OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 14 December 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 14 December 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
15th Meeting 2021, 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)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Kirstie Campbell (Scottish Government)
Hugh Masters (Scottish Government)
Marie McNair (Clydebank and Milngavie) (SNP) (Committee Substitute)
Kevin Stewart (Minister for Mental Wellbeing and Social Care)
Maree Todd (Minister for Public Health, Women's Health and Sport)
Carolyn Wilson (Scottish Government)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 14 December 2021

[The Convener opened the meeting at 08:40]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome, everyone, to the Health, Social Care and Sport Committee's 15th meeting of 2021. I have received apologies from David Torrance.

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

Members *indicated agreement.*

Perinatal Mental Health

08:40

The Convener: Our second item today is an evidence session with the Minister for Mental Health and Wellbeing and the Minister for Public Health, Women's Health and Sport, as part of our inquiry into perinatal mental health.

I welcome to the committee Kevin Stewart, who is the Minister for Mental Health and Wellbeing; Maree Todd, who is the Minister for Public Heath, Women's Health and Sport; Hugh Masters, who is the chair of the perinatal and infant mental health programme board for the Scottish Government; Ruth Christie, who is the head of the children, young people and families unit, improving mental health and wellbeing, at the directorate for mental wellbeing and social care in the Scottish Government; Kirstie Campbell, who is the head of maternal and infant health, improving health and wellbeing, at the directorate of children and families; and Carolyn Wilson, who is the head of the unit for supporting maternal and child wellbeing.

I remind members to put an R in the chat box if they have supplementary questions. I will try to take as many questions as time allows.

To start things off, I have a question for Kevin Stewart about the "Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services" report, which made 28 recommendations in 2019. What progress has been made on those recommendations? How have they been put into policy?

The Minister for Mental Wellbeing and Social Care (Kevin Stewart): Would it be appropriate to make some opening remarks before answering your question, convener?

The Convener: That is fine. I am sorry—I did not realise that you had opening remarks to make. Carry on.

Kevin Stewart: Thank you, convener.

I welcome the opportunity for my colleague Maree Todd, Hugh Masters and I to assist the committee with the inquiry into perinatal mental health in Scotland.

I thank everyone who responded to the inquiry. The huge range of responses from professionals, organisations and individuals shows just how important the issue of perinatal mental health is right now, so I am pleased to be able to provide my support by coming here today.

I also express my gratitude to those who kindly shared their personal experiences, which helps us to open up the conversations, to address stigma and, most important, to get a better understanding of what works well and what we need to do better.

We recognise the impact that the pandemic has had on the mental health of new and expecting parents. The responses to the inquiry highlight the sobering reality of what that can look like daily.

As a Government, we are making significant investments in our mental health services to encourage recovery and renewal as we emerge from the pandemic. It is in that context that I would like to share a brief summary of my vision for perinatal mental health services in Scotland.

Since 2019, the perinatal and infant mental health programme board has overseen investment across community perinatal mental health services, the third sector, mother and baby units, infant mental health services and maternity and neonatal psychological interventions.

In October, we published the new "Perinatal and Infant Mental Health Programme Board: delivery plan 2019-2020", which sets out the next steps in our ambitious and compelling long-term goals not only to develop and sustain perinatal and infant mental health services in the most challenging times, but to ensure a systems approach to service development and delivery of those vital services.

We will continue to build on the achievements of the programme board to offer the right kind of support to those who need it, at the right time. This year, more young parents, infants, fathers and those who have previously experienced pregnancy and neonatal loss are receiving support, thanks to the organisations that are funded through our small grants fund for the third sector.

08:45

The programme board will also continue to ensure that lived experience is at the heart of service development, implementation and provision. As I mentioned earlier, it is incredibly important to us that service provision be led by the needs of women and families, and that it builds on good practice and learning from positive and negative experiences of current services.

We will take forward the work of the new delivery plan in collaboration with our partners and we will ensure that there is continued focus on raising awareness, promoting understanding and reducing stigma.

I am extremely grateful to our statutory and third sector services for their continued passion and co-operation in delivering our strategic aims during the pandemic. With continued collaborative working, we can offer invaluable support for perinatal and infant mental health services across Scotland in providing a lifeline to parents, carers and families when they need it most.

The inquiry responses also touch on pregnancy and baby loss; Maree Todd will answer questions on those issues. I assure the committee that, with the rest of the Scottish Government, Maree Todd and I recognise the tragic impact of baby loss and the profound effect that it can have on the lives of the bereaved families. We are committed to ensuring that women and families are provided with the right information, care and support, taking into account their individual circumstances.

I look forward to working closely with you all on our important agenda for perinatal mental health to ensure not just that we are listening to the women and families of Scotland but that we inform our policies with their lived experiences in order to deliver high-quality and person-centred care.

I will turn to your question, convener. We have made real progress on delivering on the report's recommendations. Since March 2019, we have invested more than £16 million in perinatal and infant mental health services to develop a range of services, from specialist acute in-patient services through to third sector support for women and families who are in the perinatal period. We are focused on ensuring equitable access to sustainable mental health support throughout folks' pregnancies, as well as on ensuring that we get it right during the perinatal period and in the child's infancy.

The voices of lived experience must be at the heart of our approach—I will probably say that again and again today, because I believe that it is immensely important in getting policy development and service delivery right.

The programme board is making good progress on meeting the recommendations on delivering effective services. For example, it is providing £6 million of funding in 2021-22 across all health boards to establish specialist community perinatal mental health teams.

In health boards that have more than 3,000 births a year, we have also funded enhanced psychological support for maternity and neonatal settings. Five boards—Fife, Greater Glasgow and Clyde, Lanarkshire and Lothian among them—are in the process of establishing dedicated multidisciplinary infant mental health teams, with a majority of other health boards embedding an infant mental health focus within their perinatal teams.

We have funded an increase in staffing for mother and baby units and have created the mother and baby unit family fund to support families in visiting their loved ones in in-patient

care. We have also established the perinatal and infant mental health third sector fund, which so far has supported more than 2,000 parents, parents-to-be and infants. That comes with £1.8 million of funding.

Beyond that, the committee will also be interested in finding out what is happening on the ground. We are looking very closely at the overview of service developments across Scotland. The situation is improving; some parts of the country were slow in using the resources that were allocated to them, but Hugh Masters, the board and I have been in fairly regular contact with some boards to ensure that they are back on track.

On the service development front, we are looking at four key areas: perinatal mental health, infant mental health, the neonatal psychological interventions in the larger boards that I referred to earlier and, most important, the lived experience of and the level of engagement that boards are having with parents and families with regard to service delivery.

The Convener: We have spoken to parents, and something that has come up in those conversations—and which you alluded to—is inconsistency around the country. You have just said that you are looking at parts of Scotland to check whether there is consistent service delivery. Can you say a little bit more about how you are gauging progress? By the sound of it, you seem to be doing that by getting feedback from mothers and fathers about their experience. What form has that taken?

Kevin Stewart: Your question covers a number of issues. When I came into post and started looking at the matter—I looked at it as a constituency member, too—I saw quite clearly that some areas were doing better than others in delivery as well as in recruitment, which is key to development of services. Some areas had used the resources that we had given them well, but some health boards had spent barely any of the money, recruitment was slow and the level of engagement with folks with lived experience was poor.

That situation has changed. I am not saying that everything in the garden is rosy; I think that there is still work to do in some areas, but folks are being recruited. NHS Highland and NHS Grampian in the north worried me, because they were pretty slow. However, that is changing and they are now recruiting.

Moreover, in my view, the level of engagement with people with lived experience was not always as good as it should have been. Not long ago, I met Let's All Talk North East Mums—or LATNEM—which is a women's group in Aberdeenshire. I know that you have been contacted by some of those folks as a constituency member, convener. They had mixed experiences of services and did not feel that they were listened to enough. I think that that situation has changed.

After having spoken to NHS Highland late last week, the board has sent me this week information about its work on communicating with and consulting families and the third sector. It shows real improvement in that. Its recruitment situation is getting better, too.

Convener, I am something of an old-fashioned boy—a bit simplistic, some would say—so what I have is a set of report cards that we will keep updated so that we can look at the progress that is being made across the country. What I see in the overview is more green lights than there were, some ambers where further improvements have to be made and fewer reds than there were at the beginning. However, the committee can be assured that I will continue to engage with boards that have been a bit slow in developing services and not quite good enough in allowing folks with lived experience to help.

The Convener: I see that Hugh Masters wants to add to what you have said, minister.

Hugh Masters (Scottish Government): Perhaps I can make a few comments about the work of the programme board.

It is absolutely right to say that one of the key drivers—this came from the maternal mental health change agents, whose work in bringing this issue to the fore I must pay tribute to—was the need for a national approach and national spread of services in order to avoid having areas where such services were not in place.

The programme board has identified executive leads in each health board and has asked them to set up implementation groups. We do regular monitoring and, as the minister said, we ask for returns. We also make twice-yearly visits; we will be making the next ones early next year.

On why some areas have been, as the minister said, slower to use the funding and get services set up, we are clearly talking about setting up new services during a pandemic, which has been challenging for many places. Moreover, areas were at different stages of development, with services already existing in some areas—or, I should say, already being provided by individuals and professionals—and able to be built on.

We want to focus on evaluating the impact of all that next year—in fact, it is a key priority of the programme board—not just in terms of hard data but in terms of the experience of women and families and the question whether the services fit

with what they want and expect. That will allow us to move from the "What?"—in other words, what we have been able to do—to the "So what?", which is all about the impact that it has had.

The Convener: Thank you. I will hand over to my colleagues, who will get into the detail. I suggest that some questions will be more appropriate for Maree Todd, so they should be directed towards the appropriate minister. If anyone, whether it be a minister or an official, wants to come in, they should say so in the chat box, and I will make sure that I bring them in.

Sue Webber will lead on support for at-risk and vulnerable women.

Sue Webber (Lothian) (Con): I suppose that the witnesses—[*Inaudible.*]—very upsetting—[*Inaudible.*]—many of us. We heard of quite varying—[*Inaudible.*]—in terms of how the services are set up for people who, I am sad to say, know that they are going to give birth to a stillborn baby, and for the important moment when they have to have that conversation with healthcare professionals. What improvements are being made to ensure that parents are consistently treated with compassion across the country and in every health board, and that they are not being retraumatised when they access services later on? They are a very vulnerable group of people, so I would like to know what we are doing to drill down into those issues and to help them consistently, irrespective of where they live.

The Convener: Your sound was a little bit patchy, but I imagine that the question, which is about consistency of approach across the country for families and parents who have experienced a stillbirth, was for Maree Todd. I ask the minister to respond, and we will try to get Sue's sound sorted in the meantime.

09:00

The Minister for Public Health, Women's Health and Sport (Maree Todd): Thank you. I apologise—Sue Webber's sound was a little glitchy at my end.

The first thing to say is that the Scottish Government recognises the impact of baby loss. It is absolutely clear that women who experience baby loss need the right information and care and support that take into account their personal circumstances. The loss of a baby at any stage of pregnancy is an absolute tragedy that has a profound effect on families, including on their mental and physical health.

The Scottish Government recognises that; we are very clear that women and their families need the right care and support. A lot of work is going on across the country to ensure that women and their families are provided with tailored care, including through following of guidance from the National Institute for Health and Care Excellence and the Royal College of Obstetricians and Gynaecologists.

On consistency across the country, the committee will be aware that we have started to implement an incredible programme called best start, which encourages flexible family-centred and person-centred care that is suited to the needs of the individual. Best start will undoubtedly improve the situation.

Unfortunately, however, the pandemic has struck mid-implementation. Although some health boards were far advanced in their work on best start, others were in the early stages of implementing it. We are keen to pick up best start from next year and we expect to see a great deal of improvement and consistency of services when best start is applied across the country.

We have also been working with third sector organisations, including Sands—the stillbirth and neonatal death charity—to develop the national bereavement care pathway for bereavement or loss, which will provide health professionals with evidence-based care pathways and will describe best practice for bereavement care. We are working on rolling that out across the country.

As I have said, a great deal of work is going on across the country. Although the work has undoubtedly been impacted by the pandemic, I think that we are on the right path. Once we are able to implement best start fully, we will see progress on that front.

Sue Webber: Is the sound better now?

The Convener: It is a lot better.

Sue Webber: Cat Berry, who was one of the witnesses at last week's meeting, suggested that the timescales for implementation of the specialist baby loss units can and should be shortened. Do you think that that is possible, Ms Todd?

Maree Todd: I recognise the urgency of working on that and that, for every individual who is affected by baby loss it is an absolute trauma. We want to get it right for women as fast as we can.

It would be foolish of me to make promises, particularly today. The pandemic is not finished with us yet, and we face further challenges that we had not predicted. We have been living with uncertainty for the past couple of years, so it would be foolish of me to promise certainty over the next couple of months. It is very clear, this week of all weeks, that that is not possible.

What I can do is assure that witness that I recognise the urgency and that we will work as fast as we can to ensure that every woman,

throughout Scotland, can access flexible person-centred and family-centred care when she needs it.

Sue Webber: You spoke a lot about women there, but there are also fathers to consider. Another message that has come out in the evidence is that it should be ensured that fathers are included.

All sorts of trauma can happen during pregnancy that can make women reticent on subsequent visits to the unit. Such trauma does not always result in the sad loss of a baby. What are we doing to ensure that the mental health of women who have experienced significant trauma is taken into account in the perinatal period?

Maree Todd: You are absolutely right to highlight that baby loss impacts not just the mum but the father. I said clearly that we talk about family-centred care, so I include the father and, in fact, the entire extended family.

You will be aware that, before I came into politics, I was an antenatal teacher. I talked a lot about how babies are sometimes born in a medical event, but they are always born in a social event—they are always born into a community and family, and the whole family and community need support when things go wrong.

You are right that pregnancy is an uncertain time and that sometimes things do not go as expected. Since 2017, we have provided more than £16 million in funding to support the implementation of "The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland", which we think is the solution to many of the challenges and traumas that people face during pregnancy. That five-year plan was published in 2017 and, as I said, it remains a firm programme for government commitment. Person-centred high-quality care for mums and babies throughout pregnancy and birth, and following birth, can have a marked effect on the life chances of women and babies and families, and on the healthy development of the child throughout their life.

We are aiming for gold-standard care. We want truly family-centred care that will maximise the opportunities to establish building blocks for strong family relationships and for confident and capable parenting. One cornerstone of that type of care is the continuity of carer. There has been a lot of discussion on that with regard to baby loss. Continuity of carer has a significant impact on, and makes a difference to, the experience of people and families who have lost a baby.

We are continuing to introduce continuity of carer in maternity services. That is the care that midwives have told us they want to deliver—the type of care that they want to be involved in—but it is also the care that women have told us they want to receive. They want to build a relationship with a midwife, not just through their pregnancy, birth and beyond, but in subsequent pregnancies. Where there has been loss or trauma in one pregnancy, continuity of carer becomes absolutely vital in subsequent pregnancies.

Sue Webber: That is great—thanks.

The Convener: We will move on to the theme of care pathways. Paul O'Kane has questions on that.

Paul O'Kane (West Scotland) (Lab): Last week, we heard a lot of important evidence and, as Sue Webber said, it was quite emotional at points. We heard about the planned development of specialist baby loss units. Those units are not anticipated to be fully available across Scotland until 2024. As a starting point, I would like to understand what percentage of parents get access to a specialist bereavement midwife now. What can we do to speed up specialist interventions, particularly through the baby loss units?

Maree Todd: I will bring in Kirstie Campbell to give you the most up-to-date picture of delivery across the country. Kirstie, can you give information on where we are at the moment and where we hope to be early next year? I am aware that we are again in uncertain times because of the pandemic.

Kirstie Campbell (Scottish Government): I am happy to do that.

The minister has outlined the work that we are doing on the national bereavement care pathway to support women who have experienced a loss. The pathway has been developed and co-produced with Sands—the Stillbirth and Neonatal Death Society—and a number of other third sector organisations that deal with baby loss. It sets out a package of standards for maternity units to aspire to and achieve in delivering high-quality bereavement care for women and families who experience a loss.

There are a number of elements in the standards. They include taking a parent-led approach, providing training and supportive materials, providing emotional support, providing a bereavement lead in boards, providing bereavement care facilities, and having supportive and informed discussions and memory-making activities.

The bereavement care pathway has been piloted in four boards. We commenced the piloting more than two years ago but, unfortunately, the process has slowed and paused in some boards because of the impact of the pandemic. Progress on the pathway has not stopped, but it has slowed. Our bereavement care pathway lead, Catherine

Macrae, is working with the four boards that are involved in the pilot to try to continue to make progress. We are hopeful that, given the progress that has already been made and the evaluation of implementation that is under way, we will be able to roll out the pathway in all 14 health boards in the early part of 2022. Obviously, that is dependent on capacity in boards, given the progress with the pandemic.

That is a key part of what we are doing. The introduction of the bereavement care pathway will provide a consistent approach in all boards to the implementation of support for bereaved parents across Scotland.

Paul O'Kane: If the minister could write to the committee with the specific percentages that I asked for, that would be helpful, just so that we can have that empirical data. I notice that the minister is agreeing, which is great.

I have a further question about more specialised pathways for women, particularly in relation to mental health and increased vulnerabilities such as substance misuse issues. What specific pathways or interventions are being developed to support people with mental health or substance misuse issues?

Maree Todd: The best start approach equips midwives with the skills to care for women with socially complex needs and their babies. The midwives have reduced case loads, and there is continuity of carer. There is additional training, and there are clear pathways of care and co-ordinated multi-agency support. The best start for any baby is that the mum receives continuity of carer from a primary midwife who is supported by a small team. That primary midwife is really important for women with additional complex needs, such as those with substance misuse issues.

As I said, work is under way to produce nationally consistent guidance and pathways and to cope with different levels of complexity. The midwife will always be the lead carer, but there might be a greater need to work closely with other services. Early access to care is important for building a high-quality antenatal relationship between the mum or family and the midwife. It is really important for mum and baby.

For women with a whole range of medical, social and psychological complexities, early intervention and co-ordinated multi-agency care make a massive difference to outcomes. That begins at the initial booking appointment, when the midwife first sees the mum during pregnancy. At that stage, women are asked a variety of questions about their wellbeing in order to assess the likelihood that they have additional needs.

My colleague Kevin Stewart might want to talk specifically about some of the perinatal mental health approaches that support women from the antenatal period right through to the postnatal period.

Kevin Stewart: The perinatal mental health clinical network has set out a series of five national pathways, which cover pre-conception advice, psychological support for mild to moderate concerns, specialist assessment for severe and complex needs, emergency assessment for MBU admission, and specialist assessment and intervention for parent-infant relationship difficulties.

09:15

We are developing animations to increase the accessibility and awareness of those pathways. Four health boards have fully developed local pathways for perinatal mental health, and a further seven boards have pathways in development. Boards are also developing specific pathways on birth trauma, neonatal loss, anxiety and needle phobia.

The Convener: Thank you. Does Paul O'Kane have another question?

Paul O'Kane: No, convener—that was most helpful.

The Convener: We will move on to Stephanie Callaghan, who has questions on access to services.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I thank the panel members for being here. It was reassuring to hear the cabinet secretary set out such a clear commitment and focus on taking women's lived experience into account and making sure that there is equitable access across the country. The cabinet secretary has answered what would have been my first question, which was about where the boards are with that recommendation.

What is the Scottish Government doing to improve waiting times for perinatal mental health services and to align them with the timescales of pregnancy? Have the thresholds for referral to specialist mental health services changed because of the increased demand?

Kevin Stewart: I have gone on the record many times saying that we do not want anybody to be waiting, and we are doing all that we possibly can to ensure that we are delivering for people. We will continue to invest in the recovery and renewal phase in relation to bringing waiting lists down, whether they are for child and adolescent mental health services or psychological therapy services.

We have to take the right actions in this area and, in our service delivery, we must make sure that we have a joined-up approach to dealing with

perinatal mental health. The work that we are doing with health boards is extremely important, but we need to go much further in ensuring that those on the front line know exactly what services are available and can direct folk to them.

I will give an example from my discussions with the LATNEM—Let's All Talk North East Mums—women's group, where there were mixed responses to some of my questions. It is fair to say that some women thought that their GPs were absolutely fantastic at getting it right for them. In other cases, folks were very unhappy indeed with their initial contact with GPs and they were not signposted to the right services. We have work to do to change that. We need to make sure that everything that we are doing across the country is being filtered down to those on the front line and that they know exactly what services women need and are signposting them and referring women to them.

On the development of services, I note that we require not only the acute services that we tend to concentrate on when we talk about waiting times and waiting lists, but also community services. We need to get it right in communities across the country, and that means that the investment that we have put in needs to be spent wisely on developing those community assets. Beyond that, we also need to ensure that our investment in the third sector is there to allow those organisations to play a real part, with their expertise, in helping women and their families.

For example, I met Home-Start Aberdeen on Friday in a constituency capacity, although, as is always the case, we strayed on to some ministerial matters. Those folks have a lot of experience of dealing with women and families, and their experiences and the information that they gather have to lead to the improvements that are required for us to get it right for women and families across the country.

Hugh Masters might have more to say on the subject.

Hugh Masters: The thing to bear in mind is that access arrangements will be a key focus for the programme board next year. Many of the services and developments are new and, as such, we need to ensure that the processes that are put in place meet at least the requirement of the managed clinical network for perinatal mental health, which is that women should be seen no later than six weeks from the time of referral. We will target support to boards in which that is an issue.

I want to go back briefly to the pathways for substance misuse. As the minister said, it is really important that we are able to make it clear and publicise that those services are now in place so that people understand that support is available and they can seek help. We are well aware of the issue of substance misuse, which has been identified in many settings. The "Delivering Effective Services" report highlighted the need to develop services, given feedback from women and families.

We are looking at the recommendations in the report from the managed clinical network around supporting women and reducing harm, and we will work with our stakeholders at an event early next year to consider how to take things forward, which might include a specialist care pathway. We are developing that work and some actions will emanate from it early next year.

Stephanie Callaghan: That is good, and that information is positive. Have the thresholds for referral changed due to the increased demand? What supports are in place while people are waiting for referrals to come through?

Kevin Stewart: We need to listen to the voices of lived experience with regard to how we shape services for the future. I refer back to the LATNEM women. There were mixed opinions on various parts of service delivery, but all the folks who expressed an opinion said that, during the pandemic, the Grampian resilience hub had been absolutely fantastic in responding to women's needs. We need to learn from the Grampian resilience hub's work during the pandemic and see whether we can replicate it across the board. Something went on there that obviously worked for those women, and if it worked for them, it is likely to work for others. Such services can operate in the same way in remote, rural and island areas as they do in urban areas because, in the main, communication is by telephone or video call. We need to look at that in more depth.

I will be honest with you. We would not be picking up such nuggets of information and good practice if we were not going out and hearing the voices of lived experience. I want to continue to do that.

Hugh Masters may want to say a bit more on that.

Hugh Masters: On the support that is available in the meantime, we are trying to invest in a range of services, as I think the minister said. We are talking more about specialist assessment and treatment, but we are also looking at what support can be provided by the third sector. Universal services, which we have touched on, also have a key role to play. We are offering health visitors and midwives training on perinatal mental health so that they understand the issues and have the confidence to offer that kind of support and to assess properly. We are getting some very positive feedback on that.

Emma Harper (South Scotland) (SNP): While we are talking about access, I want to highlight the challenges for rural areas. The minister comes from a rural area in the north-east and he will be well aware of the challenges. I am also thinking of the north-west and the south of Scotland. When women from rural areas access care, are we monitoring that and tracking the care and pathways associated with it?

Kevin Stewart: I am a toonser from the north-east rather than a country boy but, as I pointed out, I well understand the difficulties that often exist in accessing services in rural and island communities.

We have to adapt service delivery. Boards are often best placed to know their areas, but we want to make sure that, in shaping those services, we listen to women and families when they tell us what they need. The Grampian resilience hub, which I mentioned, might be a solution that can be replicated elsewhere. I think that such a solution would work as well in Dumfries and Galloway as it does in rural Aberdeenshire.

As colleagues who heard me speak in my previous role will know, I am a great believer in exporting best practice. Where we find best practice, we will spread it far and wide. Hugh Masters and his team on the board have been doing that anyway, but we will continue to do it. As I said, we will also continue to look for nuggets of information from service users about what works for them and we will try to replicate that across the board.

In this regard, as in every other area, we will look at the best practice. Delivery will need to be adapted for certain parts of the country, but we will try to ensure that services are shaped by the voices and opinions of lived experience.

Hugh Masters: On the data and monitoring, I assume that Emma Harper was referring to admissions to mother and baby units. We keep a very keen eye on that. We have some quite recent data on which boards are admitting to mother and baby units. I am aware that some women are instead being admitted to adult, non-MBU settings, and one of our key tasks for early next year is to interrogate the data further in order to understand the reasons behind that. We hope that we will get permission to work through the managed clinical network to do that so that we can better understand the choices that are available to women.

09:30

Another key priority for us next year is to push on with the regional aspects. As the committee will appreciate, in remote and rural areas where birth rates are low, the need for a dedicated team is not so great as there will be a much more dispersed model. We are very keen that regional links are made. That is happening in the north of Scotland as Grampian, Highland and the islands' boards are beginning to come together to discuss the issues.

On top of that, a priority for us during the pandemic was the Near Me service, which we funded, and which has worked very well for those whom it suits, and there has also been third sector funding. A final point on remote and rural areas is that we set up the mother and baby unit family fund, which provides funding to enable family and loved ones to travel and stay when the mother is admitted to an MBU. We appreciate that that is not the answer to everything, but it has certainly helped, and we are getting good feedback on it.

Kevin Stewart: Given that mother and baby units have been mentioned, I think that it is important to expand on some of our thoughts in that regard. The "Delivering Effective Services" report recommended that the number of MBU beds in Scotland be increased and said that that could be achieved through expansion of the existing units or the creation of a third MBU in the north of Scotland. The report also recommended that an options appraisal be undertaken to determine the most appropriate way to increase the number of beds in Scotland.

That work is under way and a number of options are being considered, including the creation of a third mother and baby unit in the north and the expansion of one or both of the existing units in Glasgow and Livingston. We have to look at a number of issues including equity of access, cost and safety, and the sustainability of the service. All of that needs to be considered as part of the options appraisal. My intention is that we will hold a public consultation in early 2022, which will help to inform the options appraisal and the decision-making process. We will seek to engage with as many stakeholders as possible—in particular, we will engage with as many folk who have lived experience as we possibly can.

We recognise that, as Hugh Masters rightly pointed out, folk from further afield than Livingston and Glasgow, where the existing mother and baby units are located, often have a fair way to travel. We have therefore put in place the mother and baby unit family fund to help with travel expenses for families. We hope that we can move forward on that front in the early part of next year by consulting folk on the future of mother and baby units.

The Convener: We move on to Covid-19 and the associated restrictions. Sandesh Gulhane has some questions on that.

Sandesh Gulhane (Glasgow) (Con): We know that mental health deteriorated across the United Kingdom during the pandemic, and especially during the lockdown. We also know that perinatal mental health issues have been presenting difficulties for women in Scotland and that they were doing so even before the pandemic. Those issues range from stigma to women not having a dedicated mother and baby ward that they can go to.

My questions are focused on women from ethnic backgrounds. What impact has Covid had expressly on those from ethnic backgrounds? Given that further restrictions are possibly on the horizon, what learning have we done to prevent the same issues from arising again?

The Convener: I will bring in Kevin Stewart first. If Maree Todd wants to comment on antenatal care, I will bring her in after that.

Kevin Stewart: On perinatal care, feedback from the third sector has highlighted the difficulties in navigating service delivery in a safe way during the very turbulent times of the pandemic. To support the third sector, we funded additional support that was focused specifically on wellbeing issues. We have had learning during the pandemic that we can use in the future, and the Grampian resilience hub is the prime example of that.

I do not have any specific information with me on the impact on perinatal mental health support for ethnic minority women during the pandemic. We can have a look and see what information we hold and get back to the committee on that.

I will hand over to Maree Todd to cover some of the other issues that Dr Gulhane raised.

Maree Todd: The pandemic shone a light on pre-existing health inequalities, and it exacerbated them. We have seen that in maternity care, too. Unfortunately, even in this day and age, the strongest predictor of the worst outcomes during pregnancy is a person's level of wealth. People from areas where deprivation is high are more likely to have poorer outcomes. As Dr Gulhane says, we also see health inequalities along black and minority ethnic lines. Outcomes from maternity and pregnancy are often poorer for women from black and minority ethnic backgrounds.

It is a difficult issue to study because, in Scotland, numbers are relatively small and outcomes are generally good. Outcomes from pregnancy are largely good in Scotland, and the number of cases where things go wrong is quite small. It is therefore a challenging area to study. However, we work closely on the issue with our neighbours in the other UK nations. Kirstie Campbell can explain some of the work that is going on in England, from which we are benefiting, to look more closely at how we can meet the needs of black and minority ethnic populations during pregnancy.

Kirstie Campbell: As the minister highlighted, we know from a variety of reports, data and evidence that outcomes for women and babies from deprived backgrounds and those from black and minority ethnic backgrounds can be poorer. We also expect to see, and are seeing, that that has been exacerbated by Covid. We know that women from black and minority ethnic backgrounds are more likely to catch Covid and to have severe symptoms of it, and that applies to pregnant women, too.

As the minister highlighted, our 14 health boards in Scotland contribute to a number of UK-wide audits, including MBRRACE, which stands for mothers and babies: reducing risk through audits and confidential enquiries. We participate in that audit as part of a four-countries approach. We are also part of the perinatal mortality review tool development process, the national neonatal audit programme and the national maternity and perinatal audit. The combination of all those audits has helped to shine a light on some of the disparities in outcomes for women from black and minority ethnic backgrounds and women from deprived backgrounds.

The most recent NMPA report, which was published in early November, makes a number of recommendations for health boards on improving services and attempting to reduce some of those outcome inequalities. We will work closely with health boards in the early part of 2022, as soon as they have the capacity to work with us on those things. As the minister highlighted, things are particularly difficult at the moment because of the latest challenges that Covid has presented. However, as soon as health boards have the capacity, we aim to work with them on how we can implement some of the findings of the latest NMPA report.

The findings are practical and pragmatic, and it is helpful to have them set out in a report, with evidence attached, so that we can clearly make the links between the interventions that health boards can make and the outcomes for those women.

The Convener: The Minister for Mental Wellbeing and Social Care would like to come in, and then I will bring in Hugh Masters.

Kevin Stewart: I will let Hugh Masters come in, as he might cover what I was going to say.

Hugh Masters: I have two brief points. On learning from the pandemic, the evidence is gathering pace that the impact on young families has been particularly acute. We are beginning to see evidence that it is parents with children from

nought to two years old who are reporting the most difficulties. During the pandemic, we have worked with the managed clinical network to advise statutory services on maintaining provision. We have also worked with the third sector, which developed a directory of 99 services that have continued to operate and see families during the pandemic. That has been really important. I pay tribute to them for the work that they have done and continue to do during this time.

On ethnicity, we have an equalities sub-group of the programme board, which has identified ethnicity and cultural issues as issues on which we need to further develop our work. We will do that in the near future. I highlight some third sector funding that we have awarded to Amma Birth Companions, which is based in Glasgow and which does a lot of work in the perinatal period with women and families where English is not the first language. The organisation recently won the NHS Scotland award for diversity at an award ceremony. We are looking to spread the learning from that project across other areas.

Sandesh Gulhane: The important point is that, as we have heard, black women are twice as likely to die during pregnancy and those from ethnic minorities are less likely to get the Covid vaccine and so are at greater risk. Those things combined give cause for concern.

Specifically on perinatal mental health, stigma is a big problem, especially in minority ethnic groups. I am keen to hear that we will be able to take forward the learning from the NMPA report and put it into effect. I appreciate that the numbers are not large, but the issue really matters. We need to get our approach to ethnicity right. We have had a period of some stability, so why were measures not put in place? My question is to Kirstie Campbell. You have talked about capacity, but when do you expect to be able to start helping people from ethnic minorities?

Kirstie Campbell: I do not think that nothing has happened in health boards. The report that came out in November follows on from previous reports that have highlighted the disparity in outcomes for women from black and minority ethnic communities, as you have identified. We have done a range of awareness-raising events with members of the clinical community across Scotland to ensure that the information in the reports is known about at local level and that care can be adjusted.

At the beginning of the pandemic when concerns emerged about the worsened outcomes for women from black and minority ethnic backgrounds in pregnancy, the chief midwifery officer at the time wrote to all health boards outlining measures that they could take at that point to try to mitigate some of the effects of the Covid pandemic. Those included a reduced threshold for extending care and testing. There was a range of other measures, including focusing where possible on giving women as much continuity of care as possible at the time, although there was a recognition of the staffing challenges associated with the pandemic that the NHS has faced.

09:45

Stuff has happened, but more definitely needs to be done—there is no doubt about that—and a lot more can be done. That is why we intend to work with boards early in the new year to instigate that work as soon as we can. All that is holding us back is the need to monitor where the current wave of Covid is going. As members of the committee will know, maternity services have remained an essential service throughout the pandemic. Those babies are in the pipeline, and maternity and neonatal care needs to continue.

Boards have continued to provide that care throughout the challenging times that we have had, but we are very careful not to add to the burden on them when they are under such pressure, so we want to move forward with this quickly.

Kevin Stewart: I should say to the committee that we have just engaged our second participation officer to link with minority ethnic communities and other equality groups, as part of our work in listening to the voices of lived experience. Hugh Masters mentioned resources that we have given to the Amma women's group. We also have the experts by experience reference group, which is working with Amina—the Muslim Women's Resource Centre to understand their challenges better. With our small grants funding, we have also funded multicultural family days for peer support.

The equality impact assessments that we did highlighted stigma around perinatal mental health issues among BAME groups, but that stigma exists across all communities. We have a huge amount of work to do across the board to destigmatise those issues. That is going to take a lot of work, and we all need to work together to ensure that there is a greater understanding of the needs of women and families in that area. I am grateful to the committee for carrying out this inquiry, because your findings will add to the information that we already have.

Then we will have to act accordingly. We have a situation in which some women feel so stigmatised that they cannot even go into a bookshop to buy a book with the information about how they are feeling. The small grants funds and the work of LATNEM women and others who are recognising

these kinds of issues are ensuring that folks have easy access to such things. All of us should be working together to destigmatise mental health issues, whether in the BAME community or in other communities across the board.

The Convener: Emma Harper wants to lead on a discussion of stigma later in the session.

Maree Todd wants to come in, but first I will throw in another question. The women we spoke to brought up that Covid-19 restrictions meant that their partners could not be with them at many of their appointments and that they could not have antenatal classes. That added pressure to the pregnancy experience and had an impact on their mental health. It was quite emotional hearing about the impact of not having a partner with them, particularly if they were receiving news that was not great. As you said, we are not out of the pandemic yet. What assessments have been made of the importance of having partners involved and of antenatal classes?

Maree Todd: The first thing that I want to do, if you will indulge me for a moment, is pick up on Sandesh Gulhane's point that there has been low vaccination uptake among pregnant women from black and minority ethnic backgrounds. This is an opportunity for me to emphasise just how important vaccination against Covid-19 is during pregnancy. It is perfectly understandable that there was hesitancy and concern in accepting a new product when it first came on the market over a year ago, but vaccinations against Covid-19 have now been used worldwide in millions and millions of pregnant women. The evidence is now solid that the benefits outweigh the risk.

We need to increase vaccination in pregnant women because they appear to be more susceptible, particularly to delta, than the rest of the population. One way in which we are approaching that is by holding specialist vaccination clinics in maternity services. For example, NHS Greater Glasgow and Clyde has been holding vaccination clinics for pregnant women and, because of the catchment areas, those clinics naturally target black and minority ethnic communities.

I could not let the opportunity pass to emphasise just how important it is for our pregnant women to get vaccinated and to be fully vaccinated during pregnancy. They have every opportunity to talk to health professionals and the vaccinator if they have any concerns at all. The evidence is very solidly behind vaccination during pregnancy now.

On your broader question, convener, I will simply start at the beginning. At the start of the pandemic in March 2020, every service in the national health service pivoted to a digital response. Face-to-face visiting was reduced. Those were the days before we had a vaccine, and things were very dangerous. We managed to get through the early pandemic largely by pausing almost anything and everything.

However, family nurses and health visitors worked very closely with local partners in designing perinatal and infant mental health pathways to make sure that the community could continue to be looked after. In recognition of the importance of support for new parents and babies at a time of national emergency, very few of those individuals were redeployed. If you think back to March 2020, people were being redeployed, for example, from paediatrics to Covid wards, but our health visitors and our family nurses largely were not. We know how important it is to support women and families at these times.

The importance of prioritising visits for new babies was emphasised, and the guidance was adapted throughout the pandemic. Where possible, there was an emphasis on returning to face-to-face visiting, but that has not been possible at every stage of the pandemic. We have seen an amazing adoption of digital options, such as NHS Near Me for antenatal checks, blood pressure monitoring and things like that. Support was continued, but it was not always continued face to face.

We have always recognised the importance of having partners there at significant appointments during the antenatal period, at the birth and postnatally. We have always tried to enable that to happen. There have been challenges in individual maternity units with insufficient space for social distancing in the room. We had to leave flexibility for health boards where the risk assessment was that extra people could not be in the room. However, throughout the pandemic, we have recognised just how important it is for women and their partners to go through those experiences together and to be able to support each other at antenatal appointments, during the birth and in the postnatal period.

The Convener: We move to questions on the workforce from Carol Mochan.

Carol Mochan (South Scotland) (Lab): I thank all the witnesses for their input so far. As the convener said, I want to talk about the workforce. One of the biggest things that struck me was evidence from the Royal College of Nursing that suggested that we can make the biggest difference to improved mental health provision if we address staff vacancies and the workforce, as there are significant problems with the workforce in the area of mental health. I know that the Government is trying to address the issue, but it is important that we understand what workforce planning it is doing for specialist perinatal mental health services. Has the Government done any

workforce planning? One of the things that we hear from nursing organisations is that the retention of good and well-trained staff is key. Do you have any feedback on that?

Kevin Stewart: Workforce and sustainability are at the centre of all the programme board delivery plans. Last year, the workforce sustainability group was established to explore the issue across all sectors of the perinatal and infant mental health services. NHS Education for Scotland has been expanding training places on commissioned programmes as well as ensuring that additional perinatal and infant mental health training is provided across a range of professions. That investment will result in 51 additional psychological practitioners by the end of 2021-22. There is a huge amount of work going on, not just in relation to training and getting folk in but on training others to recognise exactly what is required in this context.

As the committee knows, I have said that we will look at a new workforce strategy for mental health services within the first half of this session of Parliament. We are well on the way in this area and we can see that in the recruits we are managing to get in.

Carol Mochan: Thank you for that, minister; that is what we are looking for—training across the board. Can you give us a wee bit more clarity on the 51 practitioners? Are they new?

Kevin Stewart: Those are additional practitioners across all services. Those psychological practitioners will cover a range of services. It is extremely important that we get it right in this area, as in others. Having kept a very close eye on recruitment, I think that we are doing well. We also have to ensure that we retain those folks as we move forward, and we need to grow for the future.

The Convener: Carol, are you happy for us to move on?

Carol Mochan: Yes, thank you.

Emma Harper: Regarding the workforce, and the provision of education, I know that there are online learning programmes, including the Royal College of General Practitioners perinatal mental health toolkit. As a vaccinator, I am still accessing the Turas learning models; I did a quick check of the perinatal mental health modules and there are seven specific modules, one of which is on stigma. How do we track those modules and the uptake? Who is taking up those modules? Is it midwives, psychologists or GPs? I think that they are fabulous modules. How do we encourage our healthcare professionals to take up the e-learning modules and how can we monitor that?

Kevin Stewart: I do not have the information at my fingertips on who is accessing all those modules, but we can get back to the committee with the information that we hold. Hugh Masters has put an R in the box, so he can perhaps come in with some more detailed information.

10:00

As I said to Ms Mochan, we have worked with NHS Education for Scotland to embed perinatal mental health in undergraduate education, to increase the number of psychology trainees at postgraduate level, and to roll out the suite of materials that has been mentioned to make them accessible to all professionals across Scotland. The aim is to further develop expertise at all levels across specialist and universal services. Importantly, we have committed to investment in perinatal and infant mental health services beyond the life of the programme board, which will allow health boards to recruit the required staff on permanent contracts and will support the recruitment and retention of staff and the development of centres of expertise.

That expertise is grand—it is brilliant—but we also want others to be able to access the kind of educational materials that Emma Harper has talked about. We have made that possible. If Hugh Masters does not have the details on who is accessing the training, we will write to the committee on that.

Hugh Masters: I do not have the exact numbers but, as the minister said, we will get back to you with those. NES has figures on the number of people who have accessed the course and the number who have completed it, so we can get that exact breakdown.

I am glad that Ms Harper is accessing the materials—I have done so myself. They are very well evaluated. We see constant evaluations from NES. The materials are aimed more at enhanced or specialist training for the workforce, which we felt was important given the sudden surge in numbers of people who work in perinatal. As you will appreciate, a number of the staff have those skills but some have to develop them. That makes the posts attractive and, we hope, ones in which people will want to continue to work.

Those practitioners and others in universal services can access specific modules. Emma Harper mentioned the stigma module, and there is also an introduction to perinatal module, which we know is being accessed. In general, as the minister has said, with recruitment, we are finding that people see it as an attractive area to work in. There are still challenges and difficulties in some places but, on the whole, the teams are beginning to reach their staff complement. We should never

forget that the third sector is involved, too, and that it has issues with sustainability and making sure that its staffing is what it should be. We will come back to you with the precise data.

Kevin Stewart: Convener, a very clever person has managed to get me some figures, which show that 700 practitioners have completed the stigma module alone.

The Convener: Thank you.

Sue Webber has a quick supplementary question on workforce before we move on to questions from Gillian Mackay.

Sue Webber: According to information that we have, NHS Lothian has said that the Government needs

"to further invest beyond the recommendations".

We have heard a lot about the training, staffing and so on. I seek reassurance that there will be the continuous reassessment of the workforce and the investment that are needed. NHS Lothian talks candidly about the

"need to consider an increased staffing complement to ensure that education and training, clinical supervision and support are embedded as part of practice and held in the same parity as direct clinical care."

That is about making sure that time for self-development and improvement is included in people's working time.

I think that Mr Stewart is probably best suited to comment on that, but I am not sure.

Kevin Stewart: I am continuing to monitor that matter, as is the programme board. There are always calls for additional resources—that is the way of the world. I am keen that all the resource that has already been allocated for the work in boards be used. When it has, we can look at whether other resourcing is required.

What is key for me, at the moment, is that we ensure that recruitment is taking place, that the money is spent and that the services that are delivered are shaped by the voices of lived experience. At that point, once the report cards that I mentioned have been looked at, we can consider what else we need to do and where.

I ask all health boards to ensure first that they utilise the resources that they have already been given to maximum effect.

The Convener: We move on to joined-up care, on which Gillian Mackay has questions.

Gillian Mackay (Central Scotland) (Green): What role do universal services play in prevention of perinatal mental health problems? How can those services be strengthened or better signposted? Those questions are for Maree Todd, first.

Maree Todd: It will come as no surprise to you to hear that I believe that universal services play a key role in the prevention and early detection of perinatal mental health problems, from pre-conception onwards. Public health messaging on awareness of mental health and positive health behaviours and relationships has a significant impact on subsequent emotional wellbeing.

All the members of the team—midwives, health visitors and family nurse practitioners—play a crucial role in identifying and preventing perinatal mental health problems. That is why we have invested in the NES perinatal and infant mental health curricular framework that we have discussed. It offers a suite of multidisciplinary training options to support universal and specialist staff to develop their knowledge and skills so that they can feel confident about addressing mental health and wellbeing issues with the women whom they work with. You might want to discuss it further with Kevin Stewart, but I believe that all mental health staff can also access those modules, especially those who work in relevant specialist areas.

With regard to universal services, perinatal mental health is a fundamental part of the core curriculum. We are trying hard to make sure that, regardless of where staff work or their specialty, perinatal mental health is an important part of their training and of their continuing professional development, as they go through their working lives.

Kevin Stewart: Universal services are key in ensuring that folks are able to access the services that they need. Obviously, delivery often varies in different parts of the country, but it is essential that we get the provision right for every woman and every family.

Joined-up care and an holistic approach are key in supporting women and their families during the perinatal period. We are taking specific action to improve provision of joined-up services for women and families with complex needs, including those who have substance use issues. Maree Todd's work is intertwined with mine, and we work closely with Angela Constance, the Minister for Drugs Policy. Substance use, which was mentioned earlier, is obviously an important issue.

In order to get this right, we need to take a cross-Government approach and to work in partnership with the managed clinical network, the third sector and—I cannot emphasise this enough—folks with lived experience.

We intend to hold a stakeholder event in the near future. It will be designed to discuss ways to improve the quality and consistency of support and services for women and families.

Maree Todd: Kevin Stewart mentioned delivery of services being different in different parts of the country. Delivery of universal services has looked different during the pandemic, as well. Antenatal classes moved to online delivery and breastfeeding support groups have, largely, moved to closed Facebook groups and other social media.

Social media have provided virtual opportunities to connect not only mums who have babies but families, and to encourage outdoor meet-ups. Around the country, walk and talk groups have begun. That has happened out of necessity—because it is safer to meet outdoors than it is to meet indoors and small numbers are safer than large numbers. However, as a public health minister who is thinking about the general health of the population and the challenges that we have in getting people active and maintaining healthy weight—it is particularly important for women to be a healthy weight during pregnancy—I hope that that continues. The opportunity to meet up outdoors and walk together—to socialise through exercise—is probably a valuable step forward, but I look forward to the day when it is not the only option.

Gillian Mackay: What action can be taken to ensure that women and their families receive joined-up care? That will obviously be quite different just now from what our ideal would be after the pandemic.

Maree Todd: You have heard, throughout our evidence, about joined-up care and the holistic approach. Those concepts are a cornerstone of care in the perinatal period. We are taking specific actions to improve joined-up services for women and families with complex needs, including those in which there is substance use. We have talked about that and the best start approach.

Prior to the pandemic, we made a significant investment in increasing health visiting. We have increased the health visiting workforce by almost 50 per cent in order to build capacity and to provide more support to individuals who need it. That represents a significant difference between the approach in Scotland and the approach in the other UK nations. That is because we recognise the incredibly valuable role that our health visiting teams play for new families. We have invested in them and have supported them in their role.

The Convener: The women to whom we spoke in our informal session mentioned support for infant feeding, as did people who submitted written evidence. That brings us back to the point about consistency of approach throughout the country. In some places, breastfeeding support has not been available, or women felt that midwives did not have time to give them breastfeeding support. They felt that that added to postpartum depression.

What can we do to ensure that women feel supported? The crucial point about feeding your baby keeps coming up.

Maree Todd: That is a really important point. I will bring in Carolyn Wilson to provide some more evidence on that, but first I will give you my initial thoughts.

10:15

The issue is important. For a long time, since before the pandemic, far too many women have given up breastfeeding not because they wanted to or chose to, but because they were not given support in the early days. We have been working on the issue for a very long time. I hear what the convener says about some women feeling that they were not supported well.

However, the reality is that, during the pandemic, breastfeeding rates went up. It is complex to unpick that; we are still trying hard to understand why that was the case. The most recent infant feeding statistics show that almost two thirds of babies who were born in the 2020-21 financial year were breastfed for at least some time after their birth. That figure is up 1 per cent on the previous year. More than half of those babies were being breastfed when their health visitor first visited, which is between 10 and 14 days after the birth, and 38 per cent were being exclusively breastfed. Those figures show increases of 2 per cent and 1 per cent, respectively, on the previous year.

The proportion of babies aged six to eight weeks who are being breastfed is at its highest since records began. Many people would say that it is still too low, but the figure is up to 45 per cent, and 32 per cent of babies are being exclusively breastfed, which is an increase of 1 per cent on the previous year.

Although I would not dream of dismissing the women's experiences that the convener mentioned, the data show that we have, at population level, managed to get something right in relation to breastfeeding support during the pandemic. I am not sure whether that was because fathers were often at home or because more support was provided virtually in people's homes, so people did not have to go out to ask for help. We will unpick the details.

All the improvements have come against the background of a commitment to breastfeeding in Scotland over decades. Carolyn Wilson might be able to set the scene better than I can, but Scotland was the first UK nation to achieve 100 per cent accreditation from the UNICEF UK baby

friendly initiative, which was an important landmark in improving breastfeeding rates. The committee will be aware that there are massive cultural factors that influence whether women and families choose to breastfeed and whether they are able to and supported to do so. The UNICEF UK baby friendly initiative gave us strong evidence-based practice with which to improve breastfeeding rates in Scotland.

Carolyn Wilson (Scottish Government): I will add to what Ms Todd has set out. We recognise the importance of providing very early opportunities to breastfeed. It is important that all women get skin-to-skin care and the opportunity to have that very special time with their baby immediately after birth. In Scotland, we have set ourselves a stretch aim to reduce breastfeeding drop-off rates at various stages. We measure the rate when babies are six to eight weeks old, but we look predominantly at what happens in the initial hours and days following birth. That is linked to the maternity care that women receive.

We are well on our way to reducing the drop-off rates. As Ms Todd said, across the country, the number of women who initiate breastfeeding and who are supported to breastfeed for longer is increasing. That is due to increased financial investment and a better understanding of what support infrastructure should be around women, so that they are provided with the resources that they need to continue to breastfeed for as long as they wish to do so.

It is important to look at the very early stage. I hear the points that were made about not dismissing individual women's experiences, but we know that there has been a lot more contact with our breastfeeding helpline and with some of our virtual support. We also know that infant feeding teams were, as an essential service, largely protected during the pandemic. We remain committed to providing tiered support, from peer support up to specialist support, because we know its importance in supporting women on their breastfeeding journeys.

The Convener: Thank you. The first couple of days were highlighted to us as being a particular issue. Kevin Stewart wants to come back in.

Kevin Stewart: I will be brief, convener. Ms Mackay's question was on universality and access to services. As the committee well knows, I have an ambition to ensure that we set high-quality standards across the board in mental health services. I have talked about what we have already done with CAMHS and what we are doing now with psychological therapies.

In perinatal care, we are proposing the introduction of a service specification, which will be absolutely vital in ensuring consistency of care and in promoting joined-up care pathways. While we do that, we will also have national and local conversations with the third sector and people with lived experience to ensure that we get the specification right and can adapt it accordingly. We will carry out that vital work to ensure consistency of care across the board.

Evelyn Tweed (Stirling) (SNP): It was great to hear Kevin Stewart's opening remarks on the Scottish Government's focus on perinatal mental health services. However, the third sector advises that funding is often short term and fragile. How would you respond to that point, minister?

Kevin Stewart: To date, we have invested £1.8 million in third sector services within the perinatal and infant mental health portfolio. We have publicly committed to investing up to £1 million per annum in third sector provision. A key part of our third sector work has been investment in the sector as well as funding specific organisations.

I know from conversations that I had last week that none of this is easy and that third sector organisations would prefer it if we could provide multiyear funding. I wish that that were the case, but the UK Treasury will not give us multiyear funding, which creates difficulties.

We have given as much comfort as we can to third sector organisations. I certainly value their work. We will continue to work with them and will do our level best to provide the resources and the services that women and families need across the country.

Hugh Masters: I will be brief—I appreciate that we are short of time. The first funding that the programme board awarded was to the third sector—we do not at all see the third sector as being separate, or as a separate issue for discussion. It has come up repeatedly today. We are exploring how funding might continue beyond the life of the programme board, which is something that we will focus on next year.

We also work with a partner organisation, Inspiring Scotland, which manages the fund. It not only manages the accounting, but works with third sector organisations on how to make the funds last. It also helps organisations that are not well versed in applying for funding to do so. Inspiring Scotland has done a great job in working with third sector organisations to make them as sustainable as they can be.

Evelyn Tweed: As we look forward, given the demands on the NHS, how does the Scottish Government see the relationship between third sector perinatal mental health services and the NHS developing in the future?

Kevin Stewart: That is an extremely important question. The best way to ensure that we get

services right for women and families across Scotland is to have complete co-operation and collaboration and a lot of communication between NHS boards, the third sector and the voices of lived experience. Some of the third sector work that I am aware of is crucial; it and the voices of lived experience should be at the heart of developing services at board level. We need communication, collaboration and co-operation to get the services right for women, their babies and their families.

The Convener: We move on to final questions from Emma Harper.

Emma Harper: The minister mentioned stigma in his opening comments and took a question from Sandesh Gulhane about it, so I will not labour the matter. However, I know that the Government is doing a lot of work to address concerns and raise public awareness around perinatal mental health. One of the issues that is being addressed is concern that mothers might have their children taken away from them. There are 12 action items in the perinatal and infant mental health programme board delivery plan. Will the minister elaborate a wee bit on specific actions that are being taken to tackle stigma?

Kevin Stewart: I know that a common theme in the evidence that the committee has taken is concern from mothers that seeking help from perinatal mental health services could result in the loss of their child. To tackle that kind of stigma, it is important that we get our approach right. The forthcoming raising awareness good practice guide will highlight mechanisms to tackle that stigma on multiple levels, because we recognise that we cannot remove stigma by adopting a single approach.

We need to tackle stigma on multiple levels in order to be effective; we need to look at what works for different families, members of different communities and different groups of professionals. The modules on perinatal mental health that Ms Harper talked about include one that is focused on stigma to inform professionals and ensure that a consistent and empathem, or empathic, rather—a word that I should have avoided—approach is adopted.

I should also say, because we have not covered it, that every baby box in Scotland includes a leaflet on perinatal mental health. The leaflet is currently being updated to include the latest information on where to seek help. We are also working with See Me to explore ways to actively promote role models and highlight good practice around stigma reduction and raising awareness about perinatal and infant mental health. In February 2021, we ran a national campaign, called wellbeing for wee ones, that was aimed at increasing awareness and reducing stigma around infant mental health.

Stigma is, without doubt, an area in which we need to do much more work. We need to co-operate in order to ensure that we reduce stigma and do all that we can in that sphere. We also need the general public to recognise that what some folk go through could happen to anyone and that, as a society, we need to do all that we can to help women, babies and their families get through difficult periods and, we hope, reach a brighter future.

The Convener: That is a good note to end on. I thank both ministers and all their officials, as well as the many people who got in touch throughout the inquiry to tell us of their experiences. I suspend the meeting until 10:45.

10:31

Meeting suspended.

10:45

On resuming—

Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill: Stage 2

The Convener: Our third agenda item is consideration of the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill at stage 2. We have a substitute member: Marie McNair is substituting for David Torrance, who has given his apologies. I welcome the Cabinet Secretary for Health and Social Care to the meeting.

Before we start, I will briefly explain the procedure for everyone who is watching. There will be one debate on each group of amendments. I will call the member who lodged the first amendment in that group to speak to and move that amendment and to speak to all the other amendments in the group. I will then call any other members who have lodged amendments in the group. Members who have not lodged amendments in the group but who wish to speak should make a request to speak by typing R in the BlueJeans chat function at the appropriate point. Please speak only when I call your name.

If the cabinet secretary has not already spoken to the group, I will invite him to contribute to the debate. The debate on the group will be concluded by me inviting the member who moved the first amendment in the group to wind up. Following the debate on each group, I will check whether the member who moved the first amendment in the group wishes to press that amendment to a vote or to withdraw it. If they wish to press ahead, I will put the question on whether the amendment is agreed to.

If that member does not want to press the amendment to a vote, any member who wishes the amendment to be put to a vote should put an N in the chat box at that stage. If that happens, we will then proceed to a vote on the amendment.

If a member wishes to withdraw their amendment after it has been moved, they must seek the agreement of other members to do so. If any member objects, the committee will immediately move to a vote on that amendment.

If any member does not want to move their amendment when it is called, they should say, "Not moved." Please note that any other member present may move such an amendment. If no one moves an amendment, I will immediately call the next amendment on the marshalled list.

Only committee members are permitted to vote. Voting will take place electronically using the BlueJeans online chat function. As convener, I will provide instructions on how and when to vote, and those will also be relayed via the chat box. If any member has requested a vote on an amendment by placing an N in the chat function when asked if that amendment is agreed to, we will then proceed to a vote on the amendment as follows.

First, we will record votes for the amendment. Any member who wishes to vote for the amendment should place a Y in the chat box when prompted to do so. Secondly, we will record votes against the amendment. Any member who wishes to vote against the amendment should place an N in the chat box when prompted to do so. Thirdly, we will record abstentions on the amendment. Any member who wishes to abstain on the amendment should place an A in the chat box when prompted to do so.

To enable the clerks to record votes accurately, please do not use the chat box for any other reason during votes. If you need to communicate with me or the clerks for any other reason during that time, please use the private messaging group that we have set up.

Once voting has been completed, the clerks will check the result and pass it to me to read out. Once I have read out the result of the vote, should you consider that your vote has been incorrectly recorded, please let me know as soon as possible. I will pause to provide time for that.

The committee is required to indicate formally that it has considered and agreed to each section of the bill, so I will put a question on whether each section is agreed to at the appropriate point.

I now begin stage 2 proceedings.

Section 1—Power for Scottish Ministers to reimburse costs relating to the removal of transvaginal mesh

The Convener: Amendment 1, in the name of the cabinet secretary, is grouped with amendments 2 and 5.

We cannot hear the cabinet secretary. I can hear a bit of crackling, but that is about it.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Can you hear me now?

The Convener: Yes.

Humza Yousaf: Forgive me—I am not sure what is happening with my headphones. If there are problems, I will log out and log back in again, perhaps without the headset. I will not touch the set-up that I have now, so I hope that you will be able to hear me fine. Thank you, convener. I hope that you and all the other members are doing well this morning.

Section 1(3) of the bill currently defines "qualifying" mesh removal surgery as surgery for a person who,

"at the time the surgery was arranged",

was

"ordinarily resident in Scotland".

During the evidence sessions at stage 1, concerns were raised that the criterion was too narrow in scope. It was felt that the eligibility criterion should be widened to allow those who were not ordinarily resident in Scotland at the time that they arranged mesh removal surgery but were ordinarily resident at the time of the insertion of the mesh. During my appearance before the committee on 2 November, I gave an undertaking to consider that point further. In response to the stage 1 report, the Government agreed that the residence eligibility criterion is too narrow, and it undertook to lodge amendments on that.

Amendments 1 and 2 will therefore extend the eligibility criterion to include people who were not ordinarily resident in Scotland at the time of arranging their mesh removal surgery but who were ordinarily resident in Scotland when the mesh was inserted. I hope that the committee will welcome those amendments.

In respect of amendment 5, in the name of Carol Mochan, the bill is intended to allow reimbursement of those who have arranged and paid for mesh removal surgery. Where mesh removal surgery is arranged by a health board, it is, of course, provided free of charge, and a health board would not normally arrange surgery for a patient who was not ordinarily resident in Scotland. For those reasons, the Government cannot support amendment 5 but, as always, I am keen to continue to liaise and engage with Ms Mochan on her explanation of the amendment. We can, of course, revisit the issue if that is required at stage 3.

I move amendment 1.

Carol Mochan: I thank the minister for lodging amendment 1.

In moving amendment 5 and speaking to all the amendments in the group, I want to be clear that I am happy with the spirit of the bill and the collaborative nature of the approach that the Parliament has taken in moving forward through each stage to ensure that the women involved are reimbursed at the earliest possible time.

My amendment 5 would ensure the broadest scope for the qualifying residence element of the bill. As the minister stated, the committee has always agreed that that is the correct approach. Amendment 5 would ensure that any women who had mesh implant removal undertaken by the NHS but who were not ordinarily resident in Scotland would be included in the eligibility criterion, so that they could seek expenses and so on.

Towards the end of our discussions at stage 1, the committee touched on the rights of all women who have been adversely affected by transvaginal mesh surgery and who had any surgery in Scotland. Therefore, I lodged amendment 5 in the interests of clarifying the bill and ensuring that parts of it are not unclear for those who are affected.

The Convener: As no other member wishes to speak, cabinet secretary, would you like to wind up and say whether you wish to press or withdraw amendment 1?

We have lost you again, cabinet secretary, so you might want to give that wire a wee shoogle.

Humza Yousaf: What I could do—[*Inaudible*.]

The Convener: We will pause the meeting for a couple of minutes to allow the cabinet secretary to log off and log back on again.

10:54

Meeting suspended.

10:55

On resuming—

The Convener: We have the cabinet secretary back. I believe that you do not wish to sum up, cabinet secretary.

Humza Yousaf: I am happy to waive that right, other than to say that I am happy to speak to Ms Mochan later if her amendment is not agreed to, to see whether we can give any further reassurance in relation to stage 3.

Amendment 1 agreed to.

Amendment 2 moved—[Humza Yousaf]—and agreed to.

Amendment 5 moved—[Carol Mochan].

The Convener: The question is, that amendment 5 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Mochan, Carol (South Scotland) (Lab)
O'Kane, Paul (West Scotland) (Lab)

Against

Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Gulhane, Sandesh (Glasgow) (Con)
Harper, Emma (South Scotland) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Martin, Gillian (Aberdeenshire East) (SNP)
Torrance, David (Kirkcaldy) (SNP)

Tweed, Evelyn (Stirling) (SNP)
Webber, Sue (Lothian) (Con)

The Convener: The result of the division is: For 2, Against 8, Abstentions 0.

Amendment 5 disagreed to.

The Convener: Amendment 4, in the name of Jackie Baillie, is grouped with amendment 3. As amendment 4 pre-empts amendment 3, if amendment 4 is agreed to, I cannot call amendment 3.

11:00

Jackie Baillie (Dumbarton) (Lab): I am grateful to the committee for the opportunity to move amendment 4 and to speak to amendments 4 and 3 in my name. The amendments flow from the evidence that the committee took prior to stage 1 of the bill.

The policy intention behind amendment 4 is straightforward. It extends the eligibility period for women who have arranged surgery for mesh removal. Members will recall that the original cut-off date that was suggested by the Government was 12 July 2021, and the committee was clear that, to capture as many women as possible, we needed to be as generous and flexible with eligibility criteria as possible, and we did not want any unnecessary barriers to be placed in the way of women accessing reimbursement. At the time, the cabinet secretary said that he would give the matter further consideration, so here I am with my two amendments.

Amendments 4 and 3 have the same effect, but achieve the desired outcome in two different ways. It is very much for the committee to decide which it would prefer.

Amendment 4 places a provision in the bill to say that, in order to qualify, any removal surgery must have been arranged before royal assent. Amendment 3 stipulates that the date will be specified in the scheme but that it can be no earlier than the date of royal assent. Ultimately, the difference is whether members want to put the qualifying date in the bill or in the scheme.

I move amendment 4.

The Convener: As no member wishes to contribute, I invite the cabinet secretary to speak.

Humza Yousaf: I thank Jackie Baillie for lodging her amendments—and for being the only member whose backdrop shows that she is clearly in the festive spirit.

I am genuinely grateful to Jackie Baillie for lodging the amendments. Along with others, Jackie Baillie pressed the Government to consider whether it was right to have a cut-off date of 12 July, which is the date that we had in mind when I announced publicly the completion of the first stage of procuring an NHS referral route to private removal surgery. I thought that the arguments of committee members and, most importantly, the affected women from whom the committee took evidence were persuasive. I have always said that, ultimately, if the primary purpose of the bill is to bring justice to those women, their voices must be central to any of our deliberations.

I absolutely appreciate that there has been a delay since the announcement in July and that it has taken some time for contracts to be completed. That is not because of any lack of good will on the part of the parties involved—far from it; they have been engaging well and helpfully in negotiations. However, the fact is that the contract negotiations are complex. Having met a number of the women involved, I accept that the delay in completing those contracts has undoubtedly caused anxiety for women who have suffered for far too long, and the Government does not want those women to be penalised. The contract negotiations continue to make progress, but it is taking time to work through the intricacies around them.

I confirm now that the Government wishes to add its support for Jackie Baillie's amendment 3. We hope, too, that there is a consensus in the committee and more widely that the scheme should not be open-ended. After the cut-off date passes, all the options put in place by the NHS, including referral to private providers, should offer women the support and choices that they need. We therefore need a date so that the scheme is not open-ended—I think that the committee would probably agree with that. The Government considers that it is reasonable for there to be an extension to the cut-off date so that the scheme can include time since July to around the time of royal assent.

I took notice of amendment 4, which Jackie Baillie summed up well. However, I think that amendment 3 is better, because it retains some element of flexibility. Given the uncertain times that we are in, it would be sensible to keep open the option of adjusting the cut-off date in case there is some unanticipated development.

As I said, good progress has been made on contracts with the two private providers, and we are confident that surgery in the independent sector will be available from early next year.

I thank Jackie Baillie for lodging amendment 3. I confirm again that the Government will support it and I hope that that support allows Ms Baillie to withdraw amendment 4.

The Convener: I ask Jackie Baillie to wind up and press or withdraw amendment 4.

Jackie Baillie: An important lesson in politics, as in life, is to quit while you are ahead, and I thank the cabinet secretary for his support.

Amendment 4, by agreement, withdrawn.

Amendment 3 moved—[Jackie Baillie]—and agreed to.

The Convener: Amendment 6, in the name of Carol Mochan, is grouped with amendments 7 to 9.

Carol Mochan: In moving amendment 6, I clarify again that my amendments 6 to 9 aim to be helpful in ensuring that the spirit of the bill and the committee's discussion are captured in the bill as passed.

Amendments 6 and 7 seek to add wording that will give clarity to section 1. The committee sought to ensure eligibility for someone who incurred costs in supporting a person to have treatment, and my amendments 6 and 7 would allow that to happen.

Amendment 8 would extend the bill to cover those who might have begun the process and, therefore, incurred costs but for whom, unfortunately, the process has been halted due to travel or surgery restrictions "relating to coronavirus".

Amendment 9 is a simple amendment that lays out the meaning of coronavirus.

I seek the committee's support for this group of straightforward amendments.

I move amendment 6.

Humza Yousaf: I echo what Ms Mochan said about the collaborative and constructive approach to the passage of the bill. I will resist Carol Mochan's amendments, and if they are not agreed to, I am more than happy to work with her between stages 2 and 3 to see whether we can resolve some of her concerns.

I am grateful for Carol Mochan's explanation of the intention behind her amendments 6 and 7 and I assure her that the bill, as drafted, caters for the circumstances that she has in mind.

Section 1(4)(a) states that qualifying costs are

"as charged to or in respect of the person who underwent the surgery".

The words "in respect of" already allow for expenditure by someone other than the patient to be taken account of and reimbursed. If a person who is not the patient has directly paid part of the cost of surgery, evidence of that expenditure can be submitted and considered for reimbursement as part of the patient's claim.

As I noted in Parliament on 24 November, we expect that applicants might want to claim reimbursement of costs and then pay back any money that was made available to them or spent on their behalf by family members or friends. The draft scheme, which has been provided to the committee, includes some important details on that point.

Paragraph 17 of the draft scheme clarifies that money received from "public fund raising campaigns" must be declared in the application and might be deducted, but costs that have been met directly by another person may be included in an application. It will be for the recipient of any reimbursement to distribute the money that they receive. For example, if a sibling paid for the patient's surgery, that expenditure could be included in the patient's application, and of course, once the patient received the reimbursement, she could then repay her sibling.

I am also worried that amendment 7 could lead to people who have only a slight connection with the patient applying for reimbursement in relation to the patient's surgery. I appreciate that that will not have been intended, but in general I think that it would make sense for applications to be made for or on behalf of the patient and their supporter and then to allow any private moneys to be repaid.

I hope that that clarification has been helpful to Ms Mochan and that, as a result, she will be content to seek to withdraw amendment 6 and not move amendment 7.

On amendments 8 and 9, I am, again, grateful for the explanation. I appreciate that the plans of patients hoping to arrange mesh surgery might well have been disrupted, particularly given the times that we live in, and my officials are aware of a number of such cases, as no doubt committee members, too, will be. However, the Government is not aware of any circumstances in which travel has been actively curtailed in the way envisaged in the amendments.

That said, we consider that—[*Inaudible*.]—in the draft scheme more than sufficient flexibility to deal with individual circumstance—*[Inaudible*.]

The Convener: It looks like we might have lost—

Humza Yousaf: —made impossible as a result of the decisions of foreign Governments, and it is expected that carriers will have either refunded the costs or offered—[*Inaudible*.]

The Convener: Right. We will suspend briefly, because we have lost the cabinet secretary. We will need to check his connection and then bring him back in.

11:11

Meeting suspended.

11:13

On resuming—

The Convener: We appear to have resolved our technical difficulties. Can I just check that we have the cabinet secretary before I move on?

Humza Yousaf: Hi, convener.

The Convener: Thank you. We heard your summing up on the amendments, cabinet secretary, so I call Carol Mochan to wind up and indicate whether she wishes to press or withdraw amendment 6.

Carol Mochan: I appreciate the discussion that we have had on the amendments and accept that there will be time before stage 3 to discuss the issues further and get things right for people. As a result, I seek to withdraw amendment 6.

Do you want me to go on, convener?

The Convener: No, I will prompt you when we get to the other amendments.

Amendment 6, by agreement, withdrawn.

Amendment 7 not moved.

Amendment 8 moved—[Carol Mochan].

11:15

The Convener: The question is, that amendment 8 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Gulhane, Sandesh (Glasgow) (Con)
Mochan, Carol (South Scotland) (Lab)
O'Kane, Paul (West Scotland) (Lab)
Webber, Sue (Lothian) (Con)

Against

Callaghan, Stephanie (Uddingston and Bellshill) (SNP)
Harper, Emma (South Scotland) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Martin, Gillian (Aberdeenshire East) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)

The Convener: The result of the division is: For 4, Against 6, Abstentions 0.

Amendment 8 disagreed to.

Amendment 9 not moved.

Section 1, as amended, agreed to.

Sections 2 to 5 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill.

At our next meeting on 21 December, the committee will take evidence from the Cabinet Secretary for Health and Social Care on the budget and from Public Health Scotland on the common framework on public health protection and health security.

That concludes the public part of today's meeting.

11:18

Meeting continued in private until 11:35.

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