OFFICIAL REPORT
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Health and Sport Committee

Tuesday 29 October 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 29 October 2019

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HEALTH AND SPORT COMMITTEE
24th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Kim Atkinson (Scottish Sports Association)
Dr William Bird (Intelligent Health)
Professor Richard Davison (Observatory for Sport in Scotland)
Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Martin Hayman (Table Tennis Scotland)
Flora Jackson (Physical Activity and Health Alliance (NHS Health Scotland))
Dr Corinne Jola (Abertay University)
Kirsty McNab (Scottish Sports Futures)
Claire Thirwall (NHS Dumfries and Galloway)
Dr Katie Walter (Cairn Medical Practice)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 29 October 2019

[The Convener opened the meeting at 09:48]

Subordinate Legislation

Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Amendment Order 2019 [Draft]

The Convener (Lewis Macdonald): Good morning, and welcome to the 24th meeting in 2019 of the Health and Sport Committee. We have received apologies from Sandra White: I know that the thoughts of all colleagues are with her.

I ask everyone in the room to ensure that their mobile phones are switched off or to silent mode, and that they are not used to photograph or record proceedings.

The first item on the agenda is subordinate legislation—consideration of an instrument that is subject to affirmative procedure. As is usual with such instruments, we will first hear from the relevant minister and his officials, following which we will have a formal debate.

With apologies for the slight delay in starting the meeting, I welcome to the committee Joe FitzPatrick, the Minister for Public Health, Sport and Wellbeing. He is accompanied by Claire Montgomery from the legal directorate; Lynne Nicol, who is the head of openness and learning at the Scottish Government; and David Leslie, who is a policy manager in the openness and learning unit at the Scottish Government. I invite the minister to make a brief opening statement.

Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing): Thank you, convener. I am pleased to join the committee to discuss the draft Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Amendment Order 2019.

Providing care with safety, compassion and dignity should daily be central to every health and social care interaction that happens throughout Scotland. However, there are rare occasions on which those who provide care betray that position of trust.

Part 3 of the Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 contains provisions to allow the criminal justice system to hold individuals and organisations to account when they are responsible for serious and deliberate neglect or ill treatment in the course of providing health and social care services.

It is important to understand that those offences are not about pursuing organisations or individuals when mistakes are made. The offences are designed to deal with situations in which someone has intentionally set out to neglect or mistreat a person or persons in their care.

There are two main offences in the 2016 act: an offence that applies to care workers, as set out in section 26, and an offence that applies to care providers, as set out in section 27. The offences are intended to provide a penalty for the worst types of behaviours, such as those of the individuals who were convicted for abuse at Winterbourne View care home in Gloucestershire, where vulnerable residents were subjected to cruel and callous behaviour by staff who were supposed to be caring for them.

It is important that there is access to justice for victims when a care worker has wilfully neglected or ill treated people. It is also important that the disclosure regime contains sufficient protections, so that people who have a legitimate interest—such as potential employers in the health and social care sector—can access the information that they need in order to understand the background of a care worker who has been convicted of something serious.

The 2016 act made amendments to the state disclosure regime under the Police Act 1997, which mmeans that a spent conviction for ill treatment or wilful neglect by a care worker must be disclosed on a higher-level disclosure certificate that is issued by Disclosure Scotland, unless a sheriff orders otherwise.

The draft instrument will make changes to the self-disclosure regime to provide an added layer of security. Its main effect will be that when a person is required to disclose their spent convictions in applying for certain trusted positions or roles—work as a medical practitioner or work in provision of a care service—they must divulge that they have a spent conviction for ill treatment or wilful neglect, under section 26 of the 2016 act. That will be the case unless they have applied successfully to a sheriff for the spent conviction to be taken off their higher-level disclosure certificate.

The draft order will also have the effect of ensuring, when no such successful application has been made, that it is permissible to dismiss or exclude a person from certain trusted offices, professions, occupations and employment because of their spent conviction for the offence, or their failure to disclose it. That means, for example, that when a person is applying for a position of trust in a health or social care organisation, the organisation will have access to

information that it needs from the applicant in order to decide whether it would be appropriate to employ them, and it will be able to take that information into account.

I consider that the instrument strikes a balance between protecting the public from risk from people who might reoffend and allowing people who have made mistakes in the past to be rehabilitated and to make a contribution to society.

I am happy to answer the committee's questions.

The Convener: Thank you very much, minister. It would be fair to summarise what you as being that the impact and purpose of the instrument is to make the law consistent across the board.

Joe FitzPatrick: That is a fair summary.

The Convener: Members have no questions for the minister or his officials, so we move on to the debate on the instrument on which we have just heard from the minister. The debate is a different stage. The minister will not answer questions, but will move the motion and, no doubt, sum up as appropriate at the end. Officials may not take part; this is simply an opportunity for the committee to consider and approve, or otherwise, the instrument.

Motion moved,

That the Health and Sport Committee recommends that the Rehabilitation of Offenders Act 1974 (Exclusions and Exceptions) (Scotland) Amendment Order 2019 [draft] be approved.—[*Joe FitzPatrick*]

The Convener: As committee members have no comments, I ask the minister whether he wishes to add any final comments.

Joe FitzPatrick: The words that I would use to summarise are the ones that you used, convener. The instrument is about consistency.

The Convener: Thank you. I am glad that we are consistent.

Motion agreed to.

National Health Service (Serious Shortage Protocols) (Miscellaneous Amendments) (Scotland) Regulations 2019 (SSI 2019/284)

The Convener: The next agenda item is consideration of an instrument that is subject to negative procedure. No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has not made any comments on the regulations. However, when we considered the regulations previously, we raised a question with the Government, to which we have now received a response. Do members wish to comment on that?

Emma Harper (South Scotland) (SNP): I raised the issue of bioequivalence and the definition that we are going to use. The Cabinet Secretary for Health and Sport's letter has reassured me, as she states that we are using the European Medicines Agency's definition in allowing drugs to be replaced.

I have concerns about bioequivalence because, in my previous work as a nurse, I had concerns about medicines such as anti-seizure meds, anti-psychotics and biological medicines such as Humira. I am satisfied that the cabinet secretary has given an appropriate response.

The Convener: As members have no more comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: I suspend the meeting briefly.

09:57

Meeting suspended.

10:02

On resuming—

Social Prescribing (Physical Activity and Sport)

The Convener: The next agenda item is a round-table evidence session on social prescribing. In order to facilitate the free flow of conversation, we will, rather than my introducing our many witnesses, quickly introduce ourselves around the table. I am the convener of the committee.

Dr Katie Walter (Cairn Medical Practice): I am a general practitioner in Inverness and am involved in a number of social prescribing projects.

Emma Harper: I am a member of the Scottish Parliament for the South Scotland region.

Claire Thirwall (NHS Dumfries and Galloway): I am a health and wellbeing specialist from the Dumfries and Galloway public health department.

George Adam (Paisley) (SNP): I am the MSP for Paisley.

Professor Richard Davison (Observatory for Sport in Scotland): I am professor of exercise physiology at the University of the West of Scotland and am representing the Observatory for Sport in Scotland.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for Lothian and the Conservative health and sport spokesman.

Flora Jackson (Physical Activity and Health Alliance (NHS Health Scotland)): I am health improvement manager for physical activity at NHS Health Scotland.

Kirsty McNab (Scottish Sports Futures): I am the chief executive officer of Scottish Sports Futures, which is a third sector organisation that works with vulnerable communities using sport as our tool.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the Liberal Democrat health spokesperson.

Kim Atkinson (Scottish Sports Association): I am the chief executive officer of the Scottish Sports Association, which is the membership organisation for the governing bodies of various sports in Scotland.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I am the Scottish National Party MSP for Glasgow Maryhill and Springburn.

Dr William Bird (Intelligent Health): I have been a GP for 30 years. I have been involved with health walks and with setting up social prescribing, and I am the CEO of Intelligent Health.

David Stewart (Highlands and Islands) (Lab): I am a Labour MSP for the Highlands and Islands region.

Martin Hayman (Table Tennis Scotland): I represent Table Tennis Scotland. We run our community table tennis programme around Scotland.

Brian Whittle (South Scotland) (Con): I am a South Scotland MSP and a party spokesman on wellbeing and sport.

Dr Corinne Jola (Abertay University): I am a senior lecturer in psychology at Abertay University, and I do research on dance for health and wellbeing.

David Torrance (Kirkcaldy) (SNP): I am the MSP for the Kirkcaldy constituency.

George Adam: And a walking football superstar.

David Torrance: Yes—Scottish champion.

The Convener: Excellent. I am sure that that will not be the only bid for fame in this morning's session. I welcome all our witnesses. We want this to be a free-flowing discussion, but in order to maintain some structure to our conversation, please indicate to me that you wish to speak.

Would any of the witnesses like to comment on whether the concept of social prescribing is the right one? By using the word "prescribe", is there a risk of medicalising the concept or restricting its application? Are we all talking about the same thing when we talk about social prescribing? What should we be talking about?

Dr Bird: Having been involved with social prescribing for so long as a GP, I totally welcome this conversation—it is a fantastic move in the right direction. However, when we go in the right direction, there are always dangers, and one of the main dangers is that we will medicalise the concept. You referred to the words "social prescribing", which are very linear and hard to scale up.

My biggest worry, which I think we will discuss, is that social prescribing will take responsibility away from the people who are already doing this kind of work, and that social prescribing will be seen as a conduit to all the work that is generally being done by communities, primary care units and so on. The danger is that although we will get experts called link workers who—very successfully, I hope—will take on the role, that will take responsibility for social prescribing away from everyone else who is already doing it.

The Convener: Are there any other thoughts? I see a few nodding heads.

Dr Walter: I absolutely share William Bird's enthusiasm and concerns. I liked reading in the submissions the consistent recognition across the board that social prescribing is a really good move. However, the evidence base is weak—although it is evolving as we speak. It is difficult to adopt a lot of strategies that rely on a concept whose evidence base is still evolving.

On the problem with the term "social prescribing", I social prescribe every single day when I talk to people about walking as a means of increasing their levels of physical activity. For me, that feels as much like social prescribing as giving somebody with multiple healthcare needs lot of support and hand holding. The term masks tiered levels that involve different interventions, depending on people's needs.

Professor Davison: I agree with the comments that have been made so far. I raise in my submission the point about the risks that are associated with the capacity to deliver social prescribing. There are issues around training key workers to deal with the issue that Katie Walter mentioned, which is the range of problems that come the way of key workers. The ability to signpost to appropriate services is a triage operation.

We can look at social prescribing as being but one weapon in our toolkit against physical inactivity. I go back to William Bird's point about medicalisation: we could be radical and bring medicine much more into everyday life. Why not have GP surgeries in community centres and leisure centres, where exercise is being taken? Why not look at physical activity, sport and exercise much more as mainstream parts of the national health service?

Kim Atkinson: I echo the point that colleagues have made, that there are, as our members would identify, many opportunities for social prescribing. Acknowledgement of existing systems is a huge issue. As the committee has heard us say before, there are 13,000 sports clubs, with 900,000 people already being members of those clubs. As Dr Bird said, many people are already active and are doing their own social prescribing. Are we adequately supporting them? I hope that that is a subject to which we will return.

On Richard Davison's point, there are lots of successful examples—a particularly good one, which I think the committee has visited, being Atlantis Leisure in Oban. In partnership with a local GP, a programme that is run by Atlantis Leisure sits in the GP practice.

To answer the question, social prescribing is interesting. People have the notion that when they get a prescription and walk along to the pharmacist to pick it up, it is free. It is certainly the case that for people who deliver sport and physical activity, and more broadly across the voluntary sector, that the money does not follow the prescription, which they think is inequitable. Social prescribing is talked about as an opportunity, but we do not treat it the same way as medical prescribing.

Some 4 per cent of the population understands the chief medical officer's guidelines. Is the public's expectation that they will leave a GP surgery with a medical prescription? They might say that they do not know the CMO's guidelines or the benefits of being active, in which case GPs are, by prescribing some activity, considered to be almost fobbing them off. That is not the reality. Could we change people's perception, so that more people know the benefits of being active and the CMO's guidelines about why that is so important?

Dr Jola: I agree with what has been said so far. My interest is in the opportunities for social prescribing to address some of the issues that have been mentioned. A focus on social prescribing has to be linked to further evidence-based research, and we can advance that evidence base as social prescribing rolls on.

We can make movement and physical activity more mainstream, and we could link social prescribing with the experience of communities that offer activities. Communities, community link workers and the GPs should work together based on a more theory-driven understanding of what is missing, so that people do not stop moving more. Large parts of the population have lost the enjoyment of movement. There should also be more collaborative projects, in order to build on the existing expertise and experience.

Flora Jackson: I agree very much with my colleagues. I see social prescribing as part of a continuum. Elements of work need to be undertaken in the healthcare system in relation to the knowledge, skills and behaviours of our health professionals. We know that their awareness of the current physical activity guidelines is not as strong as we would like it to be, so there is definitely a lot of work to be done to support and upskill our health professionals. Equally, there is a risk that we might, as our health professionals become better at providing advice on physical activity and brief interventions, overburden our third sector partners outwith the NHS. In the world of integration of health and social care, we need to be mindful that we strike a balance in funding both elements.

Brian Whittle: Good morning. It is interesting to hear the initial responses to the convener's question about social prescribing. My preference

is for prescribing sport. I think that MSPs all think that my solution to every problem is to go for a run, which is not far from the truth.

We have been talking about sport, but where do art, drama, music and other such activities fit into social prescribing? They have an impact on mental health issues. Surely social prescribing is about understanding what is on offer in the community and linking up with that offer. How should that be done? It will be different in every community. It cannot be enough for a doctor or a clinician to prescribe; we must also have a pathway that allows them to engage.

The Convener: Today's focus, given our witnesses, is primarily on sport and physical activity, but you are right to say that there are other forms of social prescribing.

Kirsty McNab: My view is similar to Brian Whittle's. My organisation believes that sport can change lives.

I will pick up on Flora Jackson's point. The third sector needs money to do social prescribing properly. We are doing a lot of work just now that is based on what people are telling us is a real need around mental health. We have young-person led mental health programmes and we are working with the Scottish Association for Mental Health, which is the lead organisation for mental health, using sport as our tool.

A constant challenge for us is to make the case for using our evidence base. We do robust monitoring and evaluation: that is something that the third sector is very good at. However, we are constantly having to prove our worth and we spend a lot of time trying to get funding for projects that will alleviate pressure on child and adolescent mental health services. The number of referrals to CAMHS has risen by 2,000—another 2,000 young people are on the waiting list. The total on the waiting list is now 10,000.

We want to be completely in the social prescribing space. There is an argument about whether it should be called "social connectedness", but I think that calling it social prescribing is fine. We need to ensure that money goes to the third sector to enable it to work.

10:15

Martin Hayman: Our perspective is that of a sporting organisation that caters for many older people engaging in sport. An element of that that has the biggest impact is social engagement—participation in sport in a social environment. The tea or coffee and a blether that take place around the sport are almost as valuable to participants as the physical activity itself, and the combination of the two is incredibly important.

We have almost no link to, or engagement with, health provision and the health service in terms of a referral process. That might happen at local level, but it is not happening on a larger scale. I am very keen to see how our sport can develop and work with the NHS and health providers to provide community-based activity.

The important issue of funding was mentioned by Kim Atkinson and Kirsty McNab. A person can go to their GP, get a prescription and then get their medication at no cost. However, when they are encouraged to join a local sport group, they find that participants have to pay. The referrals have a cost attached. Table tennis classes cost a maximum of £3 or £4—often they cost less. Although it is not a huge cost, it is a barrier. All of us at the table need to consider what barriers we place between individuals who need physical activity and the community groups that can support them and provide activity. Cost is certainly one of the barriers.

The Convener: We have heard about the evidence base and accessibility. Is it the case that, although everyone agrees that social prescribing is a very good concept, there is simply no mechanism or joined-up way to allow it to happen?

Professor Davison: I was about to say exactly what you have just suggested. Around the table, we generally believe that social prescribing or something of that nature is a good idea. I suppose that the problem is in getting underpinning evidence—I think that Katie Walker started with this—on the best approach. I am an exercise scientist: we have been very good at proving the efficacy of exercise and we know that it helps people's health.

Ultimately, we are all trying to improve population health—that is our objective—in order to take the strain off the NHS. However, research also shows that six-week or 12-week interventions of social prescribing work, but not for the longer term. Social prescribing of clubs seems to be slightly more successful because, as Martin Hayman said, the social context is important. That links to what Brian Whittle said about social and psychological benefits and things being more cohesive. Social prescribing is one of the solutions, but we do not have the underpinning research evidence that says that social prescribing is the best policy, route or method.

Claire Thirwall: I agree with what my colleagues around the table have said about evidence. It is emerging—it is not quite there yet, but it is coming. A lot of work is going on across Scotland on that. I also agree that there must be a whole-system approach to social prescribing, if we are going to use it.

We have to look at the individuals at the centre, work with them to understand their needs and consider those needs in terms of their communities. Rural areas do not have the infrastructure, so we have to take different approaches. We need to look at the infrastructure around a person in order to ensure that we maximise opportunities through ensuring that health and social care staff have the skills, training and ability to signpost people to link workers. Link workers need training to ensure that they can work through the health behaviour-change interventions.

Communities need to be supported to be welcoming in terms of equalities so that they can accept people. We have been working on that in Dumfries and Galloway; we have been looking at the evidence base from our colleagues around the table, and we have been engaging with our communities to develop infrastructure that will support the process into the future.

Kim Atkinson: The World Health Organization's definition of health brings together a lot of what people are talking about—the mental, physical and social aspects. As Martin Hayman and Richard Davison said, clubs are particularly important.

To answer Brian Whittle's question, I point out that the Scottish Sports Association does a lot of work with colleagues across the voluntary sector, through the Scottish Council for Voluntary Organisations, the Scottish Volunteering Forum and the Association of Chief Officers of Scottish Voluntary Organisations, of which—with another hat on—I am vice-chair. Many challenges and barriers, such as those that Brian Whittle raised, exist across the voluntary sector, regardless of whether the organisation is involved in sport and physical activity or in other activity.

Access to resources is a continuing problem. If this is fundamentally about lifestyle and behaviour change, it is questionable whether we can assume that people will change through referring them to 12-week programmes.

Also, the vast majority of the voluntary sector gets only one-year investment, as is regularly discussed at the cross-party group on volunteering. When organisations are looking to justify and monitor their resources in a one-year funding cycle, it is simply unfair to expect them to be able to deliver their best efforts and their staff to be as fully engaged and focused as possible. That is an issue across the whole voluntary sector.

A major barrier that our members will talk about in any situation, and which has come up at the committee before, is access to resources for facilities, which are expensive, so clubs cannot use them. There is no question about the significant effect of local authority budgets, which has also been looked at by the committee. The cost of facilities is too high and clubs say that they cannot use facilities because they are too expensive or have been closed. We are saying to people that they should go to clubs because they are the best thing, and because access to volunteering and sharing with other people are important, but our members keeps coming back to us saying that cost is a significant barrier.

To pick up on Martin Hayman's comments, I say that volunteering is not free, although people have a notion that it is. People give of their time for free, but access to the training and support that Flora Jackson talked about takes time, which also comes up regularly in the cross-party group on volunteering. Support for the network is not free, so we need to invest in it and make sure that people are supported.

On the flipside, at the next cross-party group on volunteering meeting—I apologise, because I keep plugging it—the wider Scottish Volunteering Forum will discuss work that we have been doing with Volunteer Scotland on the health and wellbeing benefits of volunteering. I know that the Scottish Volunteering Forum has made a submission. There is some great evidence on the benefits and importance of volunteering to health and wellbeing. It is interesting that the evidence also shows further benefits of sport and physical activity. It also shows that people from more challenged backgrounds and people who live in areas of deprivation volunteer more in sport than they do in other fields, and that volunteering in sport furthers other people's physical activity.

There are many similar barriers and opportunities across the arts and culture and more broadly. It would be useful if the committee could help us to work through some of the opportunities and challenges .

Emma Harper: Claire Thirwall mentioned rural challenges: I know her because we have worked together in Dumfries and Galloway on some of the issues. Can you outline the rural challenges versus urban challenges? It is interesting to highlight the challenges in rural areas, including in transport to places that offer sporting activity.

Claire Thirwall: The challenges in rural areas include lack of trains and other transport, even in relation trying to get up here to the Parliament. Transport is a huge issue, as is availability of facilities. Other issues include stigma about one's circumstances, lack of ability to access what exists within the community, and lack of choice. We could run through a host of issues. How we work in our communities and what is available in our communities are fundamental. We need to make sure that people connect with their communities,

and that they work with their communities to grow their assets.

We might not have the choice that is available in urban areas, but we have a lot of beautiful landscape in our region. We have to value our opportunities: we have to make sure that people can use green exercise, and simply take a walk, for example. There might also be barriers to do with confidence and self-esteem, so we need to work with individuals to overcome those barriers.

Flora Jackson: Claire Thirwall is being very modest: she has done some great work in NHS Dumfries and Galloway. We could look at the social prescribing frameworks that have emerged south of the border, but I commend Claire's work on drafting the outline of a social prescribing framework. She is working within the context of NHS Dumfries and Galloway, which is more relevant to the Scottish context than are other models that I have seen. I recommend that the committee look at that work.

Dr Walter: There is a risk of conflating two things. We are talking a lot about social prescribing. We want to support social prescribing and think that it is a good thing because it is a way of addressing some of the social determinants of health and health inequalities. That is the foundation of social prescribing. We are also talking about how to increase people's levels of physical activity. Although there is a lot of overlap, they are not exactly the same thing.

We know that social inequalities are often compounded by rurality factors, so the right way of addressing such social inequalities might look quite different if we look only at how to increase physical activity—we were talking in the broadest sense about social prescribing and bringing realistic medicine out to society and to people, rather than just about how we practise medicine—because it might not mean a health intervention at all; it might mean an intervention in relation to transport and infrastructure. We might get a much bigger bang for our buck by making our cities and our roads in urban and rural areas accessible and safe for walkers and cyclists.

I will just give you a tiny vignette. I have been involved with a project called WheelNess, which has been running in Inverness for a couple of years. The second year of the project focused on disabilities. One of our participants lives in a small rural community. He uses two sticks to walk and has quite precarious mobility. He relies entirely on public transport and there are two buses a day in his area. His kids stay several miles away and, to get to them, he relies on public transport that does not deliver what he needs. He now has an e-tricycle, which has given him mobility and allows him to get from A to B. He arrives at his kids' school looking like the coolest thing in town. However, he does not have safe infrastructure on which to use his e-tricycle. There is a lot of focus on safe cycling and walking in urban areas, but it is a problem in rural areas, too.

Social prescribing of physical activity is very broad, and it is the responsibility of every single health professional on the shop floor, whether they be a GP or a receptionist. That will be a matter for public health Scotland when it comes into being; its first task should be to broadcast that message.

We also need to train our staff. One of my bugbears is that we are not trained for social prescribing. My practice is a large urban practice in which only two of us have done formal behaviour change training, but we are the people who are delivering the message and having the conversations.

It is a good time to be having the conversations, because the climate is changing. People want something different. Realistic medicine has unleashed us health professionals and has allowed us to start to think differently about how we deliver healthcare. Climate change and environmental concerns are part of that.

10:30

Two weeks ago, our head of pharmacy in NHS Highland came to the practice to talk about how we can work better together to demedicalise things—to try to deprescribe and to think differently about how we deliver healthcare. That signals that there is a huge attitude shift across the board. That is the case not just within the health structure, but at community level, too. In my conversations with patients, I find that people want to start doing something for the environment. The time is ripe for such discussions.

Martin Hayman: Emma Harper talked about activity in rural areas. Making access to sport as easy as possible for people is critical. We have done a little research into our participants, and it is clear that the distance from where people live to the venue is absolutely critical to participation.

That is vastly more so in areas of higher deprivation. If the venue is not within one or two miles of where people live, they do not participate. In more affluent areas, the distance can go up to five or 10 miles, because people are happy to jump in the car and travel. If we want to get people from more deprived communities to be more active, we have to make sport and physical activity opportunities as local as possible.

For a sport such as table tennis, it is possible to get small groups going in rural areas, in small village halls, church halls or school halls. In Dumfries and Galloway there are phenomenal examples of communities getting together and

playing table tennis. The approach is very effective.

We must consider how we can make sport as accessible as possible. Let us look at all stages of the process and consider the barriers that are stopping people participating, and let us work really hard at taking down those barriers and making it as easy as possible for a person to cross the threshold and get involved, because when people get involved in physical activity in the right social environment, which is fun and enjoyable, they stick at it long beyond a six-week or 12-week programme.

Dr Bird: I want to pick up on what Katie Walter said. If we look at the revolutions in healthcare, we see that there was a public health revolution in the 19th century, and there have been huge developments in modern medicine. Now there is personalised healthcare, which will be much more about genomics and individuals.

There is a fourth revolution that will sort out the three big unresolved problems. Katie Walter mentioned two of them—climate change and health inequalities. The third is the diseases that we cannot treat with medicines. We cannot treat diabetes; we can only allay it. We cannot treat cardiovascular disease. We cannot treat dementia. In many situations, we are just holding the symptoms at bay.

If we are to get to the core of the issue we have to go back to childhood and we have to address the whole social fabric of society. We therefore have to consider social prescribing not on its own but as part of a much bigger picture, which goes right back to the structure of society. We can pick up the start of cardiovascular disease and hypertension in children from the age of six or seven, which is when the problems begin. We have to see social prescribing in the context of the whole life course, not just one end of it.

Scale is another issue. Social prescribing will never be able to deal at scale with problems. We have to reach not just tens or even hundreds of thousands of people but millions of people. As Katie Walter said, physical activity promotion and social prescribing are two different things. Encouraging walking is the one approach that can be used at scale. Around the table are represented fantastic organisations, clubs and volunteers. They are essential to the fabric of society and we need to build them up. However, at scale we need the unstructured activities—mums and dads taking their children to the park, walking to school in summer for the first time and talking to their children, an the two older people going for a walk—but people can do them only if the infrastructure is in place. That is another aspect.

Social prescribing is part of the solution; it is also a segue to a bigger revolution, which is the social movement whereby everyone takes responsibility. That is about mum taking her mother and her child for a walk—taking on the responsibility for being activity leader, because she wants that social movement to address the three major problems that we face.

David Stewart: I want to touch on the points that Dr Walter and Dr Bird made about the wider issues of social prescribing, and perhaps to bring in the political aspect—not in a party-political way, but to raise some wider issues.

When budgets have been looked at in Parliament, it has been argued that a greater proportion of the transport budget should be spent on active travel. Some members—not necessarily me—argue that that money should come out of the roads budget. That is all fine and well, but we also have to look at safety. It is fine to talk about active travel, but for people who live in disadvantaged areas there are sometimes issues to do with safety. There are also wider issues about how we design our towns, our cities and our rural areas.

I have also been concerned, especially when I was a member of the Environment, Climate Change and Land Reform Committee, about toxicity in the atmosphere. In disadvantaged areas, it tends to be young developing people and older people who are more liable to face the problems of a toxic atmosphere, which is why I am enthusiastic about low-emission zones and about thinking carefully about things such as park-and-ride systems. Even if we cannot necessarily achieve modal shift among people who have to drive, we can have decent park-and-ride systems and electric buses. In Inverness, for example, maybe we could have electric buses serving the Caley Thistle stadium and the main buildings, such as Raigmore hospital.

It is about what politicians can do, so maybe we need to listen to the views of the professionals round the table on how we could include social prescribing when we design transport policies, in order to ensure that we have safer cities with less toxic atmospheres. That would encourage people to get out of their cars. For people who do not have cars, maybe we need to have safer and better developed municipal bus services, which my lot, in my party, are certainly keen on developing. I am particularly interested to hear what Dr Walter has to say on that, because she had a very good article on it in *The Press and Journal* yesterday.

The Convener: I will bring Katie Walter back in, in a moment. First, we will hear from Corinne Jola, then Brian Whittle.

Dr Jola: Since I indicated that I wanted to comment, a lot more has been said. I want to emphasise the importance of taking a whole-system approach, which Claire Thirwall and Katy Walter talked about. The social component is really important as well, as Brian Whittle, Martin Hayman and Richard Davison said. It was also mentioned in Dr Bird's comment about walking. I know that the meeting is addressing health in relation to sport, but we need to consider the importance of a whole-system approach to social prescribing. We might miss out on providing the right medication if we say, "This is just social prescribing for health and sport, so we're not looking at cultural activities or the transport sector." It seems that most of us agree on that. When we discuss social prescribing, it is important that it is not just in one sector.

On the social component, it is important to consider how we can guarantee sustainability. As someone who has done research mostly on health and wellbeing related to dance, I felt quite honoured to be invited to give evidence to the Health and Sport Committee, because dance is often doubted as a physical activity. It suffers from a lot of stigma and there is discussion of whether it is useful and is sufficient physical activity. However, it has been shown in studies to be one of the most sustained activities—people continue to do it when studies and interventions have finished. People in the control group will also engage in the activity that the other group—the dancing group—got.

Activities have many different elements. For example, physical activity that takes place outside is not just physical activity; it also involves being with other people. Dancing is not just a physical activity; it involves being with other people and it is creative, so there is an expressive component as well. We have to take a whole-system approach.

The Convener: I ask Katie Walter to respond briefly to David Stewart, and then I will bring in Brian Whittle.

Dr Walter: I am not a politician. I devolve my responsibility to make difficult decisions to my politicians. That is what we do with the civic journey, is it not? I sit here and I think, "Wow! I would not do your job", because it is a difficult job and there are difficult decisions to be made, which will cheese some people off, for sure.

However, in these dark times, when everything that is in the news and everything that is happening in the world is pretty dismal, I was really encouraged to go back and read the Scottish Government's vision about physical activity. The principles that are embedded in it are really good principles, and it is really hard not to agree with them, but how do we translate them into reality? One of the principles is better joint working at a high level, which is key. This is absolutely a time of opportunity—we are revisiting the national transport strategy, so this is a key time for health and transport to come together.

I have been working over the past few years on a number of projects, all of which are health projects and all of which are funded by Transport Scotland. For me, that shows that there is a disconnect somewhere at a high level in how we think about projects. We all agree on the right vision, but how do we deliver that in an evidence-based fashion?

At one level, it is an exciting time. I am very glad that I live in Scotland, because we are sitting here having a meaningful debate about how we can translate the vision into reality. However, as we said at the beginning, it will be scary. The evidence base is evolving and we might get it incredibly wrong. However, it is difficult to get things wrong if we invest in infrastructure, because that infrastructure will last for several generations. That is my plug.

Brian Whittle: Listening to everybody, it strikes me that we understand that if we are more physically active, eat better and are included in society, we will be healthier as a nation. However, rather than just accepting that as a logical step, we are determined to continue to prove it.

To build on what David Stewart and others said, I agree that budgets seem to be the issue. We have mentioned transport and health, but what about the education budget? What about local council budgets? We are far too focused on the health budget being here, the education budget being there and the transport budget being over there. I have heard about so much in education that is health related and so much in transport that is health related, and vice versa. With that in mind, does how Parliament set budgets need to evolve to be a bit more fluid, to allow financing of social prescribing within that framework?

The Convener: I will take Richard Davison, who I suspect will want to use that question to add to the points that he made. I will then take Kirsty McNab.

Professor Davison: I will go back to the concept of social prescribing for a second. People who visit the b GP normally do so for a reason; they are unwell. If we are talking about behaviour change, I am sure that an awful lot of those people would be precontemplators: that is, they would not be at a stage of readiness to partake in any physical activity. That is a challenge, because those are the most difficult people to transform and to get active.

We do not have that research, because when we recruit for research, we normally get the worried well: that is, people who are already

contemplators. That is a huge challenge, and I would be interested to hear GPs' comments on that.

In addition, although participation rates in things such as park runs and jogscotland have soared over the past 10 years, I bet—although I do not have the exact evidence—that the socioeconomic status of the group that participates will, on the whole, be high. We have a segment of the population that is unhealthy in the low socioeconomic groups, which we need to reach.

I am looking at Kim Atkinson when I say that that is also a challenge for sports' governing bodies. How do we lower the threshold for entry into those activities for those people, who are the people whom we really need to reach?

Kirsty McNab: This is a nice point for me to come in at because, organisationally, those are the people whom SSF is reaching.

On Dr Walter's point, I note that our staff, who work right across Scotland, are trained in behaviour change. I think that there is a job for all of us to do, as colleagues, to recognise collectively the value in each contribution. A recent Audit Scotland report highlighted that many healthcare professionals are still reluctant to refer to the third sector. That could be about awareness. I put my hands up and say that we do not engage as well as we could with healthcare professionals at local level, although we are really good at engaging with CAMHS, Barnardo's, social work services, schools and education, as well as with our sports clubs, to do early intervention and support transition.

10:45

It is great that we are all here having the debate, and we have all proved our worth, but as sectors we need to work together better and really understand the value of each sector. Scotland is a small place, but it is a bit of a jigsaw. There are so many people with so many strengths who are already highlighting the benefits of being physically active. We are working with hard-to-reach but easy-to-ignore people in areas of deprivation, and we have people who are well trained in behaviour change, but we sometimes struggle to get referrals to our programme. I highlight that that is still a challenge.

George Adam: It has been great listening to the discussion. One of my bugbears, which Martin Hayman and Professor Davison brought up, is that it is difficult to get people in areas of higher deprivation involved. I make no apology that, for me, all roads lead to Paisley. Year after year, Ferguslie Park is looked at as the ultimate area for deprivation in Scotland, and I am fed up with saying, hearing and talking about that. We need to consider being more radical. As Brian Whittle said, it is about getting everything together—health, sport and education—and putting it all in one place.

In Ferguslie Park, we have a professional football club that is part of the community—St Mirren FC. It does a lot of good work in the community and it has a community trust. Why do we not take that to the next level? There is available ground in the area, so why not find out what the community wants, as opposed to doing what councils did in the past, which was to build a shiny new building and say, "There you go—that cost £X million"?

At the end of the day, the important thing is that, if we take the example of Paisley, people are more likely to engage with a group or a sports club such as St Mirren. We have talked about a multisports complex being based there. The University of the West of Scotland is not going to invest in sports facilities now, but if everyone in the community worked together, we could make progress. Funding is not always the issue; it is about being clever with funding, saying what works and finding a way to make sure that we do it. Surely it is not beyond our wit to do that and get ourselves to that place.

I have been hitting my head off that brick wall for the past five years. The council backed the idea at one point, but then turned it into a sports complex, forgetting that the main factor is not kicking, heading or pushing a ball or running about, but getting people involved. How do we get ourselves to that point and start debating the issue not only here, but out in the real world?

Martin Hayman: I will give an example of how we can get people active in more deprived communities. I draw to members' attention the phenomenal success of table tennis in Drumchapel. The sports centre there is the heart of table tennis in Scotland and has the most successful club in Scotland. It operates out of a building that the community took over about 25 years ago, and it is still phenomenally successful. More than 300 people regularly play table tennis in one of the more deprived communities in Scotland.

There is also a big social element to the project's success—although I know from talking to the people who run it that it is still difficult to get people to come through the door for the first time. The chairman described the walk that people need to take to get to the club: they need to go past the bookies and past where people pick up their methadone. Those things prevent people from coming to the door, but when we get them through that door, they enjoy it. It is fun and they are engaged, and that makes a difference. There is a real opportunity to embed the right facilities and activities in such communities. Drumchapel should

be seen as a place where that has most definitely worked.

The Convener: It would be interesting to understand why things work in some cases but not in others.

David Stewart: George Adam's point about the role of football in social prescribing makes a lot of sense. All of us around the table know that older men, particularly in disadvantaged areas, are very difficult to reach. My local team, which is Caley Thistle, has regular blood-pressure checks happening at games. Such checks are very important. The club also organises walking football sessions, at which, I am sure, David Torrance would be a star. Walking football is very effective. I went to a session with the Presiding Officer when he did his recent tour, and we heard that one of the regular participants who has dementia has really benefited from walking football. There is a social prescribing role for sport, so that is a good signpost. I will certainly flag it up in the committee's future work.

Kim Atkinson: The opportunity is presented by social prescribing to bring together different strands. We have all talked a bit about the holistic approach—I am sure that we will come back to that—but that depends partly on budgeting, which Brian Whittle mentioned. I hope that the new national performance framework will make budgeting a bit easier.

As someone said, budgets operate under headings such as health, education, transport and planning. Sport and physical activity could be seen as budget lines, too, but because they are vehicles that weave across pretty much all areas, it is incredibly difficult to support a budget call for them. We have said to the committee before that it would be a challenge to find another budget that contributes as much as the small budget for sport does across so many agendas, but it is really difficult to demonstrate the breadth of sport's outcomes. However, George Adam said that where there is political will, there is a way. That is a fair point in relation to not just national Government but to local government. It is fundamental.

Planning came up briefly when we talked about the holistic approach. Our members had a really interesting conversation when the previous Scottish planning policy—the national planning framework 3—was introduced. I see a huge opportunity in NPF4, picking up on some of the connectors that Katie Walter talked about. We need to create environments where people want to be active and to walk, and where they are not walking beside a road. That can also connect communities exactly as Richard Davison described.

Katie Walter mentioned training for colleagues. A pilot a good number of years ago was about the questions that GPs ask, such that they would not ask just about alcohol and smoking but about how physically active people were. I am not sure whether that conversation is still happening with GPs. It would be interesting to know.

Walking is without question the most equitable activity, but research has shown that it can also be a pathway or a starting point. Our members at Scottish Golf have talked about people who have been through walking pathways and have felt able to take up golf or bowling.

Breadth of opportunity is also important. Our members at Scottish Disability Sport have reported that 47 per cent of people think that they would be more active if there were more opportunities for them to be active. Let us not forget that.

On modelling, Flora Jackson talked about Claire Thirwall's example. How do we know the opportunities that people will be interested in? There is a bit of modelling in the Sports Clubs for Health document that we refer to in our submission, which suggests the types of sport and physical activities that benefit people with particular health issues. Surely we can start to model that approach, asking what it would mean in local areas and where the opportunities are for people to be active. Can such pathways lead from walking to people being aware that there is a local table tennis club? Are they aware that there is a local golf club or that a lot is happening in bowling?

The other issue to do with budgets is that sport and physical activity are seen as a cost. We are not in an environment or a culture that sees sport as an investment. I think that that is where Brian Whittle was going with his comments. I support David Torrance's point about seeing sport as an investment. We have really good examples of money being moved from the health budget into the hugely successful active schools programme. Similarly, transport money has been moved to active travel. I do not think, however, that we have seen the same movement with regard to prevention in the health budget. Justice money has been moved into cashback for communities, where there have been so many successes but, again, that has not been replicated.

I go back to George Adam's question about how we can do things at scale. If we have a concept that we have proved works, we need to invest more. I am certainly not saying that the economics or budgeting are easy. You guys make hard decisions, but if something works, you need to continue to invest in it. The continued justification for investment in not just sport and physical activity but, as Brian Whittle said, in the broader

voluntary sector is that they are good for people so we need to invest in them.

We need to make sure that we monitor the effects, and the investment needs to be justified, but we prove and prove and prove. We are told that we require good case studies and evidence, then we are asked for case studies again, and for more evidence. Maybe social prescribing needs more evidence, so I am reassured to hear from Katie Walter and colleagues that we are moving towards having more.

However, we continue to spend a huge amount of time on proving that sport and physical activity are inherently good for people. Could we not just crack on and use the time to deliver the opportunities that Martin Hayman and others have talked about, rather than having continually to justify it and provide evidence one way or another? I am unclear about what the continued gap in evidence or research is. Social prescribing is slightly different in that regard as we know that it provides so many additional benefits. To be blunt, we just need to crack on.

The Convener: That point has been strongly made in the evidence. There appear to be two views on whether we know enough, but we hear the case that you have made strongly.

Dr Walter: I agree with Kim Atkinson, but I think that a bit of evidence is lacking—evidence on social inequalities potentially being widened in relation to uptake and sustaining engagement. To me, the risk lies in putting a lot of money into the social prescribing budget before we have evidence that we will not worsen social inequalities.

We have helpful models, from which we have gained a lot of experience, in the work on smoking cessation and alcohol. The public health issues of smoking and alcohol disproportionately affect people who are in social deprivation. We have good evidence that we need, from the bottom up, changes that engage people through person-centred behaviour change, and that we need changes from the top, in legislation.

When we talk about social activity, the same thing applies. We need good quality evidence-based and person-centred social prescribing—not for all, but for the people who need that level of intervention. However, we also need to introduce legislation that helps people to make changes even if they feel that they do not want to.

That brings me to the better linking across departments that people have talked about. I fully agree that we have an opportunity there. The Government has declared a climate emergency. What better way to link than to use that heading to review how our policies weave across departments and see whether they deliver on that front?

The Convener: Am I summarising correctly I saying that you are arguing that we need more evidence not on social prescribing and whether physical activity is good for people, but on the equality aspect?

Kirsty McNab: There is potentially a job to be done to share the research evidence that exists. Although our work has not had the title of “social prescribing”, that is exactly what our organisation and many others like it have been doing in working with the demographic that we are talking about.

Kim Atkinson mentioned cashback for communities. My organisation has been part of that fund for 10 years; we await the outcome of the next funding round. The robust evidence from internal and external research shows that impacts are lifelong and that the changes are being sustained.

There are two other two resources. The Thrive toolkit, which is based on the Scottish Government-funded physical activity fund, is available. All the Drumchapel work is in that. As a sector, we need to be able to prove the value that the conversation keeps coming back to. Actify is a similar resource. I hope that colleagues in the health professions know that those resources exist so that we can, as Kim Atkinson said, move on and get to the point at which we can do the work.

Dr Bird: I suggest that a success criterion for social prescribing would be to get 50 per cent of participants coming from the bottom 20 per cent in the Scottish index of multiple deprivation. We really need to reach those people.

There is a mismatch in the conversation between health and others. In health, we often see people at the bottom end who do not go outdoors. They are locked in, often with their children. They are in fear—they are living with chronic stress and are only just about coping with life. To expect them to start to take up sport and physical activity is to ask the impossible. Those people need to be brought really gently to a safe place. Everything has to come down to the housing estate where they are. They will not travel even 200 yards outside it, so that has to be done there.

As a reality check, I note that there are hundreds of thousands of those people. We do not often see them in general practices, because they do not even come to us. They are hidden, yet they are the people for whom social prescribing can make a massive difference. At present, they do not touch many of the systems that we put in place, and they do not trust many of the systems. The success of social prescribing will be in getting those people on board. That is hard, and the evidence is not in place yet.

11:00

Professor Davison: I will address Kim Atkinson's point about evidence. She is right—there is absolutely no doubt that there is plenty of evidence about physical activity and, in particular, physical health. There is a good amount of evidence about psychological health and a little bit less about the social benefits and how physical activity interacts with those. The key area that is missing is evidence on the delivery model. We have known for over 50 years, since the civil service study by Jeremy Morris, about the link between health and physical activity, but we have not been able to dramatically change behaviour to get more people to be active. We need more information.

Two sources of information are available to us on the health and activity of the Scottish nation—the Scottish household survey and the Scottish health survey. They are really well-conducted surveys, but they do not necessarily ask the right questions in the right way. They are cross-sectional and they are snapshots, which means that we have no idea about people's life journeys or how much activity they did when they were kids. We know that activity drops off massively as people get older, but the question of why there is a massive drop-off from school to early adulthood is a big focus. Have we not been good enough on physical literacy in schools to enable people to be confident about doing their own exercise instead of being forced to do it? What happens in older age? Other countries in Europe such as Denmark and the Netherlands have better survey information and are much better at designing policies that keep levels of participation in sport and physical activity high across the age groups. That is what we need to do.

The Convener: Before I bring in Miles Briggs, Flora Jackson might like to respond to the points that have been made on the surveys and the wider question of the different views that we hear on the importance of additional evidence.

Flora Jackson: Thank you, convener. I want to put to bed the notion that we do not have enough evidence. We do. We know what we need to do and, to be frank, we need to get on and do it. For too long, we have been on the back foot. We have been sitting on the fence and, perhaps, unwilling to act. We know enough to act. We have specific National Institute for Health and Care Excellence guidance. Although it is not necessarily applicable in Scotland, it is highly robust, and we have it across two areas—physical activity brief advice and exercise referral. Some people might sit on the fence on exercise referral, but we know enough about what works. We should go to that evidence and be pragmatic.

We could continue to seek evidence for ever and a day. That is why it is important that we evaluate and learn from what we do, and put in a system of improvements as we progress. We have actions in the health and social care delivery plan that commit to embedding the national physical activity pathway in all appropriate clinical settings by 2019. I am conscious that 2019 is quickly approaching its end, but that commitment was based on evidence. We know what we need to do.

We can draw on learning from Public Health England and others. William Bird has been heavily involved in work on moving health professionals, and the evaluation of that shows that, when health professionals raise physical activity with their patients, one in four makes a change. To me, it is a no-brainer. How can we not take forward an intervention that has such clear and compelling impacts?

We have made significant inroads and progress on the smoking and alcohol agenda, which Dr Katie Walter mentioned, because we have made significant investments not only nationally but in local health board areas. We have committed and dedicated staff who work specifically on alcohol and smoking issues. Where do we have that for physical activity? The landscape looks dramatically different there. The question is how we can set about addressing that and creating a landscape with the infrastructure, resources, staff, expertise and training that will allow us to take the evidence that we have here and now and put it into practice.

The Convener: Thank you. That gets us to the heart of the issue.

Miles Briggs: Good morning, and welcome to the panel.

I will follow on from a point that Dr Bird made earlier. We have had a really good discussion, but the issue comes back to the clinicalisation of reconnecting people to their communities. I say that not only in relation to sport but in relation to, for example, the loneliness agenda and some of the mental health work that is going on across Scotland for low-level depression.

Who is the best gatekeeper to make that reconnection happen? The Scottish Government says that ALISS—a local information system for Scotland—is the pathway to connect people to their communities once again. However, Dr Walters said in her written evidence:

"ALISS has been defunct in our area for ages—no-one uses it."

From my experience, about half of the doctors I asked about ALISS had never heard of it. However, we are expecting the system to be in place.

If people know their community, they might know what is available. I have visited GPs in many affluent parts of the country and they know what is going on and they are part of such groups. In other parts of the country—and I know that Milton, which we visited, is in Bob Doris's constituency—the link workers in the GP practices are the ones who have had to start the clubs, men's sheds and other community organisations. Therefore, to what extent can we make things happen on the ground, and is the GP the right gatekeeper? Across Scotland, it often takes a diagnosis of type 2 diabetes, or a person to present with low-level depression or loneliness, all of which we want to prevent from occurring in the first place, before that person will get involved in any activity. Should we take the system out of GP practices and, if so, what would it look like?

The Convener: There are a few people who want to contribute, either to Miles Briggs's questions or to the immediately previous questions.

Bob Doris: Miles Briggs is quite right that Milton is in my constituency. When an agency in Milton, whether it is the Ashgill recreation centre, the Glasgow club Milton or another group, runs activities, I help to advertise and promote them on social media. However, people in the community still miss out on what is available, and they do not necessarily have a pathway to access the activities. In particularly deprived, low-income communities, there could be a range of activities available, but that does not mean that people will go and support them.

Who is mapping out that information? An example in my constituency is the Maryhill activities directory, which Deacon Jim Hamilton from the local church takes responsibility for producing. It comes out every two years and gives a granular perspective on every sporting, art, drama or other such opportunity. If people in that community ask what there is to do, at the flick of a page or by checking the online portal, they can access that information. Who is mapping out where the opportunities are in the various communities that members represent, and who is monitoring to see how well used those opportunities are? That is surely the starting point in taking this forward, and I commend what happens in Maryhill.

The Convener: It comes back to the Drumchapel table tennis question about why things work in some places and not in others.

Dr Walter: I have two responses—the first is to Bob Doris's question and the second to Miles Briggs's question.

I sit on the Highland green health partnership—Highland is one of the pilot areas for the green health partnership—working in conjunction with the NHS and Scottish Natural Heritage. That has been really interesting, because, in its first year, one of the green health partnership's tasks was to map out what activities exist. ALISS has not been working in the Highlands for years—for the whole time that I have been a GP there, it has not worked. Updating it is delegated to third sector local agencies, but because of funding problems and because projects come and go, it very rapidly goes out of date. It needs funding to sustain it and that is one of the first problems.

The mapping exercise was very interesting. I have been a GP in Inverness for a few years now, and I was under the impression that there was lots out there. Actually, if you sit down and map it out, there is a lot less than people think and that is another problem. Not only is there not one clear repository for the information, some of the activities that are available can then fall by the wayside. There are also governance and quality control issues around those projects and the question of whether there is enough training. Those issues open a big can of worms in many ways.

I agree that it is a headache and a problem. I do not know what the solution is. I will be curious to see what comes out of the four green health partnership pilot areas in relation to mapping, because they have been left a lot of freedom to imagine what they do with that remit.

In answer to Miles Briggs's question about whether general practice is the right place, it is not just the right place. This is a whole-systems approach and it is not just about GP surgeries. We are stressed and under pressure and we have staffing issues, but we need to have a consistent, similar message everywhere else. It is community-wide—across health and social care. It is about having a brief intervention training that is deliverable and that people feel comfortable with. People need to know where they will signpost patients on to, even if it is just simple, low-level things that they feel confident in, so that they can start having those discussions. It has to be backed up at a community level by people who can take on those conversations in greater depth and in a person-centred fashion.

Miles Briggs: The point that I was trying to make was that, throughout the health service there is—sometimes rightly—risk aversion. If you are not using ALISS, you must be referring people because you have confidence in organisations. That is where scoping comes in. Some GPs have never referred a patient to an organisation and do not want to, because they do not know what it will be like and whether the patient will come back to them, saying, "You sent me somewhere, and it was a nightmare."

Dr Walter: Absolutely.

Miles Briggs: How do we make that more flexible and organic, so that communities can create that and so that it will be successful, without it having to be in a GP context?

Dr Walter: We need a win-win situation. All the organisations involved have to gather the right evidence and deliver it back to their funders. That is a headache; nobody likes doing it. We need to start thinking imaginatively about how we support small organisations in their data gathering. We need a small set of predefined criteria that are meaningful and do not just respond to the funder's whim. We should make that across the board and give them a portal in which they can do it. We should bring in governance requirements, so that, in order to access that easy toolkit, they have to meet the criteria. Then we start to build a kitemark and a repository of the good organisations.

Brian Whittle: I thank Richard Davison for raising the household survey, which I call half a household survey. It asked, "Are you active?" and people said, "No," but the question should have been, "If you had access to more services, would you want to be active?

On the convener's point about why Drumchapel tennis table club and Doon Valley boxing club are working, I think that it is down to individuals. We need to encourage clubs to have succession planning. With regard to health inequalities, I will be careful, because, although we have been successful with reducing smoking—we are waiting to see what is happening with alcohol—we have been more successful in wealthier areas, so our work in that regard is only half done. If we look at access to sport, we see that sport is becoming the bastion of the middle classes. We are leaving people behind. That is most evident if we look at the Olympic team. Although only 7 per cent of the population is privately educated, a third of the Olympic team come from private education. We have to be careful when we look at averages.

We are talking about encouraging people to access services. From what I hear around the table, the proposal is that people will go to a GP's surgery with an issue and will receive a social prescription. If we want to tackle health inequalities and level the playing field, should we start social prescribing before school and in primary school? That is where everybody is on a level playing field.

Martin Hayman: I will come back to access to service and the delivery model. It is a bit early to bring it in, but we have been running a pilot project called pop in and play, which is table tennis in a shopping centre. It operates in an empty retail space in the Gyle shopping centre in Edinburgh. We put in table tennis tables, opened the door and said, "If you want to play, come in." It has been phenomenally successful. For the first three months of operation, on average, more than 100 people a day were coming in and participating. We carried out some monitoring and evaluation: more than 50 per cent of those people identified themselves on the survey as inactive. We are hitting people who would not be doing any physical activity otherwise. We also reach a complete age range.

11:15

That trial was about making something easy and accessible. It is also opportunistic. The country is not short of empty retail space. We need to make the most of the right opportunities and say, "Let's turn that into an opportunity to access sport". People who come into the shopping centre during the day are from a mix of backgrounds. That offers us an opportunity to signpost. When those people are involved and engaged, we can then encourage them to participate in club activity.

What is most stunning about being in that project is watching people walk past, stop and point and say, "Table tennis!" It is often an older audience, and if we have a volunteer who immediately pops out of the door carrying a bat and asks, "When did you last play?", they might answer that it was when they were at school or on a family holiday and the next question is, "Would you like to try? Come on in!" That encouragement from a volunteer is what it takes to get someone participating and going again. It is difficult to engineer that in a different environment, because people would not see the table tennis and would not stop and there would not be a volunteer on hand.

We are trialling that model at the moment. We think that it is successful and we would like to take it further. It is a positive delivery model for getting people active.

The Convener: Thank you. William Bird mentioned the need to start from the very earliest stage, which relates to Brian Whittle's question. The other issue that has arisen is whether there are factors that hold back participation in particular communities, perhaps because the kids are simply not out on the street or their parents choose not to let them go out on the street, which might have consequences.

Dr Bird: I take Brian Whittle's point: we have to start with the children. There was a submission from Street Games, which has been doing social prescribing for younger people. It is very embryonic and we are still learning about it.

Let us think about the science. We know that adverse childhood events create problems later on. If a child is going through a very difficult

situation, they get chronic stress. Chronic stress makes the immune system change and turn against the body and causes chronic inflammation. As a doctor, I have no tool or medicine to deal with chronic inflammation, yet chronic inflammation causes diabetes and is a source of dementia, cardiovascular disease and many other things. We can measure it in children at the age of 6. Often, children living in very deprived communities have a higher inflammation count, which means that they will have a shorter life and they will have more disease. That is why we have to tackle it at an early age. It does not mean that we stop thinking about adults—we have to do it all the way across the life course.

It also means that we have to go back into education. Social prescribing should not just be in primary care. Teachers should also be doing social prescribing. Everyone should be doing this work—employers with their workforce, hairdressers with their clients. Anyone in contact with children should be doing the social prescribing and understanding it.

As a doctor, if I have someone who comes to me with iron deficiency, I give them iron. If someone has thyroxine deficiency, I give them thyroxine. It does not work that way with physical activity. If someone is deprived of physical activity, I do not just slap physical activity on them. Physical activity is an outcome of a better life. If we create a social environment—as we have heard about with the table tennis pilot—it just happens. Sport happens to include physical activity as part of its armoury, but it is always social. A happier society is a more active society—without the need to mention the phrase “physical activity”. We have to stop saying that physical activity is a cure for inactivity, because, actually, that is not the right way around. That is the medical model, but it does not work. We have to create a better and more connected society. What we should be doing is saying that social prescribing will lead to more activity, without ever mentioning that word.

We have to understand that we have a problem with chronic inflammation, which we now know is massively divisive in our society in terms of people who suffer from inequalities, and it is causing most of the problems. The only armour that we have in that regard involves ensuring that people are connected to one another so that they are not lonely; that people have a place where they feel safe and where they feel that they belong; and that people feel that they have some purpose in their life and some control over it. If we deliver those three things, we can deliver a much healthier society across the board. Social prescribing has got the energy and the wherewithal to do that, but it must work at a much wider level than just health professionals.

Kirsty McNab: On William Bird’s point about adverse childhood experiences and trauma, sport has been proven to reduce the mental stresses and anxieties of young people who have experienced adverse childhood experiences, because it discharges cortisol.

Organisations such as ours that work in communities and train young people to be peer mentors and role models are, obviously, active in areas where there are young people—often within 100m of where they live—and are trained to be trauma aware. Sometimes, the benefit does not even come from what might be considered to be physical activity. We look at physical activity in its widest sense, so, sometimes, it is just about getting them out of the house and having a chat with them, which can happen well before they progress on to anything that we would recognise as sport.

We have all the robust monitoring and evaluation that goes alongside the success of those types of programmes, and we are not alone in that regard: other voluntary sector organisations that use sport are becoming much more aware of what is happening physiologically for young people who are living with stress.

David Torrance: Should resources and initiatives be targeted at our most deprived communities, which have the greatest health inequalities, or should that resource follow the individual?

The Convener: Should there be a community-based approach or an individual-based approach? I guess that we have covered some of that this morning, but Kirsty McNab might want to comment.

Kirsty McNab: There has to be a combination of both approaches. Organisationally, because we have to justify our existence, we look—crudely—at the index of multiple deprivation. However, just because you live in a postcode area that is not one of the most deprived in the index of multiple deprivation, that does not mean that you do not need support, because people can be isolated in many different communities.

The issue goes back to what we have all been talking about today. As Katie Walter said, there is a need for a person-centred approach. You need to understand individuals and their needs and not just look at their postcode. That is quite difficult to do, because there has to be some kind of measure to guide you. Right now, the index of multiple deprivation is the measure that many of us use.

David Torrance: Getting somebody to be active is a first step. How do you do that? When I went to the doctor, they said, “Look, David, you’re borderline type 2 diabetes. Go and become active

and lose a bit of weight." It was easy for me, because I went to a walking football club that was supported by my local football club—I put on record the fact that we are Scottish champions. Because it is at the heart of the community, there are a lot of middle-aged men who were previously inactive but who go there now.

How do you get such individuals—whether they are in deprived communities or not—to take that first step? It is all very well saying that there are various activities in the area; the hardest bit is taking that first step and going to take part in one.

Kirsty McNab: It involves understanding what individuals want to do. We are all advocates of sport and physical activity because we are aware of the health benefits, but that will not be a motivational factor for some people. There is no one answer; it depends on what people are interested in. Finding that out involves getting out into the community. A lot of our young people are interested in making a difference in their own community, so volunteering is the thing that gets them through the door. For others, it might be about making new friends. It will depend on the individual.

Emma Harper: I am interested in the sustainability aspects. David Torrance talked about type 2 diabetes. From the information that I have in front of me, I see that the number of people with type 2 diabetes is going to increase. NHS Scotland currently spends £1 billion each year on the condition, and £800 million on treating potentially avoidable complications. In addition, 12 per cent of the in-patient budget is spent on treating diabetes complications.

I am a type 1 diabetic, and I know a lot of type 2 diabetics. How do we encourage behavioural change among those folks? We know that we need to signpost them towards doing more walking or exercise. How do we look at what budget savings will be achieved by avoiding all those complications in the first place? Where do we pick apart the budgets? We have talked about the budget coming from transport or other areas. The First Minister talks about climate change as the remit not only of the Environment, Climate Change and Land Reform Committee, but of every portfolio. In the same way, we are talking about how we support people's health and wellbeing, including through physical activity and sport, but every portfolio also needs to talk about that.

There are a lot of questions and thoughts in there, but I am interested in particular in how we engage the folk with type 2 diabetes in physical activity.

The Convener: There are a lot of questions, but sadly there is less time than we could use. I will take a question from Miles Briggs, and then I will bring in Kim Atkinson and Katie Walter, and perhaps go around the table for a final consideration of the issues.

Miles Briggs: I have a brief question that follows on from what Kirsty McNab said. I will not rehearse some of the arguments that I have previously made about opening up the school estate, and the fact that it is not currently open, but those are on the record.

Do the panel think that teachers should be able to socially prescribe for children and young people who will not necessarily present at a GP surgery? That could look exciting and very different, and it might potentially open up a lot of additional capacity.

Kirsty McNab: Absolutely. We do a lot of early intervention work with schools—we get more referrals from schools than from healthcare professionals. The answer is yes, that needs to happen across the board—and yes, please open up the school estates.

The Convener: Is a medical professional willing to endorse that approach?

Dr Walter: Absolutely. Teachers are the lead professionals for children of education age, so they have a key responsibility in taking on that role.

Kim Atkinson: Absolutely, on the point about teachers, and absolutely with regard to opening up the school estate. If there was a vote on that, I would hope that the committee would be receptive to doing so.

I go back to Katie Walter's point about this issue being everyone's responsibility. The provision of holistic support is a key opportunity within that. Part of the answer to Emma Harper's questions is locality. Again, I go back to the issue of the school estate—we cannot keep coming back to it—and local aspects such as clubs. People have their own parks, so they can go walking and do a range of things. Locality is definitely part of the answer.

It is also about mapping motivations, which Kirsty McNab talked about. The issues are not simple, but we need a dialogue—we need to start that conversation. I go back to Flora Jackson's point that one in four people responds to interventions and recommendations from their GP; I would certainly question whether the committee could hear a better fact today in support of social prescribing.

We have talked a little about resource. It has to be new resource—it cannot be about continuing to do more with less. I know that it is not easy, and every organisation and entity that comes to the committee will say the same, but we cannot continue to do more with less. So often, we talk about voluntary sector organisations as the people

whom we expect to undertake the delivery, but they are not seeing any money coming in as a result.

We have talked a little about disadvantaged groups. I am conscious that we have not spoken much about people with a disability, which is really important. Again, that raises the issue of holistic support. Our members at Scottish Disability Sport produced some figures for us that showed that 47 per cent of people who are in receipt of benefits are concerned that if they are seen to take part in sport or physical activity, they might have their benefits cut. There are some barriers that we need to address. I am sure that they are more perceived than real, but we need to work through them.

The other day, I had some conversations with our colleagues in the NHS. They were saying that, across a wide range of interventions, the ones that relate to sport and physical activity are the most cost effective. There are myriad interventions, but success and cost effectiveness should be important to the committee.

I come back to the idea of partnership working that we have heard so much about. The Table Tennis Scotland model is amazing. If you have not been to the Gyle, you should go—it is incredible. It is an innovation. We have space—there are unused shops throughout communities. We so often hear about the challenges that local towns are facing, so that is great. We could get a range of clubs involved. I know that Martin Hayman is keen to talk to a wide range of governing bodies, saying "Let's be innovative. What an amazing example we have—let's go and do it elsewhere." That is further paralleled by some amazing work that Table Tennis Scotland is doing in care homes.

There are many different things that we can do if there is a little bit of time for innovation. Walking football is one example. Perhaps I missed it earlier—did David Torrance say he was the champion?

David Torrance: Yes.

11:30

Kim Atkinson: This is the area where sports clubs and sports governing bodies are trying to be innovative and different. They are continually doing more with less, however, and that is not sustainable. We have those opportunities, anyway.

Returning to a point that Emma Harper made and referring to the buddy system, I mentioned Atlantis Leisure earlier. As part of its model, somebody goes and finds out what it is that the person wants to do, and they will say, "I'll come with you, Emma," for instance. "You've not been along before, so I'll come with you for a few sessions until you know people and you get a sense of whether it's the activity for you." Then, you might be happy to go on your own, and you can go and do it.

As we were saying before, there is practice that we can reflect elsewhere, but we need to be brave and bold. We do need to invest and, if an activity is the right thing to invest in, we should crack on with it.

The Convener: My final question, which is for any of the witnesses who wish to offer an answer, is whether there is one thing that we need to do to take the agenda forward and make a difference. Is there one major thing that would make the biggest difference at this time?

Professor Davison: It is a question of resource, as has been mentioned a couple of times. It is about the economic impact. Emma Harper rightly quoted the statistics and the cost to the NHS, which are quite frightening. The problem is solvable, however—that is the key thing—and we are discussing one of the solutions. The problem is that, whereas social prescribing is for people who are already ill—we know that we can help them—we want to try and stop them getting ill.

We have heard mention of social prescribing in schools. Actually, I do not like that term. How about lifestyle coaching? Let us develop a healthy lifestyle. That is what we need to communicate to our children.

Dr Jola: I return to what I said at the very beginning. For me, it is a matter of using the opportunities that social prescribing or lifestyle coaching give. We know that physical activity is good for people's health, but which physical activity is best for an individual who suffers from long-term mental or physical illness? We do not know exactly. While rolling out more social prescribing, we should link with research communities that can gather more evidence so that we can understand how best to approach different groups and individuals with different needs.

Dr Bird: As we have discussed, social prescribing in its narrowest sense has to fit into the wider social aspect—the whole-community aspect. We have come across that consensus, and that is probably the most important thing.

Wearing my other hat, I can mention that we are delivering an intervention called beat the street, and more than 100,000 people from some of the most deprived communities around Scotland have taken part. It is possible to get people from very deprived communities to see over the parapet and to see life getting a bit better as they start to experience the parks and green spaces around them and explore around their area. It is a matter of ensuring that they feel safe doing that. The

initiatives that we are discussing need to go hand in hand with a community intervention.

I have an example of a lady on a health walk. She was bereaved and very depressed, she developed hypertension and arthritis in her hips and she became housebound. A friend told her, "You must come out." After a year, she came out to her first health walk, but she just made the tea. She made the tea for every health walk for the next six months. She never actually walked; she just carried on making the tea.

After six months, she had the confidence to go on her first walk, and she carried on with a walk every week. After a year, she became a health walk leader. Then, at the age of 82, she became the most successful health walk leader.

Thinking of the journey of that person—someone in complete disillusion who was sliding down to become one of our health statistics—and the time it took for her to build that confidence, we should never underestimate people. We should start where people are—it is a matter of moving them up. For that person, it was totally about the social aspect—it was not the walking but the social aspect that got her there.

Dr Walter: I would ask you, as a cohort of politicians, to talk to each other and to people in other departments. We are not just talking about a systems approach across health and social care and sport; it goes across government. Using the thread of climate change is really helpful, because that focuses on what changes we can afford and what changes we cannot afford.

On resource, Emma Harper was quoting the local figures on diabetes for NHS Highland. Every year, £4 million is spent on drugs for diabetes, which is 10 per cent of the drugs budget. That is an enormous amount of money. If we think about what would happen if we started to reallocate some of the NHS money back towards primary care, investing in primary care in its broadest sense, we can potentially unlock some interesting things that could happen if we managed to demedicalise some conditions.

Claire Thirwall: Following on from what Dr Walker has said, I would probably advocate investment in culture change across our systems and among individuals regarding what they expect from our services, while embracing self-management approaches in accessing sport and physical activity. Culture change is also required across our systems in order to demedicalise, as is culture change within our communities, so that we actually work with our communities to ensure that they are properly supported and resourced.

Martin Hayman: If we are going to deliver the sort of change that we need, we have to make it fun—people have to enjoy it. I have a great example of that. I took a camera team into a sheltered housing setting, with a brief to give me a five-minute film on table tennis in a sheltered housing environment. The cameraman came back to me afterwards and said, "I've not got you five minutes of table tennis, but I've got half an hour of people laughing." He showed me the footage. Every now and again a ball went past, and you could see bats in hands, but the table was almost irrelevant. They had created an environment where everybody was laughing. Everybody was participating and enjoying themselves. That is what was important. Those people come back every week, because it is fun.

Kirsty McNab: I back everything that everyone else has said on resource and cross-directorate working, but it is also about real people, as in the stories that we have just heard. We have a working group of people—we have just got our youth advisory board, and it is the best thing that we have ever done as an organisation. We are truly youth led, with a group of real people who can help move things forward.

Kim Atkinson: Like Kirsty McNab, I agree with everybody else. We see sport and physical activity as an investment, not a cost. Our former chief medical officer said that it was the best investment in public health. We speak to GPs who say that it is the miracle cure and that, if it was a tablet, we would all be rich. Again—it is an investment, not a cost.

The Convener: I thank all our witnesses. This has been a very stimulating and informative discussion. I am sure that we will want to follow up on many of the points that have been raised and discussed this morning.

11:37

Meeting suspended.

11:44

On resuming—

Petitions

NHS Centre for Integrative Care (PE1568)

The Convener: The next item on our agenda is consideration of four outstanding petitions, the first of which is PE1568, in the name of Catherine Hughes, on the funding of, access to and promotion of the NHS centre for integrative care. As is evident from the note by the clerk, which has been made available to the public today, the petition has been discussed at length and in detail by the Public Petitions Committee and, more recently, by this committee.

One of the central requests of the petition is that the centre for integrative care be designated as a national resource. Ministers have been asked about that directly and have confirmed that it is not a decision for them. However, we might be able to explore the issue in a different way.

I invite comments from members.

11:45

David Stewart: Many members will agree that PE1568 is an excellent petition. If my memory serves me right, I was a member of the Public Petitions Committee, along with David Torrance and Sandra White, when the petition was lodged, and I was impressed by its strength. I think that we were contacted by Dorothy-Grace Elder, who has been an excellent advocate for the petition.

An issue that has been raised many times at this committee is the opioid crisis. I would like us to ask the chief medical officer and the Government why they are not seeking the expertise of the NHS CIC in that area. Although the trend on opioids is not quite at American levels, it is extremely worrying and we need to look at it. Without making a judgment on the next steps that we should take on the petition, I think that there are some follow-up questions that the committee should ask.

Miles Briggs: I agree with David Stewart. The petition continues to be an important vehicle for progressing reform and improvements for patients with chronic pain across Scotland. I co-chair the Parliament's cross-party group on chronic pain. Most people who attend that group's meetings feel that, for 10 years, they have been sent round the houses by the health service, and the changes to the CIC have made things even worse.

I pay tribute to Catherine Hughes, who is in the public gallery for our consideration of the petition. I believe that there are opportunities to make progress on it.

I was particularly concerned by the response that we received from Jane Grant. It was not much of a response—she simply said that people who are able to access services are happy enough with them, but the whole point is that people are not able to access many chronic pain services. We need to turn that argument on its head and find out what the Government wants to do for chronic pain patients across Scotland. We have an opportunity to make progress in the area, especially given the Government's targets and spend on waiting times. We need to look at how patients with chronic pain fit into that argument. Therefore, I would like us to keep the petition open and to use it as a vehicle to continue to make progress in the area.

Emma Harper: In my area, there is a local group of people who have myalgic encephalitis. As well as having chronic fatigue, many of those patients have pain management issues. We need to consider how those patients are being served locally and nationally. As part of our work on the petition, it would be worth keeping in mind particular populations of patients who do not have access to certain types of care. I would be keen for us to follow up on that.

The Convener: A couple of questions have been asked and a couple of points have been made, from which there has been no dissent. If we are agreed that we should keep the petition open, it seems to me that there is a gap in what we know and that we need to find out whether the NHS could designate the NHS CIC as a national service. I therefore suggest that we write to the NHS national services division to ask for its opinion on the suitability of the NHS CIC to be a national service and whether that could be considered by the national specialist services committee. Do members agree to that?

Members *indicated agreement.*

The Convener: That takes us forward. On David Stewart's point about the CMO, I agree that asking a general question that addresses whether the NHS CIC is one of the services that might be called upon to give advice or make an input on the opioid issue seems sensible. That is a separate matter from consideration of the petition, but I think that the petition encourages us to do it. Do members agree to that?

Members *indicated agreement.*

Whistleblowing in the NHS (PE1605)

The Convener: We move on to consideration of petition PE1605, in the name of Peter Gregson on behalf of Kids not Suits, on whistleblowing in the NHS. Again, the public papers spell out the

previous work that the committee has conducted and, in particular, its work on the Government's proposed changes in that area.

Do members wish to make any comments on the petition?

Miles Briggs: There are still key issues on the matters raised in the petition. The Government has acted and has introduced plans. However, the consultation on what the future will look like for people who are put in a position where they want to whistleblow has not included such people. That is where the petitioner has been trying to get more progress. I would like more consultation to take place on some of the questions that continue to be asked about the future role of the Scottish Public Services Ombudsman, how it will investigate and hear the concerns of whistleblowers and what the reporting mechanism will be. That would help to progress the principles that the petitioner has raised.

David Stewart: I support Miles Briggs's comments. Members will know that I have had a particular interest in whistleblowing following the allegations of bullying in NHS Highland, which, as you know, convener, we put directly to the board some months ago. I support the introduction of the independent national whistleblowing officer, which is to be set up at the SPSO, but the issue that Peter Gregson has raised is about how the SPSO will investigate whistleblowing concerns and hear them directly. I know that there is a good mechanism—we have already looked at that—but I am a little concerned about the gap between people having whistleblowing allegations to make and how the SPSO will actually hear about them. I would like more clarity on the system.

Brian Whittle: I support what my colleagues have said. I have a specific interest in bullying in the Scottish Ambulance Service, which is a matter that people have raised at quite a few of my surgeries. It seems that people are not willing to whistleblow any more, because of the repercussions. I am interested in how the process will work to give potential whistleblowers the confidence to come forward, and in how the Government plans to monitor the impact of the new ideas about whistleblowing that are emerging. If the outcome is the same as the current situation, in which the people who attend my surgeries are not whistleblowing because of the possible repercussions, the system will not work.

Emma Harper: I am keen to continue to follow up how the whistleblowing process, the leadership around it and the local whistleblowing champions will deal with issues that are raised. The petitioner had particular questions about clinical front-facing access and how we might support people who choose to whistleblow. The cabinet secretary is keen to ensure that, as we move forward with processes of engagement with leadership, ultimately, we should not need whistleblowers at all because people should feel comfortable about sharing information. However, I recognise the issues that members have raised with the Scottish Ambulance Service and NHS Highland as well as other local issues that have been brought to my attention. I am keen to know how the whole process will be monitored and supported.

The Convener: That is helpful.

Members will recall that the committee considered many of those questions in May, when we issued a call for views, following which we received written evidence and held an oral evidence session on how the independent national whistleblowing officer would work in the context of the Scottish Public Services Ombudsman and the structure of that role.

To go back to the aspiration of the cabinet secretary, which Emma Harper mentioned, I was reminded of the fact that, when the national health service was first founded, our predecessors thought that, once it had done its job for a generation, it would not be needed any more. I suspect that whistleblowing will always be essential, no matter how well run our public services are. I guess that our job is to ensure that we are confident that people who have whistleblowing concerns can raise them.

The last order that the Government has brought forward to implement its new system of whistleblowing has now been laid, and we have a fortnight in which we can consult on that. That will allow some of the questions that members have highlighted to be asked. I suggest that, at the end of that process, when we come to consider the order and decide whether to approve it, we could take that opportunity to invite the independent national whistleblowing officer to come to the committee and answer those questions directly. That might ensure that there is transparency in the process and give us confidence that those questions have indeed been answered.

My suggestion is that, if, at that point, we are satisfied with what we have heard and agree that the order should be approved, we could then agree to close the petition, because the issues that it specifically raised will have been addressed. That will close that chapter, although, as I said, I fear that the book will never be closed, because issues around whistleblowing will always arise.

Do members agree with that approach?

Members *indicated agreement.*

Medical Care (Rural Areas) (PE1698)

The Convener: The third petition for consideration is in the name of Karen Murphy,

Jane Rentoul, David Wilkie, Louisa Rogers and Jennifer Jane Lee, and is on medical care in rural areas, which relates in part to the new general practitioner contract.

As members will recall, on 1 October, as part of our primary care inquiry, the committee took evidence from the Rural GP Association of Scotland and the rural and remote patients group. Clearly, that evidence relates directly to the matters that are raised by the petition.

Do members have any comments?

Miles Briggs: I have a specific point, although it does not directly relate to what the petitioners are looking for. The Cabinet Secretary for Health and Sport is on record as saying that she recognises some of the concerns around the GP contract in relation to rural communities, with regard to issues such as the ability to continue to provide vaccinations. It would be useful to find out the Scottish Government's thoughts in that regard as phase 2 of the contract is negotiated and whether the cabinet secretary is saying that there will be a version of the contract for rural GPs, which would almost separate them, in a way. That might have an impact on many of the points that the petitioners have raised.

The Convener: It appears likely that that is the kind of issue that will be addressed. The question for the committee is whether the petition is a necessary vehicle for that to happen or whether we can encompass the questions that are raised in the petition in our primary care inquiry, which would mean that we could close the petition at this point but come back to the wider issues that it raises in due course.

Emma Harper: That is a suitable approach. As an MSP who represents a rural region, I am keen that our primary care inquiry addresses the issue of how we can promote equality in healthcare, regardless of whether it is delivered in a rural or an urban setting. It would be interesting to see whether all the points in the petition are encompassed in our primary care inquiry.

The Convener: That sounds sensible. With the proviso that we must encompass those matters in the inquiry, do we agree to close the petition?

Members *indicated agreement.*

Social Care (Charges) (PE1533)

The Convener: The fourth petition for consideration is PE1533, in the name of Jeff Adamson, on behalf of Scotland Against the Care Tax, on the abolition of non-residential social care charges for older and disabled people.

The committee has already agreed to consider social care in a future inquiry during 2020. Therefore, I recommended that the petition be subsumed within that inquiry and be treated as an item of evidence for it, but that, in the meantime, we close the petition at this stage.

Do members have any comments?

Emma Harper: I agree, as long as "subsumed" does not mean that it is made any less important. We need to ensure that the petitioners are kept well informed about our inquiry as we move forward.

The Convener: Indeed. We will ensure that that happens.

Birmingham Commonwealth Games Bill

12:00

The Convener: Agenda item 6 is consideration of a legislative consent memorandum related to the Birmingham Commonwealth Games Bill. Part 3 of the bill relates to areas that fall within the legislative competence of the Scottish Parliament, and the committee needs to agree whether those areas of devolved competence should be considered by the UK Parliament.

The bill provides the legal basis for certain time-limited operational measures in support of the games in areas such as funding; ticket touting; advertising; and trading and transport. The provisions in the bill are based on precedents from previous sporting events, such as the 2012 London Olympic and Paralympic games and the 2014 Glasgow Commonwealth games.

Is the committee content with the LCM and with the Scottish Government's view that the Scottish Parliament should consent to the UK Parliament legislating in this area?

Members *indicated agreement.*

The Convener: The committee will report to Parliament on that basis.

We now move into private session.

12:01

Meeting continued in private until 12:35.

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