OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 6 June 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 6 June 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
20th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Calum Campbell (NHS Lothian)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
James Dornan (Glasgow Cathcart) (SNP)
Professor Caroline Hiscox (NHS Grampian)
Carol Potter (NHS Fife)
Andrew Sinclair (Scottish Government)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 6 June 2023

[The Convener opened the meeting at 08:45]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 20th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Stephanie Callaghan and Tess White. James Dornan is joining us as a substitute, and David Torrance is joining us remotely.

The first item on our agenda is to decide whether to take agenda items 4 and 5 in private. Do members agree to do so?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Lothian, NHS Grampian and NHS Fife)

08:45

The Convener: The second item on our agenda is continuation of our scrutiny of front-line national health service boards. For this morning's session, I welcome to the meeting Calum Campbell, who is the chief executive of NHS Lothian; Professor Caroline Hiscox, who is the chief executive of NHS Grampian; and Carol Potter, who is the chief executive of NHS Fife. I thank you for being with us this morning.

We will move straight to questions. Given the increased cost pressures and increasing demand that health boards currently face, what can they do to reduce deficits as planned and achieve a break-even position?

Caroline Hiscox's light came on first.

Professor Caroline Hiscox (NHS Grampian): Did it?

The Convener: It did.

Professor Hiscox: I am happy to take that question. Good morning.

The underlying financial position is one part of a pretty complex picture. I recognise that colleagues on the committee have heard from our colleagues from across Scotland. From NHS Grampian's perspective, we are looking to do a range of things to address the deficit.

In 2022, NHS Grampian's board endorsed our new strategic intent, which incorporated our learning from the pandemic. The plan is called "Plan for the Future". The overarching principles in that and its aim are to move us to a more sustainable health and care system. Obviously, finances are a core component of that.

In the current operating environment, we are very mindful of the interdependencies of our operating performance, our financial fragility, the fragility of our workforce—which is really important—and the quality and safety of our services. In "Plan for the Future", sustainability and recovery of the financial position are key.

In looking at the overarching position in relation to health and care, we have been very cognisant of the challenges that we are faced with in Scotland and, specifically, in Grampian. In considering financial sustainability and recovery of it, we have been mindful of the projections relating to the Scottish burden of disease study; of the population's current health and what we in the health sector can do to improve that; of growing

inequalities, particularly those relating to health; and, of course, of Scotland's demographics and the ageing population demographics of Grampian.

On finances in particular, we have a very challenged financial position that is similar to that of the rest of the public sector in Scotland, specifically in healthcare. We have shared that with the committee: colleagues will have read the Audit Scotland report and have heard evidence from other chief executives, as I said.

In 2022-23, NHS Grampian returned a balanced position, which was not our projected position. In March 2022, we reported to the Scottish Government a projected deficit of £19.9 million, but the revenue position improved significantly in March because of a number of one-off funding streams from the Scottish Government and something that we were able to do with regard to our annual-leave accrual. Even though the board has managed to achieve that outturn this year, the underlying financial challenge for Grampian is significant.

It is really interesting and important that we have always achieved revenue balance in Grampian, but we are now seeing a step change in the financial challenges that we face as a board, particularly in balancing the challenges with the operational service pressures that we face.

We have submitted a three-year financial plan for 2023 to 2026 to the Scottish Government, and we have a five-year medium-term financial framework, which was endorsed by the board in April. The medium-term financial framework is to allow us to prioritise the resources that we have for dealing with immediate pressures and, importantly, for moving towards sustainable health and care services.

The medium-term financial framework acknowledges and reflects the complexity of our financial climate, including patterns of funding from the Scottish Government, funding levels, projected rises in costs, our changing demographics and the burden of disease. Under current planning assumptions, NHS Grampian will not be able to balance our revenue position with funding levels and anticipated expenditure over the next five years. The in-year financial position is expected to improve year on year, but we anticipate that we will still have a deficit by 2028.

However, with our medium-term financial framework, we are moving towards understanding what we can do to improve that position. Part of that will be the 3 per cent savings that we have set out relating to the value and sustainability programme that is being driven nationally as well as locally. To be explicit, our annual deficit position for the coming year is looking at £60.6 million in-year, which will improve, but under the current projections we will remain in deficit in year 5.

In trying to balance that, we will focus on value and sustainability and delivering efficiencies where we can. We will then focus on our transformation programmes through our strategic intent and working with our partners in the local authority and integration joint boards to redesign services. One of the biggest changes in the way in which we are spending our money is in relation to staffing costs. We are now spending a higher proportion of our resources on pay costs—54 per cent—and 46 per cent on non-pay costs.

We do not have a particularly different story to tell from anyone else who has given the committee evidence about the cost of inflation, increased demand on our health and care system and the planning assumptions that we are using, in particular around drugs.

The Convener: We will come on to pay later. Specifically on that last point, what percentage of that 54 per cent is spent on locums?

Professor Hiscox: Last year, our expenditure on medical locums was £17 million. We separate out medical and nursing supplementary staffing and agencies and locums. Medical locums cost £17 million and we spent £12.6 million on nursing agencies and locums.

The Convener: Is that locum, bank or agency, or is that all one figure?

Professor Hiscox: For medical locums—

The Convener: I am asking about nursing.

Professor Hiscox: That amount is for agency nurses.

The Convener: The £12.6 million was spent on agency.

Professor Hiscox: It was spent on agency nurse staffing.

Supplementary staffing is what I consider to be all non-substantive staffing, which includes agency and bank staff.

The Convener: I am sorry, but I want to drill down into that. I am trying to get at whether the £12.6 million is for bank and agency staff or only agency staff?

Professor Hiscox: It is for only agency staff.

The Convener: Sandesh Gulhane has a supplementary question on that.

Sandesh Gulhane (Glasgow) (Con): Thank you, convener. I want to drill into that a bit further. How much did you pay for the locum agency fee? I am not asking about the proportion that then went

to the medical staff or the nursing staff. How much money went to the agency itself?

Professor Hiscox: I do not have those specific figures in front of me. I will be happy to confirm the amount in writing to the committee. The figure varies. If I speak specifically about nurse agency, the figure varies depending on the agency with which we have to contract.

I am very pleased to say that NHS Grampian is now in the position of having no colleagues working on what we call off-contract frameworks. All our agency nurses are now on contract, which means that the percentage that goes directly to the agency is as low as it can be and is nationally agreed. We have got to that position only in the past month—we had a couple of theatre nurses whom we were having to use. I can get the specific figure back to the committee in writing.

Sandesh Gulhane: Can we have the figure for both medical and nursing staff, please?

Professor Hiscox: Yes.

Sandesh Gulhane: Thank you.

The Convener: Do Carol Potter or Calum Campbell want to come in to answer my question?

Calum Campbell (NHS Lothian): In relation to financial sustainability, NHS Lothian fortunately managed to balance the books at the end of the financial year. However, at the start of the previous financial year, we had a financial gap of £28 million. At the start of this financial year, we have gap of £52 million, so it is quite a significant challenge for us.

The largest part of the problem is that we are trying to balance performance with the money. The job of the accountable officer is to do the best that they can with the money that is available to them for the population that they serve; it is about trying to strike that balance. In Lothian, the biggest element of that is the gap between the NHS Scotland resource allocation committee funding and what we actually get. That gap comes out at about £15 million a year, which results in our having what I call a care deficit. Our sites are full and our infrastructure is ageing, so we are struggling to meet the demands of the population. A bit of growth is required over the coming period.

The Convener: Emma Harper wants to come in.

Emma Harper (South Scotland) (SNP): Good morning to you all. I will pick up on NRAC and some of the other information. The NHS Fife briefing says that the projected increase in the number of people over 65 is 30 per cent by 2043. That means an older and frailer population with more issues. For me, as an operating room nurse, that means hip replacements, knee replacements, cataract surgery and then some. When you are doing your financial planning, including in relation to NRAC, how do you deal with that projected need?

Calum Campbell: I will use NHS Lothian as an example, and Carol Potter can speak about Fife in a second.

Over the past 15 years, there has been population growth of 156,000. That is some without any additional general practices. That increase would equate, on average, to 21 additional general practices in Lothian, with an average list size of 7,500.

National Records of Scotland estimates that 84 per cent of the population growth in Scotland by 2033 will be in Lothian. Therefore, when I talk about our sites currently being full and being under pressure, that is why I say that there is a care deficit. The largest population growth will be in Lothian and the sites are already full, which is why we are saying that we need to expand our primary care and secondary care capacity.

In the Royal infirmary of Edinburgh, for instance, the accident and emergency department was designed for a population of about 85,000 a year coming through. We currently see 120,000 to 130,000 a year, which is 330 a day. The infrastructure is under quite significant pressure. That is what the population change means. You are quite right that, as the population gets older, increased burden of disease will come with that.

Carol Potter (NHS Fife): As Calum Campbell has mentioned, the NRAC issue is prevalent in NHS Fife, as it is in Lothian. Since about 2009, we have seen a cumulative shortfall of about £100 million. Just as Calum described it, it is very much linked to the care deficit. We are seeing growing demand not only in our acute settings but in primary care settings.

Fife has in recent years seen a reduction, from 56 to 53, in the number of general practices. We have also seen the list sizes grow, especially in areas of higher deprivation. There is a pressure on and a challenge for primary care and our hospital settings.

On how we will address that going forward with regard to the financials, locally we are taking a two-pronged approach to our financial planning. We are looking at financial improvement and sustainability, and we are looking at productivity. For example, we have an excellent day-surgery facility in Queen Margaret hospital, which has been really key in continuing our performance during the pandemic. We are, in managing minimal investment in the site, looking at how much more activity we can do with the same level of resource. It is not about adding additional cost; rather, it is about seeing how much more

productive we can be in relation to increasing our day-surgery capability.

The NRAC gap brings with it a particular challenge in relation to our cost reduction. Our ability to reduce cost is challenged when we have a lower funding base. We are looking at some opportunities, which my colleagues have described. Caroline Hiscox spoke about supplementary staffing, which is a particular challenge in Fife. Although I do not have the breakdown between nursing and medical staff, in the previous financial year, out of a budget of around £900 million we spent £45 million on supplementary staff. That is a mix of bank and agency staff and nursing staff and medics. Reducing our supplementary staffing costs is a real priority for us, as we seek to balance our position in the coming year.

The Convener: James Dornan joins us remotely.

09:00

James Dornan (Glasgow Cathcart) (SNP): Thank you, convener. I was just making sure that my microphone was off "mute".

First of all, good morning to the panel. Why do some boards struggle more than others to achieve financial sustainability? All boards are facing significant pressures and costs, so why is there variation?

It would be good to start with one of the witnesses who is not from NHS Lothian, which has kindly explained why it thinks it has greater costs.

Carol Potter: I am happy to take that question.

As I said, that is partly linked to the funding envelope, which is the NRAC position, so I will not repeat the point. There are also a number of nuances within that. For example, because we have an ageing population, we are seeing an increase in pressure in relation to medicines. There has been 12 per cent growth in the cost and volume of drugs, which is the second-highest area of spend after our workforce. There are areas where the increase in the ageing the population is more prevalent; people are living longer, which is fantastic, but there is an increased cost in medicine associated with that.

This is not a political statement—I apologise if it sounds like one—but I will make a comment about private finance initiative contracts. For health boards that have PFI contracts, the inflationary uplift that is tied into those contractual agreements often runs much higher than the funding increases that we receive from the Government. For example, in NHS Fife, we see a 10 per cent cost pressure as a result of our PFI contract, over and above the funding that we have available.

There is no single answer; it is a very complex and mixed position. I do not know whether my colleagues—

James Dornan: Can I just come back in to ask a question of Caroline?

I get your answer: you have named some of the issues, but I wonder why there is variation in respect of some of those issues. You talked about elderly people thankfully living longer—he says, as a 70-year-old—but why does that vary so much from one area to the other? That is probably the main question for me.

Professor Hiscox: I am happy to attempt to answer that. When we were answering the previous question, we mentioned the difference and the interdependencies with performance. Put at its simplest, different health boards provide different functions to different populations. There is a key point that we have noticed in Grampian, which puts us in a different place compared to other boards. As peers, we ask ourselves that very question about variation, and challenge ourselves all the time about the differences in our performance and financial position.

As it is for Calum Campbell and Carol Potter, NRAC parity for Grampian is a challenge—to the tune of about £18 million a year. Our positions will be different. Our performance is absolutely related to our financial position. We have touched on supplementary staffing. Depending where we are in Scotland, the requirement to use the right workforce to maintain particular services can put additional pressure on the money that we spend; we have already had a question this morning about agency staff and locums.

In Grampian, in particular, we have used an incredibly lean model over the past decade. We have one of the lowest bed bases per head of population in Scotland, and our performance from primary care and flowing out of hospitals is relatively good in comparison with the national picture.

However, we are challenged by not just the amount of money that we get from the Scottish Government but the pattern in which it comes. If NHS Grampian receives non-recurring funding, we do not have enough resilience in our system to utilise that for core services. Very often, our only option is to utilise the independent sector for things such as planned care.

One of our current pieces of work on which there is regular dialogue at the moment is on what we can do to change the pattern of funding. I am delighted to say that we are receiving, for the first time, a proportion of our planned care funding on a recurring basis. That allows us to recruit to and grow services as core services and to recruit local colleagues to support that, which makes planned

care more efficient financially, more productive and more sustainable.

James Dornan: Thank you. Does someone else want to come in on that?

The Convener: Does Calum Campbell want to come in?

Calum Campbell: No.

James Dornan: I apologise.

The Convener: Emma Harper has a supplementary.

Emma Harper: It is a quick question about financial planning. You talked about medication, which includes things such as insulin pumps and continuous glucose monitoring. I am a type 1 diabetic and have an insulin pump with continuous glucose monitoring; I have read that there is a 43 per cent reduction in the risk of fatal cardiovascular disease and a 29 per cent reduction in all-cause mortality when we use insulin via a pump. Therefore, we know that we can reduce complications by investing in pumps and such technology, but it costs more money. How do you plan that financially, and do we have a national map of CGM use in the various boards in order that we could see how they compare on complications reduction and roll-out of insulin pumps and CGM?

Calum Campbell: I am not aware that we have such a map. Certainly, each board—I can talk about NHS Lothian—would look at the balance between such things. You picked the really good example of diabetes; the same could be said about obesity management and exercise. Striking the balance between what we call primary prevention—early intervention—and acute treatment is always a challenge.

We must always look for where we can invest early to prevent disease, but one of the challenges that we unfortunately have with an ageing population is, as we know, that with age the disease burden grows. Although we can delay many things, we cannot always prevent them. However, early intervention is where we can use the universities and others to try to hit the sweet spot in terms of how much we need to invest early to get a proper return on investment. It should always happen that way around, if we can do it.

Emma Harper: Thank you.

The Convener: We will move on to our next theme—performance—which we have touched on a little already.

Evelyn Tweed (Stirling) (SNP): Good morning, panel. Carol Potter, you talk about the waiting well process and how you send out letters to patients when there are long waits. Can you explain that process for us and tell us what sort of patient feedback you are getting? It seems eminently sensible to do that, but I do not think that all boards are doing it. Is it something that we could perhaps share as good practice?

Carol Potter: I am happy to answer that. Supporting our patients who are waiting longer has been a real focus for us. We are in a fortunate position in Fife, having been able to maintain a relatively high level of performance through the pandemic. Although we have delays and patients are waiting longer, we are currently functioning at almost pre-pandemic levels, so we expect that to have helped the position over recent years.

Our process involves person-centred conversations with patients in all specialties to give them information about the expected length of the wait and the reasons for that, and to signpost them to other opportunities, such as online information or self-help guides. That contact keeps the dialogue open and gives the patient the ability to keep in touch with the relevant consultant.

That is a national initiative and colleagues across Scotland have been working on it, so Fife is not a trailblazer, although I would like to be able to say that we are. Colleagues who are here this morning will be adopting a similar approach.

Professor Hiscox: NHS Grampian has also run a “Waiting well” project in the past year. We have just produced our first review report, which I am happy to share with the committee. The project has landed very well with patients who are waiting for too long for outpatient appointments or planned care. We are evaluating the project, but the initial findings are that it has been successful for clinicians and, importantly, for patients. We have identified funding to continue that work.

As well as the specific waiting well project, we have developed our FITSurgery website, we have a process for waiting list validation—again, that is not unique to Grampian—and we have an escalation system between primary and secondary care colleagues for patients whose condition deteriorates while they are waiting for treatment.

That does not solve the problem. Our patients are definitely waiting too long, which has an impact not only on their physical health but on their psychological health. None of us are content about that, but the focus of our attention is on doing the best that we can to manage patients’ psychological wellbeing and to mitigate their concerns.

Calum Campbell: NHS Lothian is very similar. We doing as much as we can and are piloting patient-focused booking to reduce our did not attend rates by offering appointments at times that are convenient for patients. We are using text message reminders and virtual appointments and are doing as much as we can with patient-initiated

follow-up: rather than automatically bringing patients back and giving them information, we let patients highlight when they want to come back. We are also moving to as much online booking as possible.

We are evaluating all those measures to see how effective they are and I will be happy to share the final reports when they come in.

Evelyn Tweed: NHS Lothian's performance standards seem to be deteriorating in a number of areas. How are you going to get on top of that?

Calum Campbell: There are areas of strength and areas of weakness. If we look at planned care and the treatment time guarantee, data for March 2023 shows that NHS Lothian was back at around 90 per cent of our pre-pandemic capacity, while the figure for the whole of Scotland was about 78 per cent. The figure for outpatient appointments in Scotland is about 86 per cent; Lothian is at around 100 per cent. I may have the Scotland figure wrong. There are some particular hotspots within those figures.

Urology is under a lot of pressure, which is a particular cause for concern. We are seeing a significant rise in the number of men presenting with prostate cancer. We are doing something about that by moving to three-session days at St John's hospital and by trying to recruit an additional surgeon. We have also altered the pathway for men who come in with possible prostate cancer. It is a particular pressure for us. There are significant challenges in relation to theatre staff and there is a major focus on recruiting and retaining those staff because lack of capacity there can really limit our system. Getting that infrastructure in place is important. I touched on the fact that our sites are regularly at 100 per cent. That will be a problem for us.

09:15

We have challenges in our A and E department—I gave you figures for the size of our A and E department versus the population that we serve—but one of our biggest waits is in elective orthopaedics. Therefore, at a time when we are trying to free up beds, we will have to ring fence beds in the Royal infirmary of Edinburgh for elective orthopaedics to try to ensure that we do not cancel those procedures on the day. That means that we will have to do some orthopaedic rehabilitation out at East Lothian community hospital.

We are trying to alter those pathways and take those steps for each of those specialties, but it will be a long journey and, without additional infrastructure, we will struggle.

Paul Sweeney (Glasgow) (Lab): I note some of the points that you made about capacity and constraints. Those are a major concern. For example, you mentioned A and E departments being designed for a lower population. Do you have other metrics for assessing capacity and bottlenecks? I refer to process mapping of your services and areas of constraint around, say, key items of capital equipment such as computed tomography or magnetic resonance imaging scanners. Are those areas that you have identified as needing extra capital investment that would improve patient flow? Have you identified particular examples in your analysis of operations?

Professor Hiscox: I am happy to start on that question. Our picture is similar to NHS Lothian's but, to answer your question specifically, one of the most helpful emergent pieces of work that we have undertaken in Grampian has been what we call a breach analysis of our 62-day cancer pathway, which is access to the range of services that are required for a patient and their family in receiving a cancer diagnosis. As in other parts of our system, we have reviewed and renewed our process as part of that breach analysis. For every step in that pathway, we are asking how long it takes, what bits are working well and what components are challenged. We designed that work with colleagues who do that day in and day out, and it has been shared across Scotland.

You asked about bottlenecks; that work has allowed us to identify bottlenecks for each cancer type and, therefore, to target the resource to the right place. For prostate cancer or colonoscopies, it helps us to understand whether the delay in performance relating to the 62-day target is because patients cannot get access to theatre for a surgical intervention in a timely enough way or because they cannot get access to an MRI scanner or other imaging. We now have that information, which we have not had before, to a level of detail that is incredibly useful to our primary care and secondary care colleagues and allows us to target the finite resource that we have to make the pathways as efficient as possible.

Some of the other work on sustainability and what we do with the bottlenecks is not just about having more of the same kit, but involves some brilliant innovations that are under way. We spoke earlier about sustainability and planned care. Innovation has to be part of how we move forward with that. I will give a couple of examples.

I have been talking about the cancer pathway, so I will speak about our ability to use artificial intelligence in that. Grampian, in collaboration with the centre for sustainable delivery, is piloting a piece of work in breast and chest X-ray imaging. Chest X-rays are a pretty standard diagnostic tool; most people who come into hospital will receive

one. However, it has always been a challenge for us to do that X-ray and report in a timely way. In Grampian, we are now piloting artificial intelligence alongside the expertise of our radiology colleagues, which allows us to develop algorithms that prioritise patients who have red flags on their chest X-rays.

The formal process that we followed historically meant that patients' images were in a queue system from when those patients attended until the images were reported on, and imaging reporting was a bottleneck. In contrast, artificial intelligence has allowed us to prioritise images and, potentially, to improve our pathways and access and alleviate bottlenecks.

Carol Potter: I will build on that with a few examples. I will take the question in two halves: first, I will talk about capital investment and secondly, I will address bottlenecks more generally.

In the past 12 months, we have purchased two additional CT scanners, which has supported the throughput of our radiology patients—a particular challenge in Fife—and the wider pathway. We have a rapid cancer diagnostic service, which is helping how we see and treat our cancer patients, as Caroline Hiscox has touched on. Through some innovation with slightly different ways of working, we have developed the use of a procedure room in Queen Margaret hospital, which has allowed us to release one theatre per day in that site. That is where we do our day surgeries. The change has released a bottleneck in elective care, which has allowed throughput. We and the consultants are challenging at specialty level what more can be done on a day-surgery basis that does not necessarily require the specialised in-patient care in the Victoria hospital in Kirkcaldy. That is an example of where we have looked at redesign innovatively.

I will address other bottlenecks by coming at the matter from a slightly different angle. We often talk about bottlenecks at the front door of the hospital. By that, we are referring to ambulances and emergency departments. However, we have considered a step earlier in the process, which is the front door of the patient. With our colleagues in the health and social care partnership, we have been looking at how we support people who are in care homes in a different way. We have improved access to urgent care for a number of our care home residents, which has involved, through our flow navigation centre, professional-to-professional contact—what we call prof to prof. That has allowed care home staff to have direct access to a clinical professional in order to discuss a resident if they have concerns about their particular health needs.

Advanced nurse practitioners and allied health professionals are part of multidisciplinary teams that are essentially doing virtual ward rounds within care homes across all seven of our localities. We are also working with the Scottish Ambulance Service to deliver direct unscheduled care into care homes.

I mention that because it has directly resulted in a reduction of about 220 emergency admissions or attendances per month to just above 100. That success is attributed to the wider whole-system approach. We took a step back, looked at the problem from a slightly different perspective and involved different teams and professionals from across the NHS and the partnership. That approach has been better for the care home residents as they have been kept in the place where they live, with care wrapped around them, and it has avoided bottlenecks with ambulances or at the front door of the hospital.

Paul Sweeney: You have both highlighted what sound like quite impressive process improvement activities. From a cultural perspective across the health boards, how do you disseminate best practice? How do you benchmark against each other so that you are able to say, "Right. That is an excellent workstream. How do we carry that into the national picture so that we can make an impact?" Do you have a protocol or process for doing that?

Calum Campbell: The national Centre for Sustainable Delivery tries to work in areas where there have been potential improvements. It has several workstreams across a number of different specialties and aims to optimise performance in specific areas. The chief executives of the health boards meet every month and share information. We also use Discovery, which is a national benchmarking tool that enables us to look at our performance and infrastructure against that of other health boards. We can identify variations and try to explore what is behind any that we see. The tool allows us to question why things are different and what is happening that is different to our own boards so that we can try to identify where there are opportunities for improvement.

Paul Sweeney: Do you think that that is effective? Could it be more efficient? Are there ways to improve it further?

Calum Campbell: There are always opportunities to improve. Part of the reason for having the centre is to allow us to explore that. There are no massive steps that need to be taken, but there will always be incremental improvement.

Paul Sweeney: Is there team-to-team collaboration across health boards, but at a lower level than the boards, in which teams can teach

others about operational approaches that they have done well?

Carol Potter: Not only do we work as teams, with all the chief executives coming together regularly to share learning, but we work regionally. Calum Campbell, my colleague Ralph Roberts from NHS Borders and I meet regularly, and our teams come together once a month. We share learning on a variety of areas. I am sure that the boards in the north of Scotland, where Caroline Hiscox is, do something similar.

Professor Hiscox: We have a similar set-up in the north-east and the west. The ownership and motivation of our colleagues in all specialties to improve things and move things forward often results in a lot of informal networking. We also have a range of formal networks across Scotland in which best practice is shared.

To add to Calum Campbell's narrative, I note that in the recent past the CFSD has established specialty clinical groups in which clinicians from different specialties come together to do exactly as you have described—to ensure that we do what we can to share best practice in different contexts. It is important to say that, despite the pressures that we have described, we are hugely proud of our colleagues across health and care, who come to work every day and keep the show on the road. They do an amazing job and are genuinely trying to improve and to find solutions all the time in order to make the system perform more effectively for patients.

James Dornan: This question touches on financial sustainability as well as performance. Do you think that there is a need to fundamentally transform the way in which services are delivered, or is how they are currently delivered is just fine but there is a need for some of the innovation that you have already mentioned?

Calum Campbell: Undoubtedly, that question touches on performance, financial sustainability and the fact that healthcare has an insatiable appetite for resources. However, the reality is that, if we look at the demography of the nation over the next 10 to 20 years, we see that we are just not going to have the workforce to provide the services in the format and style in which we currently provide them. There will have to be a fundamental rethink of how we provide the health services that best meet the population's needs. That is where demography is taking us.

Professor Hiscox: I support Calum Campbell's position. How we transform nationally and locally has to be part of our consideration. The Scottish burden of disease is forecast to increase by 21 per cent in the next 20 years. That specifically relates back to Calum Campbell's point. If the current models of care were to remain extant, we would need approximately 33,000 whole-time equivalents on top of our current workforce. As we know, that would be a challenge. Working more to transform our system to empower communities and provide a better balance of enabling wellness as well as responding to ill health is the sustainable way forward.

Carol Potter: There is also a consideration around having a slightly different dialogue with the public about what a modern NHS looks like. Instead of our traditional approach of looking at the services that we deliver in hospitals, we need to look more widely, to the third sector, our services in health and social care partnerships, and to primary care in particular. For example, the role of community pharmacy is hugely important; pharmacists can offer a lot that might mean that someone could avoid having to see their GP or attend hospital. We also have community optometrists, who are linking more closely with our ophthalmology services.

We need a different dialogue about services. We all talk about going to see our GP, but what we really mean is that we are going to our local primary care provider, who might well be an advanced nurse practitioner or a physiotherapist. We need to shift our language and engage in dialogue with the public. We need to listen to the public, but also communicate the wider role of primary care practitioners.

09:30

Sandesh Gulhane: I want to ask Calum Campbell about NHS Lothian's hospital sterilisation and decontamination unit. Everyone has been talking about increasing the work that you do within a theatre complex, but you cannot do anything if you do not have any kit. Your specific sterilisation unit is severely under the required capacity right now. What steps have you taken, and what steps are you taking, to ensure that you can meet not only the demand right now but your ambitions going forward?

Calum Campbell: One of the conversations that we have had with the Scottish Government is about the fact that NHS Lothian would like to take forward a capital programme for a national treatment centre. We recognise that decontamination capacity, not only in Lothian but in other boards in Scotland, is fragile, so we have proposed that we look to expand the decontamination capacity for the national treatment centre in Lothian, which would be at St John's hospital. That would not only increase decontamination capacity to meet Lothian's needs, but would create some resilience within the Scottish decontamination capacity to make it more sustainable.

Sandesh Gulhane: Forgive me, but do you plan to expand that?

Calum Campbell: Yes.

Sandesh Gulhane: What steps have you taken already? You need to have done something already. In addition, one of the questions at the very beginning was about a lack of money and how you have a deficit. There is a lack of capital to support new things, especially plans to do that. How will you achieve your plans with that deficit?

Calum Campbell: The issue in Lothian is that, although we have enough decontamination capacity, we do not have any resilience around it. Our decontamination unit went down recently. When it went down, there was not enough capacity elsewhere in the country to support us, so we had to get support from down south. We moved instruments around the country.

We have enough capacity currently. We are trying to protect that infrastructure, but there is simply no resilience within it. I do not see a shortcut to our becoming more resilient either in Lothian or nationally without that expansion. That is why one of our primary capital priorities is additional decontamination capacity. I do not see an alternative or shortcut to that.

The Convener: We will move on to the next theme.

Emma Harper: We have talked a little bit about Covid recovery, the challenges of performance in relation to pre-pandemic levels, and where we are currently. A lot of responses have touched on Covid. We absolutely cannot ignore Covid. We have just come through a pandemic, and we are still recovering. A lot of folk think that there will be an overnight fix, but there will not be.

I am interested in hearing your thoughts on the recent NHS overview audit, in which Audit Scotland stated:

"The Scottish Government did not engage fully with NHS boards on the preparation of the Recovery Plan".

What do you think about that statement from Audit Scotland? Have you made changes to the recovery plan that adapt and evolve it, based on knowledge that we have learned from the pandemic?

Calum Campbell: We have a Lothian strategic development framework, which we have openly shared with the Scottish Government. That will have informed some of the planning there. We are very clear on our capacity in relation to out-patients and in-patients for each of the services that we can provide. To a degree, the unknown factor is the demand coming in.

You are quite right to say that it will be a long journey. For example, there is a lot of pressure on social care colleagues, which limits the flow through our system. When the flow is limited, the amount of activity is limited, and that affects the recovery period for the system.

You are quite right to flag the challenge that Covid has presented. Although we were under pressure pre-pandemic, we had a really good waiting list position, but it will take us many years to recover from the pandemic.

Carol Potter: I echo Calum Campbell's comments. Prior to the pandemic, we saw significant challenges.

My background prior to becoming chief executive was as a finance director. We saw the financial challenges before the pandemic, as well as challenges around our emergency unscheduled care and in relation to elective treatment in our hospitals. In some respects, the pandemic has exacerbated the problems that we were already facing.

I will talk specifically about the recovery of waiting times. There is a challenge around the financials and cost involved with that. However, equally, we are considering a range of opportunities to increase the throughput of our elective capacity to aid that recovery. As I mentioned earlier, we are looking at removing any barriers to procedures, including using day surgery. We have also spoken this morning about digital solutions and how we can support our patients using those. We are using a patient app for pre-assessment ahead of surgery, for example.

As Caroline Hiscox touched on, teams and clinicians continue to review how they can work differently. They are very committed to doing all that they can for their patients. As we have described, we have a range of improvement actions that the centre for sustainable delivery has outlined. We are working collaboratively. However, despite all that, there are workforce challenges, which is a limiting factor, and our capacity is struggling to keep up with demand. I know that that is an area of interest to the committee. The issue is prevalent across all areas.

We all have robust and detailed forward plans in relation to our ability to address our waiting times—both the length of the waits and the size of the waiting lists. However, the challenges remain. As we have already outlined, there are several specialties that are particularly stretched for a variety of reasons, including the available workforce in the particular area.

Emma Harper: What key things would you ask for that would really help to shorten the recovery period or to enhance recovery?

Calum Campbell: The biggest step would be in relation to social care flow. Our colleagues in

social care are under significant pressure. That limits the capacity in the NHS. We have to accept that health and social care are fundamentally linked. My biggest ask would be that we ease the burden on social care.

Professor Hiscox: We need the continued support of our colleagues across health and care. As Carol Potter has already mentioned, there is the question of how we engage effectively. We engage locally through routes such as our community planning partnerships and our locality networks. However, how do we truly harness the empowerment of local communities, as we did in the pandemic, in designing our NHS and social care, going forward? The NHS and social care are inextricably linked. It would help us if we were to work with local populations, as locally as possible, to support citizens as well as to be supported nationally. Having conversations with the public that are engaging and in which all levels—local, regional and national—are truly listening would help us to move recovery forward as quickly as we can.

Emma Harper: Okay, thanks.

The Convener: David Torrance joins us remotely.

David Torrance (Kirkcaldy) (SNP): Good morning. My questions are about the recovery plan and the progress that NHS boards have made. How accurate is Audit Scotland's assessment that the October 2022 progress update does not fully reflect the scale of the challenges that boards have faced and the extent to which that has hampered progress towards recovery by many boards? I put that to Carol Potter first.

Carol Potter: Thank you, David. It is good to see you.

Audit Scotland has a unique opportunity when it comes to seeing the overall picture across NHS Scotland and triangulating all the different data and metrics that it looks at. It would be remiss of me to counter what it is saying about the challenges that all boards face. As we mentioned earlier, there is no single solution for recovery. There is a short-term focus on addressing our waiting times and dealing with the pressure around the front doors of our hospitals, but we also need to focus on the longer term.

There are lots of conversations taking place among chief executives about horizon 3. At the same time as we balance the immediate priorities for recovery, we also need to look over the longer term at the health and wellbeing of the population more generally and at all the factors that are associated with people's life circumstances. We know that housing, education and lots of other metrics affect people's longer-term health prospects.

Audit Scotland has made a reasonable assessment. As a former accountant, I am not going to challenge its perception. I recognise the comments that it has made.

Calum Campbell: To expand on what Carol Potter said, in Lothian sites are very full most of the time. On top of that, what will dictate the pace of progress is the workforce that we have, and there is a significant workforce challenge. In March, there were about 4,200 registered nurse vacancies in Scotland. That goes back to the points about agency staffing. The sites are full and we need the workforce. There are about 1,500 non-registered nurse vacancies in Scotland. We are trying to get the workforce there, which takes us back to the point about demography. We need the workforce to deliver the performance, but the workforce costs money. There has to be a balance. Audit Scotland was quite right to highlight what a significant challenge that is going to be.

Professor Hiscox: I agree with Carol Potter and Calum Campbell. The evidence that was presented in the Audit Scotland report, although it is specific to Scotland, reflects a growing body of global evidence on how we manage effectively the interdependencies of risks that are associated with more infectious diseases, the cost of living crisis, a very fragile health and care system and climate fragility. The work that was presented in that report and the work that we are doing as individual boards through our delivery plans to move towards recovery will start to address that.

On what has changed, in Grampian we have absolutely noticed a change in our demand profile, as Calum Campbell has done in Lothian. In the last week of May, bed occupancy in Aberdeen royal infirmary, which is our main tertiary and secondary care site, sat at 106 per cent, whereas an optimal system should sit at 87 per cent bed occupancy. We must take a step back, learn from the pandemic and look at the evidence in the United Kingdom and globally on sustainable health and care systems. Our workforce is a key component of that. Although our workforce numbers have increased in the past year, that has not happened across all domains and it does not apply uniformly.

In Grampian, we have some highly specialised areas that are fragile. We are doing improvement work around that. I specifically cite psychiatry and paediatric anaesthetics as fragile professional specialties at the moment, where we have a small number of specialists coming through. We are working with NHS Education for Scotland and others on the pipeline. That is specific to our medical profession, but the demand-profiling workforce is key to our recovery.

09:45

David Torrance: Are there any particular areas that you can highlight where good progress has been made? What are the reasons for that?

Carol Potter: With apologies for the repetition, I return to the ability that we had in Fife during the pandemic to protect the capacity of the day surgery unit at Queen Margaret hospital. That was key to enabling us to sustain our elective programme and is fundamental to the post-recovery plan. We are expanding that further.

We need to be able to ensure that we maintain the balance of demand so that we balance the need to address the challenges that Caroline Hiscox described in capacity, unscheduled care and emergency demands on our services with the need for a throughput of patients who have been waiting too long for elective procedures. That is about how we use our infrastructure in a planned way. Calum Campbell mentioned some work at the Edinburgh royal infirmary on protecting beds. That will be key.

Professor Hiscox: I am happy to add to that. One of the key things that we have done well, and continue to do well, in Grampian is to work as a much more integrated system. I have reflected several times in this conversation on interdependencies. We now have teams that are absolutely working together.

As you will know, we are challenged on the majority of our performance metrics. The relationships between unscheduled care, planned care and cancer services are very apparent. In relation to the work that we are doing with our primary care colleagues, Grampian has one of the lowest attendances from primary care into the front-door services at hospital per head of population. Despite the challenges, our primary care colleagues continue to play a good role in that. We also have one of the lowest admission rates. Of course, our social care sector is challenged, but our work to manage issues across the system has meant that our delayed discharges have been pretty constant and they benchmark reasonably well against those in other parts of Scotland.

We have focused on improving other aspects of care where challenges remain. On psychological therapies, we made a commitment not to have any citizens in Grampian waiting more than 52 weeks for their appointment, and we have now achieved that. That is still too long a wait in relation to the target that the population deserves and expects, but we are improving it incrementally.

Child and adolescent mental health services in Grampian remain high performing in relation to the first appointment. The national target is 18 weeks, and a young adult in Grampian should get access to their first appointment after between six and eight weeks. That is great, but it also creates a follow-up challenge for us with regard to secondary appointments. It is a good-news story that creates a challenge.

We are seeing incremental improvements, but as we have discussed, the recovery will be slow and will require transformation as well as improvements. I mentioned the innovations relating to artificial intelligence and imaging. Similarly, our ability to do a one-stop radiotherapy piece of work for cancer patients has been significant and positive for patients who are suffering from cancer and require radiotherapy.

Carol Potter: Caroline Hiscox mentioned some work with the partnerships. The question was around where we have seen success, and I want to highlight that one of our successes, which has shone through, has largely been about how we have worked as opposed to what we have been doing. We use the term “team Fife” in a lot of the conversations about how we are approaching the challenges that we face, but there has been a relentless commitment from colleagues across all areas—whether that is in the health and social care partnership, our acute service or our leadership teams—to focus on the expression “complete, not compete”.

Our focus is on the end point or intention that we are working towards. Whether that has been around the challenge of delayed discharges or redesign around the front door of the hospital, all those programmes of work have been successful where the teams have worked together in a really collaborative way. It is about the relationships and not necessarily what they are doing but how they are approaching it and that single focus. In our briefing, we mention our operational pressures escalation levels tool. That language is used across the organisation. We have a shared language, a shared approach and a common purpose.

During the pandemic, we all recognised that when we came together to work collectively in a collegiate and collaborative way—whether with the public, our teams, across the community planning partnership or others—that was where we saw success. We need to build on that and develop it further.

Sandesh Gulhane: Calum Campbell, I want to ask you about audiology. FLAAG—families failed by Lothian audiology action group—has said quite a few things in public that I would like to raise directly with you for a response. It feels as though there is a lack of access to British Sign Language tutors, as well as a lack of access to speech and language therapy and appropriately qualified professional support for deaf children. What support are you putting in place for families who

are affected, and what would you say in response to FLAAG?

Calum Campbell: The first thing that I have to do is apologise for the whole issue having started in the first place. The Scottish Public Services Ombudsman's report and the work that was done through the review was quite a wake-up call in Lothian, and we are grateful for the efforts that went on around that. Jacqui Taylor, the independent chair of the audiology review, made a number of recommendations, and NHS Lothian has followed every one of those recommendations. We have communicated widely across speech and language therapy, health visitors and the five local authorities. We have been very open about the challenges. We have tried to contact every single affected family. I will come back to that in a second.

However, I make the point that we do not use only British Sign Language. We make British Sign Language available, but our speech and language therapists will say that there are other forms of sign language. I am not aware that we have in any way limited speech and language therapy.

Less than a month ago, we met a group of MSPs, and the same comment was made to us then. We have put additional resources into speech and language therapy. I accept that there is a balance and that some families might want more, but where we believe that there is a need for speech and language therapy, we have not limited it, and we have significantly invested in it. There are challenges for us, and it has been a long journey. We have retrained all our staff. We believe that we have got to everybody, but we can never be positive about that. One MSP flagged up that we had missed out one person. We have reached out to them to say, "We think we've missed you. Please come forward and we'll check."

We think that we have done everything that we reasonably can. We have tried to make available British Sign Language, although we make the point that other forms of sign language are available. We have communicated extensively and made available a telephone line throughout the period—I think that 24 calls have been made to it. If anybody, including any MP, MSP or councillor, flags up anyone to us, we will follow that up to make sure that we catch everyone.

Sandesh Gulhane: The development of speech occurs between birth and the age of three, which is when speech becomes fluent. The average age at which issues are identified is about four and a half. My understanding is that 2018 is the cut-off. What is happening to potentially affected families?

Calum Campbell: The British Society of Audiology's original review covered 2009 to 2018, and there have been two subsequent reviews. All children, from 2018 up until now, about whom we have auditory brainstem response concerns have been back to us and checked. The 2018 cut-off was the first cohort, which followed the first review. As I said, two subsequent reviews have been carried out. We have tried to be as extensive as we could in addressing the issue.

Sandesh Gulhane: To be clear, are you saying that you feel as though you have identified everyone who has been affected?

Calum Campbell: I caveat that by saying that a month ago I met some MSPs who flagged up one family whom they thought we had missed. We asked them to let us know who that family is so that we could follow that up.

We believe that we have identified everyone, with that caveat.

Sandesh Gulhane: You have increased your resources in speech and language and audiology services, and you do not feel that there is a lack of access to BSL tutors for those who want that.

Calum Campbell: I believe that within the NHS, if someone requires BSL support, we are able to get that. I cannot talk about the situation more broadly than the NHS.

Paul Sweeney: NHS Lothian's written evidence notes that you do not have a low-secure forensic unit and that there are no female high-secure beds in Scotland more widely, which means that people are being managed in units that are not suitable for them. How is your health board managing the lack of forensic mental health capacity? What could the Government do to improve the situation?

Calum Campbell: As we all know, mental health is sometimes a bit of a Cinderella service. We are having to use our medium-secure unit for some patients who could cope well in low-secure care and we have a high-secure female patient in that unit as well. Effectively, that is squeezing us—we are losing 25 per cent of our medium-secure capacity because of low-secure individuals being in the medium-secure unit and the fact that we are accommodating a high-secure female patient in it.

We have put together business cases to try to expand our capacity. We need to get right the balance between psychiatric wards, intensive psychiatric care units, low-secure and medium-secure capacity and high-secure capacity for females across Scotland.

Paul Sweeney: I will touch on one other area: the rejection of CAMHS referrals. I note a significant increase in the pattern across Scotland in the past five or six years. In 2017-18, 11 people were re-referred in Fife; last year, it was 46. Over the same periods, in Grampian, the figure was 161 and it is now 260, and, in Lothian, the figure was

287 and is now 416. Why might GPs need to try more than once before they are successful in getting CAMHS referrals? Is that due to capacity? Are the thresholds higher than those that have been assessed by GPs as appropriate? I would be interested to get your insights on what might be going on in relation to that trend.

Calum Campbell: I was relatively quiet earlier when we were talking about improvements. One of the challenges that NHS Lothian had before the pandemic was to do with the waiting lists for CAMHS and psychological therapies. The board was escalated for that. Over the past two and a half years, those waiting lists have continually reduced.

In Lothian, we have developed pathways working with partners around what we call tier 2 CAMHS, because too many young children were being referred to tier 3 CAMHS when other support services at level 2—support in the community, rather than medicalisation—would be more appropriate. We have worked hard to develop those services, and we believe that quite a high percentage of those patients could be seen there. They will be considered and will then be directed to the appropriate place for them, depending on their clinical presentation and need.

10:00

Professor Hiscox: I am happy to add to that. Similarly, we have an increasing referral rate, not just in child mental health but in adult mental health.

Specifically for CAMHS, we use the choice and partnership approach—CAPA—and triage and redirection of patients will be about identifying the most appropriate place for them. No child or young adult will be referred into our system without being signposted to the appropriate service for their level, as assessed by clinicians in Grampian. We are using and embedding the national framework for decision making in CAMHS. As well as planned appointments, we provide an emergency service: all emergency referrals in Grampian are seen within seven days.

Carol Potter: I will build on that. Certainly, over the past few years, the complexity and the mix of referrals has increased. Prior to 2021, about 50 per cent of young people were classified as high priority. That has shifted to about 80 per cent. However, there is earlier redirection into other areas of support through schools and online tools. Mental health nurses are now being rolled out into GP practices. That is certainly helping. Innovation has been an area of focus across Scotland: there are different ways of looking at pathways and adapting the CAMHS service to more appropriately support the spectrum of needs of our young people, all the way through from initial treatment.

At the moment, we have a test of change with our education colleagues who are supporting those with complex mental health needs as they turn 18 and start to move into adult services. We are looking at how we can support them with self-help tools and in other aspects, as well as face to face. It is a slightly different approach but, as colleagues have also mentioned, our performance has improved and the long waits have been significantly reduced.

However it is a complex and growing area. The past few years have been extremely difficult for our young people across Scotland.

Paul Sweeney: Are you confident that the level of re-referrals—I accept that it might be a narrow metric—will start to fall, given the measures that you have put in place, which mean that GPs are now aware of a more appropriate referral pathway? Is that what you are saying?

Carol Potter: We hope so. That goes back to that communication between the multidisciplinary teams that are working with our general practitioners and colleagues, on the appropriateness of referrals.

Paul Sweeney: Thanks. That is great.

The Convener: I refer members to my entry in the register of members' interests. Is there perhaps a case for some change of language or measurement from "rejected" referrals, which sounds very hard—about people not being seen—to "redirected" referrals, where a referral to an inappropriate service, because of the level of need or complexity, for example, could be redirected to a service that is more clinically appropriate for that person? That referral could apply at either end of the care spectrum, whether that be limited intervention or very high-intensity intervention.

Calum Campbell: That is very fair. The answer is yes.

The Convener: Thank you.

Gillian Mackay (Central Scotland) (Green): Good morning. In last week's evidence session, we heard from the State Hospitals Board for Scotland about its use of induction and peer support in recruitment. Its representatives said that there has been a focus on development of a peer support network throughout the organisation, that a number of its staff are now trained as peer-support workers, and that that has proved to be successful. I am interested to know whether similar schemes are being developed in your boards. If so, how successful have they been and, if not, are you planning to bring in something similar? Carol Potter is nodding, so I go to her first.

Carol Potter: We rolled out peer support in the organisation back in 2021. The initiative came from a number of our clinicians who had been involved in peer support in previous roles and who also had a general interest in it, so it is a great example of us listening, hearing and doing. I apologise that I do not have the details to hand. A large number of staff across the organisation—many with clinical backgrounds—are trained in peer support, and that is widely known and advertised across the organisation.

We have a huge range of staff wellbeing initiatives, and we are really proud of that. We know that we do not always get it right, but we want to listen to staff. We have everything from physical staff hubs on every site, in our hospitals—we have been very fortunate to be supported through our health charity to do that—to healthy wellbeing groups, financial wellbeing guides, menopause support and sport and leisure passes. There is a range of initiatives.

Also, importantly, we have a staff listening and counselling service for which there has been high demand. Our spiritual care team has reached into the organisation to provide one-to-one support, reflected practice and staff listening. It really goes to the heart of how people feel about life in general and about the workplace—peer support is one aspect of that.

Calum Campbell: It is similar for us. Caroline Hiscox said that staff have been great throughout, but they have had a hard time.

We have tried a number of initiatives, not only to try and recruit staff but to retain them, and there are a number of wellbeing initiatives across the organisation.

We also have "Speak up" ambassadors, because—as Carol Potter said—we do not always get it right, and when we get it wrong we have to try and create a culture where people can speak up about that. We want them to speak up early so that we can intervene early.

We recognise that a significant number of our staff are over the age of 50, so—going back to what your colleague said earlier—the wellbeing initiatives are there to try to intervene, support them early and help all the way through. There is a lot of emphasis on our workforce and our culture to try and get them right, retain our staff and keep them healthy.

Professor Hiscox: I mentioned our new strategy; one of the key things in that is our strategic intent to prioritise workforce wellbeing in a way that we have never been able to do before. We are on a journey with that and, as Carol Potter said, we do not get it right every time.

We have an overarching "We care" programme, which includes a number of initiatives that include peer support and investment in wellbeing and the capacity to support the wellbeing and culture of colleagues who are working in Grampian. That is not only for those working in NHS Grampian, but is for colleagues in the health and social care partnership who are employees of the council. We try to spread the initiatives as broadly as possible. Our peer-support model for psychological first aid has been rolled out in 11 service areas. We have "Speak up" ambassadors and an app called Trickle that allows colleagues to raise questions and have them answered.

Despite all that, the impact on our workforce during the past three years has been significant. I recently worked in staff governance where we reviewed our sickness absence data, and NHS Grampian's sickness absence data is reasonably benchmarked with that of the rest of Scotland. However, short-term absences have gone up, and the most common reasons for long-term absence in our workforce are anxiety, depression and stress. The evidence is that our workforce continues to be challenged by those.

Making the working environment the best that it can be is important for retention, particularly for people who are working for longer in life, given the demographics of our workforce. There is some specific work going on in relation to that. For example, 82 per cent of NHS Grampian's workforce is female, and a proportion of those women—I cannot remember the percentage—are at an age at which they experience menopause symptoms. We had an amazing response to our menopause awareness week, with an uptake of more than 2,500 employees who were interested in understanding what we can offer.

It is about responding to our workforce and continuing to listen. That is for those who are in the workforce now, but it also ensures that people who are considering working in the health and care sector see it as somewhere that they will be looked after, too.

Gillian Mackay: Caroline Hiscox has pre-empted my next question, which is about an assessment of sickness rates across the workforce. I wonder whether the other two boards can comment on their sickness rates.

Also, what action is being taken to support people to return to work? There is a lot of focus on reducing vacancy rates and I am concerned about the pressure that that puts on staff who feel that they have to come back. There is always a willingness among staff across the NHS to come back so that they do not feel that they are passing pressure on to other colleagues, knowing what they have been through in the past few years. You have all mentioned counselling and mental health

support. Often in organisations the counselling that is offered is quite short term. Is it limited in your boards, or do you have a longer-term approach?

Calum Campbell: In Lothian at the end of March our sickness absence figure was 5.86 per cent. That is made up of 3.2 per cent short-term absence and 2.65 per cent long-term absence. Breaking down the short-term figure, about 86 per cent was to do with physical health and 14 per cent was to do with mental health. For the longer-term absences, 65 per cent was for physical causes and 35 per cent was for mental health reasons. Therefore, your question is well asked.

For years we have invested in a pilot that provides psychological therapies, working with the occupational health service. We believe that it has been very successful, and I say that because of how heavily it is used. We are doing a full evaluation of it. We have agreed to fund it for another year, again through the NHS Lothian Charity, but if the evaluation comes out positive, we will look to bring it in as part of our core occupational health service.

Carol Potter: Just to develop that—I will not repeat what colleagues have said—we have an absence rate of around 6.7 per cent. I do not have the breakdown in front of me of short-term versus long-term absences, but it will be very similar to that of colleagues elsewhere. Again, the most common causes are anxiety and stress related.

I think it is important to acknowledge that the stress is not necessarily work related. It is difficult for us to get that level of granularity, but we need to look at staff members holistically. Working with our trade unions, we want to have a tailored focus on whether we are providing the right support at the right time for particular individuals. It is not one size fits all. Some members of staff will welcome, seek and ask for counselling and spiritual care support and other services with some of the softer skills, whereas for others that might not be appropriate, so we are looking to tailor that appropriately. It is also very linked to the fact that our workforce is ageing.

The other area that we are looking at, which has been topical this week, is the range of support that is available to staff who have long Covid. That is a complex issue across the wider population.

With regard to the actions that we are taking, I echo what the other witnesses have said, but there is always more that we can do.

Gillian Mackay: That is great.

Carol Mochan (South Scotland) (Lab): Something has been raised with me on a couple of occasions by long-term staff who have worked in core services. They have mentioned that some of the challenges that they face in their teams are related to the way in which modern funding streams work. Specific pieces of work are funded, which drains out some of the really experienced nursing staff into specialties that are then fixed. The core teams sometimes struggle with getting experienced staff, which has a knock-on effect on their ability to support new staff who are coming through. Do you recognise that in your services? Are there particular areas where that seems to be happening?

10:15

Calum Campbell: I cannot think of a particular example, but workforce is a problem and we have quoted sickness absence figures.

There is something that we could look at. My background is in nursing, and I trained through an apprenticeship model and worked on the wards as a nurse. We need to go back to asking whether someone really needs to go to university full time to become a nurse. I am not against degrees or honours degrees, but it is possible to train nurses effectively on wards.

NHS Lothian has been very successful with agenda for change bands 2, 3 and 4 by using what we would call modern apprenticeships. We used that approach in mental health and had more than 100 applicants for 20 jobs in the past two years. We will pilot an apprenticeship model this year for registered nurses, who will be much more present on the wards.

Those nurses are not eligible for modern apprenticeship money. If we had an ask, it would be for the rethinking of some of those elements. A lot of people find it difficult to give up a job and go to university for three or more years, but using the apprenticeship model would mean that they could be in employment, which would help our workforce. They would also come in with more hands-on experience than they would get from an academic programme. There is certainly a place for academia and I am not diminishing that, but it would be better to have a balance.

Professor Hiscox: I recognise what Carol Mochan says. Priorities often come with short-term funding. For the individuals who take up those posts, they provide a great opportunity to do something different and to gain more experience. Those short-term priorities are important and it is great that we can fill those posts, but, as Calum Campbell has said, if we do not have a different pipeline and cannot redesign our workforce, all we are doing is moving people around and leaving gaps in the system.

It will come as no surprise that some specialties are perceived as being harder work than others and that some are more attractive. Because of the

vacancies in our workforce, people can choose where they go. We need to do something to redesign the workforce. Calum gave an example about nursing. I have been asked about apprenticeships for allied healthcare professionals in Grampian. We should look at how to create pathways that give people portfolio careers and mean that we have the right number of colleagues coming through to reduce the number of vacancies. I recognise what you are saying, and we are trying to deal with that in a number of ways.

Carol Potter: I absolutely recognise the points that my colleagues have made about alternative roles and pathways. There is an expression, "earn as you learn", that picks up on Calum Campbell's points and is about supporting staff to come into the organisation or supporting existing staff to undertake studies while they are working.

It is also important to focus on apprenticeships and youth employment initiatives. We saw some of that coming through during the pandemic. We have a member of staff whom we used as an example in our strategy, which has a strong theme of staff wellbeing and recruitment. A member of staff who was furloughed from a media job during the pandemic joined us as a support officer in the vaccination clinic, was encouraged by staff there to join the nurse bank and is now a student of mental health nursing. That is a fantastic example of the wider role of the NHS as an anchor institution, and it shows how we can look at differently at career pathways.

Emma Harper: I have a quick supplementary question. When I did my nursing training, there were two intakes every year, which meant that entry-level and more experienced nurses worked together during their training. Should we be thinking about doing that again? Having students at different levels in classrooms or on site would make it possible to offer peer support and mentoring. Should we be considering that?

Calum Campbell: I would certainly be very supportive of that. It would stop the feast and famine situation—it is very good when the new students come out, but that happens only once a year. It would be good if we could even that out in any way, and having two intakes a year would be a good way of doing that.

Professor Hiscox: I remain a registered nurse and, in my previous role, I was the nurse director in Grampian. We had a very live debate between our academic partners and the service in relation to the pros and cons of that model. I do not think that we will ever land on one view on the issue, but I recognise Calum Campbell's point. As well as considering the intake, or output, and whether it is once or twice a year, we need to consider the attrition and uptake rates in the nursing profession. We need to consider the number of places in each academic institution and the growing gap in the uptake of those places. That is one part of the picture.

Emma Harper: Convener, can I ask another wee supplementary question?

The Convener: Yes, if it is very short, because we still have another theme to cover.

Emma Harper: Okay. Professor Hiscox, you mentioned paediatric anaesthetist consultants, who might have to work in different NHS boards to achieve certain competencies or skills. Is it easy for anaesthetists to work across boards, when it comes to competency and inclusion? Do they have to do the training on infection prevention and control, fire safety and moving and handling, no matter where they are?

Professor Hiscox: My experience is that doctors in training who wish to specialise in paediatric anaesthesia may come to the north and get all their places in NHS Grampian or they may go across other boards. I would need to double check this, but their training is partly with NHS Education for Scotland—that is their statutory and mandatory training, on health and safety and infection prevention and control. They will do components of that through NES and Turas, which should be consistent, and they will have to do specific training in each board.

For substantive consultants and trained doctors, the reality of working across boards is more complex. You have highlighted one aspect of that, which is to do with the governance around our induction and the different policies that health boards have to keep clinicians and patients safe. We could make improvements on that.

Emma Harper: Thank you.

The Convener: Carol Mochan has questions on our final theme.

Carol Mochan: I am interested in dignity at work. We no longer carry out the staff survey, so I ask each of the health board representatives to feed back on how they ensure that staff have the ability to feed into the system and on the overall trends in their board. Through your staff governance, how do you monitor that and ensure that changes happen if they need to?

Professor Hiscox: We have a range of opportunities for colleagues to raise concerns. Of course, we hope that that does not happen, but the reality of large organisations is that there will always be different perspectives. Therefore, it is critical that we create the opportunity for people to feel safe in escalating concerns to their line manager and having that level of mediation or discussion, or in going into more formal human resource investigations and so on.

I mentioned that we have confidential contacts in the organisation, and everyone has the opportunity to use the whistleblowing procedures, if that is the route that they choose. We have our human resources processes, and we have strong and positive working relationships with our staff-side colleagues. I mentioned other things that we do on raising concerns as early as possible through the Trickle app and a range of question-and-answer sessions.

We are working on our culture, on creating the psychological safety for people to challenge poor behaviour when we see it in action and on supporting colleagues with education and training to give them confidence to challenge such behaviour. Our evidence of that goes to our staff governance committee, which monitors the situation; we also have advisory clinical networks that feed in, as well as our Grampian area partnership forum.

As for overall reports, we have just considered our whistleblowing report in committee, and we had a report that broke down our bullying and harassment cases—I am trying to find the figures for that. I think that we have identified three cases this year that staff escalated to be taken through formal processes and which are under investigation. Those are our governance processes.

Carol Mochan: Are you confident that people are well supported on whistleblowing? Do you feel that they would do it if it was necessary?

Professor Hiscox: As I said, our whistleblowing report has just been considered at committee. We interview every person who raises a whistleblowing case. The feedback was that colleagues who raised concerns felt listened to and well supported during the process, which is because we have in place a process to appraise each case individually.

Carol Potter: Our governance position is similar to what Caroline Hiscox has described—it involves the staff governance committee and reporting through that route. At our board meetings, we will be bringing in bimonthly staff stories as part of the introduction, to provide an increased focus. Culture, how staff feel and whether they feel listened to are given the highest level of attention by the executive team in NHS Fife and at board level.

We have similar initiatives for whistleblowing processes. We have the “Know who to talk to” campaign and we are rolling out a toolkit on talking. We have had a very small number of whistleblowing cases, which makes me slightly curious and makes me want to dig a bit deeper to ensure that the culture throughout the organisation at all levels and in all teams is what we hope it would be, and to consider whether we can do more.

We approach all of this in a range of ways. I have emphasised the importance of visible leadership—as, I know, my colleagues here today will have done. I do regular walkabouts with the employee director. In our health and social care partnership, the director does the same alongside staff-side representatives and, likewise, that happens in our acute setting. We have visible leadership and we share information with staff, including through written updates. I have mentioned the focus and concerted effort across the organisation on team Fife and the sense of belonging. We hope that that will develop and nurture the culture that we hope for in the organisation.

Such work is a priority for us, but we can always learn more. When we leave the meeting, I will speak to Caroline Hiscox about the Trickle app, which I would like to hear more about.

Calum Campbell: Our position is similar. We have a small number of whistleblowing cases, which we always deal with as best we can. We have “Speak up” ambassadors who take people through the process.

The same as my colleagues outlined, our governance structures involve the staff governance committee. The employee director and I co-chair the NHS Lothian partnership forum, and all the other partnership forums link into that.

We are finding that a lot of our staff are coming back—in nursing, 25 per cent retire and return—which is a good indicator. We have supportive staff networks, and some, such as our black and minority ethnic staff network, are driven by our staff. I am a big advocate of networks, which provide peer support and are there to support staff throughout.

The issue is one of those things that you will never be finished with—it is \like the Forth bridge; you have to keep going round it. I do not think that we always get it right, but we try to get it right.

The Convener: I thank the witnesses for their attendance and their time. We will have a short break to change to the next panel of witnesses.

10:29

Meeting suspended.

10:37

On resuming—

Female Participation in Sport and Physical Activity

The Convener: The next item on our agenda is the final oral evidence session of our inquiry. I welcome Maree Todd, Minister for Social Care, Mental Wellbeing and Sport and Andrew Sinclair, head of the active Scotland division in the Scottish Government.

We will move straight to questions. Minister, what progress has been made towards introducing a national approach to increasing female participation in sports leadership and governance, as recommended by the "Levelling the Playing Field" report?

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): There has been a great deal of progress over the years. I am very pleased that recent data from the Scottish health survey shows a significant four percentage points increase in women meeting the UK chief medical officer's recommended levels of activity: the level has gone up from 61 to 65 per cent and the gap between levels of participation by men and women is closing. However, although we are delighted that things are headed in the right direction, I do not think that any of us would want to be complacent. We have to continue to work to improve that situation.

There have been some brilliant leadership successes, particularly with younger women taking up opportunities for leadership in sport. Again, I am delighted to see that progress but we cannot be complacent. Although we are seeing more female athletes participating in sport, when it comes to sports governing bodies and the organisation of sport in general, we are not seeing that participation reflected in the boardroom, nor are we seeing the level of participation that we would like to see in the governance of sport, in terms of officials and things like that. So we have more work to do, but we have some good things to report.

The Convener: Some of the issues that you reflected on there, minister, are issues and concerns that were raised by various stakeholders about women's traditional role in care giving and how it can become a barrier to their becoming coaches or participating in governance in sport.

Another area that the committee has touched on is how women's sport is portrayed in the media and the lack of reporting in print and on television, with some exceptions. I fully accept that there has been some improvement in broadcasting, particularly of women's football. In the 2021-22 programme for government, a Scottish sports media summit was promised. Will you update us on what is happening with that and how the Government is trying to promote women's sport to a wider audience, which, realistically, is done through the media or social media?

Maree Todd: You will be aware that, between the pandemic and the challenges that we faced in balancing the budget last year, some tough decisions were made and we did not progress with some work that we had intended to do. It is still our aim to hold a media summit and to challenge some of the reporting around female participation in sport. There are challenges. Football is our national game and everybody loves it, but it probably gets more coverage than almost all the other sports put together. I think that you heard about some of that in your evidence.

The fact that women are playing football, and playing it successfully, means that they are now gaining some coverage, but that does not help to celebrate the successes of other sports. An athlete who is involved in judo gave evidence to you, but the football coverage does not help to give her sport the profile that it deserves. Let me tell you that we are very successful at judo in Scotland and we have some fantastic female athletes participating in that sport.

There are real challenges, although I think that there is a cultural change afoot. There has been some change, particularly with broadcast media—I must credit BBC Alba for its work bringing women's sport to television. That is phenomenally important. Every year, we have a women and girls in sport week, and every time we are told just how important it is for people to see the roles that they want to be in:

> "If you can't see it, you can't be it".

That is vital. I am absolutely passionate about sport. I have not found a sport yet that I do not like. I would like to see coverage of a more diverse range of sports and, absolutely, a celebration of those female athletes who are challenging some of the stereotypes in society.

I am a passionate rugby fan. When I see some of the social media films that are brought out about the Scottish women's rugby team, where they are lifting weights and are shown as really strong physical role models, that busts the myth about women in general. It is really important that more people see those things.

The Convener: Thank you. Finally on this theme, have any decisions have been made regarding the future of the women and girls in sport advisory board? If that board were dissolved, what would take its place and how would the Scottish Government continue to progress towards gender equality in sport?

Maree Todd: The board has made some great contributions and there are some absolutely phenomenal leaders and glass-ceiling busters in that group. I think that Dee Bradbury is in that group, so there is a female president of a tier-1 nation in rugby, which has not been replicated in the rest of the world. Scotland has some very powerful people in leadership roles in that collective. Andrew Sinclair might want to say more about the future of that group.

Andrew Sinclair (Scottish Government): The group went into a slight hibernation during Covid, as much of our work did; however, it made some clear recommendations before Covid hit. We are taking those recommendations forward at the moment.

On the media summit that the minister mentioned, there has been some great progress around broadcasting of women's sport. We have seen a number of highlights, including the Scotland national women's team's move to Hampden, record crowds at Scottish Women's Premier League games and at the women's six nations and live coverage of the Scottish netball team.

10:45

However, the print media is still an issue, because the column inches that women's sports get is not good enough. Often, the women's news stories do not focus on their sporting performance but on something in their private life—what they have been up to, who they are married to and that kind of thing. Shifting that dial is what we are looking to achieve through the media summit, which we hope to hold by the end of this year.

Evelyn Tweed: We know that socioeconomic status is the biggest factor in whether people are involved in physical activity, but how can we ensure that funding is used where it is most needed and that inequalities are not further entrenched?

Maree Todd: That is a real focus for the Government, and we have committed to double the funding for sport and physical activity in this parliamentary term. We are determined to focus that extra funding on tackling inequalities. You are absolutely right that there is pre-existing inequality in participation across the board.

Football, to give it credit as our national game, is the one sport where there is equal participation across all the socioeconomic groups. Every other sport favours the wealthy, so there is a socioeconomic divide for literally every other sport. How do we tackle and improve that? We are speaking to all the sports governing bodies about that. There are some amazing programmes in place. For example, Scottish Athletics is doing some great work going into communities where it would not normally operate and targeting those groups that might not naturally participate in athletics. That is gaining it participants from those particular areas of socioeconomic deprivation, but it is also gaining athletics a more ethnically diverse participant group. That is an example of specific work that can be done.

Socioeconomic issues should not be ignored. Women experience inequalities generally because of inequality in wealth, in power and in status—when I was the Minister for Public Health and Women's Health, I used to talk about women experiencing health inequalities for those reasons. Women also experience inequalities in sport because they do not have as much money as men.

One of the basic things that we can do about that is to encourage those sports where money does not matter and make things such as participation in the daily mile integral to the school day in Scotland. That is a really important way to target absolutely everyone, so that boys and girls can participate in the same way. There are no economic barriers to participating in that activity every day.

We have 1,000 schools participating in the daily mile across 32 local authority areas, which is really good, but that is still only about half the children in Scotland—so about half of children are not doing the daily mile. It is just 15 minutes of exercise three times a week. I do my daily mile every day, let me be clear, but the recommendation is 15 minutes of exercise three times a week. For that, you get such a bang for your buck. You get measurable improvements in children's fitness and a decrease in body mass index and body fat—all the physical changes—but you also get cognitive changes. Children are more able to learn, more confident, happier and calmer. The cognitive and mood impacts are huge for a very small investment in time and no money. It is about the most inclusive programme that we have for exercise in Scotland and we are pretty keen to expand it further. Everyone should do their daily mile.

Evelyn Tweed: I assume that that is very important at the present time, minister, given that we are living through a cost of living crisis.

Maree Todd: Yes, absolutely. There are many barriers to participation in sport, including the need for kit and equipment. As, I think, the committee heard, not all sports are equal. For example, I looked at the evidence that you were given in an earlier meeting by that young female cricketer, who said that because of the equipment that is required for cricket, it tends to attract people who are from a wealthier socioeconomic background. There are many barriers to getting involved and

we, as a Government, want to bust as many of them as we can.

One of the great programmes—there are so many brilliant programmes—involved Scottish Sports Futures collaborating with Sweaty Betty, which is a luxury brand of sportswear. It provided hundreds and hundreds of bras so that young women who might have been prevented from getting involved in sport and physical activity had the right equipment. A sports bra is a really expensive acquisition—it can cost £30 to £60 to buy one decent sports bra. That is an absolute barrier for many young people in relation to getting involved in sport, so that collaboration is really phenomenal. I love the fact that that particular group of young women were getting the most luxurious brand that you could imagine. They came up and met me in Inverness and we did some sport and exercise together; it is a fantastic way to open the conversation about the possible barriers.

The need for specialist kit is not the only barrier to participating in sport. As you have heard from witnesses throughout this inquiry, those young women spoke to me about the challenges of being involved with sport while they are menstruating and the challenges of the general societal pressure to look and to behave a certain way. Women's bodies, including young women's bodies, are pretty pass-comment-able—that is the phrase that I would use—so they face a lot of commentary when they do get involved in sport.

Having money for kit is not the only barrier, but it is certainly a significant one and just now, in a cost of living crisis, it can absolutely make the difference when it comes to some women being able to exercise and some women not being able to.

Evelyn Tweed: I know that the Scottish Government is looking at perhaps restricting alcohol advertising. How will you do that while making sure that it does not negatively affect funding for sport?

Maree Todd: It is a really challenging area and that is an excellent question.

I am absolutely passionate about sport. I want sport to be well funded but I want sport to be healthy and inclusive. There are two groups who are particularly vulnerable to alcohol sponsorship and alcohol advertising. The first group are children—there was a very dismaying study a couple of years ago that looked at the Calcutta cup in 2020 and found that children saw an alcohol prompt every 12 seconds as they watched that match on television. The other group that is particularly affected is people who are in recovery; they are particularly susceptible to advertising.

I believe that we can strike a balance. We have to start from a place where we acknowledge how much alcohol harm there still is in Scotland. Over 1,000 people a year, or around 24 people a week, die of drinking alcohol in Scotland. Although we have made some progress in recent years, it is absolutely essential that we continue to make progress.

There is a perception that the people who are dying of alcohol are a distinct group that you can somehow target with your intervention. There is some truth in that—there is no doubt that the socioeconomic divide appears here as well. If you are living in poverty and drinking excessively, you are more likely to die than somebody who is wealthy and drinking excessively. However, alcohol and alcohol misuse and harm from alcohol know no bounds; we saw that over the course of the weekend, when a couple of colleagues spoke up. Miles Briggs and Monica Lennon, both of whom lost parents to alcohol, have spoken very powerfully about the stigma of alcohol dependence and misuse.

It is important for us to have those conversations about what we can do, at population level, that would shift the curve somewhat, so that fewer people find themselves in a situation where they are drinking hazardously. A discussion around sport sponsorship, promotion and advertising is a really important part of that national conversation.

Andrew Sinclair: To bring it back to women's sport, Scottish Women's Football has made a conscious decision and commitment to engage only in ethical sponsorship, which means avoiding alcohol and gambling firms. That is a good model and brings us back to the committee's inquiry. It can be done, although I accept that Scottish sport is fishing in a fairly small sponsorship pool.

The Convener: I will make a small plea to the Scottish Government that, if it is looking at reducing alcohol sponsorship, it takes some lessons from what has happened in Ireland, where there have been alcohol advertising bans. Some companies appear to be trying to get around the rules by advertising low or no-alcohol products that share the same or similar names, so they still get that brand recognition.

Emma Harper: Good morning to the minister and to Andrew Sinclair. I will pick up on Evelyn Tweed's questions about alcohol and alcohol advertising.

There are two big soft drinks companies, one of which supports the Olympic games and one of which seems to be in about all the mountain biking and soapbox racing in America. A lot of sponsorship money helps to support sport. However, I have been approached by people who

say that those are health-harming products, and we have to consider that when we support sponsorship or advertising or are helping to get young women or any young people into sport. How do you feel about implementing restrictions on advertising for products that are not alcohol related, including soft drinks?

Maree Todd: It is challenging, but there is precedent in that area. Tobacco—or certainly smoking—advertising has been restricted. Last year, I had the absolute privilege of meeting Billie Jean King, who talked about the Virginia Slims circuit, which was a big tennis tournament in America that was sponsored by a cigarette company. We have made strides in reducing the appearance of tobacco and smoking in sport.

Unusually, our sports minister in Scotland is part of the health department. I am a junior health minister, and I absolutely recognise the health benefits of sport and physical activity. The benefits are not just for physical health; they are for mental health, too. I am sure that we will get on to that.

It is really important to remember that when we consider how we fund sport. The challenge is in getting the balance correct. As Andy Sinclair has said with regard to getting access to sponsorship in Scotland, there is a relatively small pool of companies to fish in.

It is important that we consider those issues, particularly for those groups that are particularly susceptible to advertising, which are young people and people who are in recovery.

Emma Harper: I have a final question. We will come on to the theme of children and young people later, but I am interested in evidence that we took last week. Basically, there was a plea for a review of the national performance framework in order for it to include specific outcomes related to the physical, mental and social benefits of sport and physical activity. Would the Government consider making a specific target for that as part of the national performance framework? Would that help us to refocus or focus further on the importance of physical activity and sport for physical and mental health and wellbeing?

11:00

Maree Todd: I certainly try to make that link all the time. I regularly talk about sport and its benefits for physical health, mental health and social health. I think that, since the pandemic, when we were all restricted from participating in physical activity and sport and found ourselves walking outdoors to socialise because that was the safest way to do that, there has been a general, population-level recognition of the benefits of physical activity and sport for social health. I would absolutely love it if Scotland became a nation that socialises through exercise.

Andy Sinclair might want to come in on the national outcomes in particular.

Andrew Sinclair: Physical activity features in the NPF, which talks about being healthy and active. Therefore, I feel that we are quite well represented in that space. We also have the active Scotland outcomes framework, which sits below that and which talks about our whole-systems approach to physical activity and how we implement things in Scotland. That is recognised by the World Health Organization as an exemplar, and it is probably part of the reason why we are bucking global trends in getting people more active in Scotland.

Paul Sweeney: One point that came out quite strongly in a previous evidence session was that around 90 per cent of funding for sport in Scotland is channelled through local authorities. There is quite a highly disseminated model of funding. In that model, councils are faced with 80 per cent through central Government allocations and 20 per cent through council tax and charges.

There is a bit of pressure, to say the least, on council finances. Often, the first things to go are things that are seen as non-statutory service provisions. The focus is on areas such as social work and education, and things such as sport are seen as potentially less severe options when councils are looking to make savings or cuts.

What is your assessment of the impact of council finances on the provision of sport, particularly for women and girls and those kinds of specific facilities? What can you do to ameliorate that impact?

Maree Todd: I think that everyone would acknowledge that we are in challenging financial times at the moment. Things are challenging for central Government—the Scottish Government—and for local government. This particular cost crisis has come on the back of over a decade of austerity politics, which has undoubtedly had an impact on our public services for more than 10 years. We therefore face a challenging situation.

The Scottish Government has not only maintained funding to local government; we have increased it in real terms, and we are very keen to continue to prioritise local government spending in our budgeting. We recognise how challenging things are. We all see that in the press at the moment. In particular, a small number of local authorities in Scotland are making decisions on the closures of particular individual facilities. Just last week, we had a debate in Parliament about the challenging situation that is faced by Perth and Kinross Council with regard to maintaining the Dewars facility. Thankfully, it has managed to

maintain the funding for the Dewars facility, and it is secure for the next few months.

We are working with local government colleagues day in, day out to try to rise to meet that challenge and see what we can do to support them. Much of the current challenge is being precipitated by energy costs, so it is the energy-dense sports that use things such as swimming pools and ice rinks that are particularly struggling. Continuing to put pressure on the UK Government, which has many of the cost of energy levers, is an important strand of trying to tackle that particular challenge.

In the short term, things are challenging. In the medium term and the long term, there is work that we can do together to try to improve the estate so that there is less energy consumption in those facilities. That is not an overnight fix, but we have to do that. We have to make that transition anyway in order to meet our net zero targets. The Government is more than happy to work alongside local government on that.

Paul Sweeney: I know that there is a contested space around real-terms cuts from the Convention of Scottish Local Authorities. I would not want to get into that debate, because I think that the focus should be on what we can do to highlight risks in the estate that you mentioned, for example. Could things such as investment in district heating networks or capital investments be targeted? If councils are making decisions that involve a risk to the future provision of sport facilities in Scotland, is there a mechanism by which that risk can be flagged, and potential mitigating measures—for example, capital investments or targeted investments—looked at with the Government? Could there be opportunities to look at best practice in other authorities that have been able to crowd in some external investment, or where sponsorship or entrepreneurial activity has ameliorated the impact?

I wonder whether there is potential for a more developed ecosystem of feedback in relation to local government dealing with challenging situations on the ground versus sharing best practice and measures that have worked better. Swimming pools, for example, are energy-intensive assets. Could there be ways of investing capital into them to reduce the revenue costs? Is there potential to develop something there?

Maree Todd: We are doing quite a lot of work in that space already. Andy Sinclair will probably want to come in and tell you a bit more about the work that sportscotland is doing with local authority colleagues on the sporting estate nationally, to try to take a strategic view about where investment will have the most impact. We are working very closely with our local authority colleagues on that. I absolutely empathise with how tough a situation they are in. We are in a tough situation too, and difficult decisions are being made. It is a really difficult time to be in politics.

We have very open and candid channels of communication and support available. What we do not have is a limitless pot of money to help out in such situations. That is challenging for all of us. There are no easy short-term solutions in the situation that we face. In the longer term, we can certainly work to get the estate on to a better footing.

Andrew Sinclair: To give some comfort, we speak regularly with local authorities and Community Leisure UK, which is the umbrella body for leisure trusts, to understand the position, which we recognise is incredibly challenging.

As the minister mentioned, sportscotland is commencing a full facilities review for Scotland to understand the condition of the estate as regards physical activity infrastructure. The pressure on local authorities means that they need to think about doing three things: reducing opening hours to cut costs, putting up prices for people—we have spoken about the challenges that that would present regarding inequalities—and closing facilities.

Swimming pools are a prime example. Swimming pools that were built in the 1970s will never be energy efficient. If a local authority does a proper consultation process, there could be facilities that could be used in a different way. As we know, local authorities have a requirement to provide adequate facilities—that is the only requirement on them. There is no clear definition of “adequate”, so, as long as there is genuine engagement between local authorities and the people who live in those areas, they can, I hope, come up with a solution.

The Convener: When we had our witnesses in last week, Kim Atkinson queried how local authorities are held accountable for their investment in sport, given that, as Paul Sweeney has said, quite a substantial amount of the money that is put out by the Scottish Government for sport goes through local authorities. I have seen the price increases in my area, which caused a huge outcry. There was a 114 per cent increase for children and young people through a change to the discount that they had to access sporting facilities.

I appreciate that we want local authorities to be as autonomous as possible, and the Scottish Government walks a very fine line in that regard, but, given the impact that some of those price increases and closures might have, particularly on children and young people, is there more that the

Scottish Government can do to ensure that the money gets to where it should be going?

Maree Todd: That is a really difficult and challenging area. Local government is democratically accountable to the populations that it serves, and it is not the Scottish Government's role to oversee its spending decisions. There must be locally accountable decision making.

Paul Sweeney mentioned how much of the budget is already ring fenced. I think that ring fencing more of it would not be welcome. To be honest, over the course of the pandemic, we have worked really closely with local authority partners. We rose to face an incredibly challenging time for our nation together, and we navigated the challenges together.

There is keenness on both sides—the Scottish Government and COSLA—to continue that positive working relationship. Although everybody acknowledges that challenging decisions will have to be made on both sides—local authorities might contest some of the spending decisions that we make, and we might contest some of the spending decisions that they make—there is absolutely room for respect on both sides and working together to collaboratively find a way forward in this really challenging time.

The Convener: We move on to questions from James Dornan, who joins us remotely.

James Dornan: Good morning. It is 10 years since Maureen McGonigle, Alison Walker and I began Scottish Women in Sport under Maureen's leadership. One thing that was of real interest to us at that point was how girls' physical activity dropped off at a certain age, but I see that the current position is pretty much the same. How do you address that? What action can you take to ensure that girls feel safe and welcome to participate in physical activity and school play areas?

Maree Todd: You are absolutely correct, James. That drop-off around puberty is well recognised and it is a long-established pattern. It is a challenging situation to shift. For children, we see a difference in participation that becomes statistically significant only between the ages of 13 and 15. Although boys participate more than girls, that does not become statistically significant until puberty. We see that difference continue throughout life. The reduction in participation is not permanent. Girls' physical activity drops off at puberty, as does boys' physical activity, but they re-engage at future points.

For women and girls, there will be expectations around caring roles from a very early age. There are challenges when girls hit puberty, because of the changes in their bodies. On my daily mile this morning, I was reflecting on the difference in my body confidence at age 50 compared with age 15, and I think that everyone would recognise such differences.

There are challenges for girls as they come of age in a gendered society such as the one that we live in at the moment. There are expectations with regard to body conformation and there is discomfort about menstruation. On the radio this morning, I heard a triathlete, Emma Pallant-Browne, talking about a photograph that she had posted of herself running with a bloodstained swimsuit. Menstruation is still taboo and body hair is still taboo. There are all sorts of reasons why girls stop exercising as we hit puberty.

It is a challenging issue to get into, but I think that we are in a healthier space than we have ever been in with regard to the debate that is occurring. There are particular programmes and other things that will help, including women and girls-only spaces. With regard to communal changing spaces, I note that women tend to have a preference for privacy, so changing the changing rooms so that it is possible for women and girls to change privately rather than in a communal space will help.

However, there is massive societal pressure and it will take time. We must not underestimate the societal pressure on women and girls to look a certain way, which we feel most strongly at the stage of life between the ages of 11 and 15.

11:15

James Dornan: Yes. Being a grandfather—my granddaughter is now beyond that stage, thankfully, and is not having to go through all those worries—I understand what it is like at that age.

The issue came up for us 10 years ago but, 10 years on, we have almost exactly the same issues. What do society, the Government and those who are involved in sport and education need to do to try to ease the burden for young women at those ages?

Maree Todd: I agree that it is frustrating that it has been 10 years. However, if you think about the taboo around menstrual blood, that has been in place for millennia. The idea that we could overturn some of the taboos and the challenges that women face around participation overnight is, frankly, wrong.

We are now having some really good conversations. I have never before known a time in my life when elite athletes have talked openly about issues such as menstruation, contraception, pregnancy and sport or menopause and sport. It is really healthy that this debate is finally happening.

In the same way that we have seen women's health understudied, we have seen women's participation in sport understudied. Historically, there has not been an understanding of the influence that our different physiology has on performance sport, for example, because that has not been looked at. First, women have participated less in sport. Secondly, we have been studied less, as we have been studied less in medicine.

There is now a great deal more understanding of those issues. Sportscotland is doing some particular work in the elite performance athlete field, which is really helpful. There are better conversations going on and there is more understanding and tackling of the barriers. However, it would be foolish to imagine that there is just one thing that would unlock sport and physical activity for women and girls. There are multiple barriers. As I said earlier, a sports bra is a pretty essential piece of kit and the fact that it can cost £30 to £60 is a barrier that many women and girls will not be able to overcome as they hit puberty.

James Dornan: I look forward to receiving a further report in the future and seeing how well we are getting on with this. Thank you.

Emma Harper: I want to pick up on the sports bra issue. Yesterday, I visited Wallace Hall academy and I spoke to five young women—Mika, Fern, Zena, Michaela and Daisy. They are all sixth-year students or thereabouts and they all participate in rugby and running. They love all sports. They are absolutely confident, informed and empowered, but they recognise that not all young women of their age are confident or empowered to speak up about their periods or about the need for a sports bra.

An interesting thing that they spoke about was that the school has purchased for year 1 students a specific sports uniform for physical education. That has helped with equalities and acted as a leveller, because the kids come from different primary schools and it is a way to engage them all on—literally—a level playing field. I would be interested to know whether you think that we need to look at the availability of sports bras, for instance, and sports uniforms as part of the Government's uniform policy.

Maree Todd: Absolutely—that is a really good idea. We have committed to introducing during the current session of Parliament statutory guidelines for schools on increasing the use of generic items of uniform, and we have a lot of focus on reducing the cost of the school day. We have consulted on guidelines on school uniform and clothing. We engaged with pupils and undertook a public consultation. We are analysing the responses and our report summarising the findings will be published soon—pretty much around now, I would have thought. The costs of school uniform and of clothing and equipment for physical activity and sport come into it, and there will definitely be a focus on trying to reduce costs for families.

I think that looking at breast care is a really important part of that. It is definitely one of the reasons why there is a drop-off in participation. As we have discussed, there are lots of reasons, but that is one of them. Seeing what we can do to engage with that and improve the situation is really important.

Emma Harper: Another thing that the young women raised was that the boys who they play rugby or sport with or who are on the field at the same time as them are sometimes a bit sexist and misogynistic. I mentioned to the principal teacher, Barry Graham, the "Don't Be That Guy" campaign, which is quite hard hitting because it is about harassment, sexual assault and sexual violence. He is going to take a look at that campaign, but is there room for something else that might not be as hard hitting, such as an equivalent campaign for teenage lads?

Maree Todd: That is definitely an important area to acknowledge. We live in a gender-stereotyped world where girls and women are expected to look and behave in a certain way and to conform to certain roles. There is no doubt at all that, as children grow up and reach puberty, they experiment and find out who their tribe is, and they test out and explore the world that they live in. Part of that can absolutely involve thinking that women's bodies are pass-comment-able. That is the term that I use; I hope that it is okay to use it here. We face that all the time. Each and every female in this room will have had times when people have passed comment on their appearance.

It is particularly difficult for teenage girls. I hear all the time that boys' comments are a barrier to their participation. Education can help to tackle that, but we have to recognise that—as with other societal challenges such as racism—the existence of sexism and misogyny in sport reflects society. We live in a world where those things are a reality, so some of that will be reflected in sport.

However, I firmly believe that sport can lead the way on changing that culture. I believe that there are some positives that sport can lead on in shifting the culture. It is important that we harness sport's power to tackle some of those societal ills. As well as looking at education in schools, we can look at role models in sport and at grass-roots projects that might tackle some of those issues. That is a really important part of the work.

Emma Harper: My final question is about the variety of sports that schools offer. It came up in the conversations that I had that, during the

summer sports day, there were shot put and javelin events and a mixed-gender 400m relay, but also a tug of war. Not everybody wants to win a gold medal; some folk just want to participate and have a bit of fun, so Wallace Hall academy has implemented that. Can the Scottish Government do something to increase the variety of sports, taking on board the good practice in some schools, in order to get everybody not just competing but participating?

Maree Todd: I will let Andrew Sinclair comment on that as well, but that tension has always existed. There is a difference between elite sport and social or recreational sport. As a Government, we want to encourage participation across the board. I could sing the praises of sport morning, noon and night, given its benefits for physical, mental and social health. We want everyone to have access to it. If it was a pill, it would be worth billions, would it not? We want to increase participation. One way to do that is to take away the barriers and another is to offer a diversity of experience, which means a diversity of sports.

Sometimes—there might be a gender difference in this regard, although I am not sure whether it is just a perception—there are different levels of appetite for competition, and there are definitely occasions when participating just for the joy of it is really important.

Scottish Gymnastics sees itself as a feeder for all other sports. Participation in gymnastics is particularly gendered, with a very high number of girls and women participating. They often go on to other sports, but gymnastics is where they gain their physical literacy. Only a small number of people go on to compete as gymnasts, but people very often use the skills that they picked up as youngsters in that sport when they take part in other sports.

We watched the Olympic games with a lot of interest last time they were on, and there were brand-new cycling events that captured the imagination of the world, such as BMX events. Exciting innovations are happening in sport, and new kinds of competition have come along. We are going to host the Union Cycliste Internationale—UCI—world championships in Scotland later this year, and I cannot wait to see football on a bike and gymnastics on a bike. There are really interesting innovations going on and I passionately believe that there is a sport out there for everyone.

I joke that I got into rugby because I was a bit clumsy. I banged into people often and fell over quite easily and I found a sport where those characteristics were an asset to me. Admittedly, I have always participated in social sports. I was never going to be an elite athlete. I trained hard and I played hard, but it was only ever going to be a social or recreational experience. Everybody should have that.

As I mentioned, on my daily mile this morning I reflected on my journey to the body confidence that I now have at the age of 50, and participating in rugby was a big part of that. I recognised that my body could do things that I never imagined it could do; it is really strong and I can knock down people who are much faster than me. We need to recognise that there are sports out there for every single body shape, because that is powerful. We need to broaden everyone's horizons, get everyone participating and give them loads of opportunities.

A number of members of the committee were at the celebration of the 150th anniversary of the Scottish Football Association that was held in Parliament last week. At that event, we heard from Sam Milne, who talked about starting a recreational football group. She talked about a lassie called Farrah Mackenzie who came along to play recreational football. She was not competitive at all but just wanted to do social sport. Sam and Farrah talked powerfully about the camaraderie and the social benefits of football, but also about the physical and mental health benefits. Farrah spoke about losing 6 stone. She had been a type 2 diabetic who was on the brink of going on to insulin, but participating in recreational football pushed that back for her.

Let us ensure that there are as many opportunities as possible for absolutely everybody to participate in sport and physical activity. We need some competitive opportunities. I am not dismissing the elite athletes among us, who need competition. Some people who play recreational football said that they have begun to enjoy competition and they gather together once a month to have football games so that there is an opportunity for that. However, I want participation. I want us to move more, to enjoy our bodies, to be fitter and stronger physically and mentally, and to get all the social benefits that those things bring.

11:30

Andrew Sinclair: I add that we have about 200 community sport hubs across the country, many of which are based in schools, and they offer a range of activities. Over the past few years, sporting disciplines have become good at sharing participants and there is not as much competition between sports. For example, a club might say, "If football isn't for you, you could try badminton. There's also a club here." That approach is giving young people in particular a range of activities to try out, which is positive.

As an aside, I note that the Scottish Tug of War Association is the smallest governing body in

Scotland that we invest in. It does some good work.

Maree Todd: Active schools co-ordinators are good at collaborating with the assets that already exist in the community and they make those links between the sports clubs in each local area. I know that Emma Harper's part of the country is big on curling and ice sports, and my part of the country is big on shinty. We need to think about making links between the sports that are already being played in communities in order to give children and young people opportunities to join with assets that are already there. That is an important part of getting it right.

Emma Harper: Curling is good for people who are in wheelchairs, too.

Maree Todd: Curling is spectacular. I had a marvellous visit to Inverness ice rink, where I met a group of curlers. The sport nearly finished me off—you will remember that I said that I am a bit clumsy. [*Laughter.*] I did not find it easy, but there was such a supportive bunch of people and so many of them had stories to tell. Some were lifelong participants in the sport, whereas others had come to it very late.

Curling seems to be easy for older women, in particular, to get involved in. A couple of women spoke about having been widowed and said that their friends had invited them to come along. It is unbelievably social. Those women were pretty competitive, too. It was also a workout—I was sore for days afterwards. The advantages are endless.

The Convener: We move to our next theme, which is sport and physical activity in the community.

Carol Mochan: We have already touched a wee bit on community sport in our discussion on leisure centres, and I am interested in some of the questions that we have asked other witnesses about how we try to engage women.

There are three main difficulties in that respect, the first of which is safety and going to and from venues, particularly if there are no local activities for young women. The second is childcare facilities at sports and leisure centres. Have you had any thoughts about that? Thirdly, there is use of the school estate, which has been raised not just recently but in the committee's previous discussions about sport. It is an important point that we keep coming back to. What work have you done—or do you intend to do—on that issue?

Maree Todd: There is no doubt that what you have highlighted are challenges to women's participation in sport. Safety—and safe transport to and from sporting venues—is an issue, particularly during the long, dark winters that we have in Scotland, when not everyone feels comfortable being out and about at night. Frankly, some of our environments are not safe for women. Again, that is something that every woman makes decisions about every day. It is the reality of our lives: we make decisions about how much risk we are willing to take and make compromises as a result.

Designing communities with good active transport links to sporting hubs is therefore important. A couple of weeks ago, I opened the phenomenal West Lothian Cycle Circuit, which is linked to active transport routes, is well lit and has been beautifully made so that you can cycle to the track from many parts of the surrounding community.

It is important that we think about those sorts of things, including public transport. In my part of the country, and where I live now, public transport barely exists at all; indeed, where I used to live in the east of the Highlands, public transport tended to stop at a certain time of night. These are undoubtedly challenges and barriers for women, and we need to think about them by designing public transport systems that are accessible to and safe for women and by ensuring that communities are well lit and well designed.

I saw the evidence from one of the committee's earlier witnesses about the fact that women feel more comfortable and safer walking in overlooked places—say, where there are lots of windows looking out onto a path. It is not always obvious what makes the difference, but we need to do more research and ensure that our communities are safe for women.

Childcare and caring in general are really important issues, too. I have been encouraging many sports to think about opportunities to link up. Given that women do a lot of children's activities and organise a lot of aspects of children's lives, we need to provide opportunities for women to participate in sport while their children are doing the same. I remember very well what the first captain of the Orkney Rugby Football Club ladies said about her journey into rugby. She was a rugby mum who had to hang about while her wee boy was at training and just thought, "How about we start training ourselves?" Within two or three years, that women's team was picking up silverware—they were pretty phenomenal at rugby. Giving women opportunities to train while their children are training is important.

Jogscotland does a lot of that. I participated in a jogscotland group when my kids were really tiny; I could drop my children off at nursery and go for a jog with an inspirational group that was mixed gender, but mainly women, as it was during the day. There were some outstanding older women in that group who gave me, as a young mum feeling

very out of condition, a lot of inspiration about the potential for lifelong participation.

There are some real opportunities for collaboration to provide—in that first postnatal year, for example—yoga and exercises that are focused on pelvic health. That would be a win-win. Encouraging more of that, with babies coming along, too, would be a really important way of encouraging women to exercise.

As for the school estate, we have, again, lots of policies in place to enable its use, and it is seeing lots of use. More could happen and we could go further, but we have made a great deal of progress in the past years. We have had a challenging few years with the pandemic, with safety and prevention of infectious diseases at the forefront of people's minds. Trying to limit the number of people who access the school estate in a day has been challenging, and that situation has been slow to recover, post pandemic, but we are making progress.

Andrew Sinclair: I do not have too much to add. As the minister has said, the general principle of the learning estate strategy from the Scottish Government is that community facilities should be open to the community. It has been a while since we have done any research on that; I think that 2014 was the last time that sportscotland did a formal study, but it speaks regularly to local authorities and raises the school estate as a continual issue. In many cases, it comes down to scheduling more than facilities not being open but, again, it is just a case of working through all those challenges.

Carol Mochan: It is a point that has been well made before—the estate is open but it is not being accessed. Do you have any insight into why that might be? Has the Government had feedback on that?

Andrew Sinclair: It is definitely a difficult question, because, on the face of it, the estate seems to be open—the gates are unlocked—but we need to work with local authorities and governing bodies in particular to ensure that the scheduling is right. Schools quite rightly use the facilities during the day, but as soon as the school day finishes, the facilities should be available for communities. We just need to work through the issues.

The Convener: I move to Gillian Mackay for questions on our next theme.

Gillian Mackay: How do we ensure that an intersectional approach is taken to improving participation in sport and physical activity, including the participation of people with disabilities, the LGBTQ community and other marginalised and underrepresented groups?

Maree Todd: You are absolutely right to raise the issue. There is already general concern about each of those groups and the women and girls who fall into those individual categories. Undoubtedly, the barriers are greater for those who are in more than one group.

A group that particularly challenges me is people with disabilities, and I would love to see more participation from—and more opportunities for—that group across the board. When I went to a disability sport festival in Dingwall, I was so impressed by the work that was going on to target inclusion. That was probably over a year ago, so it was at a time when we were still feeling pretty cautious about the pandemic. Many of that group of participants had spent a lot of the pandemic being very isolated and very vulnerable, and it was really joyous to see them participating in sport, sometimes with siblings, as they might never get a chance to play those games or do that sport together in the way that other siblings do.

Some really important work is going on, and it is bearing some fruit, but we could do more. Last year, sportscotland's young people's sports panel ran a very powerful course that challenged us all to reflect on what adaptations we could make to encourage the participation of people with disabilities. When I speak to people participating in sport who have disabilities, almost all of them talk about how challenging it was to get involved in school; they were told to sit at the side in PE classes. As those education sessions amply demonstrated, it is really easy to make adaptations that enable everybody to be included, and my plea is for every possible opportunity to encourage inclusion and participation to be taken.

I can highlight some great examples. Recently, I went to a badminton club run by a coach called Rajani Tyagi, who had won a prize as sportscotland community coach of the year—or something like that; I have probably got the title of the award wrong, so apologies to Rajani if I have. She had done some fabulous work on encouraging participation by the black, Asian and minority ethnic community. It was just the basic things that you would expect, and what she was doing was spread by word of mouth. She targeted people; she made sure that they had a safe environment to come along to; and she held sessions at times that suited people. They were at 8 o'clock at night, which would have been quite late for me to be running around playing badminton, but it worked, because many of the people involved had caring responsibilities and it was a time of night when they were freed from those responsibilities and could participate.

It is just basic: you ask the community that you are targeting what would work for them, then you do it and you reach out. Rajani had a thriving

badminton club, and she had done quite a lot of work on cricket as a way of targeting BAME participation. Some really powerful work was going on.

As for the LGBTQ+ community and homophobia in sport, I think that the committee has heard from earlier commentators that women's sport has traditionally been quite a safe space; it has been inclusive and welcoming to everyone. We really need to be proud of and hang on to that as we go forward. Clearly, there is a debate to be had about trans participation in sport, and some challenging conversations are taking place on that issue, but I again make the plea that we focus on inclusion where possible, recognising just how important the benefits that everyone gets from participating in sport are.

Each of the communities that we have talked about will face marginalisation and challenging health outcomes, and sport can be part of the answer. We therefore really need to make sure that we consider inclusion, where possible. As I have said, women's sport has had a relatively healthy attitude to earlier discussions in previous times, and we need to hang on to that.

11:45

Gillian Mackay: Absolutely. As someone who, like yourself, found rugby because it is easier to stop things than it is to run quickly, I am interested in how we include people with hidden disabilities who might not end up qualifying for the disability sport side of things and instead end up in more mainstream sporting activities. Speaking as someone who has misjudged how quickly an opponent was coming at me and missed several tackles due to my hidden disability, I think that this is about how we make those environments welcoming and change some of that culture.

You have mentioned PE, and we also need to tackle the issue of children with hidden disabilities being ridiculed, say, for how many times they miss catching a ball. What work is the Government undertaking to improve the visibility of disabled people in sport, including those with hidden disabilities?

Maree Todd: Many of the sports are doing a lot of work on that themselves, and rugby is an excellent example of that. I am pretty sure that, as a fellow participant in the Parliament rugby team, Sandesh Gulhane will be able to contribute here, but each year we play an inclusive team, which I think is called Clan Rugby. Some of that team have hidden disabilities and some have less hidden, but the roles are adapted so that everybody can play together. It is absolutely fantastic.

Wheelchair rugby is also hugely inclusive. It is a game that men and women often play together, in mixed teams. I have a Twitter pal—I do not know her in real life; I have met her in real life, but we are mainly friends on social media—who is desperately trying to get me to go along to wheelchair rugby training on a Wednesday night. It has been a revelation for her. She has very severe asthma and has been prohibited from participating in conventional sport, but wheelchair rugby has given her the opportunity to participate again. There are ways of adapting sports so that everybody can be included.

One of the people who got a coaching prize at last year's awards ceremony was a lady from the north-east—I do not know whether you remember her name—who does inclusive swimming coaching. She was just phenomenal; she was an absolute power who reached out to people to get them involved in her sport and who made sure that they could achieve their best potential.

There are loads of challenges and barriers, but some really incredible work is going on out there. I come back to the point about default settings and inclusion: we have to ensure that everybody can experience the benefits of participating.

The Convener: Sandesh Gulhane might want to comment on the rugby.

Sandesh Gulhane: The one thing that I would never be brave enough to do is wheelchair rugby—that is quite scary.

I would like to ask questions around ethnicity in women's sport. Minister, you have spoken about how participation drops off, but that is even more acute when it comes to ethnicity. You gave a very good badminton example of a way to engage with the community.

However, my first question is about information and data, because every single time that we have had someone in front of the committee, I have asked them what data they have around ethnicity and very few of them have come back and said that they have good data around that. Is that an issue?

Maree Todd: It has certainly been a challenge in the past. I think that we have improved our data collection over the past few years; I will let Andy Sinclair give a fuller answer on how we have gone about doing that. However, certainly from a Government perspective, we are looking for ethnicity data as well as physical activity data in our household survey.

In relation to the data that sports governing bodies collect, we are doing a little bit better than we did in the past, when there was no data; we saw that in relation to health as well as physical activity. It was not really until the pandemic that we

went out and routinely collected data that gave us the level of detail that we would like about ethnicity. Although anecdotally there were a lot of concerns about particular ethnic groups participating or not participating in the vaccine programme, we did not know the details until we got the data, so data is really important.

There is a balance to be struck around data collection—I will let Andy Sinclair tell you a little bit more.

Andrew Sinclair: As the minister said, we have quite good national data through our national surveys—the health survey and the household survey provide us with a good level of understanding around ethnicity and participation. Sportscotland collects a lot of good information, particularly around its major programmes such as the active schools programme. It used to really just look at participation stats but now looks a lot more deeply at participants: who they are, where they come from and what they are getting out of the experience of active schools. Although the data is probably incomplete in some places, it is a lot better.

Again, there is a balancing act around how much to ask. We have heard in previous evidence sessions that sport relies a lot on volunteers and there is only so much that you can ask them to do in a participant session. You almost start creating false barriers when you ask for too much data to be collected, both for the volunteer coach and for the participant who may not be keen to share that information. There is definitely a bit of a barrier there around data collection, especially when you are dealing with volunteers who are just looking to put on a sports session, not fill in 10 forms.

The data that we collect through our national programmes, through the Government and through sportscotland, is not bad—it is pretty good—but with some of the community-led, volunteer-led activity, we appreciate that there are some gaps.

Sandesh Gulhane: Certainly, at that community level, it is difficult to gather data and I appreciate that. However, when an organisation is putting on organised events, I feel that it needs to think about data—it needs to think about what it has got. The reason why I asked the question is that if you do not have good data and you have a huge drop-off in participation in relation to ethnicity, you will not know why there has been that drop-off. If you do not know why, how can you possibly fix it?

You spoke about the household survey and other ways that you are gathering data—also, the organisations that we have spoken to have all said that they are looking to improve that data. Once we get the data, will you centralise it? There is no point in having the data if it does not undergo some form of research, so what research will you put in place to really try to drill down and find out why people of different ethnicities are not participating further, as we would have hoped that they would?

Maree Todd: Individual sports governing bodies are looking at that question to varying degrees. They want more participation, so it is absolutely in their interests to ask those questions and to pursue the answers. I do not think that the answer will be the same for every sport. It is also difficult to generalise about different ethnicities. Rajani Tyagi, the badminton coach whom I mentioned earlier, initially was largely targeting Muslim women's participation, but a whole variety of people of different ethnicities were coming along. What she had done was create a safe space for people of different ethnicities to participate in sport.

There are all sorts of barriers—for example, certain religions might have rules around modesty or clothing, but not all of them do. Therefore, once you get the data, you need to ask in a sensitive way what the barriers are for people and try to take them away. As I said, participation is key; we are dead keen to improve participation and all the sports governing bodies will be trying to do that.

Sandesh Gulhane: A lot of sports governing bodies that appeared in front of the committee do not have the data and said that they are looking for it, so once we have that data, will it be centralised or, if you will not have an entire database, will you at least be able to access it in order to do research on it?

Maree Todd: We will certainly be able to interrogate it to an extent with the individual sports governing bodies. However, as I said, it is a challenging area in which to coalesce all that data and to draw conclusions, because there are so many individual aspects to the sport and to the ethnicity. It is really important that we do not make assumptions, but I am absolutely open to conversations about how we improve BAME participation. There are all sorts of immense programmes around the country that are trying to do that, so it is really important that we have the data to support them and to support investment to tackle some of the exclusion that is apparent.

Andrew Sinclair: I will just add that, as part of our national governing structures, we have a data and evidence group that has BAME partners from across Scotland. We can definitely take that away and look at it in more detail.

Paul Sweeney: A theme that has come up in many previous evidence sessions is income inequality and the fact that it prevents access to sports, especially, as was mentioned earlier, when the sport is particularly expensive to access in

terms of transport, facilities, costs and equipment. What active steps is the Government taking to provide support in that regard, whether it is in the form of grants or loans for equipment or, potentially, even looking at things such as kit libraries? Is the Government looking to promote any particular measures to address income inequality as a measure of access?

Maree Todd: At the moment, one of the Government's core missions is tackling poverty, particularly child poverty. It is recognised that poverty impacts all of people's life opportunities, and participation in sport and physical activity is just one of the areas on which it impacts. It is important that we do not lose sight of that whole-system approach and the fact that, instead of just thinking about ways to fix a problem—such as getting access to sports bras for young people—we must also think about the bigger picture and how on earth we can tackle poverty and make a difference on that. That is a really important thing for us to do.

There are really good programmes that provide kit libraries. Again, the young people's sport panel came up with some brilliant work on that. That is being led by young people who have volunteered for leadership roles in sport and been supported by sportscotland to develop ideas and projects. A kit library is one of the ideas that they were working on, so that people could access and share good-quality items of kit. We need that work to happen at scale all around the country, because there is absolutely no doubt that it is a barrier to participation.

One of the challenges with regard to participation in sport is that, if you are working three jobs and struggling to keep your head above water, it is very hard to get involved in leisure and recreation activities. Therefore, it is not just about the costs but how tough people's lives are as they battle day in, day out, with an acute cost of living crisis, which is what we are experiencing right now. That makes life very hard for people.

That is a big challenge for the Government, and we are seeing huge efforts on that across the board. Yesterday, we saw statistics about the level of poverty being experienced by children. In Scotland, 24 per cent of children are living in poverty, but the figure for the rest of the UK is 29 per cent, so we are seeing huge efforts and some benefit, but it is not good enough. We need to do more, because living in poverty is all-consuming. It is hard to think about anything else if you are struggling to access food, heat and shelter.

Paul Sweeney: That is a fair point. I come from a low-income background, and one of the things that I did as a kid was swimming lessons because they were free, so my mum was able to take me to the local swimming baths.

12:00

Earlier, we mentioned the cost pressures that people face. Free swimming is an increasingly scarce opportunity for young people, but statistics from Scottish Swimming show that 60 per cent of swimmers are female and that it is the top participation sport for people with a disability, so it is an obvious community-based facility that is accessible at a relatively low cost—for equipment required, and so on. However, councils have reported an increase of 90 per cent in electricity costs and a 200 per cent increase in gas costs.

In England, they have introduced a swimming pool support fund to the tune of £60 million, of which £40 million is for capital investment and £20 million is in revenue grants. Are there plans to introduce similar relief in Scotland to try to maintain access to swimming pools? Perhaps it could be conditional on providing things such as free access to young people.

Maree Todd: As I said, conversations are going on between us and local authority partners about how we can ensure that we are able to invest in the estate in a strategic way to ensure that participation is maximised.

The challenge is that we will have consequentials from the allocation—I think that we get about £6 million in consequentials from the spend that came from that Westminster decision for England—but it goes into the block grant and the general allocation of our budget. Just because it was spent on swimming and swimming pools in England does not necessarily mean that it will be spent on swimming and swimming pools in Scotland.

We make all sorts of different decisions, not least the decision to fund the Scottish child payment, which is a uniquely Scottish benefit. It is game changing—as commentators tell us—and is clearly having an impact on the level of poverty that is experienced by children and young people in Scotland.

We will work hard with local authority colleagues to try to see what can be done, but it is certainly not automatic that because the decision was made in Westminster to invest in swimming pools we will make the same decision in Scotland. The Scottish child payment is a classic example of a different decision that we made in Scotland that is making a difference in the same area.

Paul Sweeney: I accept that there are opportunities to do things differently here, and that it might not be necessary to automatically read it across, but would you say that there is a reasonable and pretty decent business case to ensure that there is targeted discrete support for—in this instance—swimming pools? It is an obvious opportunity. Whether it is designed in the same

way as in England is secondary to identifying the threat to such facilities and addressing it specifically.

Maree Todd: Absolutely and, as I said, a lot of work is already on-going in collaboration across the board with sportscotland and local government colleagues to try to ensure that the sporting estate has adequate investment, and so that we can continue to support it. Swimming is a fantastic example of a very inclusive sport that is a brilliant life skill. Learning to swim—something that is so frightening—and succeeding at it is a brilliant educational experience, and I absolutely would not argue against investment in swimming. We have a lot of work going on to ensure that children at school can experience swimming lessons, but we are in difficult financial times and we are going to have to keep working together to ensure security for the future.

The Convener: Thank you very much, minister, and Andrew Sinclair, for your participation. It is very much appreciated.

At our meeting next week, we will hold stage 2 proceedings for the Patient Safety Commissioner for Scotland Bill. That concludes the public part of today's meeting.

12:04

Meeting continued in private until 12:37.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba