OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 31 May 2022

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

20th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Gill Bhatti (South Lanarkshire Council)
Danny Boyle (BEMIS Scotland)
Emma Fyvie (Clackmannanshire Council)
Dr Ima Jackson (Scottish Migrant Ethnic Health Research Strategy Group)
Dr Gillian Purdon (Food Standards Scotland)
Ed Pybus (Child Poverty Action Group in Scotland)
Bill Scott (Poverty and Inequality Commission)
Claire Sweeney (Public Health Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 31 May 2022

[The Convener opened the meeting at 09:03]

Interests

The Convener (Gillian Martin): I welcome everyone to the 20th meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies.

Item 1 is to invite Tess White to declare any interests that are relevant to the committee's remit.

Tess White (North East Scotland) (Con): I have no relevant interests to declare.

The Convener: Thank you, and welcome to the committee. I also thank Sue Webber, who has departed the committee, for her work during her time with us.

Decision on Taking Business in Private

09:04

The Convener: Item 2 is for the committee to decide whether to take item 5 and the next meeting of the committee, which will be on 7 June, in private. Is that agreed?

Members *indicated agreement.*

Health Inequalities

09:04

The Convener: Item 3 is two formal evidence sessions in our inquiry into health inequalities. Today, we will focus on the impact of the pandemic and examples of good practice from the pandemic.

On our first panel, and joining us in person, is Bill Scott, chair of the Poverty and Inequality Commission, and online we have Dr Ima Jackson of the Scottish migrant ethnic health research strategy group; Ed Pybus, who is policy and parliamentary officer at the Child Poverty Action Group in Scotland; and Claire Sweeney, who is director of place and wellbeing at Public Health Scotland. Good morning to all, whether you are online or here in person.

I am sure that you have already been briefed, but I remind those of you who are online that, if you want to comment but you have not been directly asked by a member, put an R in the chat box and the clerks will let me know that you want to come in.

I want to ask all of you the obvious first question about where the pandemic has had the most impact, and which groups in our society have been disproportionately affected in terms of health inequalities. I will go round each of the witnesses in turn to get their overall assessment, and that will be a good springboard from which we can ask some more specific questions.

Dr Ima Jackson (Scottish Migrant Ethnic Health Research Strategy Group): Good morning and thank you for the opportunity to speak.

I work with communities that are adversely racialised and experience racism, and the pandemic clearly highlighted the disparity between those who are racialised and those who are not. The key issue from that perspective was that, for black and minority ethnic people, the pandemic highlighted the systemic racism that is operating in society. That moment of realisation more publicly and more generally was a key moment in society's understanding of how the processes that we use, the lives that we live and the ways in which we all operate in society have been creating health inequalities that were evidenced throughout the pandemic.

The Convener: How did that manifest itself for the people you work with?

Dr Jackson: It is not just about the people I work with but more generally. From when the pandemic first hit, there were disproportionate rates of morbidity and mortality among staff in the national health service staff and the health workforce who came from minority ethnic backgrounds throughout the United Kingdom and in many other jurisdictions. That was there in evidence for all to see.

Ed Pybus (Child Poverty Action Group in Scotland): Thank you for inviting me to give evidence today. If we are to look at the impact that the pandemic has had, we have to go back to the causes of health inequalities. It is pretty clearly established that health inequalities come about because of poverty and wealth and income inequalities. The best way of addressing health inequalities is to address poverty. Treating poverty as a public health crisis is the way to deal with health inequalities.

During the pandemic, we saw an increase in poverty. Low-income households were far more affected by the pandemic's negative impacts on their finances than high-income households. The pandemic also exacerbated income inequality, which then had the knock-on effect of exacerbating health inequalities.

In our submission, we highlighted some of the figures on that. For example, 36 per cent of low-income households had to increase their expenditure during the pandemic, because they had less access to cheaper shops, for example, whereas 40 per cent of people with the highest incomes decreased their costs. The pandemic has overemphasised the inequalities that were already there and those wealth inequalities have knock on to health inequalities.

We know that there is racialised inequality and certain minority ethnic communities are far more likely to be in poverty. Most of our statistics are on child poverty, but the same applies across the board, so we know that those communities are more likely to be in poverty, which again has a huge impact on their health inequalities.

We also know that low-income households find it harder to access health services, whether that is due to fewer services being available in areas of high deprivation or due to the hidden costs of accessing services. There was a report on the hidden costs of pregnancy that looked at some of those issues, including the cost of transport when services are centralised, the cost of parking when you are attending appointments, the cost of not going to health appointments because you cannot afford to take time off work and so on.

All those issues have been exacerbating health inequalities and all those issues have been exacerbated by the pandemic, so, as Ima Jackson was saying, it has put a spotlight on the inequalities that already existed. The pandemic has highlighted them more generally.

Claire Sweeney (Public Health Scotland): Good morning and many thanks for the opportunity to be part of the session today. I will just confirm the points that the other speakers have made: we know that the pandemic highlighted and accentuated those long-term inequalities that were already in place across Scotland. We are particularly concerned about vulnerable children and young people, and, as has already been said, there are particular problems around those folk who live in poverty.

Beyond that, the pandemic has made it difficult to address inequalities because of the pause in the various services and reduced capacity to pick up on some of the pre-existing challenges, such as climate change, drug deaths and mental health-related problems.

Importantly, the pandemic has caused more problems in relation to the root causes of inequality across Scotland, particularly the economic situation that people are facing. It has widened existing inequalities. When we look at things such as disability-adjusted life years, which are an overall measure of the health of the population, we see that the gaps in the time lost to ill health have increased. We know from the premature mortality rates that there are particular challenges there that have widened during the pandemic. There are significant issues around children that I would highlight in addition to the messages from the other speakers.

The Convener: I will pick up on one thing that you said there and highlight it. In the early lockdown periods of the pandemic, there were particular issues for people with disabilities and parents with disabled children—people who rely on having services coming to their households or rely on services that are out there to help them get through their day and their week.

Claire Sweeney: That is right. We have been concerned about access to services during the length of the pandemic and all the research shows that those groups that we might also call marginalised in some way have been adversely affected during the pandemic.

Bill Scott (Poverty and Inequality Commission): The pandemic, as the Glasgow Disability Alliance has described it, supercharged existing inequalities. In the decade before the pandemic, improvement in health in the UK slowed dramatically and health inequalities increased. Health for the poorest people and life expectancy for the poorest people got worse. The gap between the most affluent and the poorest households got worse. Life expectancy dropped in the poorest households and the pandemic has added to that. The gap now between the poorest and the most affluent areas in Glasgow is over 17 years for a man—on average, the life expectancy of a man in the poorest areas is 17 years less.

09:15

On top of poverty, you have already alluded to race and disability; gender is also a factor in the health inequalities that were experienced during the pandemic. Women are more likely to be poor; disabled people are more likely to be poor; and black and minority ethnic households are more likely to be poor. However, the caring responsibilities that were thrust on to women have also caused significant mental health issues in the population. As has already been alluded to, if you were from a black or minority ethnic community, you were significantly more likely to die from Covid, and it was similar if you were from a poorer household.

However, for particular groups of disabled people, the risk was enormous. Analysis by the Office for National Statistics shows that 58 per cent of all Covid deaths were among disabled people, although they make up only about one in five of the population, so you can understand that the risk was way, way higher for those households. Within certain impairment groups, the risk was even higher. Learning disabled people were five times more likely to be hospitalised due to Covid and eight times more likely to die than a member of the general population. There are intersectional issues: a disabled woman, for example, would be at greater risk, as would a woman from a BME household.

I think that the Glasgow Disability Alliance described the situation exceptionally well in saying that existing inequalities were supercharged by the pandemic; that is the legacy that the pandemic has left us with.

Tess White: The Scottish Government's "Women's Health Plan: a plan for 2021-2024" seeks to address health inequalities experienced by women. The plan says that it

> "has not specifically investigated the impact of Covid-19".

I have a question for Claire Sweeney first, but the other panel members may want to answer it as well. Do you believe that the plan is still workable and deliverable with that caveat that it has not addressed the health inequalities that have been experienced by women due to Covid?

Claire Sweeney: We believe that the plan is still workable. There is much more to do to fully understand the impact of the pandemic. Bill Scott has mentioned some of the impacts that we know about. There has been a disproportionate effect on women throughout the pandemic and, again, it reinforces some of the underlying existing inequalities. Without doubt, there is more work to be done to fully understand the impact of the pandemic, but we believe that the plan is workable.

We are involved in a range of work relating to the health of women and children and broader issues to do with reducing the inequality gap. For example, we chair the national group on adverse childhood experiences to look at a trauma-informed approach across Scotland, bringing together a lot of different stakeholders who are involved in working with women and children and the wider community to start to get those practical changes that can make a difference.

We also work closely with the Scottish Government and many other colleagues to implement a work programme in relation to gender-based violence in particular. I am happy to share more details on that with the committee if that would be useful.

Tess White: Bill Scott has already touched on the indirect harms of the pandemic on women. The pandemic has impacted on existing health inequalities. For example, the pandemic has had a negative impact on women's mental health and there have been horrendous backlogs in life-saving screening services. What is the panel's view on the mid-term to long-term health implications on women's health inequalities, for women in general as well as those from different ethnic, cultural and socioeconomic backgrounds?

The Convener: Are you directing that question to Bill Scott first?

Tess White: Yes.

The Convener: If anyone else wants to come in, they can use the chat box.

Bill Scott: It is absolutely as Tess White said. The longitudinal studies that were conducted during the pandemic show that, in the first wave, women were more than twice as likely to suffer stress, anxiety and depression as a consequence of the lockdown. That increased again in the second wave of the pandemic and the second lockdown. As Claire Sweeney has alluded to, that requires more study. It is thought that the additional caring duties that women had, the increased levels of domestic violence and the fact that, disproportionately, many women were working on the front line in healthcare—nursing is a female profession—meant that women experienced those impacts.

Mental health has always been a bit of a Cinderella service in the NHS—it has never really had the resources dedicated to it that it requires. Mental health is—I have not seen the most up-to-date statistics—probably the fastest-growing impairment category among disabled people. Thirty-nine per cent of those who are claiming disability benefits have mental health issues, which is just behind those who have mobility issues, at 40 per cent. The pandemic has increased the number and proportion of people who have mental health issues. In the aftermath of the pandemic, much more resource will need to be dedicated to dealing with its mental health impacts.

One of the things that are talked about is that unemployment has fallen significantly. However, at the same time, economic inactivity has grown during, and in the aftermath of, the pandemic. There are 1 million fewer people in the workforce, because they have stopped seeking work. Many of those people are women who have either experienced mental health impacts, which means that they cannot cope with work any more, or had to increase the amount of social care or childcare that they provide, which means that they are unable to look for work. A lot of work needs to be done to address the backlog of mental health issues, particularly among women. The intersectional issues are all there. Disabled women and, similarly, black and minority ethnic women are much more likely to be socially isolated, which increases their risk of experiencing mental health issues. A lot of work needs to be done to address that.

Sandesh Gulhane (Glasgow) (Con): I would like to hear more about Dr Jackson's comment that systemic racism is operating in Scotland. We are all aware of the problems that the pandemic highlighted for people from black and ethnic minorities in jobs that were more front facing, but the phrase "systemic racism" really struck me. I would like to explore a little more what you meant by that.

Dr Jackson: When I was invited to speak to the committee, I asked whether it is one that understands the terminology in this area and how it operates. During the pandemic, the systems within which we operate and live—such as the economy, jobs, housing and health—were impacted by racialised inequality. By the time that the pandemic materialised, all the inequality that happens in society around people who are adversely racialised became seen in that context, which then affected our understanding of and our views on that issue.

When the pandemic first hit and was at its real height in Scotland, people from black and minority ethnic backgrounds were four times more likely to be at risk of dying, yet we did not really know why that was. In this country, we were not able to present the data in a way that would tell us enough about it. We therefore looked to the system operated in England by the Scientific Advisory Group for Emergencies, which had by then realised that its data was able to show who was being impacted the most. Subsequently, we have been working out why that was the case here: it was the effect of systemic racism in society, which operates on our health.

The second aspect that we saw most clearly during the pandemic was a greater understanding not only of what systemic racism is but of how living within it has an impact on people's health. We had global scholars and experts explaining that, and looking again at their evidence and systems so as to share understanding of how we could report health inequalities—or even what they are—and the effect of racism on people's health. It is not just about issues such as access to services; it is about the effect on someone of living a life in which their experience of racism has an impact on their health.

Many people had been arguing for that to be understood for generations, but during the pandemic it seemed to be realised and accepted because of the way in which Covid moved and operated in society. We could see that people who were not able to stay at home—because they were delivering front-line services—were also those whose jobs, lives, housing and other situations were being affected by inequality. That was impacting the life chances of people who were experiencing racism. That is broadly what systemic racism is: it is about how our systems operate.

When the Scottish Government set up the expert reference group on Covid and ethnicity, of which I became co-chair, it became a vehicle for us to examine the evidence that was being created globally, as well as in Scotland and nationally, on how such systems are created, how they operate, how we operate within them, and the mechanisms that we would need to put in place to begin to address the issue systemically.

The Convener: A couple of other people want to come in, but I am not sure whether that is on Sandesh Gulhane's question or the previous one from Tess White. Ed Pybus, which of those did you want to answer?

Ed Pybus: I wanted to respond to Tess White's question, but first I echo what Dr Jackson has said. We know that systemic racism means that certain communities are more likely to be in poverty. For example, our research found that people from such communities find it harder to access childcare, which has a knock-on impact in that they are unable to work. That then has an impact on poverty, which itself has an impact on health inequalities. Systemic racism therefore operates in many layers.

I turn briefly to Tess White's question on women's health. Our discussion has been dealing with the symptoms of health inequality. Obviously, even people who are not poor have health problems, but I make the point that gender poverty clearly needs to be looked at if we are to tackle the health inequalities that women face.

09:30

The Convener: I will bring in Claire Sweeney, before we move on to questions on children and young people.

Claire Sweeney: I agree absolutely with Ima Jackson's points about systemic racism and the profound lessons that we have learned through the pandemic. Public Health Scotland has been working with Ima to help to progress those findings. I want to let the committee know about the work that has gone on in that area during the pandemic. For example, Public Health Scotland led health inequality impact assessment work on vaccines, which taught us that people from different ethnic minority groups and those who live in deprived areas experienced a range of barriers to coming forward to access the healthcare system. It also gave clear recommendations to the Scottish Government and the rest of the system about what needed to be put in place.

It is true that there is more to do to ensure that the data that we collect is good—work on that is under way—but, beyond that, we have found it important to work directly with communities, particularly through organisations such as the minority ethnic health inclusion service, to tailor services and to learn alongside communities rather than try to put in place services that we hope are as good as they possibly can be. One of the strong messages that came out of the Covid pandemic, across a range of areas, was that we need to work more closely with local communities to get such change to happen, so that services are appropriate and tailored and so that people feel that they are engaged and involved in how such services are planned.

The Convener: David Torrance has questions on children and young people.

David Torrance (Kirkcaldy) (SNP): Good morning, panel. The pandemic has been extremely disruptive to children and young people at a time in their lives when they might have expected stability. What are the long-term impacts of the pandemic likely to be in relation to children and young people, and in particular those affected by health inequality? I ask Ed Pybus to respond to that first.

Ed Pybus: I agree that there has been disruption to health and education services for children. I do not feel that we have the expertise to talk about the impacts of that—our area of expertise is poverty—but we know that when we talk about health inequalities we mean those that are caused by poverty. As I have already stressed, the pandemic has hit low-income households harder than high-income ones and has increased the levels of inequality that people face.

We are also living in a cycle in which we are seeing rising child poverty: one in four children now lives in poverty. We know that any period of time for which a child lives in poverty has an adverse impact on their long-term health prospects. The fact that the pandemic has increased the risk of both poverty and inequality shows that it will have an adverse impact on children's long-term health in the future.

There have been some changes—for example, the temporary increase in universal credit is expected to mean a slight drop in poverty rates for the year in which it was in place. We do not yet have statistics for that year for Scotland; the data that was collected here was not sufficiently robust to bring out a child poverty figure.

The other key thing that we have in Scotland is the investment in the Scottish child payment, which has started to change the trajectory of child poverty in Scotland. If all the planned interventions take place over the next year, child poverty will start to fall and the trajectory in Scotland will move away from that for the rest of the UK, which is welcome. It is not really an impact of the pandemic as such, but the Scottish child payment has come in at a good time to help to reverse the direction of travel on child poverty in Scotland.

That said, a great deal more needs to be done. The fact that one in four families are living in poverty needs to be addressed if we are to make sure that we address the health inequalities that people face.

Claire Sweeney: Public Health Scotland has published a series of reports that are focused on exactly the issue that David Torrance asked about, the details of which I would be happy to share with the committee. We published those reports as part of the Covid-19 early years resilience and impact survey, in order to track the impact on children and young people throughout the pandemic. We know that those findings mirror much of what has been said before. Children who live in poverty experienced the worst of the pandemic to a disproportionate extent. It is clear that the families who were struggling with income before the pandemic were most badly affected.

From our data, we also know that children who had long-term conditions or were disabled experienced more substantial impacts as a result of the pandemic. It is particularly worth drawing to the committee's attention the fact that our data shows that the impact on primary 1 children who were at risk of being overweight or obesity increased across all deprivation quintiles—in other words, all children were affected. Inequalities related to that measure also increased during that time.

In addition, the impact on the education of more disadvantaged children was more significant. Again, we have data on that that we can share with the committee. The amount of education time lost was much more significant for children who were living in poverty, as was the attainment gap.

The Convener: Ed Pybus wants to come back in.

Ed Pybus: We have done some work on education. Our learning in lockdown survey was part of our cost of the school day project, which looked at some of this stuff. I thought that I had better highlight that. Among the findings of that work was the fact that children in low-income households did not have connectivity or access to information technology, so they were less able to learn remotely.

Not having free school meals was a problem, and there was a lack of childcare for low-income key workers who had to return to work. Some of those issues have been addressed. We welcome the promise to provide connectivity for all children so that they can keep connected, even outwith the pandemic, which exacerbated the issue. The provision of cash support, as opposed to vouchers, to help in holiday periods during the pandemic was welcome, too.

Therefore, there is stuff that can be done. I can forward that report to the committee. It highlights the fact that the pandemic had a disproportionate impact on low-income households. As Claire Sweeney said, that has an impact on the attainment gap. The attainment gap is all about poverty. The way to deal with the poverty-related attainment gap is to deal with poverty.

David Torrance: I probably know the answer to this question, but I want to get it on the record. If we are to focus on the inequalities in the health and wellbeing of children and young people that have been caused by the pandemic, taking into account the capacity of the system, where should we focus first in order to get the best results?

The Convener: Is that directed at Ed Pybus?

David Torrance: Yes.

Ed Pybus: We need to focus on child poverty. The immediate way of tackling child poverty is by investing in social security and making cash payments to low-income households. That is how to deal with it. We have shown that that works. Ensuring that families have adequate incomes is the best way of investing in tackling long-term health inequalities. Many of the investments in tackling child poverty also tackle wider poverty in society, so we are not talking only about children.

Beyond social security payments, it is things such as tackling barriers to work—making sure that work is well paid and tackling access to childcare. Both the cost and the lack of availability of childcare are barriers to people working.

To come back to Dr Jackson's point, tackling the barriers to work—particularly for certain minority communities, for example—is about more than paying the living wage; it is about actively understanding the barriers in all our different sectors and making sure that we can overcome them. As Bill Scott pointed out, the same is true for people with disabilities; there are barriers to them working. Those groups coincide with those that the Scottish Government has identified in the child poverty delivery plan as the priority groups to lift out of poverty, as well as lone parents, larger families and young families, so it is doing all that work.

The child poverty delivery plan starts to build on some of that. The next thing to do is to make sure that the detail is put in to make it happen. However, I cannot stress enough that the immediate way of lifting someone out of poverty is to give them more money. Those long-term changes to employment, the labour market, childcare and education can then happen, which will allow people to be lifted out of poverty in other ways in the long term.

That is our response, which probably will not surprise you.

Claire Sweeney: For Public Health Scotland, although we have talked about a lot of the challenges that we are facing in Scotland, the big message that I want to emphasise and get across is that we can do a lot about inequality. There are lots of levers and opportunities in Scotland to address it. It is by no means something that is intractable that we cannot address; we can address it.

As the committee knows, Public Health Scotland was introduced in 2020 as the new national public health agency for Scotland, and our focus from the get-go has been about impact and making a difference. I absolutely agree with Ed Pybus's point that the biggest thing now—it probably always will be—is about the fiscal levers and the legislative underpinnings in Scotland that give good public health. There is no doubt about that, but it also has to be seen in the context of what else we can do in Scotland. It is not an either/or situation.

Giving people more money is absolutely the biggest thing that can be done—for sure, there are reams of public health evidence that say that. However, if we just focus on that, it lets everybody else off the hook, and there is lots that we can do in Scotland. We know that local action will mitigate some of the effects of the underlying causes of poverty and inequality, but the spend on public bodies in Scotland is enormous. Given the millions of pounds that the public sector spends in Scotland every year, there is a huge opportunity to use that money to good effect, and we see many of those things in place in Scotland already.

A couple of the things that it is worth drawing to the committee's attention are the national performance framework, which is a really good thing, and community planning partnerships. The underpinnings of how we can address the issue are arguably already there in Scotland. The things that need to be done to strengthen that, which are currently very much the topic of debate across Scotland, are about tightening accountability. For example, we hold public bodies to account for financial and access targets, but we do not hold public leaders to account as strongly for reducing inequality. That is something really clear and tangible that could be done.

We would like budgets and spend across Scotland to be more closely aligned to impact, which exactly speaks to the point about reducing inequality and child poverty, in particular. The messages on public health interventions that make the difference are very clear, including internationally. It is about the early years, access to education and training, having good and fair work, having a good and affordable standard of living and having healthy communities in place so that people have access to green space, good transport and so on. There is a lot of agreement on what can be done; it is about how we mobilise the rest of the system to start to realise that, which is absolutely within our gift in Scotland.

The Convener: A couple of other members want to come in on that issue. We will go to Carol Mochan first, then Tess White.

09:45

Carol Mochan (South Scotland) (Lab): I absolutely believe that tackling poverty and putting money into the pockets of communities that need it is really important, so I agree with a lot of what has been said so far. I am interested to know about services and service provision. I have heard anecdotally that it has taken a bit longer for services to open up in some of our more deprived communities. We know that there are staffing problems and that it is perhaps more difficult to attract health staff and support workers into those communities. Is there any evidence of that, and has that been looked into?

Claire Sweeney could perhaps respond to my second question. We know that, if we tackle health inequalities, that helps everybody in our society. Do we look to ensure that the money that we are spending is being directed to those groups of individuals who need it most? I would be interested to know how we measure that.

Bill Scott: We know that, prior to the pandemic, the inverse care law applied—that is, resources are not where they are most needed—and that that probably applies more because of the pandemic. There are more general practitioners and health services available in affluent areas of Scotland than there are in poorer communities. That has an impact right away on identifying existing health problems. People get shorter consultations, because there is more pressure on GPs who operate in deprived communities. That means that they are less likely to diagnose conditions that, if caught early, can be treated, resulting in successful outcomes and extending lives. The inverse care law applied before the pandemic, and I am absolutely certain that some of the shortages that we are experiencing among health and social care staff are making the situation worse.

The return to normality has been more evident for some than for others. Proportionally more disabled people are still self-shielding. They are not on any list for priority booster jabs or anything. My former boss at Inclusion Scotland, Dr Sally Witcher, has been isolating at home for two years and four months now. She is not eligible for a booster jab, but she is extremely high risk.

Many GPs are still providing appointments mainly by telephone or over the internet. That is useful in many ways, but anybody who is involved in diagnosis will tell you that physical presence allows a doctor to identify things that a lay person would not notice—the colour of the whites of the eyes, for instance. That is missing. We must remember that the most deprived, poorest sections of our society are the least likely to have internet access or be able to afford to make lengthy phone calls to the doctor. Online services are good in many ways, but they exclude disabled people in particular—about one in three disabled person do not have internet access. We have to think through how we deliver services to people who are not digitally included at the moment.

We have learned valuable lessons, in that we can do some of the work that is required online, but we know that learning-disabled people need longer consultations, as it often takes time for them to understand what a doctor is looking for by way of response to questions.

I am really glad to see that annual health checks for learning-disabled people will be provided through a Scottish Government initiative. That has long been needed because, even before the pandemic, they were twice as likely to die from preventable illnesses as non-learning disabled people were.

There is much to say about where our services are and which services need to be bolstered. We know that there has been a disproportionate impact on poorer communities, as well as on disabled people and black and minority ethnic people, who are all likely to live in poorer communities. We need to begin to restructure our services so that they address the need where it is, which, as has been pointed out, is in local communities. We must ensure that we have the resources in place to deal with the inequalities that the pandemic has not only created but magnified.

The Convener: I ask Claire Sweeney to comment on that second point. However, we will have to quicken the pace a little bit, colleagues. A lot of you are asking for supplementary questions. We have a lot to cover. If I do not take you for a supplementary, you will probably get back in later, but I suggest that you roll your questions into one.

Claire Sweeney: One of the most important points on which we have already touched is intersectionality. People are complicated so, when different issues intersect, we need to put the person at the centre. We need to treat people as people and put them at the heart of everything. We also need to work closely with them to design out discrimination that is built into services, often entirely unintentionally.

We need to co-design services with people so that they are easily accessible and built around them. That notion has been around for a long time but it is getting increasing traction in Scotland, which is really good to hear. That could relate to where services are located, some of the follow-up arrangements or recognising how difficult some people's lives make it for them to access some of the services that they need.

A lot of work needs to be done on that. In Public Health Scotland, we have introduced a new approach to whole-system modelling so that we work closely with public sector providers to work through the implications of getting systems back up on their feet after Covid. I am happy to share that with the committee.

I will briefly mention one of the other points on which we have not touched, although I am sure that it will come up: the impact of the cost of living crisis on everything that we have talked about so far. That is significant and of great concern in and beyond the public health community. I am happy to talk in a bit more detail about that, but I am conscious of time.

The Convener: Tess White has a quick question, but then we must move on to questions from Gillian Mackay.

Tess White: Thank you, convener. I will be very quick. The pandemic has had a severe impact on the mental health of children and young people.

The target is for 90 per cent of people to receive children and adolescent mental health services treatment within 18 weeks. My question is for Claire Sweeney. Is the funding sufficient to enable children to have CAMHS treatment?

Claire Sweeney: We have been doing a lot of work on the targets that are in place for children's mental health. I am happy to share that with the committee and will ensure that we do so.

The real challenge in what we know that we must do across Scotland is to make the big, radical shift from focusing on the acute end and dealing with the consequences of poverty, inequality and health issues to a more preventative approach. Although there is no doubt that there is a demand for crisis services and highly specialist mental health professionals, there is an awful lot more that can be done in community settings. We are working closely with schools and headteachers to think about how we support schools in their work with children on their mental health.

There is no one answer. At the moment, we are good at counting at the acute end. However, we need to get a lot sharper at understanding the impact at a more community-based and local level of preventing those issues before they get to a crisis—at which we have those increased waiting times for access to specialist services.

Gillian Mackay (Central Scotland) (Green): Do witnesses have a view on whether universal basic income or a minimum income guarantee is an effective method of tackling health inequalities?

Bill Scott: The commission has not examined either of those; I am therefore expressing a personal opinion. A minimum income guarantee is probably easier to achieve and therefore stands the greater chance of benefiting those in low-income households.

The idea goes back to Adam Smith. The essentials of life include the ability to participate in public life. If people cannot do that without a sense of shame, they lose self-worth, and that damages their mental and physical health. We have already said that race discrimination damages people's mental and physical health; so does poverty. As Claire Sweeney has said, the current cost of living crisis will damage the health of children and young people.

A minimum income guarantee has the capacity to raise the living standards of the poorest households to a level at which they are able to participate fully in society. That is the essence of it. It is not just about having the bare essentials—the ability to heat your home and eat—but about the ability to participate without a sense of shame.

At the moment, we are damaging more young lives than we think. Normally, we talk about poverty as affecting one in four children; it does not. My colleague Professor Morag Treanor has looked at that. By the time they are halfway through primary school, more than half of Scottish children will have experienced poverty. It is not one in four; it is more than half. That is because people and households move in and out of poverty. A minimum income guarantee is a floor that stops that from happening and has an impact on the health of children—on dietary health, apart from anything else—and the ability to participate without a sense of shame, which is important to children. The cost of living crisis will make things significantly worse for a larger proportion of households. Unless we address that properly, we will live with its consequences in the impact on physical and mental health for a further generation.

Ed Pybus: The short answer to Gillian Mackay's question is yes. Poverty causes health inequalities. Both universal basic income and a minimum income guarantee would help to resolve poverty, so should help to reduce health inequalities. The devil is in the detail as to what can be achieved and what we mean by universal basic income or minimum income guarantee. This is not the place to get into the details of that. I sit on the minimum income guarantee steering group, and we are looking at those issues.

The main point is that we can have a system that should provide everyone with a certain level of income, but many people are still excluded. For example, we know that the take-up rates of means-tested benefits can be relatively low—for example, maybe only 70 per cent of children who are eligible get the Scottish child payment—so, as well as having in place such social security systems, we need to address the barriers to access, through the intersectional approach that Claire Sweeney mentioned.

Then, as I am sure that Dr Jackson would say, there is the issue of people also facing barriers to making a claim. There is no point having a universal social security system if some people face barriers to accessing it. Therefore, that must also be addressed. However, yes—in essence, if you increase people's incomes, you decrease health inequalities.

10:00

Claire Sweeney: I do not think that I can better what Ed Pybus has said. It is really simple but really complicated at the same time. There is no doubt that increased income is a good thing with regard to reducing health inequalities.

We have been doing quite a lot of work on destitution and, as Ed has mentioned, on people with no recourse to public funds. I am sure that the committee will be interested in some of that work, and I can send on details of that.

I want to emphasise again the impact of the cost of living crisis. If we were worried before about households that were experiencing fuel or food poverty, there is no doubt that they are now at increased risk. However, also at increased risk are those who we would probably term as the "newly vulnerable"—that is, people who have been accruing debts who might just have been able to manage before and people who have seen their incomes or savings reduced or their employment circumstances become more fragile, in part because of the impact of the pandemic.

There is no doubt that increases in the cost of living will have an impact on health outcomes, and there is no doubt that that will be a negative impact. We have information that I can share outwith today's meeting about the impact of Covid on the economy.

When we look at some of the other broader issues around the economy, the situation is far worse and far more significant again. We are still worried about all the groups and issues that we have already talked about in that context, including women's and children's health, emotional and cognitive development, winter mortality and so on—all the usual things that we would be concerned about. Those are all at risk of being heightened because of the financial circumstances that people will find themselves in.

The Convener: Gillian, do you have another question? If so, it would be great if you could direct it to one of the witnesses.

Gillian Mackay: Yes, I will do that—I will try to anyway. Earlier, we touched on the issues of services and intersectionality. Everyone on the panel has expertise in different areas. Perhaps I should direct my question to Claire Sweeney. Given the increasing cost of living, what would you point to as one of the biggest interventions that we could make on health and poverty?

Claire Sweeney: It is hard to choose one, but that absolutely comes back to the point about money in people's pockets. Nothing will have a better impact than that. However, if I am allowed a supplementary suggestion, I would also say that some of the drivers that I have talked about around better use of the national performance framework, better use of CPPs and more accountability in the system are essential in getting the whole system to remobilise around those issues. It is not enough to treat that as a single issue.

Therefore, it is about money in people's pockets and anything that we can do to get that cross-governmental, cross-sectoral approach focused on reducing health inequalities. We would absolutely call for that from a public health perspective.

The Convener: I highlight to the other witnesses that questions about what we can do that is positive will come up later in the evidence session.

Paul O'Kane (West Scotland) (Lab): I am keen to understand more about the policy interventions that we can make in a devolved context. The committee has heard quite a lot of evidence and had quite a lot of discussion about what happens at the reserved and devolved levels, but I am keen to get a sense of what policy makers can do in the devolved context to make a difference. I ask Ed Pybus to start, because I know that his organisation, CPAG, has been close to the work around the Scottish child payment. Ed, I am keen to get your sense of how we can go further.

Ed Pybus: In the short term, as Claire Sweeney said, it is about getting cash into people's pockets, which means increased investment in the Scottish child payment. However, there are other things that could be done. For example, the two-child limit is a universal credit policy. Unless someone conceived a child in coercive circumstances, they cannot get assistance for more than two children. The Scottish Government could try to mitigate the effect of that policy in Scotland, which would have a huge impact on some low-income households.

We are big supporters of universal provision, which removes stigma and increases uptake rates, as I have mentioned. It is no good having a system if people are not taking it up, so there must be ways that there can be universal support for people. One of the key areas that we have been considering is childcare, which has knock-on impacts, as people can enter employment and reduce costs if the cost of childcare can be reduced. That could be looked at.

In the longer term, the issues include the need for better-paid work and the need to reduce barriers to work. At the moment, entering work is not necessarily a way of getting out of poverty. People who are working, even those who are getting paid the living wage—say, two parents who are working full time on the living wage—are barely able to rise above the poverty level, and they do not get anywhere near meeting the minimum income standard with the support of the social security system. Things need to be looked at there, too.

There are calls for further investment in the social security system by Westminster, but there is stuff that the Scottish Government can do in the meantime.

Dr Jackson: Most of my work is focused on policy engagement. Although Mr O'Kane's question was specifically about the child payment, this is a wider systemic issue. I am not sure whether it has come across how serious the issue of understanding how our systems operate is, or how serious the situation is around our health research bodies, our key health professionals and our policy systems. There has not been an understanding of how racism operates within those systems. Organisations such as the Glasgow Centre for Population Health—I also mention Michael Kellet, the Scottish Government's director of population health—need support to understand how their systemic processes are not managing to incorporate perspective about how inequity is produced for those who are racialised.

My response to your question, Mr O'Kane, is that policy can be supported by bringing in expertise. We do not have an NHS health and race observatory such as there is for the rest of the UK. In Scotland, our processes for supporting policy makers with the evidence and understanding that they need to make good policy decisions are limited. I will talk later about what the Scottish Government has decided to put in place to support the process, but the key issue is that our existing systems are operating with limited understanding of how the policy processes adversely affect things and risk creating and recreating the inequity that they are essentially attempting to address, as Claire Sweeney said.

Claire Sweeney: I concur with Ima Jackson's point. The best advice that I had from Ima, when we were working together, was to listen and learn from those communities that are most affected and to think about how we work together to make things better. That advice struck me and has stuck with me.

You asked about the policy context in Scotland, Mr O'Kane. I have mentioned the national performance framework and CPPs, but there are a couple of other things to draw to the committee's attention. Thankfully, this will inject a bit of hope into the conversations that we are having today. The focus on a wellbeing economy in Scotland is getting some traction now, which is absolutely to be welcomed. The Scottish Government's commitment to consultation on a wellbeing and sustainable development bill is a good thing, as is the publication of a wellbeing economy monitor. We are involved, and we will continue to support that work.

There is an exciting opportunity to learn from the work that has been done in Wales, in particular, around the Well-being of Future Generations (Wales) Act 2015 and the Future Generations Commissioner for Wales. That is the mechanism by which to get health inequalities at the top of everybody's agenda. We think that it is a really exciting proposition that can lead to demonstrable change across the system.

We know that children who are born into our poorest communities will die around a decade earlier than children who are born into our wealthiest communities, so the differences are unfair and they can actively be addressed. The idea is that a future generations commissioner will have a focus on prevention and on protecting the wellbeing of future generations by really starting to look at addressing and putting in place the building blocks that are needed to reduce health inequalities across Scotland. There is much merit in that approach.

Beyond that, we would advocate implementing really good public health advice and principles, thinking much deeper and harder about prevention, planning in a much longer-term way, linking funding to outcomes and collaborating across the whole system. Public Health Scotland, the directors of public health and the wider public health community in Scotland are strong advocates for that.

The Convener: Thank you. We will move to questions on building on the momentum that there may or may not be.

Sandesh Gulhane: Because of what the convener said earlier about rolling questions in, I will start with a question that I had for Claire Sweeney. You said earlier that you want to work with communities on improvement. I have found that information leaflets in NHS Greater Glasgow and Clyde are provided in Urdu, Arabic, Romanian, Polish and Chinese, but there is nothing in Hindi for what is a large community in Glasgow. What can we do to stop that type of thing happening and to be more inclusive?

Claire Sweeney: During the pandemic, there has been a lot of progress in engaging with particular communities and making sure that the advice and support are tailored and accessible. There is no doubt that there is more to do, and we can do that through engaging really closely with those communities and listening to feedback about areas where there is a demand that we have not responded to. That goes not just for Public Health Scotland but across the wider system. There are things that we can do, but we also have a really important role in helping to mobilise support in the rest of the public health services and beyond.

I will take that away from today's session as a particular action. Thank you for drawing that issue to my attention. I was not aware of it before you mentioned it.

Dr Jackson: I want to raise something that it is very important to note. During the pandemic, the expert reference group on Covid-19 and ethnicity made a series of recommendations, all of which were accepted by the Government. The key issue is that, when such decisions are being made, we need a body that is not just listening to communities but has power to influence the decision makers. It is not just about going out and engaging; it is about enabling.

One of the expert group's key recommendations was the development of an oversight observatory and repository for Scotland on how such policy decisions are made and having experts on communities who understand how systemic processes discriminate against people from minority ethnic groups. I am leading on developing that infrastructure, along with Ms McKelvie and Talat Yaqoob. It will be launched next year, but we hope to have ministerial workshops so that people can engage with it and understand its importance. It will then not come as a surprise but will be helpful. It is exactly the sort of policy-focused infrastructure that Scotland needs in order to stop decisions being made without the systemic processes that impact on them being considered.

10:15

Sandesh Gulhane: Dr Jackson, I am keen to ask you for some specific examples of systemic racism. Following on from that, are there any examples of good practice—perhaps in local work—that we could push forward as Scotland-wide policies?

Dr Jackson: As Claire Sweeney will know, one of the clearest examples was the vaccine management tool, in which recording of ethnicity was carried out. We were in a pandemic that was affecting black and minority ethic people hugely disproportionately to anyone else. Evidence of that was coming out, so we had an opportunity.

An agreement was made to record ethnicity, which is the only mechanism that we have to demonstrate where inequality happens—that is the only reason for recording ethnicity. When the pandemic hit, our data was inadequate. Then, when we were making the vaccine management tool, the Government took the decision not to record ethnicity. I want to underline the impact of that. We had a brand new whole-population data set, so we could have recorded the whole of our society at the point of vaccination—it was a unique moment. However, the decision was taken not to implement that, even though other jurisdictions were doing so, because it was felt at the time that it would have created a lot of pressure. Subsequently, that decision has been reversed, although it took a year or more for that to happen.

I understand the reasons for taking such a decision, but its impact on our system is potentially generational. We are now recording ethnicity, but that approach came in only much later. That is an example of what I mean. I hope that the committee can see that that happens because of the processes that we create. If we had had people who understood the significance of the moment discussing it, arguing about it or strategising about it, we would not have made such a decision or required the huge efforts that it took to reverse it. To me, that is a recent example of systemic racism. I am not talking about face-to-face exchanges, which happen for interpersonal reasons; this is about systemic processes and people making decisions when they do not necessarily understand the impact that they will have.

The Convener: Sandesh, we must move on. If you have one more question, please make it quick.

Sandesh Gulhane: Dr Jackson, what can we do to improve our understanding of the systemic issues that you have described?

Dr Jackson: We have agreed that we are moving forward, with the Government, to create a national oversight observatory and repository. Who has all the evidence about what has existed in Scotland? Who knows where to look for such information? It is not held by the Scottish public health network—ScotPHN—the Glasgow Centre for Population Health or our research institutes. Years ago, there was such a system, but it was dismantled. I am working with colleagues on an advisory group for the observatory, the plans for which will be implemented and launched in May 2023.

It is important that all members of the Parliament support the systemic approach and understand what it means and why it will be a tool for them. It employs a similar model to that which was used in creating the Promise, which was drawn from care experience; it examines how we need to rethink our systemic processes and how they impact on decision making. As Claire Sweeney said, such issues are not intended, but, if someone does not understand the systemic perspective, they will make decisions that do not create equity. My key infrastructure ask would be for people to support that approach.

The Convener: We will move on to questions about examples of good practice.

Evelyn Tweed (Stirling) (SNP): I was interested in what Claire Sweeney said about the negative impact that the cost of living crisis is having on health outcomes. In your opinion, Claire, can the Scottish Government mitigate everything that is happening with the crisis? Will Scottish Government targets be affected? How are we tracking what is happening?

Claire Sweeney: Addressing the challenge of poverty in Scotland is multifaceted. There are various approaches, but the most important is to use all the fiscal levers that we have. Some of them sit at the UK level, but some of them sit at Scotland level.

With many other agencies, we are tracking the impact of the cost of living crisis on the population through a raft of different measures. Some that spring to mind are measures on fair work, employment, the consequences of the crisis for people's health, access to food banks and issues to do with the impact on education. The impact is multifaceted and, with a range of agencies, we are tracking it across many different measures across Scotland.

A lot can be done by harnessing the power of the public spend that is available in Scotland. We have seen some really good examples of that—child poverty payments have been mentioned. There is no doubt that some of it sits at the UK level or Scottish Government level, but things can also be done at a regional level.

We have been working hard with many public agencies in Scotland to ensure that they spend in a way that has a positive impact on inequality. For example, we work with partners to ensure that public health measures and evidence are used to inform decisions about how resource is invested or money is used in some of the city region deals and plans. That has not happened as well as it could have to date, but PHS is absolutely pushing it. When we make decisions about how resources are used, are we thinking about the good public health evidence that we have about what works? Are we thinking about the consequences that the decisions will have for a population's health? We are seeing a lot of progress on that.

Bill Scott: The commission has oversight of that and tries to hold the Government to account on it. On the Scottish Government modelling that we have seen, we may well still hit the interim relative poverty target. However, the problem is that we will miss the other targets, and they are all equally important.

Relative poverty does not take into account costs other than housing costs. Therefore, the rise in energy prices and food prices and the poorer standard of living for many households will not be reflected in the relative poverty figures. In fact, perversely, if there is a drop in the average income, relative poverty can go down, which seems unimaginable. That is one of the problems with it. However, we expect absolute property and the combination of low income and material deprivation to rise.

I will give some examples. The Food Foundation carried out a survey in January, before the energy price rise hit. At that time, one in five households already said that they faced a heat-or-eat dilemma and 1 million adults went without food in the week that the survey related to. That was 1 million adults in the UK, so it was probably about 100,000 adults in Scotland.

Claire Sweeney talked about destitution. From what we have seen, we think that destitution rose by about 50 per cent during the pandemic, which probably means that about 75,000 children went without food on a day during the past year.

Given that, we need to focus on what we can do. I do not think that we can fully mitigate the cost of living impacts in Scotland. Control over the vast majority of means-tested benefits, which are the most effective way of delivering support to low-income families, is held at the UK Government level. The package of measures that was announced last week is extremely welcome, but most of the measures are a one-off. We really need increases that are in line with inflation to be baked into benefits, so that people know that they will get help not just this year but in future years.

We can do a lot in Scotland. We can certainly address employability issues and barriers to employment, and we need to do that by speaking to people with lived experience of those barriers—they know what the barriers are and what prevents them from getting into work. As Claire Sweeney said, we also need to ensure that every public pound that is spent is, as far as possible, spent on reducing poverty and inequality. We can do that through procurement, through encouraging employers to pay the real living wage and through expanding childcare provision, which allows more women to work more hours. As I have said, women are more likely to live in poverty and to suffer health inequalities.

We can do a lot, but we have to accept that we cannot do everything at this level. I worry that the cost of living crisis will have quite a severe impact on health inequalities in Scotland.

Emma Harper (South Scotland) (SNP): When I asked Gerry McCartney about the living wage last week, he said that we needed to remember the difference between the living wage and the minimum wage. Thinking about the Scottish Government's mitigating of impacts by encouraging employers to implement the living wage, I wonder whether there is an opportunity to continue to ask for employment law or further benefits to be devolved, so that we have better fiscal control and can deliver public funding in the way that the Scottish Government chooses.

Bill Scott: I can say only that the Scottish Government's inability to set the real living wage for all employees prevents that wage from being applied to every sector of employment. Those kinds of additional powers would be welcome and would help get the vast majority of employers to pay the real living wage.

There are things that we can do. The Scottish Government has said that those involved in procurement contracts must pay the real living wage to all those employed under those contracts. That is one way of driving the adoption of the real living wage among employers, because they will know that, in order to get a Scottish Government contract, they will have to pay it to their workers. If Scotland had responsibility for more employment law, it would assist with the adoption of the real living wage, but we can do things here and now to drive wages up.

The Convener: I see that Ed Pybus wants to come in. If broadcasting could unmute his microphone, that would be fine.

Ed Pybus: I echo what Bill Scott has said about procurement. I listened to last week's committee meeting, and I heard someone point out that NHS Highland and Highland Council are becoming real living wage employers. That is great, but much more can be done. As I have said, such organisations can address barriers to employment for those who are in the child poverty priority groups, such as people with disabilities, priority ethnic groups and lone parents. Being a living wage employer is not enough—public sector bodies can still do a lot by becoming anchor institutions that drive change more widely in society. Even when powers are not held in Scotland, changes can still be made.

That is a policy decision. It is about considering an organisation's policies through the lens of tackling child poverty, health inequalities and the barriers to employment that people face, and it is also about allowing flexible working and other approaches that let people work within their caring responsibilities.

We are lobbying the UK Government to increase the minimum wage. If that power was with the Scottish Government, we would be lobbying it to do so, too. At the moment, however, it does not have that power. That said, there is more that can be done to address barriers to employment in Scotland.

10:30

Claire Sweeney: I think that you have heard the level of concern that we all have about the cost of living crisis. It is driving the issues right up the agenda, which must be a good thing. As we said right at the start of the evidence session, none of this is new—it is just bigger. We are not necessarily seeing new issues emerge; we are just seeing the ones that were already there becoming much more of a concern.

From working with partners across the system, I get a sense that there is a real recognition that the way to correct that is to use all the levers that we have in Scotland and to emphasise that need at a UK level, too. I would not quite call it hope, but there is a sense that what is going on in the system in Scotland unites everybody at the moment.

Emma Harper: I have a quick supplementary question about a rent deposit guarantee scheme that I have heard about and which is being used to support people going into private tenancies. In social housing, you get your accommodation and that is it, but, in private accommodation, there has to be a rental deposit. Will the rent deposit guarantee scheme help in Scotland more widely? Right now, I have knowledge of it working only in Dumfries and Galloway.

Claire Sweeney: I cannot talk about that scheme, but private renters are absolutely in the list of groups that we are concerned about. Indeed, we have statistics to show that that group is at particular risk.

I want to make a connected point, which relates to the example that I have already highlighted and which we, as Public Health Scotland, are trying to tackle. Where there is a good example of something that we know makes a difference, how do we ensure that everybody uses it instead of our taking a pilot-project approach in which something short term gets switched on in one area but the learning does not spread to everywhere else?

As for the housing example that you have given, I can think of many other examples in which something great has been happening but has not spread more widely across Scotland. We are using our power to convene as strongly as we possibly can to mainstream such examples.

The Convener: Our final questions are on the priorities for recovery. I suppose that we have been talking about that all morning, but we have some specific questions on it.

Paul O'Kane: In the past two years, Covid-19 has dominated every part of our lives, particularly our actions on health inequalities. I am keen to get a sense of the witnesses' views on the Covid-19 recovery plan. What should be prioritised in the plan to tackle health inequalities? I appreciate that that is a big question.

Claire Sweeney: Oh dear, it is big, but I will give a short answer.

We simply need to prioritise prevention and the maximising of income, and we need to ensure that services are up on their feet. We have a range of work on the stocks to help with that. For example, Public Health Scotland is doing a lot of work with stakeholders across Scotland to ensure that cancer services and a range of other services are on their feet. However, we increasingly need to shift the focus away from the treatment of the consequences of the underlying causes of inequality towards a preventative approach.

Dr Jackson: From my perspective, the importance of this moment in the recovery is to understand that the system in which we have been operating has unintentionally been creating and recreating racialised inequality. The Covid recovery plan has to reflect an understanding of how that process operates and the Government has to build that knowledge into what the plan is purporting to do.

Ed Pybus: It will not surprise you to hear us say that we need to get cash to low-income households in order to reduce poverty. Again, it is about taking a whole-system approach. As people have said, health inequality needs to be addressed across the system, as do child poverty and inequalities, particularly racial inequalities. All of that can be done together. We have the child poverty delivery plan across Scotland, local child poverty delivery plans in local authorities and the community planning partnerships. All those lenses have to be applied to all those decisions if we are to make the system work and solve all those problems.

In a way, this is not difficult—we know what we need to do. It is just that the whole system needs to work together to lift households out of poverty and break down barriers, and that, in turn, will deal with those health inequalities. I know that it sounds easy.

The Convener: Does Bill Scott have anything to add?

Bill Scott: I do not think that recovery from Covid can be divorced from the economic recovery. As we have heard, health inequalities are not divorced from other inequalities in society such as race, gender and disability, so our priority should be considering how we reduce those inequalities in the areas where we know that they exist.

Given that more than 50 per cent of disabled people of working age are not in work, we need to increase the proportion of disabled people in work. Given that women are more likely to be low paid, and given the gender pay gap, we need to reduce that gap if we are to address women's inequality, including in health. The same can be said of race.

Systemic approaches are definitely needed, but we also need quite a radical reform of our economic system. The first thing that I mentioned was the almost explosion in mental health issues as a driver of the increase in disabling conditions that exist in our society. That growth in mental health issues has taken place over the past 10 years; the situation has been getting worse in the past three or four years, and it is being driven by insecure employment, zero-hours contracts and a benefits system that penalises people through sanctions and deprives them of the income that they need to get by in society without feeling shame.

We can address some of those issues in Scotland, although some of them have to be addressed at UK level at the moment. However, unless we do so, health inequalities will continue to increase. We know where the inequalities exist, and we now need to devote the resources to reducing them. Health inequalities and economic inequalities are not separate—they co-exist.

The Convener: Paul, can I bring in Stephanie Callaghan?

Paul O'Kane: Of course.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Before I ask my questions, I want to say to Dr Jackson that I am really interested in the development of the national oversight observatory and repository for Scotland, and that it would be great to hear more about that come May next year, when we have more information about it.

My first question is for Claire Sweeney. You talked about linking spending to outcomes, and the importance of community planning partnerships. Are there specific people who should be on community planning partnerships? Are there people who are not on them but should be? Are there links that the community planning partnerships should be making? I know that there is variation across local authorities when it comes to who sits on those partnerships.

As a wee aside, you mentioned measuring the link between spending and outcomes. Does that sometimes get in the way when things are difficult to measure? Does it mean that the focus is not applied in the right way?

Claire Sweeney: The community planning partnership infrastructure has been there for quite a long time, and it is time to revisit the powers that the CPPs have to address some of the issues that you mentioned with regard to the decisions that they are able to make and the people who are sitting around the table. Basically, the idea of accountability should become the most important thing. That is complicated and hard to do, and it is really hard to measure, but that cannot be an excuse, because it is the right thing to do. The system in Scotland has almost been built around that infrastructure being the mechanism for making a difference, so we need to make it work.

It is important that there is a strong public health voice around that table. My personal view is that, often, there is an assumption that health inequality and public health issues are solely health problems but, in fact, all the underlying causes sit elsewhere in the system—they are far more to do with housing, the economy, jobs and employment. That means that there is a need to ensure that the community planning partnership function across Scotland is strong, that it has power and that it has teeth. We also need to ensure that budgets are aligned with outcomes, which we know is hard to do, but the focus on that in the national performance framework provides the underpinning to do that, so I am positive that that can happen.

I want to touch on an issue that has not been mentioned today, so that we can give it a bit of air time. The challenges around tackling health inequalities have almost been made to seem more simple than they are. Public Health Scotland is a relatively small organisation, and we know that we will not be able to fix the problems around health inequalities in Scotland on our own. We were introduced to help to leverage change across the system and to have a bigger impact by getting the system to use all its assets to target and reduce inequalities. There is more that we can do, but the key message that I want to get across is that the issues are complicated and interrelated. It is hard to say what outcome is due to which organisation's input. That is why it is essential that we work as partners and are clear about the measures and what they are trying to achieve.

One of the things that we have prioritised in Public Health Scotland is building what we have called purposeful partnerships, which involve partnering with people not because it feels like the right thing to do but because we have shared interests, and having clear action plans with partners. For example, when we work with Police Scotland or Food Standards Scotland, we ask how we can ensure that we are being really innovative and are focusing on the small number of big things that we can put money and resource into, so that we can start to turn the tide.

I hope that that answers your question. It is a complex problem, but we have done a lot to get us to the right place, and now there is just that extra bit to do, which involves giving the CPP infrastructure more teeth, more weight and more accountability.

The Convener: Ima Jackson, I see that you want to come in on this point, but I have a final question for you.

We had a number of informal sessions with a wide range of people, and the issue of people with no recourse to public funds came up time and again—they are probably the most disenfranchised group of people, comprising asylum seekers and people who are trying to get some sort of status in the United Kingdom with regard to decisions that are made by the Home Office. Their voices are not often heard in relation to decision making, but they are probably disproportionately affected by health inequalities and inequalities in general. How do groups such as yours facilitate getting them around the table?

10:45

Dr Jackson: I spoke about that issue when I gave evidence to the Health and Sport Committee in 2014. Part of the point of the observatory is to bring people who do not have a voice or power into the decision-making fora. Particularly with the issues that I am talking about, people make decisions about other people who are generally not there in the room or whose perspective is not represented. Coupled with that, there is an implementation gap. What I said in 2014 was that good recommendations were made, but that the implementation and the accountability mechanisms were not good.

The observatory is an oversight structure to support us to have more accountable systems. There will be experts in that space who understand participatory methods and know how to bring in lived experience. It is a case not just of co-opting people to come and ratify things but of taking a proper power-sharing approach to support the policy-making infrastructure for Government.

The Promise is a precursor to what we are proposing. Those are the sorts of mechanisms that we need in order to understand what levers we can use in Scotland and to ensure that we have the confidence to implement those in our decisions about how to support the most marginalised people, bearing in mind the different immigration rules around who is able to access what. We need to be clever about how our system can operate in that way.

There is an implementation gap, and we need infrastructure to address implementation. Good recommendations have been made about the issue that you raised, but it is hard to know what happened as regards implementation.

The Convener: I probably threw you a curve ball. I think that you wanted to respond to Stephanie Callaghan.

Dr Jackson: I wanted to follow up on what Claire Sweeney said about the implementation gap and the processes that we need, but I worked that into my response.

The Convener: Thank you.

We have gone over our time. We must have a break before we get the next panel in, but I know that Ed Pybus wants to come in.

Ed Pybus: Ima Jackson has covered the issue. When people have no recourse to public funds, that limits what the Scottish Government can do, but it can find innovative ways to get money to those households. We have called for local authorities to be provided with funding to fund food and certain payments that are not considered to be public funds.

More broadly, in parts of the social security system that have been devolved, the rules have mirrored some of the rules in the UK system, which did not need to happen. For example, the past presence test, which does not impact people with no recourse to public funds but impacts people who arrive in the UK, has been mirrored in the Scottish disability and carers benefits, although there is no reason for the Scottish Government to do that. Not doing it would send out the message that Scotland is different and would push the UK Government to remove Scottish supports from the list of public funds. That would say that Scottish supports should not be on the list of public funds and that we in Scotland should be able to support anyone whom we feel we need to support.

The Convener: I have received notice that Stephanie Callaghan wants to ask Bill Scott a specific question. We must round off, so please make it quick.

Stephanie Callaghan: I am interested in your mention of the impact of shame and guilt on people’s ability to participate in public life and the huge impact that that has on mental health, which will be a massive issue in our recovery.

Back in January, Mary Glasgow spoke about how brutal and unfair the cut in universal credit was and how it had a huge impact on children and families, not only practically and financially but emotionally. She said that that sent a message about society’s view of people’s needs and created shame and guilt. Often, the media do not help with that perception.

Notwithstanding all the measures that we bring in to address poverty, are there other things that we can do to help people to feel respected and valued, and to remove the shame and guilt that people find so isolating and that have such a bad impact on their mental health?

Bill Scott: Universal provision is one of the ways in which we can sometimes address some of those shame issues. Providing free school meals for all children removes any stigma associated with the receipt of free school meals by children from poorer households. The NHS is free at the point of need, which should remove any shame or stigma involved in coming from a poorer household.

There are certain things that work better when they are delivered universally, one of which is support for families with children. The Scottish child payment is there for families on lower incomes, but there is also still child benefit, which has not risen in value for years and was an acknowledgement by society that child benefit is an investment in the next generation, who we expect to look after us in our old age.

Universal provision is one definite way of addressing some of the issues around shame and stigma, and I certainly advocate its use in relation to school meals. To go back to the idea of a minimum income standard, everyone should be able to expect a certain minimum household income that allows them to participate fully. Once we achieve that, we will open up possibilities. Many households cannot take the opportunities that are there, not only because of shame or stigma but because of the barriers of low income. They cannot afford public transport or childcare. Free childcare for more families is disproportionately helpful to poorer families.

The Convener: I thank all our panellists. We have run significantly over time, but it has been absolutely worth it.

We will take a 10-minute break before we bring in our next panel.

10:52

Meeting suspended.

11:00

On resuming—

The Convener: In this session, we will focus on examples of initiatives to tackle health inequalities that started before the pandemic—we heard in the previous session that nothing really started during the pandemic, although things got bigger. Our witnesses have prepared short verbal presentations. We will take those in order, and then a round-table discussion will follow. Therefore, when colleagues are listening to the presentations, they should think about follow-up questions to ask our witnesses for more detail.

I welcome Gill Bhatti, employee and diversity manager at South Lanarkshire Council, and Danny Boyle, senior parliamentary and policy officer with BEMIS Scotland and the national co-ordinator of the EMNRN—do you just say the letters like that, or does it have a snappier name, Danny?

Danny Boyle (BEMIS Scotland): It is the ethnic minority national resilience network.

The Convener: Thank you.

I also welcome Emma Fyvie, senior manager of development with Clackmannanshire Council, and Dr Gillian Purdon, head of nutrition science and policy with Food Standards Scotland. Three of you join us online and Danny Boyle is here in person, but I will take you in the order in which I introduced you.

Gill Bhatti (South Lanarkshire Council): Thank you for the opportunity to share with you some of the things that we are doing in South Lanarkshire to support people with health conditions or other circumstances that make finding sustainable employment difficult. I am a great believer that work can make a huge difference to people, and I hope to be able to show, with some examples, what that difference is.

I will first give a little bit of context. Clearly, there has been some volatility in the labour market during Covid, and some of that continues. The issues are a little exacerbated at the moment, with cost of living concerns compounding precarious employment and some of the pressures around pay. Labour market data indicates that more people are doing part-time work, especially women, and that more people in our working-age population are economically inactive.

An increased number of job-ready candidates are available to fill jobs. They could be school leavers, college leavers or university leavers, or people who have recently been made redundant. That means that, for people with barriers such as health conditions who are not ready to work, or people who need significant support from employability services before taking up work, the gap is bigger, and we need to address that.

I work for a large local authority, and I think that there is a responsibility on our large public sector employers—our anchor institutions—to lead by example. In the past year, our employability support services have provided support to more than 2,000 local residents in South Lanarkshire, the vast majority of whom have multiple barriers to employment. We work closely with our partners through the local employability partnership to ensure that our services meet local needs, are targeted at those who need them the most and are focused on people and place. You can have services that are bespoke and person centred and that reflect the needs of the individual, but, in relation to place, we are increasingly seeing that work in very localised environments can make a big difference.

Funding helps a lot, especially when it can be used flexibly to meet needs. For example, the UK and Scottish Governments, in anticipating high levels of youth unemployment during Covid, provided funding, in the form of the kickstart scheme and the youth guarantee programme, that has been targeted at employability for those aged 16 to 24. Youth unemployment rates are now lower. In South Lanarkshire, the figure at the moment is actually lower than it was before the pandemic, at 3.6 per cent for 16 to 24-year-olds, which is the lowest rate since February 2018. The funding helps, but that means that there are still more than 1,000 young people who require support.

As well as addressing the needs of young people, we need to look at people who are over the age of 25 and those with health concerns. As well as looking at people who are seeking work, we should spend some time looking at providing more support for people who are experiencing in-work poverty. That is a real issue for women and people who work part time, as I think the committee heard from the witnesses earlier.

In order to address in-work poverty, we offer an upskilling programme for employees who are in work but who have low skills levels, or no skills, and are on low incomes. We aim to improve their job prospects by offering them support, through training, qualifications and skills development, so that they can progress. Our measure of success is whether those individuals get better work opportunities, such as jobs that offer the real living wage, better hours and better conditions. Last year, we supported just under 170 people in work, the majority of whom were women, to enhance their skills. When we intervened, the provision of training or qualifications did not need to be a huge undertaking; it could be quite simple, but it made a big difference by increasing people’s confidence. Most important, it gave them something that they could point to when saying that they could take on more hours and more responsibility and, therefore, they could get an increase in salary.

For parents with health conditions or disabilities who are seeking employment, we have a programme called making it work, which is funded through parental employment support funding. It assists parents to realise their potential and overcome barriers in order to progress into education, training or employment. Given the participants’ lived experience and low levels of confidence and self-esteem, it is often very easy for them not to apply for a job because they are worried about being rejected or that they do not have the skills and experience that are required. Since November last year, we have engaged with 76 parents with a range of health conditions and disabilities. More than 60 per cent of them had mental ill-health conditions. Twelve have moved into employment so far, and the remainder are undertaking skills development and confidence-building training before moving on in that journey into work. It takes a little longer with that client group—we often find that full-time work is not the answer and that part-time work might be a better solution, given their particular conditions or circumstances.

I have some examples of people we have worked with recently. Client N had left a violent relationship and was suffering from extreme anxiety. They had to relocate in an attempt to get their life back on track. N is a single parent and had no skills or qualifications to get a job. With our support, N went on a four-week intensive training course that focused on personal development and entry-level qualifications. N then managed to get an interview and a part-time job in social care, where they feel that they are valued and making a contribution. The job fits with their childcare commitments, so it suits that particular individual. We very much take a person-centred approach. The transformation of that individual just through work is wonderful to see.

I will turn to disability. As a large public sector organisation, we are concerned with our mainstreaming equality reports, part of which involves reporting on the disability employment gap. The additional funding that has been made available for employability support has enabled us to put in place more support for those with disabilities, and that is very welcome.

In the past year, during Covid and towards the end of the pandemic, we used a mixture of funding to create opportunities. Eleven per cent of people who have been recruited to work in the council have disabilities, and our bespoke support ranges from access to work to British Sign Language support and physical adaptations, such as ergonomic chairs and dedicated parking. That helps with our aspiration of reducing the disability gap. More important, those employability supports have allowed participants to fulfil their potential and become financially independent, and that puts a big smile on my face.

For example, we worked with a young man who had a range of difficulties with physical and mental ill health and who had no skills or opportunities. He just wanted, in his words, to get a “foothold in the door”. Through support for his health issues but, mainly, through interview preparation and confidence building using the funding, the young man was able to take up an opportunity—again, part time—in February of this year. The work was very sheltered initially; he was shadowing for six weeks until he managed to build his confidence. He is now transformed by work, as he is financially independent and performing very capably and independently in that role.

We have also used council and Scottish Government funding to create modern apprenticeship opportunities in the council’s workforce for care-experienced local people. That is part of our responsibility as a corporate parent. Again, we recognise that it might take a little longer for those people to settle and adapt to work, but we believe that that is worth while for those who have been so disadvantaged in their early years.

I could give many more examples but, in summary, employment is a clear way out of poverty. It is a route to financial independence and, potentially, to good or better mental and physical health.

Employability services enable us to use funding to target those who are most in need of a bit of help, in whatever form that might take, but those services do not exist in isolation—and they should not, if they are to have the greatest impact on individuals and families. As a large employer, we try to lead by example in the area. We are an anchor institution in our localities and we embrace and promote fair work, the living wage and new ways of working. The ability to work from home opens up employment opportunities for some people with disabilities or health concerns, so, with a bit of lateral thinking and joining up, services should ensure that no one is left behind. Our funding should be flexible enough to support that ambition; we should not be getting tied up in bureaucratic knots.

The discussions on multiyear funding are going a long way towards enabling that flexibility, which, in turn, will allow us to support individuals. The aspirations that are being expressed around the new child poverty and employability funding are very welcome and reflect the need for joined-up services to support individuals.

As I am sure you have heard, the cost or availability of childcare is often a barrier to employment, especially in rural areas, so the increase in nursery and early years provision helps parents in relation to work, too.

I mentioned at the beginning of my presentation that we need to support those who are in work and on low pay. The living wage campaign in South Lanarkshire has reached more than 100 employers, who are signed up to paying the living wage. We continue to bang that drum and encourage that wherever we can. I have seen the pride and relief on individuals’ faces when they receive their first pay in the bank. Financial independence is a huge confidence booster and a great equaliser. I am sure that that is familiar territory for committee members.

On that note, I will end my presentation, but I am happy to answer any questions when it is appropriate.

The Convener: Thank you very much. We will move on to Danny Boyle from BEMIS.

Danny Boyle: Good morning, everybody. I am the senior parliamentary and policy officer for

BEMIS Scotland and have also been co-ordinating the ethnic minority national resilience network.

I am here to talk about the vaccination information fund, which we set up. I thought it important, in recognition of the general positive outcomes of the vaccination campaign, to be here in person to speak to you. It feels quite poignant to be able to do that; I am able to be in the room with you because of the overarching huge success of the vaccination campaign.

It will be helpful for members if I explain a bit more about what BEMIS is and what the ethnic minority national resilience network is, and some of the practical measures that we took to enhance health—in particular, through the prism of the vaccination fund and the vaccination campaign.

BEMIS is a national race equality democratic membership organisation. We were set up when the Parliament reconvened in 1999, because it was recognised that a mechanism—a body—would be needed for the voices of diverse ethnic minority communities to engage with parliamentarians on policies and issues that affect them. We are strategic intermediary partners with the Scottish Government's race equality unit, from which we receive our core funding.

11:15

It might be helpful for members to understand how BEMIS approaches the subject of race, because that characterises how the ethnic minority national resilience network was set up and the broad scope of community issues to which we have been able to respond.

As an equalities and human rights organisation, we acknowledge that minority ethnic communities are recognised under the human rights race provisions of colour, nationality and ethnic or national origin. That takes in a significant percentage of the Scottish population. The provisions are contained in article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination, and in the Equality Act 2010. Duty bearers in Scotland in national and local government are—in the provision of a vaccination campaign, for example—bound by those provisions of recognition, which are supposed to give us an intricate understanding of the various health and other policy experiences of people in those categories.

We work with multigenerational ethnic minority communities, including Pakistani, Indian, Jewish, Irish, Polish and various African communities, newer migrant communities from eastern Europe, including Roma, Slovakian and Hungarian communities, and people who are designated by the UK immigration system as refugees or asylum seekers, including Syrian and Afghan people and people from a multitude of other communities. You can see that that is quite a complex set of people and circumstances. Some might be people whose families have been living in Scotland for four or five generations, and others might have arrived significantly more recently.

BEMIS raises awareness of and supports our membership, our colleagues, Parliament and networks to challenge and respond to issues that affect those communities. We support ethnic minority communities to develop their own democratic representative organisations, so that they can engage in, and speak on their own behalf on, policy areas and issues that affect them directly. We administer cultural integration programmes, so that those diverse communities feel that they are part of our civic society in Scotland. We also provide equalities and human rights analyses of policy and public service provision.

In direct response to the pandemic, we facilitated and organised the ethnic minority national resilience network. Where did that network come from, and how did that characterise our response to the pandemic and our rapid work in response to the vaccination campaign?

Our response to the pandemic was probably the same as that of most people at the table: we listened as individual citizens and as professionals. In January 2020, we were loosely aware of a virus emanating from China that might have significant impacts. Our interest was really piqued when we began to see the huge issues that were occurring in Italy. Part of our responsibility as an organisation, and that of the multitude of international communities that we work with, is to be aware of things that happen in the geopolitical sphere, because those can lead to community cohesion and hate-crime challenges in Scotland.

We saw that the impacts in Italy were disproportionately affecting people in poverty and elderly people. We knew from our years of working with ethnic minority communities that that would likely translate into disproportionate, different and quite significant challenges for them, too.

In March 2020, we engaged across our membership and networks to develop intelligence on the pandemic. That eventually led to the establishment of the ethnic minorities national resilience network, which is a coalition of 106 organisations and experts from across Scotland who have self-identified under the provisions of race covering colour, nationality and ethnic or national origins. They include Pakistani, African, black, Jewish, Polish, Irish and many other communities. They have been engaging with our work.

With the full lockdown at the start of the pandemic, we saw significant impacts on people—in particular, those who are designated as having no recourse to public funds. Such people were unable to access furlough funding or universal credit. There were people in precarious employment who found, all of a sudden, that they had no access whatsoever to money. It brings significant mental health challenges, as well as physical health challenges, to be unable to feed yourself.

At that point, we set up a fund. We received referrals from trusted partners, the third sector and the public sector, and we were able to provide some financial support to those people. We were having to respond very quickly.

There was a significant increase in mental health needs among diverse ethnic minority communities. We picked up a particular challenge that had been occurring. The NHS had been trying really hard to respond to the problems, but there are difficulties with translating from a person's mother tongue into English—there are not always direct translations. For example, Arabic is a much more metaphorically rich and diverse language than English, so immediate translations do not always work. We set up a free-to-access multilingual mental health service with BACP—the British Association for Counselling and Psychotherapy—involving registered mental health professionals, which could provide translations in various languages. That service is on-going.

The network had three key overarching strategic priorities: intelligence and signposting, responding and providing, and ensuring an inclusive and receptive approach. We met once a month, and even more often in the first months of the pandemic, depending on what situations were arising. Scottish Government officials, cabinet secretaries and health officials were routine attendees at those events.

I now wish to focus directly on the vaccine information fund and implementation of the general vaccination programme. I have attempted to give you a quick overview of the work that was developed, which placed BEMIS and the network in an advantageous strategic position to be an intermediary partner, by engaging people and preparing them to participate in a vaccination campaign. I hope that members will have had the opportunity to read our submission on the vaccine information fund and on the timeline, as well as the annexes with notes of the meetings that we had with Scottish Government officials.

The first vaccine was administered on 8 December 2020. On 9 December the resilience network met senior Scottish Government vaccination officials, including Julie Hoey and a couple of others whose names escape me at the moment, for which I apologise. The Scottish Government was always proactive in attending meetings and participating in the discussions. There was a really positive attitude at that time, looking forward to the impact of the vaccines.

We then received a bit of a hammer blow—as everybody else did—with the appearance of the Kent variant and Scotland going back into full lockdown in January 2021. The resilience network had to move rapidly at that point. As I think you will all remember, there was clear recognition that we were in a race between vaccination and spread. We had to ensure that the communities that we were working with had access to the information that was required to increase and inform consent. We knew from other experiences during the pandemic that not everybody accesses information and services in the same way. That was very much the case for the multitude of communities that we were working with and supporting.

In early February 2021 we cast another wide net for developing specific intelligence on the vaccine and on potential barriers to accessing it. That involved our resilience network members and others. We developed that information over the month of February. Among the challenges that came up in our discussions were people's perceptions of the vaccination campaign. Given that the actual vaccines had not been tested on a diverse enough population, and that different vaccines were being tested on different racial groups—there were different vaccines for black and white people—some people thought, "If I go for the vaccine, I might be deported." That came through very strongly.

For people who had had an incredibly negative interaction with the Home Office and who were designated as having no recourse to public funds, all those experiences built a picture of their engagement with the state. People were approaching vaccination with real trepidation that their accessing that particular method of support might have significant repercussions for them. Some of the issues were generic. The whole population was interested in what the ingredients of the vaccine were and how the vaccines were developed.

The pressure of the pandemic and of the lockdown, the increased mental health challenges and the expansion of destitution all had impacts on people's engagement with services. For people whose first concern when they wake up in the morning is how they will feed their children, things that we all might take for granted are not so obvious.

We knew that we had a professional and civic obligation to intervene. We submitted our findings to the Scottish Government, and our proposed actions and responses were suggested by our membership. We said that trusted local partners—community members in positions of respect—should be used to share information, and that events such as online question and answer sessions with health professionals, with translation support, about vaccination would help to increase the number of people who were accessing information. Not everybody accesses written information; visual information and other things are better for some people. With translation, overcomplicated language was sometimes used. We outlined a number of other suggestions, but members will get the general flavour of what we said. You can look at our submission if you want to see other proposals.

When we outlined to our colleagues in the race equality unit some of the barriers that we thought there would be and some of the solutions, they pretty rapidly provided us with funding to take the work forward. We received from the Scottish Government a first tranche of £50,000 and then a further payment of £40,000. All in all, over the full duration of the campaign we received £90,000 to try to move the dial in terms of vaccine uptake within ethnic minority communities.

We have provided a summary that you can read, so I will not go through every bullet point. You can pick up on issues on which you have specific questions. Suffice it to say that, from March to September, 45 community organisations, which are listed, were funded. From Public Health Scotland's data, we can see that uptake of first and second vaccinations increased quite considerably. On 1 May, among the racial classification "white", uptake was 64 per cent, compared with 39 per cent among Asian people, 34 per cent among African people and 37 per cent among Caribbean or black people. There were quite big disparities. By late August, uptake among Asian people had climbed from 39 per cent to 76 per cent, uptake among African people had gone from 34 per cent to 66 per cent, and uptake among Caribbean or black people had gone from 37 per cent to 66 per cent. Obviously, the NHS, Public Health Scotland and agencies such as BEMIS did a significant amount of work to move the dial, and we began to see some significant positive impacts.

One of the biggest challenges that we faced at the start of the vaccination campaign was that ethnicity data was not collected at the point of vaccination. When that data was collected, there were stories in the press about there being some malicious reason for the change, but from our perspective, we wanted to support our members, who had been calling for that for a long time. We had needed ethnicity data from the start so that we had real-time data and intelligence and would know where to channel resources. Instead, we had to cast a wide net and hope for the best. Some significant gains and positive impacts came from the change.

As the inclusive vaccination campaign continued, our community intelligence continually showed that stubborn challenges to vaccination uptake remained in African, Caribbean and black communities. In response, with the resilience network we set up the African, Caribbean and black inclusive vaccination sub-group, which continues to be chaired by Margaret Lance, from women in action, and Dr Charmaine Blaze, from Unison's black members committee. The work is on-going in real time. The group has worked diligently to respond to vaccination challenges among those demographics.

The group has also commissioned research into the vaccination experience of members of those ethnic groups in relation to first, second and third doses. As you all know, the vaccination campaign changed rapidly at times; getting on top of that was a real challenge. There were gains in the number of first doses from March to May, but we do not have the indications that the numbers have been maintained for second and, in particular, third doses. There might be a number of reasons for that, not least of which are the general success of the vaccination campaign and our ability to move further out of lockdown.

That research is on-going and is nearing its end, and will be published in August and launched alongside the Scottish Government's research by IPSOS Mori into the vaccine experience of those communities. We will do that in conjunction with the Cabinet Secretary for Health and Social Care.

11:30

There is a lot in what I have said. We look forward to discussing it with colleagues. The big takeaways are the recommendations that we have made that should be legacy recommendations for public bodies. We should recognise that, without the strategic interference of ethnic minority communities, who really led the charge at grass-roots level in increasing informed consent, the vaccination campaign for those groups would not have been as successful as it was. We would like to acknowledge that today, and we look forward to further discussion with colleagues.

Emma Fyvie (Clackmannanshire Council): Good morning, and thank you for the opportunity to present to the committee. I am the senior manager for development at Clackmannanshire Council. I have prepared a set of nine slides, which members should have before them. I will refer to those as I go through my presentation.

The title slide refers to a wellbeing economy. What is that? For anyone who might be less familiar with the concept, it is about ensuring that our society thrives across economic, social and environmental dimensions—it is about putting people and planet at the heart of our economic system. Through the wellbeing economy project, Clackmannanshire Council is working in partnership with the Scottish Government to develop and test a framework for delivering a wellbeing economy across our area.

The second slide sets out the six-stage framework that we are applying for the project. The framework builds on the five key outcomes of the inclusive growth framework, which are productivity, population, participation, people and place. The wellbeing economy framework also takes into account a wider set of environmental considerations and indicators around the circular economy, biodiversity, natural capital and land use. The framework helps us to look at all the levers in the system that could help to deliver wellbeing economy outcomes, and it focuses decisions on those outcomes rather than on specific interventions or policy areas. Most importantly, the work is about moving beyond the data and evidence to understand priority areas for action and identify the tools and levers that we have to deliver change.

My third slide is on the wellbeing economy story in Clackmannanshire. To understand how the area compared to neighbouring local authorities and to the Scottish average, performance on a variety of wellbeing economy indicators was benchmarked over a period of time. From the data analysis, we identified seven key themes covering a range of areas that are set out on the slide. As part of that process, we mapped those themes against the national performance framework, Scottish Government priorities and Clackmannanshire’s local outcomes improvement plan and child poverty action plan to ensure alignment with local and national priorities.

The fourth slide is on understanding what drives performance. In the second stage of the wellbeing economy project, we took each of the themes that we had identified and focused on understanding what was driving the outcomes in those areas. That was followed by a programme of extensive stakeholder engagement to help us to test the evidence base and fill any gaps in our understanding. We also incorporated evidence from a local business survey to better understand Covid impacts and wellbeing economy priorities for businesses in the local area.

Slide 5 is on the SIPHER—Systems Science in Public Health and Health Economics Research—systems mapping exercise, which was used to better understand the links and strength of links between different aspects of our local system. In partnership with the SIPHER research consortium, we hosted three interactive online workshops with 54 participants from Clackmannanshire Council, the Scottish Government and other key public and third sector organisations. The SIPHER workshops were based on the seven key themes that were identified in the initial stages of the wellbeing economy project, which allowed participants to explore causes, effects and dependencies in the local system.

The evidence that was gathered was used to produce a systems map showing the relationships between key components of the local wellbeing economy in Clackmannanshire. Slide 6 shows an example. With the help of the SIPHER team, we used such systems maps to strengthen our understanding and to recognise where factors that drive outcomes are impacting across multiple themes. This slide shows an example of the key factors that were identified by workshop participants as directly influencing and driving outcomes around the quality of jobs in Clackmannanshire.

Slide 7 shows the influence of quality jobs. The SIPHER systems mapping has helped us to identify where factors impact across multiple areas in the system. On this slide, you can see the potential impact of focusing interventions on improving the quality of jobs. Ensuring that individuals have access to jobs with fair pay, fair and flexible contracts and opportunities for progression directly impacts on poverty, mental health and financial security across the local area.

Slide 8 deals with priority areas for intervention. Following the completion of the systems mapping workshops, all of our data analysis and systems mapping evidence was combined to identify a list of about 30 key factors that drive wellbeing economy outcomes in Clackmannanshire. To help us to identify the most important priorities for delivering transformational change in the local area, we worked with the Scottish Government to carry out a prioritisation exercise.

The 30 driving factors that we had identified were prioritised using two dimensions: impact, which involves the impact that something is having on the wellbeing economy and how strong the evidence base is, and deliverability, which involves stakeholder preferences—essentially, how important something is to stakeholders—as well as consideration of how challenging change would be from the perspective of time and funding. The seven areas on slide 8 emerged as being key for delivering wellbeing outcomes in Clackmannanshire, because there was strong evidence to suggest that interventions in those areas would have a high impact and that they were considered deliverable by local partners.

Slide 9 gives some case studies of the implementation that we have undertaken. The in-depth understanding of our local system will help us to ensure that investment and policy interventions are targeted where they will have the most impact in delivering our wellbeing economy objectives.

One of the practical ways in which we can achieve our wellbeing economy vision for Clackmannanshire is through our community wealth building action plan. That was developed with the Centre for Local Economic Strategies and is being reinforced through formal commitment to community wealth building by the council and our community planning partnership—the Clackmannanshire alliance—with the inception of Clackmannanshire's wellbeing economy anchor partnership.

We have a number of community wealth building case studies, including the Alloa hub, in our main town in Clackmannanshire. Derelict council-owned public toilets are being converted into a high-quality active travel, heritage and community hub, using the Scottish Government's town centre funding. Community shares are being sold to raise funds and to ensure that the community has a stake in what is a valuable community resource.

Another example is the integration of community wealth building into the Stirling and Clackmannanshire city region deal, through the approved full business case for Scotland's international environment centre.

We have the Clackmannanshire good employment charter, which is a pledge that our businesses and agencies can take that commits to a range of fair work practices. We also have progressive procurement. We are funding a new procurement officer post in order to get better at using our local supply chain whenever possible.

The Clackmannanshire alliance, our community planning partnership, has agreed to the creation of a wellbeing economy local outcome improvement plan, to ensure that work that happens across the council aligns and contributes to our wellbeing economy vision. We intend to use the themes that we have identified through the wellbeing economy work as a basis for stakeholder events that will be held in support of the development of that plan.

We have the Alloa transformation zones approach, which is a place-based, whole-systems approach to transforming our largest town and is led by the council, with assistance from the Scottish Futures Trust. It is in its very early stages, but it recognises that transformational change is needed across Clackmannanshire, and specifically in Alloa. A wide range of people in the town are doing focused work and perhaps not everyone is aware of what the others are doing, so we need to consider whether there are overlaps or gaps.

We are aware that potentially significant levels of funding are coming into the town through our city region deal and other Government funding. The transformation zones approach aims to bring together all the activity and investment that is focused on the town and ensure that it is co-ordinated with the overall aim to improve community life and economic resilience.

Clackmannanshire has been selected for a full support package from the shaping places for wellbeing programme, which is led by Public Health Scotland and the Improvement Service. The package focuses on Alloa, our largest town, and will support us in looking at what impact place has on people's wellbeing, and specifically on health inequalities. The programme aims to achieve a set of place and wellbeing outcomes that are based around the national performance framework, including active travel, natural spaces, fair work, quality housing, feeling safe and influence and control. The thought process is that our people should really be able to thrive if those outcomes are achieved.

My last example is the Clackmannanshire family wellbeing partnership, which aims to improve the wellbeing and capabilities of families and young people in Clackmannanshire, working with families to support what matters to them. The council is working in partnership with Columba 1400, and the project is funded by the Scottish Government's social innovation partnership. The family wellbeing partnership works to empower young people, their families and our staff in the council by giving them voice and agency. It includes a focus on what needs to change in the existing system to shift people's values and behaviours and, through it, people have been designing, delivering and receiving support in Clackmannanshire communities since 2018. The partnership supports us to roll out values-based leadership across the whole system.

A critical foundation of the family wellbeing partnership is shared values, attitudes and behaviours that are focused on finding different solutions for what matters most in our communities. Columba 1400 has worked with young people, families and Clackmannanshire Council front-line staff, senior leaders, community partners, elected members and senior members of the Clackmannanshire alliance, and that work is on-going.

That concludes my presentation. Thanks for listening, and I am happy to take any questions when appropriate.

The Convener: Thank you, Emma. Our final presentation is from Dr Gillian Purdon from Food Standards Scotland.

Dr Gillian Purdon (Food Standards Scotland): Thank you, convener, and good morning. Thank you for the opportunity to present evidence in relation to inequalities on behalf of Food Standards Scotland.

To give a bit of context, our remit covers all aspects of the food chain that can impact on public health, with an aim to protect consumers from food safety risks and to promote healthy eating. We know that a key determinant of health and wellbeing is diet, and we know that considerable and long-standing health inequalities are associated with that.

Food Standards Scotland has a statutory objective to improve the extent to which members of the public have diets that are conducive to good health. To achieve that objective, we support the Scottish Government by providing advice and evidence on actions that will support consumers to have healthier diets, through a focus on prevention rather than treating the impact of a poor diet over the life course.

We consider that at a national level, and our work complements a lot of the local activity that we have just heard about. We explore policy options at both levels to improve diet and diet-related health inequalities across the population. To help inform our recommendations, we have monitored the Scottish diet and tracked the purchasing behaviours of people who live in Scotland for a number of years.

I will give a quick overview of diet and diet-related inequalities in Scotland. Our evidence shows that we are a long way from achieving our Scottish dietary goals, which represent the direction of travel and the extent of the dietary change that is required to reduce the burden of obesity and diet-related disease in Scotland.

Our current diet is too low in fruit, vegetables and fibre and too high in saturated fat and sugar. That problem is not particularly reserved to any particular group; poor diet exists across the whole population. However, we know that those people living in the most deprived areas tend to have the least healthy and most energy-dense diets.

11:45

A poor diet has big implications for our long-term health. The association between poor diet and health outcomes such as heart disease, type 2 diabetes and certain cancers is well established but, as we heard earlier, the pandemic has brought into sharp focus the adverse health consequences that can arise for those who live with overweight or obesity. Strong links between deprivation, diet and health outcomes exist. Individuals who live in the most deprived areas are more likely to live with overweight or obesity than those who live in least deprived areas. That has been accentuated since the pandemic.

I will talk a little bit about some of the approaches to tackling those dietary inequalities. It will be no surprise to the committee that that is a complex problem and has no single solution.

Although public information and education have a role to play, the food environment directly influences our purchase and consumption choices. It currently exploits biological, physiological, social and economic vulnerabilities to heavily incentivise and promote overconsumption of unhealthy foods. The evidence base indicates that addressing systemic issues in the food system is most likely to have the greatest and most equitable impact on diet, sustainability and, ultimately, health improvement.

Such changes are not quick fixes. They are long-term measures and it will be a long time before the benefits are realised. However, they offer the potential to reduce, rather than widen, inequalities because they require little conscious effort by individuals and help to change the dietary patterns of the population as a whole.

I will give some examples of what has been done so far and things that are currently in train. A positive example of this is the Scottish Government’s flagship policy on school food, which has undergone significant transformation since the Nutritional Requirements for Food and Drink in Schools (Scotland) Regulations 2008 came into force in 2009. The regulations were revised in relation to sugar and fibre in 2020 following advice from us and a technical working group. They have been instrumental in bringing about positive change in schools, but we recognise that there is still more to do beyond schools and with the food environment more broadly.

The planning and design of our food environment can provide opportunities to improve dietary health. Those can include, for example, scrutinising the proliferation of fast-food outlets, which are particularly of concern in our most deprived neighbourhoods, and trying to improve access to healthy, affordable and culturally appropriate food. We recommend that those issues be included in the national planning framework 4, which was recently out for consultation.

Progress towards improving the out-of-home food environment more generally has been slow, in part due to the pandemic itself but also due to the difficulties that many food businesses now face as a consequence of the pandemic. However, we are progressing a number of commitments outlined in the recently published Scottish Government out-of-home action plan to support healthier choices for everyone in Scotland. They include progressing consideration of mandatory calorie labelling at the point of choice; the development of an eating out, eating well framework to support food businesses to offer healthier food and drink; and development of a code of practice for children's menus. Those measures should help to increase the availability of healthier options. It is important that those actions—for example, legislation to put calories on menus—capture businesses that are prevalent in more deprived areas so as to avoid exacerbating existing dietary inequalities.

We also welcome the Scottish Government's plans to consult on proposals to restrict the promotion of high fat, salt and sugar foods. That should make it easier for consumers to choose healthier options when they are out shopping in supermarkets, for example. That is a critical piece of improving our food environment. We know from our data that promotions are currently skewed towards less healthy foods, so the proposed legislation will help to rebalance the situation in favour of healthier options. Contrary to what has been in the press, promotions also tend to stimulate us to purchase more than we might have intended in the first place.

I will address how we tackle wider inequalities. Looking beyond the food environment, structural inequalities that we have discussed—such as income, fuel poverty, and access to education, fairly paid work, childcare, adequate housing, and shops and healthy food—all impact an individual's or family's ability to make healthier food and drink choices. Ultimately, that can impact on their health. From the discussions, we know that the pandemic has exacerbated many of these underlying inequalities. Addressing some of those might be outwith our devolved competence, but there is still a lot that we can do in Scotland.

Food insecurity is a significant concern for many households in Scotland. Again, that has intensified as a result of the pandemic. Data from the 2020 Scottish health survey found that 8 per cent of adults were worried that they would run out of food due to a lack of money, and 4 per cent reported having eaten less than they should.

We know that food price is a major determinant of food choice, and price rises disproportionately affect lower-income groups. Analysis conducted by the Food Foundation demonstrated that healthier foods are almost three times more expensive than less healthy foods for the equivalent number of calories. Evidence from our own tracking survey demonstrates that cost remains a key perceived barrier to healthy eating in Scotland, with 45 per cent of adults stating that healthy eating is too expensive. Back in July 2021, we found that around a quarter of people in Scotland said that they had worried about being able to afford food over the past year and 14 per cent had skipped meals as a result. These findings are hugely concerning, and the situation is likely to intensify given the cost of living crisis, which we have touched on during the discussion. Actions to reduce poverty could therefore impact on dietary intakes and diet-related health in our most deprived communities, which would be very welcome.

I will round up my remarks ahead of the broader discussion. These health inequalities persist in Scotland across a range of outcomes, but one of the starkest indicators is the difference in overweight and obesity rates between the most and least deprived communities. That has a huge impact on overall health, quality of life and, ultimately, economic productivity. The pandemic has also produced disproportionate impacts for a number of groups that we have heard about this morning as well as inequalities in household income and wealth. Those impacts and inequalities are likely to increase. We need to address the causes of those differences in order to start to narrow them.

We might ask ourselves why those living in more affluent areas tend to have better diets. The food system is undoubtedly a factor. It highlights the importance of focusing efforts to increase access to affordable healthy food across the board. Income is a key influence on our purchases, as less healthy choices are cheaper and often highly processed.

For the population to start to meet its dietary goals, a focus on prevention of problems rather than tackling the symptoms of an unhealthy diet is required. That resonates with a lot of the discussion earlier today. We must retain our focus on the food environment, which represents a more equitable way of improving diet. We are well beyond the point where the answer is simply for individuals to choose to eat less and exercise more—the problems really are systemic.

We need to focus efforts on ensuring that everyone has access to sufficient resources. That can go beyond income, spanning housing, education and environmental factors, such as access to green space. The impacts of these broader societal factors must be addressed in order for Scotland as a whole to be a more equitable and healthier nation. It is clear that the adverse health consequences of continuing on our current trajectory represent a situation that is not tenable in the longer term. I am happy to take questions on any of those points.

The Convener: Thank you all for your comprehensive presentations. We have only about—gosh—15 minutes left. Colleagues, you have listened to those presentations. Do you have any questions? Sandesh, please direct your question to whoever has piqued your interest.

Sandesh Gulhane: My question is to Dr Purdon. You mentioned this in your presentation, but I would like to know your opinion about putting calories on menus. You have articulated the benefits of doing that, and I think that we can all see clear benefits. However, I have been contacted by a number of constituents who have eating disorders. They are scared that such labelling will lead them back down the route of anorexia or anxiety. What are your thoughts about balancing those concerns?

Dr Purdon: You make a good point; it is one that we are very much aware of. It is a serious issue for many people. As has been touched on, the pandemic has accentuated mental health problems across the board.

The rationale for putting calories on menus goes beyond providing information to consumers. It gives establishments information about what they are providing, which is not always known. As part of the process, establishments tend to change their minds slightly and reformulate their menus so that they become healthier.

The information is also there for the consumer, and they then tend to order food with fewer calories. We know that putting calories on menus tends to result in fewer calories being purchased, but we also know that it can have a really detrimental effect on those with eating disorders. We need to look at what we can do to mitigate that. The policy has been implemented down south, and there is the option for establishments to have menus without calories. However, we need to look at a broader range of options to see what may or may not be possible.

It is an issue of concern. The Scottish Government is consulting at the moment and we will take on board the feedback and look at what we should do as a result of those considerations.

Emma Harper: That has been one of my concerns as well, as I learn more about the issue. As part of the eating out, eating well framework, there will be an option for out-of-home menus not to have calories on them, for people who have concerns.

The eating disorder charity Beat has concerns about the matter, and the Scottish Government is working closely with it. I am sure that that will inform the evidence as we move forward. Is Beat one of the charities that is involved in developing the process?

Dr Purdon: Very much so. We have been liaising closely with Beat throughout, and it has voiced its concerns. We are taking them very seriously, to see what could be done to mitigate them. As I said, the issue has been accentuated by the impact of the pandemic.

Obviously, we collect a lot of data, including data on what people purchase, and we have a lot of information from the supermarkets. Nutritional information is readily available from the supermarkets, but we have a lot less out-of-home information.

On what is available and what is purchased, it is very difficult to tell, because the same menu item could have vastly different calories in different places. From the consumer perspective and our perspective, it is very difficult to see what is happening without having that information. We have been working with Beat and will continue to do so.

The Convener: Before I bring in Carol Mochan, I have a question for Danny Boyle. At the end of your presentation, you said that there are legacy recommendations. Something struck me when I listened to you talk about the vaccination information campaign that you and partners undertook. In terms of preventative healthcare, you might be able to use some of the lessons that you learned from that campaign to encourage more people from particular ethnic groups that do not access screening in the numbers that could come forward to do so. Is there anything in those legacy recommendations that could be applied to other health interventions?

Danny Boyle: I think so. I will be as brief as possible, given the time. We learned fundamental lessons during the vaccine information campaign about what data was or was not there to inform real-time policy. Fifty-one self-identified ethnic groups participated in the vaccine information fund.

The most recent ethnicity data that we have is from the 2011 census, so it is out of date. As the 2022 census is now under way, this is a good time to reframe how we aggregate and disaggregate ethnicity data, given that Scotland is significantly more diverse now than it has been at any point in the past.

12:00

The recommendation that we made in that regard, which would cover all the different aspects of health provision, is that

> “Health and ethnicity data must be gathered and disaggregated as a core responsibility and function to inform policy and decision making”.

One example of why that is necessary concerns the racial classifications in the vaccine information fund data, which are white, Asian, black, African and other. Those categories are not sufficient to inform a strategic health response. When we got the disaggregated data for the white bloc, it showed that the biggest lack of uptake within a specific ethnic group was among Polish people. If we had not drilled into that and suggested recommendations in response, it might have become a continuing problem. That is obviously reflected in the screening issue, which you picked up on, convener.

The vaccine information fund was a rapid stop-gap measure; it is not sustainable for BEMIS, or for the third sector or the grass-roots communities, to continue to carry that burden, although they did very well and that should be recognised. The basic principle is that, as Scotland's ethnic diversity increases, our health service will need to evolve to respond to that diversity across all provision. That will involve having a really strong grasp of what we are talking about with regard to ethnicity, race and race equality, and creating public services that are capable of understanding and responding to the demographics of Scotland in 2022 and beyond. It will require the disaggregation of ethnicity data, not the aggregation of racial classifications, which do not give us a direct or clear analysis or information on what is actually occurring.

If we then find that there is a lack of uptake or participation within a specific ethnic group, we will be in a position to direct resources to change that.

The Convener: I want to follow up on that. It was interesting to see the list of partner groups that BEMIS deployed to speak to their own communities. I know that the vaccine information fund was a one-off, but is there an opportunity for you to say to the Scottish Government, "Those partner groups undertook that healthcare intervention. Could we put other funding into their hands so that they can undertake additional healthcare interventions?"

Danny Boyle: Yes, to a certain extent. The tension there concerns duty bearers and rights holders. All the groups that are listed are rights holders and deserve a health service and other policy areas that can respond to their needs. The duty bearers' responsibility lies in their legal obligation under the terms of the international convention that I mentioned, and in respect of the provision of public services under the Equality Act 2010 based on the definition of race, which is

"colour ... nationality"

and

"ethnic or national origins."

The listed community organisations, and other citizens, can help to inform what healthcare policy looks like and how it is shaped, but it is not for them to receive funding in order to provide public services. There is a distinction there. They deserve funding and capacity support to enable them to act as active citizens and work with the multitude of agencies and duty bearers that exist in Scotland, but it is not for them to carry that burden.

Perhaps I can provide this information to the committee in writing, because we are heading into a different area here. We were members of the expert reference group on Covid-19 and ethnicity. The reality is that the proportion of our national budget that is allocated directly to equalities and human rights, and within that to the protected characteristic of race, is absolutely minuscule—it does not even register as 0.1 per cent of our national outlay. Even groups such as BEMIS and other compatriot organisations are not duty bearers. We develop intelligence and engage with Government, and we can inform policy—and strive to do so—but there has to be a complete rebuilding of public services to respond to people's diverse needs. There has to be a structural change built in with regard to how we develop a multitude of public services in order to respond to a changing demographic.

The Convener: That is coming across clearly.

I will bring in Carol Mochan.

Carol Mochan: I am interested in 20-minute neighbourhoods and, in particular, how we ensure that, if we build them, they are affordable wellbeing neighbourhoods for people. How affordable are the green spaces and the leisure activities, for example? Do they have co-operatives that provide affordable food? To ensure that that happens, we need to work more across departments. Does Emma Fyvie feel that that is developing in Clackmannanshire?

Also, does Dr Purdon feel that there is enough cross-departmental working in relation to food and whether it is affordable and in the right place? Do the planning departments make sure that they take those things on board?

The Convener: Would you like to hear from Ms Fyvie or Dr Purdon first?

Carol Mochan: Either—I am interested in how they feel that the approach is working at a local level and at a national level.

The Convener: Let us hear from Clackmannanshire first and then we will come to Gillian Purdon for the second part of your question.

Emma Fyvie: We are definitely interested in 20-minute neighbourhoods and having a whole-systems approach to everything that we are doing. That is what we are aiming for with our transformation zones approach. A huge amount of activity is going on right across the system on housing, and with our third sector partners. A range of different activities is going on and we all want to communicate and try to establish those relationships so that we can work together consistently to make sure that that whole-systems approach is happening.

We have really good partnerships with our third sector, which is very active in the area, and with our housing associations, to make sure that housing goes into the right place for the right client groups. That whole-systems approach is definitely being taken forward by Clackmannanshire.

The Convener: We come to Gillian Purdon now.

Dr Purdon: We very much support the whole-systems approach to improvements.

On whether there is enough cross-departmental working, the situation is much improved, but there is still more that could be done. There are opportunities to link in—the planning framework is a good example of where health and wellbeing could be elevated up the agenda. It is very difficult for a local authority, for example, to refuse planning permission for a fast-food outlet, even when there is a proliferation of those outlets in the local area, so there is more that could be done. We very much support that whole-systems approach.

We are linking up far better now and working with partners such as Public Health Scotland and with the Scottish Government to support one another. We are working not just with the Scottish Government health department but across the other departments, from climate right through to food and drink. Bringing all that together and having that influence across those different departments can be really powerful and it means that we can weave in some of these considerations. They might be sustainability considerations but they also touch on diet across the piece. Cross-departmental working is improving, but there is probably more that we could do.

Stephanie Callaghan: I have a question for Gill Bhatti on employability. There are specific barriers in relation to neurodiversity and a lot of anxiety and mental health issues are prevalent in the neurodiverse group, too. Quite often, the job interview process screens out neurodiverse people because of the eye contact and social communication skills that are looked for. How is that being monitored? What is the evidence actually saying? What steps are being taken to address that gap?

Gill Bhatti: Interestingly, among the 11 per cent of young people we recruited to council opportunities during Covid who have disabilities are a number with neurodiversity disorders—sometimes on their own but sometimes in addition to physical disabilities. We found that the additional supports that we were able to put in because of the additional funding were very helpful.

We have also learned that we need to prepare staff and colleagues in relation to how to work more closely with people with neurodiversity disorders. There has been an on-going discussion with our colleagues in human resources on that. Again, we have seen the benefits of having the opportunity to spend a little longer with people with those conditions and also of ensuring that their individual needs are met, as opposed to following the sometimes stereotypical assumptions that can be made by colleagues and others.

We have had direct experience of that as a result of the additional funding that we have been able to put in place to give those opportunities. That has been a good thing.

Monitoring is a constant challenge because divulging disability is voluntary and we often find that people are still worried about telling their employer or other large organisations about disability. That is a challenge. We encourage our employee networks and trade unions to reassure people that we ask for that information only to be supportive and to ensure that services will meet their needs. That work is on-going.

Emma Harper: I have a quick question for Danny Boyle about vaccine hesitancy. I worked as a nurse vaccinator during the vaccination roll-out. A number of people—particularly Polish social care workers—talked about fertility issues or were worried about foetal development. How will we tackle fake news and support people in the future to understand that the vaccine is safe? I am sure that we will continue rolling out vaccines in the coming months.

Danny Boyle: The straight answer is that that is really complicated and there is no magic bullet. The issue with Polish people was a legacy of the swine flu pandemic. In our engagement with the Polish community, they told us that there was a strong narrative within Poland that one of the side effects of the vaccination could be narcolepsy and that that had been recognised in academic studies. That narrative had some prominence in the Polish community.

People access information from their home countries, some of which have quite different interpretations of vaccination because of religious or cultural standpoints that then filter into communities here or make them more susceptible to fake news.

Fake news about all aspects of vaccination, including the content, process, side effects and long-term consequences, is a continuing and disruptive challenge. Our partners who are in community WhatsApp groups or take part in Q and A discussions tell us that that affects a number of ethnic groups. The challenge for us, Parliament and Government is that we do not see that information until it has already become embedded within society or within particular demographics. The vaccine information fund was partly intended to equip and empower communities with resources and access to information to try to push back against some of that.

Fake news will affect a swathe of policy areas and will be one of the biggest issues that society faces in the coming five to 10 years. For many issues that we come up against, whether that is the vaccination fund or one of a number of others, there is alternative and non-credible information that takes a grip in many ways that we find hard to unpick.

Although we do not have absolute confirmation of that or data about it, our perspective is that a malicious actor from somewhere else who wanted to sow tension or create issues with community cohesion in a particular society or demographic could use the vaccination issue as low-hanging fruit. Putting out information saying that ethnic group A was not supporting that as much as ethnic group B can create tension on the ground between different communities and can create a narrative that some people are not showing the same commitment to society as others. That is an on-going challenge and we will need resources to respond to it. If something like the vaccine information fund has to be continually deployed, that is fine.

The Polish community itself has done a significant amount of work on that. It would be worth asking Feniks for written information on Polish-specific issues, or speaking to it directly if the committee has another evidence session on the issue.

12:15

For the African, Caribbean and black community, we have on-going research that delves into experiences of vaccination but also how people are getting information. That will be launched in August. It will be an open launch, and committee members are more than welcome to attend, listen and participate. We will share the report in due course, because it is highly likely that there will be another round of vaccinations in autumn, as well as future vaccinations more broadly.

The Convener: That is very helpful. Carry on, Emma.

Emma Harper: I have a final wee question. Are we comparing how New Zealand handled the pandemic with how, for example, America handled it? In New Zealand there is a high level of social solidarity in tackling things, whether vaccine uptake, diversity or health inequalities. In the USA, there are challenges because healthcare is not available to everybody. Are we able to look at such comparisons to see how other people handled not just vaccine uptake but issues around diversity?

Danny Boyle: International comparisons are always helpful to set a benchmark and to see where progress has been made or where we can learn. As an organisation, BEMIS does not have the capacity to do those comparisons. It might be in the committee’s interest to make one of your core recommendations to the Scottish Government that it does a comparative analysis of the vaccination campaigns in the UK and other countries.

Our focus was entirely domestic, because we knew some of the issues that were occurring here. The survey that we did in February 2021 was not rigorous, academic-based, qualitative or quantitative research. We needed to move swiftly, because we were picking up information at a grass-roots level that we did not have the luxury of time to leave lying. Everything that we were concerned about at that point came to pass and has continued. Our focus was purely domestic: it was on getting information to people in a multitude of ways, because that was important—it was a life-or-death scenario.

Emma Harper: Okay. Thanks.

The Convener: I will come to Stephanie, and she will have to be our last questioner, but ahead of that I have a question for Gill Bhatti.

It was interesting to hear what you are doing in South Lanarkshire to facilitate people with disabilities getting into employment. It definitely sounds like it is a success story. One thing that we hear in Parliament is that there is good practice happening in X part of the country, but it is not happening in Y part of the country. Is there a mechanism for people like you who have done such work to share good practice by talking to your colleagues in all our local authority areas who might not have such programmes in place? They could learn from what you do so that they can start programmes that encourage and facilitate more people with disabilities into employment.

Gill Bhatti: There is a network of employability leads across Scotland, which meets fortnightly. We take the opportunity to share good practice there. Often it is not about individual stories but about broader issues such as challenges around data and funding, but the network would be a natural home for sharing that kind of good practice.

We also take the opportunity to share locally. We share some of these "good news stories", as we call them, with our local employability partners because often those partners have had a role in a particular person's journey at some point. That is a good opportunity for everybody to feel that their contribution has made a difference, which will encourage people to do it again.

I would definitely welcome more opportunities to share that kind of good news. It not only helps partners get involved but helps people with disabilities to perceive that they can do it too and that there is help to overcome barriers. Very often the barriers can be significant, but often they can be quite small and it just takes a little helping hand to get over that line.

The Convener: Thank you. The final question is from Stephanie.

Stephanie Callaghan: Danny Boyle, I heard from a patient who had requested access to her medical records and found that many of the medical professionals she had been in touch with had recorded her under different ethnic backgrounds—rather than asking her directly, they had made a decision themselves. Further, assumptions were also made around her diet, for example, because of her ethnicity, but they were not correct. Is that something that is an issue that you are aware of? Is it quite common? Obviously, it has implications for the data that we have. How much of a role does that issue play?

Danny Boyle: The collation and use of ethnicity data to inform public policy has been a considerable challenge for a long time in Scotland and it remains so. Our experience has been that, across the 32 local authorities, there will be 32 different interpretations of what we are talking about when it comes to race and ethnicity. That is reflected in a multitude of public bodies. There is no uniform approach to understanding race and ethnicity, and that creates the discrepancies that you are talking about in terms of the collation of information and data.

As I said in my opening remarks, BEMIS does not believe that the issue should be overcomplicated, because we have the census codes. They are not perfect, but they are good enough to give us much more accurate information. The problem is that, when many duty bearers get the information that comes from those census codes, their policy is to aggregate that into racial classifications—black, white, Asian, Arab, other and so on. However, those are not ethnicities; they are racial classifications. That means that ethnic discrepancies and diversity exist within them. One of our recommendations to the expert reference group on Covid-19 and ethnicity, and to the Scottish Government consistently, is that there should be a policy of disaggregation of that information, so that people can see the detail.

On personal relationships between doctors, nurses, police officers and core public servants and people of different ethnic groups, I think that we must be honest about the fact that there is still a nervousness around discussing race and ethnicity in our society, but that should not need to be the case. It is a simple question to ask somebody—"What is your ethnic group?"—and we have the census codes to help guide that. The question is asked because we want to create public services that are capable of responding to an increasingly diverse population. There is no malicious intent in collecting ethnicity data; it is done to create informed public services, change public perceptions and address structural issues.

We encourage local authorities and other duty bearers to have the confidence to ask these questions in relation to core public services and to be equipped with the basic information about why we are collecting ethnicity data and why it is important that we do so.

Stephanie Callaghan: [*Inaudible*.]—national health service—

The Convener: We could not hear the beginning of your question, because your microphone was muted. Could you start again?

Stephanie Callaghan: Apologies. My specific question was about the national health service and the series of different health professionals and consultants recording different information. How much of an issue is that? Is that being looked at?

Danny Boyle: It is a massive issue. I would imagine, going by our experiences, that different people in various parts of the health system—individual GPs, consultants, occupational therapists and so on—may all have different ways of recording ethnicity data, which is problematic, and some of them, due to their personal experiences, might be more competent than other people with regard to having the confidence to ask the question and have a basic discussion about the issue. There is a nervousness among public health officials about having those conversations with citizens. That is reflected in other core public services.

The Convener: I thank our witnesses for their time this morning and for their presentations. We could have spent a lot more time asking you lots of questions but, unfortunately, we have to round things off now.

Subordinate Legislation

Food and Feed Safety (Fukushima Restrictions) (Scotland) Revocation Regulations 2022 (SSI 2022/166)

12:24

The Convener: The final item on our agenda is consideration of a negative instrument. This instrument will revoke retained Commission implementing regulation EU 2016/6 imposing special conditions governing the import of feed and food originating or consigned from Japan following the accident at the Fukushima nuclear power station.

These regulations also revoke declaration OFFC 2019/S/003, which was made in terms of regulation 35 of the Official Feed and Food Controls (Scotland) Regulations 2009 and which also imposed controls on the import of certain food and feed from Japan as a result of the Fukushima nuclear accident.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 24 May 2022, and made no recommendations, and no motions to annul have been received in relation to the instrument.

Do members have any comments?

Sandesh Gulhane: Although I am in favour of the instrument, I have a concern about why the level of 100 becquerels per kg was set in the first place. If that has a negligible impact, should the level not have been higher?

The Convener: Your comments are on the record.

As there are no further comments, I propose that the committee does not make any recommendations in relation to this negative instrument. Are we agreed?

Members *indicated agreement.*

The Convener: At its next meeting, on 7 June, the committee will consider in private its draft report on its inquiry into alternative pathways to primary care.

That concludes the public part of our meeting.

12:27

Meeting continued in private until 12:41.

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