

Health, Care and Sport Committee
7 October 2026
7th Meeting, 2026 (Session 7)

Pre-budget scrutiny 2027-28: Preparing for future challenges in the health, care and sport sectors

Introduction

1. At today's meeting, the Committee will take evidence from a panel of witnesses to inform its pre-budget scrutiny for 2027-28.
2. Pre-budget scrutiny aims to influence the formulation of spending proposals while they are still in development. The Scottish budget is due to be published on Thursday 3 December, following the UK Budget on Wednesday 28 October.
3. As part of its pre-budget scrutiny for the financial year 2027-28, the Committee agreed to explore how the Scottish Government is preparing for future challenges in the health, care and sport sectors.
4. This is the Committee's first evidence session on pre-budget scrutiny, focusing specifically on health. Separate evidence sessions focusing on the care and sport aspects of the Committee's remit will be held on 28 October, followed by an evidence session with the Scottish Government on 4 November.
5. The Committee will then publish its conclusions and recommendations shortly after, and ahead of the Scottish Budget on 3 December 2026.
6. Written submissions from witnesses have been included in the **annexe** to this paper. The Scottish Health Equity Research Unit, who are unable to attend today, have provided a written submission, which is also available in the annexe.
7. A separate SPICe briefing paper (**Paper 2**) is available to inform this session.

Today's meeting

8. The Committee will hear from the following stakeholders at today's meeting:
 - Professor Linda Bauld, Professor of Public Health and Co-Head, Population Health Sciences, University of Edinburgh
 - Alison Payne, Research Director, Enlighten
 - Robbie Pearson, Chief Executive, Healthcare Improvement Scotland
 - Richard Robinson, Audit Director, Audit Scotland
9. Members will have up to two hours for the panel.
10. The focus of today's session is on high-level strategies, frameworks, population demographics, funding formulas and structural changes.

11. **Members should also note that Professor Linda Bauld is appearing in her academic capacity, and not as a Scottish Government official¹.** The Committee will have the opportunity to question the Scottish Government when it hears from the Cabinet Secretary in November, and therefore questions on matters of government policy should be reserved for that session.

Action

12. Members are invited to question witnesses on how the Scottish Government should prepare now for future challenges in the health sector.

Clerks to the Committee
October 2026

¹ Professor Bauld is also Chief Social Policy Adviser for the Scottish Government

Pre-budget scrutiny submission

Health, Care and Sport Committee

Introduction

1. The Auditor General for Scotland, working with Audit Scotland and the Accounts Commission, helps make sure public money is well spent to meet the needs of Scotland's people. Through the audit process he works to provide clear, independent and objective assurance on how effectively public money is being managed and spent. He does this by reporting in public on spending and financial management, by examining what public bodies are doing to address short- and longer-term issues, and by considering how services are designed and delivered. This is more important than ever given the challenges and uncertainties facing Scotland's public services and public finances.

Continuing demand and sustainability pressures

2. For several years, the Auditor General for Scotland has highlighted the growing pressures facing the NHS in his national and local audit work. The Auditor General reports annually on the performance of the NHS in Scotland, with his [2026 report](#) due for publication on 1 December 2026. His [2025 report](#) highlighted that despite a real-terms funding increase, the NHS in Scotland was not financially sustainable, and performance has not improved as the Scottish Government had intended. In particular, the Auditor General concluded that while NHS boards achieved unprecedented levels of savings they are still struggling to break even. In addition, ambitions such as shifting the balance of care to the community are long-standing and this persistent implementation gap, between policy ambitions and delivery on the ground, needs to be addressed.

3. Managing systems pressures in the NHS can affect both productivity and patient experience. The Auditor General noted in his [delayed discharges](#) report that in 2024/25, people spent 720,119 clinically unnecessary days in hospital at an estimated cost for hospital days alone of at least £440 million a year.

4. There also remain difficulties in gaining the system-wide information to understand how different parts of the public sector are working together. The Auditor General's joint report with the Accounts Commission on [community care](#) highlights the difficulties that a lack of comprehensive and consistent national performance information causes Integration Authorities (IAs) and Health and Social Care Partnerships (HSCPs).

The 2027/28 budget against a backdrop of reform

5. The 2026 budget takes place against a backdrop of large-scale planned structural reforms, alongside existing plans for efficiency savings. For health, we expect recent [Programme for Government](#) announcements to build upon, and align with, previous plans published in 2025, in particular

the Operational Improvement Plan, Health and Social Care Service Renewal Framework, and Population Health Framework.

6. The Auditor General recently [published a blog](#) on the importance of attention to detail for reform plans to succeed. Without clear priorities, robustly costed and adequately resourced policies, agreed delivery timelines, and well understood measures of success, meaningful reform will be difficult to deliver. It will also make scrutiny of annual budgets more difficult.

7. Managing NHS spending is critical to the wider financial sustainability of Scotland's public finances. The [Scottish Fiscal Commission's analysis of the Scottish Spending Review \(SSR\) provided in its fiscal update](#) stated that over the next three years, almost half of the £1.5 billion of efficiencies is expected to come from NHS boards. In 2026/27 alone, NHS boards are responsible for generating 44 per cent of the £563 million planned savings across all portfolios.

8. The Scottish Government chose not to publish a Medium-Term Financial Plan in 2026. As such, there is no published assessment for Parliament to scrutinise showing how the Scottish Government will manage and fund the potentially significant costs of NHS reform, alongside the continuing pressures of day-to-day delivery of services. As stated to the [Public Audit Committee](#), the Auditor General will continue to engage with the Scottish Government about the timescales for changes to NHS board structures, remits of the new structures and how it will be delivered.

Prevention and long-term change

9. Investing in prevention is a key part of the Scottish Government's longer-term plans. However, as the Auditor General stated to the [Public Service Reform Committee](#), implementing the scale of public service reform required in terms of the wider preventative-based model, including hospital at home and tackling child poverty, at the same time as implementing structural change is a significant undertaking.

10. It is encouraging that the Scottish Government has [piloted an approach to identifying preventative spend](#) earlier this year. The Scottish Government has recognised that at present, there is no comprehensive overview of Government spending on preventative activity. We agree with the Scottish Government that the budget would benefit from a clearer overview of such spending in order to scrutinise its sufficiency, consistency over time, and its relation to changes in long-term changes in the health of the population.

11. The longer-term population health changes needed to manage a sustainable budget and meet the ambitions of improved wellbeing do not depend solely on the success of spending in the health portfolio. Spending across portfolios, working together, all contribute towards meaningful change. For example, spending on poverty, education, justice and social

security all play a part. The Scottish Government will need to demonstrate and articulate how different parts of the Scottish budget work together, including how they align to the ambitions of the refreshed National Performance Framework which is expected to be published soon.

Written Submission: Health, Care and Sport Committee: Pre-Budget Scrutiny 2027-28

Professor Linda Bauld, Population Health Framework Programme Board Co-Chair

Introduction

It remains an unwelcome reality that communities across Scotland experience health, quality of life and even life expectancy differently. Evidence shows that our health is closely linked to the circumstances and environments in which we are born, grow up, live, work and age; known as the wider determinants or 'building blocks' of health. It also shows that investing in prevention is one of the most cost-effective interventions for improving population health and reducing inequalities.

Addressing these challenges requires coordinated action across all levels of government and public services, alongside communities, the third sector and wider partners. This requires action at both national and local level, with local partnerships playing a critical role in addressing the wider determinants of health, supporting people and communities to thrive, and helping to reduce inequalities.

Against this backdrop, the Population Health Framework (PHF), developed jointly by the Scottish Government and COSLA and informed by a wide range of partners, sets out a cross-government and cross-sector approach to improving population health and reducing inequalities over the coming decade. The PHF provides a common vision and framework for action across government, public services, communities and wider partners, helping to align efforts around shared outcomes. Reflecting the shared leadership underpinning the Framework, delivery is overseen by a Programme Board jointly chaired by Scottish Government, local government and the Scottish Government's Chief Social Policy Adviser.

The PHF also sits alongside wider reform and renewal activity across health, care and public services, including the Service Renewal Framework (SRF). The complementary approaches set out in the PHF and SRF support a more preventative, sustainable and person-centred system, combining service reform with action to improve population health and reduce inequalities.

Supporting a Shift Towards Prevention

Scotland has taken important steps toward a prevention-first approach through our Health and Social Care Renewal Framework and PHF, both of which provide an evidence-based focus on improving health and reducing inequalities. The PHF is underpinned by an ambition to improve life expectancy while reducing the life expectancy gap between the most deprived 20% of local areas and the national average by 2035, and by two initial evidence-based priorities: embedding prevention in our systems and improving healthy weight. Achieving these ambitions will depend on prevention and early intervention, action across the wider determinants of health, and effective collaboration between partners across the system.

Prevention must be at the heart of how we plan, budget and invest across the public sector. A preventative approach supports investment not only in services that respond to need, but also in the local services, community assets and wider determinants that help people stay well, support early intervention and reduce inequalities. Recent Budget decisions have reflected this approach, including £111 million on tackling child poverty, including increases

to the Scottish Child Payment; an additional £40 million investment in sport and physical activity; and over £160 million to support the [Alcohol and Drugs Strategic Plan](#).

The PHF supports this approach by promoting earlier action, targeting the drivers of poor outcomes and encouraging greater collaboration across organisational boundaries. Preventative budgeting is one example of how these principles are being embedded within decision-making and investment processes across the public sector. Over the past year, preventative budgeting pilots have been delivered across Scottish Government portfolios and nine NHS Boards with findings [published in June 2026](#).¹ Similar pilots are currently underway in nine local authorities, reflecting the important role of local partners in identifying and embedding opportunities for preventative investment.

Revised guidance and tools are now being used to inform a wider process to estimate preventative investment across the entire Scottish Budget. The aim is to complete a full tagging of the 2025/26 Scottish Budget later this year, with a view to integrating preventative investment reporting into the annual cycle by the end of 2026. An HSC Reform Preventative Investment Advisory Group has been established to build on the pilot outputs, explore how cross-cutting prevention issues are considered in funding decisions and generate insights on how preventative investment can be embedded more effectively.

Taking a Long-Term and Whole-System Approach

The PHF reflects a recognition that, while immediate pressures on services must continue to be addressed, sustained action on prevention and the wider determinants of health is also required. Improving population health and reducing inequalities will be important in helping to address growing demand for support and services. A persistent challenge for prevention is that action often requires sustained commitment over time. Benefits may emerge over the longer term and across multiple parts of the system.

Progress is supported through governance, monitoring and evaluation arrangements, including the Population Health Dashboard, which help to inform delivery, maintain accountability and strengthen understanding of how actions contribute to improved outcomes. In doing so, the Framework supports wider public service reform by encouraging partners to align activity and investment around shared population health outcomes, prevention and the reduction of inequalities.

Conclusion

As Scotland considers how best to prepare for future challenges, the PHF highlights the importance of investing not only in services that respond to ill health, but also in the conditions that create good health. By embedding prevention, strengthening the key building blocks of health and supporting coordinated action across national and local partners, the Framework provides a foundation for improving population health, reducing inequalities and supporting a more sustainable future.

¹ Territorial NHS Boards in pilot: NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Highland, NHS Lanarkshire and NHS Lothian. National NHS Boards in pilot: National Services Scotland and Scottish Ambulance Service.

Submission to the Health, Care and Sport Committee

For 7 October 2026

Healthcare Improvement Scotland (HIS) has a clear purpose to protect and enhance the safety and wellbeing of people who need health and care. We deliver this through two main aims: driving quality and enabling reform. Together these aims balance our assurance and regulation role with providing support to drive improvement. We are providing evidence to the committee in this context with a particular focus on current and future challenges in health and care and how improvements can be delivered, retaining a fundamental focus on the quality and safety of care.

The health and care system faces a range of significant challenges and opportunities, including technological advances, workforce evolution and structural reform. Together, these factors will influence how care is planned, delivered, and continuously improved.

In our hospital inspections we have been able to identify the areas of good practice and the pressures being experienced across NHSScotland. The inspection programme includes maternal healthcare, acute hospital services and acute psychiatric units.

While we also recognise a wealth of good practice, including staff working hard to provide kind and compassionate care, across the breadth of our assurance and improvement work we have observed gaps in the system in some of the circumstances which enable high quality care, specifically in leadership, culture and governance.

Quality and safety are not hospital issues alone. It is important that those services such as primary and community health services, which can receive less visibility and scrutiny, are given appropriate consideration. To support a truly system-wide approach to quality and safety, there is a need for better and more consistent data and intelligence across all services.

We must also recognise the evolving landscape of independent healthcare in Scotland, a sector which is rapidly expanding in scale and diversity of service models. Growth in areas such as non-surgical cosmetic procedures and online prescribing are requiring even greater vigilance by regulators. As the regulator of the sector, we are adapting our approach and frameworks with patient safety remaining as the core principle.

As the external environment continues to shift, we must ensure that future decisions on service configuration, investment and reform are supported by timely and robust evidence on outcomes, quality, safety, equity, sustainability and value. HIS is developing its approach to evidence to play a more strategic role in supporting policy development, service redesign and system transformation, focused on addressing major health and care challenges and supporting decision-making across the system.

We believe there is a need to invest time and attention on those matters which may influence safety and the quality of care at the earliest possible stage. Our Warning Signs Analytical Framework sets the major factors which can lead to a deterioration such as culture, leadership and governance and which is drawn from evidence from across the UK.

The challenges facing healthcare rarely have simple or single solutions. As an organisation, our ability to join up assurance, improvement, engagement and evidence achieves a greater impact than each function could on their own. Much of our work is delivered through portfolios across these functions including in frailty, mental health, perinatal, and urgent and unscheduled care. For example, in maternal healthcare we began inspections of hospital maternity units, published national standards for maternal care, and ensured that our perinatal improvement programme is tightly aligned with the issues identified through inspection.

Operational pressures, financial constraints and performance targets can draw leadership attention to our acute hospitals, making it difficult to redirect resources and services towards a more preventative model of care. There are however significant areas where we are working with the system to make progress towards national ambitions for prevention, early intervention, person-centred care and care closer to home, including:

- [Focus on Frailty](#): system-wide improvement and integration
- [Hospital at Home](#): alternatives to hospital admission
- [Mental Health improvement](#): delayed discharge, inpatient safety, transitions of care
- [Alcohol and Drugs](#): transforming pathways to recovery and strengthening the planning and commissioning of services
- [Primary Care Phased Investment Programme](#): providing evidence and recommendations to inform future policy and investment

Improvement should be delivered through a distinctly Scottish approach to change. HIS is supporting system reform and renewal through the [Scottish Approach to Change](#), a structured framework to help health and social care systems to manage and deliver change well. It emphasises person-centred, safe and effective services while fostering innovation and continuous learning.

It is also essential that inclusive and robust engagement with people and communities occurs at the outset of changes to the planning and delivery of health and care services and this is supported by our [Quality Framework for Community Engagement and Participation](#), developed jointly with the Care Inspectorate.

We believe that people and communities should also be meaningfully engaged in shaping and informing quality and safety priorities. Our Gathering Views and Citizens' Panel reports apply insights from targeted engagement with communities across Scotland to inform recommendations for policy makers, in areas such as medicines safety, long-term conditions, the Charter of Patient Rights and Responsibilities, and personal continuity of care.

The central lesson for NHS boards is that, regardless of wider change programmes, they must maintain a relentless focus on patient safety, quality of care, staff experience and culture, and the early identification of risks and concerns.

Submission to the Health, Care and Sport Committee in relation to the Committee's Pre-budget Scrutiny 2027-28, from the Scottish Health Equity Research Unit (SHERU) 29/09/26

The Scottish Health Equity Research Unit (SHERU) is funded by the Health Foundation and based at the University of Strathclyde, bringing together the Fraser of Allander Institute and the Centre for Health Policy. We examine how socioeconomic policy can reduce health inequalities in Scotland and welcome the opportunity to contribute to the Committee's 2027–28 pre-budget scrutiny. This budget provides an opportunity to translate Scotland's long-standing preventative ambitions into spending decisions that prioritise those at greatest risk of early ill health and premature death. Our central recommendation is that significant preventative spending commitments should be shaped by 'implementation intelligence' (i.e. the knowledge held by local areas, frontline services and communities about what makes policies deliverable and preventative).

Questions 1 and 9: Preparing for future challenges and shifting towards prevention: SHERU's 2025 *Inequality Landscape* reports show that Scotland's persistent health inequalities are closely linked to inequalities in income, housing, education and employment (Catalano et al., 2025). Recent progress in reducing child poverty is welcome, particularly given the lasting effects of childhood circumstances on health, but remains short of Scottish Government targets. There are also important warning signs for other groups. Our analysis of men aged 18–44 identifies rising, post-pandemic poverty rates and greater exposure to persistent poverty than among men of the same age elsewhere in the UK in most years since 2016–17 (Thompson, 2026). The concentration of preventable deaths from drugs, alcohol and suicide among men in Scotland reinforces the need to look beyond population averages and prioritise those at greatest risk (Catalano et al., 2025).

Public support for prevention is strong but conditional, with greater caution in the most deprived areas about shifting resources away from existing need (Catalano, Smith and Jack, 2026). SHERU's new *Prevention in Practice* report (McHardy and Smith, 2026) draws on action learning with practitioners and leaders across housing, health, employability, justice and the third sector. Participants supported prevention, but crisis demand, housing shortages and statutory duties repeatedly displaced earlier action. Recurring barriers included short, restrictive funding cycles; workforce pressures and rising thresholds that 'filter' out some at-risk groups, including single adult men; fragmented accountability at service transitions; and information systems that record separate contacts rather than people's journeys. Forthcoming community peer research further underlines the gap between preventative ambitions and lived realities in disadvantaged communities. These insights provide essential 'implementation intelligence' which, we argue, Scottish Government is not making sufficient use of. Local partners can identify how policies will interact with existing demands, thresholds and duties, and whether staff have the time, resources and authority to deliver. Involving them after commitments are set leaves little scope to change policy design, budgets or accountability. Policies, including major budget decisions, should be co-designed with local areas and frontline services from the outset.

Our action learning (McHardy and Smith, 2026) illustrates how bringing different services together can turn dispersed knowledge about implementation into practical changes. In Edinburgh, discussions helped bring occupational therapy led support into a community health setting to help people stay in or return to work, and prompted senior responsibility for housing staff wellbeing. In North Lanarkshire, learning informed a homelessness prevention pilot, coordinated support plans for single adults, particularly men, and earlier identification of tenants' difficulties. These actions help make the case for ensuring cross-service learning is built into policy design from the outset. Yet, while these actions represent small steps towards prevention, a larger shift requires implementation to be designed into national policy decisions about prevention, especially around budgets and resourcing.

Questions 2 and 5: Allocating resources and supporting alternative delivery: Resources could be released for frontline support by reducing excessive and duplicative reporting, replacing multiple top-down performance requirements with fewer collaborative outcome measures, and improving incompatible recording systems. These changes could free staff time for coordination and sustained support. Conversely, service closures and staff departures caused by burnout or uncertain funding can carry hidden costs: trusted relationships may be lost, and people who have experienced repeated trauma or rejection. Multi-year funding, workforce support and continuity should therefore be assessed as investments in prevention, with these costs considered when judging proposed savings. The Committee could test the combined effects of spending increases, cuts and service changes on groups at greatest risk of early ill health and premature death. Young adult men at heightened risk of deaths from suicide, drugs or alcohol provide one example: SHERU's research and wider stakeholder engagement suggest they can fall between policy priorities, despite repeated service contact. Considering their likely trajectories, and costing missed opportunities for earlier support, would help distinguish genuine savings from costs displaced to homelessness services, police, courts and prisons, or arising through housing and employment difficulties after release.

Question 3: International examples: Ireland's *Connecting for Life* suicide prevention strategy demonstrates the value of collaboration across sectors and policy levels to support policy development and drive implementation. Scotland could strengthen prevention by employing similar arrangements for jointly developing, implementing and adapting policy. Iceland's approach to preventing substance use among young people illustrates the value of sustained investment, local data and collaboration with local communities to shape responses within a shared national framework. Both are explored in more detail in our *2025 Inequality Landscape* (Catalano et al, 2025).

Question 8: Financial sustainability and the shift in spending: SHERU does not have the information required to assess how realistic financial sustainability is alongside planned savings but, given experiences to date, our assessment is that it is risky to bank near-term savings from intervention or policy changes where implementation has not been planned in detail or where benefits may emerge years later or in another portfolio. The Committee could ask the Scottish Government what activity will be redesigned, what resources will support the transition, and what evidence underpins anticipated savings, including whether costs may be displaced to other services.

Suggestions as to what the Committee could consider asking Scottish Government to report: For each major preventative spending commitment, the Committee could ask how local intelligence shaped its design, who is responsible for transitions (of resources and people) between services, what capacity is funded and how delivery will adapt. Where budget decisions set out savings assumptions, the Committee could ask: What evidence supports the projected scale and timing of savings? Has the delivery model been developed and agreed with local partners? What implementation costs are included, and what happens if savings arrive later or do not materialise? Given limited progress with realising preventative ambitions, it seems sensible to also ask how progress will be assessed (we propose that people's experiences of timely support, reduced repeat presentations for key frontline services, and housing stability, are important markers of progress, alongside health outcomes, and that these should be disaggregated by population group to track inequalities).

Supporting evidence: Catalano, A., Congreve, E., Jack, D., McHardy, F. and Smith, K.E. (2025) [2025 Inequality Landscape Health and Socio-economic Inequality in Scotland in 2025](#), SHERU; Catalano, A., Smith, K.E. and Jack, D. (2026) [Poverty, Prevention and Fairness: Public attitudes towards health inequality and the social determinants of health in the Scottish Social Attitudes Survey](#), SHERU. Thompson, S. (2026) [Poverty dynamics among young adult men in Scotland](#), SHERU; McHardy, F. and Smith, K.E. (2026) [Prevention in Practice: Insights from Action Learning - Scottish Health Equity Research Unit](#)