Cross-Party Group on Health Inequalities
Wednesday 19 February 2025, 6-7.30pm

Minute

Present

MSPs

Emma Harper MSP

Invited guests

Charlie McMillan, Interim Director of the Human Rights Consortium Scotland

Non-MSP Group Members

Beth Allen, Age Scotland
Anne Black, The Braveheart Association
Lauren Blair, Voluntary Health Scotland
Sara Bradley, USW
Christine Carlin, Voluntary Health Scotland
Tracey Clark , ACC / 9CC / VSS / Alliance / Inclusion Scotland / DES
Judith Connell, Kidney Care UK
Sarah Curtis, University of Edinburgh and Durham University
Sarah Edwards, The Breastfeeding Network
Helen Forrest, Children's Health Scotland
Iain Fraser, Age Scotland
Rob Gowans, Health and Social Care Alliance Scotland (the ALLIANCE)
Jen Grant, Food Train
Cindy Gray, University of Glasgow
Alana Harper, Deaf Links
Susan Hunter, Befriending Networks
Roisin Hurst, Voluntary Health Scotlandj
Samiah Iman, Saheliya
Jaki Lambert, Royal College of Midwives
Donna Lawrie, MECOPP
Andrea Ma, Age Scotland
Marianna Marquardt, Scottish Families Affected by Alcohol and Drugs
Maureen McAllister, Versus Arthritis
Ian McCall, Paths for All
Annie McComack, Poverty Alliance
Kelsa McDonald, VoiceAbility
Samantha McIntyre , Cap's
Tejesh Mistry, Voluntary Health Scotland

Justina Murray, Scottish Families Affected by Alcohol and Drugs
Nell Page, Mindroom
Helen Reilly, Queen's Nursing Institute Scotland
Bushra Riaz, Kidney Research UK
Gemma Richardson, RCPCH
Pete Ritchie, nourish scotland
Lesley Ross, GCA and also representing SACC
Kellie Thomson, Voluntary Health Scotland
Craig Tobin, Chest Heart & Stroke Scotland
Sarah van Putten, LifeCare Edinburgh
Marta Wittek, Scottish Independent Advocacy Alliance

Non-Group Members

Steve Brown, Roche Products Ltd
Susan Drummond, Cumbernauld Action for Care of the Elderly (CACE)
Frederike Garbe, NHS 24
Euan Hamilton, Equality and Rights Network (Volunteer Edinburgh)
Stephanie-Anne Harris, Edinburgh community health forum
Ben Lejac, Barnardo's
Fiona Macaulay, NHS 24
Crawford McGugan, Glasgow Life
Niomi Nichol, Third Sector Dumfries and Galloway
Rachel Shanks, University of Aberdeen
Rachel Simpson, NHS Lanarkshire
Karen Sweeney, PLUS Forth Valley

Agenda item 1

Welcome and Apologies

Carol Mochan and Brian Whittle

Agenda item 2

Approve minutes

Approve minutes of the previous meeting held on 11 December 2024.

Approved by Tejesh Mistry and seconded by Roisin Hurst

Agenda item 3

Approve new members

The following organisations have requested to be approved as members of the CPG:

St John Scotland

Third Sector Dumfries and Galloway

Media Education

Agenda item 4

Discussion topic- Human Rights and Health Inequalities

Presentations from:

Charlie McMillan, Interim Director of the Human Rights Consortium Scotland - The right to the highest attainable standard of physical and mental health.

Charlie started his presentation with a short introduction to the Consortium which is an independent organisation with a membership of 230 non-governmental organisations, voluntary organisations who are connected with human rights.

Making Human Rights Real
He provided some context to the approach to human rights in Scotland which has been quite technical. One of the primary goals of the Consortium is to make human rights real. He shared quotes from Eleanor Roosevelt and Nelson Mandela which he stressed are still critically important today. Human rights begin in small places - at home, in rural settings, in the community. These are the places where every man, woman and child seeks equal justice. Unless these rights have meaning there, then they have little meaning everywhere.

Charlie explained that human rights isn't necessarily about big international covenants, although they are very important and part of the agenda. However, what we are talking about is how people experience life on a day-to-day basis; we're talking about education, about the right to assembly, right to association, right to movement, religion, speech, and information.

We can't *give* people their human rights; people *have* human rights because they live. He explained that it is important that we hold on to the history of why we have this Human Rights Framework which came out as a result of the atrocities of World War 2 and which was developed internationally by Roosevelt and others. They did this through identifying the core, essential rights that belonged to everyone. How do we realise those rights and empower people to claim them?

We can choose to limit people's access to their human rights; sometimes we do this deliberately, for example, if we imprison somebody. But sometimes, and really importantly, when we're talking about health inequalities, it can be unintentional. It can be about some of the hardwired discrimination that our society has embedded within it that means it's incredibly difficult for some groups of people to access and promote their health and wellbeing.

Intersectionality – The Human Experience

Charlie went on to explain that we don't experience human rights in isolation. Ours and everyone else's are interconnected. Intersectionality is important in seeing how human rights connect. Many aspects go towards what makes a human being and the slide on intersectionality explains this in more detail.

Right to the highest attainable standard of physical and mental health

The right to the highest attainable standard of physical and mental health is fundamental to the international human rights framework. We want to take all of these conventions and covenants as these are the formal international treaties. The right to the highest attainable standard of physical and mental health is mentioned in no less than seven of the international treaties that Scotland is already a signatory to through its membership of the United Kingdom (which has signed all of these). The Consortium is working with the Scottish Government to develop the Human Rights Bill for Scotland, which has been postponed until after the next Scottish election.

However, all these existing covenants are critically important in terms of how we perceive, understand and prioritise and measure people's attainment to the highest attainable standard of physical and mental health.

Charlie outlined the key covenants that reference this:

- The Universal Declaration of Human Rights, the founding document in terms of the modern human rights framework, 1948.
- Article 12.1 in the International Covenant and Economic, Social and Cultural Rights, 1966.
- International Convention on the Elimination of all Forms of Racial Discrimination 1965, Article 5
- International Convention on the elimination of all forms of Discrimination against Women 1975, Article 12
- International Convention on the Protection of the Rights of all Migrant Workers and their Families 1990, Articles 28, 43 & 45
- Convention on the Rights of the Child 1989, Article 24
- Convention on the Rights of Persons with Disabilities 2006, Article 25

Race discrimination, the rights of migrant workers, the rights of children and the rights of people with disabilities along with physical and mental health are intrinsically linked in this human rights framework as is the elimination of all forms of discrimination against women. We can see how many reinforcing and interconnected articles there are in relation to the right to the highest attainable standard of physical and mental health. This should be absolutely a number one priority; how do we ensure that people are able to achieve that highest attainable standard?

Health Inequalities in Scotland

There was a comprehensive independent review of health inequalities in Scotland, led by the Health Foundation. Voluntary Health Scotland was involved in this work. It showed a really worrying situation in terms of health inequalities, essentially that those living in the most deprived local areas are being left behind.

Analysis carried out for the review shows that in 2019, pre-pandemic, (so we can only imagine what the impact has been during the pandemic and post-pandemic), there was a 24-year gap in the time spent in good health between people living in the most and least deprived 10% of local areas in Scotland. We need to be very clear that whatever the intentions are, whatever the frameworks are for addressing health inequalities, we are not delivering for everybody in our society. If you take in rurality and remote living, that could also be a compounding factor.

Health inequalities – an intersectional lens

The review found that trends in the socio-economic factors that influence health provide little indication that health inequalities will improve in future. This was underlined by increasing rates of extreme poverty. This comes back to that intersectionality point – poverty, gender, race, migrant status. All of these have to be considered if we are truly going to address health inequalities in our society. We need sophisticated policies that aim to address these inequalities. We would also argue in the Consortium that if you take on board human rights budgeting, whose rights are most at risk? We're seeing a clear identification of significant risk in terms of human rights achievement. How then do we apply that lens to budgeting and to service planning?

How do we build physical and mental health for groups of people on the margins? How do we move forward positively to ensure that they are able to attain the highest level of physical mental health? In the most recent research, people with learning disabilities are nine times more likely to die from preventable illnesses in Scotland in 2025. That is only one example, but it's completely unacceptable. So how can we use human rights to shine a light, to spotlight these issues? How do we plan policy, budgeting and other interventions to make sure that this is addressed as a matter of priority?

Recommendations to the United Nations Committee on Economic, Social and Cultural Rights – Healthcare for All

One of the ways is that we, as part of this human rights framework, are held accountable for our progress through the United Nations. The United Nations Committee on Economic, Social and Cultural Rights wants to focus on healthcare as part of its reporting cycle. Charlie was absolutely privileged last week to attend this hearing and the committee hearing. And as part of that process, they worked with their members to develop a report highlighting a whole range of different issues in relation to economic, social and cultural rights. This is the convention that goes back to 1966. The highest attainable standard of physical and mental health is one of the articles, Article 12. The team highlighted both specific health-related human rights infringements and human rights abuses that are being experienced. They reported along with 72 other organisations to the United Nations Committee. They had a two-day hearing where the UK government, including Scotland, reported back on progress or otherwise which results in a report back to them with recommendations for further action. So, it's one of the ways that we can directly apply human race monitoring and measurement and then get feedback on areas for further development.

They highlighted the experience of those impacted by COVID-19. And within that, talking about those at clinically high risk, the vaccine injured, and those also experiencing long COVID. They highlighted their health needs because they believe that here is yet another marginalised group that's developing over time and are their needs in terms of health inequalities being addressed?

Charlie asked the question - given all our sophisticated understanding of experience, data collection, etc., what more could and should we be doing to ensure their health is at the highest attainable standard of physical and mental health? They also made recommendations on poverty and focused on the Scottish Child Payment, black and minority ethnic communities and their experience of poverty and also disabled people.

They made several recommendations and the report is available on their website. Poverty has a specific impact on people's health and experience of discrimination in health. They highlighted women's health, including pregnancy and maternal health. That also links to discussion from the Health and Social Care Alliance Scotland who really focused on people's experience during the pandemic as well. Have we learned our lessons from the pandemic? Are we able to say we are moving forward, taking on board our learning?

They also made recommendations in relation to data gaps which are at a shocking level in Scotland. During the pandemic, we were involved through SCLD in discussions about the mortality of people with learning disabilities as a result of COVID-19. So much more needs to be done in terms of improving data gaps. We must get into discussions with The National Register of Scotland to try to ensure that data is forthcoming so we could target those whose rights are most at risk. We made recommendations on data gaps in relation to affordable and social housing. And again, that's the intersectionality point which absolutely leads into people's experience of health and health inequalities. They made recommendations there in terms of mental health law reform. in terms of the actual need for law reform but also that mental health promotion. They recommended a national food security strategy because hunger and the experience of poor diet and nutrition leans into health and health inequalities. The right to a healthy environment, the way in which we experience the environment can have a huge impact on our health and well-being.

Next steps

In relation to human rights and health inequalities, they are inextricably linked. Health inequality is mentioned in seven articles in seven different conventions. We can then get into the reporting mechanisms and monitoring of human rights. By using the evidence we have on health inequalities in an intersectional lens, how do we plan better? How do we address these challenges on an ongoing basis? Critically important is how do we connect that with human rights budgeting?

We will continue to monitor and report on human rights abuses and infringements in relation to health inequalities as part of our overall work. We'll push for more accountability. There is a significant issue in Scotland about accountability and implementation and the gaps that have emerged pre-pandemic and certainly post-pandemic. Also, the development of a meaningful human rights-based approach to NHS reform and budgeting is central. The language of human rights-based approach

is used time and time again in Scotland. However, we really believe that you must ask people to explain what they mean by a human rights-based approach. How is that going to help? How is that going to move forward? Really believing that prevention is better than cure, investment in preventative services is so important if we are going to enable people to achieve that highest attainable standard.

We will continue to use evidence to influence the Scottish Government, the UK government and the United Nations. It's important that we continue to work within that international and UK context as well as with the Scottish Government. And we are committed to moving forward with the development of a Scottish Human Rights Bill after the next election. And in the meantime, we must keep addressing health inequalities as a priority.

Questions and Discussion

Emma Harper MSP– this made me think about the National Care Service Bill and Anne's Law. Michael Marmot's work has been brought up at the Health Committee on many occasions in relation to inequalities, as well as David Walsh and Gerry McCartney's work and of course our Assisted Dying Bill. There is lots going on that's relevant to what you have just presented. I am also thinking of vaping/young people and alcohol MUP. We had a presentation at the Lung Health Cross Party group last Friday about how low emission zones are helping people get outdoors - children are playing in the playgrounds and parents are watching them and talking to other parents. So it helps to tackle isolation and loneliness.

Tejesh Mistry, VHS - I think there are a few things that really kind of jump out for me. One is that complexity issue. I think there's a real role for all of us across sectors to improve and understand the legislation around this. I think that focus on the social determinants of health is helpful to be able to translate into the wider work that many of the organisations represented here today and beyond will be doing on a daily basis. I think the examples you've just given are things that we really need to understand and keep front and centre because those are the things that bring it to life - it is those individual stories, experiences, barriers and challenges for people. You talked about those different levels, the UN, UK Government, Scottish Government. What are the relationships there? What are the dynamics of seeing progress across those three organisations?

Charlie McMillan - I think Scotland has always been, as in the last 10 to 15 years, identified as a real driver in terms of the international human rights agenda and its integration. I think with the last Westminster government, it was extremely challenging because human rights was not part of their agenda. The Labour Government is now picking this up. They introduced the Human Rights Act which has been relevant for Scotland for 25 years; it is in the statute book. We need to be moving forward now after what has been a very, very slow period for human rights realisation at a UK level. Whereas in Scotland, I do think we were much further down the road in terms of human rights realisation, albeit with some significant gaps. That was why I referenced the Health Foundation's research as we've got to be really careful we don't pay lip service to human rights. We're a human rights-respected country. But what does that really mean? How do we build that into our day-to-day work, practice, planning and

budgeting? And I think those are the bits that we really need to embed, especially post-pandemic.

Internationally, this was the first time I went to the United Nations to see the international machine in operation and it was hugely impressive. The Committee was so well-informed and really interested in devolution and how devolution then played out in terms of the UK's signatory to the conventions. But then we've got the responsibility to implement them. It comes back through the UK government and then to us. So, it's how we build on it moving forward and not letting anything slip. Our commitment is to build on all the work done to date.

Marianna - Scottish Families Affected by Alcohol and Drugs - on a society level the kind of stigma that families face because of stigma against substance use as well as a hesitancy to include families in their loved ones' treatment and care is something that they encounter. Something that I've seen through conversations with families is differing interpretations on human rights when they try to exercise their human rights to self-advocate for themselves. E.g. a family member could be in an appointment with their loved one, trying to exercise that right to the highest attainable standard of mental and physical health. The family member said that in trying to exercise that right, the person's (in the health service) interpretation of that right is the service or prescription that they are providing and that's them fulfilling their human right. So it's a stalemate between the rights holder who has one interpretation and the duty bearer that has another. Is there something that can be done to kind of reconcile these different interpretations of human rights within these interpersonal contexts? Where does interpretation fit into those recommendations that you shared at the end of your presentation?

Charlie - I saw an excellent presentation on deinstitutionalisation recently from the Human Rights Commission and they said we don't need further definitions. The definition is there, the United Nations has already done this work. I think it's interesting that we get into rights limiting discussions quite quickly and I think we really need to test that through discussion and through exploration. For example, I was in a discussion about producing a notebook for people on different rights, in the context of migrants. They're able to identify that this is my Article 2 or my Article 4 and this is what it means for me. I know it's a big ask, but we did do it in terms of our work with people with learning disabilities and there are now trained human rights defenders across Scotland, with a learning disability, who are speaking to people at the highest level about the challenges that they face. I think it does get complex in terms of a whole range of different situations and it's how we make sure the human race becomes just part of the language of the country. It is about giving people confidence, ability, and that empowerment to name their rights and to feed into all these different processes.

The United Nations Committee, for example, is really interested in engagement work. It wants to know what engagement work has been done to feed the responses it is receiving. We have a responsibility to feed that all through. And then it's about planning. If people are saying that this is how we exercise our rights bearer responsibility, what are they basing that on? What planning has been done? Is it a human rights-based approach?

Where's the evidence that the human rights have been considered? The Commission is going to move more towards human rights measurement. So, when you say you're doing X, Y, and Z, where's the evidence of that in terms of that human rights measurement? And I think that's something that we haven't done very well on previously.

Craig, Chest Heart and Stroke Scotland – as part of our No Life Half-Lived Strategy, we're hearing the same thing - the more deprived the area, the higher prevalence of our conditions. Fewer than half of those people with our conditions end up getting access to rehab. Our Right to Rehab campaign has been going since 2020 through the Right to Rehab Coalition to try and ensure that people have timely and accessible and tailored rehabilitation. With the Human Rights Bill being postponed, it does give us some concerns about where to land that campaign. What would be your suggestion in terms of taking that forward?

Charlie - Section 6 of the Human Rights Act, which is all about the delivery of public services, is somewhere that you should explore with your partners because it does make a commitment. The NHS Act 2003 has also got a commitment to progress in human rights. The Scotland Act as well, these commitments on human rights already exist in Scottish legislation. The Human Rights Bill could have brought a much clearer focus to that implementation and hopefully will do. But in the meantime, it doesn't mean that we can't do anything, especially in terms of legislation, because legislation is there.

Anuka - I work as a research nurse for the NHS, in stroke, which is very much a disease that is a reflection of the health inequalities that exist today. Is there a terms of reference for the outputs of this group? And how does the existence of this group impact policy-making in the Scottish Parliament? How do we measure the impacts that our conversations here are having?

Emma - I'm a member of many cross-party groups. A lot of them are health-related. I co-chair the Lung Health Cross Party Group. It started as an asthma cross-party group, but asthma is not the only lung health condition so that cross-party group lobbied the Scottish Government to implement a respiratory care action plan. Conversations can stimulate members' debates, conversations at committees can lead to commitments to write to ministers. We can invite ministers to come to cross-party groups so that ministers can hear from the people about challenges and opportunities.

So there are various approaches that cross-party groups can take and we do shared meetings, e,g. the mental health cross-party group joined up with the diabetes cross-party group because of the connections between diabetes as a long-term condition and mental health.

Anuka - I've noticed that there is CPG Improving Scotland's Health. What are the key differences between that group and this one? And it would be interesting to have a repository of information that attendees could access.

Emma – There are a lot of cross-party groups. Improving Scotland's Health has focused on stopping people smoking and reducing alcohol intake with minimum unit

pricing so there are different approaches. The Scottish Parliament website has lots of the presentations from the cross-party group meetings.

Fredi - I work for Public Health Scotland. One of the things I'm particularly interested in is climate change and sustainability and linking that to the right to a healthy environment for our population. I didn't see that featured very prominently in your presentation. I'm interested whether that's something you're coming across a lot. I know Scottish government is looking at the environmental strategy and I know there are a lot of countries being taken to court by their populations in relation to upholding those rights to a healthy environment.

Charlie - The right to a healthy environment is in a report to the Committee on Economic, Social and Cultural Rights. We're also co-chairs of the civil society working group and environmental issues come through time and time again. It does absolutely interconnect with health and health inequalities; and there are specific environmental concerns in the climate crisis that we face. Part of our challenge in the United Kingdom is the legal challenge in terms of human rights. And that's one of the reasons that we absolutely believe in the priority of the United Nations process. There's a big piece of work being done with new philanthropy capital and partners in terms of environment and a big workshop is being planned.

Jackie - Royal College of Midwives in Scotland. I'm thinking of your report that you produced about access to human rights and access to health being breached in remote and rural highlands and islands. It's about data gaps, as we know already that it is difficult to get a clear picture of the SIMD quintile in a remote and rural setting. For women - it's household income that is counted and it doesn't always give you a picture of women's access to finance and money. So many of the solutions are not just health, they're housing, transport, fuel. How do we do that when we've got short-term budgeting and we don't have the ability to impact on those wider social determinants? We know that the biggest cause of death in women in the postnatal period between six weeks and a year is mental health and the women that suffer most are those that are in the most deprived communities.
If we want to maintain communities across Scotland with equal access to rights, how do we do that when the first things that get cut are community and remote and rural and distant services? How do we change the conversation and focus on a more long-term solution?

Charlie - I talk about discrimination and in this context, health inequality has been hardwired into our society. And I think we really need to get into that wiring and understand that this system has been made by people and therefore, people can change the system. However, there has to be a willingness to do that. And I think that human rights actually gives us that lens, if we apply that lens to long-term strategic planning.

The other bit of terminology underpinning all of this is progressive realisation of human rights. And if we are to progressively realise people's human rights, we need to take a long-term view. I gave a presentation on Monday and I was using the example of gay rights. As a gay man, it's a subject very close to my heart. And from 1980 to 2013 there were 12 pieces of legislation that enabled and empowered me to achieve my human

rights. It's that kind of long-term approach that's needed because there's got to be a strategic plan.

I think all too often we get caught up in short-termism both in terms of planning and strategy. I think this zeitgeist we've got about three-year strategies - what have we managed to do in three years? And then critically, we need to look to budgeting and human rights of those whose rights are most at risk.

What evidence do we have of data gaps? How do we plan to deliver on people's individual human rights in terms of using an analysis that's focusing on race and ethnicity, gender, sexual orientation, poverty, exclusion? We must get so much more specific than thinking we're all the same. Who should we target? For me, we've got evidence that some people have been detained in hospital for 40 and 50 years. Women and gender-based violence; their rights are most at risk. That's the lens that we should be applying. And I think we can get too general far too quickly.

Emma - One of the conversations that we had recently was agreeing with the sustainable development goals. Let's all agree on the direction for dealing with housing emergencies in Scotland, for example. We might all agree that we need good quality housing. We need to work on the minutiae around that so we're having conversations like this all the time.

Charlie - I think one of the ways that we could also do that is by asking people - what does a good life look like? And then looking to develop from there.

The prime minister in New Zealand said people with learning disabilities want somewhere to live, somewhere to work, someone to love and something to hope for. Those are human rights issues. That's what I mean about building that into that commonality. Lucy Mulvey at the Health and Social Care Alliance talks about taking a human rights first approach and I absolutely agree. Let's have the programme for government in human rights terms. Let's have the national planning framework outlining how it's delivering human rights. I believe we could achieve real change. We need to use the language and use the mechanisms we have.

Christine - You spoke about paying lip service to human rights. And it reminded me of something that I read this this week which was a post on LinkedIn from Eddie McConnell, Chief Executive of Down's Syndrome. He said the same thing, the possibility that services are choosing to rethink that highest attainable standard of physical and mental health to suit what they consider to be acceptable and he referenced that in terms of Down's Syndrome. He talked about a consultant saying to a family, your brother has Down's Syndrome which was basically saying that this is the best we can do. And failing to recognise that there are other treatments and things available because people have Down's Syndrome.

Charlie - I had a similar reaction when I read that post. So much of it is based on what we call, 'diagnostic overshadowing'. We deal with these symptoms with our own unconscious biases and then base our behaviours on that. And that's what's so tragic in all of this because it doesn't need to be like that. Human rights are about the individual. If that's the case, then we need to be able to differentiate from person to person. That doesn't mean that everything's completely different, but it does mean that

experiences will be different and how do we engage meaningfully? I believe human rights give us that lens to be able to move forward. But it means sharing power as well. It's like all the good equal opportunities training from the 1980s and 90s. It is all about putting the person at the heart of everything we do in a meaningful way.

Sarah Edwards - I was just wondering about the commercial determinants of health. There's a great report by the British Heart Foundation looking at them. How do we bring in that kind of human rights approach and consider that there are organisations, businesses working against what we're trying to achieve, especially considering that those most likely to be impacted are the most vulnerable, the underserved.

Charlie - I think that goes to the heart of the current geopolitical situation. I really believe that this is why we need to redouble our commitment to that international human rights framework because it gives us that balance; it gives us a focus and a clarity with which we can move forward with hope and values and belief – it's progressive democracy and action.

I therefore think we need… the belief and view of everybody working together towards those same aims to be able to counterbalance what we're experiencing.

Emma - human rights has come up in the members' bill that's going forward right now about the right to recovery from alcohol and drug harm. It makes me think about stigma and helping healthcare professionals destigmatise their language and treat people as human beings.

Charlie - mental health had these discussions 25 years ago about the right to recovery and that people can and do recover.

Tejesh - I think the thing for us to recognise (and to address Anuka's point), is that it is a critical time for decision-making in the run-up to elections, the end of the financial year and several bills going through parliament. From a human rights perspective, what is the opportunity for us as a group? I know from VHS's perspective, we're looking towards manifestos, briefings, engagement with politicians within the coming weeks and months. There's a call to action across the group around what we think we can do individually and on behalf of our organisations.

Speaking on behalf of Voluntary Health Scotland, we'll be looking at how we can integrate the language around human rights into the work that we're doing. I thought it was interesting the point about paying lip service to human rights because we can be guilty across sectors, where we talk about being trauma-informed, person-centred. I think we need some focus on what does that actually mean for us as an organisation? What are we asking for? Who will be the beneficiaries? We know there is a focus from the Scottish government around child poverty. It's interesting for us to think about the other areas that we can influence in terms of those social determinants.

At the Gathering last week, we did share some concerns with the First Minister in relation to progress on health inequalities as well as funding instability for the third sector. There was a candid recognition of the challenges that are being faced and the perfect storm, if you like of COVID and cost of living crisis and austerity. There was an acknowledgement for a commitment to more multi-year funding and we talked

about that short-termist approach earlier. So, we would hope to see that starting to come through within the next financial year and that's something that we'll continue to keep the pressure on.

We had a session at The Gathering called the Catalysts for Change - with leaders across the sector talking about what we can do to actually make a difference. One of the reflections was sometimes we try to do too much - we talk about things like the Human Rights Bill, the National Care Service etc. Are they too big?
And I did have a personal view that these things can be huge and can we make progress? I think the opportunity to break things down is quite important. One of the other panelists, Justina Murray, talked about the opportunity for us to celebrate our 'wee victories'. We keep talking about how we create health. How can we remove those barriers and create health for people? And I think the examples and the lens that Charlie has provided today have given me another way of thinking of how a human rights-based approach, when done well, is hugely impactful in creating health for the people that we're often trying to reach.

Agenda item 5

Any other items – none listed

Agenda Item 6

Lauren - There is the CPG and Voluntary Health Scotland garden lobby reception taking place on the 14th May. Emma is sponsoring this and we have Minister Jenny Minto speaking on the night. The invites for that event will be coming out shortly and the next official meeting of the CPG will be in June, dates tbc.

Contact Lauren Blair with any CPG questions: lauren.blair@vhscotland.org.uk