OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 14 March 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 14 March 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
9th Meeting 2023, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Katie Heath (The Young Women's Movement)
Jenni Snell (The Young Women's Movement)
Maree Todd (Minister for Public Health, Women's Health and Sport)
Annalena Winslow (Scottish Government)
Will Wood (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 14 March 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

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

I thank everyone who came along to our informal engagement sessions in Dunfermline yesterday. Those sessions were extremely informative—not to mention fun; the latter ones were especially fun—and they will be very useful in informing our inquiry into female participation in sport and physical activity. We had an informal round-table session with the Scottish Sports Association and many other sports bodies from throughout Scotland, which was extremely informative. We then went on to the Carnegie Judo Club and heard about the Fighting Chance Project in Dunfermline. We finished off at Dunfermline Reign Basketball Club, which hosted us. We were put through our paces in both clubs—some of us more than others. We will see that when the photographs emerge from the sessions. It was a fantastic opportunity to speak to women from a couple of different demographics who are involved in sport. I thank them for hosting us.

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

Members *indicated agreement.*

Patient Safety Commissioner for Scotland Bill: Stage 1

09:01

The Convener: The second item on our agenda is our final evidence session on the Patient Safety Commissioner for Scotland Bill, at stage 1. Today, we will take evidence from the Minister for Public Health, Women's Health and Sport, Maree Todd, who is joined by Scottish Government officials. Annalena Winslow is safety, openness and learning unit head and Will Wood is the Patient Safety Commissioner for Scotland Bill team leader. I welcome all of you.

I believe that the minister has an opening statement to make.

The Minister for Public Health, Women's Health and Sport (Maree Todd): Yes, convener—I have a brief one.

I thank the committee for inviting me to give evidence, and I pay tribute to the work of Baroness Cumberlege and her team and the patients, healthcare staff and professionals who have worked hard to contribute to development of the bill. I am certain that future generations will benefit from safer care because of their efforts.

It will be helpful to make some brief opening remarks to summarise the intention behind the bill.

Patients, their families and the wider public have told us that, too often, they do not feel listened to when they raise concerns about the safety of their care. The patient safety commissioner for Scotland will be an independent public advocate whose primary focus will be on ensuring that the patient voice is heard in the healthcare system, in order to make care safer for all. Patients told us that the commissioner must be independent of both Government and the national health service. That is why we are proposing that the commissioner be answerable to Parliament directly and, therefore, to the people of Scotland. The commissioner will be directly accessible to patients in order to hear about their experiences and about what could have been better. People sharing their stories will be the key to making the role work and to making healthcare safer for all of us.

The commissioner will focus their attention on the concerns that patients tell them matter most, and will listen to patients' accounts of their experiences and combine those with data from other organisations to identify systemic safety issues and to recommend improvements.

The commissioner will not necessarily be the person who is best placed to investigate every

concern that patients raise with them, and they are not intended to take on and resolve individual complaints. There are already well-established processes for those functions, which are delivered by other organisations, including health boards and the Scottish Public Services Ombudsman. The commissioner will hand over to them, where that is appropriate, but we propose that the commissioner has substantial information-gathering and investigative powers for situations in which they wish to look further into an issue that other organisations, such as Healthcare Improvement Scotland and the Scottish Public Services Ombudsman, are not better placed to take on.

I look forward to answering questions from the committee and to the discussion.

The Convener: Thank you, minister. In your opening statement, you talked about what the patient safety commissioner will not do: they will not handle individual cases. You mentioned other avenues that patients might go down to have their concerns met. Why is there a need for a patient safety commissioner, given that there are all those other bodies that patients could go to if they have concerns? Can you articulate the overarching need for a commissioner?

Maree Todd: It is clear, particularly from the Cumberlege review but also from experiences prior to that, that the patient's voice has not been heard. There are some very obvious examples of that, such as the mesh-injured women, the families injured by sodium valproate and those who were given infected blood. Those people made representations for many years as they tried to have their voices heard, but were not heard by the system. So, there is clearly a role for a commissioner who will ensure that the patient's voice is heard and that when concerns, particularly systemic ones, are raised, those are picked up and acted on.

That will give all of us confidence in safety. There is lots of work going on across the NHS on safety and on quality improvement, but having a commissioner will give us all confidence that patients' concerns are being heard and acted on.

The Convener: I am interested in how Government will evaluate the success of the patient safety commissioner, once that person is in place.

Maree Todd: There will be a strong role for Parliament in scrutinising what the commissioner does. As I said in my opening statement, patients have been clear that they want a role that is distinct from the NHS and from Government. They want someone other than Government to scrutinise what is happening in the NHS. There will be a strong role for Parliament and therefore for the people of Scotland.

We can look at other commissioner roles to see how they function. A similar role, with a slightly narrower remit, is also being developed in England and we will look at how that works, in order to find the best way forward for our patient safety commissioner in Scotland.

The Convener: The committee heard from the Patient Safety Commissioner for England. It was useful to hear from her and from Baroness Cumberlege. They told us about some of what they learned in setting up that role. My colleagues may speak about that later.

Tess White has some questions.

Tess White (North East Scotland) (Con): Some submissions that the committee received in response to its call for views emphasised that patient safety would be better served by investing in safe staffing levels. We explored that idea in some detail. For example, doctors undertake twice as many patient contacts each day as is recommended, which is caused by poor workforce planning.

Do you envisage the commissioner having a role in safe staffing, given the implications for patient safety?

Maree Todd: A lot of work is going on in Government and in the NHS to establish safe staffing levels. There is work to ensure that our workforce is developing sustainably.

That issue is slightly separate from the work of the patient safety commissioner. Staffing can be a contributory factor to safety. However, in the examples that I gave in my earlier response—the mesh-injured women, the valproate-injured families and those who were given infected blood—safe staffing was not an issue; the problem was that those injuries happened and the system did not listen to people. The primary function of the safety commissioner will be to ensure that the patient's voice and concerns are heard.

My colleagues may want to say more about safe staffing.

Will Wood (Scottish Government): If patients felt that staffing had an impact on safety and were raising that issue with the commissioner, it would be within the scope of the commissioner's role to look at that, if they wanted to. It would be up to whoever is appointed to decide whether to take that on.

Tess White: I will have to read out my second question, because the list is quite long. In Scotland, we have the Scottish patient safety programme, the NHS incident reporting and investigation centre, Health Improvement

Scotland, professional regulatory bodies such as the General Medical Council, the Patients Rights (Scotland) Act 2011, the patient advice and support service provided by Citizens Advice Scotland and the Scottish Public Services Ombudsman. In your view, will the commissioner create duplication in the saturated patient safety landscape?

Maree Todd: That actually illustrates just why it is a valuable thing to develop the role of a patient safety commissioner. It is a complex landscape with lots of people working in the area. I have personal experience of working with the Scottish patient safety programme when I was a clinician. That has a very different role to the ombudsman, but patients do not necessarily understand that complex landscape.

The role of the commissioner will be to help patients to navigate that complex landscape and make sure that their story is heard by the right people who can act on it. There have been enough incidents where that has not happened to need to recognise that. Patient safety is of vital importance: first do no harm.

Patient safety is absolutely crucial, so it is understandable that there are quite so many systems designed to ensure that care is delivered in a safe way, and to investigate when things go wrong. That is perfectly reasonable, but patients find it quite bewildering and disempowering. That is the bit that we want to make sure is not the case going forward. I and all of you on the committee will have heard stories directly from patients who have been harmed by the system and we want to make sure that that does not happen again.

We want to learn the lessons each time. Therefore, the role of the patient safety commissioner is very much unlike that of the GMC and other professional regulators, who will sometimes take action. The focus of the patient safety commissioner will be different. That role will be very much about establishing what happened and trying to help the system to learn from that, rather than punishing or taking action against individuals within the system.

The Convener: Sandesh Gulhane has a question on that, before we move on.

Sandesh Gulhane (Glasgow) (Con): I want to pick up on something that the convener asked you, which was about evaluation. How will you evaluate whether, in year 1, 2 or 3, the patient safety commissioner is doing what we would expect them to be doing?

Maree Todd: Do either of my colleagues want to come in on that, if my earlier answer was not sufficient?

Will Wood: I just reiterate the point that the minister made about one of the things that was repeated again and again when we consulted with patients and the public, and in the engagement thereafter, which was the importance of the separation between the commissioner and the Scottish Government.

Sandesh Gulhane: That is absolutely true, but how will you evaluate that? The question was about evaluation. We understand the concept and the people who have spoken, but how will we evaluate whether the PSC is doing what they are supposed to be doing?

Will Wood: Part of that will come through looking at the reports that the commissioner lays before Parliament about their work. It is difficult to be very specific as to how we will do that because of the commissioner's independence. There is a really important element, which is the commissioner deciding what their priorities are based on what patients tell them and using that to inform how they will carry out their role.

Therefore, I suppose that there will be an element of looking to see what the commissioner sets out as their priorities in the early days of their job, and there will probably be something for the Scottish Government to look at after that. That being said, I reiterate what the minister said about seeing Parliament as the primary means of holding the commissioner to account through its responsibility to the people of Scotland.

The Convener: It speaks to the independence of the commissioner, does it not? In effect, Parliament will be the main judge of how that is going. That is quite fundamental to the whole idea of the patient safety commissioner.

Maree Todd: It is absolutely fundamental. The idea is that Parliament will scrutinise the reports that the commissioner produces. Such reports will, of course, be of interest to the Government and there will be action points for us to take note of, but the intention is that Parliament will scrutinise the information that the commissioner produces. That is much the same in relation to the children's commissioner; when I worked as the Minister for Children and Young People, the children's commissioner was very clear about his role: he was appointed by Parliament and he was accountable to Parliament. The patient safety commissioner will be independent from the Government—that is what patients are asking for.

09:15

Emma Harper (South Scotland) (SNP): We heard from Dr Henrietta Hughes, the Patient Safety Commissioner for England, who produced a report reflecting on her first 100 days in the role, which considered what the remit could be and

what could be explored more widely. Could that approach be used as a way to measure how we take the role of the patient safety commissioner forward in Scotland? The report could be made to Parliament.

Maree Todd: Certainly. I would expect the committee to be involved in how the role develops, and to meet and speak to the commissioner. The Government will undoubtedly be interested in what the commissioner has to say and their early thoughts on how the role should develop, the remit of the role and the priorities that they want to set. I think that we will find that, as the role evolves, each commissioner will bring a different flavour. However, it is important that the Scottish people hold that commissioner to account.

Emma Harper: I am sure that the role will evolve, because different projects will be undertaken and problems will be solved. For instance, an approach that works in one session of Parliament might be different to what works in another session.

Maree Todd: Undoubtedly. We will be watching. I imagine that our commissioner will be looking very closely at what is happening in England and will work very closely with that commissioner to see exactly how they are working and how that role is developing. Our commissioner will have a slightly broader remit than the commissioner for England, who is focused largely on medicines. Is that right?

Annalena Winslow (Scottish Government): Yes. They also focus on medical devices and medical safety.

Maree Todd: Our commissioner will have a slightly broader role. It is a new role and the commissioner will learn in the job. However, the point of the role is to listen to patients, hear what they are saying and ensure that the healthcare system is able to pick up and act on safety concerns that have been raised by patients because we know that that has not happened in the past or has not happened fast enough.

The Convener: Let us move on to talk about the remit, which we have mentioned a bit already.

Gillian Mackay (Central Scotland) (Green): Given that, as you have just mentioned, minister, the remit is slightly wider than that of the Patient Safety Commissioner for England, do you have any concerns about duplications on the medicine side of things and between the roles of the two commissioners? Do you think that the role for the new commissioner for Scotland is realistic, given its breadth and potential workload?

Maree Todd: I absolutely appreciate the challenge and the tension there. It will be tricky to get that right. However, our ambition should be to be as broad as possible to ensure that we can deal with all of the concerns that patients raise. As I have said before, it is a complex landscape with many people operating in different ways. It is really important to have a patient safety commissioner who will help to draw all the information together.

I do not think that it will be the norm for the patient safety commissioner to have to carry out inquiries themselves, so I do not think that there will be duplication of effort. I would still expect bodies such as HIS or the ombudsman to carry out inquiries when issues are raised with them. However, I would expect the commissioner to be looking at the evidence that those organisations find and pull it together, in order to help patients navigate that complex landscape and to pick up on systemic issues given that opportunities to identify those have been missed in the past.

Gillian Mackay: To what extent are you sympathetic to extending the PSC's remit to include acting as the voice of staff? Do you agree that widening the remit could enable the PSC to get a clearer picture of patient safety concerns, given the different ways in which such concerns are raised, or do you think that it would risk adding duplication or potentially streamlining the remit across all those different ways?

Maree Todd: It should be perfectly possible for staff to raise concerns and for the patient safety commissioner to listen to those concerns. I expect the patient safety commissioner to be an ear in the system and listening to staff would be an important part of that.

We need to make clear that staff can raise their concerns. We are at stage 1 of the legislation and I am open to ideas about how we can make sure that that is clear. Essentially, however, the commissioner should be a listening ear. It would seem odd to me if they were not listening to staff.

Paul O'Kane (West Scotland) (Lab): Good morning, minister and witnesses. Could you expand a wee bit further on where the remit might go. Social care is obviously a very hot topic that is of significant interest to the committee. Dame Sue Bruce's on-going work is on social care and its regulation. Have you factored that view into your planning? Given all that is going on in social care, might the PSC have a regulatory role in that context?

Maree Todd: I guess there is the tension; are they patients when they are in social care? The patient safety commissioner will be very focused on patient safety.

As social care develops, people are looking very carefully at how to build in some of the systems that are focused on safety that are used in the NHS. At the moment, however, the focus of the remit should be on healthcare. It should not cover

social care. If it was to be broadened to cover social care, the role might well be too broad initially and we could lose the essence of what the patient safety commissioner is about. That would be the concern.

Paul O'Kane: I am detecting an openness to consider the matter, as social care and the role of the PSC develop, and that there can be a conversation on that.

Maree Todd: There will be a conversation as we go on. I have already mentioned the Scottish patient safety programme, which uses a really effective quality improvement methodology in the NHS to empower coalface clinicians to improve the system in which they work. That is such an effective method of improving patient safety that I think we would be crazy if we did not use it in all sorts of other systems.

When I was Minister for Children and Young People, we started to use similar methodology in care of children and young people. As we build a new national care service, we need to think about safety and quality and how to build that in with the bricks so that the system can improve itself continuously. However, I am not sure that the role of the patient safety commissioner applies to social care at the moment because it is essentially about ensuring that when people are harmed and when the system is harming people, their voices are heard.

The Convener: Emma Harper also wants to ask about the remit.

Emma Harper: The minister will know that I am interested in the remit of the patient safety commissioner as far as it covers advocating for people and groups of people. For 20 years now, people in the south-west corner of Scotland have had to get radiotherapy in Edinburgh instead of going to Glasgow, and that means unnecessary travel. I am interested to know whether that might be something that a patient safety commissioner could pick up on by advocating for and listening to people who are really upset after 20 years of asking, "Why am I driving past the Beatson and going to Edinburgh for my radiotherapy treatment?" Could a patient safety commissioner advocate for, listen to and support a specific group of people such as the one that I have just described?

Maree Todd: The main focus of the patient safety commissioner will need to be patient safety. I think that what you are describing is perhaps systems lacking patient-centredness. I am very passionate that our NHS should be person centred. Sometimes, however, we find that people are having to travel long distances, past other services that they could use. That does not make sense to them, but it does not necessarily introduce a safety risk. Our patient safety commissioner will have to be very focused on safety. It is fundamental to the role.

There are perhaps other ways that we can ensure that there is patient-centredness in the system. All the work that happened on realistic medicine, which is essentially about getting high-quality person-centred care in the right place at the right time, with the patient being a sharer of decision making in their care, is absolutely what we are striving to deliver in our NHS.

Emma Harper: In a previous evidence session, Matthew McClelland talked about direct links between safety, care and compassion, and thought that the patient safety commissioner could play a role in encouraging grown-up conversations about the risks and benefits of medical interventions and so on. At the same session, Dr Chris Williams from the Royal College of General Practitioners said that safety needs to be the focus of the commissioner, at least initially, so that we can target the safety issues rather than the issues that I have described.

Maree Todd: You are right about care and compassion. We brought in a duty of candour in 2018. That duty does what it says on the tin. It is about trying to remove the defensiveness and hostility that sometimes comes across when patients are trying hard to understand what has happened and why outcomes have been the way that they are. We very much want the role of the patient safety commissioner to be on inquiry and helping the system to learn. We want them to look honestly and openly at what has occurred and try to learn the lessons compassionately to ensure that that does not happen to patients in the future. It is about care and compassion. There is probably also a role for helping people who have been bereaved to understand what has gone on. I can see that that would be a powerful role for the patient safety commissioner.

Paul O'Kane: We are interested in the appointment process and what alternatives were considered. In evidence from the English commissioner, we heard that the role is a department of Government, which, it was thought, allowed it not to be overlooked. However, the converse of that, with regard to the bill, is the importance of the independence of the role. What is your rationale for choosing that direction?

Maree Todd: When we asked that question, the answer that came loud and clear from people who had been affected by safety issues was that they wanted the role to be independent, and that a different organisation that was either part of the NHS or part of Government would not cut it. What would cut it is someone who is there primarily for them and is accountable to the people of Scotland. I can absolutely understand that. I can see the

pros and cons of all sides, but I agree about the importance of independence from the Government and from the NHS itself. As MSPs, we will all have mailboxes full of people saying, “They’re marking their own homework,” and who do not have trust in the system.

It is important that people who come to the patient safety commissioner can trust and have confidence in the process. That independence from both the Government and the NHS will help that.

09:30

Paul O’Kane: We would certainly recognise that from the evidence that we have heard.

To what extent do you feel that the commissioner, sitting where it does, will have the right powers? People want to see a resolution, which will very often involve some end point of action. Are there enough powers in relation to exerting pressure on the Government, pushing for changes to policy in the NHS or the important learning that has to happen where there have been issues?

Maree Todd: I am bound to say that I think that we have got the balance right. I can understand where Paul O’Kane’s questions are coming from, as it is difficult to get that right. However, as I have mentioned, a key point is that we do not want it to become another organisation that is looking to apportion blame. That is the last thing that we want. The two absolutely key things that we want from the patient safety commissioner role is for the patient’s voice to be heard and for the system to learn lessons. Those are really key.

I think that there are enough powers to make sure that the commissioner can inquire and take action, that Government has to listen to them and that there is an accountability to Parliament. However, as with any new role, there will be lessons learned and evolution as we go along.

Paul O’Kane: I will push a little further on that.

Everybody wants to work in a collegiate fashion and ensure that there is encouragement in relation to change and learning lessons. However, that does not always happen; for example, in large organisations, it can often be difficult to get to that end point of a change in process or taking the learning on board. Although I know that “enforce” is not always a word that we like to use, because we want to see that collegiate approach, is there enough ability to enforce? In social care, for example, we would recognise enforcement as happening in the care home sector or other such places. Is there enough power, or any power, to enforce, if that is required?

Maree Todd: There are powers to enforce in other parts of the system. The professional regulatory bodies can take action and the police can take action if there is a police concern. A number of different bodies other than the commissioner can ensure that enforcement occurs, should it be needed. The key point in relation to the commissioner is for the system to learn lessons. We have a responsibility there.

If we think of the big issues that have been raised with us—for example, by mesh-injured women, the valproate families and infected blood people—those people were asking for a long time for their story to be heard and for inquiries and explanations to be made. They did not necessarily want blame to be apportioned; in fact, the infected blood people were very keen simply to have an apology and an acknowledgement. Ensuring that the system learns, and that issues are picked up and dealt with, is really very powerful, because we can see so many examples of where that has not happened in the past.

The Convener: A number of colleagues want to ask questions on powers. May I bring them in?

Paul O’Kane: Yes, of course.

David Torrance (Kirkcaldy) (SNP): Good morning, minister and witnesses.

In evidence to the committee, witnesses expressed that the patient safety commissioner should have additional and regulatory powers. The minister just said that she does not think that it should. Will people take heed of the commissioner’s recommendations if it does not have those powers?

Maree Todd: Yes. The commissioner will have power to require organisations to provide evidence. Those are robust powers.

If I may explain, it is a role that is really about encouraging a culture of openness and inquiry, and it is absolutely in the system’s best interests to adopt that culture. That is how we will give the best patient care.

If we do not learn when mistakes happen or when safety issues arise, mistakes will be repeated, which is not in the interests of patients or the system. Therefore, I think that there will be enough power, but I am open to suggestions, if you think that some powers need to be strengthened. I am listening and I am open to that, but it is very clear how the concept of this role has evolved, so I would like to think that there is a wish and a will in the system to learn those lessons to prevent further harm.

David Torrance: I was wondering whether the patient safety commissioner role would evolve into having such powers.

Maree Todd: We need to be careful that we do not duplicate existing powers. Regulators can take action against individual professionals, there are the police and there is the potential to take action in various ways, so we need to ensure that we are not duplicating effort. The fundamental role of the patient safety commissioner is to ensure that the voices of patients are heard and that that open learning culture is fostered so that the system learns and prevents further harm, rather than these things going on for far too long and harm continuing while those issues unfold.

Paul Sweeney (Glasgow) (Lab): During our evidence-taking session with Dr Henrietta Hughes, the Patient Safety Commissioner for England, we discussed the issue of escalation. She was emphatic about the need for collaboration and a culture of openness, rather than for an inquisitor who would come in and berate people for failures. That is an important insight to note.

However, where there have been egregious problems, there will need to be very clear recommendations that ought to be implemented. In situations in which there is an area of injustice or an issue that needs to be urgently addressed and which could not simply be left to collegiate encouragement, perhaps there is a need for an escalation process. In responding to my question about that, Dr Hughes said that it was quite early days and that she would not necessarily be clear about what the next step of escalation would be in that instance. Obviously, the reporting line in this case is to Parliament rather than to ministers. Does the minister have a view on how the bill might better define that process of potential escalation, if there is such a lack of co-operation in the future?

Maree Todd: I am open to proposals on that issue, and as the role beds in, it might be an area that evolves, if it becomes a challenge for the patient safety commissioner to ensure that organisations take account of what the commissioner is saying, report accurately and take achievable actions. Therefore, I am open to the idea that more might be required. As introduced, the bill allows for dialogue on the best way forward. There is potential for collegiate working, which is generally the best way to enable such openness and learning. However, I understand that there is concern.

I genuinely believe that a patient safety commissioner would add something to the landscape. There are lots of people and organisations that are able to take action—including punitive action—and to hold organisations to account, but I think that the patient safety commissioner offers something different. The big tragedies when patients' voices were not listened to, their stories were not heard and action was not taken soon enough are an example of the kind of systemic issues that I am absolutely certain that the patient safety commissioner will be able to pick up on.

Paul Sweeney: Dr Hughes said that "Multiple paths already exist" in the healthcare system. Earlier, you cited the police as an example. Dr Hughes also said:

> "It is partly about understanding the powers that others have, but it is also for others to understand the powers that exist in the system and to work collaboratively"—[*Official Report*, *Health, Social Care and Sport Committee*, 21 February 2023; c 36.]

to achieve the common goal.

Bearing in mind that the reporting line is to Parliament rather than to ministers, is there provision in the bill for there to be an assessment period after a certain time to see how the PSC works with other organisations and, if necessary, to define further through secondary legislation those interactions and interfaces? Is that something that the committee could consider in its report?

Maree Todd: That is certainly something that the committee can consider. It is a really complex landscape, which is almost impossible for patients to understand—it is quite hard even for health professionals and those who work in the system to understand it. There is an issue around making all the slightly different organisations that have a keen interest in safety work together to get the best possible outcome. We are always open to the idea of going back to look at whether we have achieved our aim and whether legislation is working as intended and delivering the best possible results. There is always the opportunity to look again at that.

The Convener: We turn to questions on the resourcing of the post and the office, on which Evelyn Tweed will lead.

Evelyn Tweed (Stirling) (SNP): Good morning. Are you confident that the resources that are proposed will be sufficient for the commissioner to carry out their functions effectively?

Maree Todd: We think so. We think that the budget is appropriate for the commissioner's proposed remit. The commissioner will be an advocate for patient safety and the patient voice, and that role will be underpinned by formal information-gathering powers. We are not intending them to be a new regulator or to have a primarily investigative role. We would say that, largely, other organisations will do the investigations and the patient safety commissioner will work collaboratively with them. We developed the costs that are set out in the financial memorandum on that basis.

As Parliament scrutinises the commissioner's work, it will take decisions on whether the remit of the role and its accompanying funding need to change.

Evelyn Tweed: That leads me on to my next question. In the evidence session with the Patient Safety Commissioner for England, the committee heard that it is already expanding its office and bidding for more resource, although Dr Hughes felt that it was better to start small and to be agile while having a

"plan for future expansion and growth."—[*Official Report*, *Health, Social Care and Sport Committee*, 21 February 2023; c 38.]

Does the minister have a plan for expansion and growth?

Maree Todd: I am open to that. The Patient Safety Commissioner for England is right: we should start small and be agile with the role. It is a brand-new role and we need to think carefully about how it evolves.

I think that we have gone for about the same size of budget in Scotland as the UK Government did for the role in England, and there will be similar numbers working in the team, yet there are 10 times as many people living in England. That reflects our slightly broader remit.

I am certain that we are adequately resourcing the role as it starts out. As we have all said, the role is likely to evolve and we might need to look at that in the future. However, I am certain that we are starting out in the right place.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I would like to look more specifically at the issue of data analytics. The chief of staff to the Patient Safety Commissioner for England highlighted the importance of the team having the capacity to provide data analytics. You have already said that you will look at the data that comes from other organisations that carry out investigations, but surely there is a need to pull all that together and look underneath it. Where does that role sit at the moment?

Maree Todd: That is certainly possible. I am somebody who loves data. Data does not lie, so if you can get your analysis correct, it will tell you a lot about what is going on.

09:45

I am not closed to the idea that there may need to be a role for somebody with data analysis expertise. However, in my view, we already have the best data analysts in Scotland in Healthcare Improvement Scotland, and we need to take care not to replicate roles. We need to understand how the organisations that might already be looking into issues are able to gather and analyse data and come up with understanding and insights into how situations evolve. I am not sure that we need another organisation with that capacity checking the numbers from those organisations.

As I said, however, I am not totally closed to the idea. The role will evolve as time goes on, and there is hardly a role in any part of Government—or in public life, because this role will be independent from Government—that would not benefit from a bit of data analysis.

Stephanie Callaghan: So we will be evaluating and monitoring what is going on and seeing what the needs are as we move forward. Is that right?

Maree Todd: Yes. There are people with that type of expertise who do a lot of independent consultancy work, so an individual role may not be needed. It may simply be that expertise is needed in one situation, and there might be capacity to think about using individuals with specific expertise as the role develops.

Stephanie Callaghan: That is interesting.

The Convener: We have a further question on resourcing, from Sandesh Gulhane.

Sandesh Gulhane: I want to pick up on what Stephanie Callaghan talked about. In my initial question, I asked about the need for evaluation with regard to resources. You were very clear, minister, that we need to start small and agile; the Patient Safety Commissioner for England and others who have come before the committee have agreed with that.

Without evaluating whether the patient safety commissioner is doing well, however, it will be difficult to say whether they will need more or fewer resources. Will we be able to ask the patient safety commissioner, once they come into post, to set out, as one of their first actions, the criteria on which they will be evaluated?

Maree Todd: Absolutely. That will be part of the dialogue when that person is in post. We will undoubtedly be interested to hear what the commissioner thinks that their priorities are and how they intend to measure the outcomes and demonstrate robustly to Parliament and to other interested parties that they are doing the job that we intended them to do.

Sandesh Gulhane: That is fantastic.

You said that you want the patient voice to be heard. I am fully aware that it is not intended that the patient safety commissioner will take up individual cases, and you made it clear that the commissioner will not be doing investigative work.

However, to pick up on Emma Harper's questions, should the patient safety commissioner and their team listen to individual patients when they have a story to tell or something to talk about,

in order to collate and catalogue each case and look for the golden thread?

Maree Todd: Yes, absolutely—I think that that is clear.

It is not that the commissioner will never do investigations; we have given them some investigative powers because we think that there may be occasions on which it would be useful for them to do that. By and large, however, other organisations will do that work.

Nevertheless, I think that listening to individuals is important. Awareness of the big tragedies that I have mentioned a couple of times this morning started with one patient speaking up and then grew. It is important that the patient safety commissioner is able to listen to patients and pick up on the noise from the system. It seems to me that we do not currently have an organisation that is able to do that.

When such issues have arisen before, that has occurred as the result of an individual situation—nobody has been able to put it together. The patient safety commissioner will be able to put together that picture and listen to the noise from the system.

Sandesh Gulhane: That is fantastic to hear, but it brings me to the question of resource. After all, it is very labour intensive to listen to someone's story, pull out the thread, catalogue it and then get it checked to see whether there are any other such threads. As knowledge of the patient safety commissioner grows and people start to go to them, might we see a significant expansion of their budget simply to deal with those patients?

Maree Todd: We might, and as I have said, I am open to that possibility. As the role develops and is evaluated by Parliament, that might well be an issue that we as parliamentarians will need to consider.

However, the commissioner might develop a really slick way of working with all the other organisations that do such jobs and be able to help individuals to navigate the system. It is very clear, for instance, that individual patients do not know how to get their issues investigated or how to get an appropriate resolution from the healthcare system. The commissioner might therefore develop in a very slick way and help patients to navigate the system and ensure that their voices are heard, as well as picking up on those systemic issues that we have not been fast enough or slick enough at picking up on in the past.

That will depend on how well the commissioner works with all the organisations in this space. That collaboration will be absolutely key.

Sandesh Gulhane: I have a very quick final question about the extra cost. What would you say to those people who are very concerned about the cost—full stop—given that there are lots of patient safety commissioners?

Maree Todd: I would say that the need is well established. We have shown and demonstrated that such a role is currently absent and that it would help to prevent harm.

The types of harm that I would envisage the patient safety commissioner picking up on and preventing are not only devastating for patients but often very costly to the system. Therefore, I think that this is a reasonable investment to prevent harm. We have established that the current system is not managing to prevent harm in the way that we would have hoped that it would.

Sandesh Gulhane: Thank you.

The Convener: Paul Sweeney has a question on this issue.

Paul Sweeney: I raised the point about data with the English commissioner and asked her about the

"huge risk of data inundation"

and having to make sense of large streams and volumes of information that might have been collected for completely different purposes, might not be comparable, might not have the same baselines and might as a result have accuracy risks. In response to being asked how "meaningful conclusions" could be drawn from the different streams of data being fed into her office and how they would be processed, the commissioner said:

> "Having a data and digital function in my team so that we can use and manipulate that data in a way that can bring fresh insight that will help the system to attend and listen to things that it may not have been aware of in the past is key."

Moreover, Dr Duncan, the chief of staff, said that the commissioner was

"right to say that, without a data analytics function, the novel insights that a commissioner could have would be limited."—[*Official Report, Health, Social Care and Sport Committee,* 21 February 2023; c 39.]

Do you agree with that assessment?

Maree Todd: It seems reasonable to me. We do not want the patient safety commissioner to be picking up noise from the system and dismissing it as something anecdotal rather than an evidence-based concern. Sometimes having the data is the only way of dispelling concerns about whether what you are picking up is genuine or just some incorrect signal.

There will have to be a robust capacity for data analysis, but I am not going to write the job descriptions for the various job roles in the team

now. I should say, though, that there is a lot of data analysis expertise already in the system, and that will have to complement the work that is being done, but I get what was said last week about being able to crunch the data and develop fresh insights.

Paul Sweeney: You mentioned the opportunity of collaboration across the system, which was also mentioned by the commissioner. She mentioned that partnership working would have value here. Is there an opportunity to further define that in the bill to say that there are obligations or say where we would expect interfaces to work in the system?

Maree Todd: That is a reasonable aim for us to have, and if it is not clearly spelled out or well understood, it is probably worth reflecting on that and seeing whether we can refine it any further. Will Wood might want to say something on that. It certainly seems reasonable that if there are concerns that it is not clear how the commissioner and organisations would collaborate, we would want to make sure that the bill is clear.

Will Wood: From memory, I think that the bill sets out at least a couple of instances in which the commissioner and organisations such as HIS are expected to co-operate with each other. As the minister said, we will consider whether that can be further elaborated on and clarified.

Paul Sweeney: Thanks for that. Minister, the point that you hinted at earlier was important. We often hear qualitative insights from patients, as we did in relation to the mesh scandal. The Public Petitions Committee unpacked a lot of that because the system did not respond. Doctors were dismissing patients saying that it was psychosomatic or imagined. A data signal was not being transmitted through the healthcare system to illustrate that there was a problem. That sort of case might be an opportunity for the commissioner to instruct the gathering of data.

Maree Todd: However, the mesh scandal has changed the way that medical devices are monitored and information is gathered about them, so there are much tighter and better systems in place. On medication, the yellow card system will pick up signals, but there was not the same level of robustness in picking up on issues related to medical devices.

I am the minister for women's health, and there a reason why that post exists. Women face health inequalities because of our inequality in power, status and wealth. Many of the issues that we are talking about are because women are not listened to when we come forward with concerns. We absolutely need to recognise that that is the case and make sure that the system is picking up on that. A great deal of work has been put in to improve the post-surveillance of devices once they have been implanted.

You touched on something in your line of questioning that troubles me about how the system currently listens to people raising concerns, who we find easy to ignore and dismiss and who we pay attention to. The patient safety commissioner role will undoubtedly be key to making that more equitable.

Paul Sweeney: To go back to the point about powers, will there be an appropriate element of compulsion for the commissioner to exercise when it is instructing, for example, health boards to gather certain types of data based on complaints that have been picked up that we cannot verify through data? Is there a mechanism whereby the commissioner could say that people should start assessing the issue at primary or secondary care interfaces, to enable us to gain a greater understanding of the issue? Could that be defined?

Maree Todd: That is reasonable. That may be something that the commissioner asks health boards to provide evidence on or try to improve the system around.

Tess White: Focusing on the positive, could there be a role for the patient safety commissioner in spreading good practices in one part of the Scottish NHS across the whole of the NHS?

Maree Todd: I hope so. There are pockets of brilliant practice all over Scotland in many areas. One of our challenges is making sure that that practice is the same all over Scotland and making sure that the same quality and safety focus happens everywhere. That would be a good outcome, but I do not see it as being a primary one, because, remember, this role is absolutely focused on the voice of the patient. Where the commissioner finds good practice, that might be one way of improving the situation if they found a safety concern in one part of the country.

10:00

The Convener: We will move on to the views of the Finance and Public Administration Committee.

Emma Harper: It was interesting to read that the Scottish Parliamentary Corporate Body said:

> "The process is complicated, but we are moving into a period in which it is becoming regarded as a casual thing to suggest and implement the establishment of another commissioner".—[*Official Report, Finance and Public Administration Committee*, 10 January 2023; c 20.]

That is not the language that I would have used, because I think that ensuring patient safety and addressing and preventing harm are absolutely reasonable. I say that as a former nurse who worked in situations in which there were issues in

operating theatres. I am interested in knowing what you would say about the evidence that was submitted to the Finance and Public Administration Committee about the establishment of a new parliamentary commissioner or new commissioners becoming "a casual thing" that takes insufficient account of the associated budgetary consequences for the Scottish Parliamentary Corporate Body. I ask that on behalf of the Finance and Public Administration Committee.

Maree Todd: I am bound to say that I personally feel passionately about the area, not simply because of my role as the minister for public health and women's health but because of my professional background. I can see the need for such a role. I can see the need for somebody who is independent of the systems that already exist. There is a powerful need for the role and for the commissioner to be accountable to Parliament. I will not comment on all the other commissioners, but I think that there is an undeniable need for a patient safety commissioner.

On the concerns about the budget, that is a worry for the Scottish Parliamentary Corporate Body. One of the reasons for starting small and trying to be agile is to allay the concerns about its taking on a huge resource and to ensure that the Parliament will not have to become a regulatory body with a vast web of actions throughout the NHS. The role is a specific one that is very focused on the voice of the patient and patient safety, and we will see how it evolves, with careful evaluation as time goes on.

Emma Harper: Okay. We have six commissioners and an ombudsman. With the potential for future commissioners, does the Scottish Government need to look at how we can ensure that a more strategic approach is taken to resourcing and establishing additional commissioners? Is work being done now to look at that?

Maree Todd: The commissioner's role came from the Cumberlege report. It was not the Government that came up with it, and it was not the Parliament that suggested it, as has happened with many other commissioners. There were really solid reasons to bring forward the commissioner's role.

There probably is a need to look at the commissioners as a whole strategically. There is always room to look at where the whole Government's focus is and what resources are going where—that often happens around budget time—as opposed to the individual commissioner whom we are discussing.

The Convener: We have asked all the questions that we wanted to ask. We thank the minister and her officials for their time this morning.

I suggest that, next, we take item 4 on our agenda, which is consideration of subordinate legislation, before we have a break in advance of taking evidence from our panel on women and girls in sport, if members are happy to do that.

Members *indicated agreement.*

Subordinate Legislation

Public Health Scotland Amendment Order 2023 (SSI 2023/24)

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2023 [Draft]

10:04

The Convener: The next item on our agenda is consideration of two negative instruments. The Delegated Powers and Law Reform Committee considered the instruments at its meeting on 21 February 2023 and made no recommendations in relation to either instrument.

The first instrument is the Public Health Scotland Amendment Order 2023, which amends the Public Health Scotland Order 2019. The order would allow Public Health Scotland to make arrangements for the vaccination or immunisation of persons against any disease. The policy notes accompanying the order state that that is required due to the expansion of the role of Public Health Scotland in vaccination and immunisation-related activities.

No motion to annul has been lodged in relation to the instrument. If members have no comments, I propose that the committee makes no recommendations in relation to that negative instrument. Are we all in agreement?

Members *indicated agreement.*

The Convener: The second instrument is the Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2023. The purpose of the instrument is to increase the charges recovered from persons who pay compensation in cases where an injured person receives national health service hospital treatment or ambulance services. The increase in charges relates to an uplift for hospital and community health services annual inflation.

No motion to annul has been lodged in relation to this instrument. If members have no comments, I propose that the committee makes no recommendations in relation to the negative instrument. Are we all in agreement?

Members *indicated agreement.*

10:06

Meeting suspended.

10:30

On resuming—

Female Participation in Sport and Physical Activity

The Convener: Welcome back to the Health, Social Care and Sport Committee. We now move to our first evidence session as part of our inquiry into female participation in sport and physical activity. I welcome to committee Katie Heath and Jenni Snell from the young women lead committee in the Young Women's Movement, who did a similar inquiry around about 2019 and produced a very good report, "Young Women Lead", as a result.

I was reading the report a couple of nights ago and a lot of it very much chimed with things that prompted our investigation. One of the main reasons why we are doing this inquiry is the evidence that we heard when we did our children and young people inquiry in the first year of this parliamentary session. The issue of female participation in physical activity and sport came up a lot in our informal sessions with younger women in particular.

I know what prompted us to do this, but why was it the topic that you homed in on, of all the many things that you could have chosen to focus on?

Jenni Snell (The Young Women's Movement): First of all, thank you for inviting us along today. We really appreciate the opportunity to share our findings with the committee.

For me, the reason why we decided to explore young women's barriers to participation in sport and physical exercise came from part of the young women lead programme. Every young woman who took part in that process shared their key barriers, thoughts and ideas around the needs of young women in Scotland at the time of applying for that voluntary programme, and sport was a clear issue across all responses.

We also explored a number of other topics. We decided on young women in sport because we thought that it was a manageable topic within the six-month timeframe that we had for the inquiry and because it tied into wider inequalities that covered the other topics that we were exploring, some of which were around eating disorders or young women's nutritional and food experiences. Young women in physical education and sport tied into all that.

Katie Heath (The Young Women's Movement): There was also interest around barriers in relation to socioeconomic backgrounds as well as ideas around schooling. We felt that

looking at those from a sport angle was a way to bring in a lot of the interests of such a diverse group, and to bring together a number of inequalities and see how they interacted with one key subject.

The Convener: You are right that it is about not only sport; it touches on so many other areas as well. You mentioned body image in particular, and I know that your report mentioned the impact of social media on that.

In a way, you are your own focus group, because you are young women and bring those experiences with you. With the exception perhaps of Gillian Mackay—and I hope that I am not offending anyone—that is not the case for us. It is a long time since I was a young woman.

Although we are looking not only at young women's participation but at the participation of women and girls, I would like to ask for your advice as to how we can hear the voices of young women in order to inform what we do here. We are doing a number of outreach events, but I would be interested to know how you went about engaging with people.

Katie Heath: One of the key things for us was understanding, as young women, how we communicate with one another. A large part of that is done through social media. That is where a lot of us get our news and our political understandings, and it is also largely where we interact with one another. We thought that it was important to reach out to people in that way, because we could access a more diverse range of people than we had in the room.

We also knew that it was important to interact with sport and local community groups. A big part of the work that we did was about understanding how to reach out to community groups that were showing best practice and getting the lived experience of other people, because we were and are very aware that we do not necessarily represent the views of all young women in Scotland. We tried to reach out to as many groups as we could, and we found that schools and organisations such as Girlguiding Scotland were a really good way to get a lot of diverse opinions.

Jenni Snell: I was part of the young women lead cohort that worked on our inquiry, but I have since become the chief executive officer of the Young Women's Movement. In our organisation as a whole, the approach that we take in our work with young women and girls is to ensure that their voices and experiences are central. We have a participant-led research process for all our research programmes, including our status of young women Scotland annual research, and we ensure that our young women know and young women lead processes are all co-designed with young women and girls. The intersectional, lived experience, young women-led approach that we take has been modelled and practised in a lot of different programmes and research, and I encourage that approach when thinking about what other organisations are out there.

We focused a lot on protected characteristics, but we did not get a lot of responses to the survey from young women from black and ethnic minority communities. We know that there is a massive issue in terms of such young women accessing sport, but, due to the time limitation for our project, we were not able to do targeted outreach with those groups. To get the strong and robust lived experience of young women and girls, I would encourage using organisations that are already working in those spaces and have expertise in youth-led, participatory models and intersectional approaches.

The Convener: When we were doing our outreach sessions yesterday, someone said, "Don't make any assumptions". Obviously, the very reason that you decided to do your inquiry was the experiences of people in your group. However, as you did the outreach work and put together your report, was there anything that surprised you? Was there anything that you had not anticipated at the start? Am I putting you on the spot with that question?

Katie Heath: From our experience, we obviously had the perception that there were barriers to sport. However, we were shocked by how much someone's socioeconomic background impacts their ability to access sport. We assumed that there would be an impact, but 81 per cent of the people who responded to our survey indicated that that was a key barrier for them, which was disheartening. Although we thought that there would be an impact, we were surprised by how big it was.

Jenni Snell: It is crucial to consider that as part of the committee's inquiry, because our report was done before the pandemic and the cost of living crisis. We could make the assumption that the proportion of young women who now face disproportionate impacts of the cost of living crisis is much higher than 81 per cent. They will also face additional barriers to accessing sport due to service provision having been closed down during Covid. There is definitely an increase in that. Although the statistic was shocking and startling when we did the report, I think that it would be even higher now.

The Convener: I will let my colleagues in now. Sandesh Gulhane has a question on the report.

Sandesh Gulhane: My question is focused on the methodology. I am in no way trying to attack you; I am trying to ascertain how you got to where

you got to. What was the ethnic minority and religious mix in your advisory group?

Jenni Snell: Do you mean what was the mix in the group of young women who were part of the young women lead programme?

Sandesh Gulhane: I mean those who were on the advisory group.

Jenni Snell: I do not have the specific stats with me today. I can make a guess—it was a diverse group and we had diverse representation on it. After the meeting, I can definitely follow up with an email with the actual breakdown, if that would be useful.

Sandesh Gulhane: Absolutely—please send information on the minority ethnic and religious mix, if appropriate.

Jenni, you have spoken about the small number of responses from people from an ethnic minority background. The sample rate was too small to address religion and belief. You reached out to the girl guides, but they are not particularly ethnically diverse. You have reached out to a group such as the girl guides but you do not have ethnicity data; I do not fully understand why you did not reach out to another group.

Katie Heath: One of the key things for us, and one of the limitations, was that there were six meetings overall. The group was voluntary, and it included young people who were still of school age and attending school, people working full time and mothers. There were limitations to the time in which we could do the research and the report. A lot of the research that we could do was therefore based on the particular direct links that we had in the community. It just happened that someone in the group had a link to girl guiding and had access, allowing them to set up a focus group in a really short period of time. They already had approval to do that and they had links to the group. That was the reason why we focused on that group in particular. If we had had more time we would have wanted to follow that up by reaching out to and making connections with more groups, but we felt that we were not able to do that fully in the time.

The Convener: We now move on to questions from Evelyn Tweed.

Evelyn Tweed: Good morning, Jenni and Katie. Thanks for all your hard work so far and for being here today.

I was interested in your comments. Lack of access to well-fitting kit, for example, is more likely to have an impact on people from a less well-off socioeconomic background. How do you feel about a proposal to provide free sports bras, for instance? Might that make a difference?

Jenni Snell: Absolutely. One of the key findings from the inquiry was that there is a lack of awareness around the best equipment that young women and girls can use in sports. That links specifically to body image and how young women and girls feel. We found that the key point at which young women and girls start to drop off from sport is around puberty and the transition from primary school into high school.

One of our recommendations was about access to period products—and there has been progress on that since our inquiry. Further progress and increased awareness raising for young women and girls on the support that is available for them with kit and equipment, including sports bras, would be really welcome.

Regarding the socioeconomic barrier and the impact of costs, we found that there is a massive barrier to young women and girls participating in sport, especially in competitive, elite or professional sports, where there is a high equipment cost. Any additional support such as free products would represent really welcome progress.

Katie Heath: There were some good examples from schools that had put in place initiatives. The report mentions an initiative on shoes. The idea was almost like the approach when people go bowling: people could take trainers if they needed them. That removed the barrier of a school trying to seek out people who it had to provide for; there was a universal offering. That was quite effective in that it took away a lot of the shame around requiring shoes. It was just taken for granted that trainers were there. It would be good to have such initiatives in place, so that we need not rely on individual schools to create that sort of best practice. If such initiatives were provided, that could level the playing field.

Evelyn Tweed: Gender inequality and sexist attitudes are entrenched from a young age. We know that. It is important that the onus is not on young women and girls to make changes. Do you have any examples for us of schools that have successfully engaged with young men and boys on these issues?

Katie Heath: I do. I am a schoolteacher, and I know of a couple of initiatives where schools have run equality and equity groups and have asked boys, especially those in football teams, to be part of the discussion. Boys have been asked to engage on ideas around equality, and some ideas have been set out about how to create an inclusive school community. A focus group involving young women fed into that, to help to understand the barriers to physical education that the young women were facing. That provided awareness.

10:45

A number of things are happening in schools, but there is inconsistency across the board and there is a reliance on schoolteachers taking an interest or understanding the situation, which is not happening equitably across Scotland.

Jenni Snell: There are also a number of third sector and youth work initiatives. They are not part of the formal education curriculum, but programmes such as the mentors in violence prevention programme or "Don't be that guy" are running in schools and being led by youth work or third sector organisations.

As Katie Heath said with regard to equity, it is important to ensure that there is collaboration, rather than putting the onus on formal educators and teachers. Information and opportunities can be shared and there can be joined-up, collaborative work between third sector and youth work organisations and schools so that there is a holistic approach to education on misogynistic behaviours from a young age.

Emma Harper: The report is interesting. I have a couple of questions. One is about the report's recommendations regarding the fun side of sport. Not all women want to be elite athletes. If they do, we give them support to develop. There is a difference between being competitive and engaging with or participating in sport. What did you find out about competition versus participation for fun?

Jenni Snell: A number of the barriers for young women and girls arise during the transition from primary to secondary school. Young women reported that primary schools gave them a number of opportunities to participate for fun, but that, as soon as they transitioned into high school, physical education became more focused on technical skill, competition and talent, particularly when they were in mixed classes with boys and especially with more male-dominated sports such as football or rugby. There was a focus on skill and talent.

We got a lot of feedback about young women wanting the opportunity to participate in safe spaces, just for fun, and to try out new sports such as rugby or football without too much focus on developing technical skills. They wanted more focus on the health and wellbeing aspects of fitness.

We found that there are a number of opportunities for boys and young men to participate in community-based sports once they are at secondary school. There are five-a-side football teams or local, volunteer-run sports clubs for boys and young men, but there tend not to be the same opportunities for young women and girls.

A number of compounding factors contribute to that. One is the lack of opportunities for women to become volunteer coaches or to find pathways into leadership within their communities. During the cost of living crisis, women have been disproportionately impacted—bearing the brunt of childcare or taking on a lot of unpaid work—which means that they do not have the flexibility or free time to volunteer as community sports coaches. That can be compounded by the lack of experience of and opportunity in sport that they had when they were growing up, which means that they cannot offer that opportunity to young women and girls.

There is a lack of opportunity for young women and girls to participate in community sport for fun. The focus is on whether someone has talent, technical ability or skill and can be fed into competitive sports clubs. That is not for everyone. There can also be barriers. Sports clubs might be in the two major cities—Edinburgh and Glasgow—but someone might live in a rural community in the Highlands. Affording equipment and competition costs can also be a problem.

We heard a lot of feedback about creating more opportunities for young women and girls to participate for fun, within their communities. A number of actions could be taken. There should be leadership opportunities to get young women into coaching positions at community level, a breaking down of cost barriers and support for grass-roots community and youth work organisations to provide facilities.

Emma Harper: My other question is about the types of sport that are offered to young women and girls. Were you able to determine—by local authority, for instance—whether there was a wide variety in the sporting activity on offer? Jenni Snell mentioned that some facilities might only be in Edinburgh or Glasgow. For instance, the Edinburgh International Climbing Arena seems to be increasing in popularity, and a lot of schools have climbing walls and things like that. However, in Dumfries and Galloway, where I am from, which is rural, people have to go to Carlisle or Edinburgh to compete, or even just to have fun.

I am interested in whether you carried out an audit of the sports offer. There is such a variety of sports, such as track and field, cross country, team sports, individual sports and gymnastics. I have had an opportunity to experience kayaking, which I absolutely love, although it is a bit scary on the water. Did you conduct an audit of the offer for young women and girls?

Jenni Snell: No. Our methodology did not include a formal audit of local authorities. That would have required too much intensity and capacity of the young women in the programme. However, we got feedback from our survey

responses. We engaged with about 600 young women and girls during the project, and they fed back that, predominantly, the sports that were on offer to young women and girls differed from those that were on offer to young men and boys.

I think that Katie Heath has an example.

Katie Heath: Yes. Many young women felt that, after school education, the offer to them was more limited and they were often not offered things such as football and rugby, because those were not considered to be things that they would be interested in. There were not really opportunities in schools for tasters of sports that people could then continue. That was a real barrier to young women and girls taking up the chance to enjoy sport and get engaged in later life.

There is no mention of enjoyment in the benchmarks for schools—they are skills based and about developing skills. There is no fundamental understanding of sport being enjoyable for people, and that continues in later life.

One organisation where we saw excellent practice was Netball Scotland. Its bounce back programme is designed for people who have been away from the sport for a while and are coming back to it later in life. Netball Scotland had programmes across local authorities but, since Covid, a number of them have struggled to reopen. That has had an impact in major cities. Some of the offerings might be limited by that.

Emma Harper: Thank you.

The Convener: Stephanie Callaghan has questions on the same theme.

Stephanie Callaghan: I thank the witnesses for being here.

Yesterday, when we were out having a chat, we heard that women and girls want agency and choice. Rudi Urbach—I hope that I have pronounced that correctly—from Scottish Rugby spoke about being flexible by, for example, changing the rules of rugby, and making it about fun and enjoyment. However, we heard that many girls drop out during the early years of secondary school, and that has also been mentioned today. There seems to be too much focus on organised sport rather than on healthy activity. Are there examples of teenage girls helping to co-design what happens in physical education in school for girls? Should we be thinking about that?

Jenni Snell: There are anecdotal examples of that. Some schools, especially rights-respecting schools, focus on participatory approaches and ensuring that girls are designed into the curriculum. Such schools have focus groups and implement the results of those. However, it again comes back to a lack of consistency. There is no real focus on that as part of the development of the curriculum. Fundamentally, we keep coming back to the point that the voices that you need to hear are those of the young women and girls who you are looking to engage—they are the best people to speak about that. If that was done consistently across schools, that could have a greater impact.

Stephanie Callaghan: Maybe we need to collect richer data on that.

Katie Heath: Yes.

Jenni Snell: We have not got an example of young women's participation in co-designing sport and physical exercise, but The Young Women's Movement has been working with the National Society for the Prevention of Cruelty to Children across Dundee, Perth and Angus on the young women know programme, which is working with three high schools in each of those local authorities to bring together a group of young women and girls to co-design resources specifically for teachers, youth workers and parents on the topic of healthy relationships.

The young women and girls work with us and the NSPCC in safe spaces that are focused on wellbeing and inclusion to co-design those resources, which can then be rolled out across schools for teachers to use in their own practices. The model has worked really effectively for that topic and it could also be explored for sport and physical exercise in schools.

Stephanie Callaghan: The Make Space for Girls website talks about how parks and play equipment in public spaces for older children and teenagers are currently designed around the default male, and how we need to start making spaces for girls.

Girls can feel quite intimidated going into a multi-use games area, especially if it has high fences and a narrow entrance and things like that. What are your views on that, and are there any examples of that kind of design working for girls and girls being involved in it?

Jenni Snell: Absolutely. Our young women lead programme's Glasgow cohort of 2021 focused on feminist town planning as its place-based inquiry topic, and the recommendation from that report focused on adopting a feminist town-planning lens for future policies and practices in Glasgow City Council. Councillor Holly Bruce took it to the council and it was passed in October 2022.

That specific report around feminist town planning, which was co-designed by young women and girls, focused on parks specifically. We found that a high proportion of young women and girls want to use parks and green spaces for physical exercise and activity but 20 per cent do

not feel safe in parks during the day, which number rises quite significantly in winter when the nights draw in and it is dark. That is because of heightened risks of assault, harassment, abduction and other violence against women and girls because of the lack of light and security in those park spaces and because of the things that Stephanie Callaghan mentioned, such as high hedges and lack of exit and entry points. The report is an example of how young women in Glasgow explored a topic and used the information to influence system change at local level, but it could be rolled out across other local authorities in Scotland to put that feminist town planning lens with young women and girls meaningfully at the centre.

Stephanie Callaghan: We focused on play earlier, and it is important to note that play is not just for little kids. It is for teenagers and older children, and it is also for adults.

However, when the general public sees play, especially among older teenagers at secondary school, people are quite negative about it. They worry about antisocial behaviour when MUGAs are opened. Some areas in South Lanarkshire have been padlocked by neighbours who live nearby. Do we need to change that attitude and thinking and put play out there as being important right across the board?

Katie Heath: That came through really clearly. We spoke to the Judy Murray Foundation, which cited the impact of peer groups and joining sports activities as part of a group as being crucial to get women into sport. It is easier to cross the barrier to get in if you are in a little group of women who have come together. We also noted that women tend to drop out in groups. The idea of play and creating that sense of sociable fun around sport was crucial in getting them engaged in any meaningful way.

Jenni Snell: There is a lot of stigma around young people in general that needs to be broken down holistically across Scotland. There is some great youth work practice happening across Scotland. I know that YouthLink Scotland and the National Youth Agency have a number of policy responses to how we break down the stigma of young people in spaces such as parks and other green spaces. There is a general need to destigmatise young people's play behaviour in green spaces and parks.

Stephanie Callaghan: There are lots of amazing young people; I could not agree more.

11:00

Gillian Mackay: A part of the inquiry that I am interested in is how we build a movement toward sport for life, which is probably difficult to do for the age group that you were looking at. How can we better facilitate changes in activities that naturally happen during people's lives—such as switching from one sport to another? Can we focus, in particular, on where following pathways into elite sport comes in for those young people in late primary school and early secondary school? Also, how do we ensure that they have the skills to be able to go out for a run or go to the gym, which are the physical activities that most people do weekly?

Katie Heath: The move from primary to secondary school coincides with puberty for most, and a lot of the issues are tied up in body image and access to materials, as we have spoken about. It is important that they feel comfortable in the clothes that they are wearing, and that they have the capacity to feel like they can then rejoin their school day or interact after participating in sport. We got a lot of feedback that issues with changing room facilities and the ability to feel clean and hygienic after taking part in sport were a barrier to taking part.

There is also a drop-off in participation when women start to have children. There are a lot of great examples of people who are creating diverse and open spaces that encourage women to bring children when they exercise. Having open spaces where there are childcare facilities or classes where they can bring their baby along helps to get women back into exercise.

Having open spaces and collaborating with women who have lived experience will be crucial. There is not a one-size-fits-all approach, which is a problem. It is hard to make a succinct recommendation because there are so many diverse needs.

Jenni Snell: Just to echo the comment about the lived experience of young mums or mums who have just got back into sport, one of our findings was that there is a really high number of women who experience pelvic incontinence after childbirth, and that is a massive barrier to their participation in sport. It can take up to seven years for them to seek help with that, which is seven years when they potentially will not access any physical sport or do any exercise, such as going for a run.

The feminist town planning report that we did in 2021 highlighted a lack of facilities—such as toilet facilities—in parks and green spaces. That is another thing that could be implemented in the short term, and it would mean that women would have the opportunity to take part in runs or park-based exercise while having access to toilet facilities, which would be good for new mums.

We also need to increase awareness of women's healthcare issues and reduce the stigma around that more generally. That can be done by

speaking out about those topics on social media platforms. Young Scot is doing some fantastic campaigns for endometriosis month right now. Its campaign on that will reach lots of young women and girls across Scotland. There are some really great platforms that could be used as awareness-raising campaigns to help new mums to, for example, understand that their healthcare issues do not need to be stigmatised or shameful, and that they can get help. Something like six sessions of physiotherapy is all that it would take to reduce pelvic incontinence and help them back into sport, but without that, it could last for seven years, so we need more campaigns and awareness raising.

The Young Women's Movement is currently undertaking research on women's access to and experience of the healthcare system across Scotland. The report on that is due to launch at the end of April. It looks holistically at the experiences that young women and girls have of accessing healthcare, and we would be happy to share it with the committee, because I am sure that there will be intersections and crossovers with the inquiry.

The Convener: We will take you up on that, for sure.

Gillian Mackay: You mentioned changing facilities. What else do you think could be done to improve facilities? Some activities in Falkirk, for example, take place in the high schools after the school day has finished, so the lights are often off in the rest of the school, and it is quite an oppressive environment to walk into when it is mostly in the dark. Are there any other examples of ways that we could make the buildings better for women to participate?

Katie Heath: Although spaces are often separate, it would be great to have things such as shower curtains in place for areas of privacy. A lot of young girls stated that the lack of such things has been an issue, as they are private people who need private space. The sort of horror of getting changed in front of a roomful of people has been a real barrier to them.

Small changes could be made to give the option of spaces with a little bit of privacy, and there could still be open spaces that are more communal. There are a lot of oppressive situations. The point about spaces needing to be well lit is important. We have spoken a lot about the fact that sport is really tied to body image and how young women view themselves. We cannot underestimate how much that will have an impact.

Jenni Snell: A lot of the feedback that we got was around creating safe spaces for young women. Across all our Young Women's Movement programmes, we definitely find that there is a need for safe, welcoming, inclusive spaces.

On international women's day, our young women lead Fife programme launched its safe spaces community toolkit, which is a resource for communities to create safe spaces for young women and girls. That could potentially be co-designed with young women and girls in school settings. What does an inclusive, safe and welcoming space look like for PE, and what are the lived experiences of young women and girls in a specific school that might be different from those in a school in a different local authority or in a rural community?

Young women and girls have different lived experiences, so there is not a one-size-fits-all approach. It is about working with young women and girls, listening to their lived experiences, and co-designing spaces that work for them within their settings.

Tess White: Thank you, Katie and Jenni. I thought that your "Young Women Lead 2021" report was excellent. It found that communal changing rooms could be a barrier and an obstacle for girls and young women, particularly with regards to privacy and being able to be free from harassment. Do you support women-only changing facilities? That is my first question.

My second question is: do you have any examples of best practice in the provision of safe spaces in changing facilities for women and girls?

Jenni Snell: I do not think that there would be communal changing spaces for women and men in many school spaces. There would normally be gender-specific changing rooms.

The key finding in the report was that even in safe spaces for women, such as gender-specific changing rooms, there is often a lack of privacy. Having private cubicles was a key recommendation. Having gender-neutral changing rooms would possibly not even be an issue; it is about having the safe space of your own private cubicle and getting that privacy if you need it.

In our findings, we did not have any specific feedback on that topic.

Tess White: What is your opinion?

Katie Heath: I would like the option of having a private space. I know that a lot of secondary schools have male and female changing rooms but also have spaces where you can go if you would like to have privacy.

It comes back to the point that individual schools and teachers have to take on individual requirements and needs, and it would be great to have some consistency on that. It is important to provide spaces for people to go to if they would like privacy.

Jenni Snell: There needs to be an approach that is based on lived experience and is intersectional, as young women and men have lots of diverse experiences of accessing sport. Some people's lived experiences might not be the same as others', so taking a diverse intersectional approach is really necessary.

Tess White: I am a black belt in karate and have done martial arts for a long time. There are significant risks with mixed-sex sparring. Should schools provide single-sex sports?

Katie Heath: There was a lot of feedback that that is the way that young girls prefer to take sports. There were examples where girls felt more engaged when they were able to do swimming lessons alone. There were examples of team games in which there had perhaps not been an awareness of strength when throwing a ball. The feedback that we got was mostly that girls would prefer to do physical education in school in a girl-only space.

Tess White: We had a session yesterday in a sports club and one of the topics on which we got feedback was the attitudes of boys and men. Could more be done, whether in schools or sporting, to provide more education for boys and men?

Katie Heath: Yes. We spoke about taking an holistic view of how we would take physical education in school forward and the recommendations that we make on that. Part of that holistic view could concern attitudes to sport.

More could definitely be done to educate people on safe spaces and when it is appropriate to make comments on women's bodies and their ability with sport. Much of the feedback that we got related to traumatic events when women had comments made against them about their bodies and their ability in sport. It had completely changed both their perception of themselves as they grew up and their interaction, even as adults, which impacted the ability that they felt that they had.

Jenni Snell: There is an increased risk at the moment with the misogynistic rhetoric that is coming through social media accounts, especially those of influencers. Young men and boys are being heavily influenced by that. We see it in the chat that goes on between them in school spaces and playgrounds.

There is a need for work to take place specifically with young men and boys on what positive masculinity looks like. What does it mean to be a young boy or young man in Scotland today? No Knives, Better Lives and the Scottish Violence Reduction Unit are conducting a great programme of research about how to work with young men and boys on what positive masculinity looks like to try to tackle some of the misogynistic rhetoric, which is a real risk in terms of increased harassment and violence against young women and girls not just in sports spaces but across the board. It will be a risk in every aspect of their lives. There is a big need to push that education for young boys and men.

Tess White: A joke or something else that someone has said can be hurtful to women and girls. Do you have any thoughts on how that education might be done?

Katie Heath: There are some great programmes, such as one by Basketball Scotland, in which mentors are put into schools. Those are often targeted at young people who are having issues with social interaction and the sport is used as a means to build social skills, encourage teamwork and encourage positive interactions. There are strong ways to provide sporting mentors to young women and young boys that can develop a sense of community and teamwork. That could be really positive.

The Convener: I will use some convener's privilege and build on what Tess White asked about. I will ask the same question as one that I asked our sports bodies yesterday.

We have the broadcasters coming in front of us. You talked about social media but what would you say to the broadcasters about the way in which women's sport is portrayed in the mainstream broadcast media? I do not know whether you had them in front of you but we will.

Jenni Snell: No, I do not think that we engaged with broadcasters specifically but a big piece of feedback throughout the research was about role models more generally and how young women and girls can see themselves represented in sport. The media have a massive role to play in that.

Some great work has been done already by Gender Equal Media Scotland, which is a collaboration between women's organisations and media organisations on gender equality in the media more holistically, not just focused on sport and physical education.

There is a real need to challenge those narratives in the media. If I was speaking to people in the media, I would ask them to represent women's sport in a fair and equitable way in comparison with men's sport, and to really platform and profile women's sport. We have seen an increase in that happening in women's football, for example, but other sports could still do with getting platformed more frequently. We also need more awareness raising with regard to the variety and diversity of sports out there that young women and girls can access.

11:15

In addition, we need to challenge some of the language that is used to speak about women in sport. It is very different from the language that is used for men; it is always—well, not always, but a lot of the time—focused on body image. For example, it is about what type of kit a tennis player is wearing, rather than that person's achievements or talent. The media tend to take a misogynistic and sexist narrative with their language, so a lot of work needs to be done to regulate language in the media and ensure that women and girls in sport are represented fairly.

Katie Heath: To build on that, we took evidence from the Judy Murray Foundation, which has examples of great female role models in tennis who are doing impressive things and are real advocates for their sport. However, the foundation said that what was damaging was that young women would come and talk about Serena and Venus Williams and cite them as role models, but in the press and the media, those players were dismissed, and their bodies and what they were wearing were commented on often just as much as their accolades. They were not necessarily being represented fairly for their achievements. The foundation said that it undermines a lot of the work that is being done to engage women in sport when such clearly impressive role models are diminished in the media.

Paul Sweeney: It is interesting to follow the conversation around sex-segregated sport, in particular in educational settings, and the context in which misogyny can come into it, especially in team sports with the introduction of the element of competition.

I was reflecting on your point about public facilities such as parks and accessibility in that respect within a feminist town-planning perspective. One initiative that has been quite positive, certainly in Glasgow, has been the parkrun initiative. It has been quite successful at seeding community-based sporting activity in otherwise sterile public spaces. In that context, it is a mixed-sex activity.

You made an important point about the appropriate context depending on the type of sport that is involved, and you talked about the idea of tasters for different sports that are perhaps not traditionally female oriented. With gender, there is a bit of nuance needed about what might be more appropriate in different contexts. For example, a mixed setting might be appropriate for the parkrun, but there might be other instances such as swimming—Glasgow has traditionally had female-only swimming evenings—where nuance might be needed. Have you identified certain areas where a mixed setting might be more appropriate than it would be for others? Is that something that you have looked at?

Katie Heath: Parkrun is such a great example of encouraging a mix of abilities and people in the community, but in a lot of scenarios it is more about choice, and having the option to interact in the setting that you choose.

We looked at a gym called Projekt 42 in Edinburgh, which provides classes that are mixed, classes that are women only and classes that cater to trans people. All of that is about people having the space in which they like to interact. That nuance is important. There is not an opportunity to say for every single sport, "There is going to be a gender mix"; it is about taking the time even to think about women when you are designing those community-based projects and how you can make your sites more inclusive.

Jenni Snell: A lot of the barriers to young women's participation in sport and physical exercise are wider gender equality barriers. We need the safe spaces for young women and girls to build their confidence and their skills and to feel included and safe, but that does not mean that that is not a pathway into opportunities where there is more nuance in terms of mixed sports. Tackling some of those underlying barriers of gender inequality could definitely lend itself to enabling young women and girls to feel empowered and supported in mixed spaces if they are not being faced with harassment or feeling shamed about their body image, and if they feel confident in that setting. There absolutely are examples where sport could be mixed, but that background work needs to be done in order to support young women and girls to feel confident in that space.

The Convener: We move on to talk further about role models.

David Torrance: Could social media be used better by Government organisations to promote positive role models and support for young women? I am thinking about TikTok, which is where a lot of young people get their role models. We only need to think about an influencer and what they managed to do with a certain juice product. I was interested to see on the BBC last night the agency that is the top influencer on women in Scotland. It has a huge following but none of it is to do with sport; it is all to do with clothes and image. Is there a place for social media that could really impact on young people?

Katie Heath: We engaged with a couple of influencers who were looking at positive body image and a positive idea of sport and exercise that is sustainable and inclusive. It was really interesting to hear their understanding of the issue. We also spoke to Dr Helen Sharpe, who is

a professor at the University of Edinburgh, about a move among some influencers away from a sort of thinspiration idea, which is all about weight, to providing fitness inspiration to young people. We found that, although a lot of young girls were interacting with that, it was not necessarily having a positive impact on them, because a lot of the fitspiration and body ideals were promoting an unattainable body image, or an unattainable idea of what a female body should look like, especially an active one.

It is really important for women to have role models who are accessible to them, especially in social media, but it is also important that they are not being sold ideas that are completely unattainable, for example really controlled ideas around eating or exercise. Exercise should be portrayed as something that is positive, and not as a punishment or a way of changing your body. The messaging is really important. There is such a great role for people who are doing that positively, and there are many wonderful examples of that.

David Torrance: There are positive aspects to social media, but there are negative ones, too, as many of us know. To what extent do you feel that the impact of social media fitness content on young women's body image has changed since the "Young Women Lead" report was published, and in what ways?

Jenni Snell: We conducted this report prior to the Covid-19 pandemic, and there has been a massive shift in digital accessibility and an increased social media presence during the pandemic. As Katie Heath mentioned, body positivity movements have increased in that time. An area that we did not look at in the inquiry was digital fitness and access to online classes and so on. A massive number of social media accounts now focus on online support and physical education—sport, dancing and all that sort of stuff. That content really reduces the barriers in a positive way for young women who potentially have disabilities and cannot access stuff in person, or who are feeling low in confidence and cannot access in-person classes.

However, there is also an increase in the negative side of things as well. As I have mentioned, we are seeing an increase in misogynistic content on social media. There is a bit of a backlash against young women and girls who are participating in sport, and a lot of potential role models for young women and girls are being targeted by online misogyny and toxic behaviours. There have been both positive and negative changes since the report.

Katie Heath: I think that there has been an expansion in the number of social media sites. If TikTok was around when we were doing the report, it did not seem like it. Our report did not interact with it.

I guess that this comes down to a lack of understanding. We are all reacting to how big all of this has become and how much of an impact it is having on young people's lives, and that largely comes from a lack of understanding and regulation with regard to what is happening in those spaces. TikTok, in particular, is all about the user; it caters to your needs. The feed is incredibly clever at understanding what you like, which means that, if you look at damaging content, that is what you will continue to see. Indeed, we have found that a lot around food patterns and eating; if you are consuming content on disordered eating, that is what you will continue to see, and that is where things can become really negative. If your feed is based on body positivity, that is what you will see all the time, and it will have a really positive impact.

The Convener: I call Paul O'Kane.

Paul O'Kane: I am very grateful, convener. Good morning, witnesses.

We have just had a quite important discussion about role models for young women, but much of this comes down to men, their behaviour and how we, as men, change our behaviour and attitudes and attack systemic misogyny. To what extent are role models for men crucial in this? Andy Murray sticks out as someone who is always seeking to challenge the in-built bias that we see. Did you find that women responded to the fact that the onus is on men, too? Are there other examples of good role models in male sport who can be held up as examples of good practice and used to push people to do more?

Jenni Snell: Absolutely. We did not explore it as part of our inquiry, but it is generally understood that men have a massive responsibility with regard to changing behaviours in order to tackle gender inequality. I have seen a number of recent instances of men in sport providing positive role models. Gareth Southgate, for example, has set a really positive example to young boys and young men by showing a very different style of leadership in his management of the England football team. Marcus Rashford, too, has been a really positive role model in football in showing his campaigning and activism side and his care, compassion and empathy for other people. We have also seen what has happened with Gary Lineker, Ian Wright and Alan Shearer.

There are definitely amazing examples to highlight, especially in football, which is one of the sports that men are drawn to and around which there is perhaps a kind of traditional more misogynistic rhetoric. Positive role models are coming from football who could be used as

examples of good practice for young boys and men.

Katie Heath: That sort of thing could easily be built into what happens in schools through sportscotland's active schools programme. I know that a panel of young male and female activists work with that programme, which is encouraging those kinds of role models early on. It is incredibly important that we put the onus on young boys, too, to play a part in creating inclusive spaces.

Paul O'Kane: That was very helpful; it is an issue that we want to consider as part of our work.

I want to ask about horrendous examples of, in particular, sexual violence and misconduct perpetrated by men in sport. That has had an impact on women's participation, because very often they feel that clubs are not safe spaces. Being part of a wider club is all about identity and belonging, but women to whom I have spoken often do not feel safe in such spaces. Indeed, there are now a number of campaigns to tackle the issue. I know that there are sports clubs out there that do not have policies for handling people who are found guilty of sexual crimes or for handling reports of sexual misconduct. I appreciate that the issue is perhaps not reflected in the report, but I just want to ask the broader question: do clubs—and, indeed, governing bodies—need to go further to give women confidence?

Jenni Snell: Absolutely. It comes back to what I said at the beginning about leadership pathways for young women and girls. A lot of governing bodies and sports clubs have trustee boards that are heavily dominated by white 60-plus males, so the voices of young women and girls are not heard on challenging policies and on allocation of resources, or on use of good practice and so on.

We need, in order to start challenging some of that, to bring the voices of young women and girls—and women more generally—into those spaces. We need to ensure that they hold management, non-executive and executive positions in clubs and governing bodies in order that we can build policies in, and bring to the table lived experience of what it feels like to be a woman in sports.

11:30

More research probably needs to be done with regard to specific sports. However, again, it should be young-women-led and women-led participatory research on how we can build spaces that are safe, inclusive and welcoming for young women and that are created by young women, and how that can be done in a bottom-up rather than top-down way, because a lot of the decision-making processes still take a one-viewpoint approach rather than appreciating diversity. Many clubs and governing bodies are moving towards that, but a lot of work still needs to be done at community level and in privately owned sports clubs.

Katie Heath: A lot of education is needed around that because, oftentimes, there is not malicious intent on the part of the governing bodies: everyone wants what is best for their sport. However, unless one has lived experience of it, it is difficult to understand or appreciate the risk that young women feel when they access those spaces or the concerns that they might have. It is difficult to understand how big a message it sends when people do not act on sexual misconduct or sexual violence against women. What does that say about what people believe about women's entitlement to access a sport. Without interacting with those voices, it will be very difficult ever to know the impact that those things have. The message that is sent is, "We don't care about you as much as we should", so it is important that those voices are heard.

Paul O'Kane: Thank you, convener.

The Convener: Thank you, Paul. The next questions are from other Paul—Paul Sweeney.

Paul Sweeney: Thank you, convener.

The Convener: I am sorry about that. [*Laughter.*]

Paul Sweeney: I do not know whether there is a collective noun for Pauls.

I want to touch on the addictive aspects of unhealthy body image, social media and role models.

You mentioned the education context. A traumatic incident in school could really damage a person's self-confidence and create destructive behaviours in terms of addictions. I do not necessarily mean addictions to substances, but addictions with regard to creating unattainable goals in terms of physical image. Do you have a view on the reinforcing mechanisms of social media algorithms, and whether they can lead to the real harm that you have identified?

Katie Heath: It is interesting that the age range that we are looking at is a time in life when people try to understand who they are as a person and do not necessarily have a fully developed sense of self. As they are trying to figure that out, they are also trying to interact more with social media and with ideas about their body. It is a crucial stage for developing the mechanisms to do with control and their understanding of their body and how they interact with the world around them.

At the time of the report, TikTok was not around, Instagram was less used and we did not have reels and video-related content. We did not

examine closely the impact of the constant push of notifications and the addictive effects. However, from anecdotal evidence, we could see the damage that was being done, and we could see that people were consistently coming back to social media for a sense of who they were and how they defined themselves, and that problematic behaviours were being reinforced and encouraged through social media.

Paul Sweeney: You mentioned earlier that there were some good examples, so can you elaborate on that? Are they examples that we could reinforce from a public policy perspective, through public health advertising to push things in the right direction?

Jenni Snell: One positive example of social media is Young Scot, which does an amazing job in terms of access to information for young people. It is working closely with sportscotland on the young people's sports panel and on role models, and has been using social media to share information and create young-person-led content for young people, so that they have peer role models and hear a healthy narrative around sports. That is an example that has worked really well. Do you have other examples, Katie?

Katie Heath: I do not, off the top of my head. We have interacted with a couple of influencers. However, it is largely about the messaging, rather than about the individual. The messaging needs to be about exercise being inclusive and about body positivity and autonomy, rather than about being about control or about presenting it as a form of punishment. Exercise should not be seen as a way to change yourself; it should be seen more as a way of freeing oneself and as something that can help with the mental and physical aspects of a person's health.

Paul Sweeney: Rather than simply take a laissez-faire approach to social media influencing, should the state have a more active role in promoting positive messaging through influencers to direct people in positive directions, particularly through targeted advertising to young people?

Katie Heath: Yes—I guess that there could be more of a role for the state in that, and in understanding where the damage is happening, as well as its having a more active role in either regulation or promoting positive aspects.

However, the problem is that, once a person is in those areas of misogyny or problematic body image, they are already entrenched in them. There are so many links, ways around the algorithms and ways of finding things, so it would perhaps be better to shut down or help to regulate such spaces in some way.

Paul Sweeney: That is helpful. Are particular messages needed to offer reassurance around managing diet and activity, so that those things are not seen as some sort of self-flagellation exercise to chase an unobtainable image, but are instead about the person taking control. Is there a powerful public health message that we could push more?

I have previously mentioned in a debate on vaping in the chamber the iconic public health advertisements in the 1990s. I wonder whether we can revisit the ideas behind that, because the advertising was highly effective.

Katie Heath: We have found that people felt that the messaging was all about sport being a form of punishment. There was lack of understanding about how sport can play a positive role in a person's life. That message about the positive impact that sport can have that is not related to the body was not cutting through to a lot of young people.

Jenni Snell: Our "Status of Young Women in Scotland 2019" research focused on body image. One of its key findings was on Instagram being one of the strongest influences on body image. There was a call from young women and girls across Scotland to have more monitoring and regulation of how social media platforms operate. I know that that is not within the powers of the Scottish Parliament, so that would be more about it using its lobbying powers. That influence was counter to the more positive narrative about sport and physical exercise being for health, general wellbeing, connectedness, enjoyment and building friendships. That narrative, as opposed to an unhealthy narrative, potentially offers a workaround for some of that.

Paul Sweeney: Thanks. That is really helpful.

Stephanie Callaghan: I go back to conversations that I had when speaking to people at judo last night. I spoke to an amazing mum who is a teacher and plays competitive rugby. She was talking about Stuart Hogg getting his 100th cap for Scotland. When it is being highlighted that only five people have reached that number, the other three guys, who have between 105 and 110 caps, are mentioned first in any news articles. However, she told me about Donna Kennedy, who, with 115 caps, has more than any of the men. From 2004 to 2016—for more than 10 years—she was the world's most capped woman player. That is an amazing achievement. I guess that what I am about to ask is a rhetorical question. Do you agree that we should be highlighting such things? It would be amazing to hear Stuart Hogg and others in the media talk about how amazing Donna Kennedy's achievement is.

Jenni Snell: Yes, I absolutely agree. That goes back to earlier comments about media

representation and ensuring that women's voices and achievements are celebrated and amplified.

I know that a lot of work is being done around Scottish women and girls in sport week, which is an amazing example of how to use such opportunities to highlight stories. However, they must become part of the everyday mainstream media narrative. Men can play a role in that by recognising that their female colleagues also have great achievements and by celebrating that as a sign of allyship. I agree with that point 100 per cent.

Gillian Mackay: Paul Sweeney was just talking about exercise being seen as a punishment and how, with influencers and so on, we do not want that to become a thing for young women and teenage girls. However, there is still the older cohort of young women for whom, in the early noughties and so on, that was the reality of physical exercise and activity. Many of us shied away from exercise and organised team sport for those punishment-related reasons. Many of those women will now feel that they should know what physical activity and sport they enjoy doing.

How can we reverse that damage and give that age group opportunities—without stigma—to come back to physical activity and take up new things of the sort that they shied away from when they were younger?

Katie Heath: When we started the panel, there was a lot of discussion about that, because many of us felt like that. Although we had a real interest, there was partly exactly that feeling that it was not an area in which we always felt comfortable. There was a level of discomfort in exploring that.

We found that motherhood, although it is not something that everyone experiences, is a great route to re-engaging. Not only are mother and baby classes a great route in, but they provide relaxed spaces and shorter windows of time that enable women to engage. That is really good for enabling people to experience some form of movement and to remind themselves that it can be enjoyable and can be something that they do with a community of people who are going through the same life changes. There are great examples of mother and baby yoga or gym classes.

Those are good ways to build community around more than just sport and around what is happening in a person's life at that time. That was just one of the areas that we looked at.

Jenni Snell: University is another example. Not every woman will go to university, and there are certain socioeconomic barriers for women who do not. However, my experience was that going to university was how I got back into netball.

Freshers' fairs and sports fairs are a great way to show the opportunities and to offer tasters. I wonder whether learning can be gained from the university model and taken to a more place-based community context in order to support women who do not go to university and women who explore other routes.

Gillian Mackay: Obviously, among the other barriers for women coming out of university is when they go into a working environment and have to establish new routines, as is the case when they go into a different working environment and must establish a new routine. Everyone at the table would probably say that our current employment is definitely a barrier to our getting out and getting active. Would four-day weeks, flexible working and things like that provide more space to mothers, women with caring responsibilities and those of us who are just plan busy, in order that we could get out and prioritise our health a bit more?

Jenni Snell: The Young Women's Movement operates a four-day working week. All our staff are on four-day weeks on a full-time salary—it is not pro rata. That offers flexibility for women within our organisation to choose what they do with that extra day.

I have not asked any specific questions about whether people are using that day specifically for sport and exercise, but they are definitely using it for wellbeing.

Gillian Mackay: They are using it for overall wellbeing.

Jenni Snell: Yes. We have been operating under that model for more than a year and we would definitely not return to a five-day week. The staff wellbeing response has been overwhelming. Implementation has been very positive, such as in ensuring that there is flexibility in the working day to take lunch or go for walks when that works for individuals. For example, in winter, one of our staff members tends to start early then finish earlier in the afternoon so that they can run and walk in daylight hours, because of safety. Offering such flexible approaches to work is really important in encouraging the overall wellbeing of women and men in employment situations, specifically in relation to their being able to access sport and exercise.

11:45

Gillian Mackay: I agree. It is key that we tackle the big structural issues as well as individual behavioural issues. That comes down to the planning side and to the employment side.

The Convener: The final theme is inclusivity. We have touched on that throughout the meeting, but Paul O'Kane has specific questions about it.

Paul O'Kane: This theme is about the intersectionality of the issues that impact on women and girls in sport. Your report covers various areas, but I am interested in LGBTQ+ young women in particular and their access. How do we support those women to feel secure, supported and safe in sport? You have touched on that already, but I wonder whether you want to add anything to that.

Jenni Snell: It goes without saying that there is a general need to reduce stigmatisation in relation to the LGBTQ+ community. In our survey, there was some feedback on changing rooms, for example. We need to reduce the stigma around lesbian and bisexual women specifically being able to access changing facilities without pressure or potential stigma from their peers.

Trans inclusion in sport is really important. The Young Women's Movement is an intersectional organisation. We whole-heartedly support the trans community generally and trans women specifically to be able to access the same sport and physical exercise opportunities that women are able to access. It is really important to highlight the additional barriers that they will face in accessing sport and physical exercise. It is already difficult for cisgender women to access sport and physical exercise. The barriers that trans women will face will be even more augmented and compounded because of the inequalities and prejudice that they face across society. A real intersectional approach needs to be taken to ensure that their lived experiences and voices are included in any recommendations.

There are a number of organisations out there, such as LGBT Youth Scotland and trans organisations, that are the experts in supporting trans women, trans men and the LGBTQ+ community. Those organisations should be part of the conversation to ensure that lived experiences are heard and meaningfully embedded.

Katie Heath: To go back to the report, 25.8 per cent identified themselves as being LGBTQ+, and 22 per cent of those people had had a negative experience with sport. I think that the impact on the ability to access sport is even higher for those who would identify as LGBTQ+, so it is crucial to understand the lived experience of people and how services can be improved to make them feel that they have more access.

Paul O'Kane: I want to pick up on the previous theme of the discriminatory language that we hear, and the fact that clubs and governing bodies do not always tackle homophobia appropriately. We have seen a lot of focus on that recently. Obviously, that has been more in the male space, and it has been to do with male players in football in particular. However, it is clear that there are issues around homophobic language in women's football in particular, and there is often stereotyping of women who play football. Did that abuse and that language being a real barrier and clubs and governing bodies maybe not dealing with that appropriately come through in any meaningful way?

Katie Heath: That did not necessarily come through in the report, because that was not the focus. We looked more at the school experience and earlier than that. However, what came through was how females who play sport were abused for their bodies not looking typically feminine—for not looking like a cultural ideal of what that is. I think that that will only be further replicated in a professional setting; I can only imagine that it is even worse in a professional setting.

Paul O'Kane: There is so much to get into with all of these issues. I am particularly interested in the socioeconomic factors that affect, or create barriers for, many women and girls in sport. Do you see that when people have to access materials or kit? Sport is often played in a very particular way that is geared towards men. Many aspects of life are male-centric and dealt with through a patriarchal structure. Does that add cost barriers to access for some sports?

Katie Heath: It does. Especially if someone is disengaged from sport and is struggling, it is hard for them to justify investing in joining a club or buying materials or resources to be able to play sport. That is difficult for someone who has thus far not been successful at sport or is not already engaged.

That goes back to what we said about feminist town planning and safe spaces. Many community spaces are a means of free access. If they are not safe, that throws up further barriers not only for women's safety but for people from lower socioeconomic backgrounds. It stops them being able to play sport in a safe place.

Jenni Snell: There are a number of good examples across Scotland. North Lanarkshire Council has an active teams free membership for young people from, I think, 11 to 16. We have recently seen the success of free bus travel for under-22s, which is available through the Young Scot card. There is already good infrastructure in place that could be harnessed to ensure that young women, especially those who are under 26 and have access to a Young Scot card, could have free access to leisure facilities and gyms.

Katie Heath spoke about parks and green spaces. Many community organisations offer free sport or fitness opportunities, but there is a lack of

awareness and understanding of those. There is a need to increase the campaigning and public health messaging about where women can access those opportunities. Perhaps information that tells new mums how they can get back into sport and fitness could be part of the baby box initiative.

Paul O'Kane: In a previous answer, you touched on the potential for gym classes and sporting activities to come with an element of childcare attached. Do you feel that that is important in creating more flexible options, so that people can work sport into their life?

Jenni Snell: Absolutely. Recently, the cost of childcare for young mums—as it has for all mums and parents—has significantly increased. The Poverty Alliance did some research on the impact of the cost of living crisis on women. They are bearing the brunt of childcare, which will certainly impact their ability and capacity to take part in sport. Having accessible childcare options within leisure facilities and sports clubs, or being able to take part in baby and mum or baby and parent classes, is an important part of lowering that barrier.

The Convener: I want to ask about disabled women. Yesterday, we had a meeting with some sports bodies. Representatives from Disability Scotland talked about some of the barriers that disabled women face in accessing physical activity and sport. Those barriers were not only at the drop-out points; there were barriers throughout youth, adolescence and young womanhood. Did you get any evidence about that?

Jenni Snell: We spoke about protected characteristics, and disability was part of that, but we did not get a high enough response in that area to be able to make any huge claims about that.

To go back to what we said about the other protected characteristics, it is important that young women who are facing disability are part of the process and have their voices embedded in it, so that they can get involved in co-design and can share their feedback about what does or does not work for them.

We also need more capacity building and training for coaches, teachers and youth workers around how to meaningfully support young women, and other women, with disabilities in a sport setting and how to make inclusive, welcoming and safe spaces that have the voices of those women at the centre. Across all the protected characteristics, the approach should be standardised so that we ensure that lived experience is taken into account and meaningfully involved in the process.

The Convener: It is about designing things with people rather than hearing their issues after things have been structured.

Jenni Snell: Absolutely.

The Convener: Sandesh Gulhane has a question.

Sandesh Gulhane: I have two brief questions. The first is about periods. Beth England, a footballer in England, has talked about how periods affect her and how, when it came to training, she felt washed out. Obviously, girls and young people have not grown into their bodies and do not really know about those issues. What does your report say about how periods affect girls and their participation in sport, and about what we can do to help?

Katie Heath: At the time, we spoke a lot about period products being crucial for access to sport and to enable people to feel comfortable and supported to play sport. We also spoke about the lack of diagnosis for things such as endometriosis. Young girls can be in a lot of pain as a result of health conditions but might not know their bodies well enough to know when something is not necessarily normal. The pain that they are feeling can impact on their ability to exercise or engage in sport, which is really troubling, but they do not necessarily have the language to communicate that in a school setting or to teachers.

There is perhaps not enough awareness of menstrual issues even among teaching staff who have to provide plans or programmes for exercise. There is now more awareness of how your menstrual cycle affects your ability to interact with different levels of exercise, and of the fact that you should probably tailor your training or level of exercise based on your cycle. Young girls do not necessarily have enough knowledge or resources around that.

One of our recommendations was about providing a space for young women to get clear public health information on the changes to their body and the impact that their periods could have. That would probably be linked to how periods might affect their mood and energy levels or fatigue. In a school or education setting, when you are in a class full of people, it can be really uncomfortable to ask difficult questions or to feel like you are experiencing something different from your peers. Having somewhere to go that has clear and easy-to-understand information is crucial to removing some of the stigma, even just among young girls.

Sandesh Gulhane: My second question is about pregnancy. You said earlier that you spoke to young mothers. To go back to the England women's football team, Toni Duggan, the Everton player, finally got maternity leave but, in general,

women who have children do not tend to be involved in elite sport. I know that this is part of the point about role models, but that gives a bit of a negative image. How can we make it more normal and encourage women who have children or who are pregnant to participate?

Jenni Snell: That goes back to awareness-raising campaigns and public health messages. We need to ensure that there are good practice examples of how women can still participate while they are pregnant, and we need to challenge some of the perhaps more damaging messages that suggest that, if you are pregnant, you should not be doing sport. That is the normal narrative, but there is a lot of evidence to suggest that, if you are already active, you can continue to participate in sport.

It is about healthy advice. We perhaps need to support midwives, healthcare professionals and others who come into contact with women who are about to have a child to provide safe public health messages. We also need awareness-raising campaigns involving role models who are already doing that—perhaps not in elite sports but in community-based sports. It is about building awareness and showcasing good practice examples of how that is already happening.

Katie Heath: I think that that comes back to the lack of women in sports governing bodies. If you do not have their voices discussing the idea of maternity rights and taking time out for maternity leave at elite level, you will not encourage those rights to come into play. The more we can encourage women into places of decision making in sport, the more those questions can start to be answered.

12:00

Stephanie Callaghan: You touched on endometriosis and heavy periods, which I suffered from really badly when I was younger. You are absolutely right about the fact that we are not educating young women and girls about what is normal—what they should expect—and when they should seek support, and I completely agree with your points. It was sometimes a challenge for me to get through a full school period, never mind go to PE and jump about. My concern with that is about how we ensure that teachers and support staff are listening to girls and taking them seriously, because, across different portfolios and remits, we repeatedly hear that women and girls are often not listened to. What can you say about that?

Jenni Snell: In general, women's healthcare tends not to be a subject that is widely researched, especially when it comes to endometriosis and periods. A lot of young women would not have awareness of or know about premenstrual dysphoric disorder, for example, and if young women are not aware of it, teachers, educators, youth workers and other professionals in that space might also not have awareness of it. There needs to be some capacity building and training, as well as resources, which could be co-designed by young women, on how they are feeling. A specific piece of work could be done with young women who have been diagnosed with endometriosis, for example, to co-design training, toolkits, resources and information for teachers, and that could be rolled out across Scotland to raise awareness of issues—

Stephanie Callaghan: Can I just pause you there? My biggest concern is about the fact that it often takes a long time to get diagnosed with endometriosis or heavy periods—I know that there is a correct name for that, but I do not know it off pat—and there is a big issue about women and girls being trusted if they do not have a diagnosis. For example, they might go and speak to a teacher—it can take a huge amount of courage to have that conversation—and be fobbed off by the teacher saying, "Stop trying to get out of PE and get on with it." That is the issue that I want to get at.

Katie Heath: Coming from an educational background, I think that there is more of a push now towards understanding young people's voices, taking them into account and co-designing things. It is largely an education piece when it comes to the barriers that women face. I do not think that many people who go into education are not doing it for the right reason and are not looking out for the best interests of the children.

As I said, it is all about education. I imagine that a lot of people who go into teaching physical education have not had barriers to sport and have found it to be an easy route to success. Therefore, it could be important to have adequate training for staff—linked to in-service education and training days or local authority training—that educates them on how such issues impact young women. It is not just about the physical education of children; it is across the board. As you have said, it is difficult to focus when you are in an excruciating amount of pain. To go to six or seven lessons throughout a day and have to explain yourself in each one can be very difficult. There are certainly ways in which that information could be communicated kindly and constructively, but we would have to speak to schools and educators about that to understand it better.

Stephanie Callaghan: It is good to know that there is co-design and that people are talking about trust and agency and girls being understood.

The Convener: Thank you for your time today. We have kept you longer than we said we would, but that is because everything that you have said has been so valuable. What has been particularly valuable for me and the clerks is the other groups that you have mentioned that you are aware of, which we can pick up on.

At our next meeting, we will undertake routine scrutiny of NHS boards, and we will continue our formal evidence taking as part of our inquiry into female participation in sport and physical activity. That ends the formal, public part of our meeting.

12:04

Meeting continued in private until 12:20.

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

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