OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 19 December 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 19 December 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
39th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

COMMITTEE SUBSTITUTES

Sue Webber (Lothian) (Con)

THE FOLLOWING ALSO PARTICIPATED:

Dr Iain Kennedy (British Medical Association)
Ian Maxwell (Scottish Football Association)
Julie Mosgrove (Optometry Scotland)
Mhairi Templeton (Society of British Dental Nurses)
Laura Wilson (Royal Pharmaceutical Society)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 19 December 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 39th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Ivan McKee and David Torrance.

The first item on our agenda is to decide whether to take items 5 and 6 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Healthcare in Remote and Rural Areas

09:15

The Convener: The second item on our agenda is our fifth oral evidence session as part of the committee's inquiry into healthcare in remote and rural areas. Today, we will hear from representatives of healthcare professional associations. I welcome to the meeting Dr Iain Kennedy, chair of the British Medical Association Scottish council; Julie Mosgrove, chair of Optometry Scotland, who joins us remotely; Mhairi Templeton, who is from the Society of British Dental Nurses; and Laura Wilson, the Royal Pharmaceutical Society's director for Scotland.

We will move straight to questions. Sandesh Gulhane will ask the first questions.

Sandesh Gulhane (Glasgow) (Con): I declare my interest as a practising national health service general practitioner and as a BMA member, given that Dr Kennedy is here and my first question is for him.

I am rather concerned about the potential for a two-tier health service, given the issues that we have with recruitment and more generally, specifically when it comes to physician associates. I saw a job advert for a physician associate at Raigmore hospital that said that they would actively undertake clinical supervision of ward nursing staff, junior doctors and student PAs to facilitate the development of clinical skills and practice. NHS Highland followed up by saying that that was an error and that the role in question was a General Medical Council-recognised role. Given that PAs will be regulated by the GMC, might an increasing number of PAs across rural areas be supervising doctors?

Dr Iain Kennedy (British Medical Association): I was concerned after seeing that PA advert when it came out at the weekend, because a PA who has perhaps had two years of training after a science degree would be supervising doctors who might have had 10 years of training, so I was not too surprised when I saw the Twitter storm yesterday involving many of my members across Scotland. A senior executive in NHS Highland has told me that that was an error, and NHS Highland has said on Twitter that it was an error.

The BMA Scottish council is concerned about the position with physician associates and anaesthesia associates, and we have made representations to the Cabinet Secretary for NHS Recovery, Health and Social Care about that. We would prefer it if they were called assistants, not

associates, because they are not of the profession. They are not doctors, and we know that patients are confused when they see them because they think that they are seeing a doctor.

We have also asked the cabinet secretary whether he would consider using a regulator other than the General Medical Council, which was, of course, set up to ensure that patients were seeing doctors. Therefore, I share your concerns about PAs.

On your general point about there being a two-tier service, I have said many times that I think that we have a three-tier service. There are people in Scotland who can afford to pay for private healthcare; there are more fit, less frail patients who access services such as the national treatment centres; and there are older, generally frailer patients who are languishing on NHS waiting lists. Over a number of years, BMA Scotland has been speaking up about widening inequalities. We are sleepwalking into at least a two-tier service; I would argue that we have a three-tier service.

Sandesh Gulhane: Specifically on the need to address the situation in rural areas—there is a distinct difference between our urban belt and our rural belt—has the GP contract, which has centralised the provision of things such as vaccinations, been a success in our rural Highland areas? Was the Government warned in advance of the contract being introduced that it could cause a specific problem for our rural and island populations?

Dr Kennedy: I am here representing BMA Scotland—I am the chair of BMA Scotland—but I think that it is well known that I led the “no” vote on the GP contract in Scotland when I was the medical director of the Highland local medical committee, so my views on the 2018 GP contract are very well known. The Government was advised at that time and I advised it on behalf of my colleagues, who made very strong representations.

The 2018 contract has been only partially implemented across Scotland and, sadly, it has not been a success anywhere. From listening to my rural members across the country, I know that they remain deeply unhappy about the outcome of that contract because of how it distributed resources and because, arguably, it made inequalities worse—not only in rural areas but in deprived areas.

There is one potential solution, which the chair of the BMA’s Scottish GP committee, Dr Andrew Buist, is pushing the Government to implement, and that is phase 2, which would help to address the excess costs of delivering health in rural areas, including staff costs. The aim of phase 2 is to help GP practices pay for their staff expenses and their non-staff expenses, which are much greater in rural areas because of the excess cost of supply.

Sandesh Gulhane: We will be coming on to recruitment, so I will not venture into questions about that.

I want to ask about optometry. We have got some fantastic examples in Lanarkshire and in Glasgow of people being able to go directly to their opticians to get help with their eyes, to be referred to the hospital and to then pick up prescriptions. They can have that wonderful dialogue without going to their GP. Quite frankly, opticians are better at eyes than I am as a GP. Why has that not been rolled out across the country? What are the barriers to that happening?

Julie Mosgrove (Optometry Scotland): It has been a question of funding. There has been a shared care roll-out of the glaucoma scheme across Scotland, which has allowed us to see glaucoma patients with a low risk. We have been able to see glaucoma patients within community eye care practices.

For the anterior eye—the front of the eye—there is the eye health network in Grampian and also in Lanarkshire, as you mentioned, but that is happening only in pockets at the moment. The issue is funding. We have spoken to the Government about that. In the background, we have developed pathways that would enable us to do that more widely, but the process is being held up because of funding. If we had the funding, that would allow us to see certain conditions within community eye care practices across Scotland.

Sandesh Gulhane: My final question is for Laura Wilson. Looking specifically at our rural population, pharmacy first is a great initiative, which allows people to go and get help very quickly when they need it from somebody who is skilled and who knows what they are doing—it is really important to stress that the pharmacists involved are trained to provide such help. However, are there enough pharmacists in rural areas and is there enough time for them to be able to do that fantastic work, or is there a slight difference between what we see in the urban areas and the rural areas?

Laura Wilson (Royal Pharmaceutical Society): Yes, there is definitely a variation in the number of pharmacists that are available in remote and rural areas, as there will be with GPs, optometrists and so on.

On the provision of the pharmacy first service in rural areas, a number of issues arise, such as access to training. For a one-day training session, a pharmacist from a remote and rural area might require two days of travel. Training is very centrally located, and it is important to recognise

the impact that even just accessing that training has on people. What would be helpful for us would be support for those pharmacists to undertake that training closer to home so that they can provide those services. Once they have qualified and they are providing those services, on-going support would be good, because they can be isolated, and we want them to flourish in those roles and to provide those services.

It is a question of identifying the pockets where those services are needed and gathering data that would allow us to see where they are and are not provided. We could then target people and offer them support to undertake the training to provide those services. I know that access to records has been one of the themes; access to records would be massively helpful in expanding those services and enabling them to be used to their fullest. That would allow us to continue to provide those services and to expand them as appropriate for remote and rural communities and the population as a whole.

Carol Mochan (South Scotland) (Lab): Good morning. My question probably leads on from what Laura Wilson was talking about, as it is about the models of training for staff in the NHS. For a lot of professions across the NHS, we have a very university-based style. We have heard a lot of evidence about that and about how we encourage people in remote areas to train and stay in their own area, in order to build a workforce that cares a lot about that community.

I would be interested to hear from each witness, when it comes to their profession and the wider NHS, what models they think that we could use, or what the universities could do, to get a better balance for people.

Laura Wilson: The pharmacy course is very university orientated. At the moment, it is a science degree, not a health degree, so it is important to have university input. That degree is provided by two universities in Scotland—one in Aberdeen and one in Glasgow. People from remote and rural communities therefore do not necessarily see pharmacy as an option for them, because they would have to leave home to study it.

Support needs to be provided for people in such areas. Different models have been trialled. For example, in the Highlands, a person would be almost sponsored to attend university—their travel back and forth was paid for, so that they maintained their links with the community—but that is a high cost burden for one person, with no guarantee that they will go back at the end of their course and stay in the remote and rural community. That approach has been tried, but that cost cannot be borne for many students.

If we get people from such areas to go to university to become pharmacists, we need to think about how we maintain their links with remote and rural communities while they are at university. We need to allow them to get the experiential learning there. We must make sure that they get the experience, because if they have never experienced it, they will not know whether they like it. We also need to think about how, once they have qualified, we encourage and support them to go back to those areas and take up the places that are available.

Carol Mochan: I am sorry to interrupt, but do you have any good examples of where that has happened, or is it something that still needs to happen?

Laura Wilson: It is something that we need to look at. Different models of education could be provided. Those could involve the provision of supported travel to and from university or a completely different model that maintains the structure and integrity of the university course while also allowing the remote and rural connection to be maintained. That is important, and we would support its being looked at.

Carol Mochan: Mhairi Templeton, I do not know whether you have any examples.

Mhairi Templeton (Society of British Dental Nurses): Unfortunately, due to timescales, I have not been able to gather the information that I needed to deliver today, but it is interesting to hear all the feedback, and I am willing to take that back to the board and feed back next time.

Carol Mochan: That would be great—thank you.

Do we have any good examples of what is working in optometry?

Julie Mosgrove: Up until two years ago, Glasgow Caledonian University was the only university in Scotland that offered optometry, but in the past two years, the University of the Highlands and Islands has started an optometry course, in the hope that students will graduate and stay in the NHS Highland area and that awareness of the profession will be raised in the area. It is more of a blended programme, whereby students will come out into community eye care practices. That has not happened before.

In the United Kingdom in general, the optometry course has been completely overhauled, so that will change over the next two years. In Scotland, the idea is to embed independent prescribing, so that optometrists will come out qualified and be able to prescribe medication. That will be a blended course through both universities. At the moment, it is unclear how those placements will be supported and how that will look from a funding

point of view, but that will all change in the next couple of years.

Carol Mochan: That is lovely, thank you. I put to Dr Kennedy the same general question about models of training. I am also interested in the extra medical training places that have been provided. Was the remote and rural aspect part of the process of working out what medical training was needed?

09:30

Dr Kennedy: I will quickly declare a couple of conflicts of interests: I was born and bred in Inverness, and my wife is a lecturer at the University of the Highlands and Islands.

We do not have a medical university in the north of Scotland, and the five medical schools that we have drain people away from the area. That includes me: I trained in Edinburgh.

We know that people are more likely to work in a rural area if they are born and bred there. I am an example of that. I did not plan to go back to a rural area, but it happened.

We need to grow our own and actively recruit people from remote and rural areas of Scotland. That means getting involved with them when they are at school. An example would be to get pupils into care homes. It is good culturally to get intergenerational interactions, so it would be good to get school pupils exposed to that at a young age.

I think that you were perhaps alluding to an apprenticeship training model. The BMA does not support that, although there are pilots in parts of England that might be worth watching in the years ahead.

On your specific question around the 200 extra medical students, a senior doctor and I were talking last night about the fact that we have not managed to fill those places. For some reason, school pupils in Scotland are not choosing to go into medicine; they are choosing engineering or science degrees. We need to ask ourselves why that is.

I will give you a specific example on training, although it is not at undergraduate level. I am doing a little bit of work with the new national centre for remote and rural health and care at the moment. Three training hubs are being developed across Scotland, in GP practices, to train advanced nurse practitioners, advanced clinical pharmacists and perhaps practice nurses and healthcare assistants. One of the hubs is at my main practice in Inverness, and the others are in Stonehaven and Galashiels. That approach adopts the grow-your-own model in which people are trained where they will work.

Carol Mochan: Lovely.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I have a quick question for Dr Kennedy about the Scottish graduate entry medicine programme before I move on to my theme. ScotGEM is unique to Scotland and has been created to address rural healthcare needs. Basically, it is a graduate entry medical programme to train people who, for example, already have a degree in healthcare. My understanding is that the programme has been quite successful in Dumfries and Galloway. What is the perception of ScotGEM in your world?

Dr Kennedy: The BMA in Scotland, and colleagues more widely, have a very positive perception of ScotGEM.

I highlight another conflict of interests: my practice trained the first batch of ScotGEM students in Inverness. I can remember groups of six students coming in. We had one of our GPs freed up for a full two days every week purely to train ScotGEM students. The students are highly motivated, mature and brilliant.

One concern is whether the students come back to work in rural areas. However, ScotGEM is regarded as a success. I think that we should try to emulate the bursary that those students get for undergraduate medical students at our universities, so that they can be funded to go to rural areas, which obviously attract much greater costs.

Emma Harper: Okay—thank you.

I am interested in picking up issues to do with continuing professional development such as additional training. It is challenging if, as Laura Wilson said, you have to travel for two days to get to your place of education. Is there a role for delivering more multiprofessional CPD in rural areas directly, such as through the clinical skills managed education network's mobile skills unit? Is that something that we could look at doing better?

Laura Wilson: Yes. We would support any training that can be done more locally, that does not take pharmacists away from their practice for longer than is necessary and that allows them to build up skills.

Also, the pool of senior pharmacists who can provide peer review and support is far more diluted in remote and rural areas. It would be more than welcome if attempts were made to encourage them to take part in those things and to provide them with support and training to do so.

Emma Harper: I probably need to declare an interest, as a former clinical educator for nurses in remote and rural areas. Are there more digital opportunities for pharmacists in particular? Online learning could be the way to deliver education.

Laura Wilson: Yes, and pharmacists do a lot of online learning. For the clinical skills that Dr Kennedy mentioned, a hands-on approach is necessary, and it is vital to provide that closer to home. However, pharmacists do quite a lot of online learning through NHS Education for Scotland and other organisations such as ours. Organisations provide learning online and pharmacists undertake it, which is great because they can do it during their working day and are not taken away from their practice.

Emma Harper: Nothing beats hands-on clinical skills training, whether it is a simulation with mannequins or something else.

Education budgets are often the first to be cut, and clinical educators are then disposed of. Is there a way to take a standardised approach to certain clinical skills or methods of training so that the same course can be delivered for different professionals? I know that pharmacists, dieticians, physiotherapists and GPs have completely different roles, but is there an opportunity for some education to be standardised for multiple professionals?

Laura Wilson: Yes, there is to an extent. Certainly, when I did clinical skills training, we learned about ears, nose, eyes, chest and all those kinds of things. We have to make sure that people are going to use those clinical skills, because there is no point in training people if they are not going to use them—otherwise, they will lose them. I could not listen to a chest now, because it has been too long. A general approach would allow more people to be trained, but we would need to evaluate whether it was worth training them in everything, if it is not all applicable to their practice. However, those are always useful skills to have, and they certainly are well learned. The issue is whether people will keep up the skills and maintain that competence in the future.

Emma Harper: Is there enough time for education? I put this question to Dr Kennedy as well. Some GP practices close for half a day for continuing professional development, for all the staff in the area. Is there enough time in the day to do the education that is needed for continuing professional development?

Dr Kennedy: Unfortunately, protected learning time in general practice in Scotland has gone. The resource has been removed from NHS 24, so GPs no longer have that. Last night, I was speaking to a hospital doctor who works on Skye, and he appealed to me to ask for resource to be built into hospital doctors' contracts and GP contracts to provide continuing professional development in remote and rural areas. Clinicians in those areas require a much greater range of skills than those in the city. A far greater breadth of skills is required, but those clinicians are not funded in any way to do that.

On the remote online learning idea, a good example of where you absolutely need to be in the room or in the field is basics training, or pre-hospital emergency care training. That involves doctors and nurses from across primary and secondary care—it is multidisciplinary learning. Some of that can be done online as well, so there is a mixed approach.

However, rural doctors tell me, "Please don't have us doing remote consultations with our patients and remote learning—remote everything is not the solution." There is nothing like seeing patients and your colleagues face to face.

Julie Mosgrove: To add to what colleagues have said about training, when you are working in a remote and rural area, it can be very isolating and difficult. Once healthcare professionals have qualified, as well as needing on-going support while living in such areas, by working together, they can learn from and support each other in that.

Another point, which one of my colleagues touched on, is that we need to have face-to-face placements available in hospitals in rural locations to be able to upskill the professionals who work there.

Emma Harper: Thank you.

Ruth Maguire (Cunninghame South) (SNP): My question is about multidisciplinary team work. It would be helpful for the committee to understand how well multi—it is a very hard word to say this early in the morning—multidisciplinary team working is being implemented. Do you have examples of where that has worked well, or of where there have been challenges, that would help our understanding? Laura Wilson, you are nodding, so I will come to you first.

Laura Wilson: The pharmacotherapy service that Dr Kennedy alluded to is a good example of pharmacists and pharmacy technicians becoming embedded in a multidisciplinary team. We had a fantastic example of a pharmacist and a pharmacy technician who, by working with a patient's usual prescriber, reduced a patient from being on six or seven medicines, housebound and unable to take part in any social activities to now appearing as Santa at a local children's hospital, after undergoing a polypharmacy review. That began with the pharmacy technician, who referred the patient to the pharmacist for on-going support and consideration of his medicines. By working with his usual prescriber within the practice, they were able to completely change the patient's life.

Ruth Maguire: Did that happen because they were located in the same place or because of a differently structured way of working?

Laura Wilson: They had well-defined roles, a good mix of skills and an understanding of each team member's role and of how they were going to interact. They worked well together. Each one knew their own limitations and was able to call on the support and help of someone else within the team. It was a collective effort.

Ruth Maguire: Were they literally in the same building, or were they part of a virtual team?

Laura Wilson: They were together most of the time. The pharmacy technician covered two sites. The pharmacist worked for one practice and the GP prescriber was there too. They were not always physically together, but they spent more time together than was usual in the past.

Ruth Maguire: Iain Kennedy do you have anything to add?

Dr Kennedy: If you say MDTs, as I am going to do, that is far easier than saying multidisciplinary teams.

Ruth Maguire: Okay.

Dr Kennedy: I have quite a lot to say about MDTs. They are crucial in remote and rural areas, where sharing a common purpose and having good relationships makes a good team.

I am told that it is sometimes possible to recruit MDTs but difficult to retain them, because of issues with housing, childcare and schooling. We spoke about the 2018 GP contract, the whole idea of which was to deliver MDTs to GP practices across Scotland. That has not been implemented and it did not work well for rural areas because the resources simply did not provide the number of MDT staff required. Lots of practices in the Highlands have very few pharmacists, mental health nurses, physios or other staff in additional roles.

My own practice in Inverness is a good example, although it is not quite rural.

Ruth Maguire: I was going to ask you about that, because you described Inverness as rural and I was not really sure about that.

Dr Kennedy: My own practice is not really rural, but I can use it as an example. We have four practices, two of which are rural. We have a training hub for the MDT and then team members go out to Cromarty and Foyers. There are also training hubs in Stonehaven and Galashiels. NHS Education Scotland is very much behind the idea that the whole purpose of those hubs is to build multidisciplinary teams within the workplace.

That is the way ahead. We must incentivise MDTs—not just doctors but the whole team—to live and work in rural areas. That might require adding 20 per cent to their pay, so that we can get those people in and so that they will stay.

Ruth Maguire: I will come back to talk about housing and other structural issues.

Two weeks ago, Derek Laidler from the Chartered Society of Physiotherapy told the committee about the challenges of being located in general practices and reported that there was some pushback from GPs about hosting people physically in their premises. Will you tell us a bit more about what your members say? Why might that be the case? What are the difficulties?

09:45

Dr Kennedy: It is very much about space and rooms. If there are not enough rooms, there is an opportunity cost to having a physio or a mental health nurse in a room that a GP might need.

Sadly, over the past two decades, we have invested very little in primary care premises. The focus has been on hospitals. In Scotland, as is the case in most western countries—the issue is not unique to Scotland—the quality of the primary care estate has gone down. General practices in Scotland simply do not have the necessary number of rooms to accommodate MD teams. I am lucky that my practice was extended recently, so I can fit people in, but many of our smaller rural practices struggle with space.

Ruth Maguire: In the Ayrshire constituency that I represent, one general practice in an urban setting has co-located in a community hub. The staff are not there all the time, but they go in and out. Could such a model work for multidisciplinary teams in rural areas?

Dr Kennedy: I have probably worked in about 30 rural practices in Scotland. I am trying to picture all the village halls, some of which were quite close to the practice, but I cannot really visualise that sort of accommodation. I do not think that it exists.

Ruth Maguire: The community hub was a new build. When we look at renewing community facilities, is there an opportunity to consider wider needs?

Dr Kennedy: Absolutely. The model that you have described sounds very attractive. The way forward involves increased accommodation and co-working with the community.

Ruth Maguire: Does Mhairi Templeton have anything to add?

Mhairi Templeton: Not specifically—I would need to ask for feedback in order to get more answers.

Ruth Maguire: Okay. Does Julie Mosgrove want to come in on the issue of multidisciplinary teams?

Julie Mosgrove: I have nothing specific to add.

Ruth Maguire: Do you want me to leave my next questions until later, convener?

The Convener: Thank you. Sandesh Gulhane has a supplementary question.

Sandesh Gulhane: I have a couple of very quick questions. MDTs include not only our physios and pharmacists but people who work in schools, for example. I recently worked in NHS Fife, and children in schools there cannot be given basic medication such as Calpol unless a GP has prescribed it. Dr Kennedy, how is that helping our primary care services?

Dr Kennedy: I have not come across that issue personally, nor have I heard members mention it recently, although it has been a feature in the past. I think that most GPs in Scotland would push back if they were asked to do that. I would be concerned about that, and BMA Scotland would certainly be willing to take up the matter if you gave us more details.

Sandesh Gulhane: The Fife local medical committee said that that was the case and that it had been struggling for a year to get schools to change their minds.

My second question also relates to NHS Fife. Those of us who work in primary care want to try to keep people out of hospital—I love to be able to do that as much as possible. In NHS Fife, people who work in primary care are not able to order pretty routine tests, such as a brain natriuretic peptide test for heart failure. Why are there such differences across the piece? There are some basic things that we can do, and I do not understand why it can be said that it is not acceptable for someone who is trained to order an examination that will keep someone out of hospital.

Dr Kennedy: A BNP test—which, as you know, is a test for heart failure that can be done in the community—can be done in my practice in NHS Highland, so I am not sure why it is not possible to do that in Fife. We want to minimise that sort of variation. Following the GP contract, NHS Fife was relatively well resourced compared with health boards that cover remote and rural areas, but Fife is one of the areas in Scotland that is really struggling to recruit GPs, so there are particular pressures there—that is for sure.

Emma Harper: I have a quick question for Dr Kennedy about the NHS Scotland resource allocation committee—NRAC—formula. I was at the NHS Borders update on Friday, and Ralph Roberts, the chief executive, was talking about how the NRAC formula works for the funding of remote and rural areas. Do you think that the NRAC formula needs to be revised or altered in any way?

Dr Kennedy: None of those formulas, including NRAC, is perfect. For the GP contract, the Scottish workforce allocation formula certainly had its flaws. We need to examine those formulas, and we need to look at the data as it is now. We know that, in remote and rural areas, we attract the older patients in the population, as they tend to go out to rural areas. There is therefore much greater frailty in those areas, with all the comorbidities that go with age. The formulas need to be rural proof, but none of them is. They tend to be suited for urban areas.

One of my colleagues from NHS Grampian often talks about “geographical narcissism” and “urbansplaining”, which are international academic terms describing how people in cities tell people in rural areas what is good for them. We have to stop doing that, and we must dig deep into the data in remote and rural areas, ensuring that formulas are fit for purpose or that some kind of adjustment is made once the formula is applied.

Gillian Mackay (Central Scotland) (Green): Good morning. What benefits could be realised in remote and rural areas from having improved sharing of information technology systems such as electronic prescribing, single patient records and more joined-up access to patient information?

Laura Wilson: We have long advocated for access to patient data, particularly for community pharmacists. As we mentioned earlier, we could expand pharmacy first plus and pharmacy first services, creating far greater equity of access to treatments that are available in the community, rather than having to identify them, with patients—particularly those in remote and rural areas—having to travel long distances to their GP to get treatment that it would be appropriate for a pharmacist to provide. Single shared patient data would be transformative for the whole of community pharmacy, particularly in remote and rural areas, where it would prevent a lot of unnecessary travel for patients and would allow them to access care closer to home.

Dr Kennedy: The electronic patient record is reasonable in primary care in Scotland, although our systems are quite out of date—they need to be updated. In secondary care and in hospitals, there is no electronic patient record. Having such a record would offer a huge improvement, particularly for clinical governance and learning. There is a big gap there.

SystmOne is used in England, and it has been very successful, but I understand that we cannot afford it in Scotland. An electronic patient record is a must, however. We should have had it decades ago; it would certainly improve patient safety and

the patient journey, and it would absolutely improve clinical governance.

Gillian Mackay: Do colleagues online have any thoughts?

Julie Mosgrove: To reiterate what has already been said, it is a matter of getting a lot of information. In prescribing medication to patients, we need to understand their general health conditions, what medications they have and any complications. As colleagues have already said, it is also about safety and the amount of time that it takes to get information, which can hold up the process for the patient and the clinician. There is a need to improve the patient journey, safety and governance.

Gillian Mackay: Are there specific data gaps in the information that is available in relation to rural health services? If so, what are they, how do we make things better and what impact do those gaps have on service planning?

Dr Kennedy: There are huge data gaps. The lack of data is probably one of our greatest infrastructure problems in Scotland. We need data on our patients, their comorbidities and their health needs, and we must do proper needs assessments for our remote and rural populations. However, we also have an absence of data on workforce. The ageing demographic affects not only patients but the workforce, generally as regards people aged over 50.

Gillian Mackay: Laura Wilson is nodding, so I will come to her next.

Laura Wilson: In pharmacy, we need data on where our students come from and where they go back to. We need to know where the gaps are so that we can try to plug them and find solutions. We do not have workforce planning for pharmacy in the way that we do for medics and nurses, so we do not know what the gaps are. If we do not know that, we then struggle to get the right number of people in the right places.

Every year, we train hundreds of pharmacists, and the workforce plan contained a commitment to provide additional funding to do so, but we are still short by about 70 places. We therefore train 70 people in Scotland who gain experience in remote and rural areas, have the chance to go and see those places, and then leave—more than likely to go to England or Wales—to practise and do their foundation year. We need the basic data on workforce, and we also need the patient data to be accessible.

Gillian Mackay: I put the same question to Julie Mosgrove.

Julie Mosgrove: We have very much the same challenges. There is definitely a lack of information on workforce, work patterns, behaviour, planning for the future, the students that are coming through, how many optometrists we need across Scotland, and also patient information. Many different systems are being used, but not all of them talk to one other. Therefore, although there is a lot of information out there, it is not easily shared among the different professions.

Gillian Mackay: Thank you, convener.

The Convener: Can I come back to Dr Kennedy on one point? I might have misheard you when you were talking about electronic patient records, but what about the EMIS system?

Dr Kennedy: EMIS is one of the systems that is used in primary care in Scotland. In Practice Systems Ltd's Vision is the more commonly used one, but EMIS is used purely in general practice and not in hospitals.

The Convener: No, it is not. Here I should declare an interest as a registered mental health nurse. I was using EMIS on Friday in a community addiction team, so I can say that it is used in other parts of the NHS. I am pretty sure that it is used in mental health in-patient services, too.

Dr Kennedy: Thank you for educating me. That system is not used in Highland so I am not familiar with it in that context.

The Convener: I just wanted to clarify that.

Paul Sweeney: Dr Kennedy mentioned SystmOne, which is used in England. Of course, there are constraints that you described as financial. I have been in contact with GPs in my area in Glasgow who described any improvement to services or deployment of new technology being constrained by a practice's capacity to take itself offline to deliver any new system or to train staff. Do you see such constraints as being an issue in rural settings as well?

Dr Kennedy: Yes, absolutely. In my career, I can remember there being two IT changes, which were hectic, chaotic and stressful. Putting in the software and the infrastructure is often done at weekends. If that can be done, it always helps. However, practices and hospitals in Scotland could do with a lot of support the next time a major change happens such as learning a new system.

Paul Sweeney: What support would be practical and useful? It might be hard to describe it precisely, but in general, what additional resource could be supplied by health boards or by the Government directly?

Dr Kennedy: The issues are all the things that would happen with any change management project. IT systems tend to land on our desks literally on the day, and we have to get on with it. However, we do not introduce changes in that way for anything else that we do. We would normally

have preparation, planning and support throughout. There should also be on-going support in the form of people being either physically in the building or quickly accessible online to help when glitches occur. However, I agree that we need to invest in that area.

Paul Sweeney: Are there any supplementary points on that?

10:00

Laura Wilson: Yes. Pharmacy systems can change, but, in the community, a change is usually implemented by the contractor. As Dr Kennedy has said, support is usually provided to do that. If it is planned for, it is usually manageable, and if it is for the better, teams will work through it.

Paul Sweeney: Is there a feedback loop whereby practitioners describe a problem and a solution is developed and co-designed with them, or are changes dumped on you and you just have to deal with the adaptation?

Laura Wilson: It is probably different for community pharmacy because independent contractors decide themselves what system to use, then implement it. There is usually a conscious decision to go with a different system and they undertake the change themselves. It is not usually a block change as such.

Paul Sweeney: If there is fragmentation, does that introduce problems with interactions with other healthcare services?

Laura Wilson: There is no interaction with community pharmacy systems and other healthcare systems, including IT systems.

Paul Sweeney: If there were to be a desire to integrate in the future, would it be challenging because of the fragmentation?

Laura Wilson: Yes. One of the challenges is the interoperability of the systems and the variety of systems that are out there.

The Convener: We move to Tess White, who is joining us remotely.

Tess White (North East Scotland) (Con): Dr Kennedy, you raised the issue of the closure of care homes. You said:

> "The closure of care homes and the ongoing recruitment struggles in the care sector have created a crisis."

You gave the example of Broadford hospital, which was left in limbo. In Aberdeenshire, the closure of smaller care homes in rural areas causes a huge issue with delayed discharges. Will you say a bit more about that, please?

Dr Kennedy: I am trying to recall the quote that you gave there. Perhaps it is something that has gone out via BMA Scotland in advance of today's meeting.

I am certainly aware of care homes closing across Scotland, which is a huge concern, as is the whole of social care. Recently, at the Scottish GP conference, the cabinet secretary set out his vision of, first, the patient, then social care, then primary care and then secondary care. That is a good model. Obviously, care homes are very much part of social care, so, given the ageing population, it hugely concerns me when I hear about care homes closing across Scotland. It is an issue in rural areas. I mentioned my practice in Cromarty earlier; the one and only care home in Cromarty closed last year.

Tess White: In relation to the location of clinics, could you talk about the difficult balance to be struck between having the economies of scale that arise from centralisation in high-population areas and trying to deliver for rural areas?

Dr Kennedy: Yes. In Scotland, we have a completely unique geography with a very dispersed population and not enough hospital consultants to work in all those areas, so we have some decisions to make. Should consultants travel out to Orkney, Shetland, the Isle of Skye, Fort William or wherever and therefore spend 30 per cent of their paid time on the road not seeing patients, or should we have them working in the centres but seeing patients remotely on NHS Near Me or by telephone? At the moment, we probably have a mix, and I think that some patients really appreciate remote consulting and being able to avoid those 100-mile journeys to see specialists.

However, there are huge concerns coming from primary care that patients are often being seen on screen by the consultant and are then being told to go and see their GP, because a particular examination needs to be done or because something gets picked up that needs to be addressed the same day. However, it is inevitable that we will need to provide a variety of methods from face-to-face clinics to the use of technology.

Tess White: Thank you. Convener, would you like me to cover demographic challenges now?

The Convener: I have a quick supplementary and then I will come back to you, Tess.

My question is specifically for Mhairi Templeton. I am keen to hear about some of the issues in dental health. We have heard a lot in other sessions about the impact of travel time on accessing services. What is the impact of that on people accessing dental health services in remote and rural areas and what impact might it have on health inequalities?

Mhairi Templeton: One thing that I can say is that there are no consultants in orthodontics down

at the Borders general hospital, and because of that, a group of us travel down at the weekends to do the clinics on Saturdays and Sundays. We are taking time out of our personal lives to travel down there and to try to get through all the clinics. We are doing a good job in that respect, but we do not know when there will be a consultant to continue with that care.

Having worked with NHS Borders prior to coming to NHS Lothian, I know that you have to cover a great area to get to Kelso, Coldstream and Galashiels. I was spending a lot of time getting to those clinics, and the patients would have to travel, too. Also, if they needed an emergency appointment and you could only offer them an appointment with a general practitioner in Eyemouth so that they could get seen, they could, if they were coming from, for example, Hawick or Peebles, spend the whole day travelling. Because some of them did not drive, they had to access buses, trains and taxis, but some could not afford to do that. I do not know whether the solution is as easy as getting more dentists down to rural areas such as the Borders.

The Convener: Does that have an impact on existing health inequalities with regard to oral health?

Mhairi Templeton: For dentistry, I think so, because we cannot get NHS patients seen by our public dental service and general dental practitioner practices.

The Convener: I will hand back to Tess White.

Tess White: Thank you, convener.

Dr Kennedy, we know that patient numbers in remote and rural areas can change significantly. The RPS has said that when cruise ships come into ports, the population can go up by as much as a third. You are based in Inverness, and I have been highlighting the example of Braemar. How is the impact of tourism taken into account in funding and workforce planning?

Dr Kennedy: It is not really taken into account at all. Invergordon gets 100 cruise ships a year, I think, and places such as the Isle of Skye, because of certain TV programmes, get lots of tourists from across the world. It is very difficult to get moving in parts of Skye in the summer.

I know from doing locums in rural areas that the summer months are extremely busy, with a lot of road traffic collisions. That is one of the things about rural areas: as a doctor, you get involved in everything, as do other healthcare professionals. It is scary work; indeed, we know from research that a lot of city doctors do not go to rural areas, because it is quite frightening and the skill set that you require is massive.

Therefore, the busiest times of the year in remote and rural areas are often the summer months, when the tourists are there. Whether they come from a UK city or from abroad, tourists have no idea about the difficulty of providing healthcare in remote and rural areas, and they expect the same immediacy of service that they are used to in their own areas. The situation is very demanding and, other than having the provisions for temporary residents, we do not do much at all to take account of the excess numbers of patients and the fluctuation that occurs in the summer months in particular.

Tess White: That was helpful.

My second question is different and relates to the ageing population.

The Convener: Tess—

Tess White: Earlier, you talked about there being much greater frailty. You know of the example from the Highlands and Islands, and from Inverness, in particular, and I would also highlight the fact that, in Aberdeenshire, the ageing population will be increasing by around 28 per cent over the next seven years. That is huge. The question is: how will such steep increases be factored into budgets, forecasting and workforce planning?

The Convener: Tess, I think that Julie Mosgrove wanted to come in earlier.

Julie Mosgrove: I am sorry, but going back to the previous question, on tourist areas, I would point out that an increase in tourism can also have an impact on accommodation. We are trying to get clinicians to areas where accommodation can be difficult to find and where hotels and bed and breakfasts can be very expensive. Sometimes it can be hard just to get a clinician into a remote and rural area.

Tess White: Wow! Thank you, Julie. It is good to hear you reinforce that point, because it is something that is coming across loud and clear in the inquiry.

To go back to the ageing population, Dr Kennedy, I highlighted the whopping figure of 28 per cent. Have you any thoughts on that? Is it just a crisis waiting to happen?

Dr Kennedy: We knew that it was going to happen, and we have not prepared for it.

You mentioned the Grampian area. My members in Grampian, particularly in general practice, have expressed serious concerns. Of course, we have a lot of rural GP practices in the Grampian area, but we are also hearing concerns about vacancies from doctors in the hospitals there.

Primary care doctors in Grampian are calling for direct investment in GP practices. The resource for delivering the MDTs that were meant to have been provided under the GP contract has not been used and the GPs in Grampian are asking—pleading—for it. I think that £10 million should have come their way but it has not done so. The GPs in Grampian are pleading for that resource to be directly invested in their GP practices. It is by investing in primary care that we will address the issue of the ageing population. By the time patients get to hospital, it is too late; we then run into difficulties with getting patients out of hospital, because of our problems with social care.

Of course, for an ageing population, social care provision is probably more important than healthcare. That will come down to resource. We have to pay our social carers a decent wage—it might be £15 an hour—so that we get the social carers that we need to look after our frailer patients. I should also point out that there is an ageing demographic not just among our patients but among the workforce, too. That is of huge concern to the BMA in Scotland.

Tess White: You have covered a couple of themes, and I will drill down into them.

One GP in a practice in Aberdeen told me that they have to hand money back, because they cannot recruit people into the multidisciplinary teams, but they need that funding to provide GP cover. They talked about an imbalance in the formula that you described earlier. Does the Scottish Government need to look again at that formula to ensure that it addresses the needs that GPs talk about?

Dr Kennedy: Yes. As I have said, all formulae are flawed, and there is no doubt that the Scottish workforce allocation formula was flawed, too. The situation that you have described with regard to the inability to provide the MDT team is what I was alluding to. Obviously, the GPs who are appealing to you are having to do the work that would have been done by the MDT teams, but they are not being given the resource. The resource is there, but we need to rethink and maybe move on that issue, so that we can make greater healthcare provision in general practices in areas such as Grampian.

10:15

Tess White: Finally, you have used the phrase "geographic narcissism", which I have not heard before. Do you want to say a couple more words about it? It is quite a loaded term.

Dr Kennedy: It was a new one to me, too, on 1 December, when I first heard it mentioned by Dr Samantha Fenwick, the LMC medical director in Grampian. She was speaking to all the GPs across Scotland, and she made quite a challenging statement about geographical narcissism, which is often called urban narcissism.

You have also heard me use the phrase "urbansplaining". It is what happens when professionals—not just healthcare professionals—say to rural professionals, "When are you coming back to the city?", as if going out to a rural area would be something that a professional would do only on a temporary basis. I have also been aware of people who have never worked in rural areas telling those of us who do how things should be done. It is something that is known internationally—geographical narcissism is part of the human condition.

Tess White: Thank you, Dr Kennedy.

Ruth Maguire: We have been talking about sustaining the MDTs and the wider infrastructure challenges in that respect and, in the inquiry, we have been hearing quite a lot about the specific issue of housing. Previous panels have given us some examples. When nurses on the Isle of Bute were doing their training, workarounds were found with hotels or colleagues providing digs, such as spare rooms; obviously, though, that is not a long-term solution, and it is not likely to attract qualified professionals.

Iain Kennedy, I notice that you were previously with NHS Highland. Are the health board and the local authority having conversations about what a whole-system fix might look like? Are there examples of more sustainable solutions to the issue of housing? I know that the college on the Isle of Skye provided land to a housing association, which shows that the shortage of housing affects not just medical staff but everyone across the board. If discussions have been had on housing, have there been any ideas for solutions?

Dr Kennedy: I was a non-executive director of NHS Highland from 2011 to 2014, so it was a wee while ago, but I have spoken very recently to doctors on the Isle of Skye and rural doctors across Scotland about housing, and the message that they have given me is quite clear: we need to invest in permanent healthcare staff.

The housing problem is not some temporary rent issue; the question is whether people can go in and buy a house. I make it absolutely clear that this will require paying healthcare professionals, whether they be doctors, midwives, pharmacists or physios, a decent wage so that they can afford to buy a house and live permanently in remote and rural areas.

Ruth Maguire: I just want to press you a little bit on that. We have heard that some of the challenge is to do with the availability of housing. I appreciate that affordability might be an issue for individuals, too, but this is literally about the supply

of housing across the country in rural areas. I have to say, though, that Skye is an area I am familiar with.

Dr Kennedy: Availability is often cited, and Airbnb and holiday homes are mentioned as the reasons for those houses not being available or affordable.

I have been asked to continually mention the importance of continuity. We know that the best outcome for patients occurs when they get continuity with a healthcare professional and that seeing the same healthcare professional will do more for the health of patients in remote and rural Scotland than anything else. The evidence of that is largely there with regard to seeing the same GP, so we need continuity of care with the remote and rural GPs in Scotland. That will mean attracting GPs and resourcing them so that they can move with their families and stay in the area for a generation.

Ruth Maguire: Do you and your members feel that there is a place for health boards, local authorities and the Government to work together to provide that infrastructure and housing, or to find solutions to how they get built?

Dr Kennedy: I am thinking about the times I have worked across remote and rural areas. Sometimes I would stay in health board accommodation next to a practice, or even within the practice. It is not the most attractive thing to think of doing over the long term. I suspect that health boards and local authorities could not afford to do that now, and even if they could, I do not think that it would attract individual healthcare professionals to move there with their families on a long-term basis.

Ruth Maguire: That is interesting, but we might be thinking about different things. I am thinking about the land that some health boards have and which is not being used. Are there solutions for how boards might dispense with it—and not necessarily for the type of health accommodation that you have described? You have given us an image of some hostel-type thing that might not be attractive to permanent workers. Just to be clear, you are saying that you did not have that kind of whole-system housing and that childcare was not mentioned in your conversations with the board.

Dr Kennedy: It was mentioned often. The issues that we are discussing today have been discussed for decades.

Ruth Maguire: Yes, but are there solutions to them? Do health boards have a part to play in getting to those solutions?

Dr Kennedy: Again, the solutions that we are talking about are similar, but it often comes back to investing in healthcare professionals and giving them the necessary resources to commit to an area for the long term.

Ruth Maguire: Does anyone else have anything to add?

Laura Wilson: We have certainly heard more about the cost of things from pharmacists. I know of somebody who was going to work in a remote and rural area, but when they found out that the rent was somewhere between £800 to £1,000 a month, they declined.

The challenges definitely exist. We talk about London weighting and using that to offset the cost of additional accommodation as well as the additional costs of accommodation but, from what we are being told, we are now seeing the same thing happening in remote and rural areas. As Dr Kennedy has said, it forces a challenge on everyone to try to address it.

Ruth Maguire: Okay. Thank you.

Emma Harper: There are also challenges facing dentistry in remote and rural areas. For a start, there is a crisis with the lack of dentists in Dumfries and Galloway. Is there a role for dental nurses to step in at some level to support good oral hygiene, especially in children and young people? Childsmile has been quite a success, but is there a role for dental nurses to help support people through our dental crisis?

Mhairi Templeton: We have a lot of extended duties courses that we can put the dental nurses through, from radiography to impression taking and photography, to try to take the pressure off dentists. However, they are pretty expensive—they are usually set at around £1,000. Can each person afford to pay that themselves, or does the NHS fund it for them? I am not too sure. I self-funded my radiography course, because the general practice that I was in could not afford to pay for it.

Now that I am in the British Dental Institute, I am not able to use my skill set as I would like to, because radiographers come in to us from NHS Lothian. I feel that I will lose my skill set in radiography, but we have a lot of extended duties that dental nurses can carry out. It is about finding the time to put the nurses through the courses. A lot of it is about time and whether we have enough nurses to cover clinics with the dentists. If we had enough trained nurses, I am sure that we could try to take the pressure off any orthodontic needs in general practice or the public dental service.

Emma Harper: Dental nurse work is taking place in a range of locations. It could happen at an NHS hospital—indeed, you mentioned Borders general earlier—as well as in dental practices, so there is a wide range of opportunities to implement those skills. Is that right?

Mhairi Templeton: Yes. I trained in general practice, having left school after sixth year. A lot of dental nurses train after school, or as a second career, and some go on to do dental therapy and oral health science at universities across Scotland or down south.

The Convener: I thank the committee witnesses for attending today. Just for clarity, and to put it on the record, I must declare an interest: I hold a bank nurse contract with NHS Greater Glasgow and Clyde.

We will briefly suspend while we change panels.

10:26

Meeting suspended.

10:40

On resuming—

Scottish Football Association

The Convener: Agenda item 3 is an evidence-taking session with the Scottish Football Association. I welcome to the meeting Ian Maxwell, the organisations' chief executive.

We will move straight to questions. I call Sandesh Gulhane.

Sandesh Gulhane: Thank you, convener, and I should first declare an interest as a former club doctor for Queen's Park Football Club.

I want to start with transparency, if I may. Look: all fans, regardless of whom they support, think that there is a conspiracy against their club. That is just the way of it. However, with the introduction of video assistant referees—or VAR—there seems to be huge uncertainty about what is happening. Fans in the stadium do not know what is going on, and those watching at home are never overly sure of what is happening, what counts and what does not count. Obviously, I have to be very careful, given that my party leader is a referee, but, for the average fan, there does not seem to be transparency in the game when it comes to decision making and the way that the game is going. How would you respond to that?

Ian Maxwell (Scottish Football Association): I would not agree that it is a transparency point; I think that it is an education point involving educating supporters about VAR and how it works. VAR is still in its infancy in Scotland; this is only the second season that we have had it. The Scottish FA sits on the International Football Association Board, which is responsible for the laws of the game, and at a meeting last month, we talked about how we can improve the interaction between supporters in the stadium and supporters at home in terms of VAR and any decisions that are made. I fully appreciate that there is nothing worse than sitting in a stadium and being unaware of what is being checked or why.

Until recently, there was no opportunity under the laws for decisions to be broadcast in stadiums. However, such an approach was recently trialled by FIFA in the club world cup. In that trial, which can be rolled out to any competition that wants to put it in place, match officials were linked to the public address system and could speak to what the decision had been and why it had been made. For example, if checks were made and there were a change of decision to a penalty, because of a handball, they would announce, "VAR check—penalty decision because of handball", and that would give the supporters in the stadium more of an understanding of what was happening. After all,

football is a spectator sport, and the last thing that you need is for those in the stadium not to know what is going on. That uncertainty does not help anybody. It is therefore more of a point of process than a transparency point.

Sandesh Gulhane: You say that it is an education point. In England, you can see the decisions being discussed with a referee, but you do not get the same in Scotland. Is that something that the SFA is actively stopping or is it just—

Ian Maxwell: It is not something that we are actively stopping; it is more something that we have not started yet. It is worth remembering that VAR has been in place in England for seven years now, and they are having problems with it from the point of view of decisions. Arguably, they have had more problems with it than anybody—certainly a lot more than we have had.

We are on a journey with VAR with regard to transparency, understanding, efficiency of decision making and all of those things. It is something that is under review, but we are not quite there yet in terms of the journey that Scottish football is on. It is a big step to take. I can understand why it has been done in England, but as I have said, they have been doing it for a lot longer and the match officials are more experienced. It is something that we will continue to monitor.

Sandesh Gulhane: Turning to regulation, I am sure that you know the research that has been carried out by the University of Edinburgh. According to that, only 12.9 per cent of supporters believe that the SFA does a good job for the Scottish game and 11.1 per cent believe that the current governance structure in the Scottish game is sustainable. How do you respond to those figures?

Ian Maxwell: Anybody in any sort of governance role knows how difficult it is. Everybody has an opinion; everybody feels that they can do it better; and everybody thinks that things should be different. From a Scottish FA perspective, we think that the governance in the game is robust.

That is an interesting statistic that you have pointed out. Our statistics are based on a UEFA study, which highlights the fact that there is a real misunderstanding about what the Scottish Football Association does as an organisation. Of those who understand what the organisation does, about 80 per cent feel that we are doing a good job. There is an educational piece of work for us to do to ensure that football supporters know what we do as an association, what we are about and the difference that we make to communities—

Sandesh Gulhane: Forgive me, Ian, but how long has the SFA been around?

Ian Maxwell: We have been around for 150 years—you were at the anniversary.

10:45

Sandesh Gulhane: Indeed.

So, in 150 years, the SFA has not let people know what its function is.

Ian Maxwell: We have let people know what its function is. Football fans concentrate on their team and what is happening on the pitch. There is less awareness of, and desire to understand, what a football association does. Since football began, there has been a narrative that referees get decisions wrong and all the things that we all talk about regularly.

We want to talk about the good work that the association does, the huge amount of work that our clubs do, the impact that we have on communities and the way that football can save and transform lives. That is the message that we need to spread as an association. Today, it would be great to talk about that and how we can help the committee and the Government to move forward on all those areas.

Sandesh Gulhane: Yes, absolutely. My colleagues will certainly come to those topics.

Recently, we saw a very sad case in England, when one of the Luton Town Football Club players had a cardiac event on the pitch. We have seen such events on multiple occasions. What does the SFA have in place to ensure that we try to prevent those things from happening but also to reassure people that, if something were to happen here in Scotland, we have robust processes in place?

Ian Maxwell: Scottish Professional Football League players have a cardiograph—I cannot remember the technical term, but I can find out and write back to you. However, medical checks are carried out when players are signed, and I think that those are done every three years. Those check for heart irregularities or anything like that. Obviously, players undergo very strict medicals when they sign for any football club. Let me take that question away. I will come back to you with the detail on the provisions that we have in place, but medical checks are done from a health perspective to make sure that the players are fit.

Sandesh Gulhane: Thank you. We would really appreciate that information.

A massive 96.2 per cent of people felt that independent regulation would be a positive step for Scottish football. There are other figures on that that are up in the 90s. That view is overwhelming on the part of supporters because you are right that everyone concentrates on their club. Therefore, from your point of view, why

should we not look at implementing independent regulation?

Ian Maxwell: The idea of an independent regulator down south has had a high profile. That was born out of four different incidents. One was the potential breakaway for the European super league and the fact that English Premier League clubs were being courted for that; another one was the financial failings of clubs down south that had gone into administration, with Bury, Derby County, Macclesfield Town and a number of other clubs facing issues; one was the impact of Covid on football clubs and their ability to withstand that financial pressure, given the extreme financial pressure that football was under generally; and one was the changes that club owners had made, with, for example, Hull City and Cardiff City changing club badges and colours and making decisions that they had not engaged with their supporters on. None of those elements is relevant for Scotland.

The idea of an independent regulator is a difficult issue. Geographically, we are next to the biggest footballing superpower in the world—the English Premier League. People think that, because something happens in England, it should happen in Scotland. They think that only because we are next door. In Scotland, we have had nothing like any of those four issues that I just outlined. Our governance procedures are robust. Everybody has a different view and everybody thinks that it could be better. Anyone in any sort of governance role knows how difficult governing is, in any shape or form.

The review in England was led by an independent MP. There was engagement with every stakeholder in English football. One thousand hours of evidence were taken; it was a thorough and robust approach. The fan-led review that was published in Scotland was written by one supporters' association that did not even engage with the other supporters' associations in Scotland. It was very much the view of a couple of individuals about what was appropriate for Scottish football. We do not see that in the same way.

The idea of an independent regulator has had little coverage, there has been little clamour for it and little interest in the media. That tells you that, although we can improve, and always look to do so, the process in Scotland is fit for purpose.

The Convener: Sandesh Gulhane touched on VAR. How many female VAR officials are there?

Ian Maxwell: I can double check that and come back to you. I am not sure. I do not think that we have any female category 1 referees in Scotland at this time, but it is definitely a key area for us. With the growth and development of the women's game, we want more female players, and we want more female coaches and referees. We are working hard—

The Convener: We will come on to some of that later on as we develop themes.

Gillian Mackay: Project Brave was implemented around six years ago, refreshing a previous strategy. Does the SFA plan to undertake an evaluation of the successes, failures and perceptions of project brave?

Ian Maxwell: That is constantly being evaluated. We should stop talking about project brave, because it was a project at a specific time; it was the name given to the changes that were made to the youth development system, and we now have club academy Scotland and the player development pathway. The approach is constantly being assessed, changed and tweaked. Player development is obviously a key area for the SFA, because we want better Scottish players, and we want the Scottish players that we are developing to be as good as they can be. Clubs want to develop the best players possible.

Gillian Mackay: What work is being done to support smaller teams to ensure that they can nurture local talent and give young people a positive place to play? I raise that because, in the past few years, some smaller clubs—Livingston Football Club and Greenock Morton Football Club were just two of them—decided to scrap their youth systems altogether because of some of the criteria behind Project Brave. What is being done to ensure that those clubs get the support that they need?

Ian Maxwell: The club academy Scotland programme is tiered to allow every club in Scotland to find its place in that landscape. We have an elite tier, and it goes right down to advanced youth and community. Livingston, interestingly, is now part of club academy Scotland.

Whether youth development is a key priority for clubs is a club decision; it is not for us to force clubs to develop players. The club needs to want to do it and have the resources available to do it, but the club academy structure allows clubs at every level to find their place in the club academy landscape.

Gillian Mackay: Who makes the decision on where those clubs come into that structure?

Ian Maxwell: That would be for the club to decide. The club could determine which level it wanted to apply for, and it would go through the process with us. Provided that it meets the criteria, there is no reason to think that it would not be accepted at whichever level it wanted to enter.

The Convener: Tess White joins us remotely.

Tess White: Do JD performance schools effectively prepare children for a life outside football, should they be released from their academies?

Ian Maxwell: Obviously, the kids are being educated as part of that school experience. It is, in effect, the standard school experience but with football aligned to it, so that they get more opportunity to participate in football and enhance their footballing ability. It is not a question whether the JD performance schools prepare them for life after that. They are being prepared because they go through the standard school curriculum, as any other child does.

Tess White: Can you outline what support systems are in place to safeguard mental health and wellbeing?

Ian Maxwell: Our child wellbeing and protection team engages regularly with the kids who participate in the JD performance schools. When they go back to their clubs, they can engage with the child wellbeing and protection officers at their clubs. All SFA member clubs have a designated child wellbeing and protection officer. I can come back to you with further detail on exactly what provisions are in place, but we are very aware that mental health is a challenge across society at the moment. We are doing as much as we can to help kids, players and anybody in the football family who needs such support.

Tess White: I am aware that the SPFL Trust runs mental health training for all SPFL clubs, but there is a view that more needs to be done. Do you monitor how many people a year go through that mental health training?

Ian Maxwell: I am not sure. It is an SPFL Trust programme, but I can find out the detail about it.

As you said, being aware of mental health and able to provide support is absolutely a concern. I do not think that anyone is doing enough, which is not a comment about football but about society. It is a big issue and we must all work together to make improvements and to help those who need it.

Tess White: Performance is really important and is a high priority, but 99 per cent of players do not become professionals. What evidence is there that the SFA's 2019 wellbeing and protection strategy has been a success and that children's wellbeing and safety are being prioritised?

Ian Maxwell: We recently commissioned the Children's Parliament to undertake a study of participants in youth football. I will send you a copy of the results, which were overwhelmingly positive. More than 90 per cent of those who play football feel better when they do it, enjoy the feeling of being part of a team and like the physical exercise that they get from football. A number of the statistics that came out of that study show that the strategy is working and that our projects are effective. This is a developing area and we will never stop working in child protection and children's wellbeing. I will send more information in due course.

Tess White: That is great.

I have a final question. There is evidence that children's health and safety are at risk in the grass-roots football environment and that the situation has been like that since football began. What new approaches is the SFA exploring in order to eradicate the culture of shouting and bullying that children can be exposed to by both coaches and parents?

Ian Maxwell: That is a great question. The study by the Children's Parliament asked participants if they felt safe playing football. What was interesting was that the overwhelming fear was of injury, rather than about the other types of safety that you asked about. Children were more concerned about being injured than about anything else. They feel safe and feel that they have a trusted adult in the coaching staff whom they know they can speak to.

Can you remind me what the second part of your question was?

Tess White: It was about shouting. You said that children are more afraid of injury, but as many as 23 per cent of respondents to a survey that we have worried about adults shouting at them and making them cry. A quote from that survey says:

"Nobody checks on the adults."

Ian Maxwell: I am sorry that I forgot the second part of your question. That is a very good point. You are absolutely right: one key piece of feedback from our survey was that kids love playing football but hate it when their parents shout at them, at the referee or at each other.

We are doing a piece of work with the affiliated national associations—the Scottish Youth Football Association, Scottish Women's Football and the Scottish Amateur Football Association—to understand how we can have an impact on parental behaviour. That is absolutely a challenge in Scotland, but it is also a challenge across the world. One of the main areas of focus for the International Football Association Board over the next 12 months will be to produce a plan to help football deal with those cultural issues, which are a big challenge.

Anyone who has recently stood at the side of a youth game will know that the atmosphere can very quickly become toxic. We are trying to encourage young people to play football and to enjoy themselves, so that is not the right setting

for such behaviour. Given the scope and scale of football, that is a big area and a difficult problem to solve, but we are absolutely willing to do that and are working with the affiliated associations to understand how best we can have an impact, because we need to deal with that.

Tess White: I have one final comment. I know what it is like to stand on a football pitch and hear people shouting. Is there any consequence management? Do you follow up with people who constantly bully and shout?

Ian Maxwell: That would be done by the affiliated associations, so the SYFA or the SWF would get involved. It is not as stringent as it could be. The difficulty is that football happens in public parks, so you do not know if the person at the side of the pitch is a parent, a carer or someone who is watching the game. Understanding that landscape is an important part of formalising our plans to deal with that behaviour, which we really want to eradicate from football.

11:00

The Convener: In April 2017, during the previous parliamentary session, the then Health and Sport Committee undertook an inquiry into child protection in sport, during which it heard evidence from the SFA and the Scottish Youth Football Association. The committee's report was critical of the SFA. It said:

"We consider the SFA has been asleep on the job and continuingly complacent in this area"

of child protection and looking after children's welfare. How has the relationship between the SFA and the SYFA progressed since 2017, when dealing with children's wellbeing and protection? Has the SFA adopted a more hands-on approach?

Ian Maxwell: Absolutely. The relationship has grown immeasurably. I came into post in 2018, so I can talk only about what has happened since then. We have very stringent protocols in place for the checks that coaches must do for their coaching qualifications as well as for the protecting vulnerable groups scheme. Coaches need to have a PVG check before they can take part in any coaching. From my understanding and recollection, a big part of the problem in 2017 was that the PVG operation was not being handled appropriately. That is now all monitored via our football administration system, so that we can monitor whether coaches are appropriately checked.

There is on-going communication with the SYFA, SWF and all the other constituents of football that have children playing for them. The Scottish FA issued a board directive in 2016 that requires affiliate national associations to comply with four or five different criteria for the checks and balances that need to be in place. There is on-going dialogue: we sit on a non-professional game board that meets every quarter, the SYFA is along the corridor at Hampden, and there is regular dialogue between our child wellbeing and protection leads and the individual child wellbeing and protection leads at each of the affiliate national associations. There has been a huge shift. A significant number of people in Scottish football are now working full time on child protection and wellbeing to make sure that the processes are correct across the game.

The Convener: Have all SFA board members completed child protection training?

Ian Maxwell: Yes.

The Convener: Does that also apply to the Scottish Youth Football Association? Previously, those board members had not, which came up as an issue.

Ian Maxwell: I can talk only about the Scottish FA board. We have done that training and we do it on a regular basis. I will come back to you about the SYFA.

The Convener: It would be helpful to know that.

Another issue, which was also raised by the previous children's commissioner, was about children, particularly boys, signing for clubs on schoolboy forms or whatever, which had an impact on children's ability to play for other clubs. Can you update the committee on where the SFA is on that issue?

Ian Maxwell: I am not aware of the circumstances that you have outlined regarding registration and do not remember that happening. Again, that predates me. I have not heard anything from any football constituents indicating that that is a problem.

At the time, we were dealing with a couple of matters to do with when FIFA training compensation was due. We have changed our rules and regulations to ensure that it is due only at the point at which the player signs their first professional contract, which is in line with FIFA regulations and the committee's recommendation.

There was a question about registration periods. There was a 30-month registration period that the club was effectively in control of from a youth player's perspective. That has recently been changed, to start from next summer because we have moved from a summer season to a more traditional season, which is a bit of a technicality. Players in the elite level of club academy Scotland who are aged 15 and upwards will sign a two-year registration agreement, which will be agreed between the player, their parents and the club. That is a much more joined-up approach, as the club cannot control the player's registration

unilaterally. An agreement will be signed at the same time by the player, the parents and the club, which is an improvement.

The Convener: It is really helpful to get that update.

When I asked about VAR, you said that there were no category 1 female referees. Are there any category 2 female referees?

Ian Maxwell: I would need to double check.

The Convener: It would be really helpful if you could do that.

Ruth Maguire: Good morning, Ian, and thanks for being with us. I want to ask you about fan representation and voice, and then accessibility of matches.

Gate receipts represent 43 per cent of total football income in Scotland. My understanding is that that is quite unusual among the UEFA countries—it is the highest.

Ian Maxwell: Yes.

Ruth Maguire: The Scottish Football Alliance believes that the representation of supporters' voices and fans in decision making does not reflect how crucial supporters are to the survival of our game. Would the SFA be open to including a fan representative on the board?

Ian Maxwell: Fan representation is obviously important across the game. Fans want to be heard, and they should be heard at clubs. There are varying governance models in clubs. Some are fully supporter owned and supporter run; some have a hybrid model, with a board and some supporter engagement; and some are not quite there yet. It is ultimately for a club—

Ruth Maguire: To be clear, I understand the different structures in clubs in Scotland, but I am asking about the SFA board specifically. Would the SFA be open to having fan representation on the board?

Ian Maxwell: Our board structure at the moment is two representatives from the professional game, one from the non-professional game, three office bearers and two independent non-executive members. I argue that the independent non-execs are football supporters. They obviously have an involvement in football and an engagement with football and want to be part of the board structure, so I argue that we have an element of supporter engagement on the board.

Ruth Maguire: Further to that, the Scottish Football Alliance recommends that Scottish football season ticket holders be allowed to vote for the president of the SFA. The alliance argues—forgive me, but this is quoting directly—that that would replace the

"antiquated and undemocratic process of 'procession to office' and 'blazer procession'"

with a fair voting structure. How do you respond to that?

Ian Maxwell: This is a suit jacket that I am wearing, not a blazer.

The president is elected by the membership of the association, and it feels like a fairly standard and structured operational process for the members of an organisation to elect the president and vice-president. There are opportunities for fan-owned clubs to put forward a representative of their club for the position of president. That person can come from across the football family and people can be put forward by any of the membership. From a structural perspective, it feels like it makes sense for the membership to determine who the president and vice-president are.

Ruth Maguire: Putting that slightly pejorative language aside—it is a very nice suit jacket, though—can you see the benefit in opening up the process? We talk about the value of supporters and trust in the SFA. Opening up that process to make it more democratic could be beneficial for the game.

Ian Maxwell: There needs to be an understanding of football, though. Anybody who comes in as a president or vice-president of a football association needs to have some sort of understanding of football. There is no better place for that to come from than the membership. We have got—

Ruth Maguire: That is not how democracy works. Everyone gets a vote and they decide who will represent them. There is no test.

Ian Maxwell: I am sorry, but I do not get the point.

Ruth Maguire: The Scottish Football Alliance suggests that all season ticket holders could vote for the president. I do not know the details of how those elections would be held, but I presume that qualified individuals with experience would put themselves forward, and then there would be some sort of voting process.

Ian Maxwell: Taking a step back, my point is that clubs have the opportunity to put forward whoever they want. Season ticket holders at a club could decide to put forward someone from their club, so they would in effect have a say in that. Trying to get Scottish football as a whole to agree on anything is a near impossible task, so whether you could do it—

Ruth Maguire: We manage elections in other contexts, so I do not think that it would be beyond the Scottish public to vote for the president, although I hear what you are saying. In principle, are you not for more fan involvement?

Ian Maxwell: Fan involvement is absolutely key in football. I was at a club that was very engaged with supporters. Football fans want to be heard within their club structure and they want a voice in how their club is run and its operation. We need to be careful, because fans are very emotional—they are fanatics by definition, and they make emotional decisions when running football clubs. However, they need to have a voice, and they need to be heard and understood, and it is absolutely right that they are given that opportunity.

Ruth Maguire: I do not think that the point is necessarily that fans want to run the SFA; it is maybe that they want more accountability and a say in who the executive is. Could you see the benefit of that?

Ian Maxwell: I have set out our position. Fans have the opportunity, through their clubs, to put forward whoever they feel would make the most sense from a club perspective. We have a structure that is voted on by the membership and has been in place for a considerable time.

Ruth Maguire: Given Viaplay's recent announcement that it is going to end its involvement in UK sport coverage in early 2024, how realistic is it to expect that the SFA will take the opportunity to make future television coverage of the men's national team free to air?

Ian Maxwell: The nuance to the situation is that Viaplay is under contract with UEFA until 2028 for men's national team rights. That has not changed. We have not heard that it will not be the broadcaster from that point. I understand that Viaplay is going through a process and potentially looking to offload some of its rights.

I would frame the question differently. It is not on the SFA to ensure that the games are free to air. It is on the free-to-air broadcasters to ensure that that is the case. Anybody can bid for our national team rights. We do not control the process, which is centralised through UEFA. Ultimately, it comes down to value and finance.

We receive money from the UEFA centralised deal. We use that money to do the good work that we do across the country. As long as those financial terms are met, anybody can show our games. I would love the games to be on free-to-air TV, but it ultimately comes down to whether the free-to-air broadcasters can commit the required finance. It is for the committee to have the conversation about how we ensure that that happens. It would be great for us and for the game.

Ruth Maguire: It is down to me how to frame questions. You can answer them in whatever way you wish.

Are there other avenues of revenue that the SFA could explore to make up that funding?

Ian Maxwell: We are constantly considering avenues of additional revenue. Ultimately, the vast majority of the income that we bring in goes back out to the clubs or to do the excellent work that Scottish football does across the community, as an association and as clubs. We want to drive that as much as we can.

We fully appreciate that, later today, we have what is widely regarded as the most difficult budget since devolution. Cuts will be included in that, but we should be talking about the ability that sport has to transform lives and make a significant impact across the country. Anything that would diminish our ability to do that does not make sense to the association. We are absolutely focused on driving additional revenue to ensure that we can continue to do the good work that we do.

Ruth Maguire: I acknowledge that there are wider issues involved, but what can the SFA do to help to ensure that our national team sport is free to view? I can afford to go to football games. Not everyone can. We talk about the benefits of sport. Everyone around this table absolutely understands those. They include watching and being part of sport. What can the SFA do to help to ensure that football is accessible and free, particularly to young boys and girls who want to watch their national team?

Ian Maxwell: We regularly engage with the BBC in particular. It has the Scottish cup rights at the moment. The rights for future years will go out for offer soon. We are engaging with the BBC to ensure that it is across that and can do as much as it can to secure as many of those games as possible.

The challenge is that, as with all 55 national associations under UEFA, the international rights are centralised through UEFA's process. It is for the BBC to have a conversation with UEFA about how that looks. We can be involved in those discussions but, ultimately, under the terms of the agreement, UEFA will decide what that looks like.

It is for any free-to-air broadcaster to have a conversation with UEFA. Provided that the value is right, there is no reason why the matches cannot be on free-to-air TV in future.

Sandesh Gulhane: You have repeatedly mentioned how sport can change lives. I completely agree. There has been a bit of focus on men's football, so I will turn to women's

football. It is a huge growth market. It is a huge growth game. More than half of our population are women and potentially want to be involved in it. What is the SFA doing not only to promote the women's game but to make it more robust and get more money in to continue its growth?

Ian Maxwell: It is absolutely a key area for us. We have 22,000 registered female players across the country, which is the highest number that we have ever had. That number continues to grow. Clubs are committing more and more resource to their women's teams at an elite professional level and at a grass-roots level.

More women's recreational teams are popping up across the country. There is a real demand for that. Thinking about the growth of the game, the challenge is around facilities. We have 160,000 registered players and we think that close to one million people are engaged in football, whether that is playing it for recreation at a grass-roots level, volunteering at clubs, coaching at clubs, or dropping the kids off at the weekend. A huge amount of the population is engaged in football.

11:15

Although we are seeing a growth in participation numbers, we are seeing a decrease in facilities. Those two things do not make sense. More and more girls and women want to play football, but the only let that they can get is 9 o'clock on a Friday night, because that is all that is available. Historically, lets have been taken up by other parts of the game.

There is a real drive from the SFA to see what we can do to improve the facilities and to increase the facility provision around the country. I would love to spend some time talking to the committee about the impact that we can have, the impact that football has, and the impact that sport can have. Recently, every time I pick up a newspaper, it has articles about potential swimming pool closures and hockey pitches that people cannot get access to. How do we provide solutions for the Government?

As I said, we have got a really difficult budget coming up. There are financial pressure across the board. In times like this, we need to make sure that the money is being spent as efficiently and as effectively as possible. Sport can play a huge part from a preventative perspective in terms of healthcare spend. We are focusing on dealing with people when they are unwell and have already got diabetes or heart issues, but we need to think about what we can do to spend preventatively to get people active as early as possible. That would stop a certain amount of money being spent on health, because the return on investment from investing at the front end is hugely disproportionate.

Sandesh Gulhane: I agree with all of that, but if it does not come across in response to questions from other members, it would be great if you could write to us with specific things that you are doing to grow the women's game. That would be fantastic.

Ian Maxwell: Absolutely.

Gillian Mackay: Just to piggyback off one of Ruth Maguire's questions, given the SFA's large take from tickets, do you believe that greater consideration should be given to the voice of fans over broadcaster demands, particularly on issues such as fixture scheduling, which is something that we have seen issues with in recent years?

Ian Maxwell: What do you mean by "given the ... take"?

Gillian Mackay: Given the amount that supporters spend on tickets and on going to matches and so on, should their wants and their convenience in relation to scheduling of matches not be given priority over broadcaster demands? People have had issues with getting to and from matches because of matches being changed due to broadcaster demands.

Ian Maxwell: Unfortunately, that is the reality that we live in. Sport across the world has changed. Traditional kick-off times are no longer a thing. The National Football League has recently agreed to take eight matches outside of America and play them in other parts of the world. An element of the issue is what has been traditional. I understand the question, but the reality is that football and sport are completely different now. A huge amount of money comes into the game from broadcasters.

Gillian Mackay: Do you not think that it would show a basic level of respect for fans to ensure that they can make it to a game by public transport, or that it is not played at an inconvenient time, or that the time is not suddenly changed because of a broadcaster demand to a time that would negatively impact them? Fans are not going to return to games if they do not feel that they are also respected by the SFA. When we talk about funding and given that the take is so high from ticket sales, should it be a basic principle that fans are respected in such decisions?

Ian Maxwell: Ultimately, we have to find a balance.

Gillian Mackay: Is that a no?

Ian Maxwell: No, it is not a "no". Significant revenue comes in from ticket sales and matches and a bigger revenue comes in from broadcasters. As I said, that income comes into the Scottish

Football Association and goes out to help do the good that we do across the country. We want to keep driving that.

National team matches under UEFA are part of a week of football, so UEFA tells us when the games are—we do not have any say in when those games are scheduled. As I said, the traditional 3 o'clock Saturday kick-off at that elite level of football no longer happens regularly. The English Premier League has just announced a £6.7 billion TV deal with a thousand more games that are going to be shown. They are going to be shown at all times of the day and night; some will be shown together and some will be shown on their own. That is just the world that we live in. The way that people consume sport has changed. The younger audience in particular are not interested in sitting down at 3 o'clock on a Saturday and watching a game. The world has changed.

Gillian Mackay: Why should the broadcasters be prioritised if people are consuming it in different ways? Why should we not prioritise the fans who are going to the games rather than the ones who are watching online, if people can watch on catch-up and in various other ways?

Ian Maxwell: It is about finding the balance—that is the reality. It is about finding the balance between people who want to come and watch football and the broadcast element. As one of your colleagues touched on, we have the highest number of supporters per capita in Europe going through the turnstiles on a regular basis and that is a big part of Scottish football. However, we also need to be cognisant of the broadcast element and the partnership element, because they drive significant revenue into the games that lets clubs go and do the good work that they do across communities and to help improve lives. We need to find the balance of all those things together.

Gillian Mackay: Okay. Thanks, convener.

The Convener: I will pick up on Gillian Mackay's line of questioning. Was it income from broadcasters that led to the decision to change the time of the Scottish cup final?

Ian Maxwell: There was a broadcast element to that decision, and there was also the fact that the Football Association cup was scheduled for the same time and so was the UEFA Women's Champions League final. There was communication between us and the committee on that. The Scottish cup final is a showpiece event, so we wanted to give it its own space. We wanted to have it at a point when people across the UK could sit down and watch it and not be distracted by other events. As I said, we wrote to the committee at the time; a bit of communication went back and forward between us.

The Convener: There certainly was communication between us, and there was certainly a lot of disquiet from the fans, as Gillian Mackay was referencing. Are you saying that income from broadcasters was an element influencing that decision?

Ian Maxwell: There are a number of factors that go into a kick-off time. Broadcaster preference is one—

The Convener: I am looking for a simple yes or no here. Was income from broadcasters one of the drivers?

Ian Maxwell: It was part of our decision—yes.

The Convener: We move to Tess White.

Tess White: I have one final question. We recently conducted an extensive inquiry into female participation in sport and physical activity. Have you reviewed that report and discussed it with your board?

Ian Maxwell: The report has been reviewed by the senior team at the Scottish FA. It has not gone to the board yet.

The growth in female participation is absolutely key and fundamental to everything that we are trying to do as an association. Driving the female game forward, as one of your colleagues touched on, is such a huge growth area. It makes such a difference to individuals. It is absolutely right that we are doing as much as we can in that space.

Tess White: That partly answers my question, which was more about the inquiry than about football. However, because football is so important in Scotland, it provides a way to build on the work. The reason why I mention the inquiry is to ask you if you can be a champion for its findings, so that it does not get left on a shelf. Thank you.

Carol Mochan: I am interested in some of the points that you have made around the balance between grass-roots community sport, with football as part of that, and the national team and the drive to get quality in that team.

First, on community space, I know from what we have read that you have an influence on it and you meet with stakeholders about it. Where are we at the moment in terms of having good quality space for people to play ordinary games of football?

Ian Maxwell: In simple terms, we do not have enough. As I touched on, the increase in participants has been significant. The decline in facilities has also been significant, and very little finance has gone into upgrading football pitches or even pavilions and spaces, particularly for the girls and women who want to come and play games. Football changing areas are not adequate for that any more.

We are very focused as an association on what we can do to drive that. We got some funding from the UK Government's levelling up fund and some from the Department for Culture, Media and Sport. We have had £18 million in funding, and by the end of 2024, we will have distributed all of it through partner funding and turned it into more or less double. We are using that money to improve and develop facilities across the country.

Making sure that we continue to do that has to be a key area for Government and for everybody on the committee, because, from a preventative spend perspective, the facts are undeniable. We are in Edinburgh, so let us take Spartans as an example. There are 1,700 footballers in that club. That produces a healthcare benefit of £1.8 million over the lifetime of those footballers, because it is reducing diabetes, heart disease and obesity and it is helping to impact on mental health issues.

There are social benefits that come from a reduction in crime as a result of the diversionary activity that happens. There is also economic value through people paying for pitch lets and buying petrol to get to and from training. The economic impact that grass-roots football has in the country is worth over €1.2 billion annually; that is huge, and €700 million of that is in benefits to the health service. The numbers are in euros because it is a UEFA study.

That goes back to my earlier point, which is that there is absolutely no doubt that investment in sport and investment in football—because we are the biggest sport in the country by a distance—will positively impact on the health and wellbeing of the vast majority of individuals across the country.

The question is how football can help the Government to make that impact happen and bring it to life. Times are tough and finances are tight for everybody, so we need to ensure that we maximise revenue and that we are getting as much out of it as we possibly can. There is no doubt that football can play a huge part, and we are here to try and help. We want to be the vehicle for improvements and changes across the country, because they are so important.

Carol Mochan: Do you have a strategy to try and work with stakeholders? I think that everybody here would agree with your point that having those facilities is important for preventative health impacts, but have you started to pull together a strategy for that? Who might be able to work together to improve grass-roots clubs?

Ian Maxwell: We are pulling that together at the moment. Historically, looking at facilities has always been a local authority issue. We have concerned ourselves with getting participants on the pitch, and it has been up to others—through cashback programmes and other such things—to worry about facilities.

Obviously, the landscape has changed, so the association has put more of an onus on itself. Although it is a multistakeholder problem, football needs to play its part in the solution and we have asked what we can do. For example, every penny that we make from the Euros in 2024 will go into a facilities fund that will help us put facilities across the country. We are very committed to doing as much as we can.

Unfortunately, that will not touch the sides; there needs to be much more involvement and engagement. We have been speaking to the Scottish Government about that. Tomorrow, I have a meeting with Michael Matheson and Marie Todd to talk about a long-term strategic partnership that tries to pull together all the different strands of the benefits that sport can bring in a long-term sustainable way, rather than in the piecemeal, year-on-year process that we have at the moment. The association is doing as much as it can.

We need to think about how we generate investment in the game. Part of that investment needs to come from the Government and from local authorities. I get that there are challenges with the finance, but given that we can prove that the bang for your buck that will come from investing in football is so significant, it is not something that we can ignore. We need to keep pushing. Any support that the committee and individuals round the table can give us to help plug us into the right departments in Government, or to external funders that would be happy to see investment into facilities going back into local communities, would be very welcome.

Carol Mochan: I appreciate the drive that you have put into that. I hope that the committee will get a chance to find out what developments there are, particularly if you are working with the Government.

Given the time, I will move on to ask about the national team. We have had some papers saying that there is a hope to develop a very top-end training complex. How far ahead are you with that, and given some of the discussions we have had, I would like to know whether that will involve only the men's game, or whether it will involve the women's game? Who will be able to use that facility?

Ian Maxwell: You are referring to comments that Steve Clarke made about a training facility. We are very much considering that. Facilities are a problem at every level of football—whether at the elite end of the game or down in the grass-roots game. Understanding the facilities issues across the country is an on-going piece of work, but our priority is facilities for the grass-roots game,

because without that we do not have enough places for the people who want to play football to do so. That can be said about sport more generally, and it will have a negative impact on the country, so it has to be our focus.

Emma Harper: Good morning, Ian. You talked a little bit about growing the game for women and you have taken a couple of questions on that already. I am interested in how we can support growing the game, especially when dealing with sexism.

The Children's Parliament report for the Scottish Football Association is titled "Getting It Right for Every Child in Football." The report quotes a girl who says:

"As a girl playing in what is seen as a boys sport it can be really hard and lots of sexism still exists especially from parents."

Another girl says:

"There is lots of sexism from boys towards girls playing football making me not want to participate in school PE class games as I have been purposely targeted by boys and hurt because they don't think girls should play."

What is the Scottish Football Association doing to tackle sexism in football?

11:30

Ian Maxwell: That is a good point. The situation is not perfect—I will not sit here and say that it is—but we are working hard. Real education is required across the game.

You quoted a young child saying that they are unhappy with those types of comments coming from parents: it is unacceptable. We are doing an educational piece with participants in particular—we have more control over them because they are in a club environment and we can engage with them regularly and make them understand what is right and what is wrong.

A lot of what manifests itself at football matches is actually part of a societal problem. When we think about unacceptable conduct and things that happen at matches that nobody wants to see, a lot of those things are societal issues that tend to show up at football matches. There is an educational piece required for a wider group. It is not necessarily a problem for football on its own to fix, but we have programmes, such as "Show racism the red card", to address that. We go into all our clubs and deliver programmes and training to players across the game.

We are working with numerous partners to ensure that there is education to help participants in particular to know what is right and what is wrong. Alongside that, there is the parental aspect. How we educate parents is—as I touched on earlier—a far bigger challenge, but we are committed to trying to make an impact in that regard.

Emma Harper: The report that I mentioned talks about

"sex and sexism, disability and discrimination, race and racism, and rurality and exclusion."

Before I come to the topic of sectarianism, does further work need to be done on inclusivity more widely?

Ian Maxwell: Inclusivity is a big driver for us. We were the first national association in the world to implement a para-football association, which takes all versions of para-football and gives anybody in the country, regardless of the challenges that they face, the opportunity to take part in the game. That includes power-chair football and amputee football, and there is a mental health league. We are broadening out the game as far as we possibly can to ensure that anybody who wants to play can play, because inclusivity is a big driver for us.

Football is our national sport, and we want as many people as possible to be able to play. There is a para ANA—affiliated national association—that meets regularly and is driving opportunities in specific areas for people who cannot play "traditional" football. That is very much a focus for us.

Emma Harper: My final question is about sectarianism.

Bigotry, sectarianism and racism remain key issues in Scottish football, and are often fuelled by footballing rivalries. The "Scottish Football Supporters Survey" notes that 89 per cent of supporters "witnessed" and 41 per cent were "subjected to" sectarianism. In addition, 56 per cent of supporters "witnessed" and 4 per cent were "subjected to" racism. The percentages for racism seem to be lower than the figures for sectarianism. What is being done to look at the issue of sectarianism in Scottish football?

Ian Maxwell: Again, that is part of our wider work. I mentioned our "Show racism the red card" campaign. We have a "Show racism the red card" day across the game, when clubs engage with spectators and there are programme adverts and educational pieces and programmes to raise awareness of the issues.

As I touched on, there are things that happen at football matches, and matches become a microcosm of society. What we are seeing is not specific to football—such incidents do not happen only at football games. They happen across wider society, and it will take a multistakeholder approach to make an impact on all those elements.

Education is key, as I touched on. Clubs do a huge amount of work on education and input for players, telling them about racism and sectarianism and what is right and wrong in all those areas. However, there is also a wider population piece, and we need to understand how football plays its part in dealing with that. Unfortunately, it cannot do that on its own, as there is a wider societal issue in Scotland that it will take a lot more than football to fix, but we are happy to play our part in that.

Emma Harper: And we will monitor the numbers and the data to see those percentages for sectarianism and racism reduce.

Ian Maxwell: Absolutely—that has to be the aim.

The Convener: I just want to pick up on some of my earlier questions, particularly with regard to female referees. When I look through your website, the first picture that I see on every landing page that I go to, right down to category 6 referees, is of a man. On the "Become a Referee" page, where you are obviously trying to recruit people, three of the four pictures are of males. When I click on the referee kit shop, I find that all of the clothing appears to be for males and in male sizes. How is the SFA using its website to actively promote female referees, when, as a woman, I see that sort of thing and it seems to me that women are not wanted?

Ian Maxwell: I will take back that feedback. I should say that we have had female-only referee coaching courses, and we have done a lot of work to encourage females in every aspect of football, whether it be to participate or whatever. With our female-only coaching courses, we have tried to encourage females to come and do that sort of thing in a female-only environment, because the feedback that we had was that females were more inclined and more willing to participate if the environment was female only. We have done that from a coaching perspective and from a refereeing perspective, too, but I will take back your feedback about the website and we will review that internally. In general, female participation across every area of football is absolutely a key driver for us, because we see the opportunities there.

The Convener: I certainly appreciate that you are doing that with regard to playing, but officiating seems to be for men only. Even when you click on to the Referees Association, which there is a link to on your website, you see that it is all men. I actively encourage you to go and have a look at your website, if, indeed, the SFA is trying to recruit more female officials.

Sandesh Gulhane, did you have a further supplementary on this?

Sandesh Gulhane: Yes. I want to ask specifically about what the SFA is doing to increase diversity in refereeing. We have heard from the convener about female referees, but we need to see wider society being represented, too. What specifically is the SFA doing to actively recruit people from diverse ethnic backgrounds?

Ian Maxwell: I can get back to you on the specifics, because there are programmes in place. Obviously, when we talk about inclusivity, diversity will be a key part of that. We want the Scottish FA and Scottish football to be representative of the communities and the society in which we live, so it is a key area and opportunity for us. We want to get as much engagement as possible, but I can write back to you with details of our plans from a diversity perspective.

Sandesh Gulhane: Is there is equivalent diversity in the SFA, too?

Ian Maxwell: In terms of the organisation?

Sandesh Gulhane: Yes.

Ian Maxwell: We are on a journey, from a diversity perspective. There is no doubt about that. It is something that we are working hard on. We have a number of human resources plans in place. We have recently signed up to the Merky programme; I do not know whether you are aware of that, but it happens through Adidas and looks at employing individuals from diverse backgrounds. We will continue to strive in that area.

Sandesh Gulhane: Could you write to us about that, too?

Ian Maxwell: Yes.

Sandesh Gulhane: Thank you.

The Convener: Thank you very much, Mr Maxwell.

ur next meeting will be after the new year, on 16 January, when we will take evidence on the Scottish budget for 2024-25 from the Cabinet Secretary for NHS Recovery, Health and Social Care, and I take this opportunity to wish everyone a happy and restful festive period.

That concludes the public part of our meeting today.

11:38

Meeting continued in private until 12:16.

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