OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 21 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 March 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

10th Meeting 2023, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Claire Burden (NHS Ayrshire and Arran)
Cathie Cowan (NHS Forth Valley)
Kirsty Garrett (Glasgow Life)
Kate Joester (Living Streets Scotland)
Euan Lowe (Scottish Swimming)
Patrick Murphy (South Lanarkshire Leisure and Culture)
Cecilia Oram (Sustrans)
Ralph Roberts (NHS Borders)
Maree Todd (Minister for Public Health, Women's Health and Sport)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 March 2023

[The Convener opened the meeting at 09:04]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning, and welcome to the 10th meeting in 2023 of the Health, Social Care and Sport Committee. I have not received any apologies for today's meeting.

Item 1 is a decision on whether to take items 6 and 7 in private. Does the committee agree to take those items in private?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Ayrshire and Arran, NHS Borders and NHS Forth Valley)

The Convener: Item 2 is the first in a series of scrutiny sessions with all the national health service boards in Scotland. I welcome to the meeting Ralph Roberts, chief executive of NHS Borders, and Cathie Cowan, chief executive of NHS Forth Valley. Although she is not quite with us at the moment, we expect Claire Burden, chief executive of NHS Ayrshire and Arran, to join us remotely.

I will kick things off. Thank you for coming in today. By no means—[*Interruption*.] I am sorry; I forgot to go to Sandesh Gulhane first.

Sandesh Gulhane (Glasgow) (Con): Thank you, convener. I declare an interest, having worked in NHS Ayrshire and Arran and NHS Forth Valley.

The Convener: Thank you. That is now on the record.

We are not singling out any particular boards; we are trying to fit in a session with every board over the next couple of years.

I want to ask about financial sustainability. I am particularly interested in how inflation and the increased cost of fuel are affecting your boards. We tend to talk about these things in domestic terms—how they affect families. That is how it comes out in the media, but such costs will have an impact on your boards and people who need their care. I am interested to hear about your boards' financial sustainability and the impact of inflation and fuel costs on your operations.

Ralph Roberts (NHS Borders): It is a significant issue. The overall position around financial sustainability is extremely challenging. We can get into more detail on that.

Your point about the impact that inflation and the cost of living have on our patients and staff is also important, and they are certainly having an impact on our costs. You will have seen from the draft financial recovery plan that we submitted to the committee that our financial position has deteriorated during the past couple of years and going into next year. There is no doubt that part of the reason for that is inflation. I would need to double-check this, but I think that we are projecting about £1 million more in energy costs going into next year. That is not an insignificant figure. I will double-check that and make sure that I am quoting the right figure.

However, it is not just about energy costs; it is also about procurement costs across the board. Prescribing costs are also going up. Some of that

is to do with activity, but I have no doubt that there will also be underlying cost pressures in the supply chain for medicines. We have to recognise that those cost pressures are significant, and the reality is that they are not matched by the general uplift that health boards have had in the past couple of years and will have going into next year.

Cathie Cowan (NHS Forth Valley): Like NHS Borders, we pull financial sustainability and value together. The situation is extremely challenging, although we are reporting a break-even position for 2022-23. Our three-year plan, which we have shared with the committee, highlights the areas that we will focus on during that period. Our big focus will be on inequalities and trying to shift resources into prevention through primary and secondary interventions and transformation.

In relation to inflation, we have a unitary charge issue in relation to our three big estates—Forth Valley royal hospital, Clackmannanshire community healthcare centre and the Stirling health and care village. That is linked to the retail prices index, and when inflation goes up, it goes up. We will therefore see an increase of about £5.2 million in alignment with inflation.

We are projecting a 30 per cent increase in energy costs. Like Ralph, I do not have the exact figure and would like to check it, but we are planning for a 30 per cent increase.

The price of medicines is also subject to inflation, and our staff and patients are being affected by the cost of living and by fuel costs. We are keeping a very close eye on our patients and on non-attendance rates, to see whether there are trends within communities.

The Convener: I was going to ask about that. Are you monitoring the impact that the cost of living crisis might be having on people presenting to you, as well as on things such as staff absence?

Cathie Cowan: We are looking at patients in particular. Our director of public health is looking at links to deprivation categories, so that we can have more insight into how to work in partnership with councils to help our patients get to hospital or to consider how to take services to our patients.

The Convener: That is really interesting. Ralph Roberts, are you doing something similar to ascertain how the situation is impacting on your patients?

Ralph Roberts: We are trying to. Our public health department is looking again at how it runs services and at what support can be put in to build greater resilience in communities. We are not focusing on individuals, but are looking more broadly at how to build resilience in communities.

The Convener: I would have asked Claire Burden about the situation, too, but she does not seem to be online yet. I throw the questioning open to my colleagues. Paul Sweeney has some questions for our panel.

Paul Sweeney (Glasgow) (Lab): My main interest is in how capital investment can be used to drive revenue savings in the national health service. I would be interested to know what your boards have done to utilise capital investment as a way of reducing revenue costs for utilities in particular through investing in things such as district heating networks.

There is a good model at the Golden Jubilee hospital, which has recently worked in partnership with West Dunbartonshire Council to introduce the Queens Quay district heating network scheme. The scheme will deliver a major cost saving for the hospital estate as well as benefiting the wider community and getting people off the gas grid by using the river-sourced district heating network. Could that kind of model, which offers a high return on capital investment, be a way of conquering the current challenge of high utility costs?

Cathie Cowan: We are looking at every opportunity to reduce energy costs in our acute hospital. I do not have the exact figures in front of me, but we are implementing a grant that we got from Scottish Government and are taking every opportunity to reduce costs, particularly for lighting and heating. As you would expect, we are also investing significantly in electric vehicle charging at all our sites to help both staff and patients. We are very committed to that. I do not have the exact figures in front of me—I apologise for that—but I am happy to share information about our schemes.

Paul Sweeney: That would be helpful. Do you have a slate of proposed capital investment schemes and a formula that tells you your expected return on investment?

Cathie Cowan: We do. We take our capital plan to the board and analyse how we use and heat rooms, where we could invest and what the return in benefits realisation would be. We have that information. I do not have it in front of me, but would be very happy to share it with committee members.

Paul Sweeney: That is definitely helpful. Thank you.

The Convener: Emma Harper has some questions.

Emma Harper (South Scotland) (SNP): My questions are about investments and saving money on energy. NHS Dumfries and Galloway has a £200 million hospital but has not put a single

solar panel on the roof. Has NHS Borders assessed the opportunities that would come from investing in solar panels?

09:15

Ralph Roberts: We are certainly looking at a variety of energy efficiency projects, and solar energy will be part of that. Going back to the previous question, we need to consider district heating systems. I was in Shetland in my previous job, and that was part and parcel of the approach there. The hospital was on the district heating system, but such systems are not that common. There would be no opportunity to do that in the Borders because the local infrastructure is just not there, but we are looking at other forms of energy efficiency.

In our plan for next year, we have assessed potential savings of around £390,000 from a variety of energy efficiency schemes. In the longer term—over 10 or 15 years or more—we will be looking to refurbish and replace our district general hospital. We are conscious that the overall availability of capital is restricted. We have a formula for the allocation of capital for minor schemes, and the vast majority of that is allocated to equipment replacement, infrastructure maintenance and some of the energy efficiency schemes, but we have to build long-term business cases for the more fundamental redesign of our estate.

The Convener: I want to bring you both back in before I move on to other colleagues—I will bring Paul Sweeny back in in a second.

The purpose of the uplift that you got from the Scottish Government was to reduce waiting times, and, I imagine, to support a certain amount of recovery from Covid. You mentioned that it was not to deal with things such as fuel costs and inflation, because at the point at which the uplift was decided, those issues were not as acute as they are right now.

This is an obvious question—it is almost a rhetorical question—but what is your assessment of how the two factors that we have talked about affect your ability to deal with waiting times?

Ralph Roberts: Our uplift is there to address the broad range of costs that we have, which changes from one year to the next. It is fair to put on the record that in addition to the core uplift that we get, we have had a commitment that, going into next year, the additional funding over the basic level of uplift that we got for the pay awards will be funded separately. It is important to recognise that.

The money that we get for access and waiting times normally comes as a separate allocation. NHS Borders has its NHS Scotland national resource allocation committee share of the waiting times money for next year, which is just over £2 million, and the breakdown of how we suggest we will spend that is included in our submission.

We talk about the financial challenge, but it is important to recognise that although there is no doubt that finances are challenging, the workforce position is equally challenging. The headline figure in our financial plan shows a projected overspend next year in the order of £22 million. However, the reality is that if you gave me an additional £22 million tomorrow, I could not spend it, because I would not be able to recruit the staff.

The challenges around access are not purely about the money. They are as much, if not more, about our ability to attract the workforce that we need and create the capacity in the system as a result of that workforce, which then allows us to protect our elective programme.

The Convener: A number of colleagues are going to look at staffing, but that is a good and helpful basis for that discussion.

Cathie Cowan: My comment is similar to Ralph's. Our 2 per cent uplift, which equates to around £12.4 million, and our NRAC share, which is £600,000, has been added to our baseline of £630 million. We have in-year allocation of just over £108 million to come in, and we have factored that into the plan, which we have shared with you.

As Ralph says, workforce is a big issue. We took a decision in 2021-22 to invest in the workforce in a recurring way, which has benefited our scheduled care position. Members will see that our scheduled care position is reasonable compared with that of other areas, but there is still a long way to go when it comes to patients waiting. Taking that decision has given us an advantage. We took it through a risk-based approach with regard to non-recurring allocations coming year on year and, rather than using that money in a non-recurring way, we decided to invest recurringly. Taking that decision has paid dividends for us. However, as Ralph Roberts has said, we are now all looking for a workforce together, and that workforce is short of workers in certain key areas.

The Convener: I will not impinge on my colleagues who want to come in on staffing.

Paul O'Kane (West Scotland) (Lab): Thank you, convener, and good morning. I want to follow up on the issue that was raised around people attending inappropriately, if you like. There was an ambition in the recovery plan, as part of the review of urgent care, to reduce the use of hospitals as the first port of call by 15 percenatge points to 20 per cent, although Audit Scotland highlighted that

there has been a lack of progress on that. Are you tracking the number of people who attend accident and emergency as their first port of call when that is not the appropriate setting for them? What impact are those attendances having on the overall budget?

Cathie Cowan: My background is nursing, and I worked in an emergency department a very long time ago. I am a bit cautious about people attending inappropriately. At NHS Forth Valley, we are very keen for patients who could have gone elsewhere to redirect, but we are also keen to provide support and education so that the next decision that they make is the right decision—the right place, right time, right personnel and so on.

I worry about older people, in particular, who hear messages about us being really busy—they are the patients who usually do not turn up, but I suggest that they are the patients who should turn up. We are taking a measured approach, including through our triage system. When people present to the emergency department, they quickly go through primary triage, and we are very clear in saying when a patient could go elsewhere—to a pharmacy, the minor injuries unit in Stirling or wherever—and in doing redirection and education work about what else is there, particularly with mums who have young babies. We do a secondary triage so that people are very quickly moved around the department to meet their needs.

The emergency access standard is a system measure, and it is not even half of the story; behind that measure are a number of critical safety measures. As chief executives, Ralph Roberts and I watch our time-to-triage numbers very carefully, and when it starts to creep up over 15 minutes, there is a safety alert in our systems that make us think about what to do next. I say that in answer to your question about redirection.

There are people who are repeat offenders—they turn up when they could go elsewhere—but our approach is that we try to educate the public in our space and we look to national campaigns to support that. I hope that that is helpful.

Ralph Roberts: I echo everything that Cathie Cowan has said. I want us to understand slightly better what is going on. If you look at the overall numbers of people coming through emergency departments—certainly those in our system—you will see that they are only just back to, or slightly under, pre-pandemic levels. That suggests that a number of patients are now being seen elsewhere in the system and that those who are coming into emergency departments are the ones who absolutely need to be there. We have our flow navigation centres—that is our primary care bit at the front door, which is streaming out some patients.

From the data that I have seen, there is no doubt that the level of activity in primary care is higher than it was pre-pandemic, although it is not as good as I would want it to be. We are making progress in ensuring that people are seen in the right place. Our front-door clinicians do not say to us that they are seeing a lot of patients that they would say were inappropriate. As Cathie Cowan has said, the challenge and responsibility for us is to ensure that, when patients come in through the front door, we triage them and, where appropriate, we turn them around and signpost or move them on to other services; where appropriate, we treat and discharge them; or, where appropriate, we assess, admit and treat them.

The Convener: Paul Sweeney will now ask questions about performance, although we have touched on that already.

Paul Sweeney: The witnesses have already talked about people presenting at A and E departments. Among member countries of the Organisation for Economic Co-operation and Development, Scotland has the highest acute hospital expenditure but the lowest preventative and community-based expenditure. The equation seems to be very lopsided. There are worrying metrics that show that there is, for example, low provision of key diagnostic equipment and beds per capita. Do you tend to keep track of those metrics? For example, do your boards keep track of how the provision of MRI or CT scanners per capita compares with international benchmarks?

Ralph Roberts: We do not measure our service in that way, but we are very conscious of the level of capacity in our diagnostic services. As part of our access plan for next year, we are providing additional mobile CT and MRI capacity. We have just gone through a process of replacing our MRI scanners, and we are due to replace our CT scanners next year so that they are up to date. Instead of looking at things on a population basis, we focus on the capacity and demand in our system. To some extent, given that we cover a relatively small population, the figures would be skewed if we looked at things purely on a population basis.

We are very conscious of our diagnostics. We believe that we have a very good record of performance against our cancer targets, and a key aspect obviously relates to the diagnostic stage of someone's cancer pathway. We focus an awful lot on ensuring that we have the capacity to deliver against our targets.

Paul Sweeney: I will jump to the other end of the patient journey in acute hospital settings. Do you actively track the opportunity costs of delayed discharge in hospitals and the impact that that has on your overall capacity to deliver community-based services? Is there almost a reflex situation

in which delayed discharge denies us opportunities to invest in more appropriate care settings?

Ralph Roberts: There is no doubt that delayed discharge is a very significant issue. We monitor daily where our delayed discharges are and what they are waiting for. The responsibility is with the whole system. It is not just about social care; it is about the way in which our clinicians make decisions and how we support people through the system.

Something like 30 per cent of our beds in the Borders are currently occupied by delayed discharges. Before the pandemic, there were probably about 20 delays at any one time, and we felt that that was too high at that point, because, notwithstanding the impact that delayed discharge has on the system, every delay represents an individual not receiving the care that they need at the right time in the right place.

We have been running at upwards of 50 delayed discharges—yesterday, we had 68 in our system. That represents a huge opportunity cost. One consequence of delayed discharge is its impact on our elective capacity. Another one of the number of issues is that delayed discharge increases the overall length of someone's stay, so we have been required to open additional beds, which we have struggled to staff. That has had a knock-on impact. As of yesterday, we had 15 additional beds open in the hospital. Up until last week, that number was 20. We have also opened eight additional spaces—which we aim to staff—in our emergency department to reflect the fact that we have additional people in our system. Delayed discharge is therefore a fundamental issue.

Paul Sweeney: It certainly is, as you have observed. Can you envisage a viable mechanism for unravelling the situation so that a more sustainable approach is taken? It seems very much to be wrapped up in a self-perpetuating cycle at the moment. How do we recover the situation?

09:30

Ralph Roberts: For me, there are two issues. One is ensuring that, in the health system, we make the right decisions at the right time to support people through their treatment programme, and that includes the point at which we make decisions around what sort of support they will need. We discharge well over 90 per cent of our patients without any delays, and it is important that we remember that.

During the past six months, we have done quite a lot of work focusing on continuous improvement of our individual processes. There are issues around realistic medicine—or value-based medicine, whatever phrase you want to use—about the choices that clinicians make with patients about the level of treatment that is appropriate for their needs and without being unrealistic about that.

However, beyond that, there is no doubt in my mind that there is an issue with the level of social care support that we have. I recognise that a large part of the driver for that is the recruitment and retention issues that exist in social care—I have a lot of conversations with our social care colleagues about that. The health and care systems have to address that.

Cathie Cowan: I do not want to repeat everything that has been said but, yesterday, our system had 93 delayed discharges in it. On top of that, we had just over 50 transfer waits. Those have a huge impact, particularly on the acute site. That also has a huge impact on our four-hour emergency access standard, because that is a system measure, which means that it has implications. Included in those figures, we have about 33 patients who have adults with incapacity issues, and we are thoughtful about how we support families through the decision-making process.

Equally, I would not want you to think that we are not investing in prevention or community care, because alongside that—similar to Ralph Roberts's board and other NHS boards—we have been particular about investing in respiratory pathways and in community teams so that we treat patients at source when they present at hospital. We have put a big emphasis on outpatient parenteral antimicrobial therapy, so we are doing that in the community.

We also focused on a rapid assessment and care unit so that patients go through a different front door when they present at the hospital with issues related to that. That means that we redirect ambulances and so on to treat patients who have long-term conditions. If they have heart failure, we want to do a quick and thorough diagnostic assessment so that we can support people in the community.

Our whole-system approach is very much about prevention. The thing about prevention is that it takes a while to see changes come through, but it is absolutely the right thing to do.

Coming out of the Covid pandemic—although we still have a lot of Covid around; we have 40-plus patients at our acute site today—we are very keen to focus on how we support an infrastructure that takes account of patients who did not present during Covid, and who have high blood pressure and so on. That could also include some of the secondary prevention around diabetes and hypertension, for example. I agree with Ralph

Roberts that the patients who present are acutely ill; we see that acuity at the acute site, and we are desperately trying to sort that out, but we also think about prevention.

Paul Sweeney: Okay. You mentioned the preventative spend bill, and I want to ask about preventative maintenance, in particular. We know that some health boards have severe repair backlogs on capital investment. Such repairs can end up becoming far more expensive over time if they are not preventatively tackled. Is that a challenge in your health boards? Do you have a repair backlog that is concerning? Is it a risk that you see to be significant? How do you approach preventative maintenance?

Cathie Cowan: In our health board, we are fortunate—although unfortunate in respect of the conversation that we had earlier about inflation and the RPI, and so on. We have one facility in our community hospital estate, in Falkirk, and there are some issues at Bellsdyke hospital, where we have about a £30 million backlog. We are addressing that through our capital spend and ensuring that our decisions mean that we are using our estate really appropriately.

The other big area that we are considering as a whole system with the local authority is our primary care infrastructure, because if we are serious about supporting services in the community, we have to ask what that infrastructure should look like. Some of our primary care facilities are really outdated. Notwithstanding what Ralph Roberts said about capital and business case development, we have a programme of investment to turn those facilities around.

We are thinking with the council about whether we can do things jointly to add value to the public purse.

The Convener: We must move on, Paul. A lot of members want to come in.

Claire Burden has now arrived. She had significant connection issues. Good morning, Claire. I will not bring you in immediately and try to make you catch up with everything that you have not heard. You can put an R in the chat box if you want to come in on anything but, otherwise, I will leave members to bring you in.

Gillian Mackay has a question.

Gillian Mackay (Central Scotland) (Green): My question on this theme has been adequately covered so, in the interest of time, you can move on, convener.

Emma Harper: I have a supplementary question on the back of what Paul Sweeney asked about the availability of CT scans, additional capacity and prevention in the community. On Friday, when we met at our usual elected members briefing, Ralph, you talked about how beds were used as a currency when we should be looking at the services that are delivered, such as pulmonary rehabilitation or mental health care in the community, which prevent acute admissions.

A lot of work is being done on how we deliver things differently. I heard about a diabetes outreach bus that is being developed in Glasgow by Dr Brian Kennon, which goes to Ibrox stadium, for instance, and helps to do some of the health inequality outreach for people with type 2 diabetes.

Should we focus on that? Rather than just looking at beds as a measurement of how successful things are, should we look at service delivery? Will you comment on that?

Ralph Roberts: As I said on Friday, we absolutely have to consider that. If you look at the way that healthcare has evolved over my career of 30-plus years, it is completely different now. When the Borders general hospital was built, it had an ophthalmology ward. We do not admit people as in-patients for ophthalmology now; it is nearly all done on a day-case basis. Healthcare continues to evolve in that way. As Cathie Cowan said, we are considering virtual respiratory pathways and hospital-at-home services.

In addition to the delayed discharges that are measured as formal delays, a number of times a year, we do an exercise to consider what the needs of all the patients in our hospitals really are. From that, we can see that a significant proportion—well over 30 per cent and, at times, towards 50 per cent—are people who could be cared for differently. Therefore, we need to think differently about that.

In the Borders, we have four community hospitals, one of which is relatively new—it was opened in the early 2000s—and three of which go back to the 1950s and before. To return to the backlog, maintaining the standards of those hospitals is a significant issue. However, on how we use those facilities, different alternatives could be put in place to support people in the community, which is not about a traditional hospital service.

We must change the dynamic around that and not get hung up about hospital beds. The issue is the need that the individual patient—the person; the member of our population—has. There are different ways that we can approach that, such as some of the examples that you used, and different ways of providing care in the community. Our local council has been considering care villages and is in the process of developing business cases for two of them. That will change the way in which we

provide support in the community for people in the long term.

Emma Harper: I suspect that my other questions will come up later, so I will pause there.

The Convener: This is a good opportunity to bring in Claire Burden from NHS Ayrshire and Arran. We have talked about financial sustainability, and it is only fair to ask for your assessment of how your health board is managing its finances and balancing its budget, given the current strains on its finances.

Claire Burden (NHS Ayrshire and Arran): Good morning. I apologise that, along with my information and communications technology challenges, I have a voice challenge from the local cold.

I inherited a deficit of £26 million, which we have been unable to chip into over the past year. The themes are similar to those that colleagues have shared—we have been unable to pull ourselves away from the additional beds in our system, and some of our reform ambitions have been achieved more slowly than expected.

Going into 2023-24, our underlying position is deteriorating. However, that does not stifle our ambition, in that we know what good looks like and we have good support from system partners.

As has been discussed, dealing with delayed transfers of care—getting people into the right climate—is where we will make the greatest gains against our deficit. We have a core bed base of about 850, but we have extended into a bed base that is just shy of 1,000. Because of post-Covid legacies and so forth, we have 185 beds that we need to remove from the system. We, too, are struggling with Covid outbreaks, which have been the rate-limiting factor in 2022-23.

The year has been very difficult for teams but, as a system, we have a greater understanding of where we can work together to make positive inroads into the deficit. About £14 million of it is associated with bed-based care alone; other pressures in the system are from medicines, energy and our infrastructure.

People have talked about the investment that is required in our infrastructure. We have some ageing estate. When I came into the system, the caring for Ayrshire programme was about preparing the system for a new hospital, but it is clear that that will not happen in the very near future. The backlog maintenance programme and some reform have slowed up over the past three or four years. The pandemic had a dramatic impact, which has resulted in backlog maintenance and underlying infrastructure weaknesses being a bit more exposed as we go into 2023-24.

The Convener: Thank you—I wanted to give you the opportunity that others have had to set out your challenges.

Stephanie Callaghan has a question.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Convener, can you hear me?

The Convener: Yes—we can.

Stephanie Callaghan: Thank you—I could not find the right button. I will pick up on what Cathie Cowan said about community pathways and teams. The committee often hears about the importance of early intervention and preventative care. Should we be doing things in key performance standards to ensure that early intervention and preventative care are better reflected as a higher priority? Does that fit in at all?

Cathie Cowan: Yes—that gives me the opportunity to build on what Ralph Roberts said in response to a previous question. Our performance framework counts the things that we can count, but we must think about what else we need to focus on, because the framework directs attention, and what we pay attention to improves performance.

We chief executives have been talking about what else we could measure in prevention and early intervention, in ways that demonstrate not only value but best practice that we could share and could replicate to fit local circumstances—not everything is transferable from A to B. It would be beneficial to focus on that and have such measures, so that we could begin to think about how we pay attention to those and direct and support change.

09:45

Ralph Roberts: That question is really important. If we are honest with ourselves, we have had an ambition for—again—probably as long as I have been in the health service to invest more in preventative care, but we have not done that.

That leads us to some really challenging policy choices. I accept that those are difficult, but, over that period, we have continued to invest heavily in acute care, because of access issues, and have not got upstream around preventative activity.

We have continued to invest very significant moneys in high-cost medicines. I accept the argument around that for individual patients—obviously, it is very emotive, and the desire to do it is very understandable—but it means that we are spending more and more money on some of that acute and very specialist care, and are not

releasing the resource to spend on preventative care.

There are therefore some very challenging policy choices in there for us as a society, about how we choose to use the resources that we have. We have to get into conversation with our communities about the type of health and care system that we want in the future.

Certainly, if my medical director was here—going back to that question about realistic medicine—she would say that we have to have honest conversations with patients about what is realistic when it comes to their long-term care—or even their short-term care, depending on the circumstances.

As I have said a couple of times, we as a society have to get into some very significant policy issues.

Claire Burden: I was going to raise similar issues to Ralph Roberts. We have made some positive inroads with realistic medicine, in all care settings. We have good working relationships with primary carers, who do their best with the living well agenda through the proactive management of patients who have chronic disease, and we link well with our community partners.

It is fair to say that, if we can distribute more funds to the prevention and living well agendas, so that we tackle the health inequalities agenda for the longer term, that will bear fruit. However, as was mentioned earlier, pressure draws resources back into acute medicine, here and now, and into addressing the backlog. It is not for the want of enthusiasm in our health and social care partners and council colleagues for working with us on that agenda.

The Convener: We move on to Covid recovery.

Sandesh Gulhane: I will start with Ralph Roberts. Does NHS Borders expect to be able to access the treatment centre in Inverness, in the Highlands?

Ralph Roberts: We would probably not expect our patients to go to Inverness, but we expect them to go to the Golden Jubilee hospital—as they already do. As other treatment centres come on stream, it is important that we increasingly look at them as a national resource and look at how they will help us to address the backlog across Scotland and achieve as much equity as possible in access.

As a board, our primary focus is to ensure that, whenever possible, patients get care locally, but in our case, we need to be realistic that a number of patients will always travel outside the Borders. They do that for specialist treatment and will increasingly do it for some of the general—

Sandesh Gulhane: I am not talking about specialist treatment; we all accept that patients have to travel for really specialist treatment. I am talking about ASA 1 and 2 patients who need, for example, a hip or knee operation. You are saying that, when the treatment centre is online, you will expect such people to go not to the Highlands but to the Golden Jubilee.

Ralph Roberts: I would not expect such people to go to the Highlands, but I would expect them potentially to go to Fife, to Lothian when that comes online or to the Golden Jubilee. The bit that we will need to get right in the Borders is the balance between patients going outside the Borders and patients whom we can treat locally. We have to sustain a trauma service and an unscheduled care service in the Borders, and that requires us to ensure that we have orthopaedic surgeons. Our surgeons are not split between elective and urgent care, so we need to get the balance right and continue to ensure that such jobs are attractive for our orthopaedic surgeons.

There will be a balance in what is treated locally. However, I am absolutely up for a conversation on what access we get to address the backlog in particular and then, beyond that, what the balance of care is between what we provide locally and what we provide elsewhere.

Sandesh Gulhane: So you will need a further conversation to find out about things such as the extra costs that might be associated with a 23-hour in-patient stay and other resources that you might need to put into a patient going to the Golden Jubilee or other treatment centres.

Ralph Roberts: Yes. We need to look at that and compare it with the cost of providing that care locally.

Sandesh Gulhane: Okay—thank you.

I have questions about the health recovery plan. In the reading that I have done, it has been suggested that the recovery plan was not discussed extensively with health boards. When the recovery plan came out, how close were you to being back to pre-pandemic levels of out-patient elective work?

Ralph Roberts: It is fair to say that we have been challenged to get back to pre-pandemic levels of activity. Over the past three or four months, we have been running at just under 80 per cent of our previous out-patient activity and at between 50 and 60 per cent of previous in-patient activity. Some of that is about capacity in the system in relation to beds, particularly for the elective care programme, and some of it is about challenges that arise from issues that are specific to us in one or two specialties.

A significant part of the deficit compared with pre-Covid activity in out-patients is associated with ophthalmology and dermatology, which is to do with the workforce rather than capacity. In orthopaedics, the issue is more about elective bed capacity and theatre capacity. The situation is different for individual services.

Sandesh Gulhane: The position is mixed. I ask Cathie Cowan the same question. What levels of elective work are you at compared with pre-pandemic levels?

Cathie Cowan: At 1 March 2023, we had a total of 4,271 patients waiting, so we are making inroads. Within that, we have 2,372 who have been waiting more than 12 weeks. We have tried—

Sandesh Gulhane: I am sorry, but my question was about the comparison with pre-pandemic levels of elective work.

Cathie Cowan: In terms of pre-pandemic levels, percentage wise, certainly in diagnostics, we are probably about 86 per cent on track to get back to where we were. As I said, we have invested significantly in scheduled care in—

Sandesh Gulhane: I am sorry, but my question was specifically about where you are with elective surgery now compared with pre-pandemic levels.

Cathie Cowan: In terms of waiting times, I would say that we will be back on track in specialties such as orthopaedics and trauma in the next six to nine months. That is very clear in our recovery plan, in terms of out-patients. Targets have been set to get us there—on 78 and 52 weeks and so on—and we will meet our 52-week target at the end of March.

Sandesh Gulhane: Sorry—

The Convener: Sandesh, I need to bring in Claire Burden.

Sandesh Gulhane: I am just trying to ascertain the answer to the question, which was about the comparison with pre-pandemic levels. It is not about the 52-week wait.

The Convener: I understand that, but we have half an hour left and a multitude of themes to cover. You have had several questions, and you have come back with the same question a few times. I appreciate that you may not be satisfied with how Cathie Cowan has answered it. I will bring in Claire Burden to answer your question.

Claire Burden: We had 8,553 patients on our surgical waiting list at its peak in 2022. We now have 7,947. We are at 99 per cent of our pre-Covid rates in out-patients and at 78 per cent in surgery. Our limiting factor has been that our critical care unit was no longer fit for purpose in its original area, and it is where day case activity used to take place. We have had some change in baselines.

We were not at those levels at the beginning of 2022, and it has taken a good eight to 12 months to get back up to them. Although the swing is of only 600, it is positive that we have started to achieve a modest reduction in total numbers. For our constant improvement in returning to pre-Covid levels, our ambition is to be at 90 per cent of pre-Covid levels. That is rate limited by access to theatres because of the relocation of our critical care unit at Crosshouse.

Paul O'Kane: I wonder if I can expand on your Covid recovery plans. Audit Scotland was critical of the lack of consultation with NHS boards on the development of the national recovery plan. It also highlighted that many boards desired greater autonomy in their own recovery plans. Would it have been helpful to have had a more localised recovery plan that you could have worked to within your resource allocation?

Cathie Cowan: The national recovery plan has a number of headlines that are not dissimilar to the headlines in NHS Forth Valley. We have flexibility in the actions that we can take, whether that is investment in primary care, in urgent and unscheduled care or in community care.

I referred to best practice. It is really good to learn from each other about what we are doing, but local circumstances sometimes prevent us from doing exactly the same thing and getting the same return. Our population might differ in its demographics or in its epidemiology, in terms of presentation.

I do not think that our recovery plan in NHS Forth Valley is at odds with the national plan, and there is local flexibility within that. As Ralph Roberts and, I think, Claire Burden mentioned, the rate-limiting factor is the workforce and how ambitious we can be about that. In Forth Valley, we have invested in the workforce that we have. You will see from my submission that we have invested in creating more band 3 jobs and that 800-plus people have moved from band 2 to band 3, because they have the skill set to do that. We are really trying to get everybody up to the top of their licence to beat the backlog, to go back to the previous question. I am not uncomfortable about the national approach versus the local one.

Paul O'Kane: Did the Government ask you specifically about workforce issues in relation to the national recovery plan?

Cathie Cowan: As a health board, we were asked to submit our workforce plans, which we have done. Those plans identify gaps in specialties or in the workforce and the things that we are doing on that.

In my system, we are working with local authorities and so on to think about how we can get people into health and care. Health boards' workforce plans are on record and have been shared with Government colleagues.

The Convener: We will go to Ralph Roberts and then we will have to move on. We need to dig into a number of themes, including staffing, and I am conscious that we have only half an hour left with the panel.

10:00

Ralph Roberts: I will probably just repeat what Cathie Cowan said. I have no problem with there being a national recovery plan, because it is helpful to see the overall policy direction that people want us to take. Individual boards have adapted that to their local circumstances, which vary. As Cathie Cowan said, we engage with Scottish Government officials monthly, if not more frequently, when issues that affect the workforce are flagged and discussed. The balance between having an overall direction at national level and then understanding what that means for us locally and having an on-going discussion about progress is perfectly appropriate.

The Convener: Emma Harper has questions on progress under the recovery plan. I know that we have mentioned it, but if you could ask your question, Emma, we can then move on.

Emma Harper: Sure—I will be quick. I have two questions, but we could park for later the question about the use of the long Covid pathway, rather than the long Covid clinics that have been established in the NHS Borders area. I am interested in knowing about the best way to look after long Covid patients.

The other issue goes back to what Ralph Roberts said on Friday, which was that making progress on recovery has required working with registered social landlords to look at housing and wider aspects of supporting people in order to practise reablement. We do not use that word a lot, but it simply means supporting people to get the best care and to get them home. Is that part of what you are doing to make progress on recovery?

Ralph Roberts: As I said on Friday, the long Covid pathway is about signposting people with long Covid towards the right care, because they will have a variety of needs. We do not run a long Covid clinic; instead, we signpost people into the right service for them as individuals.

The council and the health and social care partnership have been putting quite a focus on reablement. For me, it is about reducing the need for social care over time, which will release additional social care capacity. If we can support people over the initial period when they are discharged from hospital and then adjust their social care packages to meet their on-going needs, that will help to create capacity in the system. The output that we have seen from the initial work that has been done is that that has been successful. I see it helping in the future with the issues that we referenced earlier, such as delayed discharge. In itself, that work will be important for creating capacity in hospitals so as to allow us to address the backlog issues.

The Convener: Now we have questions from Gillian Mackay on the escalation framework.

Gillian Mackay: According to the submissions, all the boards that are represented have been escalated to higher levels of the framework, and they all have higher turnover than the national average. Is the high level of turnover linked to poor culture in your board areas?

Ralph Roberts: As regards NHS Borders, I do not think so. We need to be honest with ourselves that, in an organisation the size of the health service and in one that is the size of mine, there will be issues in individual services and, at times, issues between individuals. We need to have appropriate mechanisms in place to support people by understanding and addressing what is behind those issues.

When I joined NHS Borders four years ago, leadership was one issue that we had been escalated on. We were de-escalated for that part way through the pandemic. We have put a lot of work into how we lead the organisation and engage with our staff, and we are trying to shift our approach. We often talk now about having a compassionate leadership approach and we have just started a programme on that for staff across the organisation. We have introduced what we are calling our quality management approach, which sounds like management speak but simply focuses on how we engage with the public and our staff. We are making progress on that, but it would be incredibly naive of me to sit here and say that we should be complacent about it. We need to continue to work on that at all times, because it is important.

I do not particularly think that that relates directly to the turnover issue. In our circumstances, that issue is more directly related to the age profile of our workforce and in particular to the issues that people have experienced over the pandemic. There is no doubt that that has had an impact on people making different choices.

Cathie Cowan: Absolutely—my response is very similar to Ralph Roberts's. I know that nobody underestimates the pressures that have been on the workforce during the pandemic. We

continually say a huge thank you to our staff for that. During the pandemic, which we have not yet come out of, and as we have moved forward, a number of staff have made work-life balance choices.

A number of people—particularly in nursing—have taken retirement, a number of people have gone into new employment and a number of people were on fixed-term contracts as a result of the pandemic, whether that was in test and protect or whatever. Like Ralph Roberts, I do not think that turnover has a correlation to culture, but like him, we are not complacent. We have, equally, put in a compassionate leadership programme, which Professor Michael West is supporting us in.

If committee members follow the boards, they will have seen that I brought in an external review of our emergency department way back in 2020-21 because of poor culture, so we are not shy of that. We will absolutely take appropriate action because we want people to come to work, have a good day, enjoy their work and be supported in the workplace, whether that is with training, development or good leadership. We have significantly committed to that.

Claire Burden: I deal with similar themes to those of my colleagues—[*Interruption*.] I am sorry; I have a cough. The culture plan is predicated on our commitment to retention, attainment, professional development and recruitment. People have definitely made some life choices, as described by Cathie Cowan—we have many more people reducing the hours that they are offering, and our medical workforce has many contracts that are much smaller now than they were two or three years ago. We have 500 nursing vacancies and we are constantly on a recruitment cycle.

It would be fair to share that, nationally, the NHS has a reputation challenge in that the view in the media is that it is not a great place to work in and people are under constant pressure. However, our experience as chief executives is that we have exceptionally dedicated staff who genuinely love their jobs, and we do not get the opportunity to speak to that. Individually, we work hard on social media to raise the profile of the dedicated people who are holding things together for us, but that gets lost in the other national things that are going on.

As health boards, we give weight to the importance of the training and retention components because—particularly in rural boards—we desperately need to keep people in our patch. We are absolutely wedded to people having lifelong careers, but we are mindful of the backdrop of people not choosing the NHS and being greatly influenced by the media.

If we as a leadership body have a concern, it is that this is the first year in which nursing courses have gone to clearing. The idea that we are not filling all our university places for our future nurses is something that we need to tackle for Scotland. We need people genuinely to choose healthcare because it provides a profession that is lifelong and rewarding. If there is a piece of work that we are keen to work on, it is the national bit. We understand that we are in recovery and that there are pockets of exceptional stress that we work through every day, but a lot is going into supporting our workforce.

The age profile is a big thing for all of us, as is the national position of primary care. We know that turnover in that will be extraordinary in the next decade, so the retention and recruitment arena is equally as important as the internal culture and our visible leadership commitments.

Gillian Mackay: I will be first every time to stand up and say that those are good careers and that that is not the reality in every single department in every single hospital. However, I think that when staff are telling us about the conditions we must address them and ensure that workplaces are supportive for absolutely everyone.

For my supplementary, I want to go back to Cathie Cowan, given that NHS Forth Valley was escalated on the basis of its culture. I spoke to a number of staff members before escalation; they all told me that senior management were remote from the workforce and were rarely seen. When five respiratory consultants resigned, they all cited the toxic culture as a reason. Since the escalation, psychological therapy staff have been in touch and have said that because of the two-year waits they are so worried about patients that they are working unpaid hours. What is being done to acknowledge the culture that staff have been working under, and how will the situation be sorted? We seem to be talking about three or four departments in NHS Forth Valley alone.

Cathie Cowan: With regard to the escalation, we acknowledge that there are issues, but we are tackling them. We have been able to recruit additional staff in psychological therapies, in which we previously had below the national average. The fact is that being below the national average has an impact on performance.

I am very close to staff and have high visibility. The areas that have been referred to are on the acute hospital site, in particular, and people who have been following what has been happening there will have seen that a number of staff were, for a variety of reasons, not working in their substantive posts but were acting in posts. In order to fill the space, we decided to bring in an acting manager while we looked to recruit to other

posts, which has enabled people—for example, our chief nurse on the acute site—to go back to their substantive posts and has allowed us to bring in an additional doctor for our front door. If you were to ask staff just now, as I regularly do, they would say that things feel better.

For me, the litmus test is not just what the staff say, but what our staff side representatives—our trade unions—say. We have very close working relationships with them, and they have said that stability at the acute site feels much better with the additional management capacity and leadership.

Gillian Mackay: For context, I point out that it was just in the past 24 hours that the psychological therapy staff member to whom I referred was in touch about staff having to work unpaid hours because they are so concerned about patients.

I am slightly concerned about what we will do until the new staff who have been recruited are actually in post, given the lag that often comes with recruitment. I think that your submission mentioned 12 weeks, in that regard.

Cathie Cowan: We have been able to change things in that respect with our union colleagues; NHS Forth Valley had been an outlier in respect of allowing people to give only a month's notice and recruiting to those terms. The trade unions were keen to have three months' notice, which gave us a huge gap for redistributing case loads while we filled vacancies. Our staff side has worked with us to resolve the situation, so we are now in the same place as other NHS boards, which will certainly help us.

As for the member of staff who spoke to Gillian Mackay, I will absolutely follow that up. We would not expect anyone to work unpaid hours in order to address waiting times. In fact, you will see from our submission that we have worked hard to address long waits. As far as performance is concerned, we have continually sat in the 70 per cent area, even with the backdrop of our not having staff in post.

The Convener: Ralph, did you want to come in briefly?

Ralph Roberts: No.

The Convener: That is great, because we do not have an awful lot of time and we need to talk about staffing more generally.

Paul O'Kane: From the evidence that has been submitted, I think that there is a huge issue not just with recruitment of new staff but with staff retention. For example, 30 per cent of leavers from NHS Ayrshire and Arran were retiring, and that sort of turnover in your boards is higher than the national average.

First, is retention in the system the significant issue? Secondly, what action is being taken to encourage staff to stay to ensure that we are not facing the twin challenges of having to recruit new staff while trying to keep staff in the system? Perhaps we can hear first the perspective of NHS Ayrshire and Arran.

10:15

Claire Burden: [*Inaudible*.]—the programme there is multifaceted, as you can probably imagine. Training staff and getting people to a position from which they can see a way out of the current operating processes will make a genuine difference.

Over the past three years, single-disease management has stifled careers; Covid, by its nature, has meant that people have not specialised or had the opportunity to specialise. In the current climate, releasing people to specialise is a challenge. Our recruitment and retainment commitment therefore includes release of people to training.

Would you like me to cover anything else, Paul?

Paul O'Kane: You said that people have not had the chance to specialise. Do you acknowledge, however, that the major issue is stress and burnout?

Claire Burden: There is a lot of anxiety: anxiety and stress are key drivers of staff absences, because the current climate is tough. Staff are looking after people and working with the equivalent of a five-year backlog and the system remains under pressure. The wellbeing programme, on how we keep people fit for work, is without a doubt equally as important as ensuring that people are able to find careers and can see themselves progressing beyond their current position.

The commitment to get people into training in order that they can see a future that is different from what they see now is an important part of the retention programme. If you and I were to walk around any part of the health system we would hear, first, requests for more staff. The second request would be that staff need more time together and more opportunities to train.

Our health professional' professional development has been stalled for three years, which will have ramifications for a long time. As we get into recovery and get back to working at a rate at which we genuinely start to chip away at the pressures in the elective programme, we will be able to support more training for our staff.

We are doing a lot of work with NHS Education for Scotland on development of new roles and finding new career pathways for people. For

people who are retiring early or who choose to take a break, there is always retention and callback, but there is also an appetite to come back and do slightly different things. A person who has been working in the acute sector might have the opportunity to do something different in the community with a different skill set. Our staff welcome that, so we will continue to work with NES on how we generate new posts to give people new avenues through which to pursue caregiving and intervention.

We talked earlier about prevention. People are leaving the NHS by choice and are taking retirement at 55 and beyond, given the pension options that we are all living with. We believe that if we can create posts that are genuinely different, however, we will see people return.

The Convener: I will go to Ralph Roberts then Cathie Cowan. I will not be able to go back to Paul O'Kane for a supplementary question, I am afraid. I apologise for that, but we have another panel waiting to come in, so I cannot let this session overrun.

Ralph Roberts: My comments will probably complement what Claire Burden said.

It is important that we do not jump to some single-issue assumptions. For any member of staff, the choice to leave, move on, retire or whatever will be multifactorial.

From my point of view, the issue is partly about the working age of our population in rural areas, and the choices people make around that. Some of it is to do with people's experience over the pandemic. We moved a number of staff at that time because we had to, which was more or less popular, depending on the individual.

I turn back to culture. There is no doubt that what I hear most from staff is their frustration about not being able to do the job that they came to do, because they do not feel that they are delivering the quality of care that they previously delivered. That is a big driver of the pressure in the system.

We must accept that the issue is multifactorial. We need to support people through it with professional development, as Claire Burden outlined, and we need to focus on retire and return so that, after they have retired, we support people back into part-time roles and build on their skills.

Fundamentally, if we get recruitment right, it will support retention, because it will take some of the pressure off staff. We have done masses of work over the past year on international recruitment and have been very successful in bringing international recruits into the organisation. That has been challenging, but it is paying dividends. If we can do that and it reduces pressure on our staff, that will improve retention.

To some extent, that goes back to the point that I made much earlier about one of the reasons why our staff experience pressure—in particular, in the acute hospital, although there are different circumstances in the various parts of the system. We have additional beds open and have therefore had to spread staff more thinly, which puts pressure on them. If we get to the point at which we can close down the extra beds that we made available during the pandemic, that will allow us to improve staffing levels and retention.

However, we have to recognise that we need to work hard at that, and that in the medium term the working-age population is shrinking, so we will have to look differently at how we staff our services.

Cathie Cowan: I will be very quick. As Ralph Roberts and Claire Burden said, there are significant pressures in the system, but we have been fortunate. I will give you an idea of our recruitment and retention. Of the 127 new nurses whom we have recruited over the past couple of years, we still have 118 in our system. That is a good measure for us. To go back to culture, our iMatter scores are up there among those of the rest of the boards in Scotland.

We also try to give staff space to do things. Our mental health staff have been awarded the Royal College of Nursing accreditation—which is a unique accreditation—because we gave them time to do that. That lets them shine and feel proud about what they are doing and how they are doing it.

As I said, we have invested in bands 2 and 3, which demonstrates a culture of inclusiveness and commitment to development, and those staff are staying with us. Similar to what Ralph described, we have been able to secure colleagues from other countries. Our international recruitment is focused not only on employment but on welfare and the bringing of people and their families to Scotland, and it has been hugely successful.

We have also done work on our anchor institution concept, which is about how we create local jobs for local people. We think about how to do that with local authorities, and we recently secured a unique partnership with our college and university. We are working in that space to bring school leavers into the health service and social care, but it is a tough gig that I would never underestimate.

To go back to Gillian Mackay's question, I note that the acute site in NHS Forth Valley is a particularly tough place to work, because it is primary care, given the demand that comes through our systems. We must respect our staff

and acknowledge the circumstances that they work in. That is what they want to hear from us as leaders, so that they get reassurance that we know about the pressures that they work under. Training and development, and a commitment to protected time so that people have a bit of downtime are things that we are working on, and we are doing a bit of work on reconnecting, reskilling and so on. Our focus is very much on recruiting and retaining staff, and doing different things with our staff so that their skill sets increase.

Tess White (North East Scotland) (Con): I have two questions. The first is for NHS Borders. Mr Roberts, in advance of the meeting, we asked for a four-page document. You have provided a document that has no fewer than eight embedded papers and did not provide what we asked for. So that we have a written response from you that is similar to the other boards, could you please provide us with what we asked for?

Ralph Roberts: I am sorry if what I sent did not meet your expectation; I am certainly happy to review that. We tried to give you as much information as possible. We will reflect on that.

Tess White: Thank you. If you could just deliver exactly what we asked for, that would be appreciated.

My second question is for NHS Forth Valley. Sickness continues to be an issue across the boards. What percentage of sickness among nurses and midwives is physical sickness and what percentage is mental illness, such as burnout or depression?

Cathie Cowan: We have a breakdown of that, but I do not have it in front of me. As Claire Burden said, stress will figure highly in the absence rate—there is no doubt about that. We do significant deep dives into that, so we can say that stress is not all about work, although it plays a part. The cost of living and other factors in people's lives are also parts of that.

Tess White: I am sorry, but that does not answer the question. What percentage of absences among nurses and midwives is because of physical illness and what percentage is because of mental illness?

Cathie Cowan: I do not have that figure in front of me, although we have a figure and a breakdown of causes within it.

Tess White: If you can provide that, it would be appreciated.

Cathie Cowan: Certainly.

David Torrance (Kirkcaldy) (SNP): We have talked about stress and burnout, but what are you putting in place for the wellbeing of your staff? I do not mean anything related to profession and careers, but what is in place for the wellbeing of your staff so that they continue—

The Convener: Can that question go around to all three witnesses?

David Torrance: Yes.

Claire Burden: We have an extensive wellbeing programme and we have a very positive spiritual team to lead it. There is dedicated space and time, and we have a wide range of resources that provide access to financial advice, occupational health and therapy. A legacy of the pandemic is that we have, for the first time, psychiatric and psychological support. It is rather sad that we need that to be at the level that we have. Between them, the spiritual team and our professional support services have a steady flow of people.

The staff response to the wellbeing areas that have been created has been very positive. There are also timeout sessions, which goes back to the cultural commitments of the team management structure. Making time for teams to make use of those facilities is a core part of our commitment to professional development.

Now that we have, over the past 12 months, entered an era in which distancing and so forth have diminished, we are in a better position to offer break-out support, and we have invested independently as teams have needed that support. Sadly, bad events happen in the NHS. That is the nature of the beast, but we have commissioned specific support programmes following specific incidents or for teams that have experienced a serious incident. We also have wider-stream more generic processes and services available through our cultural plan and our human resource teams, through which teams can commission time out.

What we provide is wide ranging—from highly specialised support when it is needed, to wellbeing spaces that people can access 24/7, to team development programmes.

The Convener: Thank you. I ask the next witness to be brief, please.

Ralph Roberts: We offer a range of support. There is very targeted support for individual teams in relation to individual incidents or issues when they happen. More generally, we have staff counselling services, the occupational health and safety service, psychological support for staff, and a wellbeing group that has looked at issues around meals and the space that staff have, for example.

We explicitly ran a workforce conference in the autumn to try to focus on our workforce issues. That was attended by probably close to 100 staff, and it was really successful. We are working up to

a wellbeing week in June this year to try to maintain a focus on wellbeing.

10:30

I have heard that the thing that staff want most of all, in addition to individual targeted support where that is necessary, is fundamentally the sense that they are doing the job that they came in to do. That is about us supporting them, supporting staffing levels and, as Claire Burden said earlier, trying to get back to the point at which the health service is seen as providing good careers. To be frank, staff have found very difficult the transition from being clapped on the doorsteps at the beginning of the pandemic to the point at which they now feel that they are under endless pressure from the public, politicians and others. There has been a really difficult shift in mindset for them. We all have to recognise that and support them through that.

The Convener: There are the media headlines, as well. To go back to what you said about the national conversation that we need to have, I note that what makes the headlines are not nuanced stories about things going well; the headlines are always about waiting times.

Ralph Roberts: Our staff say to me a lot that they are looking for the acknowledgement that is needed to radically change the health service, and that we need to change the dynamic and the conversation that we have about that and recognise that the health service needs to continue to evolve. Probably more than anything, they are looking for recognition that we cannot simply go on flogging the service as it currently is, and we need to change it.

The Convener: I will let in Cathie Cowan. We must then move on.

Cathie Cowan: I will be brief.

Ditto, what Ralph Roberts and Claire Burden said. We are thinking about the health service at the local level and what needs to change. Mobilising our clinical teams to be part of that is really important. We have produced a wellbeing plan or strategy that outlines all the things that we have been doing and all the things that we continue to commit to do, which are targeted or generic. I can provide the plan, or people can access it to see its significance in respect of the investment that we have put in.

The Convener: We must move on. We have two other themes—mental health services and reform—but I might not be able to call all members who have asked to ask questions. I apologise. I am afraid that Evelyn Tweed can ask only one question on mental health services.

Evelyn Tweed (Stirling) (SNP): I will roll my questions up together then. Thanks, convener.

I direct my question to Cathie Cowan, whose board covers the Stirling area. Constituents at the end of their tether have contacted me regarding child and adolescent mental health services. I know that things are getting better and that your numbers are getting better, but what have you done to enhance those services, how quickly will we see more progress and, crucially, what is being done to help people in the period in which they cannot be seen—in the 18-week waiting time—when they are in a crisis mental health situation?

Cathie Cowan: I will start with primary care. We have worked with council colleagues and the Government on investment in counselling. We are taking a prevention and early intervention approach so that we are not seeing escalation into the tier services in CAMHS, and we start where kids are engaging.

In primary care, we have invested in staff CAMHS workers so that general practitioners have access to that service. Most important is that we have laid out a proposal about referring people into primary care and subsequently into services.

You are right to point out that we have made progress. Coming out of the pandemic, our focus was on dealing with our long waits. You will see that they were significant. I am pleased to say that we have addressed those long waits, and I think that staff feel really good about that, because they impact on staff with children and families whom they feel they are not supporting.

Tackling of long waits is now enabling us to deal with the front of the waiting list, so you will very quickly see us moving from a really poor position of having 18-week waits to achieving the standard by the first quarter of this year, in April to June.

The Convener: Thank you for that. I apologise because I cannot bring you back in, Evelyn.

Two more members—Stephanie Callaghan first, then Sandesh Gulhane—wish to ask questions on reform. I ask for succinct questions. Please direct your questions to specific witnesses, as much as possible.

Stephanie Callaghan: I had thought that someone was going to add this point to their question, so I apologise.

Are there specific recommendations that you would like the committee to make on early intervention, in order to ensure that it is a priority for the future?

The Convener: Let us go round everyone quickly.

Ralph Roberts: I return to a point that I made earlier about prioritising early intervention. That

will mean that we will need to examine our performance framework and how we prioritise it. There is certainly work that we can do to focus on early intervention, but that requires us to consider the whole scope of our resource and to make judgments about how and where we prioritise it across the organisation.

Cathie Cowan: I would say something very similar. I spoke earlier, in relation to the performance framework, about the incentive of having standards to work towards. That would help us to refocus our energies in that area.

Claire Burden: On our diagnostic work and technical infrastructures, unifying of our ICT will genuinely help us with reconnaissance of our population, as we work to national models to improve access to diagnostics and get into the prevention agenda by adding to and building on Ralph Roberts's and Claire Burden's platforms. That would be my ask: diagnostics and technology.

The Convener: Thank you—that was very helpful. We will have one last question from Sandesh Gulhane.

Sandesh Gulhane: I will say, as a doctor, that being in healthcare is a great career. I want to acknowledge clearly that I and all of us on the Health, Social Care and Sport Committee acknowledge and thank our NHS staff for all their hard work.

As far as questions go, I have been disappointed by some of the answers that I got. I am sure that we have other questions, so perhaps we could write with them.

The Convener: We will write and pick up on things that we have not had time to get to.

Sandesh Gulhane: I have a question to put directly to Claire Burden about information technology infrastructure. I was very interested to hear about how you are trying to develop an all-in IT infrastructure. Could you tell us—very quickly, as we are running over time—how close you are to implementing that?

Claire Burden: [*Inaudible*.]—work going on for the platform—the network. We have quite a lot of remedial work to do before our colleagues will start to see that.

The technical infrastructure—the platform from which we can unify our system—is the work that we are doing first, and the two pieces of software are TrakCare for hospitals, which allows us to unify three pieces of kit in one, and the electronic patient record, to which we are committed and which is "once for Scotland" compliant. We have support from our health and social care partners, and they will ensure that we are all able to share that.

The Convener: I thank all three of you for your time this morning. We will write to you with questions that we have not managed to ask. As you are aware, there are a great many things that we wanted to ask you and that you wanted to tell us.

10:38

Meeting suspended.

10:46

On resuming—

Female Participation in Sport and Physical Activity

The Convener: This is the second evidence session in our inquiry into female participation in sport and physical activity. The session will focus on community sport and physical activity.

I welcome to the committee Kate Joester, who is policy and influencing co-ordinator for Scotland, at Living Streets Scotland; Patrick Murphy is a senior manager at South Lanarkshire Leisure and Culture; and Cecilia Oram is head of behaviour change at Sustrans Scotland. We also have two panel members online: Kirsty Garrett is sports development and physical activity manager at Glasgow Life, and Euan Lowe is chief executive officer of Scottish Swimming.

We have a number of themes to cover, so members might want to direct their questions. Some questions might be more general, in which case we can go round the panel. However, with five panel members, not every panel member will be able to answer every question—we would be here until next week.

I will kick things off. A number of you pointed in your submissions to a lack of female role models in sport and physical activity. It struck me that there are lots of females in sport and various physical activities who are probably a role model within that sport. However, it is not so much about that; it is about cutting through to people outwith that sport and people seeing them as role models in the media and so on. It is also about a lack of women in leadership roles in sport.

Being completely hypocritical after what I said about focusing questions, I would like to go round everyone and ask what could be done to encourage more women into leadership roles in sport and how we promote those female role models, which would make all the difference.

Kate Joester (Living Streets Scotland): It is funny talking about role models when we are talking about everyday walking. We know that a lot of importance is attached to role modelling within the family and family habit forming. It is important that walking as a means of transport and as a pleasant thing to do happens within families. It is less to do with celebrity role models; there is less evidence that that is a factor.

However, we need women in leadership to create the structures within which women walk. It is important to see more women in the places where we talk about planning and transport planning and that sort of thing, because our transport and places are, broadly speaking, planned by male-dominated professions, which is sometimes very obvious. Sometimes you can see that transport is planned around a very typically male commute, which goes from home to work and back again, and not around more typically female trip chaining, whereby women might drop the kids at school before they go to work and then do the shopping or drop in on a relative they care for on the way back. Transport does not support that.

It is also about the ways in which we see paths being planned, for example. Women pay closer attention to safety, and we often see that that is not supported by the places that we are walking through.

The Convener: That certainly chimes with me, as a rural person. The idea of a radial journey into the centre of town does not take into account the fact that you might have to go elsewhere before you even get to your work.

Patrick Murphy (South Lanarkshire Leisure and Culture): As our submission reflects, there is a lot of good work with females out there just now, especially for young leaders. There are programmes such as active schools, and programmes in local authorities in and around the scenario for care-experienced young people in particular. We will see that work bleeding into the narrative, as females come in and become role models and leaders in their local communities. It involves everything from sports leadership sessions in primary schools through to walk leaders and leaders in sport in positions of influence, so I am quite positive about it.

Cecilia Oram (Sustrans): I echo what Kate Joester said about the need for more female leaders and female perspectives in transport and urban planning. Sustrans ran a campaign called AndSheCycles, which was based on workshops with teenage girls across the country and looked at the barriers to their becoming more active physically in their local environments. That has progressed to a social media campaign, in which young women are leading on content about being physically active. That proves that locally based initiatives that empower young women to be physically active can have a good impact, and it showcases what is possible.

The Convener: As you were speaking, I was reminded that I asked a teenage person in my life why girls do not do as much physical activity, and she said, “It’s because your pals don’t.” There is that peer pressure. The kind of thing that you are talking about, in which it is seen to be okay to take your bike to school or whatever, might mean that more girls will do that.

I will go online and speak to Kirsty Garrett.

Kirsty Garrett (Glasgow Life): Hi there—thank you for inviting me along.

With regard to role models, we have an example from 2019, unfortunately just prior to Covid and lockdown. We established a programme called Energise-Her, and the brand was "Aye She Can". The programme was about insight, training and support to engage and attract a wide range of females to a variety of activities in their community. It also included the Ment-Her initiative, in which female mentors would share their skills and knowledge to empower others and excite young women and girls to get involved in sport.

As part of the programme, we also had Activate-Her, in which people came forward from different sports clubs and organisations and we trained and supported them to deliver projects and activities in their community. There was a small fund attached to that, to the value of about £1,000. We definitely saw the need for role models in communities, and that is why we went out to our network of clubs and organisations to take that project forward.

A real mix of women came forward. The programme was co-produced, with involvement ranging from women from what we might call the performance end of sport right down to women who were not involved in sport or physical education when they were at school, so there was a genuine mix. It carried on into 2020, but unfortunately Covid arrived. We are now trying to go back and reinvigorate that programme, but we already have it in place.

Another aspect of role models relates to the fact that this year we are celebrating Glasgow as the European capital of sport 2023. During February, we celebrated women and girls in sport month. We celebrated all the activities that were happening in our city in sports clubs and organisations during that month, in order to enable them to raise awareness in their communities of all the things that were going on. We put out regular tweets and newsletters. The hope was that young women would know about what was happening in their community and would therefore take part. We are really keen on role models.

We are also looking, as part of the European capital of sport, at a "meet your heroes" initiative, so that women and young women can identify people whom they look up to or aspire to be and meet them. For example, we had a young woman meet her hero, the Scottish football player Jen Beattie. We are trying to develop opportunities for women to get involved in activity throughout the year.

With regard to leadership roles, I am a sports development and physical activity manager and I am a female. I am pleased to say that I have roughly just over 100 members of staff, and there is quite a nice 50:50 split between males and females. Within our own organisation, I am comfortable that we have a split of male and female staff with strong roles, who are in communities helping people to get involved with sport and physical activity.

Euan Lowe (Scottish Swimming): Good morning, everybody, and thanks for inviting me along. To pick up on that very last point that Kirsty Garrett made, I am conscious that I am a male speaking on this subject matter; we were very conscious of that even coming into this committee meeting today. There is another member of the team we would have liked to bring along to the meeting, but they are committed elsewhere, so you are having to put up with me today.

However, when it comes to leadership, I am part of a senior management team in which three out of the five people are female. Our board has 10 members, and three of them are female. Also, the Scottish Swimming organisation is just about to have a female president, which is a fairly prominent role.

From a swimming perspective, you need to be able to see it, understand it and believe it to be able to want to participate in it. We are quite fortunate in that swimming is a popular activity and there are probably more females than males participating in it recreationally. About 64 per cent of our members are female. If we look at people with leadership roles who have influence over that membership base, we see that 63 per cent of the workforce, 62 per cent of officials and 62 per cent of coaches are female, so there is a female drive across the sport.

Picking up on comments that have been made, one aspect that I am mindful of is first impressions. Getting people involved in the sport—or even interested in activity and leisure and sports more widely, full stop—comes from quality experiences. The active schools programme was mentioned earlier as quite a prominent activity to get people introduced to leadership roles. We have taken it a step further with our young volunteer programme, which is about not just gender but ability and ethnic minorities. We try to get a range of people involved in the programme to develop our leaders of the future. Quite a high percentage of females are involved in that programme and it is driven by a female.

We are also mindful of other aspects of that "see it and do it" piece. Some of the names that people might be familiar with include Hannah Miley, a prominent and successful Scottish swimmer who has an MBE for promoting services for girls and women's sport and is very active in the world of promoting all the values of being interested in activity, and others coming through, such as Katie Shanahan—Kirsty Garrett will know

Katie's name. They are role models, along with Toni Shaw from Aberdeen, a para-athlete who is an ambassador for our learn to swim programme to encourage youngsters to get involved. That is about not just the female aspect but the disability aspect. It is about saying that anybody can get involved in this activity. We are working on that where we can, but we are conscious that there is more to do, given the challenges of getting any part of society involved. Participation is an on-going challenge but particularly in relation to girls and women.

The Convener: Thank you. Paul Sweeney has a couple of questions on this.

Paul Sweeney: I recently met people from Boxing Scotland, which is based in Glasgow. They told me about their work in trying to get women and girls into sport, particularly into sports that are traditionally male dominated, such as boxing and football. There was a feeling that, if you do not get young people into a sport early in life, it is harder to encourage that engagement once they are young adults. Do panel members have a view on what steps can be taken to encourage women and girls into sport at a young age, especially in ways that encourage them to participate and stay involved in physical activity in the longer term, and how you can make that introduction to sports that are traditionally male dominated such as boxing?

Patrick Murphy: I do not know whether to answer that—

The Convener: I will maybe bring in specific people on that because it was about sport rather than just physical activity. I will bring in Kirsty Garrett first.

Kirsty Garrett: Thanks for that question. We actively work with any sports governing body that wants to work with Glasgow Life. For example, we would work with Boxing Scotland and introduce it to our colleagues in the active schools programme, which is run by Glasgow City Council, and we would try to arrange activities that can happen in school or create links from the school to the club. We have examples of that going on in the city. We would openly work with any governing body that wishes to work with us, and we would support them with getting into the school environment or support young people in the school to move into a club environment. That is basically what the club development team does; it tries to ensure those connections. We would ask for the person to contact me, and then we would take that forward.

11:00

In Glasgow, we also have a physical activity finder, and we encourage all sports clubs and organisations in the city to sign up to it. If a person puts their postcode in, all the clubs in their area will become visible, or if they put in that they want to do boxing or another activity, all the opportunities in boxing and other activities will pop up. We try to ensure that people are aware of the activity finder and therefore can find a certain activity or sport that is on their doorstep.

We actively encourage boxing organisations to support the active schools programme to try and encourage young women to get involved.

Patrick Murphy: I think that Kirsty Garrett is right. There is another element with females, specifically in the sport that Paul Sweeney mentioned, which relates to the teenage drop-off at the age of 13 or 14. That applies especially in specific sports, and it is very difficult to combat. Again, the leadership role plays into it.

However, it is critical to recognise where sports and clubs are in their state of readiness as they approach their communities. Quite often, they can be intimidating places that are not ideal for people who are vulnerable or not confident. It is as much about the sports and clubs addressing their state of readiness as it is about the issues of convergent access and the teenage drop-off.

Paul Sweeney: Those are really helpful insights. There is a balance between passive advertising of availability versus engaging with groups of people—young women, in particular—who might not feel comfortable and who could feel intimidated by a sport such as boxing, and encouraging them to do a taster of it and have a go at it. Maybe the active schools programme could be looked at as an opportunity; it certainly sounds interesting.

We have heard stories about young people in physical education classes being split into groups to do stereotypical sports. The girls would go off and do dancing and the boys would go off and do football. That stereotypical streaming of different sports can be extremely counterproductive. Have you observed that happening, and how do you think the active schools programme could address it?

Patrick Murphy: I will use football as an example. At the moment, the Scottish women's game has never been in a better place. I think that all of the players in five of the top premiership teams are full time. That is a positive, and some seriously good role models will come out of it.

PE has work to do in the co-production collaboration about where people's positive destinations are, and that is a challenge. There are also some really positive things happening, such as the transition to girls playing football and boys playing netball. We are in a good place.

Paul Sweeney: That is good to hear.

Kirsty Garrett: I would also like to give an example. We have boxing clubs in Glasgow Southside—Southside Boxing Academy, for example. Our support and funding through the club and officials award meant that Antonia Quayle was able to secure a Boxing Scotland level 1 course qualification, and therefore she was able to start delivering boxing coaching in the Southside Boxing Academy. We support females who want to become coaches and so on, and there are opportunities through our funding to ensure that more female coaches are visible in our communities.

The Convener: I would like to move on to talk about safety and harassment, which have come up in many submissions. Those issues can put many women and girls off doing physical activity and sport.

Tess White: I have three questions, the first of which is for Patrick Murphy. How could sports environments and changing facilities be improved to ensure that women and girls feel safe?

Patrick Murphy: At the moment, one of the main roles of my job is around efficiencies and our shrinking estate in relation to delivering all the sports and physical activities that we provide across swimming pools, golf courses and everything else. There is a second challenge, which relates to the part of your question about the physical environment.

The situation is extremely difficult at the moment, especially given that we have an ageing estate. In some cases, the estate is not fit for purpose for certain groups or for certain diverse elements of the community. I think that we face a real challenge in that area with regard to funding and finance.

Tess White: So that is a huge issue.

Patrick Murphy: It is massive.

Tess White: I direct this question to Euan Lowe. At the weekend, a swimming coach told me that a huge issue at the moment is the fact that girls do not feel safe in mixed changing rooms, particularly because of the use of mobile phones in those spaces. He said that girls are being put off swimming, including at elite level, because pictures are being taken of them in mixed changing rooms. What are you going to do to keep women and girls safe in swimming?

Euan Lowe: That is interesting. I would be happy to follow up on that outwith the meeting and to get a bit more detail. However, it is important to keep in mind that we put the safety and wellbeing of all participants at the heart of everything that we do, particularly in the light of the Whyte review of gymnastics across the United Kingdom, which encouraged people to come forward and discuss any issues or concerns that they had. To help to facilitate that at local club level, we operate a system whereby each club must have at least one wellbeing and protection officer in place to promote safe environments. That covers the point that you made about the use of mobile phones.

From a societal point of view, mobile phone use is a challenging area, given that there are apps that encourage youngsters to take snaps and photos at any opportunity. That is a challenge for any sport, not just swimming, to deal with. To mitigate that, we have a mobile phone use policy, which we ask clubs to adopt. Many of them do that, and they reinforce the message on appropriate use of mobile phones through their committees and with their members. At a swimming venue, that relates particularly to the inside of a changing space. We are doing what we can to promote the need to make sure that mobile phones are used in the right way, where at all possible.

On the changing side and the changing village aspect, as Patrick Murphy outlined, sport and leisure at all levels are facing a challenge with upkeep maintenance and the ability to run a good-quality service, given the funding situation and the problems that we face with rising energy costs and the workforce issues that we have, which many of our partners are contending with. Those financial burdens make it a challenge for any council or trust to provide as good a quality of experience as they would like to, and that includes the changing environments.

The changing environment is not something that we typically support sports and/or local authorities and leisure trusts with, but there is sportscotland guidance to refer to on the design and build of changing spaces. The more modern approach, which has been around for a good number of years, is to have changing villages that are open to all. That is done with the right intent of making those facilities as inclusive as possible. I am aware that, in some circumstances, depending on the authority, there are options to be able to secure or lock down particular sections of those changing villages for particular user groups if that is required and needed, but it is very much up to local operators to be able to manage those situations.

There are mitigations in place, and many of those things probably come down to local decision making. I do not mean that in a negative sense; I mean that we need to understand the communities and how best to work with them on the mitigations that are in place in order to provide the right experience.

It was not pleasing to hear your earlier comments, and I am happy to pick the issue up at a later date.

Tess White: The answers from Patrick Murphy and Euan Lowe do not fill me with trust and confidence. It was a very simple question with a very long answer, which did not really get to the nub of the problem.

My next question is for Cecilia Oram. What measures could be introduced to improve the reporting and investigation of harassment, bullying and abuse in community sport?

Cecilia Oram: We work on physical activity in communities. With regard to reporting and investigation, we would like to see incidents being reduced. I am not sure that I can speak for—

Tess White: I am just asking about improving reporting. Do you have any thoughts on how to improve the reporting of harassment and bullying in community sport?

We can follow that up separately afterwards, if that is okay.

The Convener: It is possible that, coming from Sustrans, Cecilia does not have much to say on that area.

Cecilia Oram: Yes. We do not work with community sport as such. We promote physical activity, such as everyday walking and cycling.

Tess White: I just wondered whether you personally had any views on the issue.

The Convener: Perhaps we can go to someone who is more involved in sport. Kirsty Garrett, might have some thoughts on this.

Kirsty Garrett: Euan Lowe might have thoughts on it, too. We try to ensure that clubs and organisations are as inclusive and safe as possible. Sometimes, it is very difficult to do that, but we have training and education in place, whether that is through the governing body, the local authority or organisations such as Glasgow Life. For example, we provide the "In safe hands" training, and training on child protection and safeguarding vulnerable adults.

Ideally, you expect the club to have good governance and good finance structures but also a good code of conduct. Therefore, if an incident were to happen, the person would know exactly who to speak to and the club would take the incident down an appropriate route. That might require the involvement of a governing body or Glasgow Life, depending on the circumstances.

We expect our sports clubs and organisations to have a code of conduct, best practice, fair play and so on within their structures to ensure that issues can be dealt with at a local level. If they cannot be dealt with at a local level, as I say, it can be escalated to the governing body or us.

The Convener: I want to ask Kate Joester and Cecilia Oram about the fact that a lot of women and girls who are not necessarily involved in structured physical activity might cut out the few bits of physical activity that they get by opting not to walk to some places for reasons to do with safety and harassment. I count myself as one of them. I have very few opportunities for physical activity, but when it comes to the winter months, we make a choice about whether we walk home or to a particular place, or whether we do something that feels safer. I will go to Kate first to ask how we can tackle that.

Kate Joester: We all know that, in general, women are less physically active than men. Everyday walking is one of the things that have the potential to be absolutely transformational, in the sense that it can move a huge number of people from a position of not being sufficiently active to get the mental and physical health benefits to a position of being sufficiently physically active. It is something that we can do every day as part of our routine. It does not take a lot of time, it does not require equipment and it does not require new learning. However, we have the problem that women feel less safe simply walking to work and girls feel less safe walking to school.

The issues around that are very complex. There are a lot of issues around perceptions of safety and actual safety, and the way that, as women and girls, we are trained to take responsibility for our safety and to be blamed for any lack of safety. Therefore, there is a lot to be said about changing how we talk about women's physical safety in public spaces. However, there is also a lot to be said about changing the facts of how we as women and girls experience public spaces.

Harassment needs to stop and to be taken seriously at every level, and that is work for men and boys to do, as much as it is for women and girls.

I will come back to another point—every time that you come to me, I will talk about design and planning.

11:15

The Convener: That is why we invited you. [*Laughter*.]

Kate Joester: That is superb.

When we choose whether to walk or not, we make an assessment of the space that we would be walking through, and different people make different assessments. Women and girls look not only at who in that space might be a problem, but at who is there to safeguard them. That includes passive surveillance—if you are walking through a

space where people are looking out of their windows, they could see anything bad that might happen to you. For women and girls and others who experience disproportionate harassment, that is extremely important when they are making an assessment of the safety of the spaces that they are walking through.

We need that lens to be represented every time a new street, development or active transport route is planned. We need to make sure that the people who are doing the work are competent to make that assessment, whether that is through training or rigorous consultation, or through adequate equality impact assessments. In this area, adequate equality impact assessments are absolutely not done. There is a huge amount of evidence that equality impact assessment in planning is appalling and not adequate enough to meet basic standards.

Harassment in public places can be built in and we can build it out, but we also need to talk about behavioural change around how women are treated. We are entitled to be safe in every space that we want to go to. There is work for women and girls to do in asserting that right and, for example, reporting harassment, but it is primarily for those who carry out the harassment to stop doing so.

Cecilia Oram: I will mention some of the things that Kate Joester mentioned about safer infrastructure. More women report that cars pass by more closely when they are out cycling. There is quite a lot of evidence about that, and segregated cycling infrastructure would help that situation.

We also need better lighting in public spaces where women and girls might be walking at night. Kate mentioned passive surveillance, which means eyes on the street. Where it is possible, places should be overlooked by buildings, so that there is more natural vigilance in the area.

The Convener: I will come to colleagues in a minute, but I am just thinking about the one time that I took my bike from my village outside Aberdeen into the college that I used to work in. The cycle paths were really not meant for a commute; they were meant for leisure, so they went down by the river. There are no houses in that area and, in wintertime, you would not put yourself in that situation. That speaks to what you are saying about paths being built not just as part of segregated cycling infrastructure but in places where there is other infrastructure around them. I see that in Aberdeen city, and you must see it across Scotland.

Cecilia Oram: Yes—there is evidence that some cycle paths feel very unsafe, and they are very unsafe if they are not being used by a lot of people. That applies late at night, in the dark, and in the winter months.

The Convener: Euan wants to come back in.

Euan Lowe: I am going slightly off this thread, but I want to come back to the points that were made around dissatisfaction with our responses. Kirsty Garrett highlighted very well what happens typically in a governing body from a club and membership point of view. Clubs are expected to have codes of practice and wellbeing and protection officers in place. There are behaviours that are expected. Governing bodies expect clubs to have corporate governance in place, to make sure that complaints are handled appropriately and that concerns can be raised.

Those things are in place across governing bodies. From a club membership point of view, they exist. As Kirsty highlighted, on certain occasions when issues or concerns are raised, they are managed and dealt with by the leisure trust or the council, if that is appropriate. If that is not a satisfactory answer, my question back to the committee is: what do you expect?

The Convener: I will come to Paul Sweeney on the issue of safety and harassment.

Paul Sweeney: Planning is a major factor and it plays an important part in making women and girls feel safe. For example, I know that Sustrans's submission indicates that just 39 per cent of women in Scottish cities feel safe cycling in their area. Planning can be a male-dominated space and it can often be confrontational and egocentric. Do Living Streets Scotland and Sustrans have any suggestions on how we can make sure that gender concerns are considered and that women are adequately consulted on planning decisions and on active travel, particularly with respect to the new development plans that have been drawn up by local authorities in the wake of national planning framework 4?

Kate Joester: A little while ago, we did some research on the use of equality impact assessments in planning at a local level. The national guidance, which embraces equality, is great, but we found that the closer you get to street level, the less likely it is that adequate equality impact assessments will have been done. We looked at 20 examples, including plans for snow clearing and plans for specific developments, and we found four equality impact assessments that were available for those 20 projects. For example, a project had gone to a planning committee—I apologise; it was a regeneration committee—and although the answer to the question whether the required equality impact assessment had been done was no, the project went straight through the committee. At the moment, the stipulated requirements are not being

met at even the most basic level. Planning committees could up their game and require that kind of work to be done.

Training people who work in planning will also play a role. That will take time to come through the system, so we also need to hit continuous professional development hard. We need to make a generational change in planning, as there is a lack of cultural competence in the sector relating to people's understanding of equalities. The point of the public sector equality duty is that equality impact assessments should be done by the people who are doing each project. However, they are not being done and people do not demonstrate an understanding of what doing them would involve.

Paul Sweeney: Are there any ways to try to codify that so that there are clearer rules on design for urban spaces? Are there exemplars that could be used to create national standards?

Kate Joester: In many cases, the national standards are fine; the problem is that they are being ignored.

Paul Sweeney: Okay. That is interesting.

Cecilia Oram: Our figures show that only 13 per cent of UK transport professionals report that they always consider gender in their day-to-day work, 46 per cent of people never consider it and 41 per cent somewhat consider it. In Scotland, the transport sector has, at 6.25 per cent, the lowest proportion of women represented in senior positions in the public sector. The knock-on effect of that is that gender perspectives are not really being considered. Involving more women in transport planning is the way forward.

The Convener: It sounds like it.

Emma Harper: My question is for Cecilia Oram. I had a quick look at the Sustrans toolkits for creating better spaces. Safety is mentioned where it relates to reducing the speed of cars, but the toolkits do not seem to mention safety in the context of protection of and support for women. That does not seem to be mentioned in the information and the toolkits that you provide, or am I just missing it?

Cecilia Oram: At the moment, we have some research under way on safety in public space, but it has not appeared in the toolkits just yet.

Emma Harper: Thanks.

Sandesh Gulhane: I want to ask specifically about the use of mobile phones, which was raised earlier. Now that more and more people are taking videos in the gym—and, I imagine, other places—and then posting them online, do you have a specific social media policy in your spaces? That sort of thing can make people feel very uncomfortable. That question is directly for Kirsty Garrett and Patrick Murphy—and, obviously, anyone else who wants to come in.

Patrick Murphy: We do not have any specific social media policy, but we have a code of conduct and management rules on what is and is not appropriate and beyond that a reporting mechanism for child—and, indeed, adult—protection. That is in place.

However, it is difficult to manage, because there are always people coming in and going out, and what we are talking about is people's own personal property and what they do with it. I think that what local authorities, leisure trusts and so on would say is that this is all about training staff and ensuring that they are challenging behaviours in such public spaces.

Kirsty Garrett: We have a social media policy, but it is for staff and employees of Glasgow Life, and it talks about ensuring that responsible social media content goes out, managing our comments and so on. I do not think that we have such a policy for the public, but I can look into that.

The Convener: If you do not have something to hand just now, we are happy to take it as a follow-up.

I will stick with Sandesh Gulhane, who has questions on inequalities.

Sandesh Gulhane: There is an issue that I am keen to hear about. If you do not know where you stand with regard to the number of people from different ethnicities, it is very difficult to make improvements. My first question, therefore, is a very simple one. Patrick, do you have a breakdown with regard to people from different ethnicities?

Patrick Murphy: In some elements of our business, we do, but in others, we do not. I will break that down for you. In a number of health intervention programmes that are co-produced by health and social care, we have everything from which Scottish index of multiple deprivation zone people are in right through to their protected characteristics and so on. In some instances, then, the answer is yes, we have that breakdown.

In other instances—for example, with casual users of the gym or swimming pool—we will not have that information. Any approach in that respect would be based on the pretty simplistic theme of removing barriers to access, which would mean that, as a result, you would not be asking reams of questions—not even the most basic health questions, never mind anything on diversity. We therefore do not have that breakdown for our entire estate.

There are 319,000 people in South Lanarkshire; we know that 25,000 of them have memberships,

but there will be a number of casual users, too. There is a real split in that respect.

Sandesh Gulhane: Fair enough. I am particularly keen to hear about swimming, because I think that there is a bit of a problem with regard to ethnicity and people wanting to take up the sport. I do not know exactly why that is, but do you have an ethnicity breakdown for memberships? What policies are you putting in place to increase the number of people from ethnic backgrounds going into swimming?

Euan Lowe: I am assuming that that question is for me, so I will pick it up.

The challenge is getting meaningful data. Every year, we ask the membership to complete equalities data questions that would provide the sort of information on SIMD and protected characteristics that Patrick Murphy has referred to. However, although we have some information, it is not rich enough, I would suggest, to allow us to make informed views on particular measures that we might want to put in place. We have revisited the questions that are asked on the annual membership return—which is, I should say, coming back in at the moment—and the purpose of that redesign is to get more accurate information so that we can put measures in place.

Our approach to equalities is directed primarily at the first experience through the learn to swim programme and through working with our partners to encourage as many people as possible to get involved in the sport.

The challenge that we have is in understanding the needs of the user group and, equally, the needs of those who we cannot yet reach, particularly those with protected characteristics. If they want to get involved in a sport, it is about what activities we put in place. We work with a number of different leisure trusts and local authorities that support programmes that are put in place to pick up particular groups. Nonetheless, we have challenges ahead, for sure.

11:30

Sandesh Gulhane: Finally, I will go to Kirsty Garrett. What do you have in place to promote the participation of women from ethnic backgrounds?

Kirsty Garrett: I mentioned earlier that in February we promoted all activities around women and girls in sport. Obviously, that was also about including people from black, Asian and minority ethnic groups as well as people with disabilities.

We actively encourage the promotion of all activities for women and girls, in particular for black, Asian and minority ethnic communities. I am fortunate enough to have within my team a cohesion team that looks at inequalities and champions and leads on the equalities, diversity and inclusion agenda. We are very proactive in promoting opportunities for the black, Asian and minority ethnic communities in Glasgow. It is not perfect, but we are focusing on the issue as an organisation.

Patrick Murphy: All local authorities and leisure trusts would also be able to tell you about the make-up of their workforce.

It is also important to note that, under the community planning framework, all local authorities and trusts will be working within neighbourhood planning areas on areas of interest to communities. That may be working with women or on the holiday hunger agenda; it could be any kind of agenda. Neighbourhood planning is a good way to find out what those communities of interest require.

Paul O'Kane: Good morning to the panel. I will ask about socioeconomic issues for women and girls in sport. We had a response from Lanarkshire health and social care organisations that told us clearly that physical activity and sport are costly. That presents a challenge when it comes to targeting subsidy and access with reduced rates and things like that, which can make a huge difference. I would be interested in Patrick Murphy's take on my question initially. In the context that we are in just now, in which local authority budgets are increasingly pressurised, how can we do some of that with a reducing resource?

Patrick Murphy: With great difficulty, Paul.

We currently work with Lanarkshire health and social care partnership on social prescribing. Some people call it GP referral and some people call it physical activity prescription, but it is all the same thing. It involves health professionals, GPs, practice nurses and physios. At the moment, if someone presents to their GP, they get a four-week free pass. However, that simply knocks down the line the fact that, at some point, people will have to pay a bit.

It is also about working with my colleagues here and some of the other green space programmes, as physical activity does not need to cost anything, as we all know. That is a fairly obvious thing to say. Social prescribing is an excellent gateway or pathway into that.

There are concession schemes in which individuals are able to get some funding, or it may be that the concession scheme gives a discount. For an adult accessing our facilities today, it would be £25 a month to swim or to go to the gym every day. The concession price would be £12.50 a month, which is half of the adult price. Those are our current costs.

Paul O'Kane: In a previous life, I served on the board of a culture and leisure trust, and there were certainly challenges. There was always a tension around reviewing charging and the eligibility criteria for concessionary rates. Have you found having to change the margins of that a particular challenge, with more people maybe moving outwith the opportunities for concessions?

Patrick Murphy: Very much so. At the moment, our concessionary rate is 50 per cent but, given the challenges down the line that we have been talking about, it looks like the price will go up a bit from 1 April. That is a constant challenge.

Paul O'Kane: I will pose a question to Kirsty Garrett on a slightly different topic. It follows on from Dr Gulhane's points about black, Asian and minority ethnic women and girls. You mentioned initiatives taking place in February that tried to look at some of those areas. To what extent has Glasgow Life sat down and spoken to people from communities about their needs and what could be delivered that would help them? We will get the most acute and correct knowledge of the barriers when people who have that lived experience tell us about them. To what extent have you had engagement?

Kirsty Garrett: We have engagement all the time with our communities, especially sports clubs and organisations. For example, we have 21 community sports hubs spread across the 23 council wards in Glasgow. The hubs serve roughly 100 organisations or clubs with about 10,000 members. Our job is to go out and find out what the needs of the clubs are, as well as of the community—

Paul O'Kane: Sorry, Kirsty, could you pause? Maybe I was not clear. I am speaking more specifically about women from a BAME background who are engaging, or not engaging, in sport. To what extent has Glasgow Life formed focus groups or engaged with Muslim women's organisations, for example, so that they can speak about what their particular needs are?

Kirsty Garrett: As an example, our February initiative included Women on Wheels, which is a group that is predominantly for Muslim women.

As I mentioned before, we have a cohesion team that is tasked with ensuring that we engage with black, Asian and ethnic minority communities. However, the wider team does that work as well. We identify community groups and organisations, and then go out to the identified communities to find out what their views and aspirations are. We work with a lot of community groups; for example, we helped Glasgow Afghan United with a women's empowerment programme. We have significant staff on the ground who are in the communities in the 23 wards to make sure that we can and do engage with groups that potentially do not take the time to be involved in sport or physical activity.

In terms of the socioeconomic challenges, you are absolutely right. We are moving into a difficult landscape because of the cost of living and so on.

However, we have activities that are free, such as health walks. We have 54 health walks each week. They are run by volunteers. The majority—73 per cent—of the walkers are female, and 74 per cent of the volunteers are women. We also have closed walks, during which we train organisations to take their own walks forward. We might train, for example, link workers in the health and social care partnership, Glasgow Afghan United or others. We train organisations that wish it so that they can do other walks with their communities of interest. We do that through our relationship with Paths for All, which has been established for a significant length of time.

There is provision in the city that is free, but it is challenging. Where possible, we also try to do targeted provision for people who have challenges because of their socioeconomic background. A bit like Patrick Murphy's organisation, we have memberships, including full memberships and concession memberships. We have concessions for individuals on universal credit, income support, jobseekers allowance, a pension or carers allowance so that they can access our Glasgow club, which currently has 29,000 people as members. Funnily enough, of the people who pay monthly, the majority—57 per cent—are female. We have good information on our Glasgow club and our 29,000 members that we are happy to share.

The Convener: Emma Harper has a quick question on this point before we move on to talk about infrastructure and town planning in more depth.

Emma Harper: It might be a question for just Kirsty Garrett or Patrick Murphy. It is about wheelchair rugby. Rugby is becoming something that everybody plays; it is becoming important for women to take up, for example. Wheelchair rugby is quite a leveller because disabled folk can play with non-disabled folk and you can have mixed-gender teams as well. Is that something that is growing or can be pursued in order to level the playing field and encourage folk?

Kirsty Garrett: Yes, we already have a relationship with wheelchair rugby in the city and our venues have been used for it in the past, be it the Emirates arena or another venue. A member of our staff in Glasgow Life is also involved with wheelchair rugby. Under the cohesion team that I talked about, we also have a focus on disability sport to ensure that people with physical or learning disabilities are involved in any type of

activity. We try to support everyone, be it young people or adults, so we have been involved with wheelchair rugby in Glasgow.

Patrick Murphy: I think that most local authorities will have a sports council, which involves third sector committee members and volunteers. Most of them will also have a disability element—we do in South Lanarkshire. Our approach will be slightly different in that, rather than going right in there with rugby specifically, we will have a wheelchair multisport club. It could be wheelchair basketball or it could be another wheelchair sport. The sports council branches are funded by the local authorities and our branch will be funding the wheelchairs for that club. That will be in the local authority setting and it will be inclusive to all. Anyone can come along, including, as you say, able-bodied people. Often—I am thinking especially about the female participation scenario—there is an opportunity to bring along a sibling. That is great, because Emma Harper is right to say that it is an absolute leveller.

Emma Harper: I remember that there was an advert on the telly showing people playing wheelchair rugby and, at the end of the game, an able-bodied person who was joining in stood up. Able-bodied people joining in and playing the game with siblings is something that can happen—maybe the need to highlight that is a question for the media folks when they come in front of us as well.

Patrick Murphy: For the record, I will not be playing wheelchair rugby, because it is really rough.

Emma Harper: I know. It used to be called murder ball and now it is wheelchair rugby.

Patrick Murphy: Yes, that is right. You can count me out.

The Convener: Our most heavily subscribed theme is next—oh, I am sorry; the clerk has just reminded me that I ignored Euan Lowe, who wanted to come in before we move on to the next theme. My apologies, Euan.

Euan Lowe: Thanks. I can share my view, from sitting outside a council or leisure trust, that probably the biggest thing that the leisure and physical activity sector will be facing from an inequalities point of view is around affordability and cost, as a result of the circumstances that we are having to endure as a country at the moment.

In our sport, swimming, we are picking up signals from our clubs that they are preparing for increased access costs to venues—10 to 15 per cent more for some and higher for others. Last week, we heard about a particular area that was going to increase the club let costs by what worked out at 107 per cent. The club fees would increase from £33,000 per year to well over £60,000 per year, which is just not affordable. Those pressures are coming to operators because they need to be able to afford the costs of providing the service. Unfortunately, those increased costs will be passed on to members of the community at some point and I think that one of the biggest challenges that we are going to face from the equalities point of view is affordability.

We are one of the country's top participation sports, with a high percentage of females involved either through membership or through recreational participation. When pools start to close, that will have an impact on the health and wellbeing of communities and the country at large. We need to be mindful of affordability.

The Convener: Euan, I am going to push you on that because we had a conversation offline about this; swimming is one of the physical activities and sports that women do in later years as well, so would you agree with me that this would be a particular problem for older women, who might not be doing high-impact stuff but might be swimming right up until their later years?

Euan Lowe: I would. The unique properties of water, such as its weight-bearing properties, make swimming genuinely accessible to all ages and abilities, from the elderly and infirm to those who are recovering from injuries. For those who are unable to access or take part in any other type of activity and have no alternative, being in water provides a number of unique and different properties that allow them to be physically active. In particular, the proportion of girls and women who take part in the activity is a concern, given that we are starting to see the threat of pool closures ahead.

11:45

The Convener: A lot of members want to ask questions on facilities, infrastructure and town planning. I ask everyone to bear in mind that we have only 25 minutes left, and we have another item to get to.

David Torrance: Good morning, everybody.

How can community sports facilities be improved to allow female participation? For example, on booking times, a lot of community facilities have long-term bookings from males, and as female participation in sports such as football has increased, women have found it very difficult to get into community facilities. How can we improve that?

Patrick Murphy: I am not sure that I understand your question. For most facilities these days, booking will be online, so it is equitable.

David Torrance: It happens with a lot of clubs. I play walking football, and we have had a long-term booking at a time that is accessible to us all. Any other groups, especially female groups, that come in now are getting times late at night—the 9 o'clock or 10 o'clock bookings.

Patrick Murphy: That is not my understanding of what is out there just now. As I said, if you are talking about club lets and casual bookings, it is very equitable. Anyone can book online to do that, so I do not see that as an issue.

I think that I know what you mean about the traditional bookings. We have 10 taxi drivers at the John Wright sports centre in East Kilbride—they have a 6 o'clock slot, and they have had it for 25 years, but they still need to try to book that on an annual or a 12-week basis.

David Torrance: I am thinking especially of local authority community centres. In many cases, they are shut at weekends and those groups find it difficult to get into facilities like that to participate.

Patrick Murphy: I am sorry—I disagree. I do not think that people being able to get the slots that they would like is an issue for accessibility.

David Torrance: I would probably disagree when it comes to Fife Council. The best example that I can give is that, when people are off for summer holidays for seven weeks, all the community halls are shut.

Patrick Murphy: Not in South Lanarkshire.

David Torrance: How would you get women to participate in sports, especially when there is good weather?

Patrick Murphy: That is challenging if a facility is closed. However, in South Lanarkshire—Kirsty Garrett can probably speak to this in Glasgow—we certainly have a 52-weeks-of-the-year operation, from 6 in the morning until 10 at night at most sites. There is availability for people to book slots and go and do physical activity. I can speak only for our area.

The Convener: Let us go to Kirsty Garrett and find out what the situation is in Glasgow.

Kirsty Garrett: In Glasgow, we have in place, as part of my team, a community of venue programmers. Ideally, if an organisation such as a women's sports club came to us and was looking for a particular time slot, the programmers would look across the estate to try to find a suitable venue at a suitable time. That might mean that we move somebody else from one venue to another, because that space would be better used by another group or organisation.

We might say that if young men are playing football at peak time but that means that the kids are going to be playing at 9 o'clock at night, that is not a good use of the space and time. There would be negotiations and conversations with organisations to try to programme our venues more equitably. We have people who look at that, as it is important.

There can be challenges, because some people have had lets for a significant number of years and do not necessarily want to budge. We try to address that through our programmers to ensure that there is an equitable approach, but it can be difficult.

With regard to Glasgow Life, our sports venues are—as Patrick Murphy said about his venues—open for pretty much 52 weeks of the year, from morning to night, so we would hope that we can find availability for people.

Gillian Mackay: Everyone else will talk about buildings and things like that, but I want to talk about the social infrastructure that we need for people to be able to have time to be active. That relates to Kate Joester's point that, if a person is trying to drop kids off at school, do the shopping and come back, when will they actually have time to take a meaningful walk, go for a cycle or participate in a class in a local authority setting.

Not everybody might have an answer from their working experience, but I wonder whether anyone can reflect on what changes we need to make. For example, the Green Party is a big advocate of the four-day working week, which would allow people more time to focus on things that are important to them. We also need to look at caring time. Does anyone have thoughts on the social infrastructure that we need to facilitate women and girls having time to take care of themselves?

Kate Joester: That is an enormous question, and it involves addressing things such as the care burden and how households are structured—it goes to the very root of everything that we do every day. There are some simple things. For example, people can travel actively to work but only if they have time to get there via active travel or public transport. Actually, public transport is a huge facilitator of active travel, because very few people have a bus stop outside their house and their work. However, if someone has to drop off their kids at 8.50 am—which is when primary schools usually start—and has to be at work at 9.00 am, active travel is not generally feasible. Therefore, we need to talk about softer starts to the working day so that people can work more flexibly.

A lot of it is about making changes so that things are structured more equitably so that women and girls have the space in their lives that men often take for granted. We also need to understand that there will always be people who struggle to find that space in their lives because caring happens,

and having children happens. We need to work out how we build that social infrastructure by considering issues such as how we should build the working day.

It also comes back to planning because, if shops are a five-minute walk from someone's house, they will walk to them. Social infrastructure is important, but that is underpinned by physical infrastructure and, very literally, planning.

We need a fundamental change in how we do everything in society.

Gillian Mackay: Just a small one for a Tuesday morning.

Patrick Murphy: We currently have a programme with Clyde Gateway in the Rutherglen and Cambuslang area in which we are working with two local schools—we are not working in isolation—to help to deliver a childcare programme that allows individuals to work longer or search for work. That is a free programme, and it is just about to be scaled up to cover one of our more rural areas, because sometimes challenges are more exacerbated in rural areas than in urban areas such as Rutherglen and Cambuslang.

We provided a report along with our written submission to the committee, and there are some related statistics in that. I cannot quote them, but they are in the report.

Stephanie Callaghan: I want to ask about making spaces for women and girls. We know that parks, play equipment and public spaces for older kids, teens and adults are currently designed around the default male. It is interesting to know about Glasgow's feminist town approach. There was also a great motion in South Lanarkshire that was about recognising that unstructured play is for older children rather than just an activity for younger children.

My question is for Kate Joester, Kirsty Garrett or Patrick Murphy. Do you have any examples of older girls, teenagers and women successfully co-designing public spaces where that has increased use by women and girls? Feel free to send in any further examples you might come across, as well.

I should mention that I was a member of the sports council at South Lanarkshire, and that I have known Patrick Murphy for too many years to mention.

The Convener: I am not sure who wants to answer first.

Patrick Murphy: Not me—not after that!

The Convener: It is a great question about examples of where there has been co-design. I will go to Patrick first, and then I will come to Kate.

Patrick Murphy: I am not aware of any examples in planning. However, we have some good examples—as I mentioned in my first babbled answer—involving care-experienced children co-producing some of the programmes that I highlighted, such as the active schools programme and stuff on leadership. That is the only example that I can give just now, but I will check with regard to the co-production of green space and other unstructured play areas in South Lanarkshire.

The Convener: It sounds like Stephanie Callaghan is already making some recommendations for the report that we are going to produce.

I saw that Kate Joester was shaking her head in response to Stephanie's question.

Kate Joester: I am not aware of any examples. I wonder whether Cecilia Oram might have more to say, because Sustrans does quite a lot more in the design space than we do.

Cecilia Oram: The examples that I can think of are not in the United Kingdom.

The Convener: So there is precedent elsewhere that we can potentially learn from. We may need to factor that into our recommendations on that subject.

Kate Joester: We know that with street design it is economically much more helpful to get it right the first time, rather than having to go back and fix mistakes. Bringing in disabled people in particular to design spaces and to say, "Please don't mess it up in the first place," is valuable, and that would also apply when we are looking at participation in public space.

The Convener: I come to a question from Emma Harper—or perhaps not.

Emma Harper: No—I am okay, convener.

The Convener: I will go to Paul Sweeney, then.

Paul Sweeney: I am conscious that yesterday the leadership of South Lanarkshire Council called for the Scottish Government to consider the creation of a swimming pool fund, similar to that which was announced by the Chancellor of the Exchequer last week for swimming pools in England.

I go to Euan Lowe of Scottish Swimming first. Do you support those calls? Does Scottish Swimming have a view on how such a fund could be used to improve facilities and support the needs of women and girls?

Euan Lowe: In answer to your question on whether we support those calls—yes, we do, and I have actively written to the First Minister and the Minister for Public Health, Women's Health and

Sport to suggest that the Scottish Government considers following a similar route, with a two-phase approach. That would involve supporting providers and operators of swimming pools, in particular local authorities and leisure trusts directly, with some form of energy relief in the short term. Equally, over the longer term, where more active support is needed, it would involve taking a broader look at some of the current Government's net zero requirements and ambitions in order to invest in infrastructure properly to secure leisure facilities and swimming pools.

Paul Sweeney: I wonder whether Mr Murphy might have a view on why South Lanarkshire took that step.

Patrick Murphy: It did so because of the current circumstances. Our operating budget is £38 million for everything that we do, from running the zoo through to the nine swimming pools and golf courses. Of that amount, we bring in about £18 million, and the other £18 million is the funding from South Lanarkshire Council, which is constantly reducing.

As I have mentioned, that will not work as we move forward, especially in the light of some of the aspects that Paul Sweeney talked about, and the pressures in and around our communities and how they want to access and use our facilities. It is about all those things coming together, so we would absolutely support the introduction of some sort of relief that would allow us to move forward and to keep people, especially women and those from vulnerable backgrounds, using our facilities.

The Convener: I apologise to Paul Sweeney for coming in at this point, but I note that keeping those facilities open is also about making them sustainable, and I want to press Euan Lowe on that. We have seen that some areas of the UK are doing something different with regard to how they heat pools. Perhaps there is a potential opportunity there.

As I said, that links in with the issue of equalities. More women swim, right up until the end of their lives, than take part in any other sport, but it is very costly to keep pools open. If we do something in the sustainable space, we could keep them open. I throw that question back to Euan Lowe.

Euan Lowe: I will give the committee an example. I understand that in some areas, some operators are facing a doubling, if not a tripling, of their energy costs associated with swimming pools alone. It will probably come as no surprise to hear that, on the leisure side, swimming pools are currently one of the highest energy users, but there are rapid increases in technology and investment in renewables that may reduce costs.

For example—as you alluded to, convener—there is an example involving a data hub company that stores data, which exudes a lot of heat that is being put to good use to heat the water for swimming pools.

12:00

It has been evidenced down south that that is working. There are a number of other sites where Passivhaus technologies have been developed, and there are examples of whole-pool and whole-building design with regard to energy use, from air temperature to air circulation to the plant room—to take that example of heating water—to filtration and the use of chemicals. Those technologies are all advancing to reduce energy costs. The technology exists and there is an opportunity to invest in it.

The Convener: That is great. I wanted to get that on the record, because that technology is exciting, and it could be an answer to a lot of problems.

Tess, do you want to come in on that?

Tess White: Thank you, convener. I want to build on that. The reasons why that is so important have been mentioned. Whether it is solar panels on the roof or examples such as the one that we have just talked about, can Scottish Swimming explore new technologies further?

Euan Lowe: Yes. We have just commissioned a company to not only understand the landscape of pool positioning across the country but map that against the needs of communities with regard to the right size and shape of pool for those particular user groups and communities. The third part of that piece of work is to evidence and provide case studies of examples of renewables usage or new tech that could reduce energy costs for swimming pools. We are trying to get some case studies to evidence to government in a larger sense that this is worthy of investment.

I am aware that this is a world and European problem, and our European partners are likewise investing in renewables for leisure centres to reduce the burden of energy costs for swimming pools. It is an advancing sector.

The Convener: We are rapidly running out of time, but Evelyn Tweed and Sandesh Gulhane have questions on good practice and the ways forward. I am afraid that we will have to wrap up after that.

Evelyn Tweed: Good afternoon. My first question is for Euan Lowe. Emphasising the fun factor of sport is important, but given that women's professional sport is not taken as seriously as men's sport, it seems that there is a need to simultaneously work on access to elite sport,

where that is desired. How can the two things be balanced and not occur in isolation from each other?

Euan Lowe: It is difficult to know where to begin in answering that question. To a degree, it goes back to role models and perception. In the sport that I am involved in, we are fortunate to have a number of very successful world championship and Olympic and Paralympic medallists who learned to swim in Scotland, have lived in Scotland and are performing on the world stage from a Scottish base. It is about empowering those role models.

I go back to the example that I used earlier of Toni Shaw, who is a world championship medallist and who is our ambassador for the learn to swim programme. Part of the point of the ambassadorial role is the fun and engagement and the early experience, because that is why people bother to get involved in an activity in the first place.

Toni is great at sharing her knowledge and experience. We are particularly mindful of that point about fun and engagement, and I go back to our young volunteer panel. We are listening to our youngsters, who are keen to show the other aspects of the sport—the less formalised or less competitive angles of the sport—and to encourage more of a "jumpers for goalposts" engagement in the sport and enjoyment of the fun aspects that go with that.

There are other examples from around the world of changing the profile of the activity itself. There was a television series called "International Swimming League", which had a performance-based profile and involved elite swimmers. However, with that came razzmatazz, lights, cameras and a different kind of social media engagement. It brought to life some more of the fun aspects of the sport—the things that people loved best about being involved in swimming. We could perhaps look at opportunities on that side of things in the future.

Evelyn Tweed: My second question, which is for Kirsty Garrett, is about ensuring good representation of women in coaching. I think that Kirsty mentioned coaching in one of her earlier contributions. Do you have any examples of good initiatives to make pathways to coaching more accessible?

Kirsty Garrett: I mentioned our energise programme, which involved the provision of insight, training and support to engage with and attract a range of females to a variety of activities that they went on to deliver in a community setting. That energise programme was co-produced with the women who were involved in it. I mentioned the Activate-Her role—those people got additional training and support from my team so that they could deliver projects. We put funding towards that.

Another good initiative was the one that involved the Ment-Her mentoring role, through which we aligned people so that they could share knowledge, experience and practices in order to empower women and give them the confidence not just to take part in sport and physical activity, but to deliver it in their community.

There is a difference between sport and physical activity. With the traditional sports, there are coaching badges and qualifications, but we do a range of things around physical activity, such as our health walks, on which we provide training. We have coaches, officials and a training team, and we try to identify women—including young women—who could take part in physical activity and sport coaching.

With our active schools colleagues, we also deliver a modern apprenticeship programme that involves getting young women and young men involved in sports coaching and activity, and—we hope—putting them on a pathway to employability. There are opportunities for engaging with young people in the school setting with a view to getting them into coaching, as well as for engaging with people in the community setting.

However, I have to say that, in Glasgow, we are going through challenges of the kind that Patrick Murphy mentioned. The pressure on public sector funding and the reductions in that funding mean that all the fantastic things that we can do are at risk. It is really important that we continue to invest in those activities because, otherwise, we will see a huge increase in health and financial inequality, not only in Glasgow but in other cities. We must recognise that there is pressure on public sector funding for sport and physical activity, which is affecting not only our venues but other opportunities.

The Convener: I will bring in Patrick Murphy for a quick comment, after which Sandesh Gulhane will ask the final question.

Patrick Murphy: I have two concrete answers to Evelyn Tweed's question. Every year, we have a dance festival, which all 18 high schools in South Lanarkshire come along to. The pupils are mentored by dance activators, who are young leaders—volunteers who are young girls—who go into the schools prior to the dance event and build capacity. That is a brilliant example.

The second example relates to an initiative on which, I am told, a parliamentary motion has been lodged. Through Euan Lowe's organisation and our organisation, young people are identified to become swimming teachers. It is a great model, given the lifelong benefits that we have talked about. Those young people are given £550 to do a

level 2 swimming teacher qualification, which allows them to teach. They go on to be employed while they are at university or college or whatever. That is a great model of practice.

The Convener: This will be the final question before we move on to the next panel.

Sandesh Gulhane: My question is for Kirsty Garrett. Even though £17 million was spent on upgrading Tollcross swimming pool, it is to be closed, along with eight other sites. What impact will that have on the community and on getting women and girls into sport? What are you doing to further improve access to facilities and to sport for women and girls?

Kirsty Garrett: As far as Tollcross is concerned, Euan Lowe and someone else mentioned the fact that pools take money to heat and maintain. Glasgow Life has also had a challenge with recruitment of staff to run our venues. Post-Covid, there has been a decrease in the number of people applying for jobs as pool lifeguards. As Patrick Murphy mentioned in relation to South Lanarkshire, we are trying to provide new opportunities for people to train to get pool lifeguard qualifications and then secure a job with Glasgow Life.

There are different factors at play. There is a financial side: it is challenging to run pools because of the cost. There is also the issue of recruiting staff to run our venues. There are two issues.

As far as improving women's access to our venues and activities is concerned, I mentioned our Glasgow club, which has 29,000 members, 57 per cent of whom are female. When it comes to developing and refreshing our venues and sites, we engage with women to make sure that those are safe and welcoming environments. We also listen to women to find out what else they want to get involved in. We provide things such as group sessions and group activities. As well as being able to go to the gym or to take part in classes alone, there are group activities for women, which avoid them having to turn up on their own.

There are different factors at play. There is a financial side, which makes it challenging to keep our venues open, and a staffing side, which is also a challenge. When we improve our facilities, we engage with people as best we can to make sure that they are as inclusive as possible. I hope that I have answered the question.

The Convener: We have run out of time; we could have spoken to you for a lot longer. If there is anything that you wanted to draw to our attention that you feel got missed, we are happy to receive information in writing. Thank you for your evidence.

I suspend the meeting briefly to allow for a changeover of witnesses.

12:11

Meeting suspended.

12:13

On resuming—

Subordinate Legislation

Health and Care (Staffing) (Scotland) Act 2019 Amendment Regulations 2023 [Draft]

The Convener: Agenda item 4 is consideration of an affirmative Scottish statutory instrument. The purpose of the draft regulations is to make ancillary provision to correct some technical errors in the Health and Care (Staffing) (Scotland) Act 2019 that arose due to amendments that were made to the Health and Care (Staffing) (Scotland) Bill during its parliamentary passage. The Delegated Powers and Law Reform Committee considered the draft regulations at its meeting on 28 February and made no recommendation.

We will take evidence on the draft regulations from the Minister for Public Health, Women's Health and Sport and her supporting officials. Once we have had all our questions answered, we will have a formal debate on the motion.

I welcome Maree Todd, the Minister for Public Health, Women's Health and Sport, and her officials. Sarah Cartwright is policy officer in the Health and Care (Staffing) (Scotland) Act implementation team and Cecilia McCullough, who joins us remotely, is a solicitor for the Scottish Government.

I thank you all for joining us today. I invite the minister to make an opening statement.

The Minister for Public Health, Women's Health and Sport (Maree Todd): The Scottish Government is committed to ensuring that there is appropriate staffing in the national health service and care services to enable the provision of safe and high-quality services and the best outcomes for the people who use them. In 2019, the Parliament passed the Health and Care (Staffing) (Scotland) Bill to provide a statutory basis for the provision of appropriate staffing in both the NHS and care services. That enables a rigorous, evidence-based approach to decision making relating to staffing requirements and supports an open and honest culture that engages staff in those processes. Among other things, the 2019 act inserts new provisions relating to staffing into the National Health Service (Scotland) Act 1978 and the Public Services Reform (Scotland) Act 2010.

12:15

Implementation of the 2019 act was paused to redeploy personnel and resources to the Covid-19 pandemic response. A new implementation team was convened last year, and the Cabinet Secretary for Health and Social Care announced in June 2022 that all the act's provisions would come into force by April 2024.

The 2019 act was reviewed as part of the implementation work, and six technical errors were identified. During the bill's passage through Parliament, numerous amendments were made at stages 2 and 3. On some occasions, to ensure that amendments were properly reflected throughout the bill, cross-references to other provisions in the bill required to be inserted or amended. That was completed in the majority of cases, but in six instances those updates were not made, and the act contains errors. They now require correction to ensure that amendments that Parliament made to the bill are properly integrated. That will ensure that the act can be given full effect and the Scottish Parliament's intention delivered. The draft regulations that are before the committee make ancillary provision under section 14 of the 2019 act in order to achieve that.

The first amendment will ensure that the obligation on health boards and the Common Services Agency for the Scottish health service—commonly known as NHS National Services Scotland—to raise awareness among staff about procedures for notifying any risks that they identify relating to staffing levels under new section 12IC of the 1978 act will extend to all relevant aspects of that notification procedure.

The second amendment will ensure that the obligation on health boards and NHS National Services Scotland to raise awareness among staff about the procedures that are put in place for the escalation of risks under new section 12ID of the 1978 act will extend to all relevant aspects of those escalation procedures.

The third amendment will ensure that each health board and NHS National Services Scotland must, under new section 12IL of the 1978 act, provide employees with information about how it has identified and taken all reasonable steps to mitigate risks as part of the common staffing method.

The fourth amendment will ensure that the Scottish Ambulance Service board will, under new section 12IM of the 1978 act, be under a duty to report to the Scottish ministers annually on how it has carried out its duties under new sections 12IE, 12IF, 12IH and 12II of the 1978 act. Those are the duties to have arrangements to address severe and recurrent risks, to seek clinical advice on staffing and to ensure that adequate time is given to clinical leaders, and duties relating to the training of staff.

The fifth amendment will ensure that the Scottish Ambulance Service board will have regard to guidance that is issued by the Scottish

ministers, under new section 12IN of the 1978 act, about the carrying out of its duties under new sections 12IE, 12IF, 12IH and 12II of the 1978 act.

The two amendments that relate to the Scottish Ambulance Service board will largely bring it into line with other health boards and special health boards that deliver direct patient care in terms of its obligations relating to staffing.

The final amendment relates to the review and redevelopment of existing staffing methods by Social Care and Social Work Improvement Scotland—better known as the Care Inspectorate—under new section 82C of the Public Services Reform (Scotland) Act 2010. The amendment will ensure that the Care Inspectorate may, in a revised staffing method, require persons who provide care services to put and keep in place appropriate risk management procedures, in the same way that it could when developing a new staffing method under section 82A.

Stakeholders including representatives from health boards, relevant special health boards, NHS National Services Scotland, local authorities, integration authorities, Healthcare Improvement Scotland, the Care Inspectorate, professional bodies, trade unions and professional regulatory bodies have all been invited to participate in working groups to prepare the statutory guidance to accompany the 2019 act. As part of that process, the proposed changes that are detailed in the draft regulations were circulated for comment, and no objections were raised.

I fully support the draft regulations as the means of correcting technical errors in the 2019 act. They will ensure that the act can be given full effect and that the Scottish Parliament's intentions can be delivered. I am happy to answer any questions that members have.

The Convener: Thank you. With that, we move on to agenda item 5, which is the formal debate on the Health and Care (Staffing) (Scotland) Act 2019 Amendment Regulations 2023, on which we have just heard evidence. I remind members that they should not put questions to the minister during the formal debate and that officials may not speak in the formal debate. I invite members to contribute.

Emma Harper: I want to have it clarified that these technical amendments will help to allow staff to understand that they can raise issues with risk associated with staffing or staffing concerns. They will allow staff who work in NHS Scotland—I am a former employee; I need to remind folk that I am a former nurse for NHS Dumfries and Galloway—to understand that they can raise issues with risk.

Paul O'Kane: These technical amendments have to be made—this is a tidying-up exercise, if you like. Is it still the minister's view that the timescale of April 2024 is the one to which the Government is working for full implementation?

The Convener: Would members like the minister to cover anything else in her summing up?

Members: No.

Maree Todd: We are certainly working to that timescale. It is worth understanding that the working groups on implementation have been working according to the will of Parliament, so it expects the technical amendments to be made.

In response to Emma Harper's point, I note that some of the amendments are intended to empower staff to ensure that they know the process for identifying risks and who they should report them to. They are simply technical amendments that will ensure that cross-referencing within the act is accurate and that it contains the will and intention of Parliament.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Health and Care (Staffing) (Scotland) Act 2019 Amendment Regulations 2023 [draft] be approved.—[*Maree Todd*]

Motion agreed to.

The Convener: That concludes consideration of the draft regulations. Thank you, minister.

At our meeting next week, we will continue our scrutiny of NHS boards as well as taking further formal evidence as part of our inquiry into female participation in sport and physical activity. That concludes the public part of today's meeting.

12:23

Meeting continued in private until 12:30.

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