Health, Care and Sport Committee
2 September 2026
2nd Meeting, 2026 (Session 7)

Overview of key issues in the health sector

Introduction

1. This is the first in a series of formal committee meetings in the early part of September which will enable Members to gain an overview of the key issues in the health, social care and sports sectors, by hearing from a cross-section of key organisations and individuals who work in these sectors. The Committee will also be hearing from the Scottish Government's ministerial team.

2. Whilst it is not possible to hear from every different organisation, it is hoped that the choice of witnesses will provide Members with a good grounding of the issues that different people perceive to be priorities for session 7.

3. Once these sessions are complete, and once Members have been able to review the Scottish Government's Programme for Government (due in early September), the Committee will then be able to make decisions about its early work programme.

Today's meeting

4. Today's meeting of Committee focuses on the health sector in the broadest sense. Subsequent meetings will focus on social care and then sport.

5. Three panels of witnesses will attend today. Please note that some witnesses in Panel 3 will be attending remotely. Those attending are:

   Panel 1 (broadly representing key public sector bodies and key advisers)

   - Caroline Hiscox, Chief Executive of NHS Lothian and Chair of the NHS Scotland Executive Group
   - Alison White, Chair of the Chief Officer Group, Health and Social Care Scotland
   - Professor Sir Gregor Smith, Chief Medical Officer, Scottish Government
   - Paul Johnston, Chief Executive, Public Health Scotland

   Panel 2 (broadly representing trades unions, staff bodies and professional bodies)

   - Lilian Macer, Scottish Secretary, UNISON
   - Dr Nóra Murray-Cavanagh, Chair-Elect of Scottish Council, British Medical Association
   - Eileen McKenna, Scotland Associate Director (Nursing, Policy and Professional Practice), Royal College of Nursing Scotland
   - Charlotte Waite, National Director, British Dental Association Scotland
   - Glenn Carter, Head of RCSLT Scotland, Royal College of Speech and Language Therapists

Panel 3 (containing a cross-section of charities, campaigning bodies and patient groups)

- Sara Redmond, Chief Officer of Development, Health and Social Care Alliance Scotland (the ALLIANCE)
- Janet Sylvester, Trustee, #MEAction Scotland
- Kirstin Laing, Chronic Pain Group
- Jane Ormerod, Chair and Stuart McIver, Trustee, Long Covid Scotland
- Kenny Stewart, Head of Public Affairs and Communications, SAMH

6. Where the organisations or individuals have provided written evidence in advance, this can be found in the **Annexe** to this paper.

7. A separate SPICe briefing paper (**Paper 2**) is available to help Members prepare for this session.

8. Members will have up to one hour for each of the three panels.

Action

9. Members are asked to discuss with the different witnesses what they perceive to be the main issues facing the health sector in Scotland and their respective roles and functions.

Clerks to the Committee
August 2026

Scottish Parliament Health, Social Care and Sport Committee

2 September 2026

NHS Lothian key issues briefing

Submitted on behalf of Professor Caroline Hiscox, Chief Executive, 24 August 2026

Thank you for the invitation to speak to the Committee about the opportunities and challenges facing NHS Lothian. This briefing note provides an overview of NHS Lothian's current service performance, financial, infrastructure, workforce and prevention issues, and sets them in the wider strategic context for NHS Scotland.

As the Committee will be aware, Scottish Government issued DL 2025(25) in November 2025, implementing sub-national planning structures for Scotland East and Scotland West and requiring Boards to collaborate through those structures on the planning and delivery of the five objectives set out in the DL. These objectives deliver key aspects of the Health and Social Care Service Renewal Framework (2025–2035), the Population Health Framework, as well as wider ambitions related to public sector reform, and include the development of plans for achieving the Treatment Time Guarantee for orthopaedic elective services; emergency healthcare services; a Once for Scotland approach to Business Systems and the MyCare.scot service. The Scotland East Sub National Planning and Delivery Committee is chaired by the Chair of NHS Lothian and the Chief Executive of NHS Lothian is the lead Chief Executive for Scotland East.

NHS Lothian is planning activity for achieving waiting times standards in both unscheduled/urgent care and elective care through the Scotland East structures, along with planning for financial sustainability. Therefore, this brief includes information on the work being led by Scotland East where appropriate, and Professor Hiscox is happy to discuss this work in more detail with the Committee.

A. Service performance

1. Waiting Times Standards performance summary

A summary of current performance against the Waiting Times Standards is attached at Appendix 1. The most recent NHS Lothian Integrated Performance and Quality Report, presented to the Board on 12 August 2026, can be found here: NHS-Lothian-Board-Papers-12.08.2026.pdf (item 9).

There have been significant reductions in patients waiting >52 weeks since July 2025. Outpatient long waits have fallen from around 21,000 to around 3,700 in July 2026 - a reduction of more than 80%, with particularly strong progress in dermatology, ENT, general surgery, ophthalmology and urology.

Inpatient and day-case long waits over 52 weeks have reduced from around 4,900 to about 1,700 in July 2026 - a reduction of more than 60%, with improvement across most specialties. There is continued focus on the high pressure areas of gynaecology, and trauma and orthopaedics.

However, performance against several national access standards remains below target, particularly within unscheduled care, cancer services, diagnostics and mental health pathways. In many areas performance improvement is constrained by wider system factors including hospital occupancy, workforce constraints and flow through health and social care services.

In respect of cancer performance, achievement against the 62-day Cancer standard (95% of patients starting cancer treatment within 62 days of an Urgent Suspicion of Cancer (USOC) referral) remains below both the national standard and local trajectory. Cancer Services receive enhanced executive oversight.

The principal challenge is a backlog of patients who have already waited longer than the national standard before treatment can begin. NHS Lothian has therefore prioritised reducing the number of patients waiting longest for treatment. This is improving patient experience and reducing the backlog, but it can temporarily suppress reported 62-day performance because patients who have already exceeded 62 days are still counted within the measure when their treatment starts. In simple terms, the service is currently prioritising treatment of the longest waiters, and the benefit of that work is expected to become visible in the reported 62-day standard over time rather than immediately.

Performance against the 31-day standard remains considerably stronger, with a consistent average of around 94% of patients starting treatment within 31 days of a decision to treat. This indicates that once patients enter the treatment phase of their pathway, the vast majority receive treatment within the national standard.

Current plans anticipate continued reduction in the backlog with clearance by December 2026, with improvement in overall 62-day performance expected to become evident from March 2027.

Impact of Sub-National planning and co-ordination:

As detailed in DL 2025 (25), coordinated planning and collaboration is required across NHS Scotland Boards to eliminate long waits and improve equity of access to services across Scotland. Trajectories have been submitted for all East Boards, working in a co-ordinated review process, for Planned Care performance to March 2027 which show significant progress towards eliminating waits over 52 weeks for both outpatients and treatment time guarantee (in-patient) lists. NHS Lothian trajectories show no waits greater than 52 weeks by April 2027. This process has reduced the planned care funding requirement from £61.0m to £52.4m whilst increasing planned activity from ~31,000 to ~39,000 procedures. This collaborative work demonstrates that working at scale enables better use of resources, improved consistency, greater overall system impact and better value for the public purse.

Scottish Government requires that eliminating long waits must not result in deterioration in diagnostics, cancer or unscheduled care performance, and NHS Lothian and Subnational East will continue to monitor this closely through their delivery and assurance arrangements.

2. NHS Lothian Maternity Services

Following a Healthcare Improvement Scotland (HIS) inspection report on safe delivery of care in maternity services at Edinburgh Royal Infirmary, published in October 2025, NHS Lothian Maternity Services were escalated to Level 3 of the NHS Scotland Support and Intervention Framework.

NHS Lothian has made significant progress in important areas, including transformation in patient care pathways, improved staffing levels with more than 70 new midwives recruited and recurring investment of £1.5 million in additional staffing, training, escalation and rotas. There is renewed focus on Maternity Early Warning Score (MEWS) recording and improving assessment at triage.

Safety and quality of the service, and improving staff wellbeing and culture continue to be high priorities. There are detailed improvement plans being implemented to improve staff experience and respond to concerns raised. Adverse events with harm are reviewed regularly to establish if there are any areas or recurring themes which require further focus or action. Our improvement actions are informed by the recommendations from national reports into the safety of maternity services (Ockenden and Amos) and the new HIS Midwifery Standards, all of which highlight staffing levels as a central factor in safe maternity care.

We continue to work closely with Scottish Government on the detailed criteria and timescales for de-escalation of maternity services.

3. NHS Lothian CAMHS

NHS Lothian was escalated to Level 3 of the NHS Scotland Support and Intervention Framework for Child and Adolescent Mental Health Services (CAMHS) in December 2024 because it was not meeting the waiting times standard of 90% of children or young people who meet the requirements of the standard to have their treatment start within 18 weeks of referral. NHS Lothian has made significant progress in driving down long waits, with the number of children or young people waiting over 52 weeks reducing to zero by the end of April 2026, with ongoing action to prevent recurrence.

The improvement trajectory for NHS Lothian CAMHS waiting times aims to reduce the number of children and young people waiting more than 18 weeks for their first appointment to no more than 10% of the waiting list by March 2027.

NHS Lothian continues to discuss the de-escalation criteria and timetable with Scottish Government. We are committed to further improvements in this waiting time standard to ensure that children and young people have timely access to these critical services.

4. NHS Lothian Neurodevelopmental (ND) Services

Adult service

Adult ND pathways are delivered by each Health and Social Care Partnership (HSCP). Each HSCP is experiencing demand significantly above capacity. In June 2026, over 12,800 patients were waiting for an Adult ND assessment across Lothian. Some patients are still projected to have to wait years for an assessment, which is not an acceptable position.

There is an Adult ND sub-group overseeing improvement work. This sub-group has delivered some important foundations, providing greater consistency of access to services across the 4 HSCPs - referral criteria, validation of waiting lists, trajectories for capacity and demand, transition work and governance structures. All Lothian lists remain open for referrals and there is a 7-day triage process in place across Lothian, although there are staffing challenges in meeting this standard consistently. Each HSCP is exploring and testing different recovery models, and a digital sub-group has been established to explore a digital screening and self-management platform.

Workforce availability and funding are the major constraints to delivering rapid improvements in this service.

Children's ND service

Children's neurodevelopmental assessment and support is delivered through a number of routes, reflecting the child's age, presenting needs and the different clinical and professional contributions required. Community Paediatrics and CAMHS have distinct

but connected roles, alongside wider services and local authority partners, particularly education services. The current improvement work is therefore focused on creating a more coherent whole-system pathway, with clearer referral routes, reduced duplication, effective hand-offs and clarity about responsibility for assessment, intervention and support.

The CAMHS neurodevelopmental service has very long waiting times and large waiting lists, with continued growth in demand. At the end of July 2026, there were a total of 12,279 children and young people waiting on the CAMHS Neurodevelopmental assessment pathway.

There has been some improvement in Community Paediatrics service delivery with a reduction in total waiting list size and average time waiting, which is currently approximately 36 weeks

There is a significant amount of improvement work underway in both the Community Paediatrics and CAMHS ND pathways. This includes work on referral routes, triage, assessment models, standardisation of approach, use of questionnaires/tools, pathway redesign, competency frameworks and potential digital or data improvements.

The improvement programmes for both adults and children's ND services have Executive oversight from the NHS Lothian Performance Support Oversight Board (PSOB), chaired by the Chief Executive. PSOB supports the services to strengthen the link between improvement activity and operational outcomes, including priority actions, quantified impact, delivery milestones and expected trajectories.

5. Mental Health services stabilisation and transformation

NHS Lothian has prioritised stabilisation of mental health services, investing £8 million in service improvement since 2024 and establishing a Mental Health Executive Oversight Group and an Operational Whole System Improvement Group in September 2025. The intention of these forums is to provide system grip on trajectories, flow, workforce and service redesign.

CAMHS performance is described in section A3 above. Psychological Therapies performance is broadly in line with the Scottish average, with 78% of patients seen within 18 weeks in July 2026 (Scottish average in July 2026 is 81%)

The MH Executive Oversight Group has agreed a core set of objectives for safe occupancy levels; timely flow through reducing average length of stay and community step down; alternatives to admission through strengthening urgent response and community pathways; and expanding early intervention and urgent community support. The intention is to shift mental health provision from reactive to planned care through timely triage and proactive follow-up in the community.

The improvement group will focus on workforce & financial sustainability, in order to reduce reliance on agency/bank nursing and embed financial scrutiny of cost drivers (occupancy, unfunded beds, workforce), and greater use of data and intelligence to drive evidence-based decision-making and track delivery of system improvements.

Building on this operational stabilisation work, NHS Lothian is now moving into transformation and strategic redesign of Mental Health services across Lothian, to develop a safe and effective target operating model over the next 24 months.

B Prevention

The demands on health and care provision are ever increasing. This is due to changing population demographics, increased multi-morbidity, widening health inequalities and increasing expectations of what the health and care system can and should provide.

At the same time, public sector resource is finite and becoming increasingly limited.

The essential need for prevention is well-recognised. Both the Population Health Framework (PHF) and the Health and Social Care Service Renewal Framework (SRF) set out the requirement to focus on population health and a whole-system approach to prevention.

NHS Lothian has reinforced its commitment to improving population health and tackling inequalities through the Lothian Strategic Development Framework (LDSF), the Prevention Framework approved by NHS Lothian Board in April 2024 and subsequent Prevention Plan approved in June 20206, and its commitment to becoming a population health organisation and embedding prevention through its core business.

NHS Lothian has five objectives to further embed prevention in local health and care system activity:

- **Make prevention a system-wide priority** - prevention-focused conversations and engagement with senior leadership teams and LSDF programme boards.
- **Maximise spending on prevention** – Public Health and Finance colleagues contributing to national approach to optimise preventative spend.
- **Embed prevention in performance frameworks** –currently developing an outcomes measurement framework and embedding these measures within the Board performance framework.
- **Support the local system to embed prevention in strategic plans and service delivery** prevention actions will be embedded in LSDF programme board implementation books to ensure system-wide ownership of prevention activity.
- **Establish an effective learning and accountability system** – currently working through governance arrangements to ensure NHS Board oversight and scrutiny of prevention activity, and alignment with existing LSDF reporting mechanisms.

The Prevention Plan is built around three high-level priority areas:

1. **Building blocks of health** – optimising our role as an Anchor Institution and our work with Community Planning Partnerships to improve population health outcomes through employment, income, housing and environment, and climate and sustainability.
2. **Improving maternal, children and young people's health** – recognition that work in the early years of life provides the best return on investment in terms of improving future population health and tackling health inequalities.
3. **Tackling the burden of disease** – a number of workstreams planned to tackle the burden of disease and healthcare inequalities through work on: modifiable disease risk factors (smoking, obesity, blood pressure, blood lipids, blood glucose); missingness; Waiting Well; supporting self-management; mental health; drugs and alcohol; dental health; immunisation and screening; frailty and falls prevention.

C. Finance

NHS Lothian was one of four Boards to achieve a financial break-even position in 2025-26, delivering £60 million (3%) of savings. NHS Lothian did not require brokerage funding from Scottish Government in 2025-26.

No additional NRAC (NHS Resource Allocation Committee) funding was provided to Lothian for 2025-26 due to the health board sitting within the parity target of 0.6% (Lothian at circa 0.5%). Despite the reduced NRAC gap, NHS Lothian was £10 million below parity in 2025 -26 with a cumulative shortfall over the last decade of £160 million. There is a collective annual NRAC gap in East Boards of circa £30million, and NHS Lothian is committed to working across all health boards and with Scottish Government to identify a medium-term approach to bring parity to Boards.

The Board's strategic intent in respect of finance for 2026-27 is to deliver 3 ambitions:

- A balanced outturn for the financial year 2026-27
- Creation of funding flexibility to support budget realignment for 2027-28 onwards
- Reduction of the recurrent underlying financial gap of c£88 million

The Financial Plan for 2026-27 was approved by the NHS Lothian Board in April 2026 and requires £68.5 million of savings to deliver the Scottish Government's 3% recurring savings target. There was a small shortfall by end of May 2026 in savings delivered, with £6.3 million of savings delivered against a target of £7 million.

NHS Lothian has submitted a Q1 forecast to Scottish Government setting out a balanced year-end outturn and remains confident this position is realistic and can be delivered. It reflects Board and Business Units' continued commitment to deliver the 3% savings requirement in full and reflects NHS Lothian's strong historic performance in delivering against required savings targets.

The main areas of financial pressure are as predicted in the Financial Plan: non-pay - Acute Drugs, Medical Supplies and Property Costs and pay – Medical and Dental all overspent at the end of June 2026.

NHS Scotland Sub National Planning actions:

Improved financial sustainability is a key aim of the Sub-National Planning arrangements introduced by DL 2025(25). The East region Boards (Shetland, Orkney, Grampian, Tayside, Fife, Lothian and Borders) are working collaboratively to build a financially sustainable framework that enables improved outcomes for the populations we serve.

Initial assessment indicates that the recurrent underlying gap across the East region is in excess of £30 million.

Boards are working together to

- learn from best practice, which includes benchmarking of good financial performance and identification of low-cost practice in the higher spend areas of nursing, medical staff, drugs, supplies and property/facilities to reduce variation in performance;
- build resilience across finance teams; and
- develop better support tools to understand and manage cost pressures, including tools for enhancing costings at patient level (PLICS).
- collectively assess the efficiency programmes developed within boards to identify opportunities for sharing of ideas and developing scalable efficiency initiatives.

D. Infrastructure and capital spend

NHS Lothian faces significant infrastructure challenges due to rapid population growth - 84% of Scotland's population growth over the next 10 years is expected in Lothian and 74% of growth over the last decade has been in Lothian, impacting on primary care in particular.

The 2023 pause on major infrastructure projects halted major reprovisioning projects, including NTC-Lothian, Hospital Sterilisation and Decontamination Unit (HSDU), the Cancer Centre at the Western General Hospital and 25 primary care facilities.

The current capital formula funding is insufficient to meet a £101.2 million backlog, maintenance and infrastructure requirement, with £86.7 million of this assessed as high-risk. Key risks include

- Western General Hospital has a rapidly deteriorating estate condition. Urgent capital support is needed for site redevelopment, decommissioning, and demolition planning to enable safe service decant.
- the Princess Alexandra Eye Pavilion reprovision restarted in 2025, following an urgent closure which required c.£2m of maintenance before reopening. Further multi-million investment will be needed until reprovision is complete, including significant potential decant costs.
- the HSDU is a major service continuity risk due to limited capacity across Scotland and the private sector.
- Primary care infrastructure expansion: Lothian's practice list population has grown by c.156,000 between 2008–2023, with further growth expected. The 12 priority projects deemed essential within the next five years to meet statutory service delivery requirements will be progressed. The transfer of GP-leased premises to Boards adds significant maintenance pressures on ageing estates.

Lothian's Business Continuity planning has a £297 million investment need over the next three years against a forecast capital allocation of £181.2 million. In addition, several major Business Continuity Planning projects will require decant of services, which comes with additional costs and operational impacts. There is a lack of available space to progress all the decants required.

The end of the Royal Infirmary of Edinburgh (RIE) PFI contract in 2027 will result in NHS Lothian taking on significant life cycle maintenance requirement. In 2022, ahead of the planned handover at the end of 2027, NHS Lothian carried out an enhanced contract management review and significant detailed investigations to assess the building condition and ensure contractual obligations were being met. This identified shortfalls in fire measures which were reported to the Scottish Fire and Rescue Service, Consort and other stakeholders.

Agreement has been reached on a Handback Supplementary Agreement following extensive negotiations and advice from legal, technical and financial experts. Alternative approaches carried risks, including potential disruption to patient care. Funding of £86 million will be provided for upgrades, but there is a sizeable deficit which requires to be addressed.

E. Workforce

NHS Lothian has a consistent establishment gap of c3-4% between funded posts and the total whole time equivalent (WTE) of staff in posts each month. Services which operate at an establishment gap above this level are at greater risk of being unable to meet demand and maintain standards of care, placing increased pressures on staff wellbeing.

The reduction in the working week for Agenda for Change staff, agreed as part of the 2023-24 pay award and fully implemented from 1st April 2026, effectively reduced capacity across most of our workforce by 4%. For context, in Lothian this is a reduction of c200 WTE nursing staff. This puts further pressure on nursing, AHP and Pharmacy recruitment and retention, which has been mitigated in part using funding made available for the reforms but is subject to available supply.

Remaining gaps, particularly in nursing, may require to be covered by supplemental staffing. Since October 2024, registered nursing establishment gaps have remained below 5%, contributing to a 23% reduction in supplementary staffing and near elimination of agency usage, except within mental health services, where WTE establishment gaps of approximately 9% persist.

There is a continuing risk to nursing workforce levels from the predicted shortfall in fill rates for undergraduate registered nursing programmes. NHS Lothian has been very successful in recruiting and retaining newly graduated nurses and we will continue with targeted recruitment programmes.

NHS Lothian continues to have the second lowest sickness absence rate of the 5 largest NHS Scotland Boards, at 6.25% (June 2026).

The Public Sector Reform Strategy and the Fiscal Sustainability Delivery Plan states that there will be a re-profiling of the public sector workforce, control of the public sector pay bill, and simplification and greater integration of services with more emphasis on prevention. It is understood that control of the pay bill means a 0.5% reduction in relative Public Sector workforce costs for each of the coming five years.

Right-sizing the NHS workforce to meet those requirements, while also transforming delivery to meet future demand and have an increased focus on early intervention and prevention, is a highly complex problem. It ~~will~~ requires reducing workforce costs in a way that is safe and effective for service users and staff, whilst still meeting challenging financial, service access and performance trajectories and achieving substantial system transformation.

There are some obvious tensions that must be worked through carefully, for example meeting safe staffing and other regulatory expectations is a challenge whilst working within / saving against existing funded establishment; reducing workforce costs whilst also being an Anchor organisation which widens access to employment. Sector specific guidance on workforce re-profiling for Health and Social Care is awaited.

Summary of Performance against the Waiting Times Standards

Source: NHS Lothian Board Integrated Performance and Quality Report August 2026

Measure	Latest Month Performance	Performance 3 Months Previous	Performance 12 Months Previous	Latest Available Scottish Comparator	Target	Trend
4 Hour Emergency Access Standard	65.9% (Jun26)	64.9% (Mar26)	74.1% (Jun25)	66.2% (May26)	95%	Stable
Inpatient/Day Case Waiting List Size	22,125 (Jun26)	21,825 (Mar26)	20,011 (Jun25)	157,191 (Jun26)	-	Stable
% Inpatient/Day Case Patients Treated within 12 Weeks	55.7% (Jun26)	54.2% (Mar26)	59.4% (Jun25)	56.3% (Jun26)	100%	Stable
Outpatient Waiting List Size	80,936 (Jun26)	83,421 (Mar26)	100,334 (Jun25)	496,349 (Jun26)	-	Improving
% New Outpatients Seen within 12 weeks	51.5% (Jun26)	48.9% (Mar26)	37.5% (Jun25)	49.3% (Jun26)	95%	Improving
% Endoscopy patients seen within 6 weeks	47.3% (Jun26)	36.5% (Mar26)	25.7% (Jun25)	51.6% (Mar26)	100%	Improving
% Radiology patients seen within 6 weeks	84.9% (Jun26)	75.4% (Mar26)	49.0% (Jun25)	78.3% (Mar26)	95%	Improving
% patients starting cancer treatment within 31 Days of a decision to treat	93.0% (Jun26)	91.8% (Mar26)	97.3% (Jun25)	94.5% (Mar26)	95%	Stable
% patients starting cancer treatment within 62 days of an urgent suspicion of cancer referral	63.8% (Jun26)	66.1% (Mar26)	76.1% (Jun25)	72.2% (Mar26)	95%	Deteriorating
% patients starting CAMHS treatment within 18 weeks	69.3% (Jun26)	68.9% (Mar26)	61.0% (Jun25)	92.0% (Mar26)	90%	Stable
% patients starting Psychological Therapy treatment within 18 weeks	73.8% (Jun26)	82.6% (Mar26)	79.9% (Jun25)	81.1% (Mar26)	90%	Stable

Please note, the most recent NHSL data is included here. The most recent NHS Scotland benchmarking published data may lag behind.

SCOTTISH PARLIAMENT HEALTH, CARE AND SPORT COMMITTEE

MEETING OF 2 SEPTEMBER 2026: KEY ISSUES IN THE HEALTH SECTOR

NOTE FROM THE CHIEF MEDICAL OFFICER

I am most grateful to be invited by the Committee to answer questions on key issues in the health sector in Scotland. I look forward to the occasion.

The Committee invited the submission of written comments in advance of the hearing and I offer a note here. In this, I address two issues:

1. The main themes of my most recent annual reports, in particular the population health challenges facing Scotland, and how they might be tackled; and,
2. Inequalities experienced by women and girls and racialised health inequalities.

1. The Chief Medical Officer's annual report

One of the roles of the Chief Medical Officer is to offer the Parliament and Scottish Ministers independent clinical advice connected to health issues and relevant wider public health responsibilities of the Scottish Government. As part of the exercise of this function, the Chief Medical Officer has traditionally published an annual report.

In previous annual reports I have described what I regard as the four key population health challenges facing Scotland: :

- The ongoing threat of infectious disease: we must remain prepared for continuing and future infectious disease threats, maximise protections from vaccination and combat antimicrobial resistance.
- Widening health inequalities and reversal of positive trends in healthy life expectancy: Poverty, deprivation and discrimination continue to drive unequal health outcomes (and I address two elements of this challenge in section (2).
- Creating a sustainable health and care system: An ageing population, new medicines and technology and rising long-term illness are increasing complexity, acuity, demand and costs.
- Addressing the planetary crisis through a public health lens: Climate change, biodiversity loss and air pollution are themselves major threats to human health.

These four challenges to population health are not separate but inextricably interlinked and must be tackled together in a balanced approach

Failure to tackle the planetary health crisis will result in new human health threats and vector borne disease, some of which we are already observing; experience shows that these will have a disproportionate impact on those who already bear the burden of health and socio-economic inequalities.

The overall burden of disease in our most deprived communities is approximately twice as high as in the least deprived areas (50,305 vs 20,955[i] Disability Life Years (DALYs[ii]) per 100,000) with resulting increased pressure on health and care services. Around one third of these DALYs were associated with deprivation, increasing in turn the risks of economic

inactivity and poverty. In the prevention of disease, large gradients are seen in the uptake of immunisation and screening between Scottish Index of Multiple Deprivation (SIMD) areas, and may contribute further to this disease burden. In order to improve the overall health of the population and create a sustainable health and care system, it is critical that we tackle these four challenges together.

In my most recent annual report I expand on these challenges and continue to recognise:

- Rising demand and complexity driven by ageing, multimorbidity and increasing burden of disease (Scottish Burden of Disease suggests 21 per cent increase in burden of disease experienced by population by 2043)[iii].
- The wasteful use of resources due to over-treatment, over-investigation and over-diagnosis.
- Deep and persistent inequalities, including large gaps in healthy life expectancy and higher burdens of preventable illness in deprived communities.
- Workforce pressures including burnout, workload, staffing challenges and moral injury, often driven by the pursuit of greater efficiency and industrialised, transactional care.
- Fragmented services with poor continuity, access difficulties and duplication.
- Disruptive challenges from AI, misinformation, digital exclusion and cybersecurity risks.

I also describe some key themes for how these challenges should be tackled:

- **Systems that Serve**: the need to design services around people, trust, continuity, inclusion and the need to support workforce wellbeing. Systems should be designed around continuity, accessibility, inclusion and collaboration.
- **Harnessing Disruption**: we should use technology, AI and digital innovation safely while protecting humanity and trust. We must harness AI, digital innovation and disruption safely and ethically and recognise the limitations in this technology.
- **Creating the Conditions for Health:** Reducing health inequalities through targeted and equitable action. We need to continue to focus on the social, economic and environmental determinants of health and collaborate with colleagues across professional boundaries. A wellbeing economy approach linking health, work, education and prosperity is fundamental to improving the health of our nation. Partnership working across healthcare, communities, schools and employers can help improve the health of those we serve.
- **Realistic Medicine:** careful and kind care, shared decision making, stewardship and value-based care can help us understand and deliver the outcomes that matter to those we serve.
- **Trust**: is the foundation of healthcare relationships, careful and kind care, and is key to building a sustainable system and maintaining public confidence.

I emphasise that prevention of ill health before it arises should be our preferred approach because:

- Primary prevention is estimated to be 3–4 times more cost-effective than treatment.
- Rising disease burden, population ageing and increasing complexity are creating unsustainable demand for health and care services.

- Without a stronger preventative approach, health spending will consume an increasing share of public expenditure, with effects for monies available for investment in education, housing, employment and other determinants of health.
- Prevention delays the onset of long-term conditions such as cardiovascular disease, cancer and diabetes.
- It increases uptake of vaccination, screening and early intervention and reduces exposure to major risk factors including smoking, obesity, alcohol and drug harms.
- Prevention narrows health inequalities and increases years lived in good health, with resultant societal benefit reducing economic inactivity and contribution to communities.

And I offer some recommendations for action:

- Prevention should prioritise tackling smoking, obesity, movement and inactivity and harmful alcohol use and we should together support healthy ageing over the life course to help people stay healthier for longer.
- We should continue to pursue value-based health and care through the practice of Realistic Medicine, shared decision-making and careful and kind care.
- Governments should invest in the social, economic and environmental determinants of health, including housing, education, fair work and income security. Inequalities should be tackled intentionally through proportionate universalism and resource allocation based on need.
- Build a whole-system approach to health involving communities, employers, education and public services and strengthen collaboration across government, local authorities, education, employers, communities and the third sector.
- Strengthen social connection, continuity of care and community-based support.
- Support our health and care workforce's wellbeing and create cultures that enable good work.
- Harness technology and AI responsibly with appropriate governance and safeguards.
- Pursue health equity and environmental sustainability together. Actions such as active travel, sustainable diets, reducing waste and prevention benefit both people and the planet.

I hope it is useful to the Committee for me to set out the ways in which I have sought to consider the broad challenges facing the health care system in Scotland, and therefore the logic that stands behind the advice that offer to Ministers and to the Parliament on particular matters. I will be happy to expand on these matters in questioning.

2. Inequalities experienced by women and girls and racialised health inequalities

I also wish to highlight to the Committee two elements of inequality in healthcare and in health outcomes that I plan to address in the report I will publish in 2027.

Women and girls

Women and girls are 51.4% of Scotland's population, but they face inequalities in their health, and in their healthcare.

The publication of the Women's Health Plan in August 2021 was a first, important step in a long term approach to address these inequalities. Since its publication, there have been noteworthy elements of progress:

- Professor Anna Glasier OBE was appointed as our Women's Health Champion.
- A Women's Health Information Platform has been established on NHS Inform.
- Steps have been taken to raise awareness of the symptoms and impacts of menopause and endometriosis, and there is wider availability of menopause specialists in the NHS.
- We have prioritised menopause and menstrual health education for those working in the NHS, and published a workplace policy for NHSScotland on these issues.

In January 2026 Phase Two of the Plan was published, with a renewed focus on prevention and early intervention, particularly focusing on optimising future health with new action on brain health, bone health and pelvic floor health. Phase Two also establishes the target of eliminating cervical cancer, by 2040.

Phase Two also commits the government to addressing the excessive waiting times women are currently experiencing in gynaecology.

Gynaecology is the only single sex speciality. In the 10 years between June 2016 and 2026, new outpatient waits increased by 164 per cent (the largest increase for any speciality) and inpatient waits by 264 per cent (the second largest for any speciality)[iv]. Gynaecology remains the speciality with the most in-patient waits per 100,000 of relevant population. Women are waiting too long while enduring often distressing and painful symptoms that can be difficult to manage or mitigate.

The government is tackling these long waits, urgently. In 2025/26, over £13 million was allocated specifically to reduce gynaecology waits. More action will be taken this year, focussed by the publication of a National Plan for Gynaecology. I strongly welcome this, because as well as action to reduce waits, we must implement changes to the ways that services are offered so that women can access the gynaecology care they need when and where they need it. I consider there is an important, positive opportunity to gradually move the specialty to become more community-based, with theatre time remaining important, but much less so than in the past.

The large increases in waiting times experienced in recent years were of course caused in the first place by the sudden and unprecedented shocks caused by the COVID-19 pandemic. I do wish however to consider published and emerging evidence about how effects have been felt more severely by women and girls, and how these short term effects might link to a longer term pattern of women's health needs and priorities being deprioritised, even if only unconsciously. I plan to explore this issue in the report that I will publish in 2027.

<u>Racialised health inequalities</u>

Racialised health inequalities persist in Scotland. Evidence from Scotland and the wider UK demonstrates that many minority ethnic communities, including Gypsy Traveller communities, experience inequities in access to and experience of healthcare, as well as adverse health

outcomes. The COVID-19 pandemic brought these inequalities into sharp focus, highlighting the disproportionate impact of pre-existing social, economic and health inequities on many minority ethnic population groups.

A growing body of evidence and insight, including analysis from Public Health Scotland and the NHS Race and Health Observatory, shows that racialised inequalities are present throughout healthcare pathways, affecting prevention, access, experience and outcomes across a range of services and conditions. In particular these have been documented in maternity care, mental health, cardiovascular disease and type 2 diabetes, cancer care, screening and vaccination programmes. Evidence increasingly demonstrates that structural racism is a significant determinant of these inequalities, operating alongside other social and economic drivers of poor health.

I plan to explore this issue, alongside multimorbidity, the benefits of co-ordination and continuity of care, and the role of physical activity and movement (and inequalities affecting women and girls, as noted above), in my 2027 report.

PROFESSOR SIR GREGOR SMITH
Chief Medical Officer
August 2026

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[i] Prepandemic inequalities in the burden of disease in Scotland due to multiple deprivation: a retrospective study

[ii] The burden of disease is calculated using the disability-adjusted life year (DALY). One DALY represents the loss of the equivalent of one year of full health. The website of the World Health Organization provides more detail.

[iii] Scottish Burden of Disease Study, Public Health Scotland, November 2022

[iv] Stage of Treatment Waiting Times - Datasets - Scottish Health and Social Care Open Data

Public Health Scotland

Helen McDade MSP
Convenor, Health, Care and Sport Committee
Scottish Parliament
Holyrood
Edinburgh, EH99 1SP

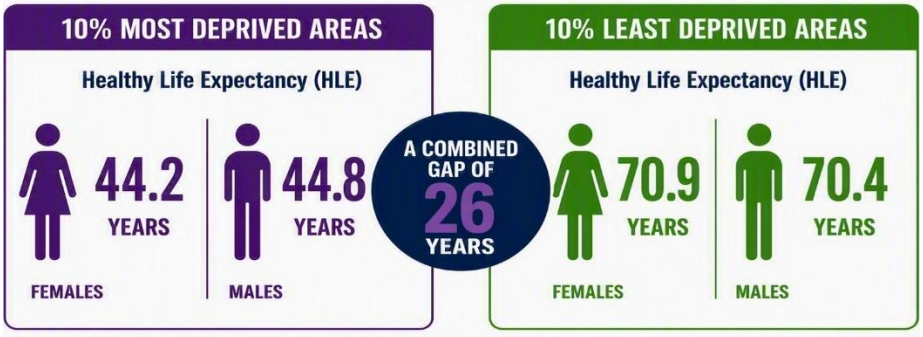
24 August 2026

Dear Ms McDade,

Public Health Scotland support for the Health, Care and Sport Committee

Thank you for inviting me to give evidence to the Health, Care and Sport Committee. I welcome the opportunity to discuss the challenges facing Scotland's health and care system and the role that Public Health Scotland (PHS), alongside partners across national and local government, can play in improving population health and reducing inequalities. This submission highlights some of the key issues that I would like to explore during the Committee session.

Scotland's health is improving too slowly. While life expectancy has begun to recover following a period of stagnation, healthy life expectancy continues to decline. As a result, many people are spending more years of their lives in poor health, with those living in our most deprived communities affected most significantly. The implications extend far beyond the health and care system. Poor health limits opportunities, reduces quality of life, increases demand for public services and places a growing constraint on Scotland's economic and social wellbeing.



These challenges are not unique to Scotland. Across the UK, healthy life expectancy has fallen over the last decade, and international comparisons show that the UK now performs poorly relative to many comparable countries. However, Scotland's longstanding and persistent inequalities mean that the consequences are often experienced more sharply in some communities than others.

It is increasingly clear that these challenges cannot be addressed by the health service alone. Health is shaped by a wide range of social, economic and environmental factors. Income, education, housing, communities, access to services and the places where people live all play a fundamental role in determining health outcomes. Tackling poor health and health inequalities therefore requires coordinated action across the whole of the public sector and beyond.

This means recognising that health is everybody's business. No single organisation can deliver the scale of change required in isolation. Lasting improvement will depend on strong leadership, effective partnership working and a collective focus on outcomes that matter to people and communities. It will also require organisations to place shared objectives ahead of organisational boundaries and interests, creating the conditions for a more joined-up and preventative approach to public service delivery.

Prevention could play a central role in delivering long-term improvements. Investing earlier to prevent ill health improves lives, reduces inequalities and helps moderate future demand on already stretched services. While the benefits of prevention are often realised over the medium to longer term, the evidence is clear that failure to invest in prevention carries significant human, social and economic costs.

The Scottish Government's Population Health Framework provides an important opportunity to align partners around a shared vision for improving health. It offers a route map for collective action, bringing together the organisations and sectors that influence health outcomes and creating greater clarity around priorities, outcomes and responsibilities. Realising its potential will require sustained commitment, clear accountability and a shared determination to act on the evidence available.

In this context, wider public service reform and the review of the National Performance Framework provide an opportunity to strengthen accountability for improving health and reducing inequalities. Alongside reform of services themselves, there is a need to ensure that progress towards better population health is measured, monitored and reported in a way that drives sustained action across the system.

PHS supports this agenda by providing the evidence, data and insight needed to inform decision-making. We work with partners across government, the NHS, local authorities and communities to understand what is driving poor health outcomes, identify where inequalities are greatest and support action where it can have the greatest impact. Our role is to help ensure that decisions are informed by the best available evidence and that progress can be tracked over time.

The scale of the challenge facing Scotland should not be underestimated. However, neither should the opportunity. By focusing on prevention, strengthening partnership working and maintaining a relentless focus on improving health and reducing inequalities, Scotland can create the conditions for healthier lives, stronger communities and more sustainable public services.

Yours sincerely

Paul Johnston, Chief Executive

Delivering a Scotland where everybody thrives

Public Health Scotland

Five key asks of the Scottish Parliament

The next five years are full of potential. The Parliament can champion an ambitious programme of change that will improve the health and wellbeing of people across Scotland.

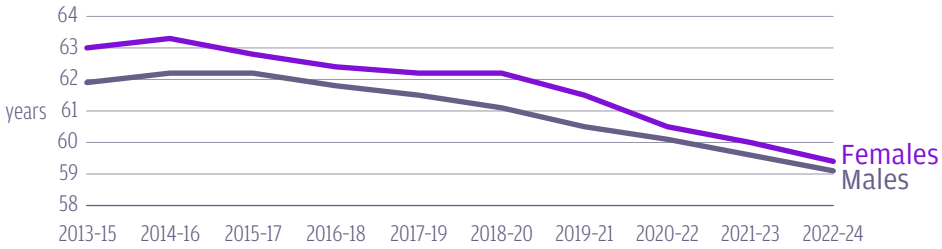
Public Health Scotland (PHS) recommends the following areas should be considered as national priorities:

- **Fully deliver the Population Health Framework (PHF)** to improve health and wellbeing and tackle inequality, as part of a new approach to shared national outcomes.
- **Make prevention central to the Scottish budget**, with all public bodies increasing and reporting spend.
- **Put whole-family support** at the heart of service redesign to cut poverty and economic inactivity.
- **Legislate for healthier food environments** and make healthy choices affordable.
- **Achieve a tobacco-free generation** and **reduce drugs and alcohol deaths** through a national approach.

The case for change: Scotland's health challenges

Healthy life expectancy trends in Scotland are in decline

Healthy life expectancy at birth, 2013-2015 to 2022-2024



Source: Healthy Life Expectancy, 2022-2024 - National Records of Scotland (NRS)

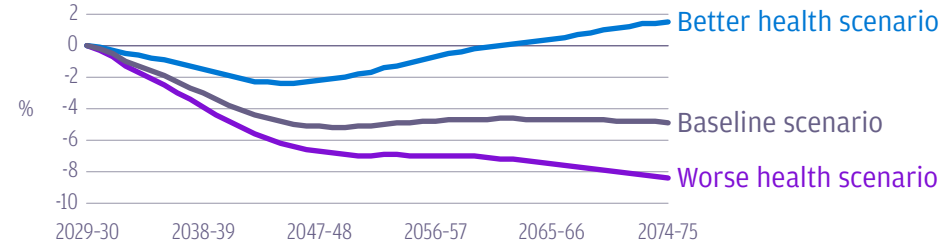
Life expectancy has started to improve after a period of stagnation. However, healthy life expectancy continues to fall.

People in our poorest communities spend around a third of their lives in ill health.

Health risks cost Scotland's economy billions every year...

...but bold public health action can make a difference.

Gap between devolved spending and funding



Source: Scottish Fiscal Commission, 2025

This graph shows that improving health now will save money later. Doing nothing will cost more and may become unaffordable.

Together we can…

Change the direction of Scotland's health

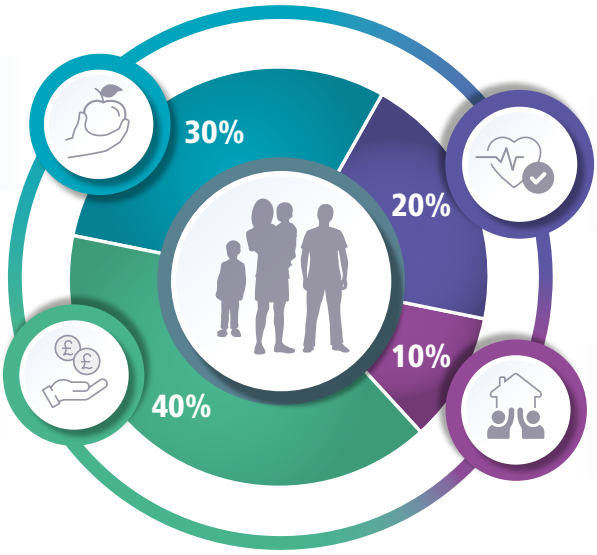
To improve health, tackle inequalities and reduce the demand on public services, we must fully implement Scotland's PHF. It is based on robust evidence, and was developed in partnership with the Scottish Government, the Convention of Scottish Local Authorities (COSLA) and the NHS. It sets out specific and system-wide actions that, if implemented, will deliver change.

Prioritise the building blocks of health

As the diagram shows, an individual's health is shaped by the social and economic conditions around them – the physical environment they live in, the opportunities available to lead a healthy life, and their ability to access timely and effective health and care services. Coordinated action across these areas, combined with a focus on preventing ill health, will improve population health, strengthen Scotland's economy and ensure that everybody can thrive.

Health behaviours which are driven by the availability and affordability of products like healthy food, alcohol and tobacco.

Social and economic factors, like family income, education and having nurturing relationships from birth.

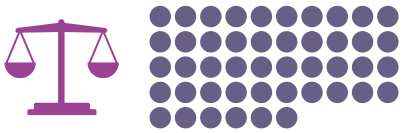


Health services and our ability to get timely access to quality care.

Places and communities which support us and allow us to access the activities and services we need.

Invest in prevention

For every £1 invested in prevention the public gets back:



£46 for legislation (e.g. smoking ban)

£34 for vaccines (e.g. COVID-19, flu)

£5 for improving healthcare (e.g. disease management)

Source: BMJ Journals | Return on investment of public health interventions: a systematic review

The role of PHS

PHS is an NHS board, sponsored by the Scottish Government and COSLA on behalf of local government.

PHS works to protect and improve health, and to inform decisions through our evidence, statistics, data and intelligence. We know existing evidence provides solid foundations for national reform – by acting now, collective action will bring positive change for Scotland's communities.

Scan the code to read the PHS 10-year strategy

To discuss further, email: **phs.chiefexecutive@phs.scot**

UNISON Scotland – Written Submission to Scottish Parliament Health, Care and Sport Committee – August 2026

Introduction

UNISON is the UK's largest health union. More than 60,000 UNISON members work in the NHS in Scotland: nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics, occupational therapists, cleaners, porters, catering staff, medical secretaries, clerical and admin staff and scientific and technical staff. UNISON cares passionately about the future of the NHS as a publicly funded service that is free at the point of delivery. We welcome the opportunity to contribute to the Scottish parliament's Health, Care and Sport Committee's evidence session.

Challenges within the NHS in Scotland

The COVID pandemic exposed fundamental staffing, structural and funding weaknesses in NHS Scotland. Despite numerous political relaunches and an NHS Recovery Plan which promised to drive our NHS beyond pre-pandemic levels of performance, public confidence is down, complaints are up and media outlets report multiple crises in our NHS. Here, as in other areas of the public sector, there are issues of underfunding. This is compounded by the NHS being the service of last resort. Cuts to addiction services, housing, education, public health, and policing create demand further down the line - in doctors' surgeries, Accident and Emergency (A&E) departments and hospital wards.

In turn, the NHS is dependent on other public bodies and agencies. UNISON has consistently accepted the need to reform our NHS but we can only do so if that reform is underpinned by high quality public services.

The inter relationship between social care, social work and primary care needs to be better recognised. Currently investment in public health, addiction, debt management, adult and children's mental health and carers' services is inconsistent. Often a service is cut for the benefit of balancing funds elsewhere. NHS staff and their colleagues in social work and social care are expected to do more with less resources and staff.

Significant challenges include:

- **Delayed discharge remains stubbornly high.** A major objective of integration between health and social care was to reduce delayed discharge ("bed blocking") and enable people to receive care closer to home. Delayed discharge remains a persistent problem across Scotland, with thousands of bed days lost every month because patients who are medically fit for discharge cannot leave hospital.

- **Long waiting lists despite productivity initiatives.** Reduced staffing levels throughout the 2010s correlate with lengthening waiting lists during this period and now with the Covid backlog these remain at a historic high. The NHS has pursued digital transformation, theatre productivity programmes, and service redesign to improve efficiency. Significant numbers of patients continue to wait beyond statutory targets for outpatient appointments, diagnostics and treatment. Efficiency improvements have often been outweighed by workforce pressures, demographic change and increasing demand.

- **Workforce pressures reducing efficiency gains.** Audit Scotland's 2025 report on NHS Scotland identified efficiency savings were being delivered. NHS Scotland continues to face recruitment challenges, sickness absence pressures and dependence on temporary staffing in some specialties and locations. Vacancy pressures can increase agency and locum costs, offsetting planned efficiency savings. Productivity improvements are difficult to achieve when services are struggling to maintain staffing levels and the current workforce is running on empty.

Delayed Discharge

The scandal of delayed discharge is a case in point to the major challenges currently facing the NHS. Almost 2,000 Scots who could be cared for in their own homes or wider social care, are stuck in an NHS bed, at a far greater net cost to the public purse. Delayed discharge directly impacts on patient flow, resulting in longer waits in Accident and Emergency or patients sitting for hours in ambulances in car parks or in corridor care. It is also accepted that delayed discharge is bad for patients' health. This highlights the necessity to change the current modelling assumptions which are used to resource our acute hospitals, current bed modelling assumes a maximum patient stay of three days, set in the context of an assumption that there will be continued improvements in health inequalities indicators.

Social Care

Social care is in crisis. The sector struggles to recruit and retain staff because

of low pay, insecure, unpredictable work and employers who prioritise cutting costs rather than the wellbeing of service users and staff.

UNISON is campaigning for sectoral bargaining for the contracted-out social care sector. We want social care services that value the workforce, provide fair work and fulfilling careers. We need parity of pay, pensions and terms and conditions and sectoral collective bargaining. It will be vital to:

- Deliver promises on sectoral collective bargaining for social care
- Plan the workforce we need for our rapidly growing elderly population and citizens living with long term/other conditions requiring care.
- We want an end to racism in the sector and the exploitation of migrant care workers.
- Create a visa sponsorship scheme for social care run by an independent body to help protect overseas staff from exploitation.
- Build a fully-integrated system of health and social care based on common principles, through insourcing and removal of profit from care.

We have seen the launch, and then abandonment, of a Bill to create what was called a National Care Service, but was nothing of the sort. UNISON is campaigning for a real National Care Service, that will kick profit out of care. A service that will be designed through a process of engagement with councils, unions, NHS, service users and their communities to design a bottom-up, grassroots review. It must be based around nationally agreed standards, employment conditions and resourcing, but delivered locally by councils and not-for-profit organisations working in partnership.

The National Care service we want should be based on the following principles:

- Social care should be fully funded, universal and free at the point of delivery
- For-profit providers should have no place delivering social care for children or adults
- Fair work, decent pay and improved status should be the norm for all care workers.

Those who work in care in the private and charitable sector:

- Should be paid based on NHS rates of pay
- Progress to equal pay in two years
- Four grades collectively bargained
- Sick pay, maternity, paternity pay for all workers

- No division on pay or conditions based on visa status
- Safeguards for displaced workers on visas

Prevention and Primary Care

There are many such revisions which are necessary, not least a greater emphasis on public health and community health. For example, better community mental health and addiction services would mean less crisis and less pressure on A&E departments. We need to invest in primary care to improve the health outcomes of citizens. However, evidence shows you can't turn-off funding for acute services and re-direct the resources to community services. We need NHS reform that recognises the demand for services and redirects resources to fit community need, not to balance the budget. Investing in primary care and community health is essential though it is wider and more complex than simply investing in GP practices.

A reimagined GP service could do much more, such as minor procedures: wart/mole removal, minor x-rays, arthritis treatment, knees, foot and hand injuries and rehab through physio and other similar services. Many GP services are nurse-led and that could be expanded. It would though require a fair work agreement to ensure that GP staff are on an equal footing with NHS workers.

Safe Staffing

Scotland's safe staffing legislation has failed to deliver. The **Health and Care (Staffing) (Scotland) Act 2019**, often called the **Safe Staffing Act**, was intended to improve patient safety by requiring health and care providers to ensure appropriate staffing levels. However, it essentially **created legal duties without fully addressing the workforce and funding challenges needed to meet those duties.** Several key problems have emerged in practice including:

- **Workforce shortages limit its effectiveness** - The legislation creates duties on NHS boards and care providers, but it does not create additional staff
- **Lack of enforcement "teeth"** - UNISON welcomed the right for staff to raise concerns but have criticised the Act for not providing strong enough sanctions when organisations fail to maintain safe staffing levels. Staff can escalate concerns, but there is no automatic mechanism requiring boards to provide additional resources or face significant penalties
- **Implementation challenges** - NHS boards have reported varying levels of preparedness, difficulties with reporting requirements, and challenges embedding new systems such as real-time staffing risk assessments and annual reporting processes
- **Administrative burden** - The Act requires extensive monitoring,

documentation, risk assessments, escalation procedures and reporting. Some organisations have expressed concerns that compliance can become bureaucratic and time-consuming, potentially diverting managerial and clinical time away from direct service delivery

- Awareness and training gaps - Many NHS staff were unaware of the legislation when it came into force, and a large majority had received little or no training on the new requirements. This risks undermining the effectiveness of staff reporting and escalation mechanisms
- Difficulty defining "appropriate staffing" - The Act requires "appropriate" staffing rather than setting fixed ratios. This allows flexibility, different interpretations and inconsistencies between services and health boards.
- Skill mix concerns - Meeting staffing numbers alone does not guarantee safe care. Staffing establishments may meet numerical requirements but lack the right mix of skills, experience or professional groups needed to meet safe staffing requirements.
- Social care sector pressures - Social care providers face longstanding recruitment and retention difficulties making compliance challenging in this sector

Workforce planning

UNISON has consistently accepted the need to reform our NHS, but this can only be done safely if underpinned by comprehensive workforce planning and by dealing with pay reform for NHS workers (as identified in the 2023/24 pay deal but still outstanding). We cannot simply keep expecting NHS workers to meet the challenges of an aging population with an outdated approach to reward and recognition. Like the rest of the workforce in Scotland, the NHS workforce is ageing, and this situation needs to be considered. Planned increases to the state retirement age and gender inequality in the pension scheme will all have an impact. We need to deal with pension inequality, reduce the age of retirement from the scheme, and build on retire and return.

UNISON and sister unions in the NHS have already identified a raft of measures that are necessary to support the reform of our NHS up to, and including, the disincentive for staff to take a promotion; excessively long pay scales and unequal incremental progression. We have also long argued that the following policies need to be updated and or introduced:

- High-cost area supplement (specifically for the north east)
- Update and expand the scope of the current distant islands allowance
- Subsistence for staff providing services in remote and rural communities
- Genuine commitment to a policy provision that facilitates staff to work longer in our NHS

- Recognition that whilst we have striven to agree exemplar employment policies the NHS is still physically, mentally and emotionally demanding. There needs to be a commitment to put these policies into place and genuinely make the NHS a better place to work.

Whist UNISON appreciates that the ongoing NHS reform discussion will undoubtedly impact on future workforce planning, we have been raising concerns for years over the accuracy, or indeed reality, of the current planning process. UNISON members in our NHS actively recognise the financial pressure in our NHS – they see it and live it everyday.

AI and technology in the NHS

A simplistic rigid distinction between 'frontline' and 'back-office' staff fails to understand how NHS services work and demeans the role of everyone who isn't always public facing. All staff enable the efficient running of services.

Currently automation and AI are usually discussed in terms of the removal of admin and clerical staff – with little thought as to the knock-on effect on the staff who are then left dealing with a machine. There is a role for automation and new technology. Staff struggle with outdated equipment and time-consuming processes. But automation and new technology cannot deliver the improved services that citizens need. Many still need to deal with a human and even the digitally-savvy have individual needs that cannot be met via algorithms.

UNISON understands the need to reform our NHS, but a far more sophisticated approach to AI is required. AI could be beneficial. Reading x-rays, mammograms and other diagnostic tests could significantly speed up results (particularly for non-emergency/urgent referrals). Use of these tools would release resources for more complex cases and improved direct patient care. Automated surgery (DaVinci) could be a welcome addition in respect of clinical efficiency and patient outcomes but requires significant up-front capital investment. We should introduce these new ways of working with a technology agreement that underpins a just transition.

With new technology now ever present we need a 'new technology agreement' to share and agree our understanding of the benefit for patients but also the impact on staff. That agreement should be underpinned by a renewed commitment and focus to ensure a just transition for those workers who will be adversely affected by AI. That commitment and resourcing should extend beyond transition within the health economy. A career transition agreement that provides genuine opportunities for those workers who are adversely affected by reform to retrain (either in full-time education or earn as you learn) so staff not only stay within the NHS but move into

posts and professions where there is a skills deficit, as the NHS reforms.

Paramedics and the Scottish Ambulance Service

Corridor care has been pushed into car parks as paramedics and A&E staff increasingly treat patients in ambulances stacked outside hospitals, because wards are full. UNISON research highlights that NHS staff find it distressing that patients can be stuck for long periods in the back of ambulances – often for hours. Paramedics want to be out answering calls, helping people with emergencies.

Over 126,000 ambulances waited over an hour outside Scottish hospitals in 2025, and over 9,000 were sat there for four hours or more. The waits severely compromise the quality of care, placing vulnerable patients in unsafe and undignified situations. Ambulance staff work around the clock to save patients' lives, but the incessant pressure is taking its toll on them too. Not getting a proper break on a 12-hour shift, or knowing when your shift ends, has led to high levels of stress. As the state retirement age rises, these pressures are contributing to higher sickness absence among paramedics. They deserve parity with workers in other blue light services, such as police officers and fire fighters who can retire at 55 or 60. UNSON wants a maximum one-hour limit on ambulance wait times, guaranteed rest-breaks, and a meaningful early-retirement option for staff.

Centralisation of services

An approach that will contribute little to improving our NHS is one based on centralising services. Reform that is simply about merging organisations / special boards or re-drawing boundaries does nothing to address real issues. Before any such changes could be seen as worthwhile, a comprehensive case has to be made that puts patient care at the centre of service design.

Almost 17% of Scots live and work in a rural land mass. For them, public services and the NHS are very different. The Scottish government's National Centre for Remote and Rural Healthcare is a welcome structural initiative. However, to date, it has failed to resolve many of the key challenges that NHS workers and communities experience in rural areas and the islands.

Too often, service redesigns are simply a headline for closure, forcing local citizens to travel further and further afield for healthcare. It's not just high-level clinical posts that can be hard to fill, health boards have experienced challenges recruiting and retaining catering workers, estates and maintenance and healthcare workers.

The NHS Workforce Experience

In February 2026, UNISON conducted a survey of members asking them their views on the issues impacting them most at work over the last 12 months. Responses were received from staff from all occupational groups working across all Scottish health boards and the Scottish Ambulance Service. The survey results paint a picture of a workforce under significant strain. Workloads, staff shortages, and the physical condition of workplaces are key issues. Stress levels remain extremely high, with limited access to support. Experiences of violence and harassment continue to be widespread, and employer responses often fall short. From the viewpoint of staff, patient care is impacted across multiple areas. Key findings included:

Workforce Pressures

- Jobs at risk: 12% feel their own job is at risk; 21% say colleagues are at risk.
- Vacancy freezes: Reported by 36% of staff.

When asked the how vacancy freezes are impacting staff and their service. Respondents reported they experienced the following:

- 68% say their workload has increased,
- 70% feel more stressed because of staffing issues.
- 70 % report feeling more stressed.
- 22% report they are doing tasks not trained for:
- 45% report Patients receiving worse service:
- Nearly half of staff reported feeling insufficient staff to do their job properly.

Stress, Mental Health & Impact on Wellbeing

- Workplace stress extremely high: 82% report to have experienced workplace stress in last 12 months.
- When asked if any of the following factors caused work-related stress, staff identified key factors as:
    - High workloads – 60%
    - Unsafe staffing – 40%
    - Bullying – 31%
    - poor workplace conditions 36%

When asked in the past 12 months, if staff had taken time off work for reasons related to their mental health:

- 31% took time off for mental health.
- 64% felt pressured to come to work while mentally unwell.

- **27%** have received support such as counselling or been prescribed medication to help cope with work-related stress.

Working Hours & Workload

- **46%** work beyond paid hours.
- **45%** do unpaid hours (up to 5 hours most common).
- **Unrealistic time pressures:** 38% experience this often or always.
- **47%** say their workload is *often* or *always* too high.

Violence at Work

- **22%** report personally experienced violence at work in the past year and **Over 1 in 3** experienced it more than five times.
- **Common forms that staff report to have experienced:**
  - Verbal abuse – 90%
  - Threats – 48%
- **32%** felt completely unsupported by employer following incident.
- **51%** say no effective action was taken to prevent recurrence.

Workplace Conditions & Estate Issues

Staff reported experiencing significant issues over the last 12 months:

- Buckets catching leaks – **48%.**
- Out-of-service staff toilets – **23%**
- Broken equipment – **35%**
- Asbestos – **5%**
- RAAC – **2%**

31% of staff report being aware of closures of rooms/wards/buildings due to safety issues.

- **18%** do not always have access to clean toilets.
- **23%** lack access to a break space.
- **47%** lack access to affordable healthy food.
- **55%** say there are not enough staff parking spaces.

Ambulance Staff

Ambulance staff have reported severe service pressures.

- **Queueing outside A&E:** 84% have had to wait when queueing to hand over patients in ambulance.
- **Care delivered in queues:** 48% have had to deliver care while waiting to hand patients almost every shift.
- **Delays harming patients:** 76% of staff reported patients deteriorated in care because of delays being handed over at hospital.

- **94%** of staff reported they missed breaks due to delays.

International Workforce

Staff who have been internationally recruited told us:

- **44%** work below qualification level.
- **68%** say employer has not supported them around immigration rule changes.

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Morale & Overall Climate

- **54%** rate morale among colleagues as low or very low.
- **55%** say workplace conditions have *stayed the same*, and **31%** say they have *got worse* in the past year.

The findings show a system under intense strain, where **unsafe staffing levels, deteriorating workplace conditions, high stress, and rising violence** are impacting both staff wellbeing and patient care. Support for staff is inconsistent and often absent. Workforce morale is low, and many indicators suggest pressure is increasing rather than stabilizing

Public Sector Reform

The period since the banking crash in 2008, and the onset of austerity in 2010, has seen continuous public service reform by public sector organisations pressured to 'work smarter', do 'more with less', and cut costs though digitisation, automation, outsourcing, restructuring, estate rationalisation, centralisation and shared services in response to cuts to public sector budgets.

Centralisation and outsourcing of services in health and local government has resulted in greater barriers to access, loss of local control and accountability and less transparency.

In rural areas and the islands, centralisation of services has caused serious barriers to access and has driven inequality, with significant adverse impacts on people's lives, on population retention and community sustainability. Centralisation directly undermines government aims to devolve control and empower local communities.

The £1.7 billion of 'efficiency savings' set out in the Scottish Spending Review are over and above the cuts public bodies already face to balance their budgets annually in the face of growing demand for services. There are already unprecedented levels of unmet need for services. These savings will not be reinvested – to do so would nullify the main goal of averting a national budget deficit in the face of growing demand.

Any further spending cuts will be catastrophic for the NHS and public services:

- Half of Scotland's health boards require government loans to avert financial collapse. A number have recently been or are currently under supervision by government due to financial deficits, while others are close to being in this situation. The KPMG business case and recommendations for NHS Grampian have grave implications for service provision. This is the context for the additional demand for 3% annual recurring savings against baseline budgets.

- In the Scottish Spending Review (SSR) 2026, the Health & Social Care portfolio shoulders a disproportionate share of 'efficiency savings', 60% of the total savings (68% in Year 1) mainly through the requirement for 3% annual recurring savings. Beyond 'service reform actions' there is no detail in the SSR on the nature of the 'efficiencies' or the 'productivity' gains intended to achieve this, with the scale and timing of savings 'to be determined', however the government is driving ahead with its centralization agenda of sub national planning and shared services in the NHS based on little or no attention to the evidence or consideration of the impacts.

- The spending review indicates a significant shift of budget from acute care and the ambulance service towards primary and social care . The IFS considers that if NHS boards are unable to meet these very ambitious 3% recurring savings targets, then "Without big improvements in efficiency, hospital and ambulance performance would start deteriorating again unless other savings targets, cut back to bolster core NHS funding."

But what is currently proposed is not workforce planning to meet this need and a plan to resource it. Instead, it's a plan to allow existing and future demand to go unmet, while cutting headcount by a further 20,000. Cutting more public sector jobs will exacerbate current problems. Rising demand due to demographic change and the COVID19 pandemic have necessitated higher staffing levels in the NHS and local government. In addition, ending the use of expensive agency staff in the NHS involved recruiting permanent staff, again increasing headcount.

Almost two thirds of the 'efficiency savings' in the SSR period fall on the Health & Social Care portfolio and 68% of the total in Year 1, mainly through the requirement for 3% annual recurring savings. Beyond 'service reform actions' there is no detail on the nature of these 'efficiencies' or the 'productivity' gains intended to achieve this, only that the scale and timing of savings 'to be determined', but the implication is that workforce reductions will form part of this.

It is important that efficiencies available from AI use are about improving services and not just cutting costs. It is an error to think the workforce in corporate services

like HR, IT, finance and procurement do not need local knowledge or relationships or that generic 'one size fits all' solutions can deliver the same. AI should not be used to replace human judgement. There is, unfortunately, a long history of problems in the public sector associated with technology-led top-down solutions disconnected from local service needs and knowledge. There are also known risks for the public sector in applying AI solutions particularly when the development of governance and ethics frameworks lag behind.

But the government is forging ahead with large scale top-down change in the NHS through sub national planning and shared services with the main aim of workforce reduction, and based on little or no consultation, effective governance structures, evidence or planning or attention to the impact on need and demand for services.

NHS staffing levels need to be assessed at an individual service level, the evidence bears out the experience of staff, that NHS staffing levels have not kept pace with changing demand. Detailed IPPR analysis shows that staffing restraint after 2010 and the onset of austerity led to the growth in NHS waiting lists and ultimately the post-pandemic backlog. Even during the pandemic when staffing increased, NHS staffing adjusted for demography was still only 4% above the pre-austerity level and with the recent very modest staffing increase, the IPPR's view is that "it is far from obvious" whether current staffing levels are sufficient to clear the backlog and tackle the rising challenges of demand. UNISON's NHS members can say definitively that it is not possible.

Frontline v Back Office? – The NHS is One Team

There is no current clarity about this from the Scottish government. The PSR strategy does not provide any definition of 'frontline' roles, but we reject in any case the false 'frontline'/'back-office' distinction. There is one team in NHS delivery. All parts of the workforce, and all functions, are essential for the efficient delivery of services and all reforms must begin from an informed, holistic understanding of how services work and the contribution of different roles.

Corporate functions essential to the functioning of services are particularly at risk of being designated 'back office'. Past reforms involving centralisation or shared services based on this type of false premise, at various levels within the public sector, show this is often a false economy. But the government's claim is that there is wasteful duplication in public services.

The public can see services falling apart: patients being treated in corridors, drastic ambulance wait times, community policing absent, enormous waiting lists for medical care and community mental health care, social care rationed, while the shift

to digital is exacerbating exclusion and preventing citizens from accessing their rights and more charges for services are introduced and raised. Public dissatisfaction with public services has risen steeply. NHS workers in Scotland are struggling to see where exactly there is left to cut– they have seen services eroded over time. They know it is their goodwill and dedication that keeps the NHS, social care and other services functioning.

Integration Authorities (IJBs & HSCPs)

Integration Joint Boards, responsible for social care and community health, have a combined budget gap of £449m. They are unable to meet current, let alone the rising future demand for care, given Scotland's growing demographic challenges.

- Social care is chronically underfunded and inadequate to meet current need, with statutory duties unmet. It is the single greatest source of pressure on IJB budgets now and demand is set to grow for the next two decades.

- 6,600 people were waiting on a social care assessment (July 2026) while 3,000 had been assessed but were waiting on a package.

Audit Scotland says vacancy control/understaffing is how the majority of IJBs were able to report a budget surplus.

Conclusion

In UNISON's view, there has been a real failure to properly listen and learn from the experiences of NHS Scotland staff.

In early 2025 in a speech on NHS reform, Scottish First Minister John Swinney told NHS staff that "more laps of the track" would be expected to fix Scotland's health service. The comment was made in a renewal framework speech aimed at tackling high waiting times and delayed discharges, where he warned that despite the hard work of staff, further reform and effort were necessary.

Audit Scotland indicates that NHS Scotland is under severe, unsustainable pressure due to rising demand, workforce shortages, and complex mental health service issues. Despite increased funding and staffing, high vacancies, pandemic backlogs, and delayed discharges, costing £440m annually, are causing immense strain on staff wellbeing. The Covid inquiry into the impact of the pandemic on the UK's healthcare systems recently highlighted the "almost superhuman efforts" of NHS staff despite the significant and long-lasting impact on their mental health and wellbeing. Such high levels of stress in the NHS should be ringing alarm bells. Staff

who care for others are being pushed to the point that they're becoming unwell themselves.

We need urgent action in this next Scottish parliament on workforce planning, investment and safe staffing levels

- End corridor care and make reporting of care in non-standard areas mandatory
- Invest in workforce planning and a modern reward and recognition package
- Fair work commitment for GP and community-based staff delivering NHS services
- New technology and just transition agreement for the NHS
- Realistic bed modelling and resource allocation underpinned by a fair transition agreement
- The NHS workforce should be developed through greater investment in education, training and staff development, alongside building capacity from within existing staff and academic structures.

Scotland

BMA Scotland: Priorities

Introduction

BMA Scotland has consistently warned that the founding principle of the NHS, that it should be free at the point of use, is at risk. Scotland's doctors are delivering the best possible care they can to patients the length and breadth of the country. But they are finding, that far too often, in their GP surgeries, hospitals and local communities, it is them and their colleagues who are holding together an NHS which is crumbling around them. Without urgent action, Scotland will be a country where only those who can afford it will be able to access timely healthcare, while those less financially fortunate will be left languishing on waiting lists that are simply far too long.

We need politicians to urgently deliver serious long-term and radical reform that finally puts the NHS on a sustainable footing for generations to come with free at the point of need remaining a central principle. There is an obligation on our leaders to do so in a way that builds consensus and brings us all together in our shared desire to protect and improve the NHS.

This paper outlines BMA Scotland priorities for NHS Scotland on:

- **Health service delivery**
  - Shifting the balance of care
  - Assessing how our NHS is performing
  - Development of a comprehensive long-term workforce plan
  - Ending doctor substitution
  - Vastly improve IT infrastructure
  - An NHS that is sustainably funded to meet population needs
- **Wellbeing and culture**
  - Embedding doctors' wellbeing in Scotland's NHS
  - Embedding a learning culture in Scotland's NHS, where whistleblowers are effectively supported
- **Public health**

Health service delivery

Shifting the balance of care

High quality, high performing healthcare systems are underpinned by a thriving primary care sector, and specifically a well-resourced and well-staffed general practice. General Practice is the main point of contact for patients in Scotland and is how we typically access the NHS. They provide continuity of care, keep patients who they know well healthier for longer and manage multiple morbidities, but the proportion of health budget provided to GPs has been shrinking, with the focus remaining on hospitals and acute care. As Audit Scotland has pointed out, GPs "manage complex care in the community, preventing unnecessary admissions to hospital. This makes an effective general practice good value for money"[1].

The £250m 3-year funding deal concluded with the BMA last year[2] provides some stability for general practice and has at last begun the process of reversing historical underfunding. It will enable practices to recruit more GPs and do more for their patients, but this must just be the start. With the proportion of the health budget provided to general practice having slipped to 6.7%, political choices must see this return to 11% by the end of the next Parliament and 15% in the Parliament after. There is no shortage of evidence of the transformative benefits such investment delivers – as the recent successful investment in identifying and managing individuals at risk of cardiovascular disease through proactive screening, risk assessment and early intervention in primary care proves. Yet in Scotland we are at the very early stages of what may be possible.

This change must be carefully managed. Secondary care provided in our hospitals is already at breaking point and the provision of safe care under threat. Simply moving resources out of the acute sector will undermine the benefits of investing elsewhere. ***BMA Scotland has called for a clear, detailed plan on shifting the balance of care to better support GPs and care closer to home while maintaining and supporting secondary care as the transition takes place and beyond.***

Assessing how our NHS is performing

It is vital that Scotland uses comprehensive data to understand how key public services are performing. The NHS is no exception. The only way to deliver improvements or seek assurances that care is safe is to accurately measure performance and then carefully assess the results in the round to target investment to support sustainable improvement.

The issue with NHS measurement in its current form is that it too often relies on arbitrary, politically set and motivated targets to deliver stark verdicts on success and failure. This often says little about the outcomes of patients or how safe services are, which should be central to how we judge the care being provided.

We should ask what we want the NHS to achieve and then set out a system of measurement that flows from those overall aims. All measurements that we use to judge progress and target improvements should be based on four key principles:

[1] General Practice: Progress since the 2018 General Medical Services Contract
[2] Deal to end dispute over funding restoration accepted by BMA Scotland GP committee

1. Is this a realistic proposal and are the resources – both staffing and financial – in place long-term to ensure it can be achieved?
2. Is the proposal evidence-based and does it provide insight on the quality of care delivered, or patient safety and outcomes for patients?
3. Have health and social care staff been involved in developing the measurement proposal and does it allow for considered clinical input to ensure judgement of doctors is valued and relevant?
4. Does a particular measurement recognise a whole system approach – and acknowledge the potential impact on other parts of the NHS and care system across Scotland?

We need a refreshed and renewed focus on how we measure the performance of Scotland's NHS, informed by wide engagement across the public and professions who work in the NHS, which ultimately puts patient outcomes at its heart and focuses on learning and improvement rather than apportioning blame.

In areas where evidence backs up a specific measurement, for example in terms of early diagnosis of and treatment of cancer, or the fact that long A&E waits lead to substantially worse outcomes for patients, then measurement should be used to drive improvements. Equally no measurement should be seen in isolation. For example, we know A&E waits are often the symptom or warning light of pressures elsewhere in the system, so should be viewed alongside measurements such as delayed discharge or how social care is performing.

Development of a comprehensive long-term workforce plan

There is no long-term, evidence-based plan on how Scotland will make sure it has the workforce required to deliver care for the people of Scotland for generations to come.

While the Scottish Government has taken recent tentative steps to engage the medical workforce, a consistent lack of planning means that the Scottish population doesn't have the doctors it needs. This means the country faces high consultant vacancy rates[3] as well as the counterintuitive and disgraceful position of underemployed GPs and resident doctors unable to secure specialty training places and facing unemployment[4]. These are the most obvious symptoms of the complete lack of workforce planning that has held back the NHS for far too long.

Workforce planning is a complex and rolling process and of course will require forecasting of population health, demographic need and geographical placement across Scotland mapped alongside medical career paths and how doctors can progress through them effectively. Ultimately, it needs to ensure doctors at all stages of their careers and across all geographies and specialties are at the heart of an NHS that is sustainable in the long-term. This will potentially require difficult conversations on the scale of demand, but the reality is that without effective workforce planning we will continue to see the ongoing deterioration of services, lengthening waiting lists and the increasing reliance on the private sector BMA Scotland has warned about. ***Scotland needs to see a commitment to delivering a coherent,***

[3] BMA Scotland warns workforce plans must not ignore true extent of consultant vacancies - BMA media centre - BMA

[4] 'The future feels quite bleak': Survey reveals unemployment concerns of resident doctors

long term workforce plan for the NHS in Scotland to address the escalating pressures across the medical profession.

Ending doctor substitution

BMA Scotland has consistently voiced concerns on the role of Physician Associates and Anaesthesia Associates (PAs/AAs) in Scotland's NHS and how they are used. These centre on a lack of consistency around scope of practice, the confusion that surrounds job titles, the fact these roles create additional competition for training opportunities for resident doctors as well as additional workload with doctors being asked to supervise their work.

There is a real concern that AAs/PAs will simply be used as a quick fix for the massive issues faced because of failures in medical workforce planning. Investing in additional training places for resident doctors is patently a more sustainable and safer solution than introducing substitutes for them.

Similar concerns prompted a full review in England produced by Prof Gillian Leng[5]. Key elements of the review's findings included a change in titles of these roles to reduce confusion and that they should not be seeing undifferentiated patients. ***BMA Scotland has called to immediately accept the recommendations in the Leng review and confirm they would implement both of these key elements.***

There is the opportunity in Scotland to go further and not rely on local employers to decide what is safe for these roles, and what isn't. ***BMA Scotland has asked the Scottish Government to immediately commit to introducing a nationally set scope of practice for these roles.*** The associated clarity that would deliver will protect patients and supervising clinicians, but it will also help those performing those roles, giving them the confidence they are acting within their competence and training. The BMA's safe scope of practice guidance[6] is available to help with this, and we will continue to advocate for adoption of these parameters.

Vastly improved IT infrastructure

The outdated IT systems that are still being used across both primary and secondary care in Scotland's NHS are simply no longer fit for purpose. A great deal of discussion on the future of the NHS involves the use of Artificial Intelligence (AI). While AI does have the potential to have a role in the way healthcare is delivered, we need to focus on getting the basics right first, such as an IT system that can communicate across the whole of NHS Scotland. There is no doubt that digital innovation offers huge potential to improve access across health and social care and streamline services, but it requires substantial investment and a drive to see it through long-term. There remains much to do, and areas where improvements have been far too slow in coming, such as digital prescribing***. There needs to be sufficient investment in an IT improvement plan for the whole of Scotland's NHS.***

[5] Independent review of the physician associate and anaesthesia associate roles: final report - GOV.UK
[6] BMA sets out first national guidance for the role and responsibilities of physician associates in major intervention for patient safety - BMA media centre - BMA

An NHS that is sustainably funded to meet population needs

Many organisations and experts in Scotland have warned that the NHS is not financially sustainable in its current form – and BMA Scotland agrees. Much debate on the NHS focuses on funding and Audit Scotland again this year warned that "even with increased funding, the NHS in Scotland is not in a financially sustainable position".[7]

Last year seven territorial health boards required Government loans to break even – with cumulative brokerage or loans standing at some half a billion pounds.[8] This cannot continue in the long term. It is why BMA Scotland consistently called for a national conversation on the NHS and what, as a society, we want it to deliver now and in the future. Despite promises, what was delivered was not an honest and open conversation and the time has now come to move on and deliver urgent reforms.

There must be confidence that the funding and resources provided to the NHS is sufficient to meet demand now and the demand we forecast in the future, based on what we ask the NHS to deliver for patients. ***BMA Scotland has asked not just for commitment to more funding, but for clear plans on how their commitments on NHS resourcing will deliver a sustainable NHS Scotland in the long term.***

Wellbeing and culture

Doctors and their colleagues have consistently highlight that working in Scotland's NHS negatively impacts their health. In recent BMA surveys two-thirds of consultants said that their work is harming their wellbeing[9], half of GPs said they are struggling to cope and that work is having a negative effect on their physical and mental wellbeing[10] and some 86% of resident doctors said they were dissatisfied with their career trajectory. Virtually all anecdotal evidence in this area suggests that morale amongst the medical profession has been low for some time and is getting worse. The culture in the NHS means doctors still do not feel listened to, or that they can raise concerns without fear of repercussion. ***Action needs to be taken to ensure Scotland's NHS is transformed as a place to work to a place where wellbeing is prioritised and doctors are not just listened to, but their concerns acted on effectively leading to service improvements for patients***

Embedding doctors' wellbeing in Scotland's NHS

Doctor wellbeing must be intrinsically linked to improving the NHS by adopting measures for Scotland to build an NHS that performs better, is able to meet patients' needs and relies less on doctors and their colleagues working to the point of burnout and jeopardising their own wellbeing. An easing of pressure on all services will mitigate some of the more damaging impacts on doctor wellbeing, such as managing fatigue, of working in Scotland's NHS. However, there are also core and long called for measures that will reduce risk to doctors and patients and show staff they are valued.

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[7] NHS in Scotland 2025: Finance and performance | Audit Scotland
[8] NHS in Scotland 2025: Finance and performance | Audit Scotland
[9] The Workforce Specialist Service (WSS) - National Wellbeing Hub
[10] Doctors' leaders warn government many GP practices in Scotland are 'on the brink' - BMA media centre - BMA

Doctors' wellbeing can be improved by implementing simple steps characteristic of a supportive employer such as; ensuring doctors are able to take scheduled breaks in high-quality rest facilities, predictable rotas delivered on time, embedding safe working levels across primary and secondary care and supporting protected learning time – in particular for career development, to name just a small number of examples

Given the challenges of working in medicine, even with these measures, and a better performing NHS, doctors are still likely to require access to evidence-based wellbeing support. A key example is the Workforce Specialist Service (WSS).[11] A BMA policy from 2021, this service must be protected to go on delivering specialist care for doctors and their colleagues, and all NHS boards should ensure they have well-functioning and embedded wellbeing support services which staff are able to access easily

Embedding a learning culture in Scotland's NHS, where whistleblowers are effectively supported

It is shameful that in Scotland's NHS, evidence suggests some doctors continue to feel they cannot speak up on behalf of patients without suffering personal consequences – despite all the apparent reassurances to the contrary[12]. There needs to be urgent action to better support whistleblowers to come forward, particularly younger and non-white doctors who raise concerns. NHS boards, with the clear support and backing of the Scottish Government, must do more to implement whistleblowing procedures which guarantee anonymity and protection for anyone speaking up and they must encourage reporting without fear of retaliation. We also need to see a shift in the NHS to a culture which is based on feedback and learning, not blame and finger pointing. Such a change needs to start at the very top and the new Scottish Government must focus on fostering a culture which prioritises patient safety and staff wellbeing instead of simply trying to do everything possible to manage its own reputation and that of health boards.

In light of recent issues where whistleblowers have not been listened to there is an urgent need for independent assessment of whistleblowing procedures at all NHS boards with recommendations for improvement, both for specific boards and across the NHS.

Public Health

Scotland will only make substantial progress if this is coupled with robust, focussed and evidence-based measures to improve the overall health of the population and the public's health literacy, enabling people to live longer, healthier lives and understand the best ways to interact with and use health services.

A concerted and strategic attempt must be made by the Scottish Government to end the scandal of health inequalities and people's life expectancy being determined by their postcode and its relative level of deprivation[13]. This will bring the added benefit of tackling

[11] The Workforce Specialist Service (WSS) - National Wellbeing Hub
[12] Bullied and blacklisted: New research reveals shocking experiences of doctor whistleblowers in Scotland - BMA media centre - BMA
[13] Long-term monitoring of health inequalities in Scotland by area deprivation - Long-term monitoring of health inequalities in Scotland by area deprivation - Publications - Public Health Scotland

the burden that poor population health places on the NHS. ***Improving the NHS and improving our nation's health must be seen as joint, mutually beneficial aims and policymakers must acknowledge this and place it at the heart of their planning for the future.***

The Scottish Government's Population Health Framework[14] must not be allowed to become a project paper that sits on a shelf. It should be used to reshape, in conjunction with doctors, health and social care staff and patients, how we make sure all people living in Scotland have the right and easily accessible opportunities to live healthier lives. ***Healthy choices must be easy choices and accessible for all. Ending the deep-rooted scandal that health inequalities present must be a priority for all politicians.***

A key step towards tackling health inequalities would be to place health as a determining factor for all policy making to ensure we prioritise the health of the nation. ***Health impacts all policy making, and many policies equally impact on population health. Health impact assessment reports should be a mandatory consideration for all areas of policy making and any new legislation in the Scottish Parliament.***

Demand for access to mental health services continues to rise leading to long waits and the workforce delivering this vital care feeling exceptional pressure. These long waiting times often lead to pressures being displaced onto GPs who struggle to have the capacity and time to support this growing group of patients in the way they deserve. ***A renewed and refreshed mental health strategy is required, based on effective funding and workforce planning alongside carefully planned and focussed awareness raising campaigns.***

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[14] Scotland's Population Health Framework - gov.scot

RCN Scotland views on the key health and care issues and our current priorities

Please find below a brief overview of what we consider to be key issues in health and care and information on our work in these areas.

The nursing workforce crisis amid rising demand

The issue:

- At no point has the NHS in Scotland employed the number of nursing staff it says it needs. NHS nursing vacancies remain stubbornly high, with over 2,500 posts unfilled, and care homes reporting significant retention and recruitment challenges.
- There is a major problem with retention, and the proportion of early and middle career nurses leaving the profession has increased markedly. Over 3,000 registered nurses left NHS Scotland in each of the last two years, and those leaving aged 20-49 account for more than half of all NHS nurse leavers.[i]
- Meanwhile, over the last four years thousands fewer students have begun nursing degrees than were originally planned in the targets set by Scottish government.
- Working time lost due to sickness absence among nursing staff continues to increase in many NHS boards. At 8.3% from April to December 2025, the nursing sickness absence rate was more than double the NHS Scotland absence target (4%).[ii] This is a vicious cycle as high sickness absence puts further pressure on staff, negatively impacting patient care and staff wellbeing.
- Meanwhile, use of agency and bank nursing and midwifery staff in 2025-26 cost £425m, an increase of £15m in a year. When bank nursing and midwifery is combined with agency use, the equivalent of 7,320 WTE were used in NHS Scotland in 2025-26.[iii] The WTE figure for bank and agency use across Scotland is bigger than the permanent workforce in most boards; it's equivalent to the nursing workforce of an extra medium sized health board.
- A key challenge is that the system is in such a precarious position, unable to adequately meet current health and care needs, against a backdrop of increasing need. At the same time as the population ages, the burden of disease is increasing and healthy life expectancy is reducing in Scotland, increasing demands on already struggling services.

Our work on this issue:

- Each year we publish **The Nursing Workforce in Scotland report** which sets out the bigger picture around the national workforce statistics and includes analysis of the trends in the numbers of nursing staff in the health and social care workforce across Scotland.

- In 2023 the Scottish Government recognised the pressing need to address the nursing retention and recruitment crisis and established the **Nursing and Midwifery Taskforce**. Key stakeholders, including RCN Scotland, spent over two years listening to frontline staff and developing a comprehensive set of recommendations to improve retention, culture and staff wellbeing and to attract new nurses. The Taskforce did its job, yet almost two years later implementation has barely gotten underway, and the Taskforce is yet to make any meaningful difference to nursing staff. The Scottish government has a comprehensive set of well-considered solutions at its fingertips; we are calling on Ministers to prioritise delivery and would like to see a clear commitment in the Programme for Government. We ask that the Committee considers scrutiny of the Taskforce implementation when considering its programme of work.

- **Career progression** for nursing roles has been falling behind when compared to midwives and Allied Health Profession (AHP) staff. Band 5 staff make up the largest proportion of the nursing workforce (40%). By comparison, only 10% of midwives and 14% of AHPs are paid at band 5, despite starting their careers at the same pay band as registered nurses. Nursing deserves a career structure that supports clear progression, and we welcome the SNP manifesto commitment to improve pathways to progression from band 5 to band 6 for nurses. Whilst pay is only one element of the complex web which runs through the recruitment and retention crisis, we strongly believe that providing career progression, and parity with other healthcare professions, will attract more people into the nursing profession.

Staffing for safe and effective care

The issue:

- Despite Scotland's safe staffing legislation (the Health and Care (Staffing) Act 2019) coming into force in 2024, nursing shortages continue to have a damaging impact, with many nurses caring for unsafe numbers of patients, in turn causing overwhelming pressure and burnout.

- In a recent survey asking RCN Scotland members about their last shift at work:[iv]

    - 25% said staffing levels were well below what was needed and described them as unsafe with care significantly compromised and a high risk of harm to patients. A further 47% said they were below what was needed, with risk managed but some compromises to care and pressure on staff.

    - Over half of nursing staff (51%) felt that care was compromised during their last shift.

    - 76% of nursing staff report regularly needing to make difficult decisions about prioritising care due to limited time and resources

- We have significant concerns that the nursing workforce planning tools, mandated for use in the Health and Care (Staffing) Act, are not fit for purpose and underestimate the nursing staffing establishment needed.

Our work on this issue:

- The evidence couldn't be clearer. When there are enough nursing staff, with the right skills, in any care setting, patients are safer. An increase in a registered nurses' workload by one patient increases the likelihood of an inpatient dying by 7%.[v] We are campaigning for the introduction of **mandatory minimum registered nurse-to-patient ratios** for all health and care settings, to protect patients and staff from harm caused by low registered nurse staffing levels.

- We would also like to see the Committee undertake some **post-legislative scrutiny on the impact of the Health and Care Staffing (Scotland) Act** and how health boards are meeting their duties under the Act.

- Neither the Scottish government's Health and Social Care Service Renewal Framework and the Population Health Framework include a comprehensive workforce plan setting out how the Scottish government intends to put in place the sustainable nursing workforce needed to meet their ambitions. A priority for the Scottish government must be the development of **a long-term workforce plan**, based on a robust assessment of increasing need and Scotland's ageing population.

- We are calling for **nursing to be viewed as an investment rather than a cost**. Too often staffing decisions are based on affordability rather than need, yet this is a false economy. Recent economic analysis in the NHS suggests that investing in better nurse to patient ratios is likely to be highly cost effective and may lead to net cost savings due to reduced length of stay and readmissions as well as reduced staff sickness.[vi]

Care in inappropriate places

The issue:

- Corridor care is a symptom of a health and care system that has failed to respond to the growing and changing needs of the population. What was once an emergency measure, for exceptional circumstances, has now become normalised all year round. It's unsafe and undignified, and health and care leaders still lack a complete picture of the scale of the problem.

- Almost 2,000 hospital beds per day continue to be occupied by a patient's whose discharge has been delayed[vii]. It's not possible to address corridor care and hospital overcrowding without increasing capacity in community and care home settings.

Our work on this issue:

- We declared a corridor care emergency over two years ago, and our members have spoken up time and time again about the impact overcrowding is having on their ability to provide safe care and on their wellbeing.

- Scotland is now trailing behind England in the **publication of data on corridor care**. We're calling for the Scottish government to publish accurate data, alongside a fully funded action plan and timeline for eradication, including how they intend to boost nurse numbers, increase capacity in community services and provision in social care.

The need to invest in community services and prevention

The issue:

- There is widespread agreement about the urgent need to increase provision of services in the community and to focus on prevention and early intervention. But this has been talked about for years, and there is a persistent implementation gap between policy ambition and delivery on the ground.

- For example, the workforce trends within district nursing, health visiting and school nursing services are all at odds with this policy direction. As is the nursing workforce trends within care homes.

- District nurses are fundamental to the Scottish government's plans to shift the balance of care, caring for patients with complex health needs in their own home as well as delivering preventative care and supporting long-term conditions and palliative patients. However there has been a decline in the number of registered nurses being supported to complete the specialist qualification in district nursing since 2020. NHS Board data indicates that only 24% of registered nurses within district nursing teams hold the SPQ qualification designed to equip them with the additional knowledge and skills to manage complex caseloads.[viii]

- Since 2020 the registered nursing workforce in health visiting teams has fallen by 7% and, despite a Scottish government commitment to maintain or annually increase numbers of registered nurses undertaking the specialist qualification in health visiting, data provided by NHS boards highlights that the numbers have been in decline since 2022. There is a similar trend in school nursing with the numbers declining since 2022 and reduced investment in supporting nurses to complete the specialist school nursing qualification.[ix]

- This failure to invest in Scotland's community nursing teams is at odds with the policy ambition to provide more care in the community and increase prevention.

- Fulfilling the Scottish government's objective of providing more care in the community also includes social care. Evidence shows that clinical complexity among care home residents

is rising sharply. As residents' complexity of clinical need increases, the skills, competencies and availability of the registered nursing workforce employed within care homes becomes ever more important. However, registered nurse numbers in care homes have fallen by around 24% over the last 10 years.[x]

Our work on this issue:

- Given the workforce trends outlined above, we are calling for **investment in registered nurses in community services**. Strengthening Scotland's community nursing workforce is one of the best investments the Scottish government could make.
- We're also calling for funding for the social care sector that recognises the need to **significantly increase the number of registered nurses employed directly within care homes**. Achieving parity of pay, terms and conditions for nursing staff working in social care and the third sector is also vital for addressing recruitment and retention difficulties in these services.
- A **sustainable funding model for hospices and palliative care** is also needed. To increase access to these vital services and help address current high levels of unmet need.

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[i] RCN Scotland, The Nursing Workforce in Scotland 2026 The Nursing Workforce in Scotland 2026 | Report | RCN Scotland | Royal College of Nursing

[ii] RCN Scotland Nursing Workforce in Scotland 2026 The Nursing Workforce in Scotland 2026 | Report | RCN Scotland | Royal College of Nursing

[iii] Turas NHS Scotland workforce data NHS Scotland workforce | Turas Data Intelligence

[iv] RCN Scotland, Last Shift Survey briefing Last Shift Survey | Briefing | RCN Scotland | Royal College of Nursing

[v] RCN Institute of Nursing Excellence, Registered nurse staffing levels for patient safety, care quality and cost effectiveness Registered nurse staffing levels for patient safety, care quality and cost effectiveness | Royal College of Nursing

[vi] RCN, Safe staffing: evaluating the evidence for mandatory nurse to patient ratios Safe Staffing | Publications | Royal College of Nursing

[vii] PHS, Delayed discharges in NHS monthly Main points - Delayed discharges in NHS Scotland monthly - Figures for June 2026 - Delayed discharges in NHS Scotland monthly - Publications - Public Health Scotland

[viii] RCN Scotland, The Nursing Workforce in Scotland 2026 The Nursing Workforce in Scotland 2026 | Report | RCN Scotland | Royal College of Nursing

[ix] RCN Scotland, The Nursing Workforce in Scotland 2026 The Nursing Workforce in Scotland 2026 | Report | RCN Scotland | Royal College of Nursing

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NHS dentistry in Scotland

Briefing from the British Dental Association

August 2026

The BDA

The British Dental Association (BDA) Scotland is the voice of dentists and dental students in Scotland, serving as their professional body and trade union. Founded in 1880, and owned entirely by its members, the BDA is able to focus solely on its mission to promote the interests of its members; advance the science, arts and ethics of dentistry, and improve the nation's oral health.

NHS dentistry in Scotland – key points:

- NHS dentistry is a vital part of Scotland's health service, but the oral health gap between Scotland's most and least deprived communities continues to grow, creating a postcode lottery in access and outcomes.
- Despite Payment Reform introduced in November 2023 improving the viability of high street dental practices, too many people continue to struggle to access NHS dental care when they need it.
- Nearly one in five adults in Scotland has unmet need for NHS dental care; polling by YouGov shows 12% tried and failed to secure an NHS appointment in the last 2 years and 7% have given up trying.
- Challenges in access to NHS dentistry, particularly in rural and island communities, have resulted in many travelling long distances for care, with some desperate patients resorting to DIY dentistry, or heading overseas for care that should be available in their own communities.
- Surgery to have decayed teeth removed under general anaesthetic (GA) remains the most common reason for young children to be electively admitted to hospital in Scotland, with children from the most socio-economically deprived areas bearing the greatest burden. Children and adult patients with special care needs who need treatment under GA face unacceptably long waits for such procedures.
- Polling commissioned by the BDA ahead of the 2026 Scottish Parliamentary elections found that 65% of Scots believe the Scottish Government should be doing more on dentistry, while only one in five think it is doing all it can.
- Rapidly rising operational costs, the impact of inflation, workforce challenges and increasing financial pressures continue to place dental practices under significant strain. Across Scotland, dental practices are balancing commitment to NHS oral healthcare with growing concerns about their long-term sustainability.
- While a 2025 survey of Scottish dentists showed two thirds considered the new payment system an improvement, the BDA stress that this must be the beginning, not the end of the road to reform, with more policies to ease the workforce crisis affecting NHS dentistry.
- We need a payment model which provides fair remuneration for dentists and financial sustainability for NHS dental practices, reflects modern dentistry, prioritises prevention and which is centred around the patient.

Scotland's dental access crisis & persistent inequalities

- The latest National Dental Inspection Programme data show that **stark oral health inequalities persist.** In 2025, 71% of P7 children in the most deprived areas had no obvious experience of tooth decay, compared with 90% in the least deprived areas.
- Over the past 20 years rates of tooth decay have declined, but this downward trend appears to have flattened out since the Covid-19 pandemic.
- Registration rates remain high due to 'lifetime registration' policy – 95.1% of the Scottish population were registered with an NHS dentist at the end of March of this year.
- However, registration rates vary significantly by Health Board, with as few as 64% of adults registered with an NHS dentist in Dumfries and Galloway, and just 84% in Orkney.
- Importantly, even in areas with high registration rates, these figures do not necessarily translate into access to care. Data clearly shows that participation rates – contact with a dentist within the past two years – have been falling.
- Public Health Scotland data show that only 62% of registered patients actually saw an NHS dentist within the previous two years in March 2026. This is a significant reduction from 70% back in 2019.
- **The gap in participation rates between the most and least deprived areas in Scotland is growing.**
- In the year to March 2026, 77% of children in the most deprived areas saw an NHS dentist, compared with 88% in the least deprived areas – this gap has more than trebled since 2008. Among adults, participation was 53% in the most deprived areas compared with 62% in the least deprived.
- Lower participation means fewer opportunities to identify and treat dental disease at an early stage. It can also reduce opportunities for dentists to identify signs of oral cancer, while delayed treatment can result in more complex care, poorer outcomes and higher costs to the NHS.
- Scotland faces high incidence rates of oral cancer, with survival outcomes closely linked to deprivation and early detection. Head and neck cancers are the 6th most common cancer in Scotland and are more likely to be diagnosed at a more advanced stage among people living in more deprived areas.

Payment reform

- Dentists in Scotland are paid on the basis of an 'Item of Service' list, with individual levels of remuneration for completion of discrete items of care.
- A reformed payment system for NHS dentistry was introduced in November 2023. This reduced the number of Item of Service codes from around 400 to 45 to make it less burdensome.
- Fees paid for particular treatments were also reviewed to make the payment more fair, with significant increases in fee levels for treatments requiring expensive laboratory work (like dentures) which previously saw dental practices making a financial loss.

- While the Scottish Government has increased investment in primary care NHS dentistry, the rapidly rising costs of delivering care – including increased employer National Insurance contributions and the National Living Wage – continue to put pressure on dental practices and risk eroding the impact of this investment.
- A BDA survey of Scottish dentists from 2025, found that more than two thirds (69%) considered the new system an improvement. But while these reforms are a first step towards making some NHS dental practices more sustainable, further improvements are needed, particularly to improve access for patients and reduce inequalities.
    - Only 1 in 5 (21%) dentists agree that the reformed system reduces bureaucracy;
    - Only 7% believe it enhances access for NHS patients;
    - Just 3% say it supports a reduction in oral health inequalities.
- While recent changes have made some dental practices more sustainable, there is no room for complacency. The Scottish Government must build on these reforms and continue to work with the profession to ease the workforce crisis in NHS dentistry and ensure the sector is sustainable in the long term.

Creating the dental workforce Scotland needs

- In many areas there are ongoing issues with NHS dental capacity, driven largely by recruitment and retention challenges, but also the higher levels of need which patients are now presenting with after years of delay.
- A survey from 2025 revealed that, only 10% of dentists describe the NHS as an attractive place to build and maintain a career. More than 70% report feeling burnt out, and almost half of practices fear they may struggle to remain financially sustainable.
- Workforce pressures affect not just the practices on the high street. The Public Dental Service – which provides care for vulnerable and priority groups, including people experiencing homelessness, care home residents, and people with complex medical needs – has declined by 22% in the last decade. The number of hospital dentists saw a 17% reduction in the same period.
- Scotland cannot have NHS dentistry without the dentists to provide this care on the front line.
- Workforce planning must focus not only on recruitment but also on retention. The critical question is not simply how many dentists graduate each year, but whether newly qualified and experienced clinicians feel able to continue delivering NHS oral healthcare within the current system.

What the Government must do:

- Treat recent payment reform as a foundation for further reform, not the end of the process. In the long term, Scotland needs a patient-centred model which prioritises prevention, reflects modern dentistry and provides financial sustainability for NHS dental practices.
- Ensure NHS dentistry is funded in a way that allows it to be sustainable and able to stand on its own two feet, while meeting the oral health needs of Scotland's population.
- Keep the NHS primary care dental payment system under continuous review, with the BDA involved in an ongoing process to ensure payments reflect the changing costs of delivering NHS dental care and provide sustainable funding and fair remuneration for dentists.

- Recognise the impact of increased employer National Insurance contributions on dental practice viability and access to NHS dentistry for patients. Reimburse dental practices in full, to avoid eroding the improvements brought through Dental Payment Reform.
- Double down on policies to ease the workforce crisis affecting NHS dentistry. Develop a fully costed and funded Scottish NHS dental workforce plan – covering high street dentists, the Public Dental Service and the Hospital Dental Service – to ensure Scotland has the right number and mix of dentists and dental care professionals to meet population needs.
- In workforce planning, focus on retaining existing NHS dentists as much as on recruiting and training new ones. Improve recruitment and retention incentives, such as the Scottish Dental Access Initiative grant and relevant allowances within the Statement of Dental Remuneration. Expand training opportunities, so both newly qualified and experienced clinicians feel able to continue delivering NHS oral healthcare throughout their career.
- Measure dental access by focusing on attendance, rather than registration alone, allowing comparisons between areas and over time, helping identify and address inequalities.
- Develop a National Dental General Anaesthetic Recovery Plan, restoring and expanding theatre capacity so children and other patients requiring dental treatment under GA aren't left waiting in pain. This follows on from the **BDA report on dental GA waiting times** which was published last year.

Contact us: For further information please contact us at mediaprandparliamentary@bda.org.

Briefing for the Health, Care and Sport Committee

Main issues facing speech and language therapy in Scotland and how RCSLT Scotland is addressing them

August 2026

Introduction

The Royal College of Speech and Language Therapists (RCSLT) Scotland welcomes the opportunity to provide written evidence to the Health, Care and Sport Committee.

Speech and language therapists (SLTs) help people communicate, eat and drink safely. These are basic functions that affect whether someone can learn, work, access healthcare, make decisions, maintain relationships and live independently.

Too often, communication and swallowing needs are addressed only when they have become a significant problem, rather than being identified and supported early.

RCSLT Scotland is advocating for a more preventative and joined-up approach, with SLTs working where they can have the greatest impact: in schools and nurseries, communities, primary care and multidisciplinary teams, alongside specialist services.

In this session of Parliament, we have developed four key asks:

1. **Supporting children**: embed speech and language therapists in every school and nursery in Scotland
2. **Supporting adults**: meet the changing needs of Scotland's adult population by increasing the resource available to adult SLT services
3. **Supporting our workforce**: expand access to the speech and language therapy profession
4. **Supporting all**: strengthen communication rights

Our key ask over the next five years is to begin a phased programme to embed SLTs across Scotland's schools and nurseries, starting with an additional 185 FTE. We believe this would improve outcomes for children and young people while supporting a more preventative and sustainable approach to public services.

Children and young people: embedding SLTs in every school and nursery

Our priority

Communication is a fundamental part of children's health and wellbeing. When communication needs are not identified and supported early, they can affect mental health, relationships, educational attainment and future life chances.

Nurseries and schools are where children spend much of their time and where communication demands arise. Support should therefore be available in children's everyday environments, rather than relying primarily on referral to a clinic or specialist service.

Why an embedded model matters

Embedding SLTs as health professionals in education would allow Scotland to shift towards prevention and earlier support, while retaining individual specialist intervention for children who need it.

It would:

- provide specialist expertise where children spend much of their time
- support earlier identification of communication needs through universal and targeted approaches
- build the skills and confidence of teachers, early years practitioners and families
- support communication-friendly classrooms and learning environments
- improve access for children and families who may struggle to attend appointments, particularly those living in poverty
- help prevent communication needs becoming barriers to educational attainment, wellbeing and future life outcomes
- The focus is on **changing the model of support**, rather than increasing the number of individual therapy appointments. By making specialist knowledge available to children, families and education staff throughout the week, support can be embedded into everyday practice and difficulties can be identified and addressed before they escalate.

What would it take?

RCSLT Scotland has developed a model for providing dedicated SLT time across all of Scotland's schools and early years settings, potentially reaching almost **800,000 children and young people**.

Our modelling identifies:

- **Current children's SLT workforce:** 530 FTE
- **Estimated education-based requirement:** 745 FTE
- **Additional workforce required:** around **370 FTE**

- **Proposed first phase: 185 FTE**, a 35% increase in the current children's workforce

RCSLT Scotland sought independent analytical support for this model from the NHS-hosted Health Economics Unit. The review concluded that the methodology was robust, transparent and provided a clear and defensible estimate of the workforce gap. It described the figures as a minimum capacity requirement rather than a detailed staffing plan, with local refinement required to account for geography, non-contact time and patterns of need.

We therefore see the proposal as a basis for national workforce planning, with implementation appropriately refined locally.

Supporting the Additional Support for Learning Review

The proposal also provides a practical way to support the Scottish Government's commitment to implement the Additional Support for Learning Review recommendations.

Embedding SLTs in schools and nurseries would support earlier identification and intervention, strengthen the wider education workforce, improve visibility of communication needs and provide a clearer way for health and education services to work together to support children.

It would also help teachers adapt communication, learning and assessment environments so that children with communication needs can participate more fully in education.

What difference can this make? NHS Forth Valley

NHS Forth Valley provides an encouraging example of what can happen when health and education resources are brought together and SLTs are embedded in schools and nurseries.

The service has transformed support for children with speech, language and communication needs since 2019, moving away from traditional referrals towards a model based on requests for assistance and early support.

The reported benefits include:

- **97% of children receive support within 12 weeks**, with more than one-third receiving support within a week
- Marked improvement in children's participation, inclusion and wellbeing
- teachers rate SLT as the **most effective partnership among supporting agencies**

- Families living in poverty now have reliable access to quality SLT provision
- emerging evidence of wider educational benefits, including **almost halved exclusions among pupils with additional support needs in one local authority**
- sharp increases in literacy levels
- **positive destinations reaching 92.4%**

Overall, the Forth Valley case study demonstrates that prevention, partnership and integrated working can lead to better outcomes and reduced inequalities for children with communication needs.

What RCSLT Scotland is doing

- In 2025, we brought together senior leaders from education, health and local government to develop a shared vision for transforming support for children with communication needs. We continue to promote the resulting cross-sector consensus that health and education should share resources and ownership of children's communication support.
- We are working with academic partners to seek formal evaluation of the NHS Forth Valley transformation, including its outcomes, costs, impact on inequalities, workforce implications and transferability to other areas.
- We are advocating for increased routes into the profession, including an earn-as-you-learn option in Scotland and a third SLT course, preferably in the North of Scotland.

Workforce: ensuring Scotland has the SLT resource it needs

The issue

The ability to transform services depends on having enough SLTs.

RCSLT Scotland is concerned that Scotland's SLT workforce has not grown in line with the rest of the UK.

Available HCPC data indicate that between June 2021 and June 2026, the number of registered SLTs in Scotland increased by just **1.1%**, compared with 19.6% in England, 18.7% in Wales and 11.5% in Northern Ireland over the same period.

Scotland has around **24 registered SLTs per 100,000 people**, compared with **29 per 100,000 across the rest of the UK** - a gap that has widened over the past five years, highlighting a concerning trend in Scotland’s SLT workforce.

Scotland therefore has approximately five fewer SLTs per 100,000 people than the rest of the UK.

This matters not only because the workforce is a key limiting factor in our ability to expand prevention, community services and support in schools, but because insufficient workforce growth also puts pressure on existing services. Where posts are not filled or cut due to lack of funding, services lose capacity to meet existing demand, contributing to growing waiting lists and reduced access to support. Scotland therefore needs workforce growth that enables services to respond to **current demand as well as supporting the development of new models of care and prevention**.

What RCSLT Scotland is doing

- We are developing workforce models to understand future requirements and advocating for better national workforce data.
- We are promoting new ways of working that make better use of specialist capacity, including roles across education, primary care, mental health, social care and community services.
- We engage with policymakers to ensure SLTs are included in workforce planning.

Workforce planning should reflect the number and needs of people who require services, rather than simply maintaining today's staffing levels.

Adults and social care: strengthening community capacity

SLT is not just about communication. For many adults, it is also about eating and drinking safely.

Adult SLTs support people with communication and swallowing needs arising from conditions including stroke, neurological conditions, dementia, learning disability, cancer, mental ill health and frailty.

SLTs can help people:

- maintain independence and social participation
- eat and drink safely
- reduce risks associated with malnutrition, dehydration and aspiration pneumonia
- communicate and participate in important decisions about their care
- rehabilitate after illness or injury
- remain safely at home for longer

Prevention and care closer to home

Community SLT can help prevent crises before hospital admission, reduce complications associated with swallowing difficulties and support rehabilitation closer to home.

This is particularly important for social care and delayed discharge. Effective discharge can depend on timely communication and swallowing assessment, while care home and home care staff need access to specialist advice and training.

Delayed discharge cannot be solved solely by increasing hospital capacity. Adequate community rehabilitation services are equally important.

Demand is growing faster than the workforce

Community SLT services are particularly under-resourced, with FOI data indicating that waiting lists have grown rapidly. This is compounded by the limited growth in the national SLT workforce, as reflected in HCPC data, leaving services with insufficient capacity to meet rising demand.

Better national workforce and service data are needed to understand demand, identify gaps in provision and plan effectively for future services.

What RCSLT Scotland is doing

We continue to highlight the role SLTs can play in adult community care and showcase innovative models, including SLTs working in care homes, as part of mental health and primary care teams and through community-based universal and targeted support.

Mental health: communication must be part of care

As highlighted in our recently published *Talking Recovery* report, SLTs have an important role to play in mental health care.

People with communication needs may struggle to understand treatment, express distress, participate in decisions or benefit from talking therapies. Swallowing difficulties can also create significant physical and clinical risks.

Despite this, access to SLT within adult mental health services remains limited and geographically uneven. Our survey found no funded adult mental health SLT posts in Fife, Borders, Highland or the Island boards.

What RCSLT Scotland is doing

We are advocating for:

- equitable SLT provision across Scotland

- SLTs to be embedded within multidisciplinary mental health teams
- clear referral pathways and service models
- strengthened workforce capacity and specialist training

Neurodiversity: support should be based on need, not diagnosis

People should not have to wait for an autism or ADHD diagnosis before receiving help with an identified communication need.

RCSLT Scotland is advocating for a move away from a system where diagnosis is the gateway to support, towards earlier help based on people's needs.

SLTs should have a stronger role across assessment, schools, pre-diagnostic support and adult services.

What RCSLT Scotland is doing

We are advocating for:

- support based on individual need rather than diagnosis
- recognition of communication as a core part of ADHD and autism pathways
- SLTs within multidisciplinary neurodevelopmental services across the lifespan and
- earlier and more consistent support before, during and after diagnosis

Conclusion

Speech, language, communication, eating, drinking and swallowing are fundamental to people's health, education, wellbeing, independence and participation. Yet support is too often provided only once needs have become significant, rather than using specialist expertise to identify and address difficulties early.

RCSLT Scotland's priority is to change this approach. We are calling for a phased programme to embed SLTs across Scotland's schools and nurseries, beginning with an additional 185 FTE. This is a practical proposal, supported by workforce modelling and informed by the experience of NHS Forth Valley. Over time, this model could be expanded beyond children's services to other community settings, including adult services and care homes, where earlier and more accessible access to specialist communication and swallowing support could also make a significant difference.

Delivering this ambition will require investment in the SLT workforce. Scotland currently has fewer SLTs per head than the rest of the UK, and the gap is widening as demand for services continues to increase. We also need stronger community provision so that SLTs

can help people remain independent, leave hospital safely and access health and social care.

Our message is simple: Scotland needs more SLTs, but it also needs to use them differently. By putting specialist expertise closer to where people live, learn and receive care, Scotland can intervene earlier, reduce inequalities and make better use of public resources.

Embedding SLTs in schools and nurseries should be an important step in a wider shift towards preventative, joined-up and needs-led support across the life course.

The Health and Social Care Alliance Scotland (the ALLIANCE)

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Overview of issues in the health care sector in Scotland
ALLIANCE response

24 August 2026

Introduction

The Health and Social Care Alliance Scotland (the ALLIANCE) welcomes the opportunity to give evidence to the Health, Care and Sport Committee on 2 September, and the opportunity to submit additional views in writing in advance.

The ALLIANCE considers the following issues to be the main priorities in health and social care. These are informed by extensive and ongoing engagement with our membership, which includes over 3,500 organisations, disabled people, people with long term conditions and unpaid carers. These formed the basis of 'Our Collective Voice', the ALLIANCE manifesto for the 2026 Scottish Parliament election, and have formed the basis with early engagement with Ministers and MSPs at the start of the new Parliamentary term.

- Reforming social care
- Third sector sustainability
- Health and social care reform
- Investing in prevention
- Improving Mental Health Law and Services
- Supporting people with sensory impairments
- Widening access to information about community services and resources
- Tacking gambling harms
- Supporting women's health
- Long Term Conditions Framework

Reforming social care

To improve social care, the ALLIANCE want to see the rapid development of national oversight and scrutiny mechanisms that end the postcode lottery, increase and monitor investment levels, whilst improving standards, quality and accountability. Commissioning and procurement should be reformed to take a collaborative and human rights based approach, and non-residential care charges must be abolished. Pay and conditions for the

social care workforce must also be addressed, making it easier to recruit and retain staff.

Taking urgent action now to reform and renew social care is vital to ensuring Scotland meets its human rights obligations and avoids the much greater costs of system failure in future years. High-quality, accessible social care supports people to participate fully in society, prevent or slow the progression of their conditions, and maintain higher levels of physical and mental health. As such, investment in social care should be seen as a key component of a preventative approach.

Third sector sustainability

The third sector makes a vital contribution to the Scottish economy and society, employing around 5% of the workforce and delivering essential services in every corner of the country. Much of the third sector's work is highly preventative in nature, and offers unique, tailored support that cannot always be replicated by statutory services. Despite this, the sector is under ever-increasing pressure.

The ALLIANCE's "Stretched Beyond Limit" report provides a snapshot of the crisis facing our members, with nearly two-thirds reporting financial insecurity.[1] Fair funding for the third sector, including multi-year funding that covers core, project and increased National Insurance Contribution costs, includes inflationary uplifts, and timely notification, must be progressed early in the new parliament. The third sector must also be acknowledged as an equal partner in service delivery, and fully included in public service reform, design and planning.

Health and social care reform

The Scottish Government is exploring priorities for the future of health and social care, including areas for NHS Reform. The ALLIANCE and our members have a strong interest in informing the work of the Scottish Government's Health and Social Care Reform Programme, as well as invaluable knowledge and expertise to draw upon.

A review of our extensive existing body of evidence on people's lived experiences of health and social care[2], revealed people's priorities as including: prioritising prevention over crisis management; considering broader contribution to health; and improving equity of outcomes and access to services.

Our evidence review highlighted the interplay between the four priority domains for health and social care reform (quality, access, prevention, people and place) and captured the complexity of the NHS and the challenge of disentangling people's priorities for NHS reform from those related to primary care or social care. Furthermore, people spoke frequently about the importance of taking a whole system approach, taking into account the wider environment and public services which enable their health and wellbeing, including the contribution of the third sector.

Investing in prevention

Existing investment in cost effective preventative measures must be protected and best practice, such as examples from Self Management Fund funded projects, rolled out more widely.[3] Soon to be published learning from the Self Management Fund, which the ALLIANCE administers on behalf of the Scottish Government, reveals that 1,612 people benefitted from 16 projects which were funded in the most recent round. Across all priorities, the key pillars of effective self management support shone through in the projects' successes; notably relationship building, flexibility and whole-person support. The third sector is well placed to provide this, with highly trusted organisations who know the communities they work with and the agility to adapt their services to changing and emerging needs.

As another example, the Community Links Worker (CLW) model reduces pressure on GPs whilst generating significant wellbeing benefits. A review of the ALLIANCE's CLW programme identified these to be £18.2 million in 2022, compared to £2.1 million in delivering the programme, a ratio of £8.79 in wellbeing benefits for every £1 invested.[4]

Embedding a preventative approach across public services is essential to improving health and wellbeing outcomes whilst ensuring that funding remains sustainable, and our research shows public support for a prevention focussed system. It is far more costly, in both human and monetary terms, to allow people to reach crisis point than it is to deliver early interventions. For example, improving access to screening programmes, primary care, supported self management and community services will help to limit demand for and pressure on hospital care and importantly help to improve people's health and wellbeing.

Improving Mental Health Law and Services

A human rights approach to mental health includes acting on the recommendations of the Scottish Mental Health Law Review, including on supported decision making, reducing coercion, and improving interactions with criminal justice. The ALLIANCE and our members also support the recommendation by the separate Rome Review that autism and learning disability be removed from the definition of "mental disorder", via a Learning Disabilities, Autism and Neurodiversity Bill.

There is a clear need for greater investment in mental health services, beyond the 10% target set for the previous parliament. Whilst investment in frontline NHS services will always be important, community mental health and wellbeing services play an essential preventative role. Existing investment through the community Mental Health and Wellbeing Fund is welcome, and funding for this should be renewed through this term.

Supporting people with sensory impairments

1 in 3 people in Scotland are Deaf, and most of us will experience Deafness as we age. Meanwhile, 1 in 5 people will develop a Visual Impairment, and Scotland has rising numbers of people living with Deafblindness. Yet despite this reality, people are not consistently and properly supported to access the health and social care support they need to live well with sensory impairments, and participate equally in work, education, and society.

Our More than Words: Communication for All campaign highlights that most of us will need communication support in our lifetimes.[5] Unfortunately, people who are Deaf, Deafblind or have Visual Impairments often experience unfair and unnecessary obstacles to public services. Everyone in Scotland should have a right to communication support, underpinned by enforceable guidance and mandatory training on inclusive communication, and appropriate access to health and social care services, when they need it, where they need it.

Widening access to information about community services and resources

The ALLIANCE hosts the ALISS (a Local Information System for Scotland) programme on behalf of Scottish Government. ALISS provides an online repository for crowdsourced information about services, groups, activities and resources that support health and wellbeing across Scotland. The information gathered is reused across different local and national websites, reducing duplication and complexity and providing efficient use of public funds.

ALISS is set to become a key part of the MyCare.scot service which was launched in April 2026. ALISS also provides information for policy makers about the community services in Scotland, as well as providing insights about what people are searching for to support their health and wellbeing. The Scottish Government must ensure adequate funding for ALISS to fulfil its potential as a unique ‘once for Scotland’ asset and ensure cross-directorate endorsement and support for its use across the country.

Tackling gambling harms

The ALLIANCE support a public health approach to gambling in Scotland. Gambling harm is not caused by individual behaviour but is a systemic issue, shaped by the environments in which people live, work, and spend their time. It is estimated that 200,000 people in Scotland are at risk of experiencing gambling harm, with negative effects on their health, wellbeing, employment, housing, finances and relationships.

There is a clear need as a public health intervention to restrict gambling advertising, which research shows is more likely to lead to people experiencing gambling harm. The gambling industry spends an estimated £2 billion on advertising across the UK every year, and exposure to gambling and gambling products amongst children and young people is associated with gambling harms later in life. Scotland's share of revenues from the Gambling Levy should be invested in NHS and third sector services that support people affected by gambling harms.

Supporting women's health

Despite recent process there remain significant health inequalities for women in Scotland. These are often complex and gendered in nature, creating barriers to women accessing services and information about their health. The ALLIANCE is committed to tackling these inequalities, and calls for investment, collaboration and accountability from the Scottish Government to prioritise innovation and change to improve women's health.

Our dedicated Women's Health programme supports the implementation of the Women's Health Plan through lived experience engagement and awareness raising. We look forward to continuing to work in close partnership with the Scottish Government to ensure that women's experiences are reflected in policy and service changes, and that the expertise of the third sector is integrated into future women's health initiatives. Investing in services, research and education is critical to ensuring that all women have access to timely, accessible, suitable, and high quality healthcare.

Long Term Conditions Framework

The ALLIANCE are engaging closely with the progress of the Scottish Government's proposed Long Term Conditions Framework. Based on evidence from our members to inform our response to the Scottish Government's consultation[6], we support the principle of taking a balanced approach between cross-cutting and condition-specific work, recognising commonalities in experience across many long term conditions.

However, some of our members have expressed concerns about the loss of expertise and support that has been delivered through existing condition-specific strategies. In addition, some scepticism was shown about how useful another framework would be at improving outcomes. It is important that the Scottish Government provide clarity and reassurance about the status of existing strategies and actions still underway in relation to them. They must also embed a human rights based approach throughout all frameworks and strategies.

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector membership organisation for the health and social care sector. We bring together over 3,500 people and organisations dedicated to achieving our vision of a Scotland where everyone has a strong voice and enjoys the right to live well, with dignity and respect. Our members are essential in creating a society in which we all can thrive, and we believe that by working together, our voice is stronger.

We work to improve the wellbeing of people and communities across Scotland by supporting change in health, social care and other public services so they better meet the needs of everyone in Scotland. We do this by bringing together the expertise of people with lived experience, the third sector, and organisations across health and social care to shape better services and support positive change.

The ALLIANCE has three core aims.

We seek to:

- **Empower people with lived experience**: we ensure disabled people, people with long term conditions, and unpaid carers are heard and that their needs remain at the heart of the services and communities.

- **Support positive change**: we work within communities to promote co-production, self management, human rights, and independent living.
- **Champion the third sector**: we work with, support and encourage co-operation between the third sector and health and social care organisations.

The ALLIANCE is committed to upholding human rights. We embed lived experience in our work and aim to ensure people are meaningfully involved at every level of decision-making.

Working together creates positive, long-lasting impact. We work in partnership with the Scottish Government, NHS Boards, universities, and other key organisations within health, social care, housing, and digital technology to manage funding and develop successful projects. Together, our voice is stronger, and we can create meaningful change.

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[6] The ALLIANCE, response to Long Term Conditions Framework consultation, available at https://www.alliance-scotland.org.uk/blog/resources/long-term-conditions-framework-alliance-response/

Myalgic Encephalomyelitis (ME) in Scotland

Briefing for the Health, Care and Sport Committee, August 2026

"[ME is] the greatest medical scandal of the 21st century"
George Monbiot, The Guardian

What is Myalgic Encephalomyelitis (ME)?

Myalgic encephalomyelitis (ME), sometimes referred to as Chronic Fatigue Syndrome (CFS), is a profoundly debilitating neurological disease affecting multiple systems within the body. The cause is unknown, although onset often follows a viral infection such as glandular fever. Around half of people with Long COVID have ME.[1,2] There is currently no cure.

What are the symptoms?

ME impairs the body's ability to produce energy, so organs and systems cannot function properly. This leads to a range of debilitating symptoms, most notably Post-Exertional Malaise (PEM), which is a disproportionate worsening of symptoms after even minimal cognitive, physical, emotional, or social activity. PEM can last days or weeks and may cause permanent relapse. Other symptoms include cognitive impairment ("brain fog"), sensory sensitivity, gastrointestinal issues, pain, orthostatic intolerance, and autonomic dysfunction. Severity varies; some people can work part-time, while around 25% are house- or bed-bound. People with ME report lower quality of life than those with many other serious illnesses, including multiple sclerosis, stroke, renal failure, and lung cancer.[3]

Who is affected?

There is no accurate data on the number of people with ME in Scotland. Latest research from the University of Edinburgh and the ME Association suggests that 33,000 have ME, and a further 76,000 have Long COVID with ME symptoms, bringing the Scottish combined total to 109,000. ME affects people of all ages, ethnicities and socio-economic groups. Around 80% of people with ME are women. There are significant health inequalities in diagnosis, with rates varying by ethnicity, deprivation, age and geography, reflecting unmet need rather than lower prevalence.[4,5] Children are also affected, and longitudinal studies have shown ME to be the single biggest cause of long-term school sickness absence.[6]

Are some people more severely affected than others?

Yes. About a quarter of those with ME are "severely" or "very severely" affected. This can mean being confined to bed, unable to cope with light, sound, touch or basic communication, and sometimes unable even to take food or water. Just the slightest exertion - such as exposure to a sliver of light - can worsen a person's condition. There is no healthcare provision in the UK for those with severe or very severe ME. Worse, a lack of knowledge of the specific needs of those with severe ME means that accessing healthcare can be harmful.[7] This means the burden of care often falls wholly on family members, with little to no support. ME can be fatal in severe cases.[8]

ME is a major source of economic inactivity

The total annual economic burden of ME is growing and is now estimated to be around 0.7% of GDP, costing Scotland's economy around £1.5bn per annum. This includes the cost of productivity losses, as most people with ME are of working age, as well as health and social care costs and wider impacts such as family members who need to stop working to become unpaid carers.[9] Only 12% of people with ME are in full-time paid work, education or training and a further 21% are in part-time work, education or training.[10]

Training and education for healthcare professionals especially GPs There are no specialist consultants in Scotland, so care of people with ME falls to GPs. Clinicians in Scotland are expected to refer to the National Institute for Health and Care Excellence (NICE) guideline on diagnosing and supporting people with ME (2021).[1]

However GPs do not receive adequate training, and their awareness of the NICE guideline is very poor. In a recent survey of practising GPs, 70% thought ME was rare, and 30% thought it was psychological and not physical.[11] A typical GP practice of 10,000 patients can expect to have 200 people with ME but many go undiagnosed or are wrongly diagnosed, for example with depression.

Training for healthcare professionals, especially GPs and paediatricians, is needed urgently to ensure that healthcare is delivered in accordance with the NICE guideline. Early diagnosis and proper management are vital for patients and could help prevent some from deteriorating and give the best chance of long term improvement.

Developing new services

Current ME services in Scotland are woefully inadequate. A 2024 Scottish Government review found that only three NHS Boards had dedicated ME services: NHS Lothian, NHS Greater Glasgow and Clyde, and NHS Fife. These services focus on rehabilitation and self management, with little or no medical input. The service in NHS Fife consisted of a single specialist nurse who sadly died and the vacancy has not been filled.[12]

The Scottish Government committed £4.5 million in recurring funding from 2025/2026 to deliver new specialist support for Long Covid, ME/CFS, and other similar conditions, in all NHS Boards. This is a welcome foundation, but the challenge of establishing services where they have not previously existed should not be underestimated. Specialist services need to be staffed by skilled consultants or specialist GPs, occupational therapists, and physiotherapists as a minimum, all needing to be trained. The NHS workforce does not yet have the capability to deliver this.

Referral pathways need to be developed in all NHS Boards, with cross-boundary and regional working arrangements established where boards are unable to sustain standalone services. Particular attention needs to be paid to the needs of those with very severe ME; existing services offer nothing to these patients, and there is not a single bed in NHS Scotland which meets their needs.

The Long Term Conditions Advisory Group on Long Covid/ME provided recommendations to the Scottish Government in May 2026. The Scottish Government has yet to publish the report or adopt any of its recommendations.

Investment in research

Biomedical research into ME is widely recognised as having been chronically underfunded for decades, both in the UK and overseas. Under-investment in research has resulted in a lack of knowledge about the causes and mechanisms of ME, a lack of diagnostic markers, and no effective treatments.

In Scotland there has been one landmark study into ME: DecodeME, a £3.2m genetic study looking at the differences in DNA between people with ME and healthy controls, led by Professor Chris Ponting at the University of Edinburgh.[13] Researchers examined the DNA of 18,000 people with ME and identified eight genetic signals linked to ME risk, showing that immunological and neurological processes are likely to play a part in ME/CFS. The initial results were released in 2025.

DecodeME was funded by the Medical Research Council and the National Institute for Health Research, and is the most significant UK ME study ever to have been carried out. Its results have set clear targets for further work, and while there is some funding for smaller follow-on studies there is no funding for major studies to continue the research.

Other research priorities were identified in 2022 through a Priority Setting Partnership between researchers, people with ME and their carers, set up by the James Lind Alliance and partly funded by the Scottish Government.[14]

In 2025 the DHSC published a delivery plan for ME/CFS, a multi-year strategy to improve ME research, attitudes and education.[15] However again there is no dedicated research funding.

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#MEAction Scotland

#MEAction Scotland is a volunteer-led charity which campaigns to improve the lives of people with ME in Scotland. If you would like to find out how you can help please look at our website: https://meaction.org.uk/about/about-scotland-scottish-parliament or email us at: scotland@meaction.org.uk.

Evidence to the Scottish Parliament Health, Social Care and Sport Committee

Chronic Pain Management in Scotland — Patient Experience and What I Would Like to See

Submitted by Kirstin Laing — 25 August 2026

Chronic Pain Management in Scotland - Patient Experience and What I Would Like to See Submitted by Kirstin Laing - 25 August 2026 Thank you for the very welcome opportunity to provide evidence to the Committee. My name is Kirstin Laing. I am 56 and have been a chronic pain patient since I was 23. My husband, Andrew Laing, is 62 and has also lived with chronic pain for many years. We were both rescued by NHS specialist treatment from a life dominated by severe pain, strong medication and very limited function. But now specialist treatments for severe pain are at risk of being stopped or largely reduced by Health Boards and the Scottish Government. Andrew describes what his pain was like before lidocaine: “It was like someone stabbing me under my ribcage and jabbing upwards... feeling like you were being impaled.” He described the relentless pain as unbearable. Today, because of his lidocaine treatment, he is able to participate much more fully in ordinary life. He describes the difference simply: “Lidocaine allows me to enter the world and live.” My S1 nerve-root injections have similarly transformed my life. They enable me to be more mobile and independent and to care for my husband.

HAS THE COMMITTEE BEEN TOLD

That these specialist treatments, which have transformed the lives of patients like us, are now at risk of being reduced or removed in parts of Scotland? We now live with the fear that treatments which have given us back a reasonable level of function could be taken away. Private treatment would not be an option we could afford. Scotland has a very large chronic pain population. Around 800,000 people was the Scottish Government estimate a decade ago, and some more recent estimates suggest this may now be around one million. Public Health Scotland records approximately 20,000 new referrals to specialist pain services annually. We are two of the patients with the most severe levels of pain. There are many thousands like us across Scotland. The treatments at the centre of this concern are lidocaine infusions, localised injections and radiofrequency treatments. Of course not every chronic pain patient requires these treatments, and where a treatment is clinically appropriate and demonstrably effective for an individual patient, access to it can be life-changing. For us, the NHS working well is actually quite simple: Give patients the treatment that works for them, within a multidisciplinary service, and measure the difference it makes to their lives. My concern is that this principle is now at risk.

Patients managed a breakthrough recommendation for the first time

The Scottish Health Technologies Group (SHTG) was asked by the Scottish Government to undertake a detailed review of specialist interventions for chronic non-malignant pain. The Scottish Government did not inform patients or invite them to give their views. At a later stage, we discovered that no patients using these treatments had been invited to contribute. We also discovered that the only patient representative listed was from a pain charity which received Government funding. Patients therefore had to find the process ourselves and contact SHTG directly. SHTG agreed to hear us. Thirty-four patients receiving one or more of the treatments submitted written evidence. Five people - four patients and a clinician - addressed the SHTG Council on 15 December 2025. I was one of those patients. The experience was very different from what many of us had experienced with Government or Government-related groups. Patients were listened to directly, courteously and respectfully. The patient evidence showed the real-life impact of these treatments: improved function, better quality of life, greater independence and, for some, reduced reliance on medication. On 27 February 2026, SHTG recommended that the treatments should continue to be available for consideration within NHSScotland. For me, this was a breakthrough. Patient involvement can make a difference when patients are genuinely heard. It also raises an obvious question: If patient experience made such a difference to the SHTG recommendation, why were patients excluded from the process in the first place?

What good chronic pain management can achieve

When the Highland Chronic Pain Management Service opened in 2009, I was delighted to become a patient. I have received S1 nerve-root injections for many years. They have transformed my ability to function. Self-management and clinical intervention should work alongside each other, rather than being treated as alternatives. However, without the pain relief provided by the nerve-root injections, I would not be able to do these things. The clinical intervention gives me the function to actively manage my condition and participate in daily life. Andrew has been a patient of the Highland service since 2015. His lidocaine infusions have similarly transformed his life. Neither treatment has cured us. They have enabled us to live. That is why I think the phrase “living well with pain” needs to be understood properly. For some patients, living well does not mean simply learning to tolerate severe pain. It means receiving the treatment that reduces the pain sufficiently for them to function, self-manage, work, care for others and participate in ordinary life.

The question of patient involvement

This is now one of my biggest concerns. Decisions affecting people with long-term conditions can have enormous consequences, yet patients can find themselves outside the discussions taking place about their treatment. Patients should not have to use Freedom of Information legislation to discover what Government is considering doing to treatments on which they depend. A Short Life Working Group was then formed to discuss the merits of the SHTG recommendations. This caused considerable concern among patients because, from the information available to us, some of Scotland's largest users of specialist interventions were not represented, while Health Boards which did not provide some of the interventions had representation. This raises another question I would like to see considered: How representative are Government and Health Board groups when decisions are being made about treatments used by thousands of patients? The concern is not simply who is present. It is who is missing. Patients who actually receive the treatments should have a meaningful opportunity to contribute before decisions are made about whether those treatments should continue.

The scale of the problem

Chronic pain is not a small or marginal issue. Public Health Scotland figures show 5,832 referrals to pain management services in the quarter ending 31 March 2026, with 6,894 people waiting for their first appointment. The Scottish Government has previously recorded approximately 20,000 new referrals to specialist pain clinics annually. There is also considerable variation between Health Boards in the treatments provided. This matters because variation in service provision can become inequality in patient care. Access should not depend on a patient's postcode.

What is happening to specialist interventions?

The three treatments at the centre of the current concern are: ■ intravenous lidocaine infusions; ■ localised injections; ■ radiofrequency treatments. These are specialist treatments. They are not required by every chronic pain patient. The concern is that access to them is being reduced throughout Scotland, including for patients who have used them successfully for years. Information obtained through Freedom of Information has allowed patients to see some of this variation. For example, figures supplied to patients indicate that NHS Greater Glasgow & Clyde provided approximately 5 lidocaine infusions, 570 injections and 112 radiofrequency treatments over the relevant period - around 687 interventions. NHS Tayside, with a much smaller population, provided approximately 871 lidocaine infusions, 281 injections and 79 radiofrequency treatments - around 1,231 interventions. These figures raise an obvious question: Why can access to specialist pain treatment vary so dramatically between Health Boards, when the clinical needs of patients do not stop at the Health Board boundary? I would like to see much greater transparency about what treatments each Board provides, how many patients receive them and how many are waiting.

NHS Highland — an immediate concern

The lead clinician built the Highland specialist service from 2009. I have been a patient of the service since that time. It was always very busy, and patients knew there was usually a waiting list of around 300-400 people. A few years ago, however, NHS Highland stopped referring new patients for these clinical interventions. Patients see this as the first step in the dismantling of a service which had been very popular and highly valued. Surely, if some patients were judged clinically suitable for these treatments, why did they not have the same human rights as us “historic” patients who were already receiving them? It is difficult not to believe that financial pressures are now influencing access to treatment. The lead clinician retired and subsequently returned on a contract in September 2022. However, new patients could not be referred to him for clinical intervention. By March 2026, patients were becoming increasingly concerned about what would happen when his contract came up for renewal in September. If it was not renewed, our future procedures were at risk. I contacted local MSPs for assistance. Patient concerns about the rundown or possible closure of the service were subsequently raised publicly, including at First Minister’s Questions on 19 March 2026 by Rhoda Grant MSP. In a letter to Rhoda Grant on 19 March 2026, following the concerns she raised at First Minister’s Questions, the Minister for Public Health, then Jenni Minto, said that NHS Highland had told Scottish Government officials that “no decisions have been taken about any aspect of the service”. She also said that local communities should be consulted about any proposed changes. Rhoda Grant continued to pursue the matter with NHS Highland and Scottish Government Ministers and received a huge response from patients online. She subsequently retired at the May election, but wrote to me and other MSPs asking that the matter continue to be pursued, as NHS Highland had promised to answer the questions she had raised. She has still not received those answers. I have now been informed that, on 25 August, a campaigner received a letter from NHS Highland responding to questions that had been raised as far back as April. From what I understand, the Board’s position has changed very little. The lead clinician's contract is still under consideration. An application has apparently been made to the Board, but the Board’s financial position is referred to. The response says that treatments are continuing in the meantime, but refers to injections and does not appear to address the position regarding lidocaine infusions. For patients who have been waiting six months for clear information, this is confusing rather than reassuring. At the end of August, patients are still left not knowing whether the service will continue in September. The lead clinician's current contract is due to end in late September 2026. No alternative consultant has been recruited to provide these clinical interventions. For patients who rely on regular treatment, this creates profound uncertainty and distress. We should not have to wait until a specialist service disappears before discovering whether there is actually a plan for the patients who depend upon it.

Good intentions harmed behind the scenes

I want to acknowledge that this has not always been the case. Opposition parties have generally been helpful to patients. There was also a period when the Scottish Government itself took important steps forward. Former Health Secretary Alex Neil supported specialist chronic pain care and secured Government funding for a specialist residential pain service in Glasgow. It was established to ensure that people with the most severe chronic pain did not have to be sent to England for treatment, sometimes as far away as Somerset. Scotland's first residential pain service was warmly welcomed and thrived. It was particularly important for people from areas such as the islands, where specialist services remain limited or unavailable. However, in 2025 Government funding for the service was quietly removed without patients being informed. Patients discovered through Freedom of Information that the then Public Health Minister, Jenni Minto, had asked Health Boards to pay when they referred patients. The Government subsequently described the funding as having been a "pilot project", suggesting that transferring the cost to Health Boards was therefore normal. But Government funding had supported the service for ten years, since 2015. For patients, it is difficult to understand how something funded for a decade can then be described simply as a short-term pilot when the funding is removed. Mr Neil's attempt to secure a future for specialist residential pain treatment has therefore been badly undermined, and patients were not told. This is another example of why transparency matters.

A past policy decision which is being revived

I also believe the Committee should be aware of where some of the current direction on chronic pain began. In the Scottish Government's 2020 Programme for Government, former First Minister Nicola Sturgeon wrote that a new chronic pain framework would build on self-management and "reduce long-term reliance on specialist services and treatments that demonstrate limited health outcomes." To patients, the wording suggested that a policy direction had already been decided. There was no discussion with the thousands of patients affected about what this could eventually mean for established specialist treatments. The phrase "limited health outcomes" also concerns me. Patients are repeatedly told that chronic pain is often incurable and that treatment is therefore about managing or relieving it. If an injection gives someone five months of meaningful relief, or a lidocaine infusion gives someone six to eight weeks in which they can function much better, that is a substantial outcome for that person. It can mean less medication, greater independence, fewer crises and the ability to participate in ordinary life. The question should surely be whether the treatment works for that patient, not whether it permanently removes their pain. The pandemic interrupted the policy direction set out in 2020. My concern is that it is now being revived, while patients continue to struggle to find out what is happening behind the scenes.

Self-management is not the problem

Self-management has value. Many chronic pain patients have spent years learning how to manage their condition and use these skills every day. I do this myself. The concern is when self-management is used as a reason to reduce access to specialist treatment for patients whose pain remains severe despite self-management and other approaches. It is not a case of one or the other. For many of us, effective clinical treatment is what gives us enough function to use the self-management skills we have learned. The distinction is crucial. Reducing treatment for an individual patient who finds it ineffective is not the issue. Removing an effective treatment from a patient who demonstrably benefits from it, with the agreement of their clinician, is very different. SHTG's 2026 recommendation provides a much more nuanced position: specialist interventions should be considered for appropriate patients within holistic, multidisciplinary care, with patient-important outcomes being measured. I would like to see that distinction made clear in how chronic pain services develop.

What I would like to see

1. Keep what works I would like to see the NHS provide patients with treatments that are clinically appropriate and demonstrably help them, alongside self-management, rehabilitation and other support. 2. Measure what matters Success should not be measured only by whether pain exists. It should also ask: ■ Can the patient walk? ■ Can they work? ■ Can they care for their family? ■ Can they sleep? ■ Can they reduce medication? ■ Can they participate in ordinary life? 3. Reduce postcode inequality I would like to see patients with similar clinical needs having access to appropriate specialist interventions regardless of which NHS Board they live in. 4. Be transparent about changes Patients should be told clearly and in good time when services or treatments are being changed, reduced or withdrawn. They should not have to discover what is happening through FOI requests, campaigning or individual conversations. 5. Meaningful patient involvement I would like to see patients who actually receive treatments involved early, independently and meaningfully when decisions are being made about their future. The SHTG process showed that this can work.

Conclusion

Over 20 years ago, an early Holyrood Health Committee recognised the importance of specialist pain services and helped Scotland develop outpatient provision which was regarded at the time as progressive. Since then, thousands of people with chronic pain have benefited from specialist services. That progress should not be lost. My husband and I are two ordinary patients who demonstrate what these treatments can achieve. They have not cured us. They have enabled us to live. The NHS does not need to promise every patient every treatment. It needs to ensure that the right patient can access the right treatment when it is clinically appropriate - and that patients are listened to before decisions are made that affect their lives. For me, that is what good chronic pain management looks like. Give patients the treatments that work. Measure the difference they make. Listen to the people who depend upon them. I hope my experience, and that of the many other patients who have contributed evidence, helps inform the Committee's consideration of how chronic pain services can work better for patients across Scotland.

Written Submission from Long Covid Scotland

Long Covid in Scotland: The Implementation and Accountability Gap

Long Covid Scotland (LCS) welcomes the opportunity to provide written evidence to the Committee.

LCS exists to ensure that people living with Long Covid are heard in the development, delivery and scrutiny of health and social care in Scotland. We bring together lived experience and evidence to advocate for better services, challenge gaps and inequalities in provision, scrutinise Government and NHS policy, and press for meaningful implementation.

Our central message to the Committee is straightforward: **Scotland does not need to start again on Long Covid. It needs to deliver what has already been learned, recommended and committed to.**

1. The issue is now implementation, not another cycle of policy development

Scotland has accumulated a substantial body of evidence, clinical expertise, lived experience, evaluation and strategic work on Long Covid over several years. The Scottish Parliament has previously examined Long Covid and made recommendations, while significant work has also been undertaken through the Scottish Government, National Services Scotland, clinical networks, research and lived-experience engagement.

Yet many of the issues identified several years ago remain unresolved.

The key question for people living with Long Covid is therefore not whether more evidence is required before action can be taken. It is whether existing recommendations, commitments and learning will now be implemented.

A further cycle of consultation, strategy development and policy design risks creating further delay without addressing the implementation gaps that patients are experiencing now.

The recent **Long Term Conditions (LTC) Advisory Group 5: Post-Infectious and Associated Complex Chronic Syndromes (PACCS)** report provides a roadmap for improving services for people with Long Covid and related post-infectious conditions and should now be implemented without further delay, rather than being revisited through another cycle of policy development. We strongly recommend that the authors of this report should fully brief the Committee.

The priority should be to translate the substantial work and recommendations into **consistent, accessible and effective services across Scotland**.

2. Parliamentary scrutiny and accountability

The Scottish Parliament has already undertaken significant scrutiny of Long Covid, including its previous inquiry and recommendations. However, there has been limited subsequent parliamentary scrutiny of whether those recommendations have been implemented in practice.

This creates an **accountability gap**. In the absence of sustained independent scrutiny, responsibility for assessing implementation has largely remained with the bodies responsible for delivering and overseeing services, including NHS Boards and NSS, without sufficient independent scrutiny of implementation .

There is a risk that, without independent scrutiny, the system is effectively assessing its own progress. This makes it difficult for Parliament, patients and the public to establish whether commitments have translated into consistent services, whether funding has achieved its intended purpose, and whether previous recommendations have actually been delivered.

The Committee now has an opportunity to address this gap by establishing what has happened since the Parliament's previous scrutiny, what recommendations have been implemented, what remains outstanding, and what mechanisms are in place to provide independent assurance of progress.

3. Access to care remains inconsistent

There remains significant variation in Long Covid provision between NHS Boards. The experience of a person seeking care can depend substantially on where they live, with differences in access to care, pathways, clinical leadership, specialist input, assessment, rehabilitation and ongoing support.

Our 2026 analysis of FOI responses from NHS Boards demonstrates continued variation in provision and **little evidence that the problems identified in 2024 have been resolved**. It also highlights inconsistent approaches to reporting activity, waiting times and outcomes, with persistent and systemic gaps in data collection making it difficult to assess whether services are delivering equitable access.

The evidence points to a continuing **postcode lottery in access to Long Covid care**.

Previous Scottish evidence from 2024 demonstrated substantial unmet need: **72% of respondents to Chest Heart & Stroke Scotland research said they needed support, while 82% reported difficulty accessing services. Separately, 87.36% of ALLIANCE respondents reported a negative experience of accessing Long Covid services.**

A national commitment to Long Covid services must therefore mean more than allowing Boards to develop different local interpretations. There needs to be a clear national expectation and a baseline regarding what people should be able to access, regardless of where they live.

4. People need medical care as well as rehabilitation

Long Covid is a complex, multi-system condition. While rehabilitation and self-management can form important components of care for some people, a rehabilitation-only approach does not adequately address the needs of everyone living with Long Covid.

People may require assessment, diagnosis, investigation, clinical management, specialist input and coordination across different parts of the health and social care system.

The original Scottish Government policy approach recognised the importance of care coordination and multidisciplinary working. However, implementation has been inconsistent. For example, the **absence of a consistent national pathway for the assessment and treatment of postural orthostatic tachycardia syndrome (POTS)** and other forms of autonomic dysfunction associated with Long Covid is a significant gap in provision.

The Committee should therefore consider whether current services provide a genuinely multidisciplinary model of care, **rather than services that rely primarily on rehabilitation without sufficient access to medical oversight or appropriate specialist expertise.**

5. Children and young people require urgent action

Children and young people (CYP) should be an **immediate implementation priority**, rather than an issue deferred to a future post 2027 LTC Strategy.

There is currently insufficient consistency in Long Covid provision for children and young people across Scotland, with gaps in dedicated pathways, specialist expertise, assessment, rehabilitation and ongoing clinical support. This leaves children and families without a clear, equitable route to care, with consequences for education, development, family life and wellbeing.

LCS believes Scotland urgently needs a **national framework for Long Covid in children and young people**, supported by appropriate clinical expertise and clear pathways across all NHS Boards.

6. National signposting is urgently required

People living with Long Covid should not still have to navigate a complex and inconsistent system to discover what support is available to them.

Patients need equitable access and clear national signposting now. A new LTC Strategy will set the policy direction, but it will not, by itself, change the services patients receive. It will not automatically create services, improve pathways, recruit staff or address existing gaps in

provision. Meaningful changes to frontline services could therefore realistically be pushed into 2027 or beyond.

People living with Long Covid should not have to wait for a future strategy or subsequent implementation work to access clear information about the care and support that should already be available to them under current recurrent funding.

7. Existing recommendations should be implemented

LCS believes the Committee should focus on implementation of recommendations and commitments that already exist, including those arising from previous parliamentary scrutiny.

Specific questions the Committee should seek answers to:

- Which previous parliamentary recommendations have been implemented, and which remain outstanding?
- Where implementation is incomplete, why, and who is responsible?
- How has Long Covid funding translated into identifiable services and outcomes?
- What variation exists between NHS Boards, and how is this being addressed?
- Who is ultimately accountable for delivering national Long Covid commitments?
- How is implementation independently monitored, measured and publicly reported?

The Committee should also seek clarity from the Scottish Government and NSS on **what has been delivered, what remains outstanding, how funding has translated into services, and who is accountable for ensuring that agreed recommendations are implemented.**

8. Conclusion

Scotland has already spent years identifying the challenges associated with Long Covid and developing policy responses. The evidence now points to a clear implementation and accountability gap.

People living with Long Covid cannot wait for another cycle of policy development. They need action on care, access and equity now. The PACCS recommendations should be implemented now. The forthcoming LTC Strategy can provide an important wider framework, but it should not become a reason to defer action on Long Covid until 2027 or beyond. Existing commitments and recommendations should be implemented in parallel.

Long Covid Scotland asks the Committee to focus on **implementation, equitable access and accountability**, ensuring previous parliamentary scrutiny leads to action. The PACCS report is an available roadmap now; the LTC Strategy is a future framework. The latter must not become a holding mechanism for the former.

The priority should now be simple: deliver the care that people with Long Covid have already been told they should be able to access.

Health, Care, and Sport Committee: 2 September 2026 evidence session

SAMH submission

Introduction

We welcome the opportunity to provide written evidence to the Health, Care and Sport Committee ahead of our appearance on 2 September 2026. Our evidence focuses on the ongoing mental health crisis in Scotland and the urgent need for the Scottish Government, Scottish Parliament, local government and partners - including the third sector - to ensure there is a genuine shift across the mental health system to prevention and early intervention. It also highlights the importance of prioritising the needs of people living with mental illness, and in particular tackling the mortality gap between people living with a mental illness and those without.

Beyond this written submission, we encourage the committee to read our 2026 Scottish parliamentary election manifesto. It sets out further actions across key areas – such as suicide prevention and children and young people's mental health – that we believe the Scottish Government and Scottish Parliament should take to end Scotland's mental health crisis.[1]

Scotland's mental health crisis

Scotland is in a mental health crisis. 704 people died by suicide in 2024 – almost two people every day.[2] Loneliness has been recognised by the Scottish Government as a public health crisis.[3] Meanwhile, demand for mental health support continues to far outstrip the supply of services.

In the most recent census, one in nine Scots said they have a mental health condition – more than double the rate in 2011.[4] Poor mental health is increasing across Scotland at a higher rate than any other health condition.

One of the starkest illustrations of the mental health crisis in Scotland is the fact that people with mental illness die on average 15 years earlier than people without.[5] Of these early deaths, two-thirds are from preventable causes which are too often overlooked or dismissed because of a person's diagnosis of mental illness.[6]

Scotland's mental health is not in a good place, and the system is not meeting the needs of the people it was set up to help. The case for both radical reform and increased investment has never been stronger. Yet the previous Scottish

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[1] SAMH (2026) Taking Action for Scotland's Mental Health - SAMH's Manifesto for the 2026 Scottish Parliament election

[2] National Records of Scotland (2025) Probable Suicides 2024

[3] Scottish Government (2023) Social isolation and loneliness: Recovering our Connections 2023 to 2026

[4] Scottish Government (2024) Scotland's Census 2022 - Health, disability and unpaid care

[5] Audit Scotland (2023) Adult Mental Health

[6] Dregan et al. (2020) Potential gains in life expectancy from reducing amenable mortality among people diagnosed with serious mental illness in the United Kingdom

Government made little progress against their funding and reform commitments in the last parliamentary session.[7]

Indeed, in 2021 the Scottish Government set a target that 10% of frontline NHS expenditure would be on mental health and 1% on Children and Adolescent Mental Health Services (CAMHS) by the end of that session. Data published in August 2026 covering financial year 2024/25, shows that the spending targets had not yet been met, with 9.14% of NHS spending on mental health and 0.84% on CAMHS.[8] Data from the NHS benchmarking project highlights that Scotland is spending less on mental health, particularly per-capita, compared to other UK nations and international comparators, with Scotland only spending $229 in reporting year 2026 compared to $272 in England and $592 in New Zealand (figures in USD$).[9] National waiting time targets for NHS Psychological Therapies have never been met and over a third of children and young people referred to Children and Adolescent Mental Health Services (CAMHS) are rejected.[10]

But we know that the solution to Scotland's mental health crisis cannot be solved by the NHS alone. We need more investment and capacity in the system. But we also need to change the system itself to meet people's needs – including much more community and preventative support across the country, to stop small problems becoming big problems.

How to tackle Scotland's mental health crisis

1. A meaningful shift to prevention

It is crucial that over the next parliamentary session real progress is made to reform health and social care, re-orienting the mental health system to prioritise prevention, rooted in Scotland's communities. This does not mean essential clinical support - particularly for people living with mental illness - should be cut. We recognise the extreme pressures faced by psychiatric services, including on workforce, which requires urgent action.[11] Rather, greater investment in preventative and community provision will ensure people living with mental health problems can access support quickly and in many cases before their mental health deteriorates, ultimately reducing pressure on crisis and statutory provision.

We have reason to be cautiously hopeful. Key strategic building blocks for a preventative mental health system already exist through the Population Health Framework (PHF) and Health and Social Care Service Renewal Framework (SRF)

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[7] Audit Scotland (2023) Adult mental health
[8] Public Health Scotland (2026) Scottish health service costs - summary for financial year 2024 to 2025
[9] NHS Benchmarking project (2026) International Mental Health Benchmarking Report
[10] Public Health Scotland (2026) Child and Adolescent Mental Health Services (CAMHS) waiting times - Quarter ending March 2026
[11] RCPsych (2023) State of the nation report - The psychiatric workforce in Scotland 2023

published in 2025.[12,13] We welcomed the publication of these frameworks, both of which are intended to facilitate a shift to a 'prevention-focused system', with a focus on reducing inequality and tackling the social and economic factors negatively impacting health, while centring action (and investment) in place and community. We believe this approach, particularly shifting activity and associated resource to community settings, is the right one to tackle Scotland's mental health crisis.

But while the aspirations of the PHF and SRF are welcome, more urgent progress must be made on implementation. We believe implementation and monitoring of the frameworks is an important area for the Committee to explore, including in the context of the mental health system. Unfortunately, early commitments from the frameworks have not been achieved. For example, the Scottish Government and COSLA committed through the SRF to publishing an outcomes framework in its first year, which would translate SRF priorities into measurable outcomes. This commitment has not been fulfilled. We call on the Scottish Government and COSLA to publish the promised outcomes framework and believe the outcomes framework and wider evaluation and monitoring mechanisms for the SRF and PHF should include clear definitions and reporting of preventative spend, as well as measuring the mental health and wellbeing impact of preventative spend. We echo calls made by the ALLIANCE and others that the Scottish Government's renewed prevention policy intent, provided by the PHF and SRF, must be "translated – without delay – into specific, fully resourced, and measurable actions at the national and local levels"[14].

We also believe the Committee may be interested in exploring the wider mental health strategic and policy landscape, to determine if there is alignment and coherence between the PHF and SRF and key Scottish Government and COSLA strategies such as the Mental Health and Wellbeing Strategy and upcoming refreshed delivery plan (due in Autumn 2026).

2. Community mental health support

Community mental health services - from peer support to therapeutic horticulture and beyond - provide vital support across the whole mental health spectrum, from early intervention and prevention to supporting people living with mental illness to live as equal members of our diverse communities. Enhancing and prioritising community mental health provision, much of which is delivered by the third sector, is key to shifting to a system based on prevention.

But the community health and social care system is under extreme financial pressure. Local commissioning and funding of many community mental health and social care services is the responsibility of local Integrated Joint Boards (IJBs) which are under-funded and over-stretched, resulting in damaging cuts to local

[12] Scottish Government and COSLA (2025) Scotland's Population Health Framework 2025-2035
[13] Scottish Government and COSLA (2025) The Health and Social Care Service Renewal Framework
[14] Alliance (2025) Joint statement calls for urgent action on prevention

services. Audit Scotland projected a funding gap for IJBs of £449 million in 2025/26, requiring significant cuts to local health and social care services.[15]

We believe the Committee may wish to explore funding and commissioning arrangements for community mental health services, as well as the longstanding disconnect between positive Scottish Government strategic objectives for mental health and the challenging reality faced by people trying to access help for their mental health.

In the context of mental health, the Scottish Government spends £15m annually on the Communities Mental Health and Wellbeing Fund for Adults and a further £15m annually on the Children and Young People's Community Mental Health and Wellbeing Supports Fund.[16] These funds are the Government's flagship initiatives when it comes to tackling mental health inequalities and delivering early intervention and preventative community mental health support. While welcome, they are limited in scope and have not resulted in a strategic or consistent approach to local mental health provision. There is also a lack of robust outcome data for the projects these funds support, meaning we cannot assess their impact.[17]

3. The Nook

We believe that The Nook – our national network of free walk-in mental health support hubs – can play a central role in operationalising the policy intent of the PHF and SRF, by revitalising community mental health with a high quality and consistent level of support, finally giving people experiencing mental health problems a place to ask once and get help fast.

There is no need to book an appointment or be referred and there are no waiting lists. The Nook offers non-clinical help including: 1-on-1 and group support; capacity-building workshops; information, advice, and self-help tools; wellbeing coaching; talking therapy; and suicide-related bereavement support. An extensive outreach programme runs alongside this, helping many thousands more people in areas surrounding each Nook. We actively engage with under-served communities, ensuring services are not only accessible but culturally relevant and tailored to local needs.

We believe that The Nook will – and is beginning to – reduce pressure on statutory services by supporting people early and preventing their mental health from worsening. It will also support people to 'wait well' for NHS mental health treatment such as psychological therapies. With the ability to reach thousands of people, we believe The Nook will provide clear value for money – which is why we

[15] Audit Scotland (2026) Integration Joint Boards: Financial bulletin 2024/25 Financial bulletin 2024/25
[16] Scottish Government (2024) £30 million mental health funding
[17] Scottish Government (2025) Communities Mental Health and Wellbeing Fund for Adults: impact report - year 2 2022-2023

are investing £10m of our own money, raised through donations, to create the first round of Nooks.

Since the first Nook opened in Glasgow in October 2025 – followed by another in Aberdeen in June 2026 – we have supported over 6,000 people across the network. More Nooks are on the way, with initial locations chosen to prioritise communities experiencing poor mental health outcomes but also poverty, unemployment, and social exclusion, ensuring support reaches those who need it most. But we know all communities would benefit from access to The Nook which, if made available across Scotland, could provide a systematic and consistent approach to community mental health support.

We warmly welcomed the support for The Nook across nearly all major parties' 2026 election manifestos. With the Scottish National Party forming the current Scottish Government, we were pleased by the party's commitment to invest in The Nook.[18] We look forward to seeing this translated into Scottish Government policy through the 2027/28 Scottish Budget.

We would be delighted to have the Committee visit one of our Nooks to meet staff and learn more about our stigma-free, open-access approach to community mental health support. We are also gathering significant amounts of data to evaluate The Nook, including health outcomes data for people supported by the Nook and evidence of the impact on local statutory and other services. We expect to have early data available to share in 2027.

4. People living with mental illness

The needs of people living with mental illness are too often overlooked. Nothing makes this clearer than the persistent mortality gap which sees people with mental illness die on average 15 years earlier than people without. Of these early deaths, two-thirds are from preventable causes which are too often overlooked or dismissed because of a person's mental illness diagnosis.[19,20] This injustice needs to end.

The mortality gap is longstanding, with figures published by Public Health Scotland (PHS) showing that people in contact with mental health services are over five times more likely to die prematurely than the general population.[21] The gap spiked to over eight times more likely to die prematurely during the Covid-19 pandemic, but has since returned to pre-Covid-19 rates.[22]

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[18] Scottish National Party (2026) On Scotland's Side: SNP Manifesto 2026
[19] Audit Scotland (2023) Adult Mental Health
[20] Dregan et al. (2020) Potential gains in life expectancy from reducing amenable mortality among people diagnosed with serious mental illness in the United Kingdom
[21] Public Health Scotland (2026) MH Quality Indicators
[22] Note: The latest premature mortality data for people living with mental illness was published by PHS in 2023, this included data up to and including 2022. Following a pause in annual publication, we expect PHS to resume publishing premature mortality data in 2026.

As set out on in our Show Up campaign and our 2026 Scottish parliamentary election manifesto, we believe there is clear, evidenced-based action that the Scottish Government should take to tackle the mortality gap.[23]

Issues which contribute to the mortality gap include:

- Barriers to accessing health care and screening, as well as 'diagnostic overshadowing' – where someone's physical health concerns are misattributed to their mental health.
- A lack of tailored specialist support to tackle lifestyle issues (such as smoking and physical inactivity) disproportionally experienced by people living with mental illness.[24]
- Disproportionate rates of poverty experienced by people living with mental illness.

Actions we believe would help to tackle the mortality gap, and which the Committee may wish to explore, include:

- Introducing an entitlement to annual physical health checks for people with mental illness, backed by a fully-funded and co-produced take-up strategy.

  Annual physical health checks for people living with mental illness are already offered in England – with 58% of eligible people receiving one in 2025/26[25] - and the Scottish Government already funds annual physical health checks for people aged over 16 with learning disabilities.[26] We believe everyone living with a mental illness in Scotland should have the same right.

- Ensuring everyone living with a mental illness has access to social prescribing opportunities to support their mental and physical health.

  We believe tailored support for people living with mental illness to live healthy lives should be freely available and easy to access. Social prescribing, supported by primary care and community link workers, will be a key route to this support – as will the annual physical health check.

  We welcome that the Scottish Government and COSLA's PHF includes a commitment to a National Social Prescribing Framework, with community link workers playing a central role.[27]

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[23] SAMH (2026) Taking Action for Scotland's Mental Health - SAMH's Manifesto for the 2026 Scottish Parliament election
[24] NHS Health Scotland (2017). Inequality Briefing 10. Mental Health
[25] NHS England (2025) Physical Health Checks for People with Severe Mental Illness, Q2 2025/26
[26] Scottish Government (2025) Scottish Annual Health Checks for People 16+ with Learning Disabilities, 2024/25
[27] Scottish Government and COSLA (2025) Scotland's Population Health Framework

- Tackling poverty as a leading cause of poor mental health and earlier deaths, by funding a national roll out of the Individual Placement and Support (IPS) employability programme by 2031, and ensuring our social security system is adequate and works for people with mental illness.

  The mortality gap will not be tackled without supporting people with mental illness out of poverty and preventing people living with mental illness entering poverty in the first place. Evidence clearly shows that the relationship between poverty is bi-directional with mental illness increasing the likelihood of living in poverty, and poverty increasing the likelihood of developing mental illness.[28] While tackling poverty is multifaceted, we believe that effective employability support and an adequate social security system are two key factors to address and prevent poverty among people with mental illness.

  Individual Placement and Support (IPS) is the most effective employability model for people living with mental illness. The evidence base supporting the use of IPS is clear and shows that it is significantly more effective at supporting people with mental illness into, and sustaining, competitive employment than traditional approaches.[23]

About SAMH

SAMH (Scottish Action for Mental Health) is Scotland's national mental health charity. For over 100 years we've been here for Scotland's mental health and wellbeing, providing mental health support and accessible information. We listen to what matters in each local community, and campaign nationally for the changes that make the big and little differences in life. Now more than ever, we need to make change happen. We're standing up for Scotland's mental health.

[28] Mental Health Foundation and Joseph Rowntree Foundation (2016) poverty-and-mental-health-report.pdf