OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 March 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

12th 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:

Rona Blackwood (Children's Parliament)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Pamela Dudek (NHS Highland)
Jane Grant (NHS Greater Glasgow and Clyde)
Gordon James (NHS Golden Jubilee National Hospital)
Eilidh Paterson (Scottish Student Sport)
Dr Mairi Stark (Royal College of Paediatrics and Child Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 March 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning, and welcome to the 12th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance, who will not be joining us this morning. James Dornan is here as a substitute member.

Item 1 is to make a decision on whether to take items 5, 6 and 7 in private. Do members agree to do so?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Golden Jubilee National Hospital, NHS Greater Glasgow and Clyde and NHS Highland)

09:00

The Convener: Item 2 is the second in a series of scrutiny sessions with national health service boards from across Scotland. I welcome Pamela Dudek, the chief executive of NHS Highland; Jane Grant, the chief executive of NHS Greater Glasgow and Clyde; and Gordon James, the chief executive of NHS Golden Jubilee National Hospital.

I will move straight to questions. I have been asking all health boards about their financial situation. Obviously, demand on all health boards across Scotland has increased. There are also the pressures of heating and operating, because rises in fuel costs and inflation are affecting our public bodies just as they affect the whole country. That puts pressure on health boards to manage budgets, while health problems in the population at large may be increasing because people are feeling the pressure.

I want to ask each of you in turn how you are managing that. What impact is it having and can you see how you might reach break-even?

Pamela Dudek (NHS Highland): You will see from our submission that our predicted financial situation is a bit scary because of the size of the gap that we are looking at and are trying to resolve over the next three years. That significant amount of money includes the adult social care gap, because NHS Highland is the lead agency and because of the proportion of the gap in NHS Argyll and Bute. It is our prediction of the total size of the gap that we need to close.

We are working on that. Our submission sets out some of the value, sustainability and efficiency actions that the board is taking. Our fundamental focus is on redesigning services and delivering them in a different way, by working with our partners to optimise the wider public pound in pursuit of good outcomes for our population. Significant work on all those aspects is under way through partnership working, by having programme boards looking at the evidence to see what we can do differently and by working closely with our communities.

Inflation is having an impact. We saw a 35 per cent hike in our energy bills last year and predict a 20 per cent rise this year. We are doing as much as possible to move forward with energy efficiency. All our new builds will meet net zero standards and we are carrying out risk

assessments on any current plans. Our new community hospital in Aviemore, the hospital at Broadford and the national treatment centre were built to the standards that were in place at the time of design, but are at the top of those specifications. We are engaged with a district heating system in Caithness and hope to be able to do the same in Fort William. A number of other initiatives are under way as part of our sustainability and climate work.

The Convener: Highland is probably the most fuel-poor area of the whole United Kingdom and this has been a very difficult winter for many people. Are you seeing the impact of that in the level of need that your patients display?

Pamela Dudek: We have had more of an anecdotal response to that through the reports that come in when we see people at the hospital front door and they speak about their difficulties, and we are definitely seeing that through the lens of children and families. It is well evidenced that in-work poverty is quite prevalent across the Highlands and Islands and Argyll and Bute. From a health board and social care perspective, we spend a lot of time looking at access and how we can deliver close to home, albeit that doing so can be extremely challenging in certain circumstances. We look at the matter from that perspective.

We are one of the main employers in the area, and we have welfare and support arrangements for staff in collaboration with the council. It has carried out a few initiatives relating to benefits and additional income maximisation in our board, for example.

The Convener: Okay. My colleagues will probably follow up on some of that. I ask Jane Grant for her perspective from Glasgow.

Jane Grant (NHS Greater Glasgow and Clyde): Good morning. Similarly, we have financial challenges, but we are predicting a break-even position at the end of March, which is positive. There has been hard work by colleagues in the health board.

We are going into the next year with a recurring deficit that is similar to that which we had previously. We have worked hard to manage our resource within the framework that we have. We have a number of initiatives like those that Pam Dudek has outlined to increase our efficiency and look at our prescribing budgets to ensure that we are using them in the most efficient way.

We are also looking at some service redesign and energy efficiency. We, too, have access to district heating initiatives, and we are working towards our new builds being net zero carbon, although that brings a slightly higher initial capital cost. There are a number of issues there.

On supporting our patients, it is clear that people are presenting at a more fragile stage and are more frail. We are trying to support people to access our services and to support them in their homes to try to keep more patients in their homes when it is suitable to do so. We are also ensuring that there are wraparounds for patients who are discharged to try to ensure that, where required, there are financial services or there is advice on home energy, food packages and that kind of stuff. We have engaged in quite a lot of work to ensure that, as people are discharged from hospital, we work with our social work colleagues on a whole-system basis to support those who are most in need of such services.

Gordon James (NHS Golden Jubilee National Hospital): Good morning. As Jane Grant's board is, we are forecasting a break-even position for this year. Our latest submission to the Scottish Government for 2023-24 also shows a break-even position. However, there is challenge in that. We need to find around £6.6 million-worth of savings, which is around 2.8 per cent of our overall budget. We are working in a number of areas that colleagues have mentioned, such as procurement and prescribing, and we are aligning with the national sustainability and value programme.

We are currently working on a business case to link into the Clydebank district heating system. That will be positive not just for the hospital but for the community of Clydebank, as it will allow access to the heating system for social housing around the Golden Jubilee hospital in the future. That will act as an anchor point in the community.

The Convener: Colleagues might want to pick up on that.

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for their overviews, which were really interesting. I want to come in on how you deliver capital investment and returns in district heat networks. You have outlined specific projects that you have in mind. Ms Grant, will you go into more detail about potential district heat network investments that NHS Greater Glasgow and Clyde is looking at in particular?

Jane Grant: Clydebank health centre has the potential to access the process in Clydebank, and we are looking at that. That is one of the initiatives.

We have also looked at other district heat pumps that are set up in some of our premises and the ability to have those in place in a number of properties, such as the dental hospital at Dykebar and in Leverndale and Stobhill. We are also looking at how we can maximise the waste-water-to-heat process at the Queen Elizabeth university hospital.

I heard colleagues talking about solar panels. We have them in a significant number of our health centres.

Paul Sweeney: Does the board use a metric to assess what return on investment it might get against a capital spend? Are you able to test that as a business plan?

Jane Grant: Our estates and facilities guys would do that process.

Paul Sweeney: That is great.

I also ask all of you whether you can provide an update on your repair backlog and capital investment programme to deal with that and cost avoidance efforts. As they say, a stitch in time saves nine. I am interested to know what proactive efforts are under way to address the repair backlog in your estates.

Jane Grant: We had a £98 million capital investment budget for last year. That is mainly around things such as the north-east hub approach in Glasgow, which will be a good community facility. We have spent a lot of money on primary care improvement plan premises and so on, and on new radiotherapy equipment and those kinds of things. We are trying to cover the whole range of community and primary care and acute services.

We have also spent a lot of money on a new robot and on a trauma and orthopaedic assessment centre in Paisley. We have quite a lot of premises, so we are trying to do that. We have also spent a lot of money on medical equipment, because we need to have a rolling programme of replacement.

We have significant challenges in relation to the maintenance backlog across Glasgow and Clyde. The backlog is not all in the places that you might expect; there is quite a big backlog in the Queen Elizabeth university hospital, because we have a large retained estate there. The institute of neurological sciences also has a big backlog. We are working on a business case to replace that just now, because it needs significant investment.

We are looking at a lot of energy management schemes to try and save money and ensure that we are recycling the resource that we have and are not simply pouring more money in. We have all talked about net zero carbon. We are trying to do all those things, particularly as we approach new builds, and use the backlog maintenance money that we have to refresh our estate in as sustainable a way as we can.

Paul Sweeney: Are there opportunities in relation to your retained estate to achieve capital returns from disposal of surplus estates or investment in surplus estates for other purposes, such as the former acute hospital site at Stobhill or the east house at Gartnavel?

Jane Grant: We have a range of disposals. We have a programme for that. We are also looking at whether we can maximise our use of premises with other colleagues in local authorities and so on. We look at a range of issues in relation to all those premises to maximise the benefit for the whole population.

Gillian Mackay (Central Scotland) (Green): My question is particularly for Pamela Dudek.

Given the number of older buildings, local hospitals and so on across Sutherland and Caithness, and right across NHS Highland, what programmes are under way to keep those facilities in good condition and open in the first place so that people have those services close to home? What is under way to also ensure that all services are not centralised in Raigmore hospital?

Some of those buildings are very old—some of my family are from Sutherland, so I know how old those buildings are. How is the progress of work to make sure that they can take some of the new equipment that they were never built to take?

Pamela Dudek: I will start with our backlog maintenance, as a starter, and that will answer both questions.

Our backlog maintenance sits at around £80 million. The majority of that backlog maintenance refers to Raigmore. Although it is old, our estate is generally in reasonable condition. Our head of facilities and estates is risk assessing all our buildings. He has been moving through that in the time that he has been in post and, where we have opportunities to improve things, that is happening. That is quite a reasonable programme.

Again, like others, we also have a programme of investment in relation to primary care. We take a risk assessment-based approach to that, and our high-risk backlog maintenance is now under £1 million. Our head of facilities and estates has therefore done a lot to address that.

09:15

As you say, with the dispersed population that we have, it is critical for us to have fit-for-purpose services locally. However, there is also a big question as to how we use those services and how not just the building but what we do in it is modernised and how it is all made fit for the future.

There is a real loyalty and connection to what has gone before. We need to work hard with communities on that because they often perceive the building as the thing that makes it safe for them whereas, actually, what is important is what goes on within the building. Therefore, that will be

a focus as part of our strategy and redesign. The buildings are enablers in our pursuit of what we are trying to do.

We have two great facilities in Aviemore and Broadford. We have a redesign capital project for Caithness. We also have the Belford redesign and new hospital planning under way. Therefore, that estate looks good. We are working closely with people in Argyll and Bute on what else we need to do in that region but, having visited a number of the facilities down there, I can say that some of them are really good. It is not always the case that people there are forgotten in the back of beyond and that we are not doing anything about them. The figures support that.

Paul O'Kane (West Scotland) (Lab): Good morning to the panel. My questions follow on from what Pam Dudek said about buildings as enablers and the important thing being the quality of care. Although I accept that that is true, I have a direct question for Jane Grant on NHS Greater Glasgow and Clyde.

The repair backlog at the Royal Alexandra hospital is now more than £80 million. The one at Inverclyde royal hospital is now more than £100 million. In a recent report, Healthcare Improvement Scotland pointed to the quality of care in Inverclyde being excellent, but said that there were serious challenges with the fabric of the building. How sustainable is it to run those hospitals with an ever-increasing repair backlog of those scales? Does there need to be more sustained capital investment from Government to do something about that?

Jane Grant: We have backlog maintenance requirements and capital requirements on all our sites. There is a large number of sites in NHS Greater Glasgow and Clyde, as you are aware, and Clyde is a key element of our service delivery. However, I would not single out Paisley or Inverclyde as being the key issues. The situation requires us to look across our real estate for the acute sector and primary care to ensure that we maximise it.

As Pam Dudek says, we assess risk to ensure that we use the resource that we have in the best possible way to cover the areas that are of most concern to our patients. We have everything in NHS Greater Glasgow and Clyde from brand-new real estate to—as you rightly point out—facilities that are less new. However, we have spent quite a lot of money trying to refurbish areas within all sites to ensure that they are fit for purpose.

In the Queen Elizabeth university hospital, we have single rooms, but in Glasgow royal infirmary, we still have Nightingale wards, and in Paisley, we have four-bed and six-bed rooms. We have a mixture of facilities and we need to manage our resource on a risk basis to ensure that we use it as best as we can across the estate. Of course, we could use more resource, but we have to prioritise the areas that we feel will have maximum benefit to patients.

We also have to invest in the areas that are less visible, such as lifts and windows. They are not the kind of areas that everybody wants to do shiny new things on, but we have to spend money on the fabric of the building to ensure that it is kept up to pace as best we can.

Paul O'Kane: Given that Healthcare Improvement Scotland has said that there are substantial challenges to the safety and wellbeing of patients and staff in Inverclyde, is it sustainable in the long term to run a repair backlog of more than £100 million?

Jane Grant: We clearly could do with more resource and would be happy to use it if we got some, but we have to base our decisions on risk. For my whole career, we have been juggling resource to ensure that we manage the risk as best we can. The backlog maintenance figure is high and we would like to have more resource, but we have to maximise what we have across the board and that is what we are doing.

Gordon James: I think that all boards stratify their backlog maintenance into significant, high, medium and low levels. If you look at the backlog maintenance in totality, you see that the element that is significant is very small. As Jane Grant said, we clearly focus on that element, then on our high level maintenance, based on that stratification. That is part of all boards' property and that is their management strategy.

The Convener: Emma Harper wants to come in quickly on that before we move on.

Emma Harper (South Scotland) (SNP): I have a quick question for Gordon James. You talked about prescribing, which I know is not just medication but includes diabetes tech—things such as pumps and Abbott Libre and Dexcom monitors. My question is about weighing the balance between the diabetes technology and making sure that we avoid poor blood glucose control. I know that there is a campaign called "Diabetes tech can't wait", and I am interested to know how you weigh up avoidance of complications of type 1 diabetes—I declare an interest as a type 1 diabetic pump user—against prescribing and the costs of all of that.

Gordon James: We do not deal directly with type 1 diabetic patients in the Golden Jubilee hospital. I should also declare an interest: I, too, am a type 1 diabetic and have an insulin pump. I do not know whether that question was planned with that in mind, but I do—it is sheer chance. [*Laughter.*]

Over the past year, in the Golden Jubilee we have saved more than £100,000 by moving to the best prescribing medicine for our patients. Specifically on the use of technology such as insulin pumps, we look at the whole-life cost: what does it mean for the patient on their journey through healthcare and all the way through their life?

In the Golden Jubilee portfolio, we have the centre for sustainable delivery, and within that we have an area that focuses directly on innovation, called ANIA—accelerated national innovation adoption. It looks at accelerating innovation across healthcare and it works in collaboration with the chief scientist's office. Just last week, we have seen two of what we call "value cases". One was for digital dermatology and the other was for closed-loop diabetic insulin pumps, which marry real-time monitoring with insulin pumps. I am pleased to say that the process was approved, and we will roll out insulin pumps and closed-loop systems, which we already have in stock in the NHS, across Scotland and fast-track that with investment.

The Convener: Paul O'Kane has questions on performance issues.

Paul O'Kane: I will start with a general question. At last week's evidence session, we heard some discussion about the lack of prioritisation of preventative care because, understandably, there has been a huge focus on acute care and trying to address issues, backlogs and all the rest of it. Does the panel agree with the assessment of last week's panellists that there has been a large focus on acute care to the detriment of preventative care?

Pamela Dudek: It is not as straightforward as that. We have all been active in the space of prevention for a long time, but perhaps that has not been as deliberate as might be possible or at a consistent scale across our areas. In health and social care partnerships and outwith, in community planning, I do not think that there is a board that is not active on that. I sit on the national group that looks at community planning. It did an assessment of all areas and all NHS boards were very active, with their partners, in that space around prevention and early intervention. There is something to build on there.

I am from a community background, so I am probably more of an activist in pulling back into what happens in the community, but it is inevitable to some degree in acute settings, when they have the pressures that they have and the backlog with scheduled care and everything, that they are diverted to the very urgent, here-and-now situations.

The conversations that chief executives have, both nationally and locally, are very much about how to have a reasonable amount of sustained investment in prevention, because we all know that investing in early years and in primary prevention will help us in the long term. There is a commitment to that, but budget pressures and competing demands in the here and now mean that following that through can be very difficult.

Jane Grant: We have to look across the spectrum and balance all the competing demands. NHS Greater Glasgow and Clyde has had a public health strategy since 2018 and aims to turn the tide by using prevention. We have been focusing on that as much as possible and have a range of initiatives. We try to work closely with our colleagues in public health, in health and social care partnerships and in community planning to maximise potential across the health board area. The Glasgow Centre for Population Health is also part of our public health setup, although it also has a wider remit.

The key focus for the future of our country must be on children and young people. That is what we have been trying to focus on. There is more to do on the prevention agenda for conditions such as type 2 diabetes. There is a range of work, from traditional health promotion through to more emphasis on screening. We are thinking about how to assist people to live their best lives if they have type 2 diabetes. Child poverty action plans are a good vehicle for trying to ensure that we invest at the right point in that journey.

As Pam Dudek said, it is challenging to manage backlogs and emergency demand here and now while also keeping a focus on the long term. Greater Glasgow and Clyde has a population health and wellbeing committee to ensure that we are giving enough attention to those things at board level, as well as delivering the strategy.

Gordon James: Given that the Golden Jubilee hospital is a national elective centre providing specialist heart and lung services, we do not have a remit for public health. However, I agree with my colleagues that preventative medicine should be a key focus in public health. It is also important to educate and train our citizens and to engage with them digitally. That will be key.

Paul O'Kane: I want to ask about accident and emergency and particularly about waiting times, which is a question for the territorial boards rather than for the Golden Jubilee hospital. The standard that patients should be dealt with within four hours of arrival has not been met for quite some time and, in 2022, we had the worst figures on record.

Pam Dudek and Jane Grant, can you give us a sense of why that is happening? Is there an issue with staffing and resources in A and E

departments, or are there wider issues caused by where people present? Last week, we heard some of your colleagues say that they would rather have people come to A and E than anywhere else, if they choose to present at all. Are inappropriate presentations an issue?

Pamela Dudek: I am happy to answer first.

That is not the starting point. Our A and E consultants tell us that about 40 or 45 per cent of our presentations are for minor injuries, but that those are also relatively quick and simple to deal with. They say that any performance issues tend to come from the flow of patients into the hospital: access to beds and the time spent waiting to move people into the hospital. That is caused a much wider-system issue, which relates to delayed discharges, the care home and social care position, and hospitals' ability to discharge early in the day. That is the area that colleagues highlight to us.

Our rural general hospitals' performance against the standard can vary from 100 per cent down to the 80s on any given day. However, I have seen the odd day when performance in NHS Highland has gone below that, when we had a major trauma or something. The biggest issue by far for Raigmore hospital is being able to move people on to their next destination.

In the rural generals, the consultants have told me that performance is usually down because some kind of trauma or major incident has taken place that has meant that they have a bit more to deal with than they normally would. In the wards, issues are about staffing and care home placements—we have lost 104 care home beds in NHS Highland in recent months.

09:30

Paul O'Kane: Would you say that that delayed discharge plan is a key issue?

Pamela Dudek: Yes.

Paul O'Kane: Will Jane Grant comment on NHS Greater Glasgow and Clyde?

Jane Grant: Of course. We have a range of issues in NHS Greater Glasgow and Clyde. We have five main emergency departments and a number of minor injuries units. We actively try to encourage people to use the MIU when appropriate to ensure that the main emergency departments do not become logjammed with people who would be better served elsewhere. We do, and will continue to do, quite a lot of promotion around that.

Our main issues are similar to those that Pam Dudek highlighted. We have elderly, fragile people presenting at emergency departments. You will have heard from colleagues that we spend quite a lot of time with the flow navigation hub to try to reduce the front-door demand and ensure that when, for example, virtual consultations are clinically appropriate—and only when they are appropriate—we expand our portfolio of offerings for patients. That work has been successful but there is more to do.

We have also looked at things such as taking some of those distressed patients who require mental health assessments away from the main emergency departments and into the mental health assessment units. Some additional services have been set up in NHS Greater Glasgow and Clyde, too, and they have proven to be pretty successful.

The principal issue is one of flow, and we, too, have delayed discharge challenges: around 300 delayed discharges on any given day across NHS Greater Glasgow and Clyde, which is a fairly significant number. We are working hard with our health and social care partnerships and local authorities to maximise potential, because sitting in an acute bed is not best for our patients, never mind those patients who are trying to come in.

A range of factors exist. Staffing is sometimes a factor. Although we have been pretty successful in recruiting in recent days, there have been staffing challenges. Flow is one of the biggest issues, but we need to ensure that we maximise our performance in flow 1—the minors flow—which is where the major volume of patients comes through.

There is no one size that fits all; we need to look at a range of things. We are looking at how we can maximise and redesign the flow within hospitals not just around flow 1, but also around the Glasgow continuous flow—GlasFlow—model in relation to moving patients. We are also looking at using our predicted date of discharge more accurately, ensuring that we maximise the number of discharges in the morning as best we can, and using our discharge lounges to ensure that patients who are waiting for discharge are not occupying a bed while others are trying to get in. We are trying to do a big range of things, working closely across the whole acute system and with our HSCPs.

Paul O'Kane: Jane Grant mentioned a number of alternative routes for patients to be seen and the fact that the board is trying to encourage people to go to the MIU. You did not mention the general practitioner out-of-hours service, which is a key part of the issue. Inverclyde has been without out-of-hours GPs since 2020 and no plans from the board appear to be in place to reinstate that service. Instead, the board is directing people 15 miles up the road to the provision at Paisley.

First, do you think that that decision is good value for money with regard to supporting people to be seen in the appropriate place? Secondly, what kind of impact will the fact that people cannot see an out-of-hours GP in their community realistically have on A and E front-door services? Might you be able to give the reasons behind that decision?

Jane Grant: Of course. The board has not taken a final decision yet. We are still working on a number of possibilities for GP out of hours. We are still in business continuity across Glasgow and Clyde, for the whole of Glasgow and Clyde, including Inverclyde.

As you know, there have been issues around Glasgow and Clyde's GP out-of-hours service. We completely transformed the service three or four years ago. People could just walk in, which caused difficulties and was not an appropriate mechanism. It was probably the only board in Scotland at the time that did that. We have completely redesigned the service.

We have a GP out-of-hours service in Inverclyde. There is a home visiting service and a focus for transport to Paisley if the patient needs it. A large number of consultations are now being done by phone throughout Glasgow and Clyde, and not just in Inverclyde. The service model for GP out-of-hours services is changing, along with our consultations for out-patients and so on. That virtual mechanism will become more embedded—it has certainly become more embedded since Covid—across our all-services offering, which includes the GP out-of-hours service.

We have not seen a significant increase in emergency department attendances in Inverclyde on the back of the GP out-of-hours service situation. We have been monitoring that quite carefully. However, the board is still considering the options, because we recognise that there are strong feelings in Inverclyde about the services that we are providing.

We have a GP out-of-hours service in Inverclyde and it has not increased the activity in the emergency department.

Pamela Dudek: Can I add to that? Out of hours has been a challenge for many years. I ran an out-of-hours service in another board for many years, and sustaining and configuring it was a constant struggle. It has been no different since I came to the Highlands. The bit that is tricky for us, on which we really need to work hard with our communities, is the perception of what is and is not happening in the community. It is a bit like what I said before about what people have traditionally experienced: they think that any change means a reduction in service and a lower quality service. We have many conversations like that. In the Highlands, a number of communities do not wish to use 111 and feel quite upset with us when we ask them to do so, when what we are trying to do is to have an arrangement with 111 that can help us to manage the postcode better and respond better with the local teams.

For me, though, there is something about building up confidence in communities and helping them to understand what is a safe service for them. Just because there is a change does not mean that a service is unsafe. We have a lot of conversations like that with communities, and the out-of-hours service is a key issue. If the service is not something that the community recognises, it can often feel quite unsafe. However, it is incumbent on us to change in that arena because, when we were trying to spread a thin workforce across a patch, it was probably less safe than some of the innovative ways that we might try to work as we go forward. Our clinicians want to work differently in that space, so it is about trying to bridge that gap of understanding and address that unsafe feeling, and we have definitely got that as an area of work at the moment.

The Convener: We move on to questions about Covid recovery, led by Emma Harper.

Emma Harper: I am interested to hear about Covid recovery in all three areas. We hear from the health boards that come before us and we know that healthcare is really complex. As a nurse, I worked during the pandemic giving vaccines, and I saw how busy, committed and professional the staff were. I am thinking about acute care, mental health care, emergency care and elective care. Jane Grant said that one size does not fit all, when trying to address Covid recovery. I would be interested to hear about any actions that have been taken to progress recovery from Covid. What is working? What isnae working?

Jane Grant: On Covid recovery, as you would imagine, we are working hard on the elective backlog. There is a large backlog of patients who require treatment, and we need to balance that with the high level of demand for emergency care. We are trying to manage both, at the moment, which has been a challenge. We are working hard to reduce the number of long-waiting patients, in particular, and we have had some success on that—more so in the out-patient set-up than with in-patients, which has been a challenge because of emergency demand over the winter.

Lengths of stays in emergency care have for us been quite high, which has not helped us. However, we are trying to use our ambulatory care hospitals. We are fortunate to have two such set-ups in Glasgow, and we are also looking at whether we can ring fence some beds in Gartnavel general hospital and Inverclyde royal

hospital, to make Inverclyde a centre of excellence for our orthopaedic elective work. Quite a lot of work is being done on how we can manage the bed base in a different way to protect it from emergency care and make sure that we can keep working on our elective backlog.

In addition—as, I am sure, Gordon James would say—we are making good use of the Golden Jubilee hospital and we work hand in hand with it, as one of our partners, to deliver elective care.

I am not sure whether you want me to go more widely—for example, into cancer—or just to stick to that.

Emma Harper: I suppose that the issue is competing priorities, when acute care beds are occupied by people who are not well. When it comes to acuity, patients are getting sicker before they are even in the hospital. When beds are being juggled, it is very clear that there are challenges. For example, use of the Golden Jubilee and the sequestering of beds for elective surgery or the national treatment centre, for instance, should support the management of elective treatment so that we do not have competition between bed priorities. Is that what we need to look at?

Jane Grant: You are absolutely right. We try to make use of and maximise all our elective capacity across Scotland.

We are also looking at a number of initiatives to keep people out of hospital beds, if that is appropriate—for example, through increasing our remote monitoring and our out-patient parenteral antimicrobial therapy service—and we have been pretty successful in delivering reductions in the numbers of patients who could have a different service model. That is the way of the future: to maximise potential in order to keep out of hospital people who are not best served by being there.

We recently did a day of care audit, to look at whether we could do anything else for patients in hospital, and not just those whose discharge is delayed. Some things emerged around use of allied health professionals, for example. Perhaps we could move some patients to having their AHP treatment done more in their home or in a community setting, rather than their waiting to have some of it in hospital. We are trying a few things that are emerging from that day of care audit, to minimise bed days and make sure that the beds that we use are for acute patients.

We have talked a little about delayed discharge, but if, for example, we can do more remote monitoring and treat people more in their own home or in a community setting, that is what we should do. We need to do all of that.

Gordon James: During the pandemic, a decision was taken to keep the Golden Jubilee as a green site. We restarted our planned care operation about 10 to 12 weeks after the beginning of the pandemic, which has ensured that we have continued to offer planned care all the way through. Between 2019-20 and the current year, there has been a 20 per cent increase in our surgical throughput in knee, hip and eye surgery, and within our specialist cardiac service.

As Jane Grant has mentioned, we work with boards across Scotland and support patients who have long waiting times. During the pandemic, we opened phase 1, which was our eye centre. Currently, we do about 30 per cent of Scotland's cataracts. Just over 11,500 will be done this year.

We are on plan to complete the construction of phase 2 at the end of the summer, which will increase the expansion on our site of orthopaedics, general surgery and endoscopy. That is an £80 million investment in addition to the eye centre that opened two years ago.

The original plan for those sites—phase 1 and phase 2—was a regional asset management plan all the way up to 2035. However, we have been working with colleagues in boards and in the Government on how we can bring forward full-volume throughput of the sites much earlier.

09:45

Pamela Dudek: Speaking from an NHS Highland perspective, I will, like Jane Grant, say that our system has been out of balance. Emergency demand has definitely had quite an impact on our scheduled care programme, with regard to our ability to release or ring fence beds for surgical care.

On the medicine side, we have had whole-system working across the community and the acute hospital, with the aim of achieving in-hospital interventions, or actions on planned date of discharge and early discharge. We have absolutely been assessing the mechanisms that are in place with daily oversight of the system, as we think about moving towards reconfiguration and about optimising what we do in the community so that we are able to move people out of hospital.

As for the elective side of things, it is fair to say that we are, in a number of specialties, out of kilter with our pre-pandemic performance, but the most challenging areas are those that were already challenging in NHS Highland before the pandemic. We have a plan under way with the Scottish Government to set out trajectories, and the matter of where we will get to is being refined at the moment.

Clearly, the national treatment centre, which opens next month, will be a huge asset and a really positive step forward for us. The centre will take on all the eye care that is currently being carried out at Raigmore, as well as dealing with less complex but high-volume orthopaedics cases, which will free up space and opportunities at Raigmore.

With regard to orthopaedics and trauma, we expect that by October—indeed, at three points; in June, July and October—our waits of more than a year will be down below that level and that, by 2023, we will be starting to get back into balance with the treatment time guarantee. Those are our predictions at the moment, but we will obviously keep a very close eye on things and carry out surveillance.

Moreover, once the ophthalmology and eye care service is up and running, we expect those waiting lists to get back into balance fairly early on in the life of the NTC. That will obviously create capacity that the centre can then offer to other boards, but in the first instance, we will be working with NHS Grampian on its orthopaedics waiting times, taking 30-odd per cent from the figure that I have cited.

Evelyn Tweed (Stirling) (SNP): Good morning, panel. My question, which is for Jane Grant, is about gynaecology waiting times. I think that things are looking much better with a lot of other waiting lists, but why are you still having issues with gynaecology?

Jane Grant: There is no doubt that we have had some challenges with gynaecology. Our waiting time, particularly on the out-patient side, has been lengthier than we would have liked. We have put in place some waiting list initiatives in order to reduce that, and the number of long-waiting patients is coming down, but we have had to move some of our staffing resource into obstetrics, which has, over the past few months, caused a slight imbalance where previously things were in balance. However, we have an active programme of insourcing and waiting list initiatives to reduce times as swiftly as we can, and we are seeing some early shoots growing from that work, which is under way as we speak.

The Convener: Thank you. We move on to an issue that I know we have touched on a lot this morning: progress with the recovery plan. The questions will be led by Stephanie Callaghan.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): The Scottish Government annual progress update back in October said that "significant progress" in delivering on the ambitions of the recovery plan had been made. Do you agree or disagree with that? That question is for all three witnesses, starting with Pamela Dudek.

Pamela Dudek: Can you repeat the question, please, so that I can give you the right answer?

Stephanie Callaghan: The Scottish Government annual progress report back in October said that "significant progress" in delivering on the ambitions of the recovery plan had been made. Do you agree with that, or do you have some challenges in that respect?

Pamela Dudek: I agree with that, but we still face some challenges. We have worked really hard and have used every opportunity of remobilisation and recovery to try to step up and bring our system back into balance. In our conversation today, we have described some of the challenges that we continue to face. Every day, we look at where we are and at the art of the possible, but we generally do that from a challenged position. Of course, that position is quite volatile. My experience is that it can look like we are making good progress and are on our way, but then some variables change and things become difficult again.

I do not think that we are on a smooth path, and it would be fair to say that there has definitely been movement and progress in some areas, but it can at times be challenging to sustain that future pathway and feel confident that we are on an even keel.

Jane Grant: Progress has been made. It has been a difficult period for the health service across Scotland and the United Kingdom. We have had to balance the emergency flow with fragility and frailty of patients that are greater than they had been. We have had a significant increase in things such as our referrals for urgent suspicion of cancer, which has led to a backlog that we have to work on. We have to address that, because we are dealing with people who are, rightly, anxious. We have diagnostic challenges in that respect, and we need to ensure that endoscopy and imaging services and so on are appropriately resourced to handle the backlog. Within that, we have to prioritise patients who we think are most in need and at highest risk, and we have to do all that against a significant elective treatment backlog and the emergency challenges that Pamela Dudek has outlined.

As I said, progress has been made, but we have to reflect on and recognise the fact that our staff have had two or three years of significant pressure. That is the position that we are starting from, so we have to reflect on how we can support our staff and make things easier for them, rather than just asking for more and more from them. We have spent quite a lot of time trying to ensure that our staff are supported appropriately, while recognising that we have a public duty to ensure that the services that we provide can be provided

swiftly and at appropriate quality. Undoubtedly, we are on a difficult journey.

Gordon James: I agree with my colleagues. The pandemic has been challenging not only for patients, but for all of us in society. Obviously, the winter pressures over the past few months have added to the challenges that we face.

That said, we have made progress. Last year, in the Golden Jubilee hospital we pivoted in order to address long-waiting patients across Scotland, and you will see that the number of patients who are waiting for longer periods has reduced, as a result. I think that we have made progress, but I recognise that there are still challenges in the system.

At the Golden Jubilee hospital, we have the centre for sustainable delivery, which has two pathways on which we work with specialist delivery groups—clinical and managerial groups—across Scotland, looking at patient-initiated reviews and active clinical referral and triage of patients. That is really about putting patients at the centre of the process. Through those two programmes, we have removed the need for about 100,000 patient appointments. I can use my situation as an example. I am a type 1 diabetic and, if my control is good, I do not need to see a doctor, but if my control gets worse, I can initiate a review myself. What happens really depends on the needs of the patient. Using those pathways to transform our services has helped us as we have come out of the pandemic.

Stephanie Callaghan: You pre-empted my next question; I was going to ask you about what you have been doing at the Golden Jubilee hospital. How significant is that? Should it be scaled up and applied elsewhere?

Gordon James: We are already scaling that action up. Almost all the boards in Scotland are engaged in patient-initiated reviews and active clinical referral and triage.

As I have said, about 90,000 patient appointments this year have not been required. I stress that that is based on clinical intervention. Senior clinical intervention is part of the process, and in patient-initiated reviews it is down to patients to re-engage with the service or to have a realistic medicine conversation with the clinician who is delivering their care.

Stephanie Callaghan: Is that essential in order to make an impact on achieving the ambitions?

Gordon James: Absolutely—and it is having an impact already.

Stephanie Callaghan: Do I have time for a second question?

The Convener: Do you mean a fourth question? Other members want to come in, so please make it quick.

Stephanie Callaghan: I have a quick question for Jane Grant and Pamela Dudek. In its report, Audit Scotland said that it does not feel as though there has been a full reflection of the scale of the challenges and that that has had an impact. Is that accurate, or do you feel that some of the stuff had to be quite local? There were high-level targets. Was making decisions at local level helpful or unhelpful for what you wanted to do to?

Pamela Dudek: It is really important to have the local aspect. We need both—there is a lot of learning that we can take from national direction, and there is a lot of support from that. However, the local context is important. If you consider that the NHS Highland region includes 42 per cent of the land mass of Scotland, 36 islands and a widely distributed population, you will see that one size does not fit all .The context is different, as are the assets that the board might have at the local level. The local ability to assess what is needed and to pull in partners for some of the work is important. We always try to balance the two.

There were a number of unknowns as we forged our way out of the pandemic into recovery. We are still in that territory, but the insights that we have gained will help us to understand more and more what we might need to think about differently. I think that we will be on that journey for some time. Local context is important in designing and responding to what the population needs.

Jane Grant: I agree with that. We require an overarching direction of travel, but we need local autonomy to do that. We have been on a journey for the past two or three years, and we are not at the end of that journey—even today. Yesterday, I had 487 in-patients who had Covid, which is a large number. They were not all there because they had Covid, but it brings added complexity in terms of infection control.

Covid is not over in the sense of it no longer impacting on our services: it still does. That means that we have a number of closed wards, so our bed base is still quite challenged. We need to ensure that our patients and staff are as safe as they can be, especially on the Nightingale wards that, as I have described, we still have in NHS Greater Glasgow and Clyde. One of your colleagues said earlier that it is a complex environment. That is true: it is an incredibly complex environment to manage. We are still managing Covid. We are doing so in a different way, but the numbers are high so we have not finished that work yet.

I have worked in the health service for quite a large number of years, so I know that, during the

winter period, between Christmas and new year we usually get a lull and a reduction in emergency demand. However, this year, there was certainly no such reduction, probably for the first time in my whole career. That was because of Covid, flu and so on, as well as emergency demand. This winter has not been what I consider to be a traditional winter, and we are still only in March. In order to balance everything we need both the local and national aspects.

The Convener: I will bring in colleagues. Evelyn Tweed has a question on this issue.

Evelyn Tweed: Stephanie Callaghan asked some great questions, and she asked mine.

The Convener: Emma Harper wants to come in.

Emma Harper: My question comes on the back of Stephanie Callaghan's question. Does the Scottish Government enable and support you to do bespoke local delivery? We have Pamela Dudek here from NHS Highland, which is rural; we have urban representation from NHS Golden Jubilee National Hospital and NHS Greater Glasgow and Clyde; and, last week, we had a witness from NHS Borders. Does the Government support you to deliver local plans that work for your areas?

10:00

Pamela Dudek: Broadly, yes. Some policy decisions have been challenging for us. For example, it will be no surprise to the committee if I say that our rural GPs were at odds with the GP contract. We have had a lot of press about the fact that vaccinations are now the responsibility of the boards that deliver them. In a number of areas, they are still raising with us their feeling that that area should be GP led. Such issues come along regularly. However, the reality is that, with the vaccination programme being the size that it is now, many areas are not of a mind to be involved in that way. Also, given the demands on general practice, I am not sure that we would want to add in that other layer again in the way that is being proposed.

In those circumstances we are trying to work within the local context and to understand the rationale there. There is a confidence in what has happened before, which I can understand, because it worked well. However, we have now transitioned to a very different programme, so balancing views can be challenging at times.

On the whole, I do not feel constrained; I feel that we have a lot of levers that enable us to examine locality planning and optimise our resources at that level. It is for us to drive that process in an improved way, as we have done historically. NHS Argyll and Bute, which is integrated and where everything is under an integration authority, has great leverage to support its local context and shape, and we can see the benefits of that approach. In fact, all of its secondary care pathways lead to Jane Grant's system. Again, there are great examples of cross-boundary and cross-board working there.

The Convener: I want to ask you a bit more about that. We have had petitions about maternity services—in particular, in the Caithness area—which, over the years, have been picked up as presenting an issue. I know that a review of those services is happening at the moment. Will you give us an update on what is being done to better serve women and their babies in that part of the Highlands?

Pamela Dudek: We are probably still in the middle of trying to understand what the optimum model could be. We are considering what women's voices bring to the table as regards what they want. The words "safe" and "unsafe" are common terms in relation to services. We are trying to understand what it would take for more women to give birth locally, because the birth rates there are currently low.

The committee will know, from petitions and from the work of the local campaign group, Caithness Health Action Team—CHAT—which is mindful of them, the choices that are currently on offer to the women of Caithness. We are working closely with the CHAT campaign group. At our meetings within the past fortnight, its chair has publicly announced that our working relationship is much improved and that it is keen to continue to work with us to see how we can optimise services. However, we are still in the middle of trying to understand that.

We are conducting a strategic review of maternity services for NHS Highland. Although giving birth in Caithness involves long journeys for women who are in labour or at that stage of pregnancy, so does giving birth in Lochaber, Skye or Campbeltown. We have many remote areas in which there is variation in our birth rates. We are trying to understand our system and to carry out deep dives with clinicians to see how we could perhaps shape ourselves better in the future.

The Convener: What is the projected timescale for the review's conclusion?

Pamela Dudek: We are right bang in the middle of it. We are looking to take to our May board meeting a revised business case that will set out the resources that we are looking for.

On the back of that, we have been looking at the key performance indicators and working with the team live to consider the rationale for our caesarean section and induction rates. We are

seeking to understand and explain that aspect and to improve on it where it is possible to do so.

The Convener: Does that review include getting feedback from new mothers who have been taken on a long journey to Raigmore, for example, on what they would have preferred?

Pamela Dudek: Yes. We are working with the Highland maternity voice partnership, and we are looking at how we can expand the knowledge and intelligence that we get from mums who have birthed recently on why they made the choices that they did.

Again, we hear anecdotally from people that distance is very much a choice. Do they want to take the risk and hope that everything is fine and that they manage to birth successfully, or do they want to be in a place where they can get additional care if things go wrong? That would appear to be the challenge in people's minds, but I want to test that further with women who have had that experience.

The Convener: Thank you for that update.

We will move on to talk about the escalation framework, with questions from Gillian Mackay.

Gillian Mackay: How do the boards feel about the progress that they have made under the current escalation framework and the issues on which they have been escalated?

Pamela Dudek: NHS Highland experienced escalation in 2018 in relation to finance, culture and leadership. We have also had special measures in place for some of our mental health services, particularly child and adolescent mental health services and psychological therapies.

Last year, we were de-escalated on the culture, leadership and governance aspects, but we remain at level 3 for finance and mental health measures. I will start by discussing where we are still escalated, and I will finish on the positive aspects, where we have been de-escalated.

Finance and resources are an on-going challenge for us and we have worked hard on that area. During my time with the board, I have seen significant progress in our finances, and it is very disappointing that we find ourselves in the current situation as we look to next year. However, we have a capability, and we will apply that and do our best to move forward with a confident plan. As members can imagine, we currently have a huge focus on that.

With regard to psychological therapies, there is a robust plan in place and we have made good progress. Our director of psychology, who came in to take up a new leadership role, has deployed that plan thoroughly and very well, and we are making the right progress and are confident in the plan.

With CAMHS, the process has been slower. Given the CAMHS waiting list, the model on which CAMHS was delivering services, which was not in line with the national specification, and the staffing challenges that it has experienced, we have had quite a legacy. However, again, we have brought in some refreshed leadership and we have had external support, and we are now moving in the right direction, albeit that we still have some way to go.

That goes back to our discussion about prevention and early intervention and our work with the council on education and health visiting. Early intervention needs to be part of that plan, and we are actively involved in developing an integrated children's services plan.

Those are the areas of escalation. I will now turn to de-escalation. One area of de-escalation relates to governance. We had a full programme around the blueprint for good governance, with an action plan, and we completed all our actions for improvement. We are now a pathfinder for the self-assessment of the new blueprint and, last week, we had a board development session in relation to self-evaluation and further improvement. That was a very positive session. It was testament to the work that we have done and it looked at how we can build on that. The board wants to continue to improve and move forward.

We have invested significantly in leadership across the organisation, and we have in place a development programme that we are reviewing and improving. We have a strong team working in and around that.

Culture is a funny one for me. When people talk about changing culture, I do not find that very helpful, because culture is not something that we just change. There are many cultures in a complex system, and there are many different ways in which people work. We need to create the right environment, where people can thrive and work well together. That is absolutely what we have tried to do. We have been very successful in the post-Sturrock period, closing off all the actions associated with Sturrock, and we have had the NHS Highland healing process. As a board, we have been trying to look forward while making a positive impact.

As for how different things feel for people on the front line, having been out and about lots throughout the whole time I have been in Highland and having worked in many other boards, I have found people to be very passionate about what they do and I have found teams with fantastic profiles of working together, with no grievances or real issues, as well as areas where people have

had some really bad experiences—and everything in between.

There are now many ways for people to raise concerns confidentially, including through our independent speak up guardian service, which has been really successful, and through our whistleblowing champion, who goes out all the time, both with the manager and privately, and is therefore accessible to people—and we get his reports back. We have taken every report that has been made by him, by the independent healing process panel or openly through our own reporting of iMatter, through our board. We have made great progress, but this will always be a live issue. In a big, human organisation with many different beliefs and perspectives, we will always have to work on the relational issues and support people. Michael West will be coming up this week, and he has been before. There is a big focus on "Civility saves lives", and we are pursuing work around team conversations and values.

Gillian Mackay: I am particularly interested in the area of culture. I note the number of sites where NHS Highland operates and the number of workers who are potentially not coming into contact with a lot of colleagues. How do you overcome that challenge of ensuring that everybody's voice is heard and that you are accurately hearing what is going on at different sites, given the small number of staff in some places and the potential for some relationships to be not very good? People may be much more easily identifiable if they make a complaint there, compared with what happens in NHS Greater Glasgow and Clyde and some of the bigger hospital sites that we have, where raising concerns anonymously is slightly easier, I suppose.

Pamela Dudek: There are a few ways in which we have tried to do that. You are absolutely right: in the more rural areas, we are living and working together, so home life comes into work life sometimes, and that can be tricky. Our guardian service goes out and about, and it is present in a proactive positive way among our services. One of the most recent times I was down in Campbeltown, the guardian service was present in the hospital. It is not just a person who comes along when there is a problem; they are there to give support, to hear from the team and to act as a conduit for bringing support. There are also whistleblowing champions.

We have had a huge emphasis with our leaders on the importance of knowing what is going on in their system, and we have encouraged open debate, encouraging the celebration of difference rather than excluding it. Through our performance management framework, we have spent quite a lot of time on the people measures around sickness, absence, grievance rates and the temperature of the team. We are building on that all the time.

Gillian Mackay: Do you feel that you are receiving adequate support to improve not just the things where you are still on level 3 but those other aspects of culture, so that you can continue to make progress? What other support do you feel needs to be in place to help to de-escalate the level 3 things while you keep improving on the things that are at level 2?

Pamela Dudek: We are getting very good support on the things that we need to deal with, but some of those issues are pretty tricky. On culture, it is really for us to keep doing what we have been doing and to build on that.

10:15

Culture comes from the people and the leaders, clinical and otherwise, who are in the system and from how we behave—we all need to own it. Clinical leadership is hugely important, because culture is not just about how we behave or how well we get along; it is about the standards that we work to and how we interact with our patients, among other things. We need to own the culture, continue to promote it and move forward with the initiatives around it. Culture remains a top priority for the board to focus on, and you would certainly see that. However, the board is still trying to make sure that people at every level see the difference, because we still have people who say that they do not. We need to understand why that is and what we can do about it. That is an indicator that we know about.

The Convener: A number of colleagues want to ask about culture.

Sandesh Gulhane (Glasgow) (Con): I was struck by what Pamela Dudek said about culture, because there is a big report that suggests that culture is not what it should be in NHS Highland. Fiona Hogg, the head of people and culture, has left. In January, there was a report in *The Spectator* titled "The NHS is drowning in paperwork", which talked specifically about the Highlands, as did a BBC article from 14 February titled "Vulnerable patient died 'due to lack of nursing staff'". Those are all examples of where culture is poor, because, clearly, issues were not properly escalated. There are plenty of other examples that I do not have time to go into. From what you have said, it does not seem as though you have got on top of the culture in NHS Highland. What specific steps are you taking to ensure that the culture is where it should be?

Pamela Dudek: Are you referring to the Sturrock report?

Sandesh Gulhane: Yes, but previous reports have also talked about the culture within NHS Highland.

Pamela Dudek: Recent reports that we have taken to the board formally have come from the independent panel on the healing process, which set out the areas of focus that needed improvement and, as time went on, cited improvements that we had made. On the recent health and safety case—and by no means do I mean that there are not on-going culture-based issues within our health boards; we will always have to work on the culture of our human system—

Sandesh Gulhane: What steps have you taken?

Pamela Dudek: We have taken and will continue to take steps around early resolution—monitoring and surveying how our teams are through a number of metrics, including sickness and absence, grievances raised, and our iMatter and listening and learning surveys, and through performance. Those interventions are live and on-going.

We have a range of interventions from an organisational development perspective, which involve our OD team working with other teams that are struggling. Our independent guardian service will work either on a one-to-one basis with individuals or with teams, and we have whistleblowing arrangements. Informally, we all try to make ourselves available at all levels to work through some of the issues. Clearly, when we have had a serious incident such as the death of a patient, and recognising the falls aspect of that, we use formal review processes and take the learnings back into the organisation.

The Convener: Tess White has some questions on culture and governance.

Tess White (North East Scotland) (Con): I do. I have two questions: the first is for Pamela Dudek and the second is for Gordon James.

My first question builds on the question that our convener asked about maternity services, and it is about the culture in the NHS Highland. We have had petitions on the subject, which have been referred to. You said that you are consulting women's groups, but we have heard loud and clear from women's groups in the Highlands that they feel like second-class citizens in relation to not just maternity services, but general women's health, including endometriosis.

It would be helpful if you could give your feedback on that consultation so that the groups know that you are listening to them and will follow it up.

Pamela Dudek: Absolutely. Points have been made through that route and also through chat. I see them as they come in and I review them with the team. Our local team in Caithness and the teams in Raigmore that relate to those pathways are working much more closely within the locality to understand those perspectives and look at what else can be done. I am very aware of the issue and we will continue to work with the groups to try to get to the right place.

Tess White: So it is definitely on your radar and you are working with them. Is it one of your top—

Pamela Dudek: [*Inaudible*.] I have read that and we will be looking this week at how we respond to that. When I or any of the team are up in Caithness, we certainly try to meet those people whom we can meet face to face.

Tess White: Thank you. My second question, which is for Gordon James, is about the employee questionnaire. We have a copy of the statistics for the various health boards, and I note that the figures for the Golden Jubilee hospital are declining or below average. When it comes to staff governance and the staff experience, what are you doing to address the poorer performance in relation to how staff feel about their wellbeing?

Gordon James: We are doing a lot of work around staff wellbeing. We were the first board in Scotland to launch a spiritual care strategy. It puts patients and staff at the centre; it is about love and kindness and what they mean to the staff member or patient. We launched that strategy, which is the first of its type, in January.

On physical health, we have our occupational health service, to which staff can self-refer. We have mental health first aiders who help staff through any difficult times. We also run a series of events on wider societal issues such as finance, and we bring on board the Samaritans, mortgage providers et cetera to help staff.

As well as the whistleblowing arrangements that all boards have, we have an employee assistance programme with a confidential line that staff can contact to raise any issues that they have.

We have a spiritual care and chaplaincy team that speaks to staff of all faiths and none, as well as the public, and we are undertaking a number of activities, such as mindfulness and breathing in to the weekend. We have a full programme of staff events that we have been undertaking over the past year.

Tess White: Staff might say that that is cure rather than prevention. Staffing is a big issue, so having mindfulness is not going to cure issues with staffing.

Gordon James: Do you mean in terms of the number of staff—

Tess White: I am talking about people and their wellbeing when they come to work, and whether they are stressed because of other issues.

Gordon James: That is why we have mental health first aiders et cetera. In our wider activity, we look at social wellbeing, including what is affecting the person in their daily life and how they feel in the workplace. We do things such as hold Schwartz rounds, which provide an open forum for people to discuss issues that are affecting them. Again, that is led by our chaplaincy team. We also have a volunteer team in the hospital that supports both patients and staff.

Tess White: Does it concern you that you have declining or below average performance?

Gordon James: During the pandemic, we saw a slight dip. I believe that, as we go forward into future years, given the work that we are doing, we will see an increase in the numbers again. We are absolutely committed to staff wellbeing.

The Convener: I mention to colleagues that we want to talk about mental health services and staffing issues, and we are still on governance and culture, with a number of members wanting to come in on that. We have only 20 minutes, so please keep your questions succinct.

Emma Harper: I will be succinct, convener. My question is for Jane Grant. I am looking at NHS Greater Glasgow and Clyde's website, and there is loads of information on staff support and wellbeing—there is information on peer support, self-referrals, mental health, stopping smoking and speaking up. The website says that you are listening. Put simply, how is that marketed to staff? How do they know that they can access those services, from an education standpoint?

Jane Grant: We have a variety of ways of doing that. We have our core brief, which I send out every week and which outlines some of those resources. We send out regular briefs during the week, in which we highlight things to staff. Staff sometimes raise issues that they want to put in the briefs, so that we can be clear about those. We encourage line managers to have conversations with their local teams to ensure that we get suggestions. We have an active communications and engagement department, which works hard to ensure that we do that when ideas come from staff.

Last year, we launched an internal comms and engagement strategy, and we are working on the actions within that, because communication with our staff is absolutely critical. The internal comms and engagement strategy is the focus of our work to ensure that we permeate the whole organisation. It looks at a range of things, from core values to things such as collaborative conversations and the sort of activities that Emma Harper described around ensuring that we have active staff, as well as things such as mindfulness and smoking cessation services. We recently launched a support mechanism for staff, through which they can access small grants if they are in severe financial difficulty, and which they do not have to pay back in the short term.

We are trying to do a huge range of things. The communications strategy and our comms department are the principal way in which we do that.

Emma Harper: Do you use social media, too?

Jane Grant: Of course—that is all contained in the internal comms and engagement strategy.

The Convener: Paul O'Kane has a question on that issue, and then he will move on to staffing.

Paul O'Kane: My question follows on from that point. Jane, you spoke about the work that has been done in the previous 12 months. However, do you accept that, in the past 12 months, the number of whistleblower complaints in NHS Greater Glasgow and Clyde has doubled? That suggests to me that there has been a failure to empower staff to speak out. I have heard directly from staff that there is a culture in NHS Greater Glasgow and Clyde of people feeling that they cannot speak out, particularly where, for example, someone might be the only staff member on a ward in a hospital. Do you accept that?

Jane Grant: We have tried hard to ensure that staff have access to whistleblowing processes. The speak up campaign has been successful. To be honest, I am not sure whether you would judge success to be more people or fewer people speaking up. I am keen that our staff speak up. It is incumbent on us to ensure that all line managers, as well as the appropriate mechanisms, are supportive of staff to ensure that they feel that they can raise things locally. However, when people feel uncomfortable about doing that, there has to be another mechanism, and our speak up campaign has been successful in that regard. We have done a whole review—

Paul O'Kane: Do you recognise that whistleblowing is a last resort for staff?

Jane Grant: Absolutely. We have a whistleblowing champion, as others have described. He carried out a full review of our whistleblowing processes, and an action plan was developed, which we fully implemented. At our board meetings and so on, the whistleblowing champion is positive about the actions that we are taking on whistleblowing. However, we cannot rest on our laurels on that—we have to be proactive about it all the time, because we want staff to feel that they can raise issues in a constructive way

and that they will be supported to raise things when they want to do so.

Paul O'Kane: I want to expand on that issue. We are interested in the retention of staff. We have a real challenge with keeping staff in their roles because of anxiety, stress, burnout and associated issues.

Staff in NHS Greater Glasgow and Clyde have at various points described their experience of some hospitals as "hell on earth". That is a quote from a member of staff. I go back to the point about the single staffing of wards. That was uncovered at the Queen Elizabeth university hospital and at Inverclyde royal hospital, where it has certainly happened on more than one or two occasions. Much of that information had to be found through freedom information requests. To what extent do you believe that it is a significant problem? How is it being dealt with at board level?

10:30

Jane Grant: We have had an issue with having only one registered nurse on wards. We have spent an enormous amount of time trying to address that, and we have been reasonably successful. It happens much less now, and we have a regular reporting mechanism that highlights areas where we have staffing challenges.

The key thing for us is to try to recruit more staff and to retain our existing staff. There is a lot of work going on in that respect, and we have managed to recruit in excess of 200 international trained nurses to support our staffing. We have challenges around staffing, as all boards in Scotland do, and we are trying hard to recruit and retain more staff.

It is incumbent on us to make sure that our turnover is low, which means supporting our staff when they are in post and making sure that we listen to their issues. Sometimes, issues such as short-term sickness make the challenges very difficult and, as you have heard today, the Covid position leads to higher levels of absence. It has done so for us, which makes it difficult, particularly on smaller sites, where there is less flexibility.

Paul O'Kane: To go back to the point about culture, would you accept that some staff who have found themselves in such situations have either not reported that via Datix or whistleblowing procedures, or have not spoken out because they do not feel confident or supported to do so? Indeed, they have felt that there might be repercussions if they were to speak out and express their concern about being on a single-staffed ward.

Jane Grant: We are certainly doing all that we can to encourage people to report, to make sure that we understand exactly what is going on in any ward that has only one nurse and to support colleagues when they have been under stress or duress. It is not a subject on which we can rest on our laurels; we have to be proactive all the time in trying to support people who want to raise issues.

However, as I said, we have been reasonably successful in making sure that the "Speak up" campaign has been successful. We have the whistleblowing champion, who is very active, and we do quite a lot of other things through our area partnership forum, which is most vocal if it has things that it wants to raise. We are endeavouring to respond.

Paul O'Kane: Is the board regularly informed about where that is still happening, if it is still happening, and the plans that are in place to tackle it? Is that information shared publicly through board papers and those sorts of things, or will we require to make an FOI request in the future to understand the picture?

Jane Grant: A lot of those things would be dealt with in our board committees. As you can imagine, in a board with a £4 billion budget, there is an enormous amount of activity at board level. The board committees are where we do most of our business of that sort, which is reported, and our non-executive members question and scrutinise the performance of the executive team.

Paul O'Kane: Okay. As far as wider staffing issues are concerned, there is a particular issue around the national waiting times centre and the expansion of staff—there is obviously a need to recruit a large number of staff in order to upscale. Gordon, do you think that the timescales and the plan for that are realistic?

Gordon James: Phase 2 is the new elective centre and, as I mentioned earlier, the original plan was for roll-out to extend all the way to 2035. At the moment, we are looking to accelerate that plan. We have set ourselves a target of recruiting about 250 staff by September and an additional 250 staff by the end of the financial year. To date, we have recruited 120 of those staff across different disciplines.

As my colleagues have said, there is a challenge around nursing and some of the nursing workforce. As Jane Grant mentioned is being done in Glasgow, we are successfully utilising international recruits. We are also working with our sister organisation, which is part of the Golden Jubilee and NHS Education for Scotland. That is the NHS Scotland academy, which is hosted in the Golden Jubilee. We are looking at different roles and pathways, including advanced practice roles, perioperative roles in theatres and so on, and roles prior to being a band 5 nurse. That gives us

a good opportunity to look at the skills mix that we have to recruit.

Paul O'Kane: Obviously, the national centres are crucial to our recovery and to avoiding people having to languish in a lot of pain. If we do not meet those staffing targets, will that jeopardise the expansion of those services?

Gordon James: There is always an opportunity for us to look at some of the different roles. I did not mention bank staff; we also have access to them. We have about 850 nursing and healthcare support workers on our bank whom we can use. We will consider all avenues for recruiting staff to meet the targets that I mentioned.

The Convener: We will now talk about mental health services, the questions on which will be led by Paul Sweeney.

Paul Sweeney: A major outcome of the pandemic has been the increase in mental health conditions and demand for the associated services. We note that the recent budget allocation of £290 million for mental health funding restored the £38 million provision that was cut as part of the emergency budget review. Although that is welcome, it is still, in effect, a freeze on funding for mental health across the national health service in Scotland. That is being compounded by recent announcements such as Glasgow health and social care partnership's announcement of a £22 million cut in its service provision and the consequent loss of 197 positions. I am sure that that will be carried on across Scotland.

I invite the witnesses to comment on whether that will have practical impacts on their service delivery. Is that a bit of a false economy across the public service provision for mental health in Scotland? My impression is that, in many areas, we are robbing Peter to pay Paul. As chief executives, do you share that impression?

Jane Grant: We have been fortunate to have quite a large investment in mental health, although we would always like to have more. One of the challenges has been the availability of trained staff to support that.

Mental health services are a spectrum from self-support, through peer support to traditional CAMHS and psychological therapies. One of our whole-system challenges is to ensure that we do not overmedicalise, so we are working closely with our partnerships. We work closely with psychological therapies teams and CAMHS teams, but we also work with local authorities and the third sector to ensure that we signpost people to the right place, which is often not into the health service itself.

We are not complacent at all—record numbers of people have been referred into our services—but we need to invest in a tiered system and ensure that we do not just leap to the highest tier. Our approach on that is to work closely with the third sector, the health and social care partnerships, local authorities, including Glasgow City Council, and a variety of other stakeholders to ensure that we cover all of that.

Pam Dudek made a point about prevention. We need to invest in getting to people to have the conversation before something becomes a real mental health issue. That is where we believe that our investment should be, through schools and so on, with young people. There is a big spectrum, but where people need the service, we have to consider how we support them and how we use people with lived experience to help, rather than us just doing something to people.

Mental health is a huge spectrum and a hugely important issue. You are right to raise it, because we need to ensure that we give it as much attention as physical health, if not more.

Pamela Dudek: You are right, Mr Sweeney, in that if we do not acknowledge, understand and respond to what is happening, we will end up with a disease burden of mental illness that could have been prevented. We need to recognise that.

I agree with a lot of what Jane Grant said. We need to get to the nub of what is happening in communities and what the mental health or wellbeing, versus mental ill health, of those communities looks like. We then need to consider the strategies that we can implement as an organisation or with our partners to shape services and respond to need.

Things such as suicide, drug-related deaths, the impact of poverty on our communities and the early years are all really important to us in the Highlands, and we are trying to get a collective understanding, through community planning and our services, of what else we can do to shape things differently.

At the mental illness end of things, our assessment team, which was put in place more than a year ago, has been very successful. Our police and ambulance partners have been picking up some of that workload. That is not necessarily the right response, so we have been working closely with them, and they are seeing the benefit of that.

There is an awful lot to do and a lot to keep an eye on. However, for me, things start with being sure that we understand what response is needed and not just jumping to a medical response when there is perhaps a need for a wider or broader response, as Jane Grant said. That is prevalent in the Health Foundation's recent report about inequalities, "Leave no one behind". We also need

to look at the wider factors that can influence how well someone does.

Paul Sweeney: I am conscious that your board is quite specialised, Mr James. I do not know whether you want to say anything about that.

Gordon James: We do not have any mental health services.

Paul Sweeney: Okay. That is fair.

I want to go back to a point that was made. I accept completely that overmedicalising can often be counterproductive and maybe not appropriate. However, I am looking at the metrics. I will take Glasgow and Clyde. In 2019-20, 111 people had their CAMHS referral rejected and were re-referred by their GP and, in 2021-22, 414 people were referred again after rejection. I take on board the point about appropriate presentation, appropriate referrals and whether they are required, but a second referral could suggest that a clinician—that is, a GP—believes that the patient needs that help and is not getting it on first asking, and has therefore reiterated the referral. Are budgetary pressures increasing the threshold, rather than it being a case of judgments being made about clinical appropriateness?

Jane Grant: No. We have refreshed our whole approach to psychological therapies and CAMHS, and our rejection rate is much lower now. We have increasing referrals, so we have more people coming on to the waiting list, but we have invested in a huge redesign process, additional staff and different ways of doing things, and we are now hitting the access targets for CAMHS after a period of instability. We have completely revamped that, and we are moving to a new model across Glasgow and Clyde. One of the issues was that CAMHS were managed within our partnerships and, in small partnerships, if some staff left or a highly specialised interaction was needed, we did not have the ability to easily flex across Glasgow and Clyde. The model is being redesigned as we speak to maximise our potential to ensure that children and young people in particular have access to those services in a different way.

CAMHS have been completely redesigned and, as I have said, we have been reasonably successful in delivering that. However, we are not complacent in the slightest. That is a hugely important issue for the board, and it will continue to be so.

Pamela Dudek: I will comment on adult mental health and the relationship between primary care and secondary care. When I have been out in GP practices recently, I have seen that we have definitely not quite got that right in terms of how that comes back together. There is investment in primary care, with link workers and community mental health staff being more aligned to practices, but there is definitely room for improvement in the relationship between the gatekeeping, which might be too rigid, and the referral process. We should not lose the person in the middle of it and the clinical conversation that might have a different outcome. Our teams are looking at that.

The Convener: Evelyn Tweed can ask the final question. We must then pause.

Evelyn Tweed: Do you have a sense of whether people are put off coming for mental health services because of the long waiting lists?

Pamela Dudek: I could not give you a factual evidence-based response to that question at this point, but I could go off and consider that. I am a mental health nurse by background, and I suspect that there will be an element of that, as there probably always has been. If the system feels too difficult to navigate, people might not be able to see how they can get there.

Looking at inequalities, we see that the people with the greatest need are often in a situation where it is very difficult for them to use services in the way that we might have set up those services to operate. My background is in working with addiction, and I found that to be very much the case in that area.

There is always a challenge around how we get to the people rather than expecting them to get to us when they are in that level of distress and in a difficult set of circumstances. That is an on-going issue that we will continue to work on. It comes down to our capability and expertise in considering and applying access through an inequalities lens.

Our communities are often very tapped into where we need to go and how we work with them. I am not saying that we are not tapped in—we have strong local community planning groups and community councils, certainly across the Highlands, and it is good for us to tap into those to understand the communities. Nevertheless, we still sometimes create services that are probably more service driven, because of the constraints of trying to deliver a service, and which do not always fully take account of how difficult it might be for somebody to come forward.

The Convener: Sadly, we have run out of time. I thank all three of you for your time and for answering all our questions. I suspend the meeting briefly to allow for a changeover of witnesses.

10:46

Meeting suspended.

10:55

On resuming—

Female Participation in Sport and Physical Activity

The Convener: We move on to the third evidence session in our inquiry into female participation in sports and physical activity. This session will focus on children and young people. We welcome Rona Blackwood, head of programmes at the Children's Parliament; Dr Mairi Stark, Scottish officer for the Royal College of Paediatrics and Child Health; and, joining us online and remotely, Eilidh Paterson, inclusion and culture development co-ordinator at Scottish Student Sport.

Before we move on to our evidence session and ask questions of our guests, we are going to see a short documentary film, which was sent to the committee by Daisy Drummond; she made the video as part of her media studies exam at Drummond community high school, Edinburgh.

I thank Daisy Drummond so much for sending that film to us. In a previous life, I taught students how to make television programmes. I hope that Daisy follows through in her career, if that is what she wants to do, because she has certainly shown an immense amount of talent. What a great start to our session today; it has really helped to set the scene.

We move on to talking to our three witnesses. Daisy's film has highlighted a lot of the issues from the perspective of young girls who enjoy sport and are actively involved in it; however, a lot of girls drop out of sport, around the age of adolescence in particular.

I will start with a constructive question. How do we address some of the issues that were highlighted in Daisy's film by those girls who, obviously, recognise the issues but still get on with things? How do we start to address the girls out there who are maybe not as active, and get them to enjoy and engage more with sport and physical activity? I start with Mairi Stark.

Dr Mairi Stark (Royal College of Paediatrics and Child Health): The issue is extremely important. We need to look at things in the context of all age groups. We all understand the importance of physical activity to our long-term physical and mental health.

Some people may not remember how much physical activity we are supposed to do. How many people in this room do at least 150 minutes a week of proper activity? In addition, are the men in the room more likely to do it than the women ? I suspect that they are.

We need to address the issue through the ages. Toddlers are supposed to do three hours of activity a day, so they need good play parks, forest schools and lots of activities to do. Then we go into primary school and, again, we need more activities for all children, because there are fewer gender issues among younger children. We need to get them doing things—get them active. Then, when they become teenagers, they are already doing sports. We can then do specific things for that group.

I thought that the video was excellent—I really enjoyed it—but I note that one of the people in it said that their role model was their mother. Mothers are very important role models. I go running and mountain biking and do other sports with my teenager, but the fact is that not all teenagers have mothers who want to do all those things. We therefore need to get mothers involved and see what they want to do. There are, for instance, the women in golf programmes.

We need to put in place cheaper activities for women and we need to use the likes of jogscotland and so on. We need to invest in things that do not cost too much money. At the moment, sport is extremely expensive. If you want to do any sport, you suddenly need specialist shoes and other kit—even a basic aerobics class in a village hall costs £10 a session. It is just not accessible, and if young girls do not see their mothers or other women doing these things, they just think, "Och, it's not for me. It's something that boys and men do. It's the men who walk up hills and do adventurous things."

There is a whole generation that has not done any of these things; my own child has not been on an outdoor residential course—he has had no outdoor sport. What is the reason for that? It is Covid. For two years—his primary 7 and secondary 1 years—those residential courses were closed. There are guys who will never get a chance to sit in a canoe, go climbing or anything, because—tough luck—they missed it. There is no catch-up plan.

What about swimming lessons? Many more children are drowning in Scotland. We have just heard that Perth swimming pool is not going to close this year, but what about next year? What about other swimming pools? Can we afford to run them? Our own local pool has closed. The opportunities are just not there; children of both genders need them, and they need to be really good and cost effective so that everybody can afford them.

Once we get children—boys and girls—into doing more sport, we need to look at what is stopping teenagers. A lot of it is about girls needing different activities and facilities such as changing rooms; they need to be asked, "What will

make a difference for you?" After all, we know that, if we can get teenagers into sport now, they will still be doing it in their 40s and 50s.

The Convener: What came across very clear in Daisy Drummond's film is that a lot of girls have an issue with doing sports with boys.

Dr Stark: We need to have that separation at school. Some schools do not even have enough physical education teachers—my boy has not had PE for the past two weeks, because there are no teachers. Both sexes are just sitting on their iPads, doing something else, because no PE teachers are available. If they are not getting the 60 minutes of physical activity that they are supposed to get in school, where are they going to get that activity out of school? We need local clubs for them. If there were different out-of-school things just for girls that did not cost any money, which let them be with other girls and allowed them to do some sport, too, it would help.

The Convener: Rona Blackwood, do you want to respond?

Rona Blackwood (Children's Parliament): In a piece of work that we did recently on gender stereotyping in education and learning, we found access to activity and sport to be a huge issue. You will be glad to know that the girls to whom we spoke came up with quite a long list of solutions, many of which will resonate with what we have just seen in the film.

First of all, the girls felt that teachers, school staff, coaches and so on should get generic training on gender equality and stereotyping in order to really understand the negative impact of gendered language—for example, references to "strong" and "active" boys or "neat" girls.

As was said in the film, nationwide campaigning and awareness raising and inspirational role models go a long way towards inspiring girls to be active. Moreover, the curriculum should be reviewed so that more positive female role models can be included both there and in sport in the school setting.

The girls also said that friendships needed to be encouraged. One of the reasons why girls often do not take part in physical activity or sport is that they cannot do it alongside their friends or have no friends to do it with, which puts them off. It is important that we encourage and support friendships in the school environment, because if girls know that they can do physical activity alongside their friends, that will encourage them to do that activity.

Although the girls to whom we spoke said that, sometimes, they wanted to be separate from the boys, there was a real need for them to do sport and activities alongside boys, too, and to have integrated opportunities in that respect.

A really big issue is playground space. Boys often dominate playgrounds and playing fields, and if girls want to join in, they are not encouraged or allowed to. That is often not supported by the playground supervision staff, but it is allowed to happen, and huge swathes of the playground are taken over, often by football. Girls will often want to play but do not feel able to do so. The girls felt that trained supervision in the playground was really important.

Gendered uniform does not encourage physical activity, and the girls wanted that approach to uniforms to be removed. They wanted opportunities to have a go at sport. They wanted girls to be encouraged to try sports, for sports not to be seen as being for boys or for girls, and for girls to be encouraged to do football, basketball and boxing—sports like that. As was said in the film, it is important that there are things that really improve girls' confidence. It was seen as important that we acknowledge and celebrate girls' participation and engagement in physical activity and sport.

Further, it is not just in PE that children do sport. Children often talk about wanting to be more active during the school day. A lot of school days are very sedentary, but you can do Twister maths and lots of physical activity.

The Convener: It is not just about sport, is it? It is about physical activity. Looking back on my life, this is an issue that I have seen for young women, but if young women are not particularly sporty or good at sport, that should not close off physical activity to them. We need to stress that.

Rona Blackwood: It came across loud and clear from the girls and the members of the Children's Parliament that they want to be active in their lives and in the school day. They want to be outdoors, even if it is wet, as it often is in Scotland. How can we get around that and still be active, even in the winter months? We work with children under 14 and their schools often do not have specialist PE teachers, but there is a real desire for more active learning and more time outside.

The Convener: That is a really good point. Thank you for making it. I bring in Eilidh Paterson, who is participating online.

Eilidh Paterson (Scottish Student Sport): Good morning, everyone. It is great to be here, albeit virtually. Apologies for that, but I am co-delivering an event here in Lossiemouth, so I am unable to be with you in person.

I agree with what has been said so far. It is such an important issue and I thank Daisy Drummond for that incredible video. We at Scottish Student

Sport have a very good media team—in case she is interested in joining that in the future.

The first thing that comes to mind on this issue is role models and visibility. Those are areas that we need to improve within the entire nation. What is seen as a physical female or as physically ideal certainly needs to be altered.

Parents, club leaders, staff, coaches, officials and volunteers can all play a role. The sporting sector is ginormous in terms of the volunteers that are needed to run a sport, never mind a variety of sports throughout the nation. The people who are running the clubs are hugely influential and the local impact of those roles should not be underestimated. It is important to ensure that leadership positions, such as coaches and club leaders, are diverse. It is important not only that there are females in those roles but that they lead male teams and not just female teams.

It is a really interesting topic and we at Scottish Student Sport have—[*Inaudible*.]. Such stereotypes are harmful to everybody. Nobody wins as a result of stereotypes in any sporting context, whether the stereotypes are about men and the strength element—where no one wins, because men feel like they are being overpressured—or about girls feeling underestimated, which is of no help to anybody.

Again, it is about visibility and what it means to be an active woman in Scotland. Girls do not have to be going out and winning gold medals every five minutes; it is actually just about sport and activity. Someone asked earlier what happens if girls do not feel that they are good at sport. The issue is what they think sport is, which can be an assumption that is based on what is around them. Actually, there is such a variety of sports out there—you can be standing still, moving very quickly, moving at a slower pace, and so on. Scottish Student Sport has 36 sports available for our students to take part in nationally. We have an array of opportunities for young people to take part in, alongside education, which is usually important.

Ultimately, we are all raised differently, across the nation, and what is on our doorstep varies from locality to locality, so it is about what we can do to support parents to ensure that how they raise their children—girl, boy or otherwise identifying—leads to all being able to have the opportunity to access sport.

11:15

The Convener: Thank you very much.

Stephanie Callaghan: One of the things that stood out for me in the film was the fact that many girls in that long line-up said, in answer to the question about why they do not do sports, “Boys”. We have certainly heard about the comments and attitudes that lead to girls feeling embarrassed and sometimes ridiculed, which can be a huge barrier for them. How can we address that issue and change boys’ attitudes?

Dr Stark: We can talk about it in schools. In the school that my boy goes to, kids get to choose whether they go in the boys’ group, the mixed group, or the girls’ group. Not all the boys are big physical rugby players and they do not all want to do those things either, so there is a middle path. It is about discussing things and kids doing sports together at a much younger age, before the gender issues become involved. If kids have been mountain biking, climbing or doing something for years, it does not matter whether they are male or female—the sport gradually goes with them.

Some team sports are much more for boys or for girls, so it is about giving kids opportunities to do lots of different sports that are not team sports and not necessarily traditional. Whenever the Olympics are on, many schools offer tasters of all the different sports. However, that only comes round once every four years, which leaves quite a long time in between. Why cannot schools offer all those different taster sports more often? That would allow kids to try things that they have never done before and give them opportunities to do something a bit different, which might fit. It is about showing boys and girls the kinds of sport that they can do.

Not all the boys fit into the cool rugby group at school either, so we are gender-pitching boys as well as girls. Some girls want to be in the rugby team—my boy is in a group of girls and boys, in which the only child who plays rugby is a girl. We need to get away from some of the stereotypes on both sides and encourage children to do lots of different activities, so that they find the right one for them.

Rona Blackwood: Let us talk to the boys and find out how they are feeling about this. The little bit of work that we did with boys in the gender stereotyping project showed that they did not understand or relate to the girls’ experience of feeling excluded and dismissed. A sensitive job needs to be done with boys around understanding the impact of gender stereotyping on girls. We need to talk to boys and support them to understand the impact of some of their collective actions.

We really need to encourage friendships between boys and girls in our community and our school spaces, too, so it is not about boys doing this and girls doing that, and so that friendship and mutual respect exist between boys and girls from a young age.

The Convener: Of course, that would have an impact not just on sport but on many things.

Eilidh Paterson: How our young boys perceive the issue is all learned behaviour, because not one boy is born with any of those conceptions. It is all learned behaviour—whether it is learned from their parents, their community or what they see on television or elsewhere—so I would ask who they are learning those conceptions from. Can we challenge and squash those conceptions, too, when we are speaking to young boys and men? In my submission, I noted that men and boys are a huge part of the process. We cannot make proactive strides towards equity if we do not have men and boys working alongside us. That is definitely a big area of work.

We should not blame the boys; we should ask where they are learning their attitudes. For example, there is the media. The world cup and the women's world cup are completely different, and the amount of money that is invested in them is different. There is always an argument about investment and—[*Inaudible*.]—invest before we see any outcomes. I know that the Government has plans in that space to invest further in the future, but I would like that area of work to be pushed forward.

We could even have a video talking about the issues—like the one from Daisy Drummond—being shown on national television.

I think that my video has stopped working, convener.

The Convener: We can still hear you—we turned off your video because the sound was lagging a little bit, and it is best if we can still hear you. You can keep going.

Eilidh Paterson: Okay—that is fine. I will keep going.

On bringing together young people, to go back to what Rona Blackwood said, there is sometimes no need to segregate boys and girls when it comes to activities in which they take part. Why are we segregating boys and girls from a young age? Is there any particular reason why young people need to be segregated? In physical education classes, they take part together. Segregation by gender sometimes encourages negative thoughts, instead of having people play together with the idea that they can play that particular sport very well, whether they are a boy or a girl.

We could look to education to bring in more diverse activities. One that comes to mind straightaway is a sport called ultimate Frisbee, which is about shooting a Frisbee into a net. We could look to that, rather than focus on sports that have a lot of gender stereotypes around them, such as rugby, football and netball.

All of that comes down to societal culture and learned behaviour, in my opinion.

The Convener: I will bring in Emma Harper.

Emma Harper: Good morning to youse.

I think that the question of stigma has already been answered. That issue came up when Stephanie Callaghan and I got some feedback from young women at the Mary Erskine school about their experiences of participating in sport.

Dr Stark, I am interested in what you said earlier about the need to start young. In 2012, we introduced the daily mile in Scotland. Has that initiative been sustained, and is it growing? Are schools still delivering a daily mile? It is so simple—the kids do not even need gym kit or trainers; they basically just get out of the classroom on days when there is nice Scottish weather, and both genders participate in a daily mile.

Dr Stark: I am a great supporter of the daily mile; it is a really good initiative. However, one issue is that it depends on the individual primary school. I said to the headmaster of our local primary school, "Why don't we do the daily mile in this school? It's a great initiative." He said, "I don't think we need it here."

It depends on the headteacher, so we need to get all the teachers involved and get buy-in from people. We cannot necessarily force people to do it. The Government could say that every child needs to do the daily mile, but with different individuals working in different places, we need to have buy-in from local communities.

I think that it is a great initiative, and we should be doing more things like that. For example, we should have forest schools in every nursery and primary school. Forest school education is great. We need more outdoor education to get children outside doing things and learning about their natural environment. Living in Scotland, we are very lucky in that regard. However, it is difficult to do those things unless we get local buy-in.

Emma Harper: I have a question about other research, but I can always ask it later.

The Convener: We will move on just now. I come back to Stephanie Callaghan, because we want to discuss community sport as well. Stephanie, perhaps you can lead off on that, and then I will bring in Gillian Mackay.

Stephanie Callaghan: What are the most important improvements and changes that we could make to community facilities, infrastructure and spaces to meet the needs of women and

improve safety? I put that question to Dr Stark first.

Dr Stark: We need to be very aware that we are going through a cost of living crisis and that sport is really expensive. People have to pay their rent, buy food and pay their fuel bills and council tax, so for many families the money for sport is just not there. We need to do things that do not cost anything. We need to use every bit of green space that is available to have good play parks that are safe places to go. We need to have youth clubs and activities for young people that do not cost anything.

Stephanie Callaghan: On that point about using green spaces, do you have any examples of where girls and women have successfully worked to co-create and design such spaces and that has increased the number of girls and women who use them?

Dr Stark: We have a local gym that has been set up by women in our village. It was relatively cheap, and it runs CrossFit classes, which are mostly attended by women.

Stephanie Callaghan: What about looking at outdoor spaces?

Dr Stark: There are not many examples of where people have done things with outdoor spaces. There are places to do skateboarding and things such as that, but those activities are targeted more at boys. Where there are basketball areas, the boys tend to take over the area and the girls do not get a look in.

We need to be highlighting spaces and things for girls. The kind of gym equipment that can be used in parks, such as stationary bikes, and is available in some parts of Edinburgh would help, because it does not cost any money and people can use it outside.

We need to invest in local areas and make things much cheaper. It costs a fortune to go to a swimming pool now. Many children do not have access to doing anything. Mothers will put their child's needs well before their own, so the likelihood of women doing sport as adults is far less, because they cannot afford £10 to go to the local aerobics class. It is just not affordable.

The Convener: Does anyone else want to come in on that? I will bring in Eilidh Paterson—I do not want to leave her to last every time just because she is online. Eilidh, from a student perspective, does that resonate with you?

Eilidh Paterson: Absolutely. I have a quick statistic for the committee: at the moment, 51 per cent of our student population that is active in sport is female, so we have more female than male students taking part in sports activities at university and college. That is a great statistic and is very unusual for a multisport organisation.

The committee could look to the student sector for some best practice in encouraging young women to stay active during a transitional process in their lives, when they can also create good habits, friendships and strong lasting relationships. I encourage the committee to look into that.

Some of our university members provide free gym membership to all students—no matter what year they are in or what they are studying—as an incentive, which is absolutely brilliant. That is an investment in student wellbeing and reflects how the university leaders see sport and the results of sporting activity for students and their wellbeing. The students are being physically active, but the other benefits of that probably far outweigh the cost of the services that would be leaned on otherwise, such as counselling and mental health services and other peer support, which, as the committee knows, are very expensive.

That is a great area of work that we can highlight. However, I know that my community friends and colleagues would be tapping me on the shoulder to remind me that many local facilities are at risk of closing. I cannot speak for all localities, but I do not know how that is viewed and what priority sporting activity has in that space.

The issue is not only about sporting activity; it is about how we view that activity and about wellbeing, as opposed to the NHS incurring costs. By seeing it that way, we will possibly stop some NHS services being used and that expense being incurred. Investing now in young people and creating good habits and ways of life will benefit us all in the future, with regard to health costs.

11:30

The Convener: Absolutely. Having preventative measures is the very reason for our conducting the inquiry.

Rona Blackwood, would you like to come in on Stephanie Callaghan's question?

Rona Blackwood: It is important that we go back to ask children for their views. The co-production approach is important. We should ask children what they want, how they want it to happen, and what it looks and feels like for them to take a rights-based approach.

The cost of living crisis is having a huge impact on children's anxiety and wellbeing: they are worried about their carers and mums and dads, and they are aware that they cannot take part in clubs and activities or ask for the cost of kit or uniforms. Costs and financial implications form a huge barrier to their participating.

The Convener: If I may interrupt your questioning, Stephanie, I hear loud and clear that Mairi Stark is from a rural area where people have access to green space on their doorstep. However, Rona, in urban areas you must see that that is just not the case for a lot of children.

Rona Blackwood: No, but I have recently been working with children in Shetland and the Western Isles who told me about the lack of good-quality play spaces in rural communities, which are often in disrepair and not fun places to be. Although they might have access to beautiful countryside, they often do not have facilities and clubs.

The Convener: Okay. Stephanie, do you have a follow-up question, or shall I go to your colleagues?

Stephanie Callaghan: No—that is fine.

The Convener: We move to questions from Gillian Mackay.

Gillian Mackay: My question comes off the back of Stephanie's questions on facilities and how we maintain diversity in them, notwithstanding that some are up for closure because of budget cuts. I have heard from hockey clubs and various other clubs in my local area that 5G pitches are easier to rent but are not suitable for some sports. There could therefore be a slow creep into other sports that are more generally dominated by boys and men, thus shutting off some sporting diversity for others. Have you a view on how we might not only maintain that diversity of facilities but expand it to ensure that we have as wide a range of sports as possible available for people to try, as well as facilities that allow for general physical activity? As Emma Harper mentioned earlier, the Scottish weather is not always the most inviting for going out for a walk. We see that in cycles of people perhaps becoming less active over the winter compared with the summer.

Dr Stark: We have to spend to save and invest in the basic sports and facilities. It is true that it costs a bit of money to let people have the opportunity to do things, but it improves their mental health. We have a mental health crisis that is costing millions, and we need to reduce that burden.

Yesterday, I saw a video clip of a 92-year-old woman who does Ironman triathlons, which is quite astounding. Research says that if someone is active and does strength training and so on throughout their life they will be a fit octogenarian, not an unfit one, which will save a fortune. If we can get people's hip bones and legs strengthened by doing exercises, we will see fewer fractured hips and femurs, because those people will have better bones.

It is about spending to save. We need to think about the long term. Unfortunately, many matters that are discussed in Parliament are about what will happen at the next election. However, we need to think about what will happen to our young people over the next 60 to 70 years. It is not a short-term fix; it will take money, but it will be about spending in order to save in the long term.

Rona Blackwood: Sporting facilities are not an area of specialism for the Children's Parliament. Children tell us that they want a choice of physical activities and sports to take part in and that they feel limited when only football, hockey and sports that are traditionally more popular in Scotland are on offer. They say that they would like to try different sports and try ones that are not linked to gender, but that those facilities and opportunities are not there for them.

Girls often say that they will not know whether they want to do something if they cannot have a go. There is a need for far more "have a go" opportunities and for the facilities to be able to offer those.

Eilidh Paterson: That is a very good question. You are absolutely right about the Scottish weather, which causes us to lean on indoor facilities because playing outside in certain temperature is not enjoyable.

We should focus on building better indoor spaces, because many sports rely on having a hall. I know that my colleagues from sport governing bodies, if they were here, would be tapping me on the shoulder and asking to have their playing lines marked on those halls. We need lines in those halls so sports that can be played on them, and we need partnerships to ensure that the sports that already exist in communities are being facilitated. We should also consider why other sports are not being played, because they might appeal to a completely different demographic.

Looking at our roads would allow us to take cycling and active travel into account. Gillian Mackay will be happy to hear that many students love active travel. They have their green hats on and want to look after the planet as well as being active. Our roads are of utmost importance, because we do not want anyone to fall off their bike because of a pothole.

I go back to how sport is viewed societally and culturally. Factors such as active travel are not as much of a priority as they should be, and my students would back me up on that point. Expanding access to indoor facilities is important. We have fantastic community sport hub officers and active schools co-ordinators, who know their communities extremely well. I do not want to make a sweeping statement about the whole nation on their behalf, but I imagine that they know where

gains could be made in their localities to ensure that we are facilitating for those who need facilities and are giving opportunities to those who do not yet feel catered for. That is important, too.

Gillian Mackay: I will follow up on something that Dr Stark said, which others might have an opinion on. She talked about strength training. When I was at school, we did a lot of sport-based PE, but not much gym-based PE. We did not learn how to do a squat, a deadlift or any of those things. That is not for every child, but those exercises underpin much of the training required to get better at the sports that people are doing, and much of that is based in the gym. Are we doing enough of that? Most people now get some of their activity in the gym, but there is a lot of misinformation online. Do we need to do more for younger people, so that they can learn to do that safely? I learned a lot of how to do that properly from my peers at university, when I was in my late teens or early twenties. A big opportunity is being missed earlier in life.

Dr Stark: It is really important for that group to do strength-based training.

I will give an example of gender bias. A local gym has been set up and the police are using that for some of their community activity. They take boys who are being disruptive at school to the gym during the school day to do strength-based activities as a way of trying to improve their behaviour. There was no suggestion that girls might get to learn strength training.

Doing strength training as a teenager and in your 20s and 30s is important, but all women in their 40s, 50s and 60s should still be doing strength training because it will keep our muscles strong and keep us well as we go into old age. We need to be doing that early.

Why are we not doing those initiatives for the girls as well as for the boys? Why is the strength training for the boys and not the girls? It is very niche for the girls but it should be much more for all girls, because they can gain a lot of positive mental health benefits from doing a bit of strength training.

The Convener: We will move on to talking about health and wellbeing, which we have been talking about throughout; again, that is the impetus for this inquiry. In our first year after the election, we conducted an inquiry into children and young people's mental wellbeing and physical health. That is why we thought that we would do something specifically on girls and women.

Evelyn Tweed: Good morning. Have Covid and the years of home schooling and remote learning had an impact on girls and young women in relation to puberty and body image? If so, what might we do to remedy that? I will put that to Dr Stark first.

Dr Stark: Covid and home schooling had a really severe impact on young people, both boys and girls. We are seeing the run-offs of that in our clinics. Some children enjoyed home schooling, but it made them lose out on many activities, and many young people have simply not gone back to them—probably girls, in particular. They might have been doing gymnastics before Covid, for example, but they have not gone back.

We are also seeing increasing numbers of children who have eating disorders. Some children put on weight during lockdown and some lost weight, but we are definitely seeing more eating disorders, as well as more children who are struggling with their mental health.

We also have a big group of children who have never had any opportunities to do outdoor education, because they missed that during Covid. There could well have been sports that they really would have thrived in, but they never got the opportunity to do them and they never will, because they will not be able to afford it. It depends on what their parents do.

Some children thrived during lockdown. Some people had families who went out and did lots of activities with them, but some children simply stayed at home, played on their computers, did not go out and became less sociable. Lockdown was not the same for every child, but most children were affected by lockdown. The mental health effects of lockdown are significant and cannot be underestimated. Giving children more opportunities now than they had before and allowing them to do sports and activities will, I hope, help to restore some of what they have lost.

At the moment, most of the money and impetus are focused on adults rather than on children. People in the long Covid group on children are seeing children who have chronic fatigue and lots of difficulties, but the children's group has had no money. We have not got off the ground yet and we are a year down the line. We need to have more investment in young people.

Eilidh Paterson: You are absolutely right. I absolutely agree with Dr Stark that not everyone's experience during lockdown was the same. The same goes for our students. Because we stayed in touch virtually and were able to keep in touch with all our student leaders and volunteers, we were able to get an in-the-moment response from them.

Some of the experiences were positive in that it gave our student leaders an opportunity to be very innovative and do training and club activities online. Obviously that was not the same but, in a moment of crisis, it still offered the opportunity to bring people together to socialise and to share

experiences, whether that was vocalising how they were feeling or sharing what they had been up to. That also really emphasised why sport and activity are important. The experience of being locked in our houses for a period of time differed for everyone; for example, some people were by themselves and some people had a large family and had no space to themselves. It really emphasised the need for hobbies and sport and why they are really important for communities to have.

Puberty was mentioned, and I know that there is a drop-off in participation around that age for young girls in particular. We have to continue to look ahead to that. There is an organisation called the Well HQ, which Scottish Student Sport will soon be partnering with, which does fantastic work in women's health through educating coaches and leaders on this area of work. I just wanted to make the committee aware of that organisation.

11:45

We need to encourage that age group of girls going through puberty to keep up their activities, even though things are changing. Their sport activity is the one thing that can stay consistent throughout their lives. They can obviously come and go and take part in other things, but we do not want them to feel that that activity needs to take a back seat because they are going through that change.

There are many taboo subjects around what products are being used and what support is being given to young people going through that experience. We need to be much more vocal about it; we need to talk about it. There is a whole student demographic who, I am sure, would want to be role models in this space as they share their experiences for all of our young people across the nation. We are happy to be of assistance there in the future, too.

The Convener: We will look into the Well HQ—thanks for that tip.

Rona Blackwood: I echo much of what has been said already. It is important to stress that coaches in particular would benefit from the training, support and guidance around children's participation and children's rights. With the incorporation of the United Nations Convention on the Rights of the Child, we are seeing that happening more and more in schools, although it is not necessarily reaching down into the community and sporting sectors, and children may tell us that they are getting shouted at or feel intimidated in certain sporting or physical activity sessions. It is really important to provide training and support for how to talk to and engage children in a relationship-based way.

The Convener: I take it that a lot of people are volunteers.

Rona Blackwood: Exactly.

The Convener: So, the structure is not very formal.

Rona Blackwood: Yes—exactly.

Evelyn Tweed: We saw from Daisy Drummond's video that periods can be an issue. Some girls have a good day and some girls have a bad day. How can we educate more about periods? How can education be improved, so that periods become less of a barrier to being physically active?

Rona Blackwood: The girls whom we spoke to said that periods are a huge barrier and that there is a lot of anxiety around periods and reproductive health; there is teasing and bullying around having your period. Boys do not always know or understand what is happening to girls when they are going into puberty and having their period.

Regarding physical activity and sport, girls sometimes tell us that going to the toilet—or not being allowed to go to the toilet at certain times—is stressful for them, or that the toilet or the changing facilities do not feel private or suitable for using sanitary products. You are absolutely right: that is an issue. Girls are saying some very positive things—for example, that seeing sanitary products in toilets is very good. Period pants are really good for being able to do physical activity, and girls have said that they like those types of products, which have really helped. It remains a concern, however: they want it to be talked about more openly and freely in the school space.

The Convener: I do not know if anyone else wants to come in at this point; I have other questions from Paul Sweeney—or not?

Paul Sweeney: My questions here have been covered; I have nothing further.

The Convener: Okay. Eilidh Paterson wishes to come in.

Eilidh Paterson: I do not think that, societally, we have solved how periods are viewed in this nation, and I think that sport is an extra barrier to this point of conversation. We have a lot to do in Scotland to give our girls confidence in their bodies in what is a very natural, very necessary physical period. That is the first point: as a nation, we have not solved that. Secondly, sport is an extra barrier to that.

Having free sanitary products in public spaces is a brilliant step forward. College and university spaces count within that, and our students are always giving positive feedback about how that is a fantastic step forward for them. I therefore

absolutely agree with Rona Blackwood's point on that.

Sport is at the centre of culture, and if we want to achieve a culture shift in this area of work, sport can be an assisting driver in that. We have already seen some fantastic conversations about that.

Changing the colour of shorts is not necessarily a solution—we do not want anyone leaking, whether into white shorts or blue shorts. However, just having that thought process, intention and conversation is a step forward; that is the important bit. I do not think that we are yet at the point of solving the problem, but sport can be a driver in making the conversation more natural for boys and girls. I really think that, no matter who is around the table, everyone should be aware of this bodily process, as it affects everybody. It is hugely important and it should not be seen as something to be hidden—I should not have to put something up my sleeve to hide it because I do not want anyone to know that I am at a particular time of the month.

The student sector could possible be a driver in the role model piece of work.

The Convener: As it happens, we want to talk about role models and social media. We move to Paul O'Kane.

Paul O'Kane: Good morning. The video that we watched at the start of the evidence session really helped to set in context so much of what we are discussing. We heard a lot about role models and their importance in people's lives. Let us explore that in the social media context and more broadly. What do you feel can be done to encourage more role models to share their stories in those spaces to encourage, in turn, girls and women to take part in sport?

Rona Blackwood: The age group of children that we work with is the under-14s, who should not be on the social media channels that we are probably referring to; therefore, we have not done a huge amount of work on social media and physical activity and sport. That said, children often talk about the importance of having positive female role models in sport and in the broader curriculum beyond sport. They also talk about the negative impact on body image from the vision of what young women and girls should look like. As I said, given the age group of children that we predominantly work with, we have not dug deeply into that, although we have done work with children on social media and positive health and wellbeing.

There is an importance in having drivers in social media. It is not about saying, "Don't engage with this; it's bad"; it is about young people engaging with a variety of platforms once they are the appropriate age. We want to see positive story telling, positive apps and positive messaging around physical activity and sport, body image and girls' confidence. Social media must be used as a force for good, as distinct from a force for bad. Perhaps my colleagues have more to add.

Dr Stark: Having local role models is really important. The achievements of elite athletes are great and something to aspire to, but most teenagers think that they cannot do that. However, if they see that their mum, auntie and everybody else around them are cycling or doing other sport and enjoying it—it is not just about physical activity; it is about them enjoying those things and doing them socially with their friends—that is an extremely important role model. It is important to get women doing sports so that they can be role models for their children, and it is important for teachers and everybody else in the community to do it, too.

My final point is that it is not just about periods and menstruation; for older women, one of the big barriers to doing exercise is that they might pee themselves. Urinary incontinence is huge. It is not talked about; it is a bigger taboo than periods. The fact that you cannot run, even for a bus—"Mummy, can you not get that bus?"; "No, because I'll pee myself"—is a daily issue that an awful lot of women have and do not talk about. We need to be talking about it and thinking about things such as Pilates classes being free and achievable and not something that only a small group of women can do, because they are essential.

If you cannot cough or sneeze or run for a bus, you are not going to want to do sport. It is about helping women who are older so that they can then be role models for their children, rather than have a situation where, once you are a certain age, you cannot do sport because you cannot actually move.

The Convener: I think that a lot of women do not know how to fix that, or do not know what to do to deal with that issue. That came out in the submissions.

Dr Stark: That is because the issue is not talked about.

The Convener: I will bring in Eilidh Paterson.

Eilidh Paterson: I back up Dr Stark's point—I absolutely agree that urinary incontinence in sport is not talked about enough. Dancers, trampolinists and anyone who jumps up and down in a sport will experience that, and from a very young age, actually. I would be happy to discuss the issue further at some point if the committee wishes to do so.

To go back to social media and role models, we at Scottish Student Sport are very aware of that

issue—in fact, members could follow us on social media at @ScotStuSport, if they fancy doing that. On our pages, we have some great examples of role models, and authenticity in role models. That is exactly the point—it is about the intention of the social media. If it is authenticity, that is fantastic.

Obviously, our athletes and our influencers who are in the fitness or activity industry are already doing what they can to gain followers. In general, they are very aware of the diverse audiences and people who are vulnerable to being influenced negatively. The culture of social media on activity is definitely improving, although it absolutely is not as good as it should be. Obviously, there is a whole issue about safety and social media that I will not touch on today, but that certainly could be discussed in future. It is essential to promote authentic role models who are looking to make a positive change and have a positive influence on young people.

Paul O'Kane: Thank you for those exchanges, which were helpful.

We have heard in evidence that it is on men to change their behaviour and attitudes, and that men need to influence their peers and how they behave. Do you have any reflections on that? In the social media space, do we need to encourage more male role models at national level to influence behavioural change, or is it more about the grass roots or a mixture of both? I have previously referred to some of the helpful statements that Andy Murray has made—most people would recognise that, although the issue goes much further. I am keen to get your sense of what we as men can do, because that is vital.

Dr Stark: Women have to be confident and do this, but men need to help and facilitate. We have moved on. Women are now much more career oriented and they may well be doing a lot of the work and bringing money into the household, but many women still do most of the household chores and parenting. The man of the house might go off to his football training and the gym, and might go out with his friends at the weekend to play golf or some other sport, while the woman is at home looking after their young child. In that situation, the man has to say, "Actually, it's your turn to do some sport with your friends—I'll make dinner tonight so that you can go to that class, because I know you'd like to do that but you haven't got time."

We need society to become much more equal, but we are just not there. I look at what has happened in society and see that, actually, women seem to be overloaded, because they are now having to do everything. Men have to take on more of the home work, so that women have time to do some of these activities.

The Convener: That came out when we spoke to women in Dunfermline. We went there to play basketball with women who were around my age, and many of them said that they had not done any sport since they left school or university, and they were now coming back to it in their late 40s. The caring responsibility was the main reason for that. I just wanted to mention that.

I will bring in Eilidh Paterson.

Eilidh Paterson: I thank Paul O'Kane for that question. Some brilliant campaigns already exist, such as Police Scotland's "Don't be that guy" campaign. We work with some fantastic masculinity organisations—their names are not coming to the top of my head right now, but I can submit information on that later.

It is not just about sport. Sport involves a small demographic within wider society, and how women's role is seen within society is still led by stereotypes, to go back to what Dr Stark said. The "Don't be that guy" campaign, which is about males challenging their peers, is a great example of the kind of work that I would like to see rolled out further.

12:00

At the end of the day, it is all about kindness and being a good human. Sometimes it can be overcomplicated, but respect and kindness are at the forefront. From speaking to our students, I think that a lot of it comes down to questions around what masculinity is and how it is viewed. You mentioned Andy Murray, who is a great example of a positive role model. However, a lot of young boys and men are looking instead to particular men who have quite toxic views of the world and of women. When social media is brought into the mix, we see the good, the bad and the ugly going viral, and one thing leads to another.

The Government probably has a responsibility to share some positive campaigns like the "Don't be that guy" campaign that are about peer-led support and conversations between men. I come from Thurso in the far north of Scotland, which is a very rural area. Men there do not talk about their feelings or talk to each other about how their day went, or ask how they really are. I am aware that that is a bit of a sweeping generalisation, but it is true in so many cases. The same probably goes for people at a lot of ages and stages of life, not just men in the 18-to-25 age group that I support.

The Convener: I will bring in Sandesh Gulhane, who has a couple of questions on the subject.

Sandesh Gulhane: I do, but before I start, I have another point to make. We were just talking about urinary incontinence. I would say to any

woman who has urinary incontinence, “Please see your GP.” There is a lot that we can do, from bladder training to medications, but it could be a sign of something more serious, so they should not ignore it.

I come back to the issue of social media. My question is for Eilidh Paterson. What effect do you think social media have on young girls? Previously, when women’s football was taking place, people were posting disparaging videos. After the women’s European championship, however, they have all disappeared and women’s football has become quite a big thing. Nevertheless, what effect does such social media activity have?

Eilidh Paterson: My immediate reaction—although I do not have much research to back up what I am saying—is that the social media response has been overwhelmingly positive rather than negative. For example, during the women’s Euros, we saw a positive response to the England Lionesses. I know that the Scotland team was knocked out at an earlier stage, but I think that that story, and that particular group of girls—or players, I should say—captivated the nation as a whole. It was fantastic to see that shift.

In my opinion, the reaction on social media was positive. Again, however, there are some examples of women, especially in the elite athlete sector, being treated differently from men by the media. There are groups of activists online who like to highlight that, for all the right reasons. That can be seen as a negative influence, although what I see on social media will not necessarily be the same as what other people see, because I might be in a different audience.

However, the reaction was overwhelmingly positive during the women’s Euros. We have the women’s football world cup coming up, and the women’s six nations rugby championship is currently taking place. There are a lot of positive examples of elite athletes taking part in a diverse range of sports.

Again, however, I am aware that not every single young girl wants to see elite athletes—they might just want to see somebody going for a jog or cycle and not taking it all too seriously. It is great to have positive elite role models, but it is also good to have role models who are more realistic in their level of activity.

Sandesh Gulhane: I want to look at inequalities too, focusing specifically on women and girls from ethnic minority backgrounds, and south Asian backgrounds in particular. It is quite difficult for people from south Asian backgrounds to progress in sport and to play a lot of sport, but it is particularly difficult for girls.

I come back to Eilidh Paterson. What part might role models have to play in that regard? Do you have any ideas on how to increase participation among girls who come from south Asian backgrounds?

Eilidh Paterson: Again, that is a brilliant question. I know that sportscotland is looking to come back to governing bodies and organisations such as mine on that, as the next step in the consultation process on race and ethnicity and the work on that that has been going on for the past couple of years.

In the student sector there is an incredible number of role models who would be able to do what you are suggesting and recommending. It is so important that we have diverse voices. I always talk about intersectional feminism: it is important that we think about every kind of woman when we are having a conversation on the topic. We have many diverse international students and diverse students from Scotland. We are very lucky that they all feel able to take part in sport while studying at university or college. Again, I recommend that the committee lean on the student sector in relation to its diverse population and the opportunities to demonstrate it. Those people exist; we just need to get to them and encourage them to make heard their voices.

The Convener: Stephanie Callaghan has a question. It needs to be very succinct because Tess White still has a lot of questions to ask on our final theme.

Stephanie Callaghan: My question is for Dr Stark. We spoke about mothers being huge role models but putting themselves last because of unaffordable costs. I am wondering about the early motherhood period. Is that an area that we should focus on and target in order to help mothers to understand that making their activity a priority and keeping it up, because they have a little bit of time and space to do so at that time, would have really positive impacts for their children? Could that make a real difference, going forward?

Dr Stark: Investing in the period when a lot of mothers are off on maternity leave would be beneficial. One of the things that helps their mental health in that period is doing some physical activity. It is a really good time in which to do Pilates classes that they can bring their babies along to, so that they can get better pelvic floor strength and build it after that. Thereafter, women can do activities such as exercise classes that their babies can go to so that they are together while the women do exercise for themselves. Many baby groups’ activities are not that active. Some things, such as walking groups, can be very cheap. Not everybody likes going to baby groups, or people might find them quite overwhelming, but being able to make connections with other women

and to go on walks with the baby in a pram or sling is really good for people's mental health, so we should encourage those sorts of groups.

Stephanie Callaghan: I suppose that what I am really asking is whether there is an opportunity—

Dr Stark: Definitely.

Stephanie Callaghan: —to tell women about how important it is to stay active throughout their life, and about how important the impact of that on their child will be.

Dr Stark: Some of the things that we do in antenatal classes are all about the delivery, and are not about child health or the mother's health, looking forward. It is important to discuss and look at such things because we know that when mums are active and healthy, that makes the children active and healthy. Provision of lots of opportunities in that crucial period would definitely be spending to save, because improving those things will help everybody.

Tess White: I have one question that is for each of the panellists. It is probably a good one to end on. In your opinion—we will start with Rona Blackwood and then go to Mairi Stark and Eilidh Paterson—what one or two things could we do to bring the fun factor into sport and physical activity for women and girls?

Rona Blackwood: That is a lovely question. The first thing is always to go back and ask the girls what makes them happy and gives them enjoyment. We need lots of time for dialogue with the girls. Also, because girls—I am talking about them specifically—spend so much time in school, we need to make learning active and fun. If we look at the health and wellbeing curriculum and physical activity in schools, we see that children are often not learning why they are doing sport—they are just doing it. It is important to bring the fun, creative and outdoor factors into the school environment and to keep talking to girls about what makes it fun for them.

Dr Stark: Different sports are fun to different people, so kids should have a huge opportunity to try different sports—and, indeed, to try them together. We need to show that it is not all about competition—that it is about kids having a really fun day and enjoying what they have been doing, without even realising that what they have been doing has been sport and exercise, because what they have had has been a fun time doing activities. That approach should go through all ages and all the different things that people can do.

Eilidh Paterson: Thank you for the wonderful question. Rona Blackwood is right to say that it is a lovely one on which to end the session.

Fun is a natural result of being active around other people. If you go into any community and watch people do pretty much any sport, you will see fun being had in the majority of cases. I think that that should be the central point of taking part in sport and activity—it should be fun. Nobody should be sending a child to a class, session or sport with the aim of them winning. The idea is that they are there to enjoy themselves, to have fun and to make friends with other people. I therefore encourage that to be the central point of all sport and activity, no matter the age or stage of the people involved, although that should certainly be the case in the very early stages. After all, if people do not find sport fun, they will not come back to it, they will not remain active and they will then see themselves as having been othered or will be inactive, possibly for life, because they will not see themselves as being welcome in that space.

The Convener: That was, indeed, an excellent question to end on, with excellent answers.

I thank all three panellists for the time that they have spent with us today. You have certainly given us a lot of food for thought and a lot of things to take forward with other witnesses who will come before us.

I suspend the meeting briefly to allow the panellists to leave. We have one item left to take in public.

12:12

Meeting suspended.

12:12

On resuming—

Subordinate Legislation

Genetically Modified Food and Feed (Authorisations and Modifications of Authorisations) (Scotland) Regulations 2023 (SSI 2023/59)

The Convener: Agenda item 4 is consideration of a negative instrument. The purpose of the regulations is to implement the decision that was made by the Minister for Public Health, Women's Health and Sport to modify the authorisation holders' details for 51 previously authorised genetically modified organisms; to authorise six GM food and feed products for placement on the market in Scotland; and to renew the authorisation for two GM food and feed products for placement on the market in Scotland. The regulations also amend the Genetically Modified Food and Feed (Authorisations) (Scotland) Regulations 2022, providing minor corrections for authorisations.

The policy note states that the regulations align

"Scotland with England and Wales as well as with similar EU legislation for these products, all of which have now been authorised by the EU Commission."

The Scottish Government has further confirmed that the terms of authorisation for the GMOs in the regulations are the same as the terms of authorisation in the European Union and Northern Ireland. I also point out that, when the Delegated Powers and Law Reform Committee considered the regulations at its meeting on 13 March 2023, it made no recommendations, and no motion to annul has been lodged.

If members have no comments to make, I propose that the committee make no recommendation in relation to the regulations. Does the committee agree?

Members *indicated agreement.*

The Convener: We have full agreement.

At our next meeting on 18 April, we will continue with formal evidence-taking as part of our inquiry into female participation in sport and physical activity, with a session on elite sport.

That concludes the public part of today's meeting.

12:14

Meeting continued in private until 12:30.

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