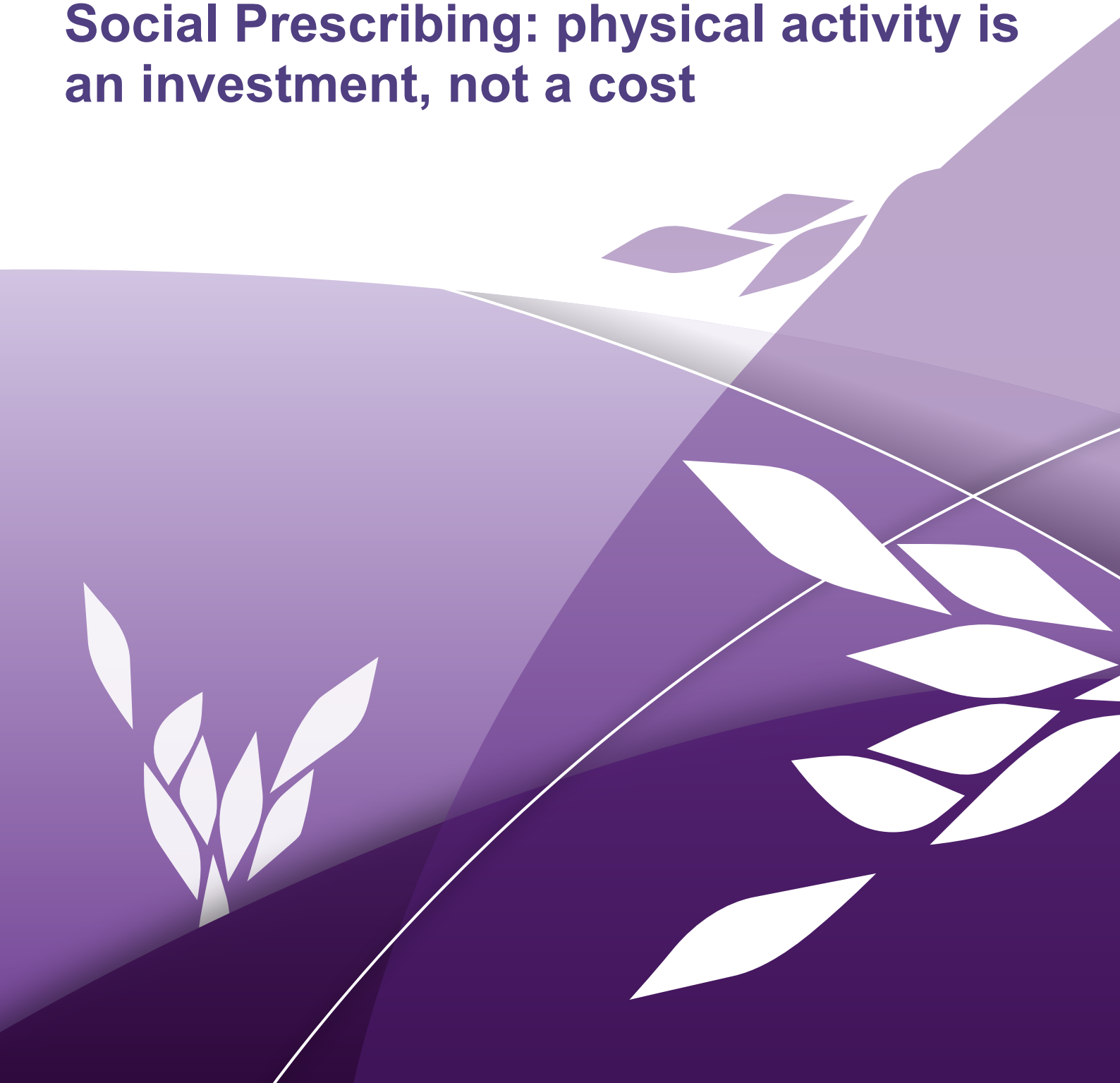
Published 4 December 2019
SP Paper 639
14th Report, 2019 (Session 5)

The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
Comataidh Slàinte is Spòrs

Social Prescribing: physical activity is an investment, not a cost



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To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

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Background to the inquiry

1. In 2019, the Committee agreed to undertake a short inquiry into the social prescribing of sport, exercise and physical activity. The inquiry occurred in response to, and was intended to complement, our more extensive primary care inquiry [1] . During phase one of the primary care inquiry, public participants were interested in the wider aspects of health and wellbeing, and healthy communities.

2. For this inquiry, we wanted to understand how social prescribing for sport and physical activity could improve the health and wellbeing of people in Scotland, and explore the key opportunities for the wider health and social care system. This included:

   - the role of sport and physical activity in preventative health care as well as self-care for health and wellbeing,
   - the role of the GP and the multi-disciplinary team in exercise referral or encouraging self-care and self-management, and
   - how social prescribing for sport and physical activity has been used in health and social care and how this can inform the way future services are managed and delivered.

3. We were also keen to understand some of the barriers to, and drawbacks of, social prescribing as a means for increasing levels of physical activity, exercise and sporting participation levels.

4. We issued a general call for evidence in July 2019, asking four questions:

   1. To what extent does social prescribing increase sustained participation in physical activity and sport for health and wellbeing?
   2. Who should decide whether a social prescription is the most appropriate intervention, based on what criteria? (GP, other health professional, direct referral from community link worker, self-referral)
   3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?
   4. How should social prescribing initiatives be monitored and evaluated?

   We received 97 responses in total. We then heard oral evidence at a round-table session on 29 October 2019. Links to the responses and details of the oral evidence session can be found in Annexe A and B.

5. In this report, we explore how social prescribing is currently used across Scotland and what challenges exist in using these approaches to increase sustained participation in physical activity to improve health and wellbeing. We further examine the potential of wider issues around access to physical activity and sport and how strengthening local assets and communities can complement social prescriptions.

Social prescribing: an introduction

6. Social prescribing is not a new concept. According to the King's Fund [2] , social prescribing approaches have been used in the NHS for many years, with several schemes dating back to the 1990s. There are a number of definitions and understandings of what social prescribing actually is. In a basic sense, most agree that social prescribing is a way for primary care professionals to connect people to a range of local, non-clinical services. NHS Health Scotland [3] further refines these services as sources of support or resources in a local community that have the potential to help people with the health problems they are experiencing.

7. We acknowledge that social prescribing should not be limited to physical activity and sport. We received strong views in response to our written consultation, and during our round table evidence session, that cultural and other forms of recreational activity should be included within the remit of social prescribing and have a proven place in improving overall health outcomes. This view has been supported by colleagues in the Culture, Tourism, Europe and External Affairs Committee during their 2020-21 pre-budget scrutiny [4] .

8. In 2016, we agreed our strategic plan [5] : Our overriding aim is to improve the health of the people of Scotland. As part of this, all of the scrutiny we undertake is focused on health inequalities, prevention, long-term cost-effectiveness and efficiency.

9. Our strategic plan also contains a focus on widening access to physical and sporting activities, including reaching and empowering all sections of the community. The main tenet of this inquiry is centred on that focus. However, we recognise and understand the benefits and importance of social prescribing of other cultural and recreational activities. Most of what we say, and conclude, in this report applies across the full ambit of social prescribing.

10. In oral evidence on 5 November 2019 [6] , the Cabinet Secretary for Health and Sport accentuated the important and valuable contribution that social prescribing can make to people's health and wellbeing. The Cabinet Secretary highlighted how more awareness and understanding of its value is needed, alongside work to ensure the right programmes and services are accessible to those that need it.

11. Existing definitions of social prescribing, and its interventions, ultimately encapsulate a reactive response to health and wellbeing, by referring in response to a health problem. However, there is tremendous potential for a pro-active approach in the wider scope of social prescribing[i] that can improve someone's health and wellbeing before they begin to feel unwell. For example, primary prevention of ill-health.

12. We are clear that approaches to ensure awareness and accessibility of services and structures of support should be preventative. We recognise that a dual

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i Oral evidence during our round table session on 29 October 2019 highlighted concerns with the term 'social prescribing' and suggested a 'social connectedness' approach might be more inclusive. Professor Davison at the same session highlighted that 'lifestyle coaching' could be used to communicate promoting healthy lifestyles.

approach, comprising reactive and proactive measures, is needed to improve the health and wellbeing outcomes of people in local communities. This could, over time, ease pressures on NHS and social care resources. Written submissions highlighted that opportunities created for people to participate in sport and physical activity also improved social connectedness, preventing and addressing social isolation. A view echoed during evidence sessions.

13. In order to maximise desired outcomes, we acknowledge the need to ensure opportunities to participate in physical activity and sport are more accessible.

14. We are convinced that social prescribing has the capacity to be both proactive and reactive. Within this inquiry, we were keen to explore and achieve balance between proactive and reactive approaches that use social prescribing to reduce and prevent ill-health and poor wellbeing.

Physical activity and sport

15. There is a plethora of existing evidence to support the use of physical activity in maintaining and promoting healthy lives. The 2019 UK Chief Medical Officers' Physical Activity Guidelines states a very clear message:

> If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat [7] .

16. According to NHS Health Scotland [8] , physical activity has multiple health, social and economic benefits, and inactivity is a leading cause of premature death. The Scottish Public Health Observatory (ScotPHO) state that when the least active people increase their physical activity, the greatest health benefits occur[ii].

17. Martin Hayman of Table Tennis Scotland [9] talked about additional benefits from participating in and engaging with sporting activities on 29 October 2019. In his experiences within an organisation that enables and engages older people in sporting activities, one of the greatest outcomes witnessed is increased social engagement.

18. We are agreed and are clear that we do not require any further evidence in relation to the efficacy of physical activity on improving health and wellbeing. Direct correlation and causation has been proven and should be accepted by all sectors.

ii The ScotPHO collaboration is led by ISD Scotland and NHS Health Scotland, and includes the Glasgow Centre for Population Health, National Records of Scotland and Health Protection Scotland

Preventative action

19. In 2018, we undertook an inquiry into preventative action nationally to support good public health outcomes [10] . That work built on the 2011 Christie Commission report on the future delivery of Public Services in Scotland [11] . The Commission highlighted that public services needed to undertake a preventative approach to address persisting problems of multiple negative outcomes and inequalities. Creating social connectedness through the concept of social prescribing has the potential to holistically challenge and change those outcomes and inequalities.

20. In an oral evidence session on 4 June 2019 held to inform our 2020-21 pre-budget scrutiny, Sandra Ross, chief officer for Aberdeen Integration Joint Board, advised:

> We need to start looking at the whole system and thinking about how to shape the prevention agenda. How do we make sure that we will have fitter adults? We need to focus on our children, then we will have a less ill population in the future. That prevention agenda will help to shift that balance. Given the demographics, it will be extremely difficult to maintain things if we continue with what we are doing at the moment [12] .

21. In our Preventative Action and Public Health report [13] , we outlined three levels of prevention:

- Primary prevention, a population-wide approach to stop a problem arising or to change the social or physical environment.
- Secondary prevention, individual approaches to identify a problem at an early stage and undertake an intervention to minimise or reverse harm.
- Tertiary prevention, individual approaches to identify and to stop a problem becoming worse.

22. Through the scope of our inquiry, it has become apparent that the full suite of social prescribing measures has the capacity to effect change at all three levels of prevention. We consider the greatest potential, greatest benefits and greatest overall savings lie through taking a primary prevention approach over the long-term. Yet, we recognise that work is also equally essential concurrently to reverse the effects of harm or stop health and wellbeing issues worsening (secondary and tertiary prevention).

23. Launching the Scottish Government's strategy for tackling social isolation and loneliness in 2018 [14] , the Minister for Older People and Equalities, set out the effects of loneliness on physical and mental wellbeing and announced it should be treated as a public health issue, and addressed using a preventative approach. We agree with this summation and note the potential of social prescribing to help prevent and tackle issues such as social isolation and loneliness through community connectedness.

What is stopping social prescribing?

24. Traditional concepts of social prescribing, seen as interventions through primary care, or rehabilitation following secondary care, are secondary and tertiary prevention. This is most commonly delivered through interactions with GPs or other members of the multidisciplinary team within primary care, but also occurs as part of rehabilitative interventions within secondary and tertiary care. As such, traditional social prescribing elements rely on interventions from health and social care professionals and contain a process of referral.

25. The Health and Social Care Alliance [15] highlight that a social prescription can involve a range of interventions. These can vary from person to person and can require different levels of input from referrers and referred-to services. They distinguish between:

- signposting to local resources,
- formally referring to a local resource, and
- a link worker process that works with an individual to support them to effectively utilise resources, in a way that is meaningful to them, that allows them to take greater control of their health and wellbeing.

26. In 2010, Deep End Report 8 [16] summarised a small survey of GP knowledge and experience of social prescribing. That report highlighted five key interventions that would support more effective social prescribing by GPs in deprived communities:

- Benefits reform that reflects the realities of life in Scotland's poorest communities.
- An internet directory of community resources: if it was user friendly, locally relevant and kept up to date.
- More medical and nursing time in consultations to respond to very challenging needs with clear explanation and guidance.
- Clear guidance for patients and organisations approaching GP practices for reports or advocacy support.
- Increased funding to voluntary and local agencies in deprived communities.

27. Following the Deep End report, the Scottish Government initiated the Links Project[iii], and Link Worker Programme[iv] to tackle these challenges. There are currently 112 [17] Scottish Government-funded Community Link Workers supporting people within the most deprived areas in Scotland according to the Scottish Index of Multiple Deprivation (SIMD). Evidence submitted to our inquiry outlines the successes of the Community Link Worker programme, but we are aware that a number of the above concerns still exist across Scotland. We welcome the Scottish Government's recent commitment to deliver 250 Community Link Workers over the life of the Parliament (by 2021) [18] .

28. NHS Health Scotland and the Scottish Directors for Public Health [19] submission to our inquiry highlighted that social prescribing has the potential to achieve sustained participation in physical activity that will improve health and wellbeing. Citing evidence from Public Health England, the submission notes the clear role of health professionals:

> It is estimated that one in four people would be more active if advised to do so by a health care professional [20]

29. The submission goes on to accentuate that successful interventions should be person-centred, include elements of health behaviour change, and signpost or formally refer to appropriate activities.

30. NHS Health Scotland has developed The National Physical Activity Pathway [21] , outlining a set of steps healthcare professionals can take to encourage the people in their care to be more active. They also undertook an audit of Exercise Referral Schemes in Scotland [22] in 2018. The results showed that most geographical locations across Scotland had exercise referral schemes, with varying approaches, structures, partners and efficacy.

31. Written evidence highlighted a number of barriers to the efficacy of social prescribing to sport and physical activity. Primary concerns included:

- referrers and referral pathways,
- differences between medical and social models of care
- resources and funding,
- awareness and understanding, and
- quality assurance.

We look at each of these in turn in the following sections of this report.

32. We welcome a further update on the Scottish Government's commitment to deliver 250 additional link workers across Scotland. We particularly welcome detail on where post-holders will be based and what their remit will be, including any differences in rural and urban areas. We recommend link workers should be tasked with helping break down any barriers people face to taking part in physical activity and sport.

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iii The Links Project involved six GP practices working together to increase their use of social prescribing

iv The Link Worker Programme was a five year collaborative project between General Practitioners at the Deep End and the Health and Social Care ALLIANCE aimed at embedding a full-time community links practitioner in seven Deep End practices

Referrers and referral pathways

33. A number of submissions highlighted referral pathways to receiving social prescriptions. There was not a consensus on whose role it should be to refer people onto such activities.

34. Most commonly, social prescriptions are issued by general practitioners (GPs). However, the evidence suggests there is mixed enthusiasm for and knowledge of social prescribing among GPs.

35. In a primary care evidence session on 19 November 2019 [23] , with members of the public, George Burton highlighted an area of good practice: a partnership between the Royal College of General Practitioners (RCGP) and parkrun UK [24] . This partnership aims to promote the health and wellbeing of staff and patients alike in local communities. Under this initiative, GP practices develop close links with local parkruns to raise awarensess, increase social prescribing and contribute to a local community and environment centred on increasing wellbeing. Likewise, during our primary care evidence session on 1 October 2019, Jonathon Burton noted:

> I am an independent prescriber and, in my pharmacy's consultation room, I have two pads on my desk: a prescription pad and a pad of TARGET[v]...self-care leaflets ...I tear more sheets off the self-care leaflet pad than the prescription pad [25] .

36. Dr Katie Walter [26] highlighted the benefits of social prescribing by healthcare professionals where there is enthusiasm, buy-in and knowledge of promoting physical activity schemes. However, Dr Walter noted this can often be person-dependent, describing barriers around a lack of training and expertise, knowledge and understanding, and a reluctance to discuss improving physical activity as a response to ill health or poor wellbeing.

37. The Physical Activity for Health Research Centre [27] , part of the University of Edinburgh, reported that in 2017, over 80% of GPs in England were unfamiliar with the UK Physical Activity Guidelines and over 70% did not discuss health behaviour with their patients.

38. The Argyll and Bute Health and Social Care Partnership [28] noted that not all GPs support the concept of social prescribing. It cited various reasons being given for this including time constraints, not perceiving it as part of their role, and a lack of strong evidence demonstrating the long term effectiveness of social prescribing.

39. We heard evidence as part of our primary care inquiry from third sector and community link worker representatives on 8 October 2019. During that session, Dr John Anderson [29] referred to the increasing role for community link workers and other social prescribers in primary care as social connectors in local communities. The Royal College of General Practitioners (RCGP) [30] highlighted the value of community link workers, viewing the roles as key conduits between clinicians and wider services. The RCGP regard link worker posts as vital to reducing clinician workload. A number of written submissions supported this view and consider the

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v TARGET —treat antibiotics responsibly, guidance, education, tools.

posts as key to achieving sustainable interaction with services and improving health and wellbeing outcomes.

40. The written submissions received did not point to one single point of referral for social prescribing. More important was the focus on person-centred and individual approaches, working with people, to ensure that activities could be undertaken and sustained. During our social prescribing roundtable on 29 October 2019, there was strong consensus that social prescribing should be part of everyone's role.

41. Dr William Bird [31] of Intelligent Health stated that social prescribing should not just be in primary care, and should be undertaken across all areas of life, including within education settings, workplaces and communities. Kirsty McNab [32] , of Scottish Sports Futures echoed this stating there was a role for everyone in society, and a need to recognise the value in each contribution. We consider there is a wider role on both referral and access to social prescribing and associated activities, which does not necessarily need to be solely the purview of health and social care professionals.

42. We recommend Scottish Government supports NHS Boards and Integration Authorities (IAs) to invest in engagement work to raise awareness and understanding of social prescribing, and other primary prevention activities round promoting physical activity, and their benefits to the public.

43. We recommend IAs develop and roll-out awareness and education work of social prescribing and other primary prevention activities around promoting physical activity, across all heath and social care professionals.

Differences between medical and social models of care

44. In Scotland, 90% of all health contact takes place in primary care [33] . Most people first experience health and social care services through visiting GP surgeries, dental practices or pharmacies when they are unwell. In these circumstances, people are used to receiving medical prescriptions or referrals to other health and social care services.

45. Kim Atkinson, Chief Executive Officer of the Scottish Sports Association highlighted the public's ease with medical prescriptions [34] . The medical model can be summarised as where a prescription is issued and fulfilled for free, with defined processes on how someone should interact with services and processes to make that happen. Medical prescriptions set out what is required, along with the how and when.

46. This is in stark contrast to social prescriptions. Abertay University noted in its submission that social prescriptions do not currently follow the same model. Both prescribers and patients are not culturally accustomed to, or familiar with, social

prescribing [35] . It outlines how systems of social prescribing rely on a number of necessary steps.

1. Health and social care professionals need to understand the benefits of the prescribed activity, to understand what local services and activities exist, and have a pathway to refer into that activity.

2. Individuals need to understand the benefits of undertaking a prescribed activity, being ready and confident to participate in the activity, and have support in place to allow them to do so. This often includes, transport, participation costs and capacity to interact.

3. Services need to understand people, be able to engage and build confidence, understanding, competence and motivation, and have support in place to help them achieve their health and wellbeing outcomes.

47. Further disparity exists around the resourcing of social prescriptions as noted in the Scottish Sports Association submission. Medical prescriptions are provided free of charge as long as they are required, based on clinical judgement. This is diametrically opposed to feedback received from some social prescribing approaches, where an individual patient is expected to pay all or part of the cost of the activity [36] . We consider this aspect of social prescribing could risk widening the inequality and access gap in Scotland. Individuals might have to pay for the activity, transport to get there, if transport is available, and, potentially childcare or other costs. Medicines don't usually require time or further money for individuals, activity does.

48. Evidence shows that while there are examples of good practice across Scotland, exclusively following a medical model to offer social prescribing will be insufficient to deliver positive improvements in the health and wellbeing outcomes of the nation. Systems are not always in place to support people through the process and there are not enough resources, structure or investment to achieve consistent positive outcomes across the country. It became apparent through the evidence submitted that social prescriptions are often viewed as an opportunity rather than a necessity.

Resources and funding

49. Evidence to our primary care inquiry suggested that a lack of resource is a significant barrier to sustainable social prescribing. The Royal College of General Practitioners (RCGP) [37] highlighted that sustainable and reliable funding of appropriate third sector organisations is required to successfully deliver social prescribing programmes.

50. The Scottish Council for Voluntary Organisations (SCVO) noted the recent resources that have gone into supporting the community link worker role as part of social prescribing initiatives [38] . They highlight the National Lottery Community Fund report [39] which recognised that the services professionals refer to are nearly always provided by the community and voluntary sector.

51. Social prescribing schemes do not fund services or offer resource to help with their capacity to deliver what is required. Regardless of referrer, social prescribing schemes nearly always rely on the availability, capacity and readiness of third sector organisations and sports clubs.

52. We are clear that further work is needed to ensure that voluntary and community organisations have the capacity and capability to fulfil socially prescribed activities.

53. We recommend social prescriptions are treated on an equal basis to medical prescriptions, when issued by health and social care professionals. This raises questions around associated resources and funding which should be addressed. We would welcome detail from Scottish Government of how that can be achieved.

Awareness and understanding

> With something such as social prescribing...we need to look at how we roll out the understanding of its value more effectively [40] .

54. The Cabinet Secretary for Health and Sport spoke to us about approaches to both self-management and social prescribing on 5 November 2019 [41] , during an evidence session on primary care. The Cabinet Secretary highlighted that acceptance by both public and professionals is key to its implementation and sustainability. Evidence from the written submissions reinforced this view.

55. A number of submissions highlighted the need for more public awareness of social prescribing and the value it can bring to people's lives was required. The general consensus was that people who are only used to receiving prescriptions under the medical model, will not be used to, or in some cases, be prepared for a social prescription.

56. As a consequence, it is clear there is a need for mechanisms to address social and cultural attitudes, and to enable capacity and confidence building with individuals. NHS Greater Glasgow and Clyde [42] noted in its submission that a successful social prescription is dependent on an individual's readiness to engage. It notes that many people may require considerable support to remove barriers, such as lack of confidence and stigma, as well as motivational intervention and information to attend services.

57. Likewise, NHS Western Isles explores a number of barriers [43] , which were also observed in other submissions. These include time to participate, the cost of participation, the location of facilities and transport arrangements, and a potential or perceived potential of intimidating environments and lack of awareness.

58. There is an education, understanding and awareness role for health and social care professionals, or other referrers. Written evidence noted significant barriers for

referrers, including a perceived lack of awareness of benefits of physical activity, what services are available in the local community, the range of services within providers and quality of those services.

59. Dr Katie Walter's submission noted that a good signposting agency or a well resourced local third sector interface organisation would be valuable [44] .

60. ALISS [45] (A Local Information System for Scotland) was mentioned in a number of submissions and in oral evidence. Hosted by the Health and Social Care Alliance (the ALLIANCE) and funded by the Scottish Government. ALISS is an online database that is intended to enable organisations, communities and individuals to view services available in local areas. The website provides a postcode and keyword search facility for people to find local organisations and initiatives within the vicinity of the postcode given. However, written submissions suggest that experience of the ALISS platform has been variable, with inconsistent application and updating of information across the country.

61. A national information tool such as ALISS, which is regularly updated, and has direct access and buy-in from other local community mapping tools would be advantageous to promote awareness of local activities and services across all stakeholders. Such a tool could be used in both social prescribing and primary prevention activities. We welcome detail on how this can be achieved.

Quality assurance

62. We became aware of some quality assurance concerns from some professional groups when social prescribing, or recommending physical activity groups in local areas.

63. In his evidence on 8 October 2019 [46] , Dr John Anderson, highlighted a reticence of health professionals to refer to local services due to concerns over quality assuring multiple organisations. Kirsty McNab of Scottish Sports Futures echoed this on 29 October 2019 [47] , highlighting a recent Audit Scotland report showing that many healthcare professionals are still reluctant to refer to the third sector.

64. We are aware of the existence of established frameworks on the efficacy of physical activity and sport initiatives on working with individuals to improve health and wellbeing outcomes. Such examples include the Active Scotland Outcomes Framework [48] and **sport**scotland's strategy, Sport for Life [49] , which outlines a vision of an active Scotland where everyone benefits from sport. We are clear that local community and voluntary organisations should have well-developed outcomes, and be able to demonstrate delivering on these outcomes. If these are generally in place, we see no necessity to prove success in relation to each referrer.

65. The UK Chief Medical Officers recommendations [50] on physical activity guidelines definitively prove that the more time someone is physically active, the greater the health benefits they enjoy. The report also highlights the risks of inactivity and sedentary behaviour for health. Their recommendation is clear that the policies and

programmes to promote physical activity, sport, exercise and active travel are vital to achieve health gains and these must be formulated and implemented.

66. NHS Health Scotland and the Scottish Directors of Public Health [51] highlight in order for social prescribing to be a success, the systems, culture and environment they operate in must also be conducive to promoting physical activity as a means to prevent and reverse ill-health.

67. The Cabinet Secretary for Health and Sport, in our primary care session on 5 November 2019 [52] , stated the need for the public and healthcare professionals to recognise the value of undertaking physical activity and of social prescribing to improve health and wellbeing:

> We need to refocus the work so that we get it pointed in the right direction. We want to roll out social prescribing in a phased way and win acceptance of it by patients and the professions.

68. While we recognise there is a need for for quality assurance, unnecessary barriers have been placed in the way of referring to services, requiring organisations to justify achievements for each individual programme. The reality is that the efficacy of physical activity for health and wellbeing is well proven. As the UK Chief Medical Officers state:

> Some is good, more is better [53] .

This is equally true of social prescribing, as it is of physical activity.

69. More resource needs to be focused on delivering more services and improving access to those services to improve health and wellbeing. Social prescribing is a key part of this and bureaucratic barriers preventing professionals from referring need to be removed.

Primary prevention

70. Primary prevention aims through proactive action to prevent a health problem from developing. Our inquiry into preventative action and public health recommended a greater focus on primary prevention. The aim being to prevent people becoming ill, to lengthen healthy life expectancy[vi] and reduce the time people spend in poor health. This type of approach is a key attribute delivered by social prescribing and wider interventions or activities to promote health and wellbeing.

71. Primary prevention work can begin to address the social determinants of health [54] , and ensure everyone has access and opportunity. In this inquiry we were equally keen to understand the extent to which social prescribing could impact on primary prevention, and the role health and social care can contribute. Our scrutiny found that promoting physical activity and sport would not only prevent ill-health, but it could prevent social isolation and loneliness and address some major causes of other mental health conditions, such as depression.

72. Public health messages have long focused on population wide measures to increase awareness of the benefits of physical activity, with the aim of encouraging increased activity. Established evidence shows being more active can provide a foundation for living longer, healthier lives with increased independence. Social prescribing should be a key way to deliver these health benefits.

73. The Scottish Government's vision for a more active Scotland is described in its Active Scotland Outcomes Framework [55] . The Framework is supported by a physical activity delivery plan, A More Active Scotland [56] , which sets out work to encourage and support people to be more active. To date, investments have been made in active travel schemes, raising and facilitating awareness with under-represented groups, engaging with children from an early age, working with women and girls, and in reducing the risk of falls in older people. We would also like to see significant investment into social prescribing.

74. In 2018 ScotPHO reported [57] only 65% of adults and 37% of children were meeting Scotland's physical activity guidelines [58] , with adults in the most deprived areas least likely to meet them. Professor Richard Davison [59] , highlighted evidence showing groups of active individuals are becoming more active whereas the least active and non-active populations are growing, many of whom live in the most deprived areas according to the Scottish Index of Multiple Deprivation (SIMD).

75. The growing inequality between active and non-active populations by area of deprivation, with its consequential health and wellbeing impacts, needs to be addressed.

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vi Healthy life expectancy is an estimate of how many years someone might live in a healthy state, compared to life expectancy which estimates how many years a person might be expected to live. Healthy life expectancy can be seen as a key summary measure of a population's health.

Health and wellbeing outcomes

76. Creating conditions for people to live healthy, active and independent lives in their local communities is key to improve people's physical and mental health and wellbeing. The Scottish Government's National Performance Framework [60] recognises that health is dependent on a number of factors and also advocates for a whole system approach to promoting good health. Increased wellbeing is central to the national outcomes in the framework, signalling a marked shift in policy towards measures of social progress.

77. We note there are significant opportunities to improve key national health and wellbeing outcomes through investment in preventative spend across portfolios. At the first international conference on place and the Place Standard in June 2019, the Cabinet Secretary for Communities and Local Government highlighted:

> A place-based approach is crucial to addressing our public health priorities, helping to improve physical and mental wellbeing by empowering people to shape their local environments [61] .

78. In his written submission [62] , Dr William Bird of Intelligent Health outlined place as central to the delivery of good health. He advocated the need for connected communities, with spaces that give people opportunities to become active and socialise, where people are connected to others and to the local natural environment. We recognise work is needed to invest in local environments to create the essential conditions needed for people to live healthy lives.

79. Numerous barriers to people interacting in localities and participating in community activities was highlighted in a primary care evidence session on 19 November 2019 [63] , with members of the public. As we have already established, many people who would benefit from increased physical activity and community connectedness are from hard to reach groups. There can be safety issues and environmental concerns in some disadvantaged areas.

80. In oral evidence on 29 October 2019, challenges of participating in activities in rural areas was highlighted. During that session Claire Thirwall from NHS Dumfries and Galloway [64] stated that sometimes rural communities cannot offer the same choices as urban areas and highlighted the need to take different approaches in localities. These included promoting green exercise, and addressing stigma, confidence and self-esteem issues that can occur in such communities.

> We need to make sure that people connect with their communities, and that they work with their communities to grow their assets [65]

81. The Chief Medical Officer (CMO) for Scotland recently highlighted that sport must be open to all, from pre-school to older generations [66] . The CMO drew attention to its many physical and mental health and wellbeing benefits and the need to draw people to social environments where they can expend physical energy with short and long-term health benefits.

82. We consider actions to promote the wider scope of social prescribing, as preventative activity delivered in local communities, will have a considerable impact on individual health and population wellbeing. We recommend the Scottish Government promotes social environments, community assets and local connectedness as key drivers in increasing individual health and population wellbeing. We look forward to hearing detail of how that might be achieved.

Shifting the balance of care

83. As identified in the previous section, delivering preventative activity within the wider scope of social prescribing in local communities is key. We received substantial evidence demonstrating that investment can be key to creating the conditions needed for people to live healthy, independent lives. Resource and expenditure directed towards increasing participation in social prescribing measures, and by extension widening participation in physical activity is clearly increasing healthy life expectancy, quality of life and wellbeing.

84. The Scottish Government has made a number of policy commitments in relation to health and social care expenditure. The most pivotal of these is the desired shift of the balance of care from the acute to the community setting. These commitments are intended to shape the budget and drive reform across the health and social care system. Recent reports from Audit Scotland [67] note the pace of change has been too slow in this regard.

85. The then Cabinet Secretary for Health and Sport wrote to us in 2017 [68] , outlining the movement of funding towards primary, community and social care. The Cabinet Secretary committed the Government that by 2021-22 over half of NHS spending will be in community settings.

86. In our 2019-20 scrutiny of the Scottish Government Health Budget [69] , we noted that integration authorities (IAs) are key to making progress in this area. Our 2020-21 pre-budget scrutiny examined ways to reduce admissions to hospital, delayed discharges and unplanned acute bed days. It is clear that increased investment in social prescribing, as well as being a cost-effective use of resources, would help with all of the above while also shifting the balance of care.

87. Argyll and Bute Health and Social Care Partnership [70] provided a compelling narrative of the need for new approaches to health and social care to meets the needs of current and future populations. They note that investing in community prevention measures, such as social prescribing and investing in physical activity, can stop or delay the onset of many health and social care issues. The partnership also notes how these measures can ease the pressure on traditional health and social care services. This includes reducing pressures on existing services, including waiting times, unplanned admissions and delayed discharges. It will also be effective in preventing long term conditions and dependence on pharmaceutical prescriptions.

88. Investment in provision of physical activity programmes and services in local communities will lead to improved health and wellbeing outcomes and increased independence and lower demand on NHS and social care services in the future. It will also significantly contribute to shifting the balance of care.

89. We believe there is a role in utilising existing community assets and resources. During the oral evidence session on 29 October 2019, the community work and community trust in Ferguslie Park in Paisley was highlighted, with suggestions that local authorities ask communities about what they want and use available space to make that happen. We also consider there is potential to open the school estate to increase opportunities for sport and physical activity participation. This was earlier identified as an area of need in our Sport for Everyone [71] inquiry in November 2017.

90. Having established compelling financial and health benefits arising from social prescribing of physical activity, and wider preventative activity, we expect a significant proportion of each Integration Authority budget should be spent on commissioning local services to increase physical activity levels and improve health in communities. We recommend that figure be not less than 5% and this target be achieved within 2 years.

91. Given that adults in the most deprived areas are the least likely to meet physical activity guidelines, we also expect the majority of that investment is spent within the most deprived areas.

92. We welcome an update from Scottish Government on its work to improve and increase a more flexible approach to using the school estate and utilising existing local authority community spaces more effectively.

Community spending

93. We have considered the value of investing in community assets and resources, such as developing social prescribing schemes and developing opportunities to participate in physical activity to prevent ill-health. To allow IAs to prioritise this as an integral part of strategic and locality planning, they will require knowledge of what resources are locally available in communities, and alongside that, a recognition of which services are essential to improve health and wellbeing to shift the balance of care. This needs to be done strategically at community planning level, with engagement from those responsible and those delivering functions on the ground in local communities.

94. The role of community and voluntary organisations is vital to delivering these ambitions for social prescribing and prevention activity. These organisations often develop and deliver services in local communities that prevent ill-health, reverse

harm or stop a problem becoming worse. They also help support individuals to engage with those services in a meaningful way.

95. On the 8 October 2019 as part of our inquiry into primary care, Gerry Power from the Health and Social Care Alliance highlighted:

> At local level, third sector organisations must not simply be seen as a default position for a lack of resources in primary care, healthcare or social care [72] .

96. Local services need to be recognised for the benefits they deliver. In the above session, Dr John Anderson of NHS Health Scotland stated:

> We need increasingly to consider primary care as including a range of community and voluntary organisations because we will increasingly have to look to such organisations to improve the health and wellbeing of the population [73] .

Provisions must be in place to commission and provide funding to local services.

97. Evidence submitted as part of our inquiry into primary care, highlights that community and third sector organisations are keen to be involved in the planning and design of services. These organisations have a depth of unique experience and knowledge they are willing to share in a collaborative way with statutory partners.

98. Yet tangible barriers exist around longevity and sustainability of current funding cycles, procurement practices, commissioning processes and the involvement of third sector organisations in the provision of services [74] .

99. Maximizing community initiatives that empower and raise confidence of people in local areas to participate in physical activities, will increase population health and healthy life expectancy, helping the population to thrive.

100. We recommend the Scottish Government review the sustainability of funding cycles, procurement practices, and commissioning processes to allow community organisations to deliver social prescribing initiatives.

101. We expect all IAs to make investment in provision of physical activity programmes and services in local communities an integral part of their strategic and locality planning. We recommend this also includes engaging with community and voluntary organisations in strategic commissioning processes.

Conclusions

102. The Committee has no doubts about the significant role physical activity and sport, and social prescribing, can contribute as part of preventative care for health and wellbeing. Addressing accessibility to, and awareness of, community and voluntary schemes will improve individuals' health and wellbeing outcomes, begin to shift the balance of care from acute to community settings and help achieve national outcomes.

103. Social prescribing and primary prevention approaches can help in preventing long term conditions and dependence on pharmaceutical prescriptions. They also have the potential to ease the pressure on existing health and social care services, as well as reducing waiting times, unplanned admissions to hospital and delayed discharges. The Scottish Government healthcare waiting times improvement plan states:

> The health and social care system needs to maintain its focus on improving public health and the development of preventative models of care (including self-management). If we want it to be financially sustainable, tackle persistent health inequalities, improve long-term outcomes and reduce pressure on the workforce, we cannot simply react to the management of patients with long-term conditions without taking long-term action across the health and care system as a whole [75] .

Social prescribing, and wider preventative initiatives to increase physical activities in communities, can directly improve waiting times, help make improvements in unscheduled care and ease pressures on A&E within hospitals

104. However, social prescribing cannot be seen as a cost-free alternative. Sport and physical activity is an investment, not a cost [76] . Systems and processes need to effectively support people to participate in and organisations to deliver this essential preventative action. Upstream funding for infrastructure, utilisation of community spaces and support for organisations to deliver prevention activities highlighted in this report is required. Cost benefits of social prescribing are not in dispute and we are unclear why if the Cabinet Secretary for Health and Sport is convinced of the need for such initiatives, this is not being delivered at scale across all NHS boards and Integration Authorities.

> We need to target our health inequalities work, so that the changes are more accessible to people. That includes social prescribing. We need to refocus the work so that we get it pointed in the right direction [77] .

Annexe A

17th Meeting, 2019 (Session 5) Tuesday 25 June 2019

8. Sports Inquiry (in private): The Committee considered its approach to the inquiry.

24th Meeting, 2019 (Session 5) Tuesday 29 October 2019

4. Social prescribing of physical activity and sport inquiry: The Committee took evidence from—

- Professor Richard Davison, Professor of Exercise Physiology, University of the West of Scotland, representing the Observatory for Sport in Scotland;
- Dr William Bird, General Practitioner and Chief Executive Officer, Intelligent Health;
- Kirsty McNab, Chief Executive Officer, Scottish Sports Futures;
- Dr Katie Walter, General Practitioner, Cairn Medical Practice;
- Flora Jackson, Health Improvement Manager, Physical Activity and Health Alliance (NHS Health Scotland);
- Claire Thirwall, Health and Wellbeing Specialist, NHS Dumfries & Galloway;
- Martin Hayman, Project Manager, Community Table Tennis, Table Tennis Scotland;
- Kim Atkinson, Chief Executive Officer, Scottish Sports Association;
- Dr Corinne Jola, Senior Lecturer in Psychology and researcher/practitioner in dance, health and wellbeing, Abertay University.

7. Social prescribing of physical activity and sport inquiry (in private): The Committee considered the evidence heard earlier in the meeting.

Annexe B

Written Submissions

- HS/S5/19/SP/1 - Cheryl Smith, Podiatry Professional Head of Service, NHS Fife
- HS/S5/19/SP/2 - Paul Jarvis-Beesley, Head of Sport & Health, StreetGames
- HS/S5/19/SP/3 - Derek Laidler, Professional Lead Physiotherapist, Argyll & Bute Health and Social Care Partnership
- HS/S5/19/SP/4 - Sheena Mcintyre, Technical Instructor, Fife Pain Management Service, NHS Fife
- HS/S5/19/SP/5 - Jo Hastie
- HS/S5/19/SP/6 - Nicola Hanssen, CEO, Roar - Connections for Life
- HS/S5/19/SP/7 - Gavin Macleod, Chief Executive Officer, Scottish Disability Sport
- HS/S5/19/SP/8 - Edinburgh Health and Social Care Partnership
- HS/S5/19/SP/9 - Edinburgh Allotments Federation (FEDAGA)
- HS/S5/19/SP/10 - NHS Lothian Department of Public Health and Health Policy
- HS/S5/19/SP/11 - Kate MacLean
- HS/S5/19/SP/12 - Dr Andrew Kirkland
- HS/S5/19/SP/13 - Pain Association Scotland
- HS/S5/19/SP/14 - Christopher Wilkins, Co-founder, The Sporting Memories Foundation
- HS/S5/19/SP/15 - Vivian Wallace, Ageing Well Coordinator, Midlothian. Physical Activity for the over 50s
- HS/S5/19/SP/16 - Age Scotland
- HS/S5/19/SP/17 - Renfrewshire Health and Social Care Partnership
- HS/S5/19/SP/18 - The Health and Wellness Hub
- HS/S5/19/SP/19 - NHS Greater Glasgow and Clyde
- HS/S5/19/SP/20 - Paths for All
- HS/S5/19/SP/21 - West Dunbartonshire Community and Volunteering Services
- HS/S5/19/SP/22 - Care Inspectorate
- HS/S5/19/SP/23 - Anne B. Murray

- HS/S5/19/SP/24 - Chest Heart & Stroke Scotland
- HS/S5/19/SP/25 - NHS Ayrshire and Arran
- HS/S5/19/SP/26 - The Observatory for Sport in Scotland
- HS/S5/19/SP/27 - Scottish Volunteering Forum
- HS/S5/19/SP/28 - British Dietetic Association Scotland Board
- HS/S5/19/SP/29 - Liz Hay
- HS/S5/19/SP/30 - Dr Andrew Soundy, University of Birmingham
- HS/S5/19/SP/31 - Health and Social Care Alliance Scotland (the ALLIANCE)
- HS/S5/19/SP/32 - NHS Orkney
- HS/S5/19/SP/33 - Prof R.C.Richard Davison
- HS/S5/19/SP/34 - Volunteering Matters
- HS/S5/19/SP/35 - British Red Cross
- HS/S5/19/SP/36 - Glasgow City Health and Social Care Partnership
- HS/S5/19/SP/37 - Hannah Grubb
- HS/S5/19/SP/38 - Highland Green Health Partnership
- HS/S5/19/SP/39 - Loch Lomond & The Trossachs Countryside Trust
- HS/S5/19/SP/40 - NHS Lanarkshire, South Lanarkshire Health and Social Care Partnership and Health and Social Care Partnership North Lanarkshire
- HS/S5/19/SP/41 - Physical Activity Special Interest Group Durham University
- HS/S5/19/SP/42 - Scottish Library and Information Council
- HS/S5/19/SP/43 - Scottish Council for Voluntary Organisations
- HS/S5/19/SP/44 - Active Stirling
- HS/S5/19/SP/45 - Yoga for Healthy Lower Backs
- HS/S5/19/SP/46 - Aberdeen City Health & Social Care Partnership
- HS/S5/19/SP/47 - Abertay University
- HS/S5/19/SP/48 - Active Aberdeen Partnership
- HS/S5/19/SP/49 - Active Highland Strategic Partnership
- HS/S5/19/SP/50 - Allied Health Professions Directors Group Scotland
- HS/S5/19/SP/51 - ASH Scotland

- HS/S5/19/SP/52 - Barnardo's Scotland
- HS/S5/19/SP/53 - Chartered Society of Physiotherapy Scotland
- HS/S5/19/SP/54 - Culture Counts
- HS/S5/19/SP/55 - Dr Katie Walter
- HS/S5/19/SP/56 - Dr Corinne Jola
- HS/S5/19/SP/57 - Dundee HSCP, Dundee City Council and NHS Tayside
- HS/S5/19/SP/58 - East Lothian Council
- HS/S5/19/SP/59 - Glasgow Life
- HS/S5/19/SP/60 - Inverclyde Health Social Care Partnership
- HS/S5/19/SP/61 - Judy Wilkinson
- HS/S5/19/SP/62 - Julius Cesar Alejandre
- HS/S5/19/SP/63 - Lorn and Oban Healthy Options Ltd
- HS/S5/19/SP/64 - Macmillan Cancer Support
- HS/S5/19/SP/65 - Marie Curie
- HS/S5/19/SP/66 - Museums Galleries Scotland
- HS/S5/19/SP/67 - National Pharmacy Association
- HS/S5/19/SP/68 - NHS Fife and Fife Council on behalf of Fife Partnership
- HS/S5/19/SP/69 - NHS Grampian Public Health Directorate
- HS/S5/19/SP/70 - NHS Health Scotland and the Scottish Directors of Public Health
- HS/S5/19/SP/71 - NHS Western Isles
- HS/S5/19/SP/72 - Physical Activity for Health Research Centre
- HS/S5/19/SP/73 - Royal College of General Practitioners
- HS/S5/19/SP/74 - Royal College of Occupational Therapists
- HS/S5/19/SP/75 - Royal College of Physicians and Surgeons of Glasgow
- HS/S5/19/SP/76 - Scottish Association for Mental Health
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- HS/S5/19/SP/78 - Scottish FA and Hampden Sports Clinic
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- HS/S5/19/SP/80 - Social and Public Health Science Unit

- HS/S5/19/SP/81 - Sport Aberdeen
- HS/S5/19/SP/82 - Sportscotland
- HS/S5/19/SP/83 - Sustrans Scotland
- HS/S5/19/SP/84 - The National Trust for Scotland
- HS/S5/19/SP/85 - Versus Arthritis
- HS/S5/19/SP/86 - West Dunbartonshire Health and Social Care Partnership
- HS/S5/19/SP/87 - Renfrewshire Leisure
- HS/S5/19/SP/88 - Scottishathletics and Jog Scotland
- HS/S5/19/SP/89 - Social Farms and Gardens
- HS/S5/19/SP/90 - Community Transport Association
- HS/S5/19/SP/91 - Cycling UK in Scotland
- HS/S5/19/SP/92 - Argyll & Bute Health and Social Care Partnership
- HS/S5/19/SP/93 - The College of Podiatry
- HS/S5/19/SP/94 - Scottish Sports Futures
- HS/S5/19/SP/95 - Scottish Sports Association
- HS/S5/19/SP/96 - The stoma and physical activity research group
- HS/S5/19/SP/97 - Intelligent Health

Official Report

- Tuesday 29 October 2019 - Evidence from stakeholders

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