an ethical process for onboarding patients into clinical trials, but those researchers have to do that 14 different ways. To be able to motor on with clinical trials, researchers and clinicians need a particular volume of patients, and there might not always be the right number of people in the one health board. There is also an issue of equity arising from the fact that they have to embark on 14 cumbersome processes. Essentially, there are opportunities in that regard in the reform agenda.

It is quite a specialist area, so my officials might want to add something at this point.

The Convener: If it is to do with the budget.

10:30

Christine McLaughlin: The investment in the ecosystem to make companies want to come here to do clinical trials is critical, so our investment in supporting our clinicians in their academic roles is vital, as is the system in which we work across Scotland as one connected research community.

This week, the Health Foundation published a report about the ANIA process. I am happy to send the committee more details on it, but it provided evidence of the benefits of taking a national approach, with implementation across all boards. That shows that there is something for us to build on.

The Convener: Thank you—I am sure that we would welcome sight of that report. Several of us have been shown the impressive research that is done by the Parkinson's group that is part of the University of Dundee's faculty of life sciences. It gets people coming from other countries—never mind from Scotland and the rest of the UK. My point is that it does not need to be a health board. In fact, that would not work for many of the rarer illnesses for which there is less funding. However, I take your point and would be delighted to see that report.

Cabinet secretary, you read my mind when you said that we would be moving on to public service reform—we have got there, an hour into the evidence session. It will be no surprise that everybody has been concerned by suggestions that the risk assessments and business case for the health board reforms have not been well evidenced. You could refute that, which would help us, but, if it is the case that they have not been well evidenced, when will those issues be addressed?

In addition, how will that fit in with consulting with others? There is a three-month period for consultation, but our constituents and organisations ask us, "When do we get asked?" We say, "Well, I do not think that it is like that for the health boards." We would like clarity on that. Will there be an opportunity for people to feed in, or is it a done deal that there will be a health board for the east and a health board for the west? People want to be clear on whether they will be given information and whether the consultation could be extended for those who think that they have something to offer—those with lived experience or professional organisations.

Angela Constance: The three-month timescale referred to intensive discussions with social care partners—principally, the Convention of Scottish Local Authorities and local government.

In relation to NHS reform and the simplification programme, when I was previously at the committee, I spoke about the need for a business case and for us, in response to my engagement with the trade unions, to put a flag in the ground and say, "This is where we are starting from, and this is what we want to do—we will work with you and trust you to work with us to develop the plans in detail." I have always been transparent and direct that I did not come to the Parliament with a finished product.

We all know that public sector reform and changes to our health and social care system are needed. That is imperative. However, from my engagement with the workforce, I know that there was frustration, with people saying, "For goodness' sake—can you no just tell us what it is that you want to do and then trust us to work with you?" I took that approach, so we got off the stocks very quickly and, after consideration over the summer, in the programme for government, we said, "Here is our stake in the ground." Subnational planning is new and beginning to work well, although it is still voluntary, and we want to move towards two strategic boards.

There is ongoing engagement, not least with the workforce, and I can set out some of the decisions and changes since I was last at the committee. We have appointed a senior responsible officer in the Scottish Government, so that NHS simplification programme sits very squarely within the Government's health and social care service. The programme is being overseen and led by the Government and has not been parcelled up and given to a particular health board.

A programme board has been established and it is meeting. Its purpose is to secure strategic input from NHS boards, including in developing the outline business case and the full business case. For any risk assessment, the purpose of this work is to flush out the potential difficulties and get them on the table now so that we can work through them. I have been absolutely clear that this will be how we proceed. The NHS simplification programme will be shaped by those who use and deliver the service, but we have had to put a structure around that. However, I can assure you that there is intensive engagement.

Subject to decisions made by the Parliamentary Bureau, I am very keen to return to the Parliament in the not-too-distant future to make a statement and to put on the record some of the processes that we are working through. When it comes to the vision and the ambition, I want to be absolutely clear and really convey that this is not just about structures; it is about people and how we can deliver better services on the ground.

The Convener: I will follow up on that, and I ask that you be specific for the benefit of the people watching and so that we know what is and is not up for discussion going forward.

If my memory is correct, the last time you were here, you did not say that it was definitely going to be east and west health boards, whereas it now sounds as though you are saying that. If that is the case, we can move on from there.

From speaking to people who are involved in the subnational planning, I know that some of it seems to have gone really well—you have referenced some of that—but it has also shown that people would have real difficulties travelling for things for which they would not have to travel as much at the moment.

I do not know whether information on who is on your programme board is public and available to people, but it would be useful to see who is dealing with the risk assessment and the business plan.

Is there any room for manoeuvre in relation to that east and west structure? If not—and this has been reported, so I feel that I can say it, although it might not be right—there is a supposition that because NHS Greater Glasgow and Clyde is the biggest health board in the west and NHS Lothian is the biggest one in the east, they might naturally be the ones that would encompass all the others. There is an issue there in that those boards have not necessarily always performed well.

It has been said that the chief executive officers for the new boards would be appointed from outside the usual suspects—I think that I can say it like that—and that the roles would not just go to the nearest person. Some people might say that a completely different view is needed and that if you are going to do this, perhaps you need somebody from industry who has reorganised companies. I am not saying that; I am just asking what the remit is.

Angela Constance: When I come to make my next statement in the Parliament, in advance of that or alongside that, I will pull together a range of information that we can put in the public domain, so that people have that at hand and can have clarity around some of the more procedural and structural aspects of how we are going about our business. That would include clear information about the aims and objectives of what we are doing.

You have asked me specifically whether there will there be two boards. I touched on the process of deliberation, because there were other options to consider. I have come to the very strong conclusion that two strategic boards would be best. That will depend on the underpinning legislative changes. I have one vote in this Parliament, and it is likely that a number of Scottish statutory instruments will be required in the change process. That is still being bottomed out—what the detail and the nature of the SSIs required will be, for example—but my very strong preference is for two boards. We need a balance between pace and ambition, and I considered other options.

On personnel, we are not at the stage of appointing folk yet, and I discourage any speculation in that regard, because we must have a fair and competitive process. I understand that, at a time of change, people speculate, look around them and make assumptions, but I am not going to participate in that.

On your point about travelling—this is separate from subnational planning, which I can talk about in more detail, if required—there are already people in various parts of Scotland who have to travel for specialist care. Most people accept that there will always be a degree of travel required to access particular types of care. The issue is how we support that. Ultimately, we want services to be delivered as locally as possible or as locally as is safe.

Jack Middleton: Cabinet secretary, it is very clear that your preferred option is to have boards for the east and the west. What does that mean for people in the north of Scotland—people north of Aberdeen and in the Highlands? How will it work for them?

Angela Constance: It will actually mean a more robust service. There is one myth that I absolutely want to bust. I will do everything that I can to persuade and convince people about this, and I will rinse and repeat this message as long as I have breath: this is not about centralisation; this is absolutely about the opposite. As well as our NHS simplification programme, we have commitments around our community first approach, and there is an established community first programme to tackle health inequalities and address some of the inequities in health provision—the unwarranted health variation. The once-for-Scotland approach will help to bolster fragile services, because we currently have 14 different ways of doing everything, including a whole host of corporate functions such as information, governance and human resources, so there is duplication in the system. If we can cut out duplication, we can steward our resources to maximum effect and get resources to where we want them to be as much as possible, which is in service provision.

Jack Middleton: How will that physically work for someone in Inverness or someone in Forres, and where in the north of Scotland would the split be?

Angela Constance: With regard to absolute splits and geographical boundaries, we have what is currently in place for subnational planning, but I will want to interrogate whether we have the balance correct between the east and the west. There is the possibility that we could continue with the current split between east and west in

subnational planning, but no definitive or absolute decision has been made on that yet, and there should not be a decision yet, because I have given a commitment to work with others, including people, representatives, staff and representative organisations from the north.

I want to convey that we should not confuse service delivery on the ground with the top tier of governance across health boards.

10:45

The Convener: That is a helpful distinction, and it is one that we will, no doubt, examine more closely. I have been around long enough to remember my father being rushed from Dounreay to Wick to get a perforated ulcer operated on. He was a councillor and, as he came round from the anaesthetic, the consultant said to him, "Now you understand why we need to consolidate our services." That was happening at the time. I wonder whether he would now end up going to Inverness. I hope that someone can tell me that there are still surgeons in Wick. I know that maternity has been an ongoing problem, and it is a real concern. There has to be a way to address the need to get consultants to work in rural areas, such as at Dr Gray's.

Paul McLennan has a question on this subject.

Paul McLennan: My question is about the subnational arrangements, which Caroline Hiscox talked about when she was here. You have touched on this, but where do you see lessons from those arrangements being taken forward on the ground? In particular, what will be the budgetary impacts of the policy this year? We have heard that more operations will be carried out and there will be efficiencies. How do you see the subnational arrangements moving forward with the two health boards?

Angela Constance: It is not about us putting new resources into subnational planning. It is actually about bringing people together to work across geographical boundaries to share resources and move resources so that we can use, in terms of planned care, every inch of capacity in the system and get more people treated, preferably as timeously as possible.

The big benefit of subnational planning is about getting folk out of, I suppose, their comfort zone. People have worked in their domains and their individual health boards, but it is about getting that cross-boundary collaboration. It is worth acknowledging that subnational planning is still relatively new. It has been around for only a year. I have spoken about the progress that has been made in reducing long waits and the progress on planned care, but other work has taken place that is focused on the flow model through the system.

There is also discussion and support around innovation more broadly, particularly on the digitisation agenda, and subnational planning has led to a number of commissions beyond planned care. The east and west regions have worked together on joint commissioning in relation to cancer, which Ms Kinross-O'Neill mentioned. Because we would have two subnational planning structures—or, in my preferred model, two strategic boards—they will have to work together, and some of those approaches are being tested now. The east and west regions have commissioned jointly and will together lead work on the implementation of an oncology target operating model. That represents a more co-ordinated national approach to cancer service redesign.

Another example is thrombectomy. We have clear programme for government commitments on that, and regional planning arrangements have been commissioned to develop a national delivery plan for equitable 24/7 thrombectomy access.

There will be future commissions on women's health, fertility and other services, and subnational planning is also working on things such as winter preparedness, ophthalmology and a range of works. Those provide good preparation and tests of approaches, but we need to get folk to work for the population as a whole. That means that questions about geographical boundaries are secondary to whether somebody in Mr Middleton's constituency, for example, gets the treatment that they need on time.

Paul McLennan: The examples that you have given can provide lessons for the committee to learn from and observe as we go forward. As I said, we also previously heard evidence from Caroline Hiscox.

The Convener: Ask your next question very quickly, Adam Harley.

Adam Harley: I have a brief follow-up question. Cabinet secretary, you have repeatedly said that the changes are not about centralisation—you just said that again. However, as part of the process of NHS reform, there will surely be some changes made to where power lies and where decisions are made. Is that not the case? For instance, would some decisions and powers not move to the ministerial level as a result of the changes?

Angela Constance: Not necessarily. There are obviously ministerial powers in place just now, and there is a much more direct relationship between our health boards and ministers than there is between ministers and local government.

We need to talk much more about the community-first approach and do more to lay out our plans for it—I take that point as a piece of

constructive criticism for myself. That approach is about communities and people, and there will need to be an appropriate level of local and regional organisation.

We have not touched on this issue, but, in relation to the preventative agenda, there are opportunities—particularly with the community-first approach—to have a whole different relationship with the third sector. We need to move beyond partnership with the third sector often being reduced to saying, "We will be consulting", because the partnership is much deeper than that. There is an opportunity for us to bolster the third sector and to work differently with it via the community-first approach.

Turning to our plans for capital investment, you will see that, notwithstanding our capital constraints, some of the priority projects relate to primary care and community plans. It is about ensuring that we have the infrastructure in place to support the community-first approach.

We need decision making and care to be at the most appropriate level; it cannot all be about sookin up into the centre. People will understand that some services need to have a more national approach—for example, to ensure outcomes in specialist care—because the sharpest clinical practice often requires there to be a volume of patients. However, our community-first approach is about being equally strident and strong in delivering services locally.

Joe Long: Social care reform is happening alongside health service reform. Professor Derek Feeley, who authored the "Independent Review of Adult Social Care" in 2021, gave evidence to the committee last week, and it was interesting to hear from him. As you have recognised today, a lot of the changes that are needed in social care are not necessarily structural. There are also questions about collaborative and ethical commissioning and workforce development and recognition, which are issues that we have already touched on in this meeting.

The lesson that we learned from five years of discussion about the national care service is that such cultural and procedural aspects can sometimes can get lost in discussions about structure, and there are concerns that that might happen again. How do we ensure that those aspects are actioned and recognised in policy decisions and the budget?

Angela Constance: I looked closely at Derek Feeley's evidence. He undertook a tremendous piece of work that, in many regards, still holds true, which found that we need care to become far more person centred and that any reform or structural change must be about enabling the workforce and people to have a connected journey. It is not all about the medical world and the national health service; it is also about the many different people who require and expect an investment in their services, because it is an investment in them.

Sometimes, our narrative and the debates around social care become very focused on delayed discharge. I am very exercised about delayed discharge because, first and foremost, it is really bad for patients. However, the social care issue is wider than the delayed discharge issue. I agree entirely with your point about culture, which is why we are proceeding with that reform journey, whether on NHS simplification or on social care. Although I am always impatient—I am a woman in a hurry, believe you me—we need to take time and care to ensure that we always have the right folk in the room and the right spread of people, because that change in culture, values and ethos is as important as change in any of the structures that are in place.

Joe Long: That is welcome to hear for those of us who have a background in the sector.

Another big part of care delivery is the workforce of unpaid carers—the 700,000 to 800,000 people who deliver unpaid care for loved ones, friends or people close to them. In my constituency, I hear it said a lot that, at the moment, we simply do not have the infrastructure to provide breaks for carers—the respite support that was a fundamental part of the Care Reform (Scotland) Act 2025. I know that we are due to have plans soon to action support for unpaid carers. I think that they were due to come out within 12 weeks of the consultation ending in May.

I heard recently that, in Fife, somebody with a child with very high support needs was told, "Well, your son goes to school, so that's your time for respite"; I have also heard that, in Perthshire, people had vouchers to access respite care but the infrastructure was not there. I hear from providers that respite care is financially quite difficult to provide and would require some sort of core funding. There is that infrastructural question about how we provide support for unpaid carers. What is your reflection on that point? When might plans come forward? What might the budget commitment look like around supporting unpaid carers?

Angela Constance: You mentioned ethical commissioning. Guidance exists in draft form and we will need to consult on the matter, which we hope to do by the turn of the year. I will undertake to get a full report to Mr Long and to you, convener, with regard to where we are on the matter of breaks and respite care for unpaid carers.

For the time being, I would say that we sometimes forget that the range of respite care that might be required is significant. For example,

some children might have extremely complex needs and life-limiting conditions. I mention that because of the Sunndach and Calaréidh residential respite service in my constituency, which has been there for about 20 years. It is currently run by the NHS and provides specialist respite care for children with a very high level of needs. However, other types of care might exist across that spectrum.

11:00

Unpaid carers are an area that we need to focus on across the Government as well, because there are issues with employability and the economy. In social security, we have made huge improvements. Unless officials have anything to add, I will get back to Mr Long and the committee in detail on that point.

Jack Middleton: Last week, Kayleigh Kinross-O'Neill and I hosted a round table, which you kindly helped to open, cabinet secretary. We heard how, under the current social care set-up, young people and their families are losing vital support when they transition from children's to adult social care services. Obviously, a person's care needs do not disappear when they are 18. That puts an enormous financial and emotional strain on the families that we heard from. How can public service reform change that, to prevent those families from falling through the gaps? In the meantime, before those changes are introduced, what can the Government do?

Angela Constance: I recognise that issue. It is not a new concern, which makes it all the more frustrating. There are different experiences of that time of transition from children's services to adult services, depending on whether we are talking about social care or a clinical service, and that will vary by specialty. A bit of grip is required in that area, and the once-for-Scotland approach is important. I sometimes wonder whether we are reinventing the wheel multiple times in different services and locations. Addressing that area should be knitted into plans. As someone goes through their life, transitions are periods when care is at risk of disruption. For some areas, there will be clear requirements about planning ahead.

I ask my officials whether they have anything to add on transitions.

Jack Middleton: I will just follow up on another issue, cabinet secretary.

At the weekend, I worked a care shift with VSA in Aberdeen, to speak to carers in their homes about the issues that they faced. A huge thing that stuck out was that, before people entered the social care world, they did not know what they were entitled to or how to access it. There was a range of information from a range of sources, but none of it was joined up. Will PSR address that, so that a single source of information lets citizens across Scotland understand their rights and what they are entitled to when it comes to social care?

Angela Constance: People need to know their rights in order to access those rights. That is an issue beyond health and care, although it applies to health and care as well. Certainly, people could communicate much better with the public right now. I am not sure that that needs to wait for public sector reform. However, I wonder whether there are important lessons to learn from Social Security Scotland. Some of its work, particularly in its early days, was about proactively engaging with people on what their rights are.

The Convener: Heather Anderson has a final point on this issue, before we move on to other prevention issues.

Heather Anderson: There is complete clarity about where we are trying to go in a shift to prevention and more community-first interventions. In the committee, we have discussed the frustrations of tagging, identifying and following the money, and the cabinet secretary has spoken about following the money, too.

We have oversight of the health boards and the financial support to them, but we do not always see where that money ends up. I am also a serving councillor, so I want to talk about how we more transparently follow the money through local authorities. COSLA has been clear that it does not want ring fencing, but are we discussing with it how we better identify preventive spend in local authorities and how they might assist in identifying where funding is going, so that we can track it from that side as well?

Angela Constance: It is important to find ways to unlock collaboration and dialogue. Ministers always want to be able to follow Scottish Government investment. That does not mean that we do not respect people's rights in different organisations or at different tiers of government.

As I mentioned, I am cognisant of the Audit Scotland report from a few years ago. I cannot quite it directly, but it spoke to the importance of data in the context of social care. I would like to see more data and measurements in and around social care. That would be helpful. It needs to be the right type of data, however. We can produce volumes of data that do not speak to one another. I am very much in favour of having the right type of focused data.

Heather Anderson: Last week, Derek Feeley talked about trying to focus on prevention but being distracted because all the targets involve acute services. Has thought been given to

identifying new targets that do more to identify community intervention and early prevention work, rather than all the indicators being focused on acute care? That skews the game all the time.

Angela Constance: I will pick up where we left off regarding the preventative budget and the budget-tackling work—sorry, I mean the budget-targeting work—where there are huge opportunities. Please bear with me, as I cannot read my own handwriting.

On the matter of preventative budgeting for this budget, it is crucial that, as a baseline, we continue to build the methodology and use it to develop the budget as a whole so that we can identify the drivers. There are huge opportunities with budget targeting.

Richard Foggo is intimately involved in that.

Richard Foggo (Scottish Government): The committee has, I think, heard evidence on the prevention budget tagging work. That included two local authorities in the pilot, and you will have seen the commentary on it. There are some issues, with tension around a bottom-up model that would start with evaluated outcomes and impacts across local government, the third sector and business. We have not yet talked much about the role of private enterprise in relation to many of the challenges, but businesses have a fundamental role in some of our preventative activity. The prevention budget tagging work is top down, and explicitly so, to make it proportionate and manageable, because the bottom-up work is very forensic and fine grained.

As you know, nine health boards and two local authorities were involved in the pilot. The commitment in the programme for government to a prevention investment framework is about taking that further. I do not think that we have the complete picture that the Parliament would encourage us to have across national Government, local government and the third sector. What has been committed to in the work of the prevention unit, and what the prevention investment framework will do, is to bring the third sector under that regime. Clearly, that is up to local government, and the committee might wish to address local government directly as to whether it wishes to participate in that. We can cover the money that goes to local government but, as you know, much of that is general expenditure, and we therefore cannot break down what it is spent on.

Our intention is for that to be extended not just to local government but to the third sector and indeed the private sector. There is absolutely no reason why we should not ask Scotland's business sector how it is contributing to preventing critical population health issues such as economic inactivity, because it is a win-win for us. I am happy to write to the committee but, certainly, for the next period under the prevention investment framework, our intention is to see that grow from the top down and from the bottom up and to cover all sectors.

The Convener: It would be helpful if you could write to the committee, as it is a broad area. We can consider whether we wish to come back to it.

We are running out of time. Before we move on from public service reform, do you have any estimates on the cost of reorganisation? Police Scotland and other bodies have had reorganisations in the past, so there is an indication that there will be a cost to doing that. I am not asking for a figure; I am asking whether the work that has been done gives an indication of what the cost might be over the next couple of years during the reorganisation.

Angela Constance: It is important to stress that we are not starting to build new organisations from the ground up and there is already considerable investment in the system. Nonetheless, it is important to quantify the impact of change, which is why the full business case is important, because it will identify any costs that are associated with change as well as savings in the short, medium and longer term. The procurement for the business case work and the modelling has now been completed, so we will be motoring ahead with the full business case, which I want to see by the end of next spring.

The Convener: That is helpful.

We are very short of time. We have a few more questions on health and we want to keep a wee bit of time for sports funding questions. Jack Middleton has questions about prevention in relation to drugs and alcohol.

Jack Middleton: I have a broad question about drugs and alcohol deaths, which continue to devastate far too many families, especially in our poorest and most deprived communities. How will the budget put more money into prevention, early support and tackling the causes of addiction to alcohol and drugs?

Angela Constance: Last week, I spoke in the Parliament about the need for a spectrum of interventions. People who are struggling in the here and now need support and pathways into treatment or recovery, which we invest in heavily. You will also have heard me talk about the importance of prevention. The budget tagging work will be important in understanding the role of our record drug and alcohol investment. However, 80 per cent of the determinants of good health lie outwith the health and care portfolio, which also applies to drugs and alcohol. Providing whole family support and addressing poverty, and

ensuring that people have purpose, work and access to education are all imperative.

In addition, the health service provision has to move away from centralised approaches. Several years ago, when I was the Minister for Drugs Policy, there were concerns about the provision of drug treatment services in Dundee. Actually, we need services that are prepared to reach out to people—not just to write letters to folk, but sometimes to chap people's doors. There is an immense need to do things differently, and that journey has started in relation to drugs and alcohol. Support is needed for the voluntary sector, which is well placed for prevention and response work. We really need that and must continue with a cross-Government approach to drug and alcohol challenges.

11:15

The Convener: We are running out of time, but Adam Harley has a question on capital investment.

Adam Harley: My question is about digital infrastructure across our NHS. GPs across Scotland have just been moved on to the Vision system, which helps them log cases, prescribe and so on. I recently met GPs in Bishopbriggs in my constituency who said that they have gone from seeing 14 patients per session to seeing seven, because the system is clunky and keeps crashing. Are you aware of the issues with the system? What will be done to sort that as soon as possible? Is the Government ambitious about harnessing some of the real benefits that could be achieved through the use of technology? As we know, there is huge potential for using technology in our NHS. Is the Government ambitious and open to that?

Angela Constance: The short answer to the second part of that question is yes, absolutely. That is why we have the ANIA project and are interested in the work of the centre for sustainable development. Again, the development and implementation of technology is a key feature in our public sector reform plans more broadly. Also, at a practical level, I do not want people who work with more than one health board having to have two laptops and operate two systems and so on, and I want there to be shared digital records.

We are continuing to roll out the MyCare.scot app, and, after next spring, there will be a phased introduction of the capacity to use it for secondary care appointments.

I have answered lots of parliamentary questions on GP practices transferring to the Vision system and have met Public Services Delivery Scotland to discuss some of those concerns. In the vast majority of cases, the transition is working well. I can see from the parliamentary questions that there are some hotspots in parts of the country where things are not working well, and I know that additional attention and support are being given to GP practices as a consequence. There is a bit of a complex history to the situation, and I would be happy to write to Mr Harley and the committee on that.

The Convener: That would be helpful.

This is not really to do with capital investment, but I am reminded of the fact that NHS Borders said that it was working across three systems, between the allied health professionals, the GPs and one other service, which I cannot remember just now. Obviously, there will be a cost in getting them all on the same system, but there are also savings to be made. It was suggested to me that we could get rid of paper prescriptions, which would save a lot of money and save GP practices having to have a full-time person printing them out so that GPs can sign them. Is there any prospect of that happening?

Angela Constance: The point about digital prescribing is well made. Again, the issue of reducing paper is a feature not just in our plans but across public services. I think that Mr McKee published some work in which he noted that, if the public sector reduced its written correspondence by 25 per cent, it would save something like £100 million—I think that there is now a target for that. Those are all points well made.

The Convener: Well, the doctor I spoke to was quite concerned about the issue.

We have 12 minutes left, and Jack Middleton has questions on sport facilities and funding.

Jack Middleton: Last week, sportscotland told us that 40 per cent of our sports facilities are now past their expected lifespan, and Scottish Swimming warned us that hundreds of pools could close in the coming decade. Clearly, we cannot talk about prevention through encouraging people to get into sport if the facilities are not up to scratch. Do you hope that the budget can prioritise getting some of the facilities into the state that they need to be in, and would you hope for that to be in future budgets as well?

Angela Constance: I recognise the importance of facilities and resources for sport. A facilities review was undertaken by a range of sport governance bodies, and we will continue to work with them on that.

I point to the fact that, in this budget, we have provided record funding for local authorities. Of course, the provision of sports facilities is much more in the local government domain than in mine specifically. I am not demurring from the pressures that are faced across public services, including those faced by our partners in local government, but local authorities have additional means of

borrowing, for example, and different ways to resource facilities.

The point is well made. Of course, it is Scottish women and girls in sport week this week, and we need to address the gender gap in participation.

Jack Middleton: I totally agree. I highlight the £12 million of funding that the Scottish Government gave for the summer of sport, which followed the participation of Scotland's men's team in the FIFA world cup and the Commonwealth games. The Commonwealth games brought more than £200 million of economic benefit to Scotland, I believe. We have other major tournaments coming up, including the Tour de France next year and the Union of European Football Associations European championship in 2028. I have made a plea for free tickets to be made available so that kids from some of our most deprived backgrounds can watch the national team at Hampden when the Euros come to Scotland. Will you back those calls? I have had a very positive response from UEFA. Will the Scottish Government work alongside it to make that a reality?

Angela Constance: Responsibility for the forthcoming football tournament sits with Mr Flynn. The issue is interesting, in that responsibility for international sporting events seems to vary. Sometimes, it has sat in external affairs and culture, sometimes in the economy portfolio and sometimes in health.

I am aware that there has been some overtures from that organisation regarding free tickets. Why would we not want sport to be as inclusive as possible?

The Convener: Heather has a final question, which is on social prescribing.

Heather Anderson: My question is about health inequalities and access to exercise. We have discussed the tension between elite performance sport at one end and helping people to get moving at the other. In Dundee, we have a successful stroke exercise class for people who are in recovery, and Heart Space Dundee runs an amazing yoga class for people who have had amputations. The sports organisations that appeared before the committee mentioned social prescribing. What are your thoughts on a bigger role for social prescribing in access to sport and activity facilities?

Angela Constance: There absolutely should be. We like social prescribing, as it is the way to make best use of resources at a community level. That is about recognising that not all treatment, recovery or interventions need to be medical in nature, and it speaks to the sense of engagement and connection with the local community, which is good for people's health, reducing isolation and helping people to get exercise.

Heather Anderson: Could we better track that? On the issue of following the money, is there any way of identifying the level of social prescribing that is being undertaken and ensuring an increase in that?

Angela Constance: Yes, I am quite sure that there is. I will bring in Richard.

Richard Foggo: We expect to publish a national social prescribing framework for Scotland in early 2027, and it is absolutely clear that we want to connect that to preventative spending. The prevention unit has identified areas for future development, including prevention through communities and the ways in which communities can support themselves. We will absolutely ensure that that connection is made, and we can report back to the committee on it.

The Convener: Paul has one final question.

Paul McLennan: The Government's infrastructure investment plan and the programme for government make reference to building new community and care hubs. Will you say a bit more about that? Those are incredibly important for local communities in bringing services back to them wherever possible.

Angela Constance: The journey on that started with the infrastructure investment plan, and we had very clear manifesto commitments, which were replicated in the programme for government—it is a triple lock, if you like. Priority projects include those in Cowdenbeath and Lochgelly, East Calder and Kincardine. The Government has written to the respective health boards to explore acceleration of those projects, because they intimate a new way forward and address what the communities need from their primary care infrastructure.

I should declare an interest. As the constituency MSP for Almond Valley, I am recused from any decisions about services in East Calder.

There are other identified primary care projects. I want to give the strongest possible signal about the importance that we place on community infrastructure, the role of community services in public sector reform and the delivery of services as locally as possible. We and our families will all attend hospital appointments in our lives, and we will all think about what could be done with the right investment and reorganisation. Those are all things that could be done more locally, which would increase uptake, improve the health of local populations and help deal with health inequalities. I would like to see much more diagnostic provision in communities, as well as interventions around eyes and ears.

The Convener: That concludes your two hours here, cabinet secretary. Thank you for a comprehensive discussion of where you are at, and for giving us information and further issues to follow up. I thank you and your officials for attending. Have a good day.

11:27

Meeting suspended.

11:34

On resuming—

Subordinate Legislation

Sale of Tobacco (Miscellaneous and Consequential Amendments) (Scotland) Regulations 2026 (SSI 2026/278)

The Convener: Agenda item 3 is subordinate legislation. Members should refer to paper 3, as we consider one negative Scottish statutory instrument. The instrument is subject to the negative procedure and I have had no notice of anyone wishing to lodge a motion to annul. Are members content for the SSI to come into force?

Members *indicated agreement.*

The Convener: Thank you. We now move into private session.

11:34

Meeting continued in private until 12:10.

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