OFFICIAL REPORT
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DRAFT

Health, Social Care and Sport Committee

Tuesday 27 January 2026

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 27 January 2026

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
4th Meeting 2026, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Fiona Bennett (Scottish Government)
Neil Gray (Cabinet Secretary for Health and Social Care)
Owen Griffiths (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 27 January 2026

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the fourth meeting of the Health, Social Care and Sport Committee in 2026. I have received no apologies for today's meeting.

Our first agenda item is a decision on taking business in private. Do members agree to take items 6 to 8 in private?

Members *indicated agreement.*

Budget Scrutiny 2026-27

The Convener: Our second agenda item is oral evidence from the Cabinet Secretary for Health and Social Care and supporting officials on the Scottish budget for 2026-27.

I welcome Neil Gray, Cabinet Secretary for Health and Social Care; Fiona Bennett, chief finance officer for health and social care; and Alan Morrison, deputy director of health infrastructure and sustainability.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Good morning. I thank the committee for the opportunity to discuss the 2026-27 health and social care budget. It delivers a record £17.6 billion for front-line national health service services, £2.4 billion to support the vital work of general practitioners, primary care and community services, and more than £2.3 billion of support for social care.

The budget was presented to the Scottish Parliament following constructive engagement across the chamber, led by the Cabinet Secretary for Finance and Local Government. It has been developed through effective engagement and negotiation across Parliament to build broad support. We will continue to work with all parties in Parliament to secure agreement on its provisions.

Our health and social care services still face challenges and that is why we will continue reform, focusing on prevention, reducing waiting times and improving access, and on shifting the balance of care to communities.

Overall, the budget provides almost £22.5 billion of investment in health and social care services. There is more than £17.6 billion for health boards, which provides a real-terms uplift of 1.8 per cent, with spending across the NHS rising by nearly £5 billion by the end of this parliamentary session—almost doubling our commitment to increase front-line spending by 20 per cent. There is more than £2.3 billion for social care, which delivers our commitment to increase funding by 25 per cent or £840 million. It supports an uplift to adult social care pay, as well as improvements to wider terms and conditions for workers.

The £2.4 billion for primary care includes support for recruitment, retention and capacity and provides more than £98 million in additional funding in 2026-27, which is part of our historic three-year £531 million deal secured with general practitioners. There is also a further £36 million to establish new high street walk-in GP services. Fifteen walk-in service centres will be established, with services focused on urgent, on-the-day

primary care needs, similar to the care provided by GP out-of-hours services. It was my pleasure to visit the first pilot site, the Wester Hailes healthy living centre, as part of the budget week.

There are funds for investment across the NHS estate, which will enable us to progress priority hospital replacement projects, embark on a primary and community care infrastructure investment programme and undertake targeted maintenance and equipment replacement.

Importantly, there is an additional £40 million of investment for sport and physical activity to support opportunities for people across Scotland to be more active.

I am in no doubt that we have an NHS in Scotland that, after the profound shock to the system that was Covid, is recovering. This is a powerful health budget that, notwithstanding the on-going challenges, will enable our health services to do more, and to do it better.

With my colleagues, I am happy to take questions from the committee.

The Convener: Thank you very much, cabinet secretary. We move straight to questions.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in picking up on what you said about walk-in GP centres. You mentioned the one that was announced in Edinburgh. The budget assigns £36 million of funding for walk-in GP clinics. Is that funding for additional staff or for other costs that are associated with the pilot? What further funding might need to be provided to implement the policy?

Neil Gray: Walk-in GP services are an important policy priority for the Government and will add flexibility to allow people to be able to access GP services. They are not about displacing or replacing core services, which is why the record funding increase that is going into core GP services is so important. We aim to broaden the primary care front door that is available to people. Walk-in services are about offering more flexibility and trying to avoid people going to the wrong places for their healthcare needs. The funding that we have attached to walk-in GP services will predominantly be for staffing. Depending on the chosen sites, there will also be a need for some interventions, wherever those sites are.

Emma Harper: You mentioned that the walk-in centres will support already established general practice. The British Medical Association was pleased with how that was negotiated with GPs and is positive about it. How will the draft budget support GP practices more broadly?

Neil Gray: I thank Ms Harper for providing the distinction. Since I took up office, I have been keen to introduce the interventions that we have been able to make through negotiation with the BMA, which will allow us to broaden and provide greater capacity in core general practice. We have reached a landmark agreement with the BMA, which is potentially generational in its impact, and will allocate £530 million over three years. This budget provides the first year of that funding—a £98 million increase that is front-loaded towards employing additional GPs.

More broadly, across its course, the deal is about improving GP surgeries' digital offering and other elements of expansion and innovation within general practice. It is also about improving data reporting to the Government so that we can see the incredible efforts that our GP surgeries go to in providing a broad front door to the health service. The announcement was well received by the BMA, and my appearance at the local medical committee conference in Aberdeen just before Christmas was positive. I believe that there is much positivity in the GP community on what the future can hold.

Emma Harper: How does the budget support direct community support, including optometry and pharmacy services? I know that we tried to move care away from hospitals to optometrists, for instance. Does the budget support that?

Neil Gray: Ms Harper is correct that there is additional funding for community optometry, community audiology and the continued expansion of pharmacy first to ensure that people have the opportunity to access the right care in the right place and so that we are able to have the broadest possible front door. It is also about shifting the balance of care. More anterior eye services and community glaucoma services are moving into community optometrists, while community audiology services are also due to be expanded, with additional investment in the budget.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. Given the committee's recent inquiry into neurodevelopmental assessment pathways, are you able to give us any indication as to where the £7.5 million that has been announced in the budget to improve those pathways for children and young people will be deployed?

Neil Gray: Ms Whitham's question allows me to speak about some of the work that has been done to support child and adolescent mental health services and the additional investment to support children who also have a neurodevelopmental condition that requires diagnosis and treatment. It is about expanding the opportunities in that side of CAMHS. We have done a significant amount in core CAMHS and have significantly increased staffing. As a result, waiting times have been

brought down and CAMHS standards across Scotland have been achieved for the first time over the past year or so.

We are now looking to make additional progress in an area that we—as well as the committee—recognise poses a particular challenge, which is neurodevelopmental pathways and providing support for children and their families in achieving a diagnosis and also with regard to treatment.

Ms Whitham knows this well, but it is important to stress that, even without a diagnosis, our policy framework is geared towards supporting people based on their need as opposed to their diagnosis. However, I know how much importance families attach to getting a treatment pathway through a diagnosis, and we are attempting to support that with additional investment.

Elena Whitham: I have a final question about something that you mentioned previously in your answer to Emma Harper. Is the announcement about community audiology setting us on a pathway to parity between how we deal with opticians and optometry on the high street and how we deliver audiology services to people in their communities?

Neil Gray: That is absolutely right. There are huge opportunities for us as we attempt to shift the balance of care and move some of the clinic-based services out of hospital and into high street and community-based services. Providing the additional funding for community audiology is about attempting to move in that direction. There are already well-established pathways in that regard because of free eye tests in the optometry space. Pharmacy first has also undergone a significant expansion, while the prescriber status in pharmacy services has allowed us to move significantly forward. It is about trying to match that progress in an area in which we recognise that there are challenges with waiting times in different parts of the country. I am pleased that we have been able to commit additional resource to community audiology services.

Elena Whitham: Thank you.

The Convener: We all saw the absolute chaos that resident doctor strikes caused in the NHS in England, and the threat of that happening in Scotland sent a chill down many people's spines regarding the impact that it could have. I was relieved, as I am sure many people were, that strikes were averted by the Scottish Government coming to a pay deal with resident doctors. Is the uplift in their pay already reflected in the budget, or will it need to be removed from the funding that has been set out for health services in the next year?

Neil Gray: The budget honours all the pay deals that have been secured. The deal that we arrived at with the BMA resident doctors committee was achieved through consensus and significant compromise by both parties. I am pleased that we were able to do that deal. As you say, there would have been significant disruption had the strike gone ahead; we reckon that more than 20,000 procedures, operations and appointments would have been cancelled in the strike period, which would have put at significant risk the incredible progress that has been made by our staff in reducing waiting times and improving access to our health service, particularly in the past six months but also over the past year or so.

I am pleased that we were able to avert industrial action. We have arrived at a deal that the resident doctor committee will recommend to its members, and we expect the ballot to proceed in short order. I hope that resident doctor members of the BMA will accept the deal.

Brian Whittle (South Scotland) (Con): Good morning. I have a quick supplementary question about walk-in GP clinics. Given that we are already short of GPs, nurses and other healthcare professionals, and given that it takes 10 years to train a GP, where will we get the staff to operate the walk-in clinics?

Neil Gray: That is one of the questions that I sought assurance on when I visited the Wester Hailes healthy living centre during the budget week a couple of weeks ago. The health board has already had significant offers of interest from GPs and wider practice staff in staffing a walk-in GP clinic. There is a record number of GPs who are currently in training, and we know that there are GPs who have recently qualified in different parts of the country who are looking for employment.

Alongside the record investment that we are making over three years in core GP services, which is about having more GPs employed in core general practice, the walk-in clinics will be another opportunity for those who are coming through the system to not just train and qualify in Scotland but live and work here. There will be opportunities across the country for GPs to have a fulfilling career, giving service to the people of Scotland.

09:30

Brian Whittle: If people are going to walk-in GP clinics, will that not take them away from GP surgeries?

Neil Gray: No. The idea is not to displace people or replace core GP services. It is about providing additional flexibility for patients to access GP services. The times that the walk-in clinics are available at are designed to ensure that core GP practices continue to predominate. The clinics will be available from 12 until 8 pm, so they are crossing over into the out-of-hours space. We are

trying to prevent people from self-presenting at accident and emergency when they do not need to be there and could be captured and treated in primary care or urgent care services. The aim is also to allow more flexibility in accessing GP services for those who work, because accessing core services is sometimes more challenging for them.

That is the design. As I said, it is a pilot. It is about testing and learning whether we have the right model. We are taking learning from how the approach has worked—or not—in other parts of the United Kingdom and are seeking to build on that to have a pilot that provides a broader front door to our health service. We believe that it will be very popular with the public, as people will be able to present without the need for an appointment and be seen by GP services.

Paul Sweeney (Glasgow) (Lab): The alcohol and drugs policy budget is facing a 1.6 per cent real-terms cut, despite the fact that the latest figures still show a significant level of drug-related deaths—I think that the figure was 1,017 in 2024. I am worried about why that is being cut in real terms. What impact do you foresee that having on the alcohol and drugs partnerships?

Neil Gray: I recognise Mr Sweeney's long-standing interest in this policy area. We have maintained a record level of investment in alcohol and drugs partnerships in this budget, of £115 million, and I expect that to support the policy provisions that we have set out, in both alcohol services and drugs services.

Mr Sweeney will be aware that we are currently reviewing our national mission on tackling drug-related deaths and our alcohol policy, and that we expect to publish that review in very short order. We will use that as an additional policy lever to ensure that we are targeting our available resources to continue to drive down on drug and alcohol-related deaths.

Paul Sweeney: At one of the joint committee meetings on drug-related deaths, we heard an analysis of the Thistle and its on-going performance. I know that there is a budget allocated to that pilot, but it emerged in discussions that there has been a change in use and in patterns of street injection, from heroin to cocaine. Because that involves much greater frequency of injection, the facility is more likely to be needed overnight. There was discussion about the fact that it would be beneficial to change the business operating model of the Thistle to have overnight provision or to move towards 24-hour provision. Obviously, that would have financial implications.

Will the cabinet secretary undertake to at least engage with the Glasgow city health and social care partnership about the prospects of such an adjustment to the service, given the complaints about needle discards and other issues that are associated with more frequent usage overnight because of the move to cocaine? That is an example of how we need to be agile in adapting service provision to meet changing behaviour, but we could be constrained by financial issues if there is a cut to the budget.

Neil Gray: Mr Sweeney is correct that the prevalence of cocaine within drug-related harm is increasing. Its proliferation is causing us considerable concern, as we are seeing additional harms caused as a result.

The service model for the Thistle appears to be going well—the service is well used and lives are undoubtedly being saved. A number of medical emergencies have been responded to at the Thistle, which demonstrates, at an early stage, that it appears to be working as intended.

Mr Sweeney's ask that the Thistle adjusts its service model would require conversations between ourselves, including Maree Todd as the lead minister, and the local health and social care partnership as to whether it wants to move to such a model.

There have been other discussions and other asks from Mr Sweeney and others around inhalation services. All those areas remain under consideration, but the current service model applies at present. Nevertheless, as Mr Sweeney said, we need to be agile in response to emerging threats. We know where those threats—for example, synthetic opioids and nitazenes—-are coming from, and we understand the impact that they have. We will do what we can to ensure that our services adapt to meet those challenges.

Emma Harper: I want to go back to general practice. The Scottish graduate entry medicine programme—ScotGEM—has been really successful for Dumfries and Galloway with regard to retention. Can you say a wee bit about the programme? It is unique to Scotland. Is it successful?

Neil Gray: I think that it absolutely is. I know that Emma Harper, as a rural MSP, takes a particular interest in the programme, and I think that it has delivered benefits for areas such as Dumfries and Galloway. It is about providing specialist education and training for people in rural practice and giving them an additional incentive to remain there because of that additional level of training and education.

We continue to evaluate ScotGEM and its effectiveness in providing our rural communities with medical practitioners who can be retained in those communities. I am Orkney born and bred, and I recognise the challenge of recruiting and

retaining staff members in such communities. I think that the programme is successful, and I would be happy to provide the committee with more evidence on its work and effectiveness.

David Torrance (Kirkcaldy) (SNP): Good morning. The budget states that certain funding streams are now baselined in the board budgets, and that that has resulted in larger uplifts than would otherwise be the case. To what extent do board uplifts reflect the baselining of funding streams, and to what extent are they the result of other factors?

Neil Gray: There is increased baselining; that is to provide not only additional transparency, which has been asked for by the committee and by organisations such as Audit Scotland, but greater certainty for our boards on their funding provision. In my response to the committee, I set out some of those areas of increased baselining, but if more information on that is required, I am happy to provide it in writing.

David Torrance: What progress is being made in addressing the concerns relating to financial management that have resulted in six of the territorial boards being placed at stage 3 or stage 4 on the performance escalation framework?

Neil Gray: The financial delivery unit in the Scottish Government supports all boards on their financial performance, and there is enhanced support available to those boards that are furthest from balance. The number of boards in that category has reduced over recent years, and we are undertaking work, which is being led by Fiona Bennett, to provide an increased level of support to those boards that are in that position in order that they can manage their balances down while maintaining service provision.

A good example of that in recent times has been the escalation of NHS Grampian. I believe that the new leadership of NHS Grampian has been getting a very strong grip on the financial perspective while also focusing on improvements in service delivery. The Government helps to provide the assurance board process at level 4 that allows boards to have additional areas of support and to de-escalate when they are in a better position.

David Torrance: Can you provide an update on the current status of the review of the NRAC resource allocation formula?

Neil Gray: I do not have an update at this stage. There is increased funding in the budget—of £36 million, I believe—to ensure that all boards remain within a very narrow gap of NRAC and to ensure that the funding fairness that comes through the NRAC formula can be maintained. That also ensures that we are accounting for rurality and other demographic issues in terms of service delivery, and it provides the fairest possible route to achieve that.

I do not know whether we have any further update on the NRAC review that Ms Bennett might be able to help me with.

Fiona Bennett (Scottish Government): I note that we review the formula yearly. It is updated in terms of population estimates and some rurality demographic factors that the cabinet secretary mentioned.

We have decided not to do a full-scale review at the moment. The present pot of funding would still be the pot of funding, and we do not want to disadvantage services that are starting to make progress. Although the formula is reviewed each year, no fundamental review of the formula is under way at the moment.

Sandesh Gulhane (Glasgow) (Con): I make a declaration of interests as a practising NHS GP.

Good morning. Given that NHS Greater Glasgow and Clyde is getting a 7.7 per cent increase in its budget and given the hideous nature of cover-up and scandal that we are seeing at the Queen Elizabeth university hospital, is it fair to say that the increase needs to come along with far greater scrutiny of the board? Will you be putting the board into special measures?

Neil Gray: The board is under significant scrutiny because of the measures that have been taken by the Government in establishing a statutory public inquiry, which is independent of Government and judge led. The families, to whom my deepest sympathies go out today, are seeking the truth and are seeking answers, and that is why we are going to get access to the truth. It is important that the public inquiry is able to do its job independently, without interference from Government.

Sandesh Gulhane: You are absolutely right that there should be no interference. NHS Greater Glasgow and Clyde admitted that there is a causal link and, given that admission and given the horrible nature of the apology given by a lawyer, it seems that increasing the money going to the board should come with conditions, and it should come with it being placed into special measures.

Neil Gray: The first thing to say is that the leadership of NHS Greater Glasgow and Clyde is substantially different from that of the period under scrutiny through the public inquiry. It is important that services are still able to be provided now by NHS Greater Glasgow and Clyde—stretching beyond the Queen Elizabeth to all aspects of service in Greater Glasgow and Clyde. The board is of course subject to the highest scrutiny possible in terms of the public inquiry, and there are also the annual board reviews and other official-led

processes that take place throughout the course of the year.

Scrutiny and conditions being attached to the board's statutory responsibilities to deliver services are a normal course of affairs in the resource allocations that are provided to health boards. On top of that, there is the additional scrutiny of the independent judge-led public inquiry.

09:45

Gillian Mackay (Central Scotland) (Green): The Coalition of Care and Support Providers in Scotland is concerned by an apparent change in policy on social care pay. It has stated that, instead of increasing the available funds to fund an increase from £12.60, which is the real living wage for 2025-26, to £13.45, which is the real living wage for 2026-27, the Scottish Government seems to have chosen to fund only an increase from the new national living wage in 2026-27. That means that the pay fund would cover an uplift from only £12.71 to £13.45, which is 11p an hour less than providers expected. That will result in a funding shortfall that the Convention of Scottish Local Authorities suggests is £15 million for adult social care services and £4 million for children's services. Will the cabinet secretary confirm that the fund to increase pay and conditions in social care has been baselined to the national living wage rather than the real living wage as expected?

Neil Gray: Ms Mackay is correct in her assertion. In the Finance and Public Administration Committee debate last week, the Cabinet Secretary for Finance and Local Government set out our position that employers should be responsible for statutory employment costs. That takes us to the minimum wage. We then fund the difference from the statutory responsibility to the real living wage.

I have received correspondence from Rachel Cackett of the CCPS. I also met COSLA's political representative in this space, Councillor Paul Kelly. Discussions on the matter continue. We recognise the challenges in the social care sector. That is why we have increased social care investment to more than £2.3 billion. We continue to fund increases to social care pay. That takes us to more than £1 billion of investment in it. However, we also recognise the pressure that the sector is under, so discussions continue.

Gillian Mackay: What consultation did the Government have with the sector on the implications of that decision for jobs and services? Was an equality impact assessment completed?

Neil Gray: Equality impact assessments are completed across portfolio areas. That is the normal course of budget setting.

Discussions with the sector are on-going. In a very tight financial envelope, we remain committed to supporting social care pay that takes us to the real living wage. I do not believe that that is matched in all other parts of the UK. We continue to do that in spite of the difficult financial circumstances of the budget settlement.

We will continue to meet, and discuss implications with, the CCPS and other social care employers to ensure that we do everything that we can to support these critical services, which touch the lives of many families throughout Scotland, including mine.

The Convener: You have spoken in the past about the challenges for the social care sector that have been caused by the UK Labour Government's changes to immigration and visas. The number of accepted visas is down drastically. Donald Macaskill of Scottish Care has been very critical of the impact of the hikes in employer national insurance contributions on social care employers. Does the budget aim to combat any of the impact caused by the UK Government on social care in Scotland?

Neil Gray: There are two areas in that. The first relates to the migration policies of the UK Government, which are causing significant harm to service delivery in Scotland. Donald Macaskill has said so, as you say, convener. Health and care visa approvals from the UK Government are down around 80 per cent compared with those under the previous Conservative Government, which, given the population demographics in Scotland as a whole and particularly in certain parts, such as rural and island communities, is devastating.

Resource challenges exist in many health and social care partnerships—I recognise that. However, the largest challenge that the sector is facing is access to staff. When one route for that is being cut off by the UK Government in the way that it is, it makes it incredibly difficult to sustain services. We have made significant representations, as has the sector, to have those migration policies changed and, if they are not, to allow us to have our own rules around migration so that we can have a service that meets the needs of the people of Scotland.

Convener, you correctly referenced the impact that increases to employer national insurance contributions are having. Last year, that impact was estimated to be more than £80 million for social care providers—I do not have the figure for this year. Given our support for care wages going up to the real living wage, which we have just spoken about, that highlights the detriment to the service. We have called for those increases to be reversed or fully funded, neither of which has happened.

The challenge to the sector in those two areas alone is profound. They are areas that we have no direct control over. However, on the migration point, the committee will have noticed that, in autumn last year, we committed to introducing a scheme to support displaced international workers in other parts of the UK. That has been incredibly successful, and the First Minister announced its extension earlier this year to allow those who have visas and are in the UK but currently have no employment to find their way to Scotland in order to be able to contribute to social care services in Scotland. I am proud of the fact that we are doing what we can within the rules to support migrant workers in Scotland.

The Convener: I put on record that I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

Brian Whittle: Cabinet secretary, on the point about how we are seeking to fill the many spaces in our social care sector—I have raised this with you before—we have pupils who want to go into that sector and who are applying to colleges across Scotland yet are being turned away because the colleges lack funds. Ayrshire College has had to turn away 71 applications for its social care courses, and colleagues from across the chamber have highlighted similar issues across Scotland. Surely we should be tackling that if we have such significant need in social care.

Neil Gray: I have visited some of our colleges that provide health and care training. They provide an incredible service, and an enthusiastic young workforce is coming through that is made up of people—and I do not seek to patronise them—whose application is truly inspiring.

We have provided increased funding of £70 million for colleges in this budget. That is a significant additional resource that is going to colleges because we recognise the fundamental role that they play in our economy, in the education system, and in ensuring that we have the workforce to meet the needs of our public services—for example, in health and care—and of the people of Scotland.

Brian Whittle: The cost of recruitment if we do not go through colleges would be offset if you allowed more college places. If we are short of places and we have home-grown people who want to work in our social care system, surely the best route for access to staff would be to allow and fund more college places.

Neil Gray: We are seeking to do both. We are providing significant additional funding to our college sector so that it can provide additional spaces. However, given our demographic projections, we need people of working age to come to Scotland, because we do not have the people to be able to meet all the needs of Scotland's services and of the wider economy.

We need migration to sustain our public services and economy. Of course, we need to train and support people to come through the system, and we are providing additional resource for the college sector to do that, but we also heavily rely on migrant labour. That will continue because of our demographic challenges and the fact that we will have a falling working-age population in years to come. That is why we need a migration system that will work in the interests of our services and wider economy.

Carol Mochan (South Scotland) (Lab): The cabinet secretary will recognise that it is the committee's job to scrutinise the Scottish Government. He mentioned the investment in social care, but it is difficult to track that spending and what is being transferred from health into social care. Can he do anything to help us with that? Can he give any commitments on transparency about where the money is likely to end up?

Neil Gray: As a former committee convener, I recognise and place incredible value on the role of our committees in scrutinising Government, and I welcome the opportunity to be here to be scrutinised on the decisions that we are making.

I will bring in Ms Bennett again on the detail but, in the correspondence that I sent to the committee on pre-budget scrutiny, I set out a number of steps that have been taken to improve transparency in budget setting in the social care space and the mental health space, on which there was significant attention last year. We want to support that transparency. I have already set that out in my answer to an earlier question, but I am happy to bring in Ms Bennett to provide any more detail on the question that Ms Mochan raises.

Fiona Bennett: I am happy to provide a breakdown of the £2.3 billion in writing, so that the member can see exactly where it has gone. The reason why it is important that we transfer that into the local government baseline is so that local government has certainty on that funding. However, we can certainly provide a historical breakdown of what makes up the £2.3 billion figure.

Carol Mochan: That would be helpful.

Do you recognise COSLA's figures on delivering the real living wage in adult social care? COSLA says that £160 million has been allocated, but it estimates that it will cost £175 million to deliver that. Do you have a plan to work with COSLA on how to ensure that that really important workforce gets that uplift?

Neil Gray: That question builds on the answers that I gave to Ms Mackay. The Government's position for the budget has been that employers should meet their statutory pay obligations. Meeting the minimum wage is a legal responsibility that employers have. We have set out to provide the additional resource that is required to go from the minimum wage to the real living wage. I recognise that that means that, compared to previous years, there is a gap.

As I set out in response to Ms Mackay, I have met COSLA already. The Government has received correspondence from the likes of Rachel Cackett of the CCPS, and discussions are on-going on that. We recognise and value our social care staff, which is why we are providing increased resource to support them to be paid at least the real living wage. That policy is not matched in all parts of the UK but, in spite of the very tight fiscal settlement that we have, we have maintained that commitment. We will continue to work with COSLA and employers on what the settlement means.

Carol Mochan: My final question is about the way in which the budgets work. Has the Government considered that, rather than transfer the money to local government, the money might be allocated directly to it? Have you had a discussion about the way in which that will work in future?

Neil Gray: I will need to double-check with Ms Bennett, but I believe that the real living wage funding has been baselined into local government's budget. I see that Ms Bennett is nodding, so some of that has been baselined.

Carol Mochan: Thank you.

Sandesh Gulhane: Earlier, you spoke about the importance of free eye care, but I notice that the community eye care budget has fallen in real terms. We also see a 2.2 per cent reduction in real terms in the money that is going to reform and improvement measures. Given that that is part of improving discharge without delay and improving accident and emergency performance in hospital and at home, and given the latest figures for A and E waits, surely those funding decisions and stated priorities are not compatible with each other.

10:00

Neil Gray: Dr Gulhane has compared the autumn budget revision position with the opening budget position, but there is still opportunity for in-year movement in budgets to support demand-led services or reform and improvement services. In that sense, the work that has been done to reduce waiting times has expanded significantly in the year compared with the opening budget position last year.

Significant structural reform improvements are on-going to ensure efficiency, productivity and capacity optimisation across the service through measures such as subnational planning—planning for our planned care system on a larger population basis—that will mean that we get a similar or better outturn to our investment. We will get better bang for our buck when it comes to the investment that is being put into the system.

Sandesh Gulhane: Therefore, a drop in the budget will improve those things—okay.

In the latest budget, I noticed that there is a 4.5 per cent decrease in spend on capital projects. What does that mean for national care treatment centres?

Neil Gray: As Dr Gulhane knows, we have set out the priority projects that are being funded through the capital programme: University hospital Monklands, the Princess Alexandra eye pavilion, the Belford hospital and the joint campus on Barra. In the infrastructure plan, we have set out a series of primary care investment projects, which will be developed through a revenue finance model in due course. That is under consideration with the Scottish Futures Trust at the moment.

Our capital budget has been squeezed and continues to be squeezed by successive UK Government budgets, which means that the investment that we are able to make in capital projects such as new hospitals, new health centres, digital and other investments is more challenging, especially when we consider the corrosive impact that inflation has had over the past three or four years. The public pound is not able to go as far due to construction inflation spiralling.

We have to make challenging and difficult decisions, but we have set out our priorities in a transparent way through the budget and the infrastructure investment plan. We continue to invest in repairs and maintenance, as well as new equipment, in order to give the people of Scotland the best service possible.

Sandesh Gulhane: I notice that you did not answer the question about the national treatment centres. What would it mean for the ones that are paused?

Neil Gray: Forgive me—

Sandesh Gulhane: Just to roll that into my next question, the Scottish Conservatives received a freedom of information response that shows that NHS Ayrshire and Arran wants to sell Carrick Glen hospital. What does that mean for national treatment centres, and will you allow NHS Ayrshire and Arran to sell Carrick Glen?

Neil Gray: On Carrick Glen, there are processes that need to be gone through before any commitment can be made to sell the site, which I want to be assured on and satisfied about. Those discussions are on-going.

On the national treatment centres, we are investing to protect planned care services at Gartnavel general hospital, Perth royal infirmary and Stracathro hospital. Although we have not put forward capital for new-build national treatment centre sites, because we do not have sufficient capital to do so, we are moving to a model of protecting planned care on a larger population basis.

That is the policy intent behind constructing new national treatment centres, and we are seeking to provide that care within existing services until we are in a position in which new capital becomes available, should the position of a UK Government change.

Sandesh Gulhane: So, is it fair to say that, for now, you are abandoning your flagship policy of national treatment centres?

Neil Gray: No—the policy intent remains, as I have set out. The pipeline of new national treatment centres, as in physical buildings, is paused, but the policy intent has continued through the investments that have gone into Gartnavel, Perth Royal infirmary and Stracathro in order to protect planned care services in those facilities.

The Convener: I have a brief question on the financing of some of those capital projects. The infrastructure delivery plan indicates the intention to return to private financing to deliver community health centres. We have seen the legacy that private finance initiative schemes have left, with huge debt that needs to be repaid every year. Can the cabinet secretary provide an assurance as to how value for money will be ensured in the use of such finance?

Neil Gray: Absolutely. Work is under way through the Scottish Futures Trust in order to ensure that the very stringent value-for-money tests that are associated with spending decisions through the Scottish Government can be met. In the absence of conventional capital becoming available as a result of successive UK Governments squeezing our capital budget, however, we need to look at ensuring that our primary care spaces are bigger and more flexible to meet the need with regard to shifting the balance of care.

We are going to be asking our primary care practitioners to be doing more as we move services—which we have spoken about—from hospital-based clinics into the community. We will need infrastructure to meet that need, which is why I have asked my colleagues in Government—Alan Morrison is leading on this work—to find a model that meets the public-value test while allowing us to proceed with capital investment that enables the realisation of the Government's policy intent for more services to be delivered in the community.

The Convener: So, the legacy of PFI, which continues to squeeze budgets year in, year out in the Scottish Government and in local authorities, will not be continued with the new model of financing.

Neil Gray: No. The extortionate PFI costs will not be emulated. We will be looking at a different model that ensures that we protect the public finances as best we can.

Brian Whittle: I will go back to the Carrick Glen issue. It was first mooted as a step down, step up health centre that would alleviate a lot of the pressure at the front doors of accident and emergency departments. It would ensure that people were being treated in the right way at the right time, and given the healthcare that they required, rather than being either in the community or in hospital. I have to say that I, personally, would support that model enthusiastically.

However, the reality now is that that looks like it is not going to happen. It has been reported that some £5 million has already been spent on recruitment specifically for Carrick Glen, which looks like it is not going to happen.

The reality is that NHS Ayrshire and Arran has a significant deficit, and that is why Carrick Glen is not happening. That is the case, is it not?

Neil Gray: No—I have already set out the perspective with regard to the overall capital budget, which has not allowed us to progress Carrick Glen at this stage. The investment in human resources—in people to staff such a facility—will have been utilised in other parts of the system.

NHS Ayrshire and Arran has a very effective frailty at the front door service; I was able to see that at University hospital Ayr very recently. It is doing great work to support some of our frailer patients. Those patients tend to come in and out of hospital and stay for longer as a result, while their condition continues to deteriorate, which means that when they return home, they require increased social care intervention.

The frailty service will, I believe, have been staffed by some of the people who were employed to staff Carrick Glen, as Mr Whittle set out. As a result of that service, we have seen a reduction in admittance to hospital and a reduction in the length of stay for those with frailty, both of which are incredibly beneficial for those patients. That

ensures a better flow within the wider system but, most importantly, a better service for those patients.

Brian Whittle: I am an Ayrshire boy; NHS Ayrshire and Arran is my local health board, and I can tell you that it is under enormous pressure at the front door.

I put it to you, cabinet secretary, that not going ahead with Carrick Glen is a false economy. If we do not go ahead with those plans, we will see significant waits at A and E and significantly longer stays in hospital.

Neil Gray: I think that I have made it clear that we wanted to proceed with the national treatment centres programme as was laid out. We believed that that was going to be the best way to reduce waiting times. However, the capital position has been such, with regard to both construction inflation—we are all aware of the corrosive impacts of inflation over recent years—and the real-terms reduction in our conventional capital budget that has come from UK Government decisions, that we have been faced with very difficult choices to make.

We have had to pause the majority of the capital programme in health. We are restarting it now in priority areas such as Monklands, the Belford, the joint campus in Barra and the Princess Alexandra eye pavilion in Edinburgh. We are also looking at what we can do around a revenue finance model for primary care facilities so that, in spite of the capital settlement that we have received, we are still able to make progress on building infrastructure that meets the needs of a modern health and social care service.

The Convener: We have a brief supplementary from Paul Sweeney.

Paul Sweeney: I want to raise the issue of preventative spend and the interdependence between social care and acute care, in particular the issue of differential pay settlements. We have seen that play out already in hospices, where issues with differential pay were affecting capacity.

How are social care providers who are already eating into their reserves able to cover underfunded contracts? Will that not just further exacerbate issues with the recruitment and retention of staff and reduce service availability? We have already seen a significant decline in the number of care beds across Scotland, which has a direct impact on delayed discharges. Does the cabinet secretary recognise that as a significant risk?

Neil Gray: There are a number of elements there. First, there is £6.5 million in the budget to support hospices to match agenda for change pay rates, so I think that Mr Sweeney will be satisfied in that space.

With regard to social care, I have answered in detail the points that were raised by Ms Mackay and Ms Mochan about the choices that we have made around the statutory obligation on employers to meet legal pay requirements.

We have taken steps to increase social care investment, which is at more than £2.3 billion now. That includes, over this winter, support for boards and partnerships, in some cases, to purchase social care beds. That is not only a better option for patients, but a more cost-effective option for the system than having people stay in the acute sector.

We are doing what we can, within the resources that we have available to us. We are working with the Convention of Scottish Local Authorities and with our health and social care partners; we meet almost weekly in order to understand the pressures in the system and provide the best possible support. We are also doing something that is, I believe, not matched in all other parts of the UK: we are funding social care pay to at least the level of the real living wage. Over recent years, more than £1 billion has been invested in social care pay.

I recognise the challenges that exist, and I recognise the pressures within social care that Mr Sweeney and other members have set out. However, we have prioritised that where we can within the budget envelope that we have.

Paul Sweeney: I am curious, though. The expectation seems to be that—

The Convener: Mr Sweeney, we need to move on. Joe FitzPatrick is going to cover the theme of preventative spend next, so you might want to come back in with a further supplementary.

10:15

Joe FitzPatrick (Dundee City West) (SNP): As the convener said, I am going to cover preventative spend, but I also want to cover the mental health budget, so I will start there.

Cabinet secretary, given that the latest data that we have for mental health spending relates to 2023-24, are you able to give us a commitment that we will get more timely analysis of mental health spending patterns in the future?

Neil Gray: Yes. As I set out in my budget analysis letter to the committee, I am happy to provide a commitment—I think that Fiona Bennett has already given such a commitment in other areas—that we will do what we can to provide transparency as best we can on the data that we have available to us.

Joe FitzPatrick: That is really helpful—thank you.

There is another area of the mental health budget that I am keen to explore a little. The mental health budgets have now been baselined to a degree; that feels like a good thing to do, but it makes our job a little bit more difficult in terms of being able to see where the money is. Is there a commitment to making sure that there is much transparency as possible, while recognising that baselining these kinds of budgets is a good thing?

Neil Gray: I recognise that. Between our direct investments from Government and the decisions that are taken by health boards, we are expecting mental health provision to be more than £1.5 billion this year. However, I recognise the challenge in scrutinising that when different board areas are going to be taking different positions based on their level of need. I understand that the budgets will be challenging to read, but we will do what we can to provide as much data as we can in that space.

Joe FitzPatrick: Thank you—that will be appreciated by future committees, I am sure.

I will move on to preventive spending, although I will stick with mental health at first. We know that there are some fantastic examples of where early spend is having an impact. One such example is the Hope Point centre in Dundee, which is having a real impact; we will, it is hoped, potentially see the benefits of that spend in terms of people not being in crisis.

That spend is always done in partnership—it never goes just to the health board. It always involves a partnership, often with the third sector. How do we ensure that we keep that focus on partnership working?

Neil Gray: I have been very clear with my board chairs and chief executives on the importance of partnership working with the community and voluntary sector. We have to recognise—as I absolutely do; I think that I set this out in a previous evidence session in response to questions from Gillian Mackay—that our community and voluntary organisations can often reach people better than our statutory services can, simply because they provide specialist services and are, by their nature, embedded in communities.

I have been clear with chairs and chief executives on the need to ensure that there is continued collaboration with services such as the one in Dundee that Mr FitzPatrick mentioned, which can, on a preventative basis and from the perspective of managing long-term conditions, provide significant benefits not only to individuals but to our public services.

Joe FitzPatrick: When I joined the Parliament in 2007, I sat on the Finance Committee, so I am aware that preventive spend and spend to save has been a continuous goal of the Parliament since then, and probably since before then. However, that is difficult to do, and it is difficult to track where money is being spent for that purpose. I know that the Government is making some efforts to be able to understand where preventative spending is taking place so that the shift can come at a later stage. Perhaps you can say a little about the work that you are doing in that area.

Neil Gray: I think that Ms Robison is giving evidence in committee next door and is probably touching on those very areas. As an example, I will set out the investment that we are making in general practice, which I see as one of the headline areas for the preventative spend that we are seeking to make. As a result in particular of the work around enhanced services, such as cardiovascular disease testing, that we put in place last year, we are able to spot things much earlier, which is resulting in better disease management in general practice. However, we can do that to a greater extent only if we increase capacity, so that was the philosophy behind my approach in seeking to increase capacity in general practice.

It was very much about working in a preventative space, moving much further upstream in our intervention rather than, as in the mental health space—which is another case in point—allowing something to escalate until it becomes an acute problem. We all know that it is much more costly—although it seems callous to put it in pounds and pence—to intervene at a later stage, through the acute system, than it is to intervene earlier in the community and primary care space. That was the philosophy behind our approach to expanding provision and capacity within general practice.

There are other areas in which interventions such as the hospital at home programme are very effective in preventing further escalation and the hospitalisation of individuals. Some areas, such as rural and island communities, are using the hospital at home service to meet the capacity requirements for incredibly complex social care that otherwise may not have been met. We recognise that meeting the demand for access to social care, given the complexity of individuals' needs and in some cases their infirmity, sometimes presents a challenge when it is addressed purely on a social care basis. Hospital at home allows us to do more of that and give people the opportunity to receive a fantastic service in the comfort of their own home.

Joe FitzPatrick: As you alluded to, the human costs and human benefits are sometimes difficult to judge. We can look at it in financial terms, but in my experience, the human benefit of the hospital at home service is potentially equal to the financial benefits.

In response to questions from the committee, you talked about some of the tools that you are using. One of those was the investment and value board, so perhaps you could say a few words about that.

Neil Gray: Yes—I will bring in Fiona Bennett to provide more detail. Ensuring that we take an evidence-based approach to the decisions that we are making, and looking at that as broadly as possible, is incredibly important. Ms Bennett might be able to provide more detail on the mechanisms that are in play.

Fiona Bennett: We have established the investment and value board, which I chair, and for the first time we have NHS boards and integration authorities represented on that. That means that they can understand the decisions that are made within our portfolio and what that does for the sector. We look at all the allocations coming through to ensure that they are still providing value for money and to see whether there is any opportunity to do things differently. We also use a holistic analytical tool that looks at some of the prevention aspects as well as the pounds and pence. It is about trying to give a rounded view, and all allocations for our portfolio go through that process.

Joe FitzPatrick: That is brilliant—thank you.

Emma Harper: I have a quick supplementary on prevention. It is not only the health portfolio that helps to support prevention; the housing portfolio also does so. We know that if people have good housing, it helps to ensure that they have better lung health, as they are not living in damp homes. Can you say a bit about the cross-portfolio working that is required in order to support prevention measures in health?

Neil Gray: Ms Harper is absolutely correct. She mentioned the undoubted linkage between housing and good health; another example of a policy area in which health and social care is probably the greatest beneficiary is our action to address child poverty. We know that poverty is one of the greatest determinants of poor health, not just among children but for people's long-term health trajectories. Work on that is being done across Government: a Cabinet sub-committee on child poverty, of which I am a member, is leading on looking at how we ensure that cross-portfolio attention is given to those areas, so that there is not a pot of money being spent in one area of Government without looking at the wider benefits that that brings.

When we have a difficult fiscal environment, it is critical that we understand where decisions are being taken that can have a multiplicity of benefits across other portfolio areas. Housing is one such area, and addressing child poverty is another. As another example, we are looking at the climate change plan and working our way through the environmental factors that drive poor health. We work collaboratively in all those areas across Government.

Paul Sweeney: I would like clarification on the cabinet secretary's perspective on wholly publicly funded service providers in social care delivering public services wholly through taxpayer funding. How can they possibly pay for a gap in uplift of pay for staff? I inferred from what the cabinet secretary said that the employer should meet that gap through reserves or some form of revenue generation. If we are talking about councils, COSLA and charities, I am not sure how that is possible.

Can the cabinet secretary elaborate on his expectation in that respect? After all, this marks a change in approach from the Government, because pay uplifts for front-line staff and those contracts were previously covered by Government pay policy.

Neil Gray: With respect to Mr Sweeney, I would extend that to the increases in employer national insurance contributions, which are having a significant and very damaging impact on the ability of service providers in the social care space to conduct their work. We have provided pay uplifts to recognise and support the fact that, as I have already set out to Mr Whittle, in a competitive economy with a working-age population demographic that is set to decline, we need to ensure that we have competitive rates of pay not just in social care but in other public sector spaces so that we are able to access staff as best we can. Moreover, the care home rate is set by COSLA through negotiation with the system, so there are other cogs in the wheels that need to be considered such as income and the route by which social care is provided.

I recognise the challenge of meeting pay costs—of course I do, and it is why we are providing this increase and asking employers to provide the statutory elements. We will, of course, do what we can to continue to discuss the implications of the decisions that have been taken, and we will seek to ensure that the social care sector continues to provide its incredible service to families across the country.

Paul Sweeney: The CCPS has told me that there has been no discussion and that it has been completely blindsided by this. I take the point about the need for visas to support the demographic challenges in Scotland, but there is a pool of 40,000 workers in the care system who are unallocated or unsponsored and who could be absorbed at any point in time. The issue, though, is that £12.82 an hour is the minimum for a social

care worker visa sponsorship, while the minimum adult wage for social care workers in Scotland is £12.60, which only demonstrates further how uncompetitive pay rates are in the sector. Again, I am not clear how the uplift can be funded by these providers, because they are just not set up to cover the gap.

I also take your point about ENICs. Perhaps I would not have agreed with that approach, but there is a trade-off here. If you raise tax revenue, you spend it on having better public services. Where is the extra uplift here? Surely it should have been used to at least cover the gap.

Neil Gray: Again, I make the point that visa threshold decisions are made not by us but by the UK Government, which perhaps partly illustrates the reason for the reduction of around 80 per cent in health and care visas over the last year that we have data for. We think that that is detrimental to our sector in Scotland, and we want it to be reversed. We also want, if not the policy levers, then better collaboration to allow us to attract and retain people in Scotland.

The member is correct in his assertion that there are displaced workers across the UK, and we have sought to target them through the investments that we have made in visa support, which the First Minister has announced the extension of. I have received the correspondence from Rachel Cackett of the CCPS; I and Mr Arthur engage with her regularly, and we will continue to engage with the sector on the impact of this issue and on whether any mitigations can be brought forward through the decisions that have been taken.

Brian Whittle: I was really interested in Joe FitzPatrick's questions, and the fact that the Government has been looking at how to develop preventative spend approaches since 2007. How are you measuring the impact of preventative spend?

10:30

Neil Gray: It is, as Mr FitzPatrick set out, incredibly difficult to do that, because it is difficult to measure something that you have prevented.

That said, I think that Mr Whittle and I have a similar ideological philosophy with regard to the power of sport, for instance, and we understand the mental and physical health benefits that come from expanding people's ability to be physically active. Therefore, another area that I would point to when it comes to preventative spend is the sport budget, which we have expanded by £40 million this year.

I should also say that, last week, Ms Todd and I had discussions with the Scottish Football Association about how we make best use of the summer of sport initiative, which will run this summer alongside the Commonwealth games and the football world cup, which the men's team has qualified for. That is a huge opportunity that we can take forward, and it will be incredibly beneficial, but, crucially, it has to be a long-lasting and sustained intervention that will support people to continue with sport. I think that Mr Whittle will agree with me that sport is an area of proven preventative intervention.

However, as I have said, it is difficult to measure the things that you have prevented by the very nature of the fact that you have prevented them.

Brian Whittle: I have to disagree. You will not be surprised to hear that I was going to come on to sport, but I would point out that we have decreasing life expectancy; we are one of the unhealthiest nations in Europe, and we are getting worse; we have, crucially, high levels of drug and alcohol deaths and other issues; we have the highest obesity level in Europe; and we have really high levels of mental health issues. That is how you measure preventative spend. At the end of the day, those are the things that we are trying to prevent, and we are not doing that.

As for sport, you are right to say that we agree on the impact that sport, and physical activity in general, can have on health, mental wellbeing and, indeed, overall wellbeing. When I came into Parliament, the sports budget was £44 million, and last year, it was £36 million. I note that it is now increasing—and you will never hear an argument from me with increasing the sports budget. However, the devil is in the detail, and some of the funding is for one-off activities related to the Commonwealth games and the FIFA world cup. I will also be interested to see whether sportscotland delivers extracurricular activity in schools. Again, that will be very welcome, because I think that it is hugely important.

However, the reality in sport is that people on the front line are really struggling to develop even basic programmes. You have told me that you are looking at the sports budget in the round, but the fact is that you have not doubled it in this parliamentary session as you said you would in your last manifesto—the budget is going into the next session. I note your commitment to sport, but how can you claim that what has been done so far in this parliamentary session has been beneficial to it?

Neil Gray: We are not far off doubling the budget, as I think that Mr Whittle would acknowledge. We have recognised the challenge, and we have set this budget in collaboration with the sports governing bodies, which we meet and closely collaborate with.

Part of the consideration has been around deliverability, which I think speaks to Mr Whittle's point about the challenge of delivering some of the provisions that we are talking about. When it comes to what we have set out, such as the swimming offer, our interventions in and support for the summer of sport initiative, and the support that we are providing to sports governing bodies, there is confidence that it will be able to deliver against the investment that has been made.

I am very pleased about that, because I have a very clear attachment to this area of policy. I have a hinterland that has undoubtedly benefited me, and I am seeking to ensure that children and young people, but adults, too, are able to benefit from the opportunities that both Mr Whittle and I had in accessing sport. Mr Whittle is also right to highlight the issue of general physical activity, and significant investment, interventions and work are continuing in, for example, active travel.

Brian Whittle: As you know, I have been calling for universal swimming lessons all along, so I welcome the narrative. However, those are not being offered during the school term. I think that we should take sport to the kids, not wait for the kids to come to the sport. If they are offered only during the holiday period, how will kids access them? There is a potential problem there, because there has to be a swimming pool that is open and kids have to be able to travel to it. If our goal is to teach kids to swim, why are we not doing it during the school term when we can, to coin a phrase, fish where the fish are?

Neil Gray: I understand that concern. We are looking to build a recurring programme. The first objective is to build on the Commonwealth games and the summer of sport and ensure that there is a response to what we hope and expect to be considerable enthusiasm among people who will want to emulate the sporting stars that they will see in Glasgow. The funding to build the programme will be recurring, and whether it is offered during term time or during the holidays, we will continue to work with governing bodies such as Scottish Swimming to make it as accessible as possible.

I recognise the challenges around accessibility. In my earlier answer to Emma Harper, I talked about the differential impact of child poverty on outcomes in health and wellbeing, and access is another area where the poverty premium applies. We will continue to work with Scottish Swimming and others to ensure that the services that are being provided are as accessible as possible.

Brian Whittle: You touched on legacy, which is an important tool for engagement. In 2014, the Commonwealth games were in Glasgow and they showed Scotland at its very best through some phenomenal sport. However, the legacy of the games is not evident. Facilities have closed down and, as I have said many times, access to sport and physical activity has become the bastion of the middle classes and those in private education. You will be aware that I have been a coach for longer than I was an athlete, and I have that concern.

We have a fantastic summer of sport coming up and Scotland will, once again, be shown to be a key deliverer of major events. Given the issues that I have talked about, how will we ensure that we maximise and deliver that legacy?

Neil Gray: Mr Whittle is absolutely right, and that issue came through in my discussions with the SFA last week. There is no point in our having one-off events that bring loads of people in but do not sustain participation—that is not a legacy. We are looking to build a legacy, and that is what the governing bodies are also looking for as they develop their programmes. Having spoken to the SFA about the programmes that it is looking to build, I can say that, from its perspective, it starts with community clubs. I declare an interest in that I coach at one of those, so I know that ensuring broad appeal, accessibility and support is incredibly important to the community club network. I expect that to be replicated in the plans that the other sports governing bodies bring forward. It was certainly part of the pre-budget discussions that we had about what they would be able to do to broaden participation and accessibility for families on lower incomes. That is a key consideration for the programmes that the governing bodies are seeking to offer; they will seek to ensure that the athletics clubs network and other sports networks at a community level are where we will make the difference by making the offer more accessible.

Brian Whittle: I had better declare an interest as an athletics coach as well. I ask the cabinet secretary to go out and speak to other sports as well, because we are struggling. It is a financial issue. Somehow or other, we have to utilise this summer of sport to rejuvenate a lot of sports, because they are on the decline. Too many clubs are shutting down.

Neil Gray: The intervention that we are making in this budget was in response to governing bodies setting out concerns such as that. I can see some of those concerns, because my children participate in athletics, swimming, football and a range of sports. I can see the strength that there is in the club network, in the community network and in the volunteers that allow these clubs to be sustained.

Another element is how we can continue to support volunteering in sport across Scotland, because that is the life-blood. That is what empowers and allows clubs to put on sessions and

take on additional teams, to get more children and young people involved.

We also need to look at how we ensure that we are providing accessible services for adults who may well be watching the football world cup and the Commonwealth games and looking to get back into a sport that they have previously participated in, or looking to pursue a more active lifestyle by getting involved in something like walking football or the jogscotland network.

We are making a broad investment to provide an opportunity for increased participation across demographics and age groups. I would be more than happy to meet Mr Whittle, or for Ms Todd to do so, to discuss that in more detail with him.

Brian Whittle: Much as I feel that I am just getting started, convener, I realise that we are running out of time, so I will leave it there.

Elena Whitham: I have a few questions about the good food nation plan. The committee took evidence and published our report on it in September. One of our conclusions was that, in order to have success in ensuring that the plan results in a better diet and improved health outcomes, there needed to be a clear line of sight to the plan's goals across very different policy areas. We know that there will be competing policy areas in the budget, and we have already spoken this morning about trying to break down the siloed approach. My question is about how governance and funding decisions will be reached in a way that will prioritise public health and a healthy diet, given the competing pressures in thinking about the economy. If we think about products that might have an impact on health but might have priority in another policy area, how do we ensure that they are thought about in relation to the good food nation plan and health outcomes?

Neil Gray: We have been exploring in depth how we balance the public health interventions that we need to make with providing increased choice. In some cases, such as food, nutrition and alcohol, choice is being curtailed, which is making it more difficult for people to make decisions about how they sustain themselves. As Ms Whitham will be aware, we are taking forward public health interventions such as minimum unit pricing and measures in relation to high-fat, salty and sugary foods, because we recognise their impact on health and wellbeing in Scotland. There are considerations—of course there are—around the wider economy, but that flips both ways. As a former economy secretary, I say that we struggle to have a growing and successful economy if we do not have a healthy workforce. Ensuring that we have a balanced approach means that we are able to take the necessary interventions that protect health but also sustain a healthy workforce that contributes to economic activity. That is the overarching approach that the Government is taking to the good food nation plan and our public health measures in improving accessibility and choice for people when it comes to their eating choices.

Elena Whitham: With regard to monitoring the implementation of the plan to ensure public health outcomes, the prevention of ill health and the promotion of healthy living, how will the Scottish Government monitor the effects on health inequalities and ensure that they are prioritised? From your perspective as the health secretary, how will you do that?

Neil Gray: I have good engagement with Ms Gougeon, who leads in this space. I believe that the legislation gives us an opportunity to do that, and I would be happy to provide more detail to the committee in writing as to the monitoring that we expect to put in place and the decision-making infrastructure that we have around some of the public health interventions that we are seeking to make.

The Convener: I thank the cabinet secretary and his officials for their attendance this morning and for their evidence to the committee. I will now suspend the meeting to allow for a change of witnesses.

10:45

Meeting suspended.

10:53

On resuming—

Subordinate Legislation

Civic Government (Scotland) Act 1982 (Licensing of Non-surgical Procedures) Order 2026 [Draft]

The Convener: Item 3 is consideration of an affirmative Scottish statutory instrument. The purpose of the draft order, which requires approval by resolution of the Parliament before it can become law, is to establish a licensing scheme for the provision of certain non-surgical procedures that pierce the skin and which do not require the input of a healthcare professional. It will ensure that such procedures are provided only in appropriate settings, and it will designate the activity as an activity for which a licence under the Civic Government (Scotland) Act 1982 is required from 6 September 2027. The Delegated Powers and Law Reform Committee considered the order at its meeting on 20 January and made no recommendations in relation to it.

We will now have an evidence-taking session on the order with the Minister for Public Health and Women's Health and supporting officials. Once our questions are answered, we will proceed to a formal debate on the motion.

I welcome Jenni Minto, Minister for Public Health and Women's Health; and, from the Scottish Government, Rachel Coutts, lawyer, and Owen Griffiths, legislation team leader. I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): I thank the committee for giving me the opportunity to speak on the Civic Government (Scotland) Act 1982 (Licensing of Non-surgical Procedures) Order. The order is part of a suite of legislation to regulate non-surgical procedures—a sector that is currently unregulated. Such procedures can cause serious and lasting damage if they are not performed correctly, and this is one of two substantive steps that we are taking to reduce the potential harm to customers in Scotland across a range of procedures. The order sits alongside the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill, which is currently at stage 1.

The order establishes a local authority licensing scheme for lower-risk non-surgical procedures that pierce or penetrate the skin. Such procedures do not require the input of a healthcare professional, as any risks can be appropriately mitigated through the imposition of hygiene standards and by requiring the use of appropriate materials. Procedures covered by the order include laser and light treatments that do not damage the skin's surface; shallow microneedling; fruit and glycolic acid peels; and advanced electrolysis.

In contrast, the bill regulates a range of more invasive procedures where we believe healthcare professional input is required to ensure safe treatment. Taken together, the two pieces of legislation will allow us to provide a differentiated and proportionate approach to the range of procedures available.

The order sets out a number of mandatory licensing conditions relating to the hygiene of premises, equipment and processes, and it also requires that non-surgical procedures not be carried out on individuals under the age of 18. Those conditions are key to protecting the public, especially young people, and they will give customers confidence in the services that they are receiving.

As with the bill, the definition of a non-surgical procedure in the order does not include procedures that are undertaken by a person acting on behalf of the health service or by a healthcare provider for the prevention, diagnosis or treatment of illness or injury. Where the removal of skin lesions, for example, is carried out by a person acting for, or on behalf of, the health service or by a healthcare provider as part of the prevention or treatment of an illness, that will be exempt from the definition of a non-surgical procedure.

Again, as with the bill, the order does not include any provision for training or qualifications. That is due to the effects of the United Kingdom Internal Market Act 2020, which we have discussed previously. We continue to work with the UK Government on that issue, and we will legislate for training and qualifications when circumstances permit us to do so.

I welcome any further questions that the committee might have, and I encourage members to support the progress of this order.

The Convener: Thank you. The committee does indeed have a series of questions for you, and we will move straight to them.

David Torrance: Good morning. What is the rationale for classing higher-risk procedures as being suitable for local authority licensing, instead of restricting them to Healthcare Improvement Scotland-regulated settings?

Jenni Minto: We have taken a lot of advice and done a lot of work on this to ensure that we feel that the right procedures are being given the right and proportionate regulation. We expect local authorities to work closely with Healthcare Improvement Scotland to ensure that, if any questions arise on the procedures covered by the

order that are being carried out in local authority-licensed premises, they get them right. As I said in my opening remarks, this is part of a suite of legislation to ensure that non-surgical procedures are given the right regulation.

David Torrance: How will the Scottish Government address concerns that, under the scheme, non-medical practitioners could end up carrying out procedures on potentially cancerous lesions? How will the list of skin lesions or blemishes be reviewed to address that risk?

11:00

Jenni Minto: Those are important questions. I know that the committee received thorough evidence in that regard from healthcare professionals and those who provide non-surgical procedures. We will clearly set things out in the guidelines, but it is fair to say that—this ties in with our promotion of the "Be the Early Bird" campaign on detecting cancer early—if someone has regular treatments, the beautician or whoever provides those treatments could advise that the person sees a healthcare professional if they notice any changes, as one would expect. Our guidelines will support that, because I recognise the importance of the issue and the questions that I was asked by the committee when we were talking about the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill.

Paul Sweeney: On the regulatory boundaries, what is the Government's response to concerns that the distinction between the respective scopes of the bill and the order might not be clear, particularly in relation to the technical thresholds of procedures? Will the Government commit to fund appropriate training for local authority officers so that they can navigate the technical challenges with enforcement?

Jenni Minto: We have been doing work in this area specifically to understand what support might be needed between local authorities and Healthcare Improvement Scotland. Those organisations already work together, but I commit to the Scottish Government working with them to ensure that there is a much more collaborative process. There is evidence of them working together previously: for example, the Scottish licensing of skin piercing and tattooing working group brought together different organisations to ensure understanding and consistency among the organisations that would be controlling that process.

We are clear that, if the procedure is covered by the bill, the responsibility is with Healthcare Improvement Scotland, and if the procedure is covered by the order, the responsibility is with the local authority.

Paul Sweeney: How will the Scottish Government ensure that local authorities can develop clear and workable guidance? There are concerns that it can be challenging to distinguish the thresholds relating to microneedling depth and chemical peel penetration, so it will be challenging for those on the ground to distinguish procedures that are covered by the bill from those that are covered by the order. How can we be confident that there will be clear and workable guidance on those technical thresholds?

Jenni Minto: Before I bring in Owen Griffiths, I note that all the work that we have done to get to this stage has been clear. The consultation responses were clear on whether a procedure should be covered by the order or by the bill, and some changes have been made as a result of those responses. In schedule 1, we have laid out descriptions of each of the procedures that the order will cover.

Owen Griffiths (Scottish Government): It might be helpful to provide a few examples of how things might work in practice. This is why it makes more sense for this to be covered in guidance rather than in the legislation.

You mentioned chemical peel. There is a distinction between the types of products that are likely to be used in procedures that are covered by the bill and those that are used in procedures that are covered by the Scottish statutory instrument. It would not be appropriate for the bill or the SSI to list individual brands, products or compositions of chemical peel, but it would be appropriate for that level of detail to be set out in guidance. That will provide an unambiguous reference point for practitioners, who will know what is likely to be acceptable, and for environmental health officers, for example—if they saw certain products being used in premises, that would provide a strong indication as to whether they were appropriate for procedures covered by the bill. As I said, it makes sense to set that out in guidance, which can provide some unambiguous steers of that nature.

Paul Sweeney: That is helpful. I also want to ask about a method of escalation for officers in local authorities. Could a central expert panel or some sort of troubleshooting service be established, or could there be an early introduction of the enforcement mechanisms so that, if there are borderline procedures or other uncertainties, they could be referred to some sort of expert adjudication?

Jenni Minto: In an earlier answer, I referred to work that was done by the skin piercing and tattooing working group. I am not ruling that in or out, but it is a suitable way of ensuring that those in local authorities have the appropriate training and understanding.

Emma Harper: We are talking about guidance rather than putting something into the bill, because procedures will evolve and there will be changes to chemicals or microneedling, which I had never heard of before we started on the bill. Do we need to allow flexibility because procedures will evolve?

Jenni Minto: I agree, and Owen Griffiths set that out clearly in his response to Mr Sweeney.

Gillian Mackay: The order does not set any knowledge, training or skills requirements for licence applicants. That is different from the Civic Government (Scotland) Act 1982 (Licensing of Skin Piercing and Tattooing) Order 2006, which requires councils to decide whether an applicant is fit and proper, based on their knowledge, skill, training and experience, or that of the people who are doing the work. It is not clear whether local authorities will be expected to make decisions on a similar basis under the new rules, or whether guidance will be issued. Will the minister provide clarity on that point?

Jenni Minto: I recognise the importance of training and qualifications standards, which was also clearly reflected in the views of stakeholders during the consultation. The Scottish Government has set out that we want that level of qualification, but we also believe that section 3 of the United Kingdom Internal Market Act 2020 will be engaged by any legislation that sets out provisions for training and qualifications, especially standards for practitioners, and prevents practitioners who do not have that qualification from practising.

When I gave evidence during the session on the bill, I indicated that we have been having in-depth conversations with the UK Government about this. Earlier this month, I wrote to Karin Smyth, who is the UK Government minister who is responsible for this area of public health, and I have copied that letter to the committee. Work on this is on-going, which is why it is not included in the order.

Gillian Mackay: Given that we are talking about the safety of those who access the services, what confidence does the minister have that that issue will be resolved with the UK Government so that those safeguards are in place for people in Scotland?

Jenni Minto: As Gillian Mackay will be aware, the UK Government is also consulting on similar regulations for non-surgical procedures, which is why we are working closely with the UK Government to understand where it has got to on this. Work is also on-going with training providers on what the courses could be.

Elena Whitham: I want to spend a bit of time looking at local authority capacity and resourcing. Local authorities told the committee that they were concerned about their environmental health officer capacity, because, as we know, there are a lot of vacancies in the system. There is also concern that the licensing fees alone may not cover the cost of the system, especially in the start-up phase, when there is a lot of training and development of processes and initial inspections that will be resource intensive. Will you set out how the Scottish Government intends to support resources or give additional support to ensure that local authorities can fulfil their new licensing duties effectively?

Jenni Minto: I recognise from other areas of my portfolio as well as this one the stretch that is required for environmental health officers in Scotland and the key roles that they carry out across the board.

I recognise that there will be some additional work for local authority environmental health officers and the licensing departments in processing licences. I also understand that the EHOs are currently doing an amount of work in this area without any direct resourcing, through investigating health and safety concerns. Under the order, they will have the ability to source cost recovery. It will be local authorities that will set the levels of fees for the licensing. We will provide guidance.

I see this as an important piece of public health regulation and, I hope, legislation as well. I will commit to working with local authorities and alongside Healthcare Improvement Scotland to ensure that we have the right structures.

Elena Whitham: One of the other issues that were raised with us is the fact that, although EHOs have been operating and dealing with tattoo and piercing licensing since 2006, this stretches their expert knowledge to an area that they are perhaps not familiar with and which is outside of their usual expertise. Will you set out how the Government—or perhaps the expert group that you talked about—could facilitate learning in order to extend EHOs' knowledge to cover this?

Jenni Minto: This is a replication of what happened with tattooing and the fact that there was a group working together to ensure that there was that knowledge. We have taken that issue away, and we will be looking at it.

Elena Whitham: Perhaps such a group is where the Government could develop and provide national tools, templates and implementation guidance to reduce the administrative burden on local authorities, which they are concerned about, and ensure that decisions are consistent across the country.

Jenni Minto: That is a good point: we need consistency across the country. There is a role for the Scottish Government to play in that, and there

is also a role for COSLA and the providers of these non-cosmetic procedures. I hope that that will be pulled together to ensure that we have consistent regulations across Scotland.

Brian Whittle: Good morning. In reply to Elena Whitham, you talked about awareness within councils. Do you commit to raising public awareness nationally? It is incumbent on the Government to ensure that the public know where to access information and that the public are aware of the status of practitioners and what they can deliver. How will the Government go about dealing with that?

Jenni Minto: As we have been going through this process, the importance of public awareness has been highlighted. It is fair to say that people assumed that this area was already regulated. The coverage that the committee has been creating in taking evidence and what has been in the media—whether that is radio, television or print—is all very important and has helped to move us along on this journey.

It is fair to say that a lot of the advertising for these types of treatments comes through social media, and the Scottish Government will look to share messages at the appropriate time on those same channels. I think that awareness is very important; indeed, you took very strong evidence on the issue in your evidence gathering for the bill.

11:15

Brian Whittle: Is it the plan to have a register that the public can access showing the status of practitioners?

Jenni Minto: What we are looking at is licensing. I will turn to Owen Griffiths to give you a response to that question.

Owen Griffiths: We have not made any provision for or announcements on a Scottish Government-organised register or a national register. However, local authorities are already required to make available information on licences that have been applied for and granted. How local authorities do that varies, but I know that the City of Edinburgh Council has a list on its website of premises and the licences that have been granted. There will definitely be space for work on guidance to make that a consistent approach across different local authorities and to ensure that the information is in a form that people can easily access. There are already some requirements in that space, and that can be strengthened through guidance.

Jenni Minto: Owen Griffiths is right—the information has to be in a space that is easily accessible, and it has to be easily understood by those who are using the facilities.

Brian Whittle: Finally, if we are looking to establish national guidance, how will consistent implementation be supported across Scotland?

Jenni Minto: If there is national guidance, we expect it to be followed consistently. However, as I said in response to previous questions from Elena Whitham, that will involve a collaborative approach with local authorities and COSLA to ensure that we get the right information out in the right places.

Brian Whittle: Will Healthcare Improvement Scotland have an input into that?

Jenni Minto: Health Improvement Scotland will have to have an input into that. I was looking specifically at the order, but if the bill itself is passed and becomes legislation, I would expect Healthcare Improvement Scotland to be involved, too.

Brian Whittle: Thank you.

The Convener: I have a couple of questions on enforcement and rogue operators. How does the Scottish Government plan to tackle unlicensed and covert operators, and will new enforcement tools or national protocols be developed?

Jenni Minto: We have experience of rogue operators in other areas of my portfolio—Food Standards Scotland, for example, works closely with Police Scotland if it discovers a rogue operator in the food universe—and I would expect Police Scotland and the local authorities to have powers to search unlicensed premises where there is sufficient evidence to suggest that non-surgical procedures are being carried out. Again, it comes back to that collaborative way of working.

As I have indicated, local authorities have been using health and safety legislation, but the order designates the provision of certain non-surgical procedures as a licensed activity, and that will give local authorities proportionate powers to regulate their provision in a consistent manner.

The Convener: How does the Scottish Government plan to address concerns that temporary licences can be granted with limited scrutiny and that they might operate for extended periods? What safeguards will be put in place to ensure that such temporary licences do not become a loophole for avoiding proper regulation?

Jenni Minto: That is an important question, and we will be working with the local authorities and COSLA to ensure that, if a temporary licence is permitted, it will be for only a specific length of time, and that the guidelines set out the right procedures for firming up such licences. That will be in the interests of the local authorities as well as the consumer, because it will mean that they

will get the resources to continue to monitor and regulate these matters.

The Convener: Thank you, minister.

As that brings us to the end of our questions, we will move to item 4, which is the formal debate on the instrument on which we have taken evidence. I remind the committee that officials may not speak in the debate.

I ask the minister to move and speak to motion S6M-20213.

Jenni Minto: I thank the convener and committee members for their consideration of this order, which will establish a local authority licensing scheme for lower-risk non-surgical procedures that pierce or penetrate the skin and will modify the general provisions of the Civic Government (Scotland) Act 1982 in that respect.

The order aligns with part 1 of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill, and together they will bring under regulation a wide range of procedures that we know are happening across Scotland. Such procedures can cause serious and lasting damage, and this is the first substantive step to reduce the potential harm to customers in Scotland across a range of procedures. I invite the committee to recommend approval of the instrument.

I move,

That the Health, Social Care and Sport Committee recommends that the Civic Government (Scotland) Act 1982 (Licensing of Non-surgical Procedures) Order 2026 be approved.

Motion agreed to.

The Convener: That concludes consideration of the instrument.

Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Amendment Order 2025 (SSI/2025/405)

The Convener: Item 5 is consideration of a negative instrument. The purpose of the instrument is to extend voting rights on integration joint boards to include service user, unpaid carer and third sector representatives.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 13 January 2026 and made no recommendations on it. No motion to annul has been received.

To support its consideration of the instrument, the committee has written to selected stakeholders to request their written views, and we have received a response from COSLA, expressing certain concerns about the instrument. In light of that, I propose that we invite a representative from COSLA and other interested parties, including third sector organisations and unions, to give evidence on the instrument at next week's meeting, along with the Minister for Social Care and Mental Wellbeing.

Do committee members agree with the proposed approach?

Members *indicated agreement*.

The Convener: At our next meeting, we will take evidence from the Patient Safety Commissioner for Scotland on her initial work priorities since taking up her post last September.

That concludes the public part of our meeting.

11:22

Meeting continued in private until 11:36.

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