OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 23 May 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 23 May 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
18th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ewelina Chin (HSTAR Scotland and BEMIS)
Michael Dickson (NHS Shetland)
Lynne Glen (Scottish Disability Sport)
Gordon Jamieson (NHS Eileanan Siar)
Baz Moffat (The Well HQ)
Robert Nesbitt (Scottish Association for Mental Health)
Laura Skaife-Knight (NHS Orkney)
Heidi Vistisen (LEAP Sports Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 23 May 2023

[The Convener opened the meeting at 08:45]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 18th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Paul Sweeney.

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

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Shetland, NHS Eileanan Siar and NHS Orkney)

08:45

The Convener: The second item on the agenda is a further session in our periodic scrutiny of front-line national health service boards. I welcome to the meeting Michael Dickson, chief executive of NHS Shetland; Gordon Jamieson, chief executive of NHS Eileanan Siar, who is joining us remotely; and Laura Skaife-Knight, chief executive of NHS Orkney. I welcome everyone on the panel and thank them for joining us.

We will move straight to questions.

I know from my time as a health minister that island boards frequently raised the challenge and associated cost of recruiting and retaining staff on the islands. How have your health boards met that challenge and what other challenges do you still face? Who wants to start off on that?

Michael Dickson (NHS Shetland): I would be happy to kick off, if that would be useful.

The Convener: Thanks, Michael.

Michael Dickson: The principal challenge remains the same. We are faced with a workforce shortage that is felt across the whole of the United Kingdom and we as island communities have to be innovative in the extreme to be able to ensure that we attract and secure the right people. Some challenges relate to political decisions taken outwith us—obviously, the impact of leaving the European Union is felt not just in the NHS but across other sectors. Equally important, however, is the way in which the tax system works. If people are willing to come and spend time working in the island communities but have a home elsewhere, they are penalised if they are provided with accommodation as a benefit in kind. It is an interesting quirk of the tax system that people are penalised for wanting to come and work in different places.

Flexibility is key. We are seeing more and more people who are interested in a mixed career. They will have reached a certain point in their career or they will have had a pandemic wake-up moment and they want to give something back to society, perhaps from a global health platform or by teaching, or they want to travel. Offering people spaces where they can come to work and where they know that they will be employed for a time and then be able to go off and do innovative and exciting work before coming back to us, is an important way in which we recruit staff.

The islands still have challenges around housing, which is in huge demand. Suitable housing is also an issue. We may choose to try to recruit people who have families and who want to come and build a life in Shetland. We are having on-going discussions at the local authority level to see what we can do. NHS Shetland recently secured funding from the Scottish Government to purchase a former guest house, which we can use to provide good-quality accommodation for some of our peripatetic staff. Understandably, if a person is travelling up to do work on behalf of NHS Shetland, they will want somewhere nice to stay. They cannot be expected to stay in a run-down location.

We do and we will continue to face challenges. That is felt in the long-term use of high-cost locums. We are doing a huge amount of work to try to mitigate and ameliorate that but, fundamentally, that is likely to remain a consistent feature for now and in the future.

Laura Skaife-Knight (NHS Orkney): My observations are consistent with those of Michael Dickson. We face real challenges in the fragility of our medical workforce. As members can see in the submission that we sent in in advance of the meeting, last year alone we spent in excess of £6 million across agencies and locums. Our task this year is to try to reduce that wherever possible and convert that arrangement into substantive arrangements, notwithstanding the challenges that come with that.

I am pleased that your question put an equal focus on recruitment and retention. Recruitment tends to dominate conversations, but the focus must absolutely be on both. From an NHS Orkney perspective, we face additional challenges on top of the medical workforce challenges. Notably, some 22 per cent of our workforce are over the age of 56. We have a conundrum—a ticking time bomb, if you like—in that we need to address that retirement question now, rather than walking into it in the years to come.

In addition to the challenges in the acute setting, we have particular challenges in the community. As of today, we have 27 vacancies in our care-at-home team and some vacancies in social work and community nursing.

That said, as Michael Dickson said, that makes us think differently, creatively and innovatively. That is one of the many benefits of working for an island board. We have some success stories, in addition to those that Michael Dickson mentioned from an NHS Shetland perspective and which I will not repeat. We have seen real success in general practitioner recruitment. From a board perspective, we are up to full complement. Post-Covid, GPs have told us that they want to come back and really feel part of a community in an island setting, so that is a success story. From a child and adolescent mental health service perspective, we have moved from two members of staff to 10. We hope to get to 15 and are optimistic that we can do that. Building on the observation in my submission, I am pleased to let colleagues know that, yesterday, we recruited a GP with a special interest in dementia. Again, that bolsters the support that we have. I am sure that we will mention fragile services quite a lot this morning, but those are the kind of solutions that we need to put in place.

Finally, convener, you asked about some of the other challenges that we face. Fragile services go hand in hand with workforce challenges. Michael Dickson also referred to the chronic housing shortage. I am sure that Gordon Jamieson will mention this, but from an NHS Orkney perspective, we are forecasting a significant demographic shift over the next decade. We need to plan for that now; if we look at our clinical strategy, we think that we have done that. We are forecasting a 35 per cent increase, between 2020 and 2035, in those over the age of 65. The number of people over the age of 85 will double, which is significant. We need to start not just solving the issues that we face now but planning for the future.

Gordon Jamieson (NHS Eileanan Siar): Our experience over the years has been that although we want to attract and retain specific individuals, when people come to live, work and—we hope—stay in the Western Isles, it is really important to provide support for the whole family. A lot of people who have come for a job for one member of the family find that their partner cannot get a job, or that they do not have housing and or access to things like childcare. A complete package makes a difference to whether people live, work and stay—staying is the really important part. We try to support people with housing, and we have got a good relationship with the local housing partnership for accommodation prioritisation. We work with all our partners, and we help people with relocation and visas. At the moment, we are considering the local provision of childcare for 0 to 5-year-olds because, again, it is critical for our staff that they have access to childcare.

We try to bring about a whole package for each person who comes to work with us. It is really important that we are as flexible as we can be around working arrangements. Being carer friendly is also important, because people have broader responsibilities. As an employer, we find that the more receptive and supportive we are, the better chance we have of holding on to people for the longer term.

However, as you will have seen in my submission, the single biggest threat to health and social care services in the Western Isles is the alarming population decline. Our current vacancies, and the number of times that we have tried to recruit to different posts, mirror that population decline. As I said, though, we work with partners—it is a community effort—to get people here and keep people here. Similarly to Michael Dickson and Laura Skaife-Knight, we all work together.

The Convener: What you are describing is how a whole-system approach of ensuring that there is childcare, housing and so on could be a double whammy: you would get staffing and you would also help to bring families to increase the population of the Western Isles and the sustainability of your communities.

Gordon Jamieson: Yes, we have people who come up to experience the working environment before they sign up to a permanent job—anaesthetic staff did that recently. We have a try-before-you-buy approach and we are flexible about bringing people up for a few weeks or months and letting them see the environment, the facilities, the community and access to childcare and so on. We think that that is the only approach. If we go out to recruit a single individual and we focus only on the success of that, we will fail on a much wider basis.

Sandesh Gulhane (Glasgow) (Con): I read through the submissions and I was particularly interested in Laura Skaife-Knight's, which says:

"NHS Orkney remains at 0.8% from NRAC parity".

Why?

Laura Skaife-Knight: That is a construct of the way in which national funding works; I am sure that Michael Dickson and Gordon Jamieson will support me in that. It is one of the areas in which we, as an island board, remain at something of a disadvantage in terms of how the funding is allocated. I am oversimplifying this, but just to labour the point, we get funding in dribs and drabs and as one-off allocations that make it difficult to spend that funding meaningfully, given the size of the board and the infrastructure that we have.

For example, when the national funding is allocated and money comes down the line, we are allocated part of a post, such as 0.8 per cent of a whole-time equivalent. That does not help us to be agile, given the size of our boards, and it does not allow us to spend that money to best effect in a way that is best for our patients and local communities.

Sandesh Gulhane: You therefore feel that you are £500,000 short of where you should be.

Laura Skaife-Knight: That is correct.

Sandesh Gulhane: I turn to Gordon Jamieson. In your submission, you say that innovation in medicine is a challenge facing your health boards. Will you expand on that a little bit, please? Are clinical trials not also part of where you need to be?

Gordon Jamieson: I apologise if I have misrepresented what I meant. We certainly approach innovation enthusiastically and we have had some excellent successes. For example, the HeartFlow example that I gave in our submission is probably one of the best examples of innovation using digital technology and artificial intelligence.

The reference that I was trying to make was that the costs of some of the new medicines that are coming along put pressure on healthcare systems. We are , however, entirely wedded to the idea of innovation in many areas. We can sustain the service only if we get the right balance between our staff and the use of innovation, digital or otherwise, and that links back to workforce and population decline. We are proactive in developing different methods of innovation, whether that be in diabetes, heart failure, cardiac or anywhere. The cost of new medicines, however, puts us under the most pressure. We participate mainly in national research and occasionally in trials, but we are enthusiastic about innovation across the board.

09:00

Sandesh Gulhane: Thank you. I will stay with you, Gordon, for my final question.

Population decline is a serious issue, as is housing. If you are earning £100,000-plus, you will probably be able to find accommodation, but not everyone is fortunate enough to be earning that type of money and many of the jobs that are you are looking to recruit for are not in that bracket. One of the jobs that I saw advertised was a consultant post—which is, admittedly, a very well-paid job—and there was an annual £1,279 "distant islands allowance". That does not seem to be a huge amount to attract people to the Western Isles. What measures need to be taken to make it more attractive for people to come to work where you are?

Gordon Jamieson: Again, we approach it in partnership and try to support people with housing. We have a growing supply of houses in the Western Isles that come through the local housing partnership. We have an agreement with it that health staff will be prioritised. To use the isle of Barra as an example, we rent a house on Barra on a continuous basis to allow us to put senior medical staff and general practice staff into accommodation. In areas such as Barra, where there are only 1,150 or so people and limited

housing, we have had to take measures to provide houses.

The health board has houses that are under its endowment infrastructure—again, those can be used to support people in the short term. Some people ask, "Why would you come to the Western Isles and not have a house by the sea?", so we try to support people when they come up to be around for a little while, by giving them supported accommodation, letting them choose whether they are going to stay and then supporting them in that decision about where they want to live.

The distant islands allowance is there as an additional incentive to people, but we look more at working flexibility, annualised hours and support with childcare, visas and relocation. Not everybody comes with a family, but we are trying to attract individuals and families, and we look at everybody to see how we can support them.

It is very much a bespoke, individual approach that involves picking out of the range of support measures that we have what best suits that individual or family.

Emma Harper (South Scotland) (SNP): Good morning to the witnesses in the room, and good morning to Gordon Jamieson online, who was a senior nurse when I was an NHS nurse employee in Dumfries and Galloway.

My question is about the innovation that Gordon Jamieson was talking about. Does that include enhancing the roles of allied health professionals and nursing staff? For instance, that could involve enhancing the role of registered nurse first assistants in the operating theatre, or enabling nurses to give midazolam in endoscopy, or expanding the role of allied health professionals in other areas, albeit within the scope of their role and by using competency-based training and assessment. Is that part of the innovation that you will take forward?

Gordon Jamieson: Yes—we are very active in that regard. In relation to allied health professionals, we have first-contact practitioners and advanced practitioners, and we have stand-alone consultant physiotherapists, who basically manage our musculoskeletal workload and do everything associated with the patient pathway.

We have a growing number of advanced nurse practitioners—we have just appointed three in Barra, and we have them in Western Isles hospital—and we have emergency nurse practitioners, all of whom are trained up to level 9 in acute assessment skills. They very much work hand in hand with junior and senior medical staff.

With that multidisciplinary multiprofessional approach, I get quite excited about how far we can take practice. I am not a person who is constrained by conventional or historical boundaries. I look for the opportunity to do things safely and effectively while broadening out as much as possible. When you get proper team working to look after patients, I find that it is an excellent environment to work in for medical staff and all the other staff. That ties back to the point about it being a good experience for the patients and for the staff.

It is about pushing the boundaries of practice. An example of that is in relation to cardiology: we were the first in Scotland, if not the UK, to adopt HeartFlow technology, which is of course in partnership with the United States. That is led by a nurse consultant in cardiology.

The Convener: I know that Michael Dickson wants to come in, but could Gordon first explain what level 9 nursing is?

Gordon Jamieson: It is, in essence, nurses who are trained up to the level of a doctor such that they can assess and clerk an acute presentation of a patient. It is common for a clinical support nurse or an advanced nurse practitioner to make that initial assessment. When patients present, it is important that whoever immediately meets them is capable of making a comprehensive and very quick assessment. The advanced nurses are trained up to that level.

The Convener: Thank you, Gordon. That was for lay people so that they are aware of what you are talking about.

Michael Dickson: As a nurse myself, I am hugely proud of the workforce that we have and the enormous steps that they have taken to embrace new and innovative roles. The future of remote and rural healthcare hangs around the principle of advanced practice of different professionals.

I mentioned nurse eye injectors in my submission. That is about people not having to travel because they have age-related macular degeneration. People were choosing not to travel because it would be so frequent and because, as I am sure that we are all aware, travel from the islands can be somewhat challenging at times. People were choosing to let their sight deteriorate or even to lose their sight for want of services in Shetland. We now have a trained nurse injector who can undertake that procedure, and nurse endoscopists.

Gordon stole all my thunder—thank you, Gordon—but it is about advanced practitioners leading services from the front and developing new and innovative pathways. It is interesting that NHS Forth Valley has led the way in nurse surgeons undertaking breast work and vasectomy—routine procedures that can be carried out in a very straightforward manner. From

my perspective, advanced practitioners are a critical part of our future for remote and rural healthcare.

Evelyn Tweed (Stirling) (SNP): Michael, my question is on the theme of the nurse injectors that you have talked about. What do they do and how beneficial is it? Are there other areas that you are interested in making sure stay in the islands so that people do not have to travel? If so, will you tell us about them and what support you might need in that respect?

Michael Dickson: The scope and range of activities that advanced practitioners can do are pretty much endless, whether it be working in a fly-in, fly-out specialist environment in the remote communities in the Shetland Islands or in Macmillan specialist support to extend prehabilitation—which is an important part of the future of cancer care—and post-care after chemotherapy. Surgery is another good example of where we can train practitioners.

The default is always nurse practitioners, but I stress that the huge range of professionals that we have in the NHS is phenomenal. Pharmacists, for example, are an excellent resource and can provide care in a different way to patients, who might well have been prescribed multiple drugs. A pharmacist can provide expert advice through the pharmacy-first principle that we are introducing, which is also really important. The scope is huge. Moreover, cardiac technicians are using our recently refurbished computed tomography scanner to review cardiac scans, and that, again, reduces the need for people to travel.

To come back to Laura Skaife-Knight's point, I think that the challenge relates to the NHS Scotland resource allocation committee. A common refrain in the islands is that people wear many hats, but it means that structuring a role can be quite difficult, because, if a person leaves, we lose not one but three jobs. NRAC parity creates a challenge in that regard, but the issue is not just that; it is that we might receive only a portion of funding for a role, and that affects sustainability. It means that, the next time that we recruit, we need to replace somebody whose job, as a whole, was made up of two or three parts.

As I have said, the range is boundless. We believe that a significant portion of our future workforce—our current estimate is about 30 per cent—will undertake an advanced role.

Evelyn Tweed: In your submission, you mention your work with LGBT young people. Can you tell us more about that?

Michael Dickson: I was approached by LGBT Youth Scotland, which recently published a report on the experience of Scotland's LGBT+ youth. Those in remote and rural areas are at a significant disadvantage, because they feel more isolated, they do not have the same peer network and there is not necessarily the same group of people who can reach out to them.

At the time, I was working between Shetland and Orkney, and I took the opportunity to connect with school nurses who engaged with that group of young people to find out what was going on in the schools. Absolutely astonishing work was being done on Shetland—a youth worker had been leading that work from the front—but innovation had taken place across all three island boards. This is not a criticism, but all three islands were working in slightly different ways to reflect their communities, and we connected those school nurses and youth workers so that they had the opportunity to learn from one another.

Most recently, the LGBT youth workers in Anderson high school on Shetland received, quite rightly, an award for what they have done, and I am really proud that NHS Shetland participated in the first Shetland Pride, which took place last year. We are talking about an important group of young people who are particularly vulnerable, particularly in rural communities, so it is important to have that presence and visibility and to recognise that their voices and experiences matter. They should know that they can, without fear of prejudice, access all our health services, not just those located in education, and that they will be cared for. That is an important NHS value of which I am proud.

Evelyn Tweed: NHS Orkney's submission mentions "IT system frailty". Laura Skaife-Knight, can you expand on that? Does that apply only to your area or does it apply nationwide, too?

Laura Skaife-Knight: It is fair to say that, from a digital perspective, we are somewhat immature, but we have an ambitious but suitably realistic digital road map to ensure that we can see the progress that is needed in that area.

I will share some examples of the work that is under way, which Michael Dickson and his team have led superbly over the past few years. For a start, the intra-island network—the connectivity with our isles—is really important. There is a feeling in the community that, if there is not that connectivity, the isles will be literally cut off, so we have done a lot of work to improve that. It helps from a clinical perspective to be able to use, for example, portable scanners on the isles or the same telephony system. That might sound like we are going back to basics, but it has been absolutely necessary to ensure that the mainland and the isles remain connected.

We are also making good progress on our single sign-on system. As you can imagine, it is hugely frustrating for clinicians to have to log in and out of different clinical systems and remember

multiple passwords, so we have moved to a single sign-on system, which is an important step forward. More recently, we have introduced e-prescribing.

I know that we all want to get to the end of the line, which will mean an electronic patient record. We have started those conversations. Clearly, such a system will be dependent on securing funding, but that is our ambition.

We have a road map that will allow us—incrementally, year on year, through our capital funding—to see the digital shift that is needed. We have made some good inroads in that regard.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I thank the witnesses for coming along.

I am interested in the key performance standards. To what extent do they drive service delivery?

09:15

Michael Dickson: There is a two-fold answer to that question. We are not entirely in control of our own destiny with performance standards. One of the key measures is our accident and emergency performance, which has been sustained at a level that I am very comfortable with. Every time someone has to wait for more than four hours, that case is reviewed and there is a root-cause analysis. Those cases often relate to off-island transport, for example, for people who require intensive care. People sometimes have to wait for an extended period: we had a patient who was delayed on-island for 36 hours, because Shetland was fogbound and nothing was getting in or out. That is just the nature of providing healthcare in a remote setting such as Shetland.

For the services that we are able to provide on-island, waiting times are way below the 18 weeks treatment time guarantee. When we look at CAMHS performance, or at adult mental health services, we see that a small number of people wait for more than 18 weeks, but we do all that we can to ensure that waiting times are absolutely as short as possible. However, we have extended delays when a patient's pathway leads them to the mainland health boards. Our performance is tied to their performance and we face the same pressures that you will have heard about from colleagues working for mainland boards.

We have a very tight grip on this. I do not mean to dismiss performance targets, but this is not about targets: it is about people from our community having to wait longer than they should for a procedure that is really important to them.

Stephanie Callaghan: I suppose my question ties in with what was said earlier about innovation. We hear a lot about how critical early intervention and preventative care are and how performance targets and priority targets can drive providers away from that. Could early intervention and prevention be made higher priorities?

Michael Dickson: They could be. With support from the Scottish Government, NHS Shetland brought in the Vanguard operating theatre to allow us to do hip and knee replacements. That was truly transformational for the community—it was absolutely phenomenal.

I came from England, where public health is very separate. We do not see that in Shetland. Our public health director is phenomenal and the public health team is absolutely integrated into our work. We are talking about returns that will be felt in decades' time. If we can get weight management right, or if we can get people's diabetes under control—or even avoid it—those things will prevent people needing more support from the health service further down the road. NHS Shetland has a very strong public health focus, which I am hugely proud of, and we saw that throughout the pandemic.

The challenge is that you have to measure something. The measures we use are not bad ones, but there might be more that we could look at. For example, one of the interesting things about knee replacement is the regret rate, which sits at about 17 per cent. National work on elective waiting times is reviewing that with patients to find out if they understand the consequence of that surgery and what it means to have a knee replacement and, once they know all that, whether they still want to go ahead. We are trying to reduce the number of people having a procedure that they would rather not have had.

Stephanie Callaghan: That was really helpful. I am keen to hear from Laura Skaife-Knight or Gordon Jamieson on this, too.

Laura Skaife-Knight: I am happy to come in and build on Michael Dickson's observations. From an operational performance perspective, there is a real risk that we hit the target but miss the point. Fundamentally, this is about delivering high-quality, safe and timely care across our elective and emergency pathways and for our cancer patients.

As Michael Dickson said about Shetland, NHS Orkney, in the main, does well at meeting the standards that are within our gift. We were a little short of the standard of 95 per cent of people having access to emergency care within four hours, finishing last year on 86 per cent. We perform well in meeting the standard that people should start cancer treatment within 31 days and we consistently perform well in meeting the

standard that people should begin treatment for non-urgent conditions within 18 weeks.

The areas where we need to do better—and this is not to deflect attention away from NHS Orkney in any way—are the areas where we rely on support from other centres. The situation has been different in the past year or two, compared with what it was perhaps just three to five years ago. Other centres are running at—or very close to—100 per cent bed occupancy most of the time, and we rely on those centres through our service level agreements. For example, the number of our patients to whom the 62-day cancer treatment time target applies is small, but the fact is that one delay for a cancer patient is one too many, and we are reliant on other centres to deliver on that target. In those areas in which the waits are longer than we would like, such as rheumatology—and ophthalmology, which is perhaps the best example of this happening—we have conversations with, for instance, the Golden Jubilee national hospital to see whether we can use some of the capacity that is allocated to us in a different way in order to address some of our longest waits.

Having worked in the NHS in England for 20-plus years, I absolutely back up Michael Dickson's comments. It might not feel like it at times, but trust me: integrated care is significantly more advanced here than it is in England. NHS Orkney has very close relationships with its public health colleagues and its local authority colleagues in Orkney Islands Council, and there are huge opportunities there. One example is how we are addressing delayed discharges. We are a small island board, but I can tell you that, as of today, 19 per cent of our beds are taken up with what are called delayed discharges.

There are things that we can do differently by working with our local authorities in a different way, and we are looking at that ahead of next winter. For instance, we can use some community capacity differently and have a step-down bed facility in the community so that we can run at the 88 per cent bed occupancy that we know is the optimal level for us.

In summary, there is room for improvement, but relationships are really strong.

Stephanie Callaghan: That is good to hear.

Gordon Jamieson: There is a similar picture in the Western Isles. Local waiting times are short. In the past number of years, we have expanded our orthopaedic service and we are very pleased with what we can deliver to the local population in that regard.

Some targets are reviewed daily and some weekly. For example, our performance on the cancer target is similar to the situations in Orkney and Shetland. Our 31-day performance, which involves more local diagnostic work, is very good, but the 62-day target is a bit more challenging. We are currently at 53 per cent in relation to that, compared with 93 per cent for the 31-day target, so we have some improvement to make there. However, as we work in partnership with others in the NHS Scotland system, some of that is due to system pressures, clinical prioritisation and the availability of generalists elsewhere.

On the emergency department target, we would all want people to be seen, diagnosed and so on as quickly as possible after appropriate presentation at such a department.

The targets drive our performance but, alongside the targets, we are carrying out a population health needs assessment to revisit the five-year and 10-year predictions for the population of the Western Isles. That does not bring us into conflict with the targets, but it tells us where we need to flex and change and develop services as well as giving us a refreshed view of the population health needs. When we last carried out such a review, it led us to redesign and enlarge our orthopaedic service, which now delivers very well for the population.

We are focused on recovery. In some areas, we are focusing on continuous improvement to get waiting times down. Alongside that, the population health needs assessment will allow us to understand where we need to prioritise and flex local services while achieving the targets that are set.

The Convener: Thank you. Sandesh Gulhane will lead on our next theme, which is mental health performance.

Sandesh Gulhane: I have some general questions based on my experience as a doctor working in University hospital Ayr, which covers a rural community, in part, along with an urban community. I know that your populations are very different, in that they are all rural. I remember that, whenever I was asked to see a patient who I was told was a farmer, I would drop everything, because farmers do not come to hospital unless something catastrophic has happened. For example, one person amputated their finger while lambing and only came to see me a couple of weeks later.

Bearing that in mind, and how people in rural committees—especially farmers—tend to be, what different approaches do you need to take to look after the mental health of your community compared with how the majority of the population in urban areas are treated?

Michael Dickson: I am happy to kick off and tell you about our very Shetland approach to that. As I have mentioned in my submission, we have an incredibly strong third sector; the default position is

that the NHS is where you go if you have mental health conditions or concerns, but research has proved time and again that having multiple points of entry is the best approach. People need to be able to access services that are available not just 9 to 5, Monday to Friday, and an NHS practitioner does not always need to be your best first point of contact.

We have promoted the reliable connections available through NHS Inform. We have also provided some sustainability through Mind Your Head, so that it can help build its service; the organisation is a strong component of our approach, and the work that it does is well known in Shetland.

When people require further support that cannot be provided through third-sector first contact or they require on-going support, we use a variety of methods from web chats to apps on phones, which some people are more comfortable using. There is still a significant amount of stigma around mental health, particularly in the communities that you have referenced.

When people have reached the point at which they require an NHS level of service, we offer a range of approaches from face-to-face appointments to digital appointments, to try to flex round individuals' needs. Our approach acknowledges that one of our biggest challenges is distance. Our mental health services are based predominantly on Lerwick; if you have a mental health concern and you need to talk to a practitioner, travelling from Unst to Lerwick will take at least a couple of hours and require two ferries. Being able to access the secure NHS Near Me facility so that you can have a conversation that you know is confidential and is in the same space as if you were walking into an NHS building can be really reassuring for people.

We also have a secure messaging facility, so people know that they can talk to someone. A conversation does not have to be face to face or through an appointment; asynchronous consultations are another part of our approach.

However, the big thing—and this ties back to the earlier point—is that the more we can do in relation to prevention and awareness, the better. I am very proud of the Up Helly Aa and the fire festivals that take place in Shetland every year. Those communities have really promoted the importance of talking about mental health, particularly to men, who are really reluctant to come forward. Full credit goes to the Up Helly Aa squads for their commitment to that and for being open about people's struggle with and experience of mental health.

Sandesh Gulhane: You have made some interesting points about the importance of talking, but my concern about rural and island areas is that people seek help when they are at crisis point rather than when something is becoming an issue. Things are much more easily and probably more quickly sorted at that earlier stage rather than when someone hits crisis.

Social isolation is a huge issue in your rural communities, but it is also something that your health board does not particularly have control over. Do you feel that, with all the methods that you use, you are able to help people with their social isolation?

09:30

Michael Dickson: One of the very special things, as Laura Skaide-Knight referenced in relation to Orkney, is how we work together as a system. With regard to the barriers that routinely exist between, for example, the police, social work, the NHS and the third sector, there will, of course, be barriers—we are different organisations, after all—but they are not the same constructs that you will see in other places. Yes, we collaborate and work together; we know vulnerable individuals and seek to find the right support for them. That collaboration and that community are at the heart of all that we do.

Do we think that it is all perfect and that everyone has access to all the services that they need 24/7? I am afraid not, but that is a reflection of the constraint on what our services are able to offer. What is important is that the community is able to access the services easily and, again, that is why longer-term investment in Mind Your Head is so important.

Sandesh Gulhane: I turn to Gordon Jamieson. I was on Uist and talked to someone who told me that there are around 1,200 people on his island and that he knows them all. In that type of small community—its size is probably one of the reasons a lot of people move out—do you think that the stigma of mental health might be a hindrance to people seeking help?

Gordon Jamieson: I am not sure, although that is a possibility. In relation to the interaction that we see, particularly in Uist and Barra, due to the work that has been done to strengthen our community services and put much more support, signposting, awareness and resource into the community, whether that is face to face or digital, I think that the communities are strong enough. There is definitely a chance that that stigma may be there, but the community spirit in most, if not all, of the Western Isles is incredibly supportive, and is probably more helpful to the community and the individuals within it.

Most of our effort is in creating stronger community services and having many more

mental health workers. We have been very well supported over the past couple of years in terms of being able to strengthen our community services. We are able to see people in CAMHS very quickly, and our psychology services have been strengthened considerably over the past five to 10 years. There has been a lot of training around psychological first aid and suicide prevention.

Loneliness is a huge problem up here, without a shadow of a doubt. It is more of a threat than most illnesses, so we need to tackle loneliness, but the communities are incredibly strong and incredibly supportive. As Michael Dickson said, there is a very strong third sector presence, which is very supportive.

Sandesh Gulhane: On your third sector, I heard of the great work that Penumbra has been doing in the Western Isles. What additional support do you give Penumbra to do the great work that it is already doing?

Gordon Jamieson: In relation to Penumbra, we have the Catch 23 drop-in centre in Stornoway and a range of providers across the islands. We are certainly in regular contact with the third sector through the community-based network. Those providers have more to offer than anybody else. Again, it is a balance with them, but they come forward with proposals, they are very much a part of our integrated planning and we work with them.

We still have quite a distance to go in reducing the acute mental health provision in order to strengthen the community provision. When our mental health strategy was agreed, it was quite clear that we would need significant additional investment over time, including in the third sector. I do not have any specific proposals just now that relate directly to Penumbra, but in general, the third sector is central when we plan to change services.

Sandesh Gulhane: Perhaps you could write to us with that.

Emma Harper: I want to pick up on what Sandesh Gulhane said about social prescribing and third sector and independent organisations. In our social prescribing inquiry, we heard about some great work that is being done in Shetland on engaging people. It is about tackling isolation and loneliness and recognising that those issues are a problem. In turn, that supports mental health. My question is for Michael Dickson. How does each local authority and NHS board interface and engage to support all of that? We know how important our third sector organisations are. I am looking at an RSPB link with nature prescriptions that can help to support people to get outside and tackle isolation and loneliness, and to join groups or whatever. Do you see that happening on the ground?

Michael Dickson: To be honest, I have never worked in a place that is like Shetland. It is not about organisations and what name is on a person's badge; it is about doing the right thing for the people of Shetland.

"Anchor for families" is a piece of work about working with vulnerable families. That could sit in a social work world or a health world, but it did not sit in either. It was about somebody without any of those statutory organisation badges working with really vulnerable families to ensure that they got the widest possible support that they needed. They would not be families that would normally access support. By doing that, problems are prevented. That ties back to the key issue of prevention for decades and potentially generations down the line. At no point did anyone say, "Actually, I want to own that. That should be a social work thing." It was about what was right for Shetland. That guides all that we do across all the organisations.

Way before my time—I think that it was around 10 to 12 years ago—the council and the NHS produced the statement that, whatever happens, the council, the NHS and their key partners will work together regardless of what is going on. I apologise for the statement politically. That guides what we do, and that means that we develop services that are about meeting the needs of our individual communities.

Shetland is not just one community; it is a community and communities. I apologise—I took that from Laura Skaife-Knight. It is about how we do things locally. We support activities that take place in Yell, Unst and Fair Isle, and acknowledge that it might not be us who are doing those. We have put a healthcare assistant in the Out Skerries, which are small islands, to support the small community out there. That is linked to the way in which the council works in maintaining the islands. That is a really innovative project, and it required both statutory partners to step aside from our organisational boundaries and say, "What's the right thing to do here?"

Emma Harper: Shetland, Orkney and the Western Isles are remote and rural. I am thinking about Stranraer in the south-west of Scotland, which is pretty rural and remote from the rest of NHS Dumfries and Galloway—its headquarters and everything. Is one of the strengths of remote and rural areas that it is not just about everybody owning areas as if they are their wee fiefdom; rather, it is about partnership working?

Michael Dickson: Without a shadow of a doubt.

Laura Skaife-Knight: I endorse that completely. Michael Dickson has already touched

on two aspects. I have been in post for eight weeks, and I can share with members my raw experience.

Our relationship with our local communities is like nothing that I have experienced in my career to date, and the collaboration and partnership working are very strong. I see a triangle of the local authority, the health board and the third sector. For me, the unique aspect is that it is not just about the formal relationships and the formal set pieces that we go to; it is also about informal relationships. At the end of the day, we do not let the governance and the structures get in the way of doing what is right for our patients and local communities. That is the start of every conversation that we have. It is very different.

Emma Harper: Okay. Thanks.

The Convener: I am looking at the performance tables that all three health boards have submitted to us. We did not get any figures from NHS Orkney on the percentages of CAMHS patients who are seen within 18 weeks or 53 weeks or more. Could you write to us with those figures?

Laura Skaife-Knight: Of course; I would be more than happy to do so.

The Convener: Tess White has questions on theme 4.

Tess White (North East Scotland) (Con): I have two questions on consultants and a supplementary. My first question is for Michael Dickson.

At the end of last year, NHS Shetland had a vacancy rate of 39 per cent for medical and dental consultants, which is against a backdrop of 6.5 per cent for the whole of Scotland. In your submission, you stated that it is

"difficult to recruit consultants with the breadth of skills needed"

for a remote and rural location

"because the NHS no longer trains staff in that way."

Can you say a bit more about that and can you give your view on how to overcome it?

Michael Dickson: That vacancy percentage seems disproportionately high, but our consultant workforce is disproportionately small versus the overall size of the board. An increase in our consultant vacancy will have a significant impact on that.

However, the point is well made. Our consultant vacancy is higher than we would like to see. I am, sadly, old enough to remember when general surgeons would be able to turn their hands to most things. Thankfully, that has changed and we do not see surgeons having a go any more, but that has a disadvantage.

We are fortunate that we still have surgeons who can turn their hand to most emergency procedures. I am talking about the kind of situation where a major accident happens in Shetland, there is a life-threatening issue and a surgeon needs to intervene to, for example, remove a kidney, which is not a procedure that they would do routinely. We happen to have a stalwart group of general surgeons who can still do that, although they have their own sub-specialties.

Fundamentally, in Scotland—and more so in England—there is a degree of superspecialty in the surgical training that is undertaken now. You now have surgeons who specialise specifically in breast surgery, for example, who would not be able to undertake a emergency procedure such as a blocked bowel. They would be able to undertake more general stuff, but not deal with those kinds of life-threatening critical issues.

Our surgeons, as fantastic as they are, are reaching a point in their life where they are going to look to retire. We already know that and we are starting to have conversations about that. So what do we do? We have put in place some of the foundations to deal with that. We have taken on a new consultant who will be trained for the wider and more frequent events that could require getting out of bed at 2 in the morning and being able to provide that intervention.

There have been comments about advanced practitioners, and they have a part to play. There also has to be consideration of what the future will look like. We may well have to recruit outwith the United Kingdom, to ensure sustainability. Outside the UK, there is still a more generalist approach to training surgeons, for example. That may form part of what we see over the next few years as surgeons retire and other people are brought on. In the longer term, I would hope that the majority of the work will be taken up by advanced practitioners under the supervision of a broadly skilled general surgeon.

Tess White: Rather than take recruitment outside the UK, is there work that could be done to revisit the issue, so that you could say, "We need to have modified training."?

Michael Dickson: It is a challenge. In my former life, I worked in England, and there was a programme called "Getting it right first time", which looked at how surgical specialties operated. There is a really good reason for why surgeons are now more specialist. The more you do something, the better the outcomes are—it is as simple as that.

There was a great model in Brighton and Worthing involving surgeons who worked in a particular specialty and would not routinely carry out surgery on children, but would have to if there was a major event at 3 o'clock in the morning. A

franchise was created so that surgeons would go and experience paediatric surgery. Surgeons would not consider themselves to be specialists in that and they would not do it all the time, but they would do it enough to keep their skills up.

There is a remote and rural component of surgeons' training, and we are building on that, to try to make the training Shetland proof, as it were. We still come back to the issue that, if you are a surgeon, you are, on the whole, expected to specialise in a particular area rather than hold general skills.

There may be good reasons for this, but I do not think that we will ever go back to having true general surgeons, the likes of whom can turn their hand to a range of activities. That creates problems for the future, and if we are to continue with a consultant-led model, that is likely to become more expensive for remote and rural communities to sustain.

09:45

Tess White: On the theme of consultants, Gordon Jamieson said in his submission that the board has a number of consultant roles that can take years to fill, so they are covered by agency staff. That has a huge cost. How many years would you say it is taking to recruit consultants, and do you have a view on the cost implications of that?

Gordon Jamieson: We have about 32 visiting specialties, so you need to bear in mind that a lot of the consultants fly in to the Western Isles, as they do on the other islands, to provide excellent care from other health boards. However, from our core of 16 permanent consultants, about half are locum staff just now. Some of them have been locum staff for three or four years. It is very difficult to recruit permanent substantive consultants. Medicine and surgery are specific examples and mental health is another, if I could mention three specialties that are particularly challenging at the moment.

An observation that I have shared recently is that we seem to have locums in the health service who want to work with us continuously but do not want to convert to a substantive post. They want to continue indefinitely on locum terms and conditions and, therefore, we have locums who are with us for a very long time. We have been unable to get them to take up or apply for substantive posts, which is a challenge. The flipside of that is that you get the continuity of a long-term locum and all the benefits for patients and the patient experience, but it comes at a significant increased cost.

When we are out to recruit new locums just now, we go to the on-framework agencies first, where there is already an agreement, but sometimes we have to go off framework and some eye-wateringly high locum rates come back. I can give you an example of a specialty where we went out to the market in the past two months. We were looking for locum costs to take someone on for a year and the lowest cost that I got back was £313,000; the highest was just over £1 million. I have never come across that before. It is alarming.

Therefore, the costs are very significant. We secured someone at the lower end rather than the higher end of that range, but the costs are an on-going pressure. For me, there is something about the people who want to continue to work but as locums. It is difficult to get them to convert to being full-time permanent members of staff.

Tess White: The Scottish Government put in place multiple schemes to bolster rural GP numbers. We got positive feedback from Laura Skaife-Knight on that, so I will not ask her my question; I will ask Michael Dickson. There was the golden hello scheme and the bursary scheme. Have those been helpful in Shetland and is there anything else, in addition to those, that you think could be useful?

Michael Dickson: Any initiatives such as those are always really welcome. I must recognise that the majority of practices that are operating in Shetland are board-run, so we do not deal with GP practices in the same way as elsewhere. However, we have a number of single-handed GP practices. In particular, one in Hillswick has a very committed long-standing independent GP, who has been trying to recruit her successor for the past six months.

Moving to a place such as Shetland is not something that you do lightly, although people think, "It's just an island". I was talking to some American tourists, who thought that they would be able to catch a train somewhere—there are no trains.

You have to understand the quantum of moving; you have to want to go there. That is part of it. No golden hello will necessarily do that for you—it has to be about the desire to live and work as part of a committed community, knowing that there are trade-offs. It is incredibly safe, but it is really isolated; it is beautiful, but you might not be able to fly out for a number of days due to fog or fragilities around the airline that is providing the services, or you might have a really rough ferry crossing. Those are all factors that people consider.

I do not think that it is just about throwing money at the problem; we have to sell the proposition. I think that Shetland, Orkney and the Western Isles sell the beauty of where we work; however, fundamentally, you must have the right mindset

and know what you are getting into. That is part of it—it is a choice.

Tess White: Great; thank you. If I may, can I bring in Gordon Jamieson, or should we move on?

The Convener: We just need to be very brief.

Tess White: Gordon Jamieson, will you give your view on that topic, please?

Gordon Jamieson: We are about to go out—either today or tomorrow—to recruit for two GP posts for Barra, and the golden hello is part of that. Michael Dickson's point is really important—we are selling Barra, where we happen to have two rural GP practitioner posts. The important thing is that we can sell the location so that people want to come to live there.

We have nine practices, including one 2C practice. Some of our GPs are retiring and returning. As Michael Dickson said, in many communities, there are very long-serving GPs. However, it is increasingly becoming a bit more challenging to get GPs in the Outer Hebrides. The next test will be in the next few weeks, when we go out for those two very different posts in Barra, which will cover the GP practice, out of hours and the inpatient beds in the hospital there.

Tess White: Thank you.

The Convener: Our next theme is Covid recovery and progress of the recovery plan. We are getting a bit tighter for time, so if we can have concise questions and answers, please, I would be very grateful.

Emma Harper: I was going to mention the Scottish graduate entry medicine programme as a success for us in the recruitment of GPs.

As far as Covid recovery goes, I know that there is not an overnight fix, and the NHS recovery plan progress update says that recovery from the pandemic will take place not in weeks or even months but in years. Therefore, I am interested in hearing your perspectives on Covid recovery. Innovation is being used—for example, NHS Near Me and digital appointments have been part of the recovery—but how do you feel that recovery from the pandemic is affecting remote and island areas specifically? Michael Dickson is nodding, so I will go to him first.

Michael Dickson: I will keep it brief, because I am aware of the time. Our performance reduced slightly during Covid—I am thinking about the performance measures that we go against—but it did not dip significantly. From a performance metric perspective, I would argue that we are one of the best-performing boards, but the impact of the longer-term consequences of Covid on social aspects and our workforce will continue to play through for many years. We will continue to wrap our support around that.

We are using trauma-informed support for our staff. It was a very difficult period of time for the whole of Shetland, but trauma-informed support is a key plank in continuing support for our workforce.

Laura Skaife-Knight: I will build on Michael Dickson's observations.

Covid recovery remains one of our top priorities as an organisation. We are back to pre-pandemic levels of activity, as you can see if you look at our elective and out-patient activity. As I mentioned earlier, we have particular pressure points in certain specialties, where we have particularly long waits. However, from a line-of-sight perspective, we know which specialties those are, both from an acute and a community perspective. We have plans in place to address those areas; notably, from an acute perspective, for us, those are pain services, rheumatology and ophthalmology.

Michael Dickson touched on the importance of staff health and wellbeing, which we should not lose sight of. There has been a lot of burn-out. Staff are tired. As health boards, we invested strongly in health and wellbeing through Covid, and we absolutely must maintain that. In fact, we must redouble our efforts in the future—we are determined to do that.

As has already been touched on, many good things came out of Covid that we need to keep, not least the acceleration of digitisation and the use of things such as virtual appointments, where that is appropriate for patients. We must also keep the increased speed of decision making, because we can take far too long in the NHS to get on and do things. We can have good governance and still work at speed. We must keep hold of those positives and build on them.

Emma Harper: I am not sure whether Gordon Jamieson wants to come in. I am interested in what I read in the recovery plan about the mobile operating theatre that was introduced in Orkney and Shetland. I think that the Scottish Government invested £2.3 million to enable 350 elective surgeries to go ahead. Has that been beneficial in addressing elective surgeries?

Michael Dickson: That was in Shetland; we hosted it. I am so sorry, Laura. The Balfour hospital is fortunate to have a truly fantastic and first-rate set of theatres, whereas the Gilbert Bain hospital does not, due to its ageing—indeed, very elderly—infrastructure and building. A Vanguard theatre was supported, and it was absolutely transformational. It showed what we are able to do by using the innovative approach of layering on top of that the mobile magnetic resonance imaging

scanner and routine diagnostic facilities that visit us. More than 400 operations had been completed by the time the Vanguard theatre went away.

There is an opportunity for the whole of Scotland in that. We used a private company, Vanguard, to provide the theatre, but we could do that within the NHS. A lot of Vanguard's staff members were NHS staff members working through a different route.

Emma Harper: That is interesting. On Covid recovery, do you agree that it will not be an overnight fix and that it will take a long time? I fully endorse supporting the mental health of all the workforce—that is critical—but it must be part of a long-term plan to address Covid recovery. Is that correct?

Michael Dickson: I agree entirely. We mentioned the pressures on the mainland boards, and our pathways lead to those boards. Even if we are doing the best that we can do, we are tied to what is happening throughout the rest of the system. You are absolutely right: we will feel the effects of Covid for many years to come.

Laura Skaife-Knight: I agree, and I will build on that. We have short, medium and long-term plans for the specialities that I mentioned in which we have particularly long waits. The plans recognise that, in many cases, the fix is changing the model of care in the service, which is why there needs to be longevity to it. It will take several years to get these things fixed and working in a different way—a way that is sustainable for the future.

The Convener: I think that Gordon Jamieson wanted to come in on the previous question.

Gordon Jamieson: I want to say just a couple of things. As the NHS in Scotland, we must ensure that we do not slip back at all from using digital technology such as Attend Anywhere and Near Me. That will take a whole-NHS-Scotland approach. It would be very easy to slip back. We saw huge benefits from and want to push ahead with the appropriate and safe use of Attend Anywhere and Near Me. I want that to happen.

For us as a very small system, Covid is still around and—do not get me wrong—it is still causing us operational interruption problems. If it got a bit busy down in Dumfries and Galloway when I worked there, I could redirect patients to South Ayrshire, across to the Borders or even south to Carlisle, but if the hospital in Stornoway gets paralysed because of an outbreak of Covid, there is no other place for people to go, so risk and recovery have to be very carefully balanced. However, our recovery is going well; our patients are not waiting for long periods of time. Protecting scheduled care is really important.

One of the good things that came out of Covid was the renewed emphasis on staff wellbeing. We will keep that and hold on to it for ever; we will never slip back on that. As we move forward, many benefits will come from the focus on staff health and wellbeing, as well as full recovery and improvement for patients.

10:00

Emma Harper: I am conscious of the time, so I will stop there.

The Convener: Thank you. Our next theme is culture and governance but, first, we have a supplementary question from Evelyn Tweed.

Evelyn Tweed: I was interested to hear Gordon Jamieson's positive comments about the health board working with the local housing partnership to prioritise housing for staff. I would like to know whether Michael Dickson and Laura Skaife-Knight's boards also have positive relationships with local housing providers. I am a housing professional, so I am really interested in that.

Laura Skaife-Knight: Very recently, in the past month or so, NHS Orkney set up a new strategic housing forum. We can make a proactive submission to the Scottish Government and can be very clear about what the gap will be for Orkney in the next five to 10 years. Those relationships are there. In fact, the partnership is even bigger than that, given the strategic contributions around the housing agenda.

Michael Dickson: We have strong working relationships and are using the experience of Western Isles as an example. We are starting to engage with our local housing association to see how we can use Gordon Jamieson's experiences and those of the Western Isles as an example for Shetland.

The Convener: The next theme is culture and governance, on which Gillian Mackay has some questions.

Gillian Mackay (Central Scotland) (Green): As well as being small health boards, there are small teams within the boards that you oversee. When there are complaints within those small teams, how are those managed? Given that people might be working in teams with single-digit numbers of staff, how are they encouraged to speak up when there are issues?

Michael Dickson: Complaints are really personal. I have worked in Northern Ireland, where people feel the same way. There is a direct connection with the community, which people who work in a larger board might not feel. We have had some quite difficult complaints about times when clinical care has not gone as we wanted it to and the consultant has been beside themselves

because the care did not go the way that they wanted it to. Staff are part of a community and are incredibly visible, which makes a difference to how they feel.

You asked how complaints are handled. When a complaint is made, we engage to see whether we can resolve it. We do that exactly as you would expect, by following the Scottish pathway for complaints that has been set out. We try to resolve complaints as quickly as we can, but we know that some complaints will reach a certain threshold. I am involved in a number of complaints that have reached that point. Visibility makes that more visceral: a complaint is not just a number or a name somewhere.

Are you asking whether both staff and patients are encouraged to speak up?

Gillian Mackay: Yes, absolutely.

Michael Dickson: We offer patients a range of ways to engage with the health board. Social media play a significant part in that. On the whole, locals are comfortable that, whether they raise an issue anonymously or with their name attached to it, they will always get a response and will always be truly heard. Of course, we can link back to the external process, if need be.

Regarding staff speaking up, our internal processes allow people to use the Datix system to raise concerns. We also use GREAT-ix, which enables people to recognise good practice, so it is a two-way process. We also have an independent whistleblowing champion, who sits on the board and frequently checks how people are feeling, and we have our iMatter survey, which is just being completed.

Laura Skaife-Knight: I will try not to repeat too much, because some of these things are national constructs.

You are right: in health boards, there is one big team that is made up of lots of small teams, and, at times, that can lead to silo working. In my experience, staff will speak up in multiple ways if they have confidence that their concerns will be listened to, heard, taken seriously and followed through on. It is important to close the loop so that there is trust in the system.

One thing that I have already started to do is to promote to staff the many formal and informal ways in which they can speak up, all the way through to the whistleblowing end of the spectrum that Michael Dickson talked about. However, we still have some way to go in order to build that trust and credibility. We are working really hard on that.

From a patient complaint perspective, I insist on seeing every complaint that comes into the organisation and there is a response from me, personally, before it goes out. Wherever possible, I will meet complainants at a venue of their choice. Being cognisant of those complaint themes, so that when there are red flags, you can nip those things in the bud and act on them in real time, is really important.

One thing that we have not mentioned is the importance of learning from complaints. Complaints are a gift. It is important to learn from feedback—no matter how small it may be—and demonstrate that something has truly changed in response to it.

Finally, whichever way you look at it, you cannot disentangle staff and patient experiences—one impacts on the other. For example, when I look at complaints trends, I often see that there is something going on in terms of staff sickness or absence, or staff experience. It is an experience package and it is really important that those things are taken together.

Gordon Jamieson: It is a hugely important area. I spent a lot of time in the world of patient safety before I came up to the Western Isles, and one of the things that I have always been alert to is the danger of hierarchy and how it can impact on clinical and multidisciplinary teams. It is critical to constantly develop a culture of openness and speaking up.

We do a range of things in that respect. We have everything from an informal sounding board where staff can raise concerns, through to the formal route. I regularly host open meetings with staff where there is no agenda and they can raise issues with me, personally. I carry out exit interviews alongside the employee director to try to learn from people who move on and see whether there is anything that we can play back into the system.

We have a real focus on early resolution where there is an issue—we try to resolve people's issues informally before going down the formal route. The formal route always becomes quite elongated and it is stressful for everyone involved. It is really important for us to get an early resolution if we can.

We have a patient participation forum that feeds back to us. The point that Laura Skaife-Knight made is really important. We now have a lot more direct contact with patients—face-to-face or, at least, telephone conversations—and the exchange of letters or correspondence is now the end of the process. It is really important to get to know people and to be personal about understanding their experience. We get a much fuller understanding of someone's experience through direct contact with them.

It is a central, mission-critical issue for us. Behaviour is everything, and we try to ensure that

everyone feels that they can speak up at any time about any issue. Likewise, we have the whistleblowing system, which is there for when the business-as-usual methods do not work.

Gillian Mackay: How do the boards monitor bullying and harassment in your workforces? I am reflecting on the nature of small teams and where that can cause issues, particularly if someone is on a small island in Orkney or Shetland, where they know the whole community and could be raising an issue with their next-door neighbour or someone across the road.

Michael Dickson: We have a staff governance committee, which is the key body for monitoring that. That is a separate governance pathway—bullying and harassment does not come to the management or the executive, but is routed through that route. We have a strong human resources department that is present and available. We also have spaces for listening for people to be able to engage on an informal basis in order to raise concerns at a lower level.

There is of course a link to occupational health, which ties back to what Laura Skaife-Knight said about staff sickness. That is all reviewed through the staff governance committee, which ultimately feeds through to the board.

Gillian Mackay: Do you want to add to that, Gordon?

Gordon Jamieson: It is a really important issue. I welcome the introduction of the iMatter system, where staff can fill in questionnaires and we can get right down to a team level. That means that, where behavioural issues start to come up in the way in which teams interact, there is an opportunity to fix that locally.

We do on-going reviews of any cases of alleged bullying and harassment that come up. Quite simply, we take a zero-tolerance approach to it—there is absolutely no room for that kind of behaviour in any of our organisations.

There is a very clear focus on that, but the more important work is around developing teams, staff wellbeing, being alert, early resolution and using tools such as iMatter to pick up on themes that might be developing in the organisation. As Michael Dickson said, that goes through the area partnership forum, which is where we meet our trade union colleagues. That is a very open forum where we have very strong partnership working. Ultimately, the board's statutory committee—the staff governance committee—will monitor issues that come up as well.

The Convener: I have a question for Laura Skaife-Knight. Laura, I appreciate that you have only been in post for eight weeks, but you will be aware that NHS Orkney had the lowest overall experience score on the employee engagement index. The committee is keen to hear what steps NHS Orkney has taken or is taking to address that.

Laura Skaife-Knight: When I commenced in post, I published a 100-day plan, and front and centre of that was how I would spend time—not only during my first three months but beyond—listening very carefully to the views of staff. I recognise that our staff engagement and experience scores are not where we want them to be.

I am already very clear that there are some clear themes being fed back from staff. They do not consistently feel heard and listened to, and they do not feel that our internal communication is what it should be. They also find it really difficult to navigate through the organisation and understand how decisions are made, how the feedback loop works and who to go to for help and support, so we are going back to basics to reset that with staff.

I continue to hold listening sessions during the week, in the evenings and over weekends, because I want to ensure that I am as accessible as I can be. That will continue beyond my first three months.

At the end of my first three months, I will publish a report to be clear, open and transparent—both internally with staff and externally with partners and the local community. The report will say: "These are the themes that I have heard, and this is what we are going to do about that." Fundamentally, it is about leading with kindness and visible leadership, and about truly listening and acting on a rolling basis; it is not just a one-off exercise.

Gordon Jamieson mentioned the importance of iMatter. As important as that is to give us a moment-in-time view from staff, and as a benchmark and comparison of how we are doing year on year, staff engagement and experience have to happen every day of the year. At the moment, those are not embedded in NHS Orkney. We are in the process of putting in place regular listening sessions with the executive team and me. We will also start doing quarterly pulse surveys in addition to the annual surveys that we have talked about today, so that they become part and parcel of what we do throughout the year and we can play that back, consistently, into the organisation.

As part of my 100-day plan, I was very clear that there were five top priorities, one of which was organisational culture. I knew that there was work to do. I am now getting underneath the bonnet of it, and I am clear about where we need to focus our efforts during the next six to 12 months and beyond.

The Convener: I am heartened to hear that you mentioned the staff partnership forum. I declare an interest, as I am a member of Unison. Where do you see the role of staff side in assisting you with that?

Laura Skaife-Knight: It is absolutely central to moving us forward. We have really strong relationships with the area partnership forum, and we are resetting the agenda so that we can ensure that the staff experience, engagement and culture programme are front and centre of that, and that they are consistent with our annual plan, which the board has just agreed to and published for this year.

We have a really healthy relationship with our employee director, but I want the area partnership forum to do what it says in the title: work in partnership and move forward on some of the big issues. I have not held back. We need to move beyond tick-box exercises and towards meaningful engagement and partnership working, and we have some great ideas as to how we can do that together.

10:15

The Convener: Thank you. We are going to move on to our final theme, which is future work.

Carol Mochan (South Scotland) (Lab): Thank you for all the detailed information. My question might give you a chance to give us some homework. The Scottish Government has committed to the development of a national centre for remote and rural healthcare for Scotland. What might your aspirations for such a centre be?

The committee has also committed to trying to undertake an inquiry into remote and rural healthcare. Do you have anything that we should specifically direct it to? Please give us some work to do.

Michael Dickson: I am happy to kick off on that one. We have touched on a lot of issues that would be pertinent to that inquiry. Front and centre has to be the workforce. Having worked in a remote setting, I see it as a badge of honour. You get a huge amount of experience. People often look at the islands and think that it will be easy and that, because it is 22,500 to 26,000 people, it will not be a problem, but there is not the breadth of workforce that there is in other organisations, so you have to be more agile and adept.

At the heart of that is our community and workforce. The committee has heard from colleagues about the importance of that package and the valuable offer that people can make. We have done some work through the rediscover the joy GP recruitment process in Shetland, whereby people come for a period of time. Allowing flexible ways of working that recognise that working in a place such as Shetland might not be for everybody for ever, but it might be for some people for a period of time, means that we can build up a profile. However, we are not talking about traditional models because current funding arrangements do not particularly support anything that goes beyond those models, and that remains a challenge for NRAC.

The workforce of the future is going to look different, and I question whether the biggest challenge that faces the remote and rural centre has to be about working many years in advance because we are facing challenges today. Separating the two is useful for ensuring that we have a broad focus rather than traditional models that have been defined by what happens on the mainland. For example, lifting a Glasgow model and applying it to Shetland just does not work. What happens through our experience will be the same as what happens in the rural areas of Dumfries and Galloway and the Highlands.

The Australian flying doctors is a brand. Everyone knows that. It is a real thing. I think that we could replicate something like that in Scotland and not just for doctors, I hasten to add. It could be a badge of honour that people embrace as part of their lifelong careers.

Carol Mochan: Thank you. Laura Skaife-Knight, you are quite new in but does anything spring to mind?

Laura Skaife-Knight: As Michael Dickson said, workforce has been the dominant theme throughout the meeting. Perhaps we should return to the theme of innovation, which was mentioned earlier. Gordon Jamieson and I have an ambition that our board should be the best remote and rural care provider in some way. What would that look like from the perspective of a remote and rural healthcare provider? If we could bottle all the pockets of innovation from remote and rural settings, how would we get all that into one laboratory, if you like, so that we can truly learn from it? We have pockets of innovation between ourselves, but if we could truly bring them together, it would be hugely powerful.

Carol Mochan: Gordon Jamieson, is there anything that you would like to add?

Gordon Jamieson: There are three things, really, the first of which is on the point that Laura Skaife-Knight and Michael Dickson made about the breadth of practitioners that are needed for remote and rural healthcare. I worked in Dumfries and Galloway, which is remote and rural, but island healthcare provision is unique. I will give you an example. A couple of years ago, I was on Barra with a chief executive from the NHS in Scotland and a GP who worked in Edinburgh.

They were talking to me about the GP facilities and service on Barra, and we told them about the range of work that was involved, particularly the acute work, hospital work and retrieval work.

The GP said to me, "There is no way on this earth that I could even contemplate working in a rural location like that, because of the acuity of patient presentations. I work in the centre of Edinburgh, and I can refer into the Edinburgh hospital half a mile away. This is a completely different world."

The message of that is that there is something about the type of practitioner that is needed for island and remote healthcare. Recruiting the GPs for Barra will be a real test, because GPs will look after general medical services, hospital in-patients and out-of-hours unscheduled care. I do not know how many such people are around just now, but we are about to test that.

Secondly, I would like a revisiting of the obligate networks in remote and rural healthcare. All our island systems depend on very strong and good working relationships with other health boards. We in the Western Isles have relationships with at least eight other health boards for a range of clinical services and service delivery, but I would like a revisiting of the obligation to keep that service up when the going gets tough. Sometimes, we see a bit of a pull-back: "Oh, we're very, very busy, so we can't come up". In rural healthcare, sustaining that relationship is important.

Finally for remote and rural healthcare is the taking forward of single-system working across health and social care, in order to develop the right type of practitioners in remote, rural and island systems to provide services. The only way in the islands is to have one system. The area is too small to have multiple bodies trying to do the same or different things. Anything that a remote or rural system could do to produce the right type of care provider and practitioner would be helpful.

Carol Mochan: Have any of you had information about when we might get some movement on the set-up of the system? Have you had anything through the health boards? You indicate that you have not.

Laura Skaife-Knight: We have not had anything formally.

Carol Mochan: That is helpful. Thank you very much.

The Convener: I have a final question. When I was in Shetland a few years ago, one of the ambitions of the people there was to grow their own workforce, so that people were already embedded in those communities and, if they left to go to university on the mainland, they were more likely to return. I am keen to hear whether that has developed, whether you have had any success with it and what the challenges have been. I go to Gordon Jamieson first, as his hand is up.

Gordon Jamieson: That is such an important issue for us. We know that 54 per cent of people who leave school leave the island, that very few return until they are in their 50s or 60s, and that they return only if they have very strong family connections. Once we lose that 54 per cent, they are really lost—to the mainland and other places.

We are therefore very active in the schools just now. We have a summer programme that involves offering multiple student posts to schools and communities, to bring people in and give them experience. We have also had a significant increase and movement forward in apprenticeships. That is critical to us because, all the time, we compete with the offshore energy sector—the wind farms—the commercial sector and the hospitality sector. We have therefore put a big push into apprenticeships.

Generally, we seek to give folk experience and exposure. We engage with schools to try to reduce that 54 per cent who go off island. We are as flexible as we can be with the workforce—when they work, when they start and when they finish—and we need to be carer friendly and family friendly. We cannot just focus on our task; we have to look at the person. In that way, I hope that we will increase the number of people who stay in work, and decrease that 54 per cent.

Laura Skaife-Knight: I am happy to build on that. First, I cannot believe that we have got to this stage in the meeting without mentioning grow your own. It is hugely important and central to the conundrum that we have talked about of addressing the workforce challenges that we all face.

Similar to what Gordon Jamieson said, the trend in Orkney is that more younger people are leaving the island. At the moment, we are bolstering our programme of work on growing our own, which includes, as Gordon Jamieson mentioned, offering work experience and ensuring that those who come to us on placement have the best possible experience. One of my first meetings in my first couple of weeks in my role was with all the students on placement. It is, largely, a good experience, but there are things that would make it even better. We know that we need to invest more in that area.

I am clear that we already have some true stars of the future in front of us at NHS Orkney. We need a proper programme to invest in, grow and nurture those colleagues, and the organisation needs to have a proper succession-planning programme wrapped around that. That needs to be done in a systematic way, starting with the

executive team and going down through the organisation. That is locked into our plans, starting from this year.

Michael Dickson: We have strong pathways that allow healthcare support workers to access nurse training through Robert Gordon University and the Open University. The advantage with the Open University is that people do not need to leave Shetland to undertake their training. We support them by giving them at least one placement on the mainland, so that they get wider exposure and there is not just a student focus. However, it has been flagged up to me that trainee GPs struggle to select their home board if they want to come back home after they have done their key training.

I am envious of Laura Skaife-Knight's strong apprenticeship scheme. NHS Orkney and NHS Shetland currently share human resources services, and I am shamelessly trying to steal that scheme, because it involves great work in supporting people to reach graduate level.

We get really positive feedback from our junior doctors and student nurses. That was highlighted in our recent board paper. We see growing our own as an ideal opportunity—I know that it is not the traditional approach, but if people have that experience, it is more likely that they will come back. Growing our own is about people who are seeking to have a career anywhere in the NHS; it is not just about health professionals. Given the breadth of experience that people get by coming to Shetland, they could easily be turned into one of our own and have future pathways. For example, we brought on two consultants at a very early stage and worked with NHS Grampian to provide their on-going support and development, because we know that they will be our consultants of the future.

The Convener: I thank Laura Skaife-Knight, Michael Dickson and Gordon Jamieson for their participation, which is very much appreciated. You have certainly given us some food for thought in relation to not just the work that we are doing today but the future inquiry. Once we are ready to progress that work, I am sure that we will be in touch with you.

There will be a brief suspension.

10:27

Meeting suspended.

10:35

On resuming—

Female Participation in Sport and Physical Activity

The Convener: The next item on our agenda is a further evidence session as part of our inquiry into female participation in sport and physical activity. Today, we will focus on inequalities and the additional barriers to participation in sport that are faced by women and girls from marginalised communities and those experiencing physical and mental health challenges.

I welcome Ewelina Chin, chief executive officer of HSTAR Scotland, which is a member of BEMIS; Lynne Glen, pathways manager at Scottish Disability Sport; Baz Moffat, CEO and co-founder of The Well HQ; Robert Nesbitt, head of physical activity and sport at the Scottish Association for Mental Health; and Heidi Vistisen, policy manager at LEAP Sports Scotland.

We will move straight to questions and we will start with Gillian Mackay.

Gillian Mackay: What actions could be taken to better enable women and girls with disabilities to take part in sport and physical activity? I ask Lynne Glen to respond first, if that is okay.

Lynne Glen (Scottish Disability Sport): It is about hearing the voices of the young girls. We have a great leadership programme—we work in partnership with SAMH on that—and it is about listening to the girls and hearing their voices. It is also about ensuring that any images across Scotland that represent physical activity and sport explicitly include them. The message that the young girls are giving us is that, if they do not see people like them or images of women with disabilities doing physical activity and playing sport, it is not relatable and they do not think that it is for them. There is then the whole issue of body awareness and body imaging.

We need to get to a place where we listen, hear the voices of young people and use more imagery and more explicit language around encouraging young females to participate in physical activity and sport. It is about working in partnership with other agencies to spread the word and encourage more young girls. That goes from the local level, with local authorities and trusts, to the governing bodies at the national level and other third sector partners, some of which are on this panel.

Gillian Mackay: On the point about images, I suppose that we also need to remember that not all disabilities are visible and that they affect different people who play different sports in different ways. I say that as someone with a

vestibular-related disability. It is absolutely important that we consider people with different physical impairments, but how can we also get those less-seen impairments out there? They can also affect people's participation in sport throughout their lives.

Lynne Glen: Absolutely. It is about working in partnership, and we have to reach wider. That is the challenge: getting the message out more widely to more people. We are doing a lot of work with others. We have a national visual impairment support group and we work with the sight loss societies that support people on the ground. Those connections are important. It is about connecting with the agencies on the ground that work locally with people, because that extra support is needed to get young girls involved in physical activity and sport.

For me, it is about working with the third sector agencies and with health and education, which are the two places where almost everybody will access services. We need to keep on getting the messaging out and being clear about our key message that sport and physical activity are for everyone, and we need to encourage more people to get involved. Does that make sense?

Gillian Mackay: Yes, absolutely. I think that Robert Nesbitt wants to comment.

Robert Nesbitt (Scottish Association for Mental Health): I want to highlight the work on which we have engaged with Scottish Disability Sport. It goes back to the points that Lynne Glen made about role models and about us telling those stories and enabling people to hear them.

In our work around mental health and disabilities, we focused on hearing what people were telling us about that. We worked alongside them in one of the programmes that Scottish Disability Sport runs—the young start programme—where they focus on mental health.

Mental health was a huge barrier and a huge issue that was often hidden for people with disabilities. From that work in partnership, and the voices of those young people, we were able to identify what those areas were and design programmes and education around those particular areas. That really helped to shine a light and bring greater understanding, again going back to the point that you were making, allowing people to see themselves in that space and allowing other people to understand what that means. That creates a space for greater participation in sport and physical activity.

Lynne Glen: I have two other points. One is around education and training. We deliver inclusion training in every tertiary institution across Scotland. It is a really fragile programme, because it is funded independently; we access the money to deliver that programme free to the universities. That programme means that every physical education teacher and classroom teacher is being trained to offer inclusive opportunities within school.

The second point is that we have the governing body for boccia, as well, and we have a girls-only programme to encourage more girls to play boccia. We are now working in partnership with more governing bodies that are recognising that, unless you build it in, they will not come. We need to have proactive interventions for young girls to participate, including girls-only programmes where appropriate.

Gillian Mackay: Are we doing that work well, in terms of joining up the physical health aspect with mental health and other issues? Is that cross-organisation approach working and are we recognising that individuals will have varying impacts from different parts of their life? Or are there areas where we can do better?

Robert Nesbitt: We have some really good examples of where we are engaging with young women and women with disabilities and people who are able bodied. We are listening to those voices and focusing on designing programmes that are designed by young women for young women or by young people with disabilities, including young women, for other people with disabilities, so that that grows. We are taking really strong steps towards that. Of course we can do more, and of course we can continue to look at what the research is telling us, what the voices of individuals are telling us, and then design the right programmes.

Lynne Glen highlighted the issue of funding. We continually look at funding and at the way in which we can create opportunities within that funding. Some of the challenge for programmes is the short-term nature of that funding. We continue to advocate for longer-term funding to allow us to reach people and engage, and to ensure that we are creating a real participation pathway to enable young women and women to be involved in physical activity and sport.

Ewelina Chin (HSTAR Scotland and BEMIS): Looking at a person-centred approach and giving women the opportunity to raise their voices and share their experiences is very important, but we also believe that education is vital for those who respond to those voices. Very often, through the decades, we have been in a position where we heard the voices but nothing appropriate happened after that. It was not because people were not willing to do something, but there was a lack of understanding and follow-up to the inquiry to provide the right action.

HSTAR works with many women from ethnic minorities, and I believe that, when we look at disability—not just physical disability but focusing on mental health and wellbeing—we need to realise that that background adds a kind of complexity. Having mental health problems, issues and struggles will be different for the Afghan community, or for the Ukrainian community, through their religion, their beliefs and the way in which their bodies respond, and we should be very well informed in Scotland. It is a beautiful place of great diversity, so the knowledge needs to be there.

Stephanie Callaghan: I thank the witnesses for being here. I will touch on the examples that Robert Nesbitt talked about of working with people to design spaces, which I am interested in hearing more about. Training and education can take us so far, but to have walked in someone's shoes is entirely different and can tackle poor design and inaccessible infrastructure. Do you have examples of projects where people have been involved in co-design and that has increased the numbers who use and access spaces?

10:45

Robert Nesbitt: I will highlight two strong areas. For the past two years, SAMH has been developing a young women in sport leadership programme to look at the importance of leadership and mental health in that space. We have worked with a group of young women who have become an expert panel for us and designed a programme that addresses the barriers and issues that young women face in sport leadership and leadership as a whole.

We involved 74 young women in a survey to give us rich data that helped us to focus the programme. The big area that we recognised coming through was that levels of self-belief, self-confidence and self-worth were strong barriers that were impacting and influencing young women's engagement in leadership.

We can look at the problem that we are trying to solve. In one of its reports, Scottish Women in Sport identified that the gap between men in leadership and women in leadership was widening, which we want to tackle.

Alongside my team and a variety of partners, the young women have helped to design a programme that embeds leadership and mental health together. I am proud to say that we will launch that shortly and that it will involve the whole of Scotland—including the islands, rural areas and the central belt—to bring young women together.

That is a real example of the voice of young women shaping and helping us to drive a programme. Over the next year, young women will tackle the question of having self-confidence, self-worth and self-belief.

Another big area for us is women in menopause, which we launched our report on with the University of Edinburgh at the beginning of May. More than 600 women shared their experience of menopause—of its impact on their mental health and its influence on their engagement in physical activity and sport. As a result of that research and our findings, we have put nine recommendations out there for people to see.

We are working with partners to bring those recommendations to life—we are speaking with the Government and individuals to shape and influence practice, particularly on things such as menopause-friendly groups, activities and resources. We have an expert group of women who have experienced menopause and they will shape, design and develop resources for women who are experiencing mental health and menopause issues, which will help to influence and shape the practice that is out there across communities.

Those are a couple of examples of where we are targeting such work, which is based on research and on the voice of women, including young women and women who are experiencing menopause. That will make a difference in communities.

Lynne Glen: We accessed UK-wide project funding from the Robertson Trust to put in place the Lady GOGA—get out, get active—pilot. In Scotland, we are not quite there with people understanding that rates of participation in physical activity and sport are lower for females and among ethnically diverse communities such as south Asians.

The Lady GOGA project gave us a bit of resource. It took an intense approach. The outcome was that in the Forth Valley area, the ratio went from one in three to one in two. That demonstrated to us that having a specific project targeted at females can encourage more females to take part.

The group of women from Forth Valley Disability Sport who were on the panel were then able to shape that programme and say, "These are the activities that we want." That comes back to the design of the activities and the women saying what they want. The positive outcome there was the increased participation of females.

The Convener: I am conscious that we have not heard from Baz Moffat or Heidi Vistisen. Do either of you want to contribute anything to the questions that have been asked so far?

Heidi Vistisen (LEAP Sports Scotland): I am happy to go first; I was just waiting to see whether Baz Moffat was coming in online. I will go back to what was said about access to facilities. I am trying to make sure that I do not lose my train of thought here; you pulled me when I was not ready.

We were talking about data, knowing who is participating and understanding that there are groups of people that we are not aware of and do not know what the levels of their participation are. We see that issue across the work that we do with LGBTIQ people, and specifically with lesbian, bisexual and trans women in sport. We have some data, a lot of which comes from third sector organisations and partners from across Europe and the rest of the UK.

However, we do not know what is happening across different sports unless those individual sports ask those questions and ask for that data. There is no centralised system where we can find out the levels of athletes or participants who have a mental health impairment, who might be LGBTIQ or who might have a physical disability or anything else.

We recommend that the inquiry considers that point. I will leave it there and see whether Baz wants to come in.

Baz Moffat (The Well HQ): I want to focus on the educational aspect that we have been talking about. We have been doing some work with CIMSPA, and for those of you who do not know what that is, it is the Chartered Institute of the Management of Sport and Physical Activity. It is a UK-wide organisation that is responsible for setting the standards from which qualifications can be written, whether those are Business and Technology Education Council qualifications, fitness qualifications or sports coach education. However, there has not been anything in the female health space—the only standard that has existed is in the prenatal and postnatal space—so all those courses on menopause or training teenagers have no standard to adhere to. There has been a real issue around the quality of some of those qualifications.

In addition to that, there is no standard level of education on female health in anything. A physical education teacher, a fitness instructor, a swimming coach, a rugby coach or a running coach will have no education on female health appropriate to their level of education as standard. You can go off and do a specialist course, but you will not know whether it is a good or bad course because there are no standards.

This summer we have written the girls and women standard with CIMSPA. It has been out for public consultation and we have had input from lots of brilliant agencies working in the space. The standard will be published over the summer, which means that whenever anyone wants to produce a new coaching course or qualification, they have a standard from which they can work out what they need to include or not. That is absolutely essential.

We can encourage people and do all the positive stuff around advertising, health promotion and engaging females better, but until we have a workforce that is educated about females, we will not have created a system in which females feel that they truly belong, whether they are females with disabilities or females from different cultures and backgrounds.

Until we educate the people who look after girls about female health—covering all the life stages from puberty, to prenatal and postnatal to menopause, including issues such as periods, bras, pelvic health and the increased risk of injury—and implement that into our coaching education, it will not matter how much we promote sport in order to get girls in, we will still see a gender gap in female participation and performance.

The Convener: Thanks, Baz. That leads us on to our next theme, which I hope that Heidi Vistisen will come in on.

Tess White: I have one question, but first I want to follow up on what Baz Moffat just said. I am going through the coaching qualification and I can see that I will have to do child protection, anti-doping and first aid as mandatory modules. Are you suggesting that in addition to those three, there could be a fourth module on women and girls?

Baz Moffat: Absolutely. However, I also feel that it is on the same continuum as welfare and safeguarding. We have just come from a sports lawyers conference and there were so many representatives from safeguarding from lots of different national sports governing bodies. They had a moment when the penny dropped and they realised that if they get female health wrong, it becomes a safeguarding issue. It can often be presented as a conflict: if we put female health in, what needs to come out? However, if we consider it as part of wellbeing and safeguarding, we will not be competing for space on coaching courses but will be saying that it is something that needs to be integrated into training.

Tess White: Thank you for that answer.

On a separate topic, we went out to talk to women and girls who do sports, and one issue that they raised was the colour of their sports kits. We know that sport is good for physical health, but they talked about mental health and the huge anxiety that they feel when their periods are coming—not just when they are on their period, but those times when they do not know when it will

come. That stops girls doing sport. However, some organisations do not see it as an issue and it is not spoken about. What further steps could be taken to minimise the impact of periods on participation in sport and physical activity?

Baz Moffat: We should broaden that point, because it affects not just the girls who compete in sport but the umpires, the referees and the middle-aged women, who are often expected to wear white shorts or skirts, or light-coloured clothing. As we know, when a woman enters perimenopause, their periods can become really erratic. We are losing coaches and supporters of younger women being active, too, purely because of what we are asking them to wear.

Fixing the issue is what I would consider to be low-hanging fruit—whether it is light-coloured shorts or whatever the bottom half of someone's kit is, it could easily be changed. We need to be far less prescriptive in what we expect young people and other people involved in sport to wear. We need to give everyone options so that they feel genuinely comfortable participating in sport, whatever their role. That is a really easy win.

However, it is not enough. Often people will say, "Oh, we've changed the colour of our kit from white to blue, so we've done female health." I know that, in Scotland, you do a brilliant job of ensuring that sanitary products are freely available in public places, but we need to ensure that wherever girls are moving, they have really easy access to free sanitary products without having to ask anyone, unlock a locker or have a conversation about it.

The other thing that we can do is educate girls and the people who support them about how important the menstrual cycle is and that it is a vital sign of women's health: if you have a regular menstrual cycle, that is your body's way of saying, "Brilliant—you are doing a fantastic job, eating enough food and being active. Your body is in balance and is coping with the stress and strain that you are putting on it."

It is not only a question of educating girls about what is healthy. Thirty per cent of women experience heavy menstrual bleeding. Some women have problematic periods, when their symptoms really affect their ability to engage in life, whether that is education, sport or music. There are lots of tools available to help them to manage their problematic period or their symptoms, and we should use those, rather than just sending them to the GP to be put on the pill. We should think about what we can do. Sports coaches can cope with that. We can put an ice pack on a sore knee or a hot-water bottle on a tummy while we are doing the team warm-up. It is a case of ensuring that people have all the tools available to help girls to manage their period symptoms.

11:00

The Convener: Does anyone else on the panel want to come in?

Ewelina Chin: I would like to add something about the importance of dynamics. When we talk about sport and being active, whether it is running a marathon or lifting weights, we are not just talking about sport. If we are to empower and encourage women, especially young girls who struggle with the mental and physical side of menstruation, we should not discourage them by not allowing them to participate. We need to create the right dynamic, which involves allowing milder exercises and having a substitute for activities so that women and girls are still included. They are still protecting themselves and doing something great, they are still being active and developing physical skills, but what is required if they are fit and are not bleeding is not relevant when they are bleeding. That way, women and girls can feel that they are fully active participants in activities.

Heidi Vistisen: We know from LBT women that being part of sport is a part of their bodily autonomy. Taking part in sport and using their bodies really helps them to find themselves and feel good about who they are.

I want to go back to the comments about kits and shorts. The issue goes beyond the colour of the shorts; it is much more about ensuring that participants and athletes can wear what they want to wear. I am sure that lots of people are aware that women's football shirts are more fitted than men's. The kit that teams are supposed to play in is just assigned to them. Women are supposed to play in shirts that are tighter and more fitted and shorts that are shorter than men's shorts.

I recommend that people should be able to wear what they want to wear. In particular, we should ensure that non-binary and trans people have something that they can feel comfortable wearing. They can be more likely to wear clothes that are baggy and they may not want to wear specific colours. It is really about having the flexibility to do all of that within different sports and settings.

Robert Nesbitt: I want to emphasise something that Baz Moffat said about education. One of the things that came through strongly from the women in the focus groups for the menopause report was the importance for them of being educated about menopause. Baz Moffat made a point about life stages. If the women had known particular things before their experience of something, it would really have helped them during that experience. That particularly relates to women's engagement

in sport and physical activity, and to seeing that as a tool to support them through an experience.

Education is hugely important. I am talking about educating organisations and services to go beyond policy and think about how they can create inclusivity in their groups and be really intentional in the approaches that they take. A big part of that must involve understanding what it means. As my colleague Heidi Vistisen said, for someone who has experienced a particular barrier, things like a kit can really help to break down such barriers. We must educate beyond policy and look at really intentional practical application across the sport and physical activity communities.

The Convener: Evelyn Tweed has a supplementary question on that.

Evelyn Tweed: Do we know whether coaches are being trained to understand how cycles or hormones impact performance? How are we helping young women and girls to understand the changes in their performance and why they happen? I saw Baz Moffat shaking her head there—perhaps Baz would like to come in.

Baz Moffat: Thank you, Evelyn. In summary, no, they are not. There is no education. People in this room might say, "Well, I know a coach who knows about it," and there might well be coaches out there who are finding that information out for themselves, but there is no standard education. That is why we need to have it mandated that coaches understand the monthly hormonal cycle that females will be going through.

Only 6 per cent of sports science research is done exclusively on females. When you hear about an athlete pulling up or a footballer getting an anterior cruciate ligament injury, people will say, "There's not enough research being done." The issue with saying that not enough research is being done is that lots of people then think, "Oh well—there's nothing we can do until we have the research." The 6 per cent of research that is done exclusively on females, which covers everything to do with females—pelvic health, breast support, hormones, all the life stages that we go through and our injury risk—is a really small amount of research from which we can start doing stuff, but we are not even addressing that research at the moment. We are not even using the research that we have. Therefore, we could do a huge amount.

No one is told about menstrual cycles, and no one is told about female health. GPs do not have as much information about women who are going through the menopause. Brilliantly, that has changed recently, but it absolutely has not filtered down into the world of sport and exercise.

Along with the standard that we have produced for CIMSPA, we have produced four courses that are aligned with the female health stages. We have a course on the female body, a course on puberty, a course on prenatal and postnatal health, and a course on menopause. We truly believe that we can demedicalise women.

At the moment, female health is very much in the hands of experts, such as gynaecologists, women's health doctors and academics who really, truly understand it. While we need those people—the brilliant minds that do all that fabulous work—we feel that everybody can cope with understanding female health on a level that is appropriate to the people and the populations that they are supporting. For example, a 50-year-old man who is coaching an under-14s women's football team does not need to know about the technicalities of the sports bra or how to fit a sports bra, but he needs to know how he can have a conversation with his squad of 20 girls about why they need to be wearing a bra, and he needs to feel safe and appropriate having that conversation and not to feel as though he is putting himself at risk.

That is what we are attempting to do—to get that education in place. The majority of girls are coached by men, and the majority of fitness trainers and the majority of sports coaches are men, so we have to create education that everyone—including people who have not had lived experience—feels that they can access without putting themselves at risk or feeling that it might be inappropriate.

The Convener: Emma Harper has a supplementary question.

Emma Harper: Thank you, convener. Good morning to you all.

I will pick up on what Heidi Vistisen said about uniforms. In the previous session, I talked about the Norwegian handball team that got fined $1,500 because the players wore shorts instead of bikinis. Wow! They broke the rules because they wanted to wear something that was more comfortable. There was also the German gymnastics team whose members wore the full-length unitard because they did not want to wear what was prescribed as normal. One of the articles on sportanddev.org says:

> "Recent conversations around women's uniforms have highlighted the deep-rooted sexism that often prevails in the sporting field."

My question for Heidi Vistisen, and possibly also Baz Moffat, is how important is it that we recognise that what women wear on the field for sports or physical activity needs to be their choice and not prescribed or mandated through a historical sexist approach?

Heidi Vistisen: Thank you, and good morning to you, too.

I talked earlier about the autonomy of being able to make your own choices and to decide what you want to wear. We see people coming out, who want to make choices for themselves about what they wear. We see the expression of their gender and the way in which they want to show who they are.

We have the idea that women must look feminine, or that a real woman looks feminine, and that we must therefore put them into uniforms, gymnastics outfits or bikinis that recognise that. All those decisions are made by sports governing bodies or competitions that are led by men. The inherently misogynistic and sexist nature of how sports have been set up and how they have been run for decades, or for hundreds of years, has filtered down to how people are expected to dress and behave. That is having a really detrimental impact on all women, and probably on all participants—especially on LGBTIQ participants, who often express their sexuality and gender in the way that they dress and present themselves. Prescribed ways of presenting themselves in sport have an impact on that.

Baz Moffat: I absolutely agree. There is a conversation to be had about team unity and the look for people who are involved with a team, but we need to give people options about what to wear for sport and activity.

The Convener: Our next theme is LGBTQ+ participation, on which Tess White has a question.

Tess White: I have a question for Heidi Vistisen. Women in Sport has highlighted that adult males have 40 to 50 per cent more upper body strength, 20 to 40 per cent more lower limb strength and 12kg more skeletal muscle mass than women. All of that has implications for trans inclusion in women's sport, as sports councils and governing bodies are finding. How would you strike a balance between inclusion, fairness and safety in women's sport?

Heidi Vistisen: I will highlight a couple of areas. I want to be completely clear. Having trans women participating and competing in sport has been presented as a threat to women's sport, on the basis of some of the evidence that you have shared today.

I do not believe that there is any evidence that that is the case. Transgender athletes are not, and never have been, a threat to women's sport. I do not know the exact evidence that you have shared, but we believe that trans women should be able to participate in sport. There are obviously some areas in which we would want to consider the evidence, and there might be areas where there should be restrictions on participation. However, we would not stand for any blanket exclusions or any bans on the participation of trans women in women's categories.

Tess White: You have not answered my question, Heidi. My question was about how you would strike a balance between inclusion, fairness and safety in women's sport.

Heidi Vistisen: I would disagree that it is not possible to have that balance in what I have described. If you use the lawful measures that are already available to restrict access when necessary, that is how you strike a balance between fairness and inclusion. Transgender people will be able to participate where they want to, and any restrictions or policies that are already in place should be followed. That is how access can be provided.

Tess White: You are still not really answering the question about how to strike a balance between inclusion, fairness and safety, but I will leave it there.

Heidi Vistisen: Thank you, Tess. It might be worth us picking that up separately, so that I can answer your question better, if that is all right.

11:15

Gillian Mackay: How do we ensure that we support trans people—and non-binary people in particular, who are often lost in some of these conversations—to participate in sport and on-going physical activity? Much of our inquiry is about physical activity. Given the issues that we have seen with the way that trans people and non-binary people—who, as I have said, are often excluded from some of the narrative—are portrayed in the media, how do we allow spaces such as gyms and participative classes to be safe for them?

Heidi Vistisen: I am assuming that that question is directed at me, too.

Gillian Mackay: Yes, please—sorry.

Heidi Vistisen: No, that is all right.

It is really important that we still see them just as other people. As we have heard from others today, we need to ensure that the voices of all our participants, and all the people who access our spaces, are heard. We need to ensure that we have in place the indicators to enable us to hear from people, and to ask, "What is it you need?" and "Why are you not participating in this area?"

We hear about young women and girls who stop participating, with a higher drop-out rate than the rate for boys at the age of 14. It is the exact same situation here; we ask, and we figure out what is happening, what kinds of barriers those people are meeting and what we can do to support them.

As for specific things, we would be talking about kit and uniforms, and making sure that there were spaces in changing villages to enable people to change in a safe space, and spaces where people could interact in that sense.

Gillian Mackay: That is great.

Lynne Glen: It comes back to the whole intersectionality conversation. Scottish Disability Sport has an inclusion model that can be used for anybody; it is participant centred, and it is about listening to people and bringing to the table all the ingredients that they need to enable them to participate in physical activity and sport.

We also have a regional team that provides bespoke support. With anyone who wanted to take part in physical activity or sport, or who came to us through a physiotherapist referral, no matter what their background—their socioeconomic background, whether they were gay or from an ethnically diverse background, or whether they had poor mental health—we would work with them individually to support them into an opportunity of their choice. If the issue of changing places was a consideration, that would need to be looked at. If it was about equipment or kit, our regional manager would provide that bespoke support.

I think that we all see, across the board, that it is about taking a participant-centred approach and looking at the issues through an intersectionality lens instead of simply looking at different protected characteristics in individual silos, because we do not want to get into some kind of pecking order situation, or a bun fight over status, or whatever. We simply use our activity inclusion model.

When it comes to competition, other considerations come into play, but with general participation, it is all about having a participant-centred approach and using the model to bring to the table whatever an individual needs to enable them to access physical activity and sport, and to remove the barriers.

Sandesh Gulhane: I agree with everything that Lynne Glen said about ensuring that we try to get everyone involved in sport, because we know that it helps with mental health and so many other things. Stigma can put a barrier in the way of people from the LGBTQ+ community wanting to participate in sport.

I turn to Heidi Vistisen. Heidi, I have some direct questions in response to your answers to Tess White. In one of those responses, you used the phrase “when necessary”. When is it necessary?

Heidi Vistisen: You will have seen the guidance around gender-affected sport—I am just assuming that you will be aware of UK Sport’s guidance. We are under no illusion that there might be competitions and sports where restrictions will be needed. However, we would always say that sports governing bodies should apply those restrictions based on the evidence available, and they should be based on actual information and research that would ensure that the impact is considered.

Sandesh Gulhane: Can I just pause you there? My question was about the phrase “when necessary”, which you used in response to Tess White. Can you give me some specific examples of when this is necessary?

Heidi Vistisen: I am afraid that I cannot, because I cannot give you any specific examples of specific sports. I apologise—I might have been broad-stroking in my answer; what I meant was that we need to ensure that we do not just blanket ban trans women from a sport, but that we potentially put in restrictions or supportive measures that mean that someone is able to participate if they are able to meet specific levels of testosterone, for example. I should say, though, that I do not think that that is always necessarily the best measurement.

I apologise if I used language that was not completely clear. I am not able to go into specifics about where restrictions would be necessary, but I believe that, to support inclusion and highlight the participation of specific trans women or specific people, it would be useful to have supportive guidance and measures in place.

Sandesh Gulhane: Okay. Let us look at someone who wants to train to be a runner or an athlete, for example. There should be no barriers to training, but when it comes to the competing side, World Athletics has said that trans people cannot compete in women’s categories. Is that an example of where the governing body has said something that needs to be put into place at the more junior levels?

Heidi Vistisen: Unfortunately, we are seeing the trickle-down effect of policies that are being put in place at the world level or a competition level. However, for many governing bodies—for example, Scottish Athletics or UK Athletics—that does not necessarily mean that the home nation needs to follow the exact policy. They can still put in place their own policies.

That said, because of the focus on the issue at the moment, there is a worry that individual grass-roots sports at the competition levels in individual countries are being influenced by the policies that are coming on to the world stage. I do not believe that competition levels will be directly affected because of a World Athletics rule set, unless it is put into restrictions or rules in Scotland.

Sandesh Gulhane: My final question is about participation in sport for everyone, whatever level they play at. If I want to play squash, I want to play

against somebody who is at my level, and I want the playing field to be level in everything that we do, because sport is inherently not fair. There are categories in everything. Do you feel—I suppose that you could give your personal opinion or LEAP Sports Scotland's opinion—that trans athletes have an unfair advantage in participating in competition compared with biological women?

Heidi Vistisen: No, I do not.

Sandesh Gulhane: Thank you.

The Convener: We will move to our next theme, which is ethnicity and religion.

Emma Harper: What I am going to ask is similar to what I asked earlier, and I will also come on to uniforms.

What are the particular challenges facing women and girls from ethnic minority groups in participating in sport? Obviously, there are real challenges; it is quite apparent from some of the statistics that have come out that ethnic minority girls and women do not have the opportunity to participate or even engage.

I will go to Ewelina Chin first.

Ewelina Chin: When we work with females from ethnic minorities, we definitely need to understand their culture. We need to understand their religion and respect what is linked to who they are.

As for sporting activities, we often hear the very upset voices of younger girls, who will say that having a hijab or scarf might affect their participation. However, they are okay with it. What is not acceptable is the response from their peers and coaches, who try to encourage them but do not understand that such factors are a part of their being. We need to understand that we cannot change someone's existence or values, because of the needs of a sporting activity.

On changing rooms and same-sex activities, as much as we support transgender women and provide therapy for them, we need to follow the needs and requirements of other communities—for example, those of the Muslim community, where being transgender is a taboo. It is hard to understand, but that does not mean that there is a lack of respect or acceptance. In sport and physical activity, our main clients are Pakistani girls, who really need to be safe, to take part in same-sex activity and to have the opportunity to be surrounded by women only. It is crucial for them to be heard and for their beliefs to be accommodated, too.

By other ethnic minorities, I mean not only Muslim or Arabic communities but the eastern European community, which looks differently at engaging in sport. I am Polish, and my belief is that being a woman involves a kind of dignity that I would like to protect. I would not really feel free if I did not have the opportunity to use all-female toilets. That is a basic human need, but I would like it to be heard and understood.

I love everyone—all human beings—and I am happy to offer support to anyone who needs it. However, ethnic minority women need to be heard, too, and their rights, religions and beliefs should not be violated just because we are pushing a general agenda. It is hard to find a gold-standard solution for everyone, but I believe that by providing person-centred approaches we will arrive at good solutions.

Robert Nesbitt: In response to your question, we worked with our partners Scottish Athletics and jogscotland to create a project called "Community strides", which aimed not only to increase participation by people from ethnically and culturally diverse communities, but to blend in mental health awareness, because of the massive stigma that we knew was around mental health issues there.

Through our work with community champions and leaders of culturally and ethnically diverse communities, we identified religion as a major influence. Beliefs about clothes and how they are worn—for example, having to wear short-sleeved clothes to take part in sport or physical activity—were big issues that we had to address. However, we were lucky; hearing the voices of the people from those communities helped us to work with others to obtain sports clothing that covered people's arms and legs, which then meant that women could participate.

Even the environment was a factor. We had to consider having a closed environment, because the idea of people watching was a great barrier. One of the best solutions involved having community leaders and champions coming in to help to influence and shape our approaches. We must do much more of that kind of work, in which the co-design and co-production of projects involve people who recognise such barriers, so that we can find solutions that lead to participants being far more engaged.

I will give you an example of that, involving a group of about 12 women. As a result of there being a champion in that group and the other women taking part in those activities, they went on to join jogscotland networks. They joined their local group, because barriers had been broken down. They felt included, they were involved in the whole design and they were involved when they went elsewhere. That was really important—it is so important to listen to people's voices and to recognise all those aspects.

11:30

Emma Harper: You spoke about the environment and the ability to participate without others watching. There is a women-only gym in Dumfries, for example—I hear amazing music when I walk past with my dogs. Today, we are talking about how we encourage women and girls to participate in sport. Part of that is about recognising the need to be able to participate in a safe place, without fear of being judged or someone criticising you for wearing a hijab for instance. We know that it is easier to buy sports hijabs now. Is getting the rock music on and having women-only gyms part of how we make progress towards greater awareness and acceptance of women from ethnic minorities participating in sport?

Robert Nesbitt: The reality is that you can have a fantastic venue with fantastic equipment and individuals in it, but you must reach out to people to help them to reach in. You have to listen to people and hear from them what will support them to go to a particular place.

We talk about three areas in relation to an environment and its culture. First, it must be safe. Secondly, it must be secure, and in a way that recognises people's points—for example, we covered windows, which meant that people felt safe in that it space. Thirdly, it must be supported.

As my colleagues on the panel, including Baz Moffat, have mentioned, if we educate and help people to understand ways in which they can bring those environments alive and support them in doing that, we will see more people engage, because their voice has been heard. They will come to those spaces that have been designed and developed on the basis of all those considerations.

It is also about choice in how people can engage, participate and achieve in that space.

Ewelina Chin: As you mentioned, when we think about some communities, especially a Muslim one, the girls cannot do sport because of stigma.

In Stirling, we have an extremely busy roller-skating group. Every session is fully booked, and there are between 20 and 30 young people skating. You would not believe how great it is. How did that happen? We heard people's voices and about the need to organise such a group.

We provide walking therapy—it is a walking support group. That is a beautiful act of inclusion. It is not a sport-heavy activity; it is the promotion of healthy lifestyles. Sometimes, we have groups of three women; at other times, there are 14. We go for a walk, and do breathing and grounding exercises. Sometimes, the 14 women in attendance are from 14 different countries.

We can bring a lot of opportunities by listening to the voices of people as Robert Nesbitt said.

Emma Harper: Inclusion is a great way to tackle racism.

Ewelina Chin: Definitely.

Emma Harper: We know that, when we live and work in the same communities, we learn from each other. What specific things could be implemented to tackle racism in sport, whether that is related to religion or to the fact that some people do not understand certain cultures?

Ewelina Chin: Not long ago, the Scottish Government was looking at its hate crime strategy. That was a great time, and very meaningful documents were created. However, there is still a lack of understanding about what a hate crime is. Maybe we could start by raising the issue of otherness, because it is not only verbal abuse that falls into the category of hate; it is not only the physical violence that creates hate. Talking about otherness and bringing knowledge of that as part of education, as well as understanding what a hate crime is, helps us to understand all aspects of racism. That shows the importance of learning about other cultures and their religions.

Lynne Glen: What everybody is saying is absolutely spot on. We need places for people to go and participate in sport, and especially for smaller groups to take part. As you will be aware, there is a leisure facility crisis going on at the moment. We need places for people to play sport, and we never get massive numbers, but sometimes there are no places. If programmes do not wash their faces to begin with, they are not allowed to grow and develop, and we do not hear people's voices. That is where we are facing great challenges at the moment.

We cannot find facilities for people to go and participate in sport, and that situation will get worse because of the current challenges for leisure facilities, which we can understand. As a result, wider health inequalities are developing. People with disabilities and other groups have been the hardest hit by Covid. There is a direct correlation between people with disabilities, affordability and employability. That links back to people from ethnically diverse backgrounds, too, because employability is a challenge, so affordability comes into it. Muslim women and men were hardest hit with Covid, as well.

Health inequalities are becoming greater. We need places for people to go and participate in sport, and we are finding challenges with that. We need to make everybody in the room aware that, if we do not do something about it, health

inequalities will become greater and greater. It is just a plea for income. You might get two or three women with disabilities who want to go on a programme together, but that will be cut short because the facilities are not washing their face. It is a barrier.

Sandesh Gulhane: I would like a one-word answer to my first question, if that is okay, and I might just go down the line of witnesses. Do you hold data on the ethnicity of people who participate in sport in your organisation?

Heidi Vistisen: Not across the board.

Sandesh Gulhane: I assume, Robert Nesbitt, that you do not have that data.

Robert Nesbitt: It would depend on the programme that we were delivering and on whether it was part of the processes and evaluation that we were doing. We have elements of that in the work that we do.

Lynne Glen: Yes, we do.

Ewelina Chin: We do.

Sandesh Gulhane: I have asked many different people—from elite sport through to other areas—that same question and, invariably, the answer is that they do not hold records. Your group is exceptional, Lynne. If we do not know the ethnicity of the women who are participating in sport, how can we know how to do better?

Ewelina Chin: Gathering basic information is key for providing the right response. An intake assessment process is part of our work. Through that, we gather basic information to provide a safe service. Getting to know someone's ethnicity is an integral part of a trauma-sensitive and person-centred approach. We do not only offer free counselling in 26 languages; we follow people's individual needs. Not only does the intake assessment give us information about family status, social inclusion and ethnicity but it identifies individual needs.

After the process of providing the service—no matter whether the person needs advocacy, befriending, counselling therapy or walking therapy—we follow up to get feedback. The feedback provides solid evidence of how well we did and how the service has made an impact on each person. When we look at the statistics by ethnicity—Ukrainian ladies, for instance—we can clearly identify which kind of activity works the best and which service is the most appropriate for certain groups. Therefore, I believe that gathering basic information should be a part of the work of every organisation.

Sandesh Gulhane: Absolutely. I highlight something that you said earlier: that the culture is different. You highlighted Ukrainian women and Muslim women, but we are also talking about different types of Muslim women. All the different ethnic groups are different, and the data that you collect will help you.

There are two big things about which I would like to ask. First, how do we encourage more ethnic minority women into just doing some sport, whether that be the gym or participation? Secondly, how do we get those women to be elite? Lynne, because your organisation has the data, I ask you to comment first.

Lynne Glen: Sure. It goes back to listening to the voice; it goes back to the opportunity; and it is about that supported and participant-centred approach, working in partnership with the agencies so that we can increase the reach. It goes back to the imagery, the language and the relatable opportunity—for example, whether the gym is a women-only one. The biggest thing is that it has to be fun and it has to be social. That has been missed from the conversation today.

It is also about the opportunity for people to dip their toe into a club or an appropriate competition. In disability sport, we support people to access competition and opportunity. We have some good examples of work with Scottish Swimming and Scottish Athletics in female-only camps. We bring people together, and peer support comes from that. There is also an element of rivalry when it comes to progressing in the sport.

For me, it is about partnership working and a participant-centred approach—listening to the individual and putting in place what they need in order to progress.

Robert Nesbitt: There is a variety of things in what is a complex landscape. As we have said, we have to understand the needs of particular groups and how to engage with those.

We need to start young. Sometimes, we have to react to situations because we have become aware of a need and we respond to it. We need to start focusing on being much more preventative and more proactive at earlier stages.

Another aspect is about recognising the need in particular groups and the barriers to participation for them. We cannot take a blanket approach. We have to be very specific with particular groups—to see where their need is and to respond to that appropriately.

As part of that, we have to empower young women to see themselves in particular places. That is important because, in our research and in the feedback that we have received from women, that sense of impact and of self-belief, self-confidence and self-worth are huge markers. The stigma that is associated with women's mental health, and the experience of that, are barriers that

are preventing women, including young women, from seeing themselves in particular places. If we are to empower them, we have to think earlier about being proactive, about the language that is used, and about how we create inclusive environments that are beyond just a policy that is intentional in approach, as I said earlier. As others on the panel have said, how we educate, how we connect, and how we have our programmes designed by the people that we are trying to support—in this case, women, including young women—has to be a big player in that.

Earlier, the idea of role models was spoken about. We have to shine a light on role models that people can relate to and see, and help them to understand not just what their story is but how they then got to where they are, so that more women, including young women, can see themselves in that place as well.

It is a complex area, but work is going on. We continue to need to enhance and grow that work and to involve people in that space.

Heidi Vistisen: I just want to go back to data, for a second. That was a great question, and I thank Sandesh Gulhane for highlighting it. I want to clarify that it is not that we do not care about such data. That is not why we do not collect it. We collect it when it is relevant. We come from a place of trust. We work with people who are not out in their sport setting or who are not out to the people around them. They might have shared their sexuality but not their gender identity. We do not always want to ask lots of questions for the sake of—

Sandesh Gulhane: Is someone's ethnicity not already out there?

11:45

Heidi Vistisen: What I am saying is that we do not necessarily always ask questions that are important for that specific work. As you said, someone's ethnicity is often already out there, so it is not always important for us to ask about it straight away in relation to our delivery.

My point is that it is not always the responsibility of third sector organisations to have all the relevant data. Of course, it is important for us to ask questions, and we use that information for lots of different work that we do. For example, we are just starting a project relating to LGBTIQ refugees and asylum seekers, and it is very important for us to know a bit more detail about the background of the people who participate. However, it is not always important to get such information from someone who joins a volleyball session on a Monday night. They do not need to give us lots of information—it is sometimes enough just to get their first name and contact details. There are therefore some instances in which it would not be relevant to ask someone for lots of information about their demographic and characteristics.

However, there needs to be more onus on governing bodies such as sportscotland to have that data. We should ensure that they ask such questions so that they can record the participation levels of different groups. That would allow us to benchmark against the percentage of people who take part in our groups and in others.

Robert Nesbitt: We also—

The Convener: I am sorry, but Emma Harper wants to ask a brief supplementary question that might tie in with what has been said.

Emma Harper: My question might tie in with what Heidi Vistisen said about data. The Scottish Government has data from the active Scotland outcomes indicator equality analysis. It is very complicated. The data shows that 77,000 people in Scotland describe their religion as Muslim and that there are 16,000 Hindus, 13,000 Buddhists and 15,000 from other religions. I will not go on but, when all those groups are combined, they still account for less than 3 per cent of the overall population. It is difficult to take apart all the aggregate data.

Heidi Vistisen talked about the need to engage with and develop folk at the grass-roots level. Is getting in about communities and supporting people to participate in whatever sport they choose what is important?

Ewelina Chin: Safeguarding must be the first consideration when providing services for female survivors of trauma. Especially if we are focusing on women from ethnic minorities, if we are to work in partnership, we need to ensure that we share information about partner organisations that are safe for our beneficiaries. Transparency and the detailed gathering of basic information are vital to the credibility of us all, to trust and to the recognition and quality of services. The statistic of 3 per cent was mentioned. I believe that the percentage might be higher if more information could be gathered. I hope that that makes sense.

Lynne Glen: Sportscotland is starting to gather information on equalities statistics. That includes information on ethnicity. We are trying to do better in that area. We are working with someone from Lifestreams Consultancy, and we are gradually working our way around our 14 member branches. It is about educating the volunteers in our branches about different cultures and how we can better engage with different groups across the country. That involves making connections with local groups such as housing associations, which are sometimes the one-stop shop for lots of different communities. I just want to make the

committee aware that we are trying to make a difference in that regard.

The Convener: We are getting a bit tight for time and we have two more themes to cover, so I ask people to keep their questions and answers short, please.

Carol Mochan: My question is linked and is about socioeconomic factors and deprivation. Lynne Glen's points were well made. Do you or other panel members want to highlight anything that we can consider when we think about how to help?

Lynne Glen: We know about the natural correlation between disability and poverty—47 per cent of households that are living in poverty have someone with a disability living in them. For us, school is crucial in accessing kids. To go back to Gillian Mackay's earlier point, how do we reach different groups and not just wheelchair users? We must work in partnership with education and use the activity inclusion model to bring to the table what an individual needs, which sometimes means finding equipment or accessing funds so that a person can access physical activity and sport.

Carol Mochan: Is there anything that is particular to women and girls, or is the issue more general? Do some socioeconomic factors specifically affect women and girls?

Lynne Glen: There are issues with benefits. Also, for females who have left school—we know that the drop-off in participation starts at 14—one thing is affordability for a female who has responsibilities, and another thing is that opportunities to get back into physical activity and sport are not always there for women with disabilities. Affordability comes into the question, too.

Ewelina Chin: Women who reside in rural places and places that are more deprived experience a massive restriction not only because of finances but because of public transport. Ladies are often scared about their safety or are unable to access transport. No accessibility is provided in rural places.

We work with women in Easterhouse in Glasgow. We have just had a conversation about the subject and the vast majority of the women said that they do not participate in any sport activities. They do not allow their girls to participate in sport activities, because that would require them to use public transport, which is not the safest after dark. Most classes are held in the evening. That is not an issue in the summer, but the summer does not last for long, so a class at 6, 7 or 8 pm for a mother or a child is unacceptable, because the risk is too high. I have no idea, but maybe ensuring safety on transportation and gathering people together at a community level could raise participation levels in sport activities a bit.

Carol Mochan: That is helpful—thank you.

Robert Nesbitt: Women whom we spoke to highlighted three factors that are significant to poverty and barriers. One was the lack of affordable childcare that was available at a time to enable women to engage in sport and physical activity. Another was the affordability of sports equipment and memberships for clubs and gyms, which was a big area. Transport—particularly its safety—was another factor. Women lead busy lives and are looking after children; when they have to get public transport, it needs to be available and safe, which means that it is difficult for women to participate in physical activity and sports at certain times. There is a correlation between poverty and those areas.

Lynne Glen: Care provision is a huge factor for women with disabilities; we know the challenges that health and social care partnerships across the country are facing. That provision is vital to enabling women and children to access physical activity and sport.

Baz Moffat: I will be quick. I will pick up on what Lynne Glen and Robert Nesbitt said about starting early and talk about the gender play gap from the age of five between girls and boys. Girls move a lot less than boys do, and they do not learn how to move their bodies in time and space. If we look at a playground, we see that girls are not doing rough and tumble play, running, landing or throwing, so they are less physically mature in their ability to move. If girls' bodies do not feel good when they are moving, and they then go into puberty and their bodies get longer and lankier and they feel even worse when they move, that exacerbates the gender gap.

We must make sure that, in the school setting, we are specifically and intentionally teaching girls how to move their bodies well, so that they enjoy movement and have much more desire to learn a sport. I know that there is a lot of socioeconomic stuff layered on top of that, but we can do a much better job in schools to teach and coach movement patterns.

The Convener: We move to our final theme of looking to the future.

Stephanie Callaghan: North Lanarkshire Council is taking a community approach and is looking at having community hubs that are located alongside schools or early learning and childcare settings, or, possibly, libraries and cafes, as a way of keeping mums there, bringing them in and getting them involved in new activities that are based on their interests.

Ewelina Chin mentioned developing a roller-skating session that grew out of people's interests. At one of our previous meetings, Rudi Urbach from Scottish Rugby talked about changing the rules of the game to suit women and what they want to do. Is that something that should start in schools? How do we stop women and girls—particularly those who are affected by other inequalities—dropping out of sport early in secondary school?

Ewelina Chin: We learn most when we are children and are like sponges. If we focus on the youngest girls and take the right approach, and if our coaches are the walking evidence of what we are talking about and are well trained and fully aware of the importance and benefits of girls' participation in sport, I believe that it will be far easier for young people to participate happily. When people are passionate about something, it is hard for them to give up after a first mistake.

The approach is very important. If sport is not mandatory, and if we show people that it is not something that they have to do but something that they might love, we can give girls time to find out whether they like it. Robert Nesbitt and Lynne Glen mentioned listening, which should happen not only prior to providing the opportunity. The opportunity should be given, and people should be allowed to withdraw without consequences. Nothing fits everyone, but a trial period can sometimes be great. I love taster sessions, because they let me find out whether I like something.

Young girls can have different expectations. They might join an activity but not find it enjoyable, or it might not be what they would like it to be. They feel guilty and embarrassed and they do not feel comfortable about sharing feedback. We should ease the pressure and should bring some excitement or passion. It is key to have passionate well-qualified people.

Stephanie Callaghan: I have another question for you, and maybe others could also come in. It is great to hear you talking about fun and enjoyment, because that is where it all starts and that is where motivation comes from.

We have focused quite a lot on sport, but healthy activity outwith sport is incredibly important too. In Vienna, all government agencies are required to have strategic plans and initiatives for equitable policy and there is a gender mainstreaming model. The research has found that girls who are aged nine and upwards barely use parks. That model has been adopted in many other countries, including in Berlin, Barcelona, Stockholm and Copenhagen. Do you think that Scotland should consider having a similar holistic model that focuses on gender alongside race, disability, mental health and other issues? I am happy for you to answer that and to open to anyone else.

12:00

Ewelina Chin: I do not believe that exclusion should be part of building diverse and equal communities. Using a holistic approach has a special power to reduce instances of a lack of understanding, so providing equal approaches is important. I believe that it is about creating an inclusive community. If there is a voice for full inclusion, of course I would say, "Why not?" However, if importance is placed on creating a sub-community that may not find everything comfortable, it is worth listening to that community. Nevertheless, a holistic approach is a great tool.

Lynne Glen: I will go back to your earlier point about keeping people involved, which is about education. We know that it is policy for everyone to be included in PE, but does it happen in practice? Unfortunately, we still hear about instances where that does not happen for people who have disabilities.

To answer Stephanie Callaghan's second question, I think that we need to work across sectors: we do not need to look at sport only but should include health, education, local authorities, trusts and third sector organisations. To achieve Scottish Disability Sport's vision of—to paraphrase—a welcoming and inclusive Scottish sporting society, we need to work across all sectors and we need education across them. We also need policy and strategy to back that up.

Stephanie Callaghan: I am mindful that we do not have much time left. We tend to design for the default male, because of who is in position. I am interested in the fact that the countries that I mentioned have a gender mainstreaming policy, which means that all government departments have to use it in their strategic plans. Wider inequalities also need to be included. Is that something that you think we should be focusing on, and could it be helpful?

Lynne Glen: Yes. If something is not in policy or in strategy, it gets lost in operational plans. The resource will not come in to back it up and make things happen.

Baz Moffat: We have to have a holistic and comprehensive approach. Sport England said that, in order for organisations to get funding, they needed to work towards having 30 per cent female representation on their boards. Now, all governing bodies that receive funding from Sport England have 30 per cent female representation on their boards.

The same happened in the field of research. In America, they said that organisations would not

get any research money unless they were studying females as well as males. Suddenly, everyone is studying females alongside males—whereas before, everyone said, "It is too complicated to study females. We will just apply what we have learned from the male population to the female population."

There is no one fix. We have talked about kit, facilities and education—we have to look at all of it as a systemic change and look at sports and exercise from participation through to the podium and performance through what we call the "female filter". That should be applied to all aspects of the work, and we should not just think that there is only one thing that we can do. Without a doubt, to my mind we need to be holistic and comprehensive. We need to mandate things, as well as do the little things. We also need to consider a carrot and stick approach.

The Convener: Before we finish up, Tess White has a brief supplementary on one of the issues that we discussed earlier.

Tess White: Baz Moffat touched on the subject of boards and we have explored the importance of having role models—females, people with disabilities or people from the black, Asian and minority ethnic group—as well as the importance of data. You said that most coaches are men. In your view, how do we shift the dial on that so that we have leaders and coaches from a wider cross-section of people, including more women, people from the BAME community and those with disabilities?

Baz Moffat: It is really hard being a coach, because it generally involves weekends and evenings. If someone has caring responsibilities, that is often when they will be caring for the people for whom they are responsible, and those with such responsibilities are predominantly female. We have to look at how we support our workforce as well as encouraging girls and women to do more sport and physical activity.

We are working with governing bodies to ensure that there are menopause policies in place and that we are creating supportive networks for females. It is not just about giving them the leadership programmes but about creating environments in which it is not expected that they will need to stick to a rigid sporting structure—for example, "You have to train on a Tuesday night and on a Saturday morning, and you have to commit to do everything." It is about taking a much more flexible approach to ensure that we have more female volunteers and coaches supporting girls and women.

David Torrance (Kirkcaldy) (SNP): Given everything that you have talked about around participation and getting women into sport, how much of a role do social media play in stopping them?

There is a reason that I highlight that. For example, we might think about the rise in women's football. Every image that we see on social media such as TikTok, which every young woman uses, is not the kind of image that you are talking just now about portraying in order to encourage women into sport. I could name one Aston Villa player who is always on TikTok, and even the equipment that these players are wearing, such as £250 Predator football boots, are things that young girls in areas of deprivation are simply not able to afford. How much do social media play a role in discouraging women from going into sport?

Robert Nesbitt: I think that social media will always play a part on some level. It goes back to some of the solutions that the panel has been reflecting on. It is important to look at who the role models are and whether they recognise the need to ensure that they do not play a further part in driving the inequality gaps across our communities.

Those aspects are significant. We have to be able to tell different stories alongside those stories, because some of those social media images encourage other young women to take part. They see those images and they have a dream and a hope, so we need to nourish and empower them in that.

We need to work with role models to look at the messaging on social media and how that comes across. We also need to recognise—to take your point about £250 boots, for example—that others might experience those images differently.

We need to look where we take imagery from. We recently worked with Public Health Scotland on a campaign with sportscotland, and one of the things that we looked at was imagery. We looked at photos in areas across the country that represented different places where people lived. We made a decision to do that. There is an opportunity for us to find real solutions where we can share imagery that is representative of the diversity of Scotland, and which represents different groups across our country.

The Convener: I have one final question, because we did not quite cover this when we talked earlier about LGBTQ+ participation in sport. My question is specifically for Heidi Vistisen.

Do you think that sport and physical activity are welcoming for lesbian women and bi women? How do we ensure that they feel included in a sports and physical activity environment?

Heidi Vistisen: I really want to say yes, they feel really welcome and included. However, that is not always what we hear. We hear that about half

of lesbian women are not out in the sport that they play, and we also hear—I want to make sure that I get this right—that only a quarter of bisexual women are out in the sport that they play; that is actually not very many.

The reason for that is simply the stereotypes that come alongside being out in sport, and the idea that you must be a lesbian if you take part in specific sports. We hear from women in the groups that we work with that they were not out when they were younger because they did not want to be branded a lesbian. They were worried that people would assume what their sexuality was or that it was because they had been turned: that if they joined their team knowing that there were lesbians in it, they would also become a lesbian. There are some clear barriers in the stereotypes that follow physically active women in that sense, and that does not just affect lesbians and bisexual women; it potentially also affects those who are on the teams of those women.

I want to go back to some of the comments about how we can get more women to be coaches or be in those sorts of roles. We have heard about that from some of the people we work with. There is a woman who is a football coach for young girls and she wants to do the job really well because she is aware that there are not many like her. She is a woman with a diverse sexuality. She does not necessarily want people to know that she has a sexual orientation that is not straight. However, the girls keep asking about it, and she is getting complaints from parents, who are saying, “You don’t need to shove your sexuality down our girls’ throats. They’re already at danger of becoming a lesbian for taking part in football.”

Those sorts of instances are not going to make women more likely to become a coach. If they already feel that they cannot be out in the sports that they play, why would they ever become a coach? Their whole life would be centred around those sorts of stereotypes, and escaping those can be challenging.

There is definitely something about the media, social media and the imagery that we use around the people who are coaching. The majority of women’s football is coached by men. We see great women leaders who are doing it, but there is definitely a lot of work to be done on the inclusion of LBTI women in that space.

The Convener: I thank you all, including Baz Moffat, who is online. You have made a very valuable contribution to the committee’s inquiry.

You can leave as we continue our meeting—you do not need to wait.

At our meeting next week, we will continue our inquiry into female participation in sport and physical activity and undertake further scrutiny of NHS boards.

That concludes the public part of the meeting.

12:12

Meeting continued in private until 12:40.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba