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Business until 17:07

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Pàrlamaid na h-Alba

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[The Presiding Officer opened the meeting at 14:00]

Time for Reflection

The Presiding Officer (Alison Johnstone): Good afternoon. The first item of business is time for reflection. Our time for reflection leader today is Natalie Beal, who is a prison governor and chair of the Prison Governors Association Scotland.

Natalie Beal (Prison Governors Association Scotland): Presiding Officer and members of the Scottish Parliament, thank you very much for the opportunity to address you this afternoon.

One of the reasons why I have spent the last 16 years in prisons is that, in 1991, I spent a summer sleeping on a church floor in Possilpark, Glasgow. To clarify, I did not break in; I did not trespass; I was part of a short-term missions trip. It was in that church that I first encountered an organisation called Prison Fellowship and spent time talking with men who were recently liberated from HMP Barlinnie. One thing really struck me about those conversations: it fascinated me just how much the men wanted to talk about their experiences, how much they wanted to be heard and the real value that they placed on feeling listened to.

Subsequently, I spent 18 years working in business and then, in a bizarre turn of events, I was recruited and appointed as a prison governor in 2008.

The thing about all our experiences is that, although they have, no doubt, shaped us, it is our reflection on those experiences that gives us insight. My reflection—my insight today—is that the very act of imprisonment not only strips a person of their identity but renders them voiceless. However, having a voice promotes active citizenship. Giving a voice helps people to feel valued and respected. It promotes fairness, justice, legitimacy, dignity and wellbeing. If we work to silence such voices, that is unjust. Having a voice is one of the pillars of procedural justice, whereby individuals are given the opportunity to share their concerns and participate in decision-making processes.

On 17 November, prisoners week will be launched, with the theme “Hear My Voice”. It will serve to raise awareness and encourage action among faith communities on the plight of prisoners, their families, their victims and those working in the justice system, whose voices often go unheard.

We are all called to act justly and, in doing so, to make fair decisions. I would contend that this is not merely about doing what is right; it is about restoring what is lacking. I agreed with the Rt Hon Lord Timpson when he said at the Prison Governors Association conference in October that good leadership, high standards and kindness really matter.

We are all in the business of people. Every person has a story and every voice deserves to be heard. Thank you.

Topical Question Time

14:03

Protection for Children (Physical Restraint and Seclusion)

1. **Roz McCall (Mid Scotland and Fife) (Con):** To ask the Scottish Government what its response is to the Children and Young People's Commissioner Scotland's call for it to introduce "legal protection for children on the use of physical restraint and seclusion in all situations where children are in the care of the state". (S6T-02182)

The Cabinet Secretary for Education and Skills (Jenny Gilruth): Restraint and seclusion of a child or young person must only ever be used as a last resort to prevent the risk of injury. A statutory framework already exists in many areas, including children's residential and secure care, for those rare times when restraint or seclusion is necessary.

Last week, we published new guidance for schools on physical intervention, which reaffirms that position and has been drafted in line with our responsibilities relating to the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. It provides further advice on prevention, training and safeguards in relation to the use of restraint and seclusion. The guidance has been developed carefully, with extensive input from key stakeholders, including the Children and Young People's Commissioner Scotland, young people, parents, staff and the teaching trade unions. We will work with partners to monitor and review its effectiveness by autumn 2025.

I recognise that there have been calls for further legislation, and we are exploring further options to strengthen the legal framework for schools. That includes my engagement with Daniel Johnson's member's bill, which I will consider carefully and respond to accordingly.

Roz McCall: We are now six years on from the Children and Young People's Commissioner Scotland's report "No Safe Place: Restraint and Seclusion in Scotland's Schools" and two years on from the "in safe hands yet?" report by Enable Scotland, which called for the publication of statutory guidance on restraint and seclusion in schools. However, the new non-statutory guidance on restraint in schools is still leaving children at risk according to teaching unions and the Children and Young People's Commissioner Scotland.

Despite the First Minister's assurances in response to my question last week and the answer that the cabinet secretary just gave, the rights of children and young people in Scotland are still not protected, which is unacceptable. Does the Scottish Government accept that its draft guidance is simply not good enough?

Jenny Gilruth: I thank the member for her question. I know that she raised the issue at First Minister's question time, and I heard the First Minister's response. I am sure that the member and I will continue to work outwith the chamber on the issues that she has raised today.

The member spoke about the delay in producing the new, updated guidance, which I accept should have been updated before now. However, it is important to say that the advice on that guidance came from the then children's commissioner at the time, that his view on the matter changed in 2022 and that the current children's commissioner is echoing the views of the previous children's commissioner about the guidance becoming statutory.

The guidance that we have updated is non-statutory, as the member knows. I am very aware of Mr Johnson's proposed member's bill on restraint and seclusion. I have committed to working with him and I have been working with him throughout the past year.

The member mentions the views of the teaching trade unions. The teaching trade unions were represented on the physical intervention working group, and the guidance has been developed carefully over time, with extensive input from more than 30 different groups. Those groups included the Children and Young People's Commissioner Scotland, young people, parents, staff, local government, teaching unions—including the National Association of Schoolmasters Union of Women Teachers—and those calling for Calum's law. Therefore, this piece of work has been taken forward by a range of partners.

I recognise the call for further action on the matter, and I commit the Government to working with members across the chamber to address this and to exploring further legislative options. However, the updated guidance is a move forward and, although there have been delays, it has been broadly welcomed across the sector. I again commit to working with any MSP, irrespective of their party, to ensure that we have legislation and support that are fit for purpose and that support our children and young people in their education.

Roz McCall: I am happy to work with the cabinet secretary on the guidance, but I fear that the words of the then Children and Young People's Commissioner Scotland, Bruce Adamson, are not fully being taken into consideration. He stated that, with regard to putting the guidance into statute,

"we have moved well beyond a position where this can be just an option for consideration in future legislation."

I raised with the First Minister last week the case of Isaac Tocher, which was yet another instance of a child being restrained—which resulted in significant injuries—and placed in seclusion. The First Minister reiterated to me that he could conceive of no circumstances in which what happened to Isaac should happen. However, the fact is that it did happen, and it is one of many cases. Experts are saying that new guidance is simply not sufficient to keep all our children safe. Is the cabinet secretary confident enough to guarantee that every child in state care today is safe from unnecessary restraint and seclusion, given the Scottish Government's new framework, which has just been published?

Jenny Gilruth: I thank the member for her question. I heard the First Minister's response and I share the serious concerns that she raised at last week's First Minister's question time, which she has raised again today. I echo—very much—the words of the First Minister, who said:

"I cannot conceive of a circumstance under which any of the detail that Roz McCall has put on the record would be justifiable under the guidance"—[*Official Report*, 7 November 2024; c 25.]

that is provided to schools on restraint and seclusion. I again put on the record that I agree very much with the First Minister's views in that regard.

The matter goes back to the safety and wellbeing of our children and young people in schools, which are absolutely paramount. Restraint and seclusion must be used only as a last resort, to prevent the risk of injury. The Government supports the intention behind Daniel Johnson's member's bill proposal, and I will continue to work with him as his bill progresses.

The fact that we have updated the guidance does not preclude the Government working with Mr Johnson on his bill. The member's bill process is at an early stage, but I will consider the bill's contents carefully and will work with and respond to the member in relation to his work on the bill.

The member queries the effectiveness of the guidance, but it is important to say that there has been a clear commitment that the guidance will be updated within the year and that we will respond to and monitor the progress and development of the guidance throughout the year to ensure that it is being used effectively. I hope that Roz McCall hears, from the tone and spirit in which I am engaging with the question, that the Government will work with members from across the chamber. It is really important that we get this right.

I know that there are a range of stakeholder views on the guidance. It is fair to say that we heard some of those views on Friday at the publication of the updated guidance. Beth Morrison, who has been leading work on Calum's law, said:

"Today is a positive step for children in Scotland".

She recognised, too, that there is more to be done, and I commit to working with MSPs from across the chamber to do exactly that.

Bill Kidd (Glasgow Anniesland) (SNP): I understand that preventative support and early intervention are among the cabinet secretary's top priorities, with a focus on improving relationships, behaviour and attendance in schools. Will she speak to the most recently published guidance under the behaviour and relationships in schools action plan and on how the Scottish Government is following up its implementation and success in schools across Scotland?

Jenny Gilruth: The new guidance that we published last Friday, on the use of physical intervention in schools, is the latest part in the delivery of our relationships and behaviour action plan, which I launched at the end of the summer. As Bill Kidd points out, the guidance advises that prevention and early intervention must be our primary approach, because we want to address the underlying causes of any behaviour that poses a risk to the safety and wellbeing of others.

The approach will help teachers and school staff to deliver a safe and supportive learning environment and will avoid the need for restraint and seclusion. I was quite taken by views that were expressed by the Educational Institute of Scotland on the approach, with some teachers feeling that they lack confidence in relation to the current policy. We very much hope that the updated guidance will provide support in that regard.

Local authorities have an important role to play in supporting staff to implement the guidance. I therefore welcome last week's statement by the Convention of Scottish Local Authorities that the new national guidance will enable the reviewing and updating of local policies and practice. Of course, the Scottish Government will work with our partners to monitor and review the effectiveness of the guidance by autumn 2025, as I previously intimated.

Daniel Johnson (Edinburgh Southern) (Lab): I thank Roz McCall for lodging the question. The guidance takes us forward, and we have clear definitions. The requirement to inform parents within the school day or, at the outside, within 24 hours and the comprehensive recording are both important.

However, in 2018, the children's commissioner's report "No Safe Place: Restraint and Seclusion in Scotland's Schools" found 2,674 instances of restraint used against 386 children. Most

concerningly, only 18 out of 32 local authorities were recording such incidents, and fewer than half the total number of local authorities were recording them comprehensively. Is that not why we need the guidance on a statutory basis—so that local authorities have to record and inform? Parents are not being informed in a timely manner and, critically, there is a gap in recording. What steps will the Government take to ensure that all such instances are recorded by education authorities?

Jenny Gilruth: Mr Johnson raises a really important point, and I recognise the work that he is undertaking on this important issue. Reflecting on the commentary from the NASUWT on Friday, I note that it raised the very point that Mr Johnson is raising about inconsistency in the approaches that are being taken by local authorities. Local authorities have an important role in supporting their staff to implement the new guidance and in updating their local policies. The new guidance includes advice on reporting, recording and monitoring restraint and seclusion to ensure that we have a more consistent approach across the piece. The guidance applies to all schools, whether they are local authority, independent or grant aided.

I recognise the issue that Mr Johnson raises, and I look forward to working with him throughout the work that he undertakes on his member's bill. I hope that he recognises and acknowledges that the new guidance makes specific reference to the issues that he has raised today because of the challenge in relation to inconsistency across the piece.

Willie Rennie (North East Fife) (LD): I support putting the guidance on a statutory footing, but is this whole debate not the result of a failure of the rest of the system? The fact that we are focused on the last resort means that the other resorts are not effective. We have significant problems with behaviour and violence in schools causing distress, and there is a failure to support those with additional support needs. Should we not be redoubling our focus on resolving those issues, so that we can reduce the use of restraint to the greatest possible extent?

Jenny Gilruth: I agree with the premise of Mr Rennie's question. Post-pandemic, in particular, some of the challenges that he talks to—for example, ASN and changed behaviour in our schools—have been very live issues to me. As the Cabinet Secretary for Education and Skills, I spend a lot of time in the chamber responding to challenges on those very points. In Government, we need to reflect on how we can better support local authorities on those issues, because, post-pandemic, things are different.

I was in an early learning and childcare facility in Balmullo, in Mr Rennie's constituency, recently and I heard what ELC practitioners in that local authority are doing in response to delays in speech, language and communication post-pandemic. It is important to work with local authorities in response to that greater need post-pandemic, and we, in Government, must better resource and support that work.

In the past financial year, we have spent record amounts on additional support needs. We have seen an increase of 725 in the number of learning support assistants, which is welcome news. However, I accept that that is not the end of the story and that the premise of Mr Rennie's question is that this issue relates to wider issues within our education system post-pandemic. I agree with that.

The Government is in listening mode. We are approaching the budget, and I am sure that, if Mr Rennie has any proposals, my colleagues and I will be happy to engage with him, because we are all singing from the same hymn sheet on this issue and want to improve the support that is available for our children and young people.

Martin Whitfield (South Scotland) (Lab): I apologise to the cabinet secretary, because I am about to amend my question to her and go back to Roz McCall's third question. The Government and local authorities have talked about review and update, and the Government is going to review the guidance in autumn 2025. So, when will all children be safe?

Jenny Gilruth: The guidance has been drafted in line with our responsibilities under the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024. It gives advice to staff about prevention, training and safeguards relating to the use of restraint and seclusion, and it sets out the types of restraint that should never be used on children and young people. That is really important.

The member asks a challenging question about the use of restraint in schools. We will have discussions about Mr Johnson's bill in the coming weeks, and I commit to working with him on it. I have heard about the challenge today and I am aware of the inconsistent approaches that are currently being taken by local authorities across the country.

The purpose of the guidance is to provide a more consistent approach across the country, and I commit to working with COSLA and with members from all parties to deliver that, to ensure that our children and young people are safe in school.

The Presiding Officer: That concludes topical questions. I will allow a few moments for those on the front benches to organise themselves before the next item of business.

Planning (Housing)

The Presiding Officer (Alison Johnstone): The next item of business is a ministerial statement by Ivan McKee on Scotland's planning system—supporting investment and economic growth and delivering quality homes. The minister will take questions at the end of his statement, so there should be no interventions or interruptions.

14:18

The Minister for Public Finance (Ivan McKee): Planning is an essential building block for a successful and growing economy. What we build and where we build it creates the right conditions for economic growth and prosperity. When planning is responsive and has appropriate resources and expertise, it can unlock economic potential and leverage in investment—in particular, in housing. Planning is a powerful tool for delivering development, including new homes, in a way that supports our commitments to net zero and nature and builds stronger communities.

The delivery plan that I am publishing today sets out the actions that we will take so that planning can play its full part in addressing the housing emergency. We are accelerating those actions to ensure tangible results in the coming months. We have already reformed Scotland's planning system to set out a strong vision with clear national planning policies for the future, through national planning framework 4.

One key objective of NPF4 is to support the delivery of quality homes for everybody who needs one. The policy is clear that applications will be supported if they are on sites that have been allocated in local development plans. Development proposals for new homes will be supported if they improve affordability and choice and address identified gaps in provision. Proposals for new homes will be supported where they make provision for affordable homes to meet an identified need. Our national planning policy on housing is permissive and not prescriptive, and that will not change.

However, our policy does not support development at any cost. Some members will be hearing calls for the so-called presumption in favour of sustainable development—a policy that pre-dated NPF4—to be reintroduced. However, that would not speed up delivery. Instead, it would take us back to more conflict and delay and do nothing to incentivise completions.

It is useful to remind anyone who is now calling for such a change from within this Parliament of the extensive engagement and parliamentary scrutiny that resulted in the Parliament adopting NPF4 in January 2023. At that time, members agreed that we needed to monitor the impact of NPF4 on housing delivery. In its annual review earlier this year, the Local Government, Housing and Planning Committee also agreed that data on that is crucial. That evidence has informed the priorities that I am setting out today.

In recent weeks, I have been working intensively with my ministerial colleagues and stakeholders to identify how the planning system can help to address the housing emergency in Scotland. Those discussions have exposed that planning is not the only or even the most significant reason for the challenges that we are facing in housing. In a report that was published earlier this year, the Competition and Markets Authority identified that, over recent years, on average, 29,000 homes have been given planning permission annually in Scotland. That figure significantly exceeds local authorities' land supply targets and it is higher than the target of 25,000 homes that industry representatives have been calling for.

We estimate that, across Scotland, more than 164,000 homes have planning permission but have not yet been built. Looking into it further, we see that analysis of house building applications shows that, in the Glasgow and Edinburgh city regions alone, planning permission has been granted for 121,000 homes that have not yet been built. Of those, around 38,000 units have been started but are not complete. The remainder may or may not be programmed by developers for build out. Land has also been allocated in development plans for a further 60,000 homes that are yet to receive planning permission.

The evidence shows that there is, in fact, no shortage of land, including land with planning permission already in place. What we need now is action to turn those permissions into homes. In the coming year, making progress on stalled applications will be our absolute priority.

There is more that we can and must do in planning to unlock more homes. Today, I am announcing clear actions that this Government will take to ensure that planning is front and centre in our efforts to turn this critical situation around. Those actions are around policy, delivery, efficiency and capacity.

First, on policy, we will continue to work with planning authorities to support them to put the new national policies into practice so that many more homes will be given planning permission every year where they are supported by agreed plans. Guidance will support that. We will also actively progress work to bring homes that have been given planning permission forward. Our work to reform compulsory purchase will contribute to that, and we will identify other mechanisms that could stimulate delivery.

Secondly, delivery is critical, too. We need to be crystal clear about the specific issues that are stalling development. My officials are now working with house builders and planning authorities to examine information that is being gathered on stalled sites. That will identify where well-placed interventions can broker solutions, as well as broader challenges. That group will meet for a detailed discussion later this week to look at the evidence and agree actions. While we will continue to respect the lead role that planning authorities play in determining the future development of their areas, over the next 12 months in particular, we will focus our efforts to help them to proactively enable development.

I announce today that we will establish a further planning hub to support housing delivery. Its approach will be informed by evidence and shaped in agreement with key partners from the public and private sectors, including the Convention of Scottish Local Authorities, Heads of Planning Scotland, the Improvement Service and house builders. We want the hub to enable more efficient, responsive and timely decisions and delivery. We are also supporting early adopters of masterplan consent areas and ensuring that new local development plans include a pipeline of deliverable housing land.

Thirdly, on efficiency, it will not come as a surprise to members to hear that making processes and systems more efficient is a passion of mine. In the delivery plan, we have taken a structured approach and reviewed the process from end to end to identify issues that are getting in the way of progress and determine where improvements can be made. For some, unfortunately, the planning process can be unpredictable, costly and lengthy. We will do more with planning authorities to improve and streamline procedures. For example, small and medium-sized house builders have raised concerns about planning conditions, so we are working to promote greater consistency in practice.

We know that we can do more to address proportionality. We are actively working to better align consents, streamline validation and provide a better service through processing agreements. That will help to speed up the planning process and complement the work of the national planning improvement champion, who has already been doing excellent work in the area.

In addition, I can announce that we are taking forward work on further permitted development rights, which could, for example, accelerate the change to residential use of properties above shops . We will consider that, and other options to use that powerful tool, which, essentially, removes the need for planning permission.

I can also advise that work to introduce an infrastructure levy will be stopped. Instead, the focus will be on improving guidance on planning agreements under section 75 of the Town and Country Planning (Scotland) Act 1997. I know that that announcement will be welcomed by the industry, and I hope that it recognises that we are listening to its concerns.

Finally, we need to do more to support and increase the capacity of planning authorities. The housing planning hub will be part of that. I have already taken steps to increase planning fees to enable authorities to recoup more of the costs that are associated with planning. Although the presumption against ring fencing means that we will not direct where local authorities invest any increased revenue, I expect them to use that income to support their planning services.

We have also initiated efforts to recruit and train additional planners through a Government graduate programme and by promoting skills and training. To encourage more people to consider a career in planning, I can announce today that, next year, we will treble the number of bursaries that are available to postgraduate planning students.

In addition, we need to improve the capacity of local elected members, who are key to the planning process. Planning Aid Scotland is developing a fuller package of training for local elected members to support that.

The First Minister has made it clear that Scotland is open for business and that growing our economy by increasing investment is a key priority. Enabling more homes to be built will help to fulfil that aim, and the measures that I have set out today will benefit wider developments and projects.

However, house building must also be about home making and giving people good-quality places in which to live. We cannot develop at the expense of Scotland’s natural capital and we must continue to work towards net zero. That is how to create a sustainable economy that harnesses all Scotland’s natural and cultural assets for the benefit of current and future generations. Our policies are now designed to incentivise developers to build out their sites more quickly and to support the provision of affordable homes that meet diverse needs. Those policies and the actions that I have outlined will ensure that homes are built in planned locations that will better meet people’s needs.

Planning has not created the housing emergency, but it can help us to find solutions to the challenges that we face. Everyone who is involved in planning has a role to play in achieving that—including, not least, the Government. Through the national planning policy on housing

and the delivery plan that I am publishing today, the Government is taking urgent action to hasten development and to create the homes all across Scotland that people need and deserve.

The Presiding Officer: The minister will now take questions on the issues that were raised in his statement. I intend to allow around 20 minutes for questions, after which we will move on to the next item of business. I would be grateful if members who wish to put a question were to press their request-to-speak buttons now.

Meghan Gallacher (Central Scotland) (Con): I thank the minister for advance sight of his statement; however, it was an admission of defeat. I was hoping for some ground-breaking planning legislation to build more homes, and a plan to fix the challenges that we face right across our housing sector, yet we have been left with another hub and an increase in planning application costs that will deter future housing developments.

The minister has the brass neck to turn up today to say that he needs to be crystal clear about the issues that are stalling development. It is his Government that is standing in the way of building more homes. How does the Government reconcile the aim of delivering more quality homes with the decision to propose rent controls both during and between tenancies, when the minister perfectly understands that that will restrict rental income flexibility and deter vital investment?

The burning question is, if the hub is designed to be the saviour of our planning system, why was it not included in the initial drafting of the Housing (Scotland) Bill? Is it the Government's last-ditch attempt to save that failing housing legislation?

Ivan McKee: Wow. In asking us to speed up the process, Meghan Gallacher asks us to bring forward more legislation, which would take years and would not add anything to the legislation that we already have.

She complained about rises in fees, but if she spent any time at all talking to those in the sector, she would understand that the sector is very comfortable with paying more fees, provided that the money goes into increasing capacity in the planning system.

She ridiculed the idea of a hub, but if she spent any time talking to those in the sector, she would know that the first ask is for a hub to be set up to help accelerate planning applications through the system.

Right across the piece, Megan Gallacher is absolutely wide of the mark, and has clearly spent no time at all talking to those in the sector or looking at any of the 23 actions in the delivery plan that was published today, which includes actions to speed up the process and make it more efficient; the master plan consent areas that are in the legislation; the fact that we are accelerating work to treble the number of young people coming through the bursary route into the system; or the many other actions that we are taking.

We are serious about the role that planning can take in tackling the housing emergency, but Megan Gallacher should also recognise that the data published by the Competition and Markets Authority shows that, on average, 29,000 homes a year have been given planning permission during the past few years, which is far in excess of the asks of the sector. That land is there to be built out already, with planning permission.

Mark Griffin (Central Scotland) (Lab): It seems that the minister has been listening to the sector, to an extent, and there is a lot to be welcomed this afternoon. However, although the minister says that our national planning policy on housing is "permissive, not prescriptive", which is technically correct, I am not quite sure that that sentiment is shared by house builders.

Based on the statistics that were released yesterday and the actions that were outlined in his statement today, when does the Government expect processing times to start to fall for major applications? The processing time is now more than a year, against a 16-week statutory timeframe.

Planning applications for sites with permission that have not been developed cost developers significant sums of money—money that they cannot borrow for. That money generally comes straight out of their cash flow, so it is not in their interest to sit on those permissions. Will the minister commit to an audit of the approvals and the sites that have been zoned for housing in the system on the basis of deliverability and the time that they have had that approval, so that we can get an accurate understanding of the capacity to build the homes that we so desperately need?

Ivan McKee: I welcome the member's recognition that we have been listening to and engaging closely with the sector. The Government stands ready to work with all parties in this place and people across the sector to deliver what we need for Scotland's planning system, housing needs and wider economy.

I absolutely commit to working to identify stalled sites as a first priority. I have asked for information on stalled sites to be pulled together so that we can understand what is in the 164 homes that have already been given approval. I have also asked for sight of large planning applications that are going through the system across all 34 of our planning authorities, so that we can better focus the resources of the hub on providing a brokerage service to address the priority need to shift the dial

on the number of homes that are being given planning permission each year and to speed up processing times, particularly on the larger developments, where processing times make a difference.

I will be honest. That data is held at the local authority level. We are reaching out to local authorities to secure it, so that we have visibility on where best to apply and focus resources to support them. We are also reaching out to Homes for Scotland and others in the sector to ask them to provide information on applications that are stuck in the system, so that we can help to move them forward. As I said, we are very keen to work with all parties to make a big difference.

Emma Roddick (Highlands and Islands) (SNP): The minister indicated in his statement that the Scottish Government has already made significant reforms to planning policy. Although Labour down south has also promised significant reform, I will not be alone in feeling that the proposed actions fall short. I hope that the Scottish Government has more ambition. Does the housing sector need further reform to enable more house building? What is the minister planning to do to move that reform forward, and how does that work compare with what is being progressed by the United Kingdom Government?

Ivan McKee: As I indicated earlier, we are happy to work with anyone who can help us to move the agenda forward.

I am just back from a British-Irish Council meeting last week, where I had close engagement with not only the Northern Irish Government but the Welsh Government, the Government of Ireland and the UK Government's new housing minister in the House of Lords. We had a very useful conversation about what we can learn from each other. It is interesting to note that we all face the same challenges.

We have had a close look at what the UK Government is proposing, and we are already either doing or working on delivering pretty much everything on its agenda.

The calculation method is interesting. When we use the UK Government's proposed new calculation method for housing targets against our housing landscape, we find that it delivers a lower number than we already have in place through the housing need and demand assessment and minimum all-tenure housing land requirement system.

The UK Government is taking forward a five-year housing land supply requirement, which is already in place through our local development plans. It talks about a 10 per cent affordable target, and we are already at a 25 per cent affordable target. The UK Government talks about brownfield and community infrastructure activities, which are already in NPF4 policies. It also talks about increasing fees, which we have already taken steps on, and about 300 more planners, which we will more than match on a proportionate basis.

We are working closely with others and learning where we can, but it is interesting to note that we are already delivering on much of what the UK Government is proposing.

Alexander Stewart (Mid Scotland and Fife) (Con): The minister's statement does not address the impact of the Government's proposed rent controls between tenancies, which is a policy that continues to be of major concern to investors. How does the Scottish Government plan to mitigate the likely decline in housing supplies as a result of those restrictions?

Ivan McKee: Mr Stewart might not be aware that, today, we are talking about the planning process and how it can help to support house building.

With regard to rent controls, my colleague, the Minister for Housing, has already lodged amendments to the Housing (Scotland) Bill to address those concerns.

As I identified in my statement, we need to address many factors in order to resolve the housing emergency. Planning has a significant role to play, but many other parts of the system are working hard across Government to deliver on other aspects.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): Good housing is central to health and wellbeing, but it is difficult in rural areas, such as the Scottish Borders, to have house builders engage in small developments. Some communities might feel that they will be sidestepped in the interests of accelerated house building, and many, as we know, only become engaged in the planning process late in the day.

I welcome reference to Planning Aid Scotland. Frankly, local members should be well aware of its functions, but most of the public are not. What can the Scottish Government do to help communities to engage with Planning Aid?

Ivan McKee: Planning Aid Scotland is an excellent organisation that I was not aware of until I became planning minister. I have had a number of meetings and events with the organisation over the past months. To give it a plug, Planning Aid Scotland uses the services of current and retired experienced planners to support individuals who are engaging with the planning system. I thoroughly commend the work that it is doing. Communities and individuals who want to avail

themselves of those services should reach out and engage with Planning Aid Scotland.

Daniel Johnson (Edinburgh Southern) (Lab): The minister is correct to identify the need to bring on more planners to deliver against those targets. However, he knows that the workforce of planners currently sits at its lowest, with 1,205 town planners working in local authorities. Skills Development Scotland estimates that we need 700 more planners to replace people leaving the workforce and meet demand. The University of Dundee is the sole institution that is training planners, and the bursaries that he mentions fund just 10 planners at present. Can he confirm that his proposals will increase that number only to 30? Will we have more centres to train planners? When will the Government bring forward more detail on the work-based training for planners that is outlined in the action plan?

Ivan McKee: That is a valid point. One of the things that struck me in my engagement with planning authorities and the planning ecosystem is the demands on planning resource. That is a consequence of a number of factors. As the system has become, rightly, more complicated and we have more challenges to address—such as climate, flooding, biodiversity and the housing emergency—and as other private sector organisations require more planning resource in the housing space, in energy and in many other aspects of the ecosystem, the supply of planners has not kept pace with the demand. That is why we are addressing the issue.

Adding 30 more planners a year to the total is not an insignificant thing to do. That is one element of what we are doing through the bursary scheme, which is the quickest, most cost-effective way to deliver planners—and I am absolutely open to increasing that further if there is capacity in the system. Very soon, we will bring forward information on the proposal for graduate planners to be employed within the Scottish Government as they go through their courses, in parallel with the bursary scheme. That will add a significant number of additional planners into the pipeline, and that will be targeted to start in the next academic year—in 2025.

In parallel with that, we have identified a need to encourage retired planners to come back and perhaps work part-time, and to identify where those who have left the planning profession mid-career can come back into the system. It is also a matter of identifying roles that can be played in the planning system through digitisation, automation or process improvement, or by individuals who are not fully trained planners. In all those aspects, we are taking forward work that we believe will have a cumulative impact on the resource within the planning system.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): How will today's announcements help in areas of rapidly growing populations, for example here in the capital? Will they help to progress the Granton waterfront development, for example, as a strategic site? Can the minister reassure the Parliament that stopping work to introduce an infrastructure levy will not affect the provision of necessary services in those areas of rapidly growing populations, such as general practices, primary schools, secondary schools and road infrastructure?

Ivan McKee: Those are all very good points. We absolutely recognise the points that the member makes about the infrastructure levy. When we considered the issue, we came to the conclusion that the existing section 75 provisions, which raise far more money than the proposed infrastructure levy would do, represent the most effective way to continue to provide infrastructure.

An infrastructure-first provision is part of the planning process in national planning framework 4, so we absolutely recognise the need for joining up infrastructure provision with housing development. We think that there are other ways to deliver on that more effectively.

On the Granton waterfront, the member will not be surprised to know that, as planning minister, I will not comment on any individual applications. More generally, in Edinburgh and other parts of the country that are experiencing rapid population growth, we will be identifying stalled sites and applications that have been in the system for a considerable period of time, working closely with planning authorities to see what needs to be done to unblock them and move them forward through the brokerage service to be provided by the new planning hub.

Ariane Burgess (Highlands and Islands) (Green): I welcome the move to promote the change of use of properties, such as those above shops, to residential use. That measure will support us in creating three homes for the price of one.

Will the planning hubs enlist ecological specialists and provide an opportunity to fund empty homes officers to be deployed where needed?

Ivan McKee: I am glad that the member welcomes the focus on change of use. She is right that that can provide additional capacity within the system to bring more homes on to the market. We have carefully considered how best the planning hub can deliver on the need to increase significantly the number of houses that are available as they come through the planning system. For that purpose, the work of the hub will be closely focused on those large stalled sites

where we see that there is scope to make a difference quickly.

We also absolutely recognise that work needs to be done with small and medium-sized enterprises on smaller sites. We are taking that forward in parallel with other provisions that we have described in the delivery plan that I have outlined today.

The member is right that, in the increasingly complex planning system, there is a need for other professions—and environmental services is absolutely one of those. Flooding experts, biodiversity experts and a whole range of other skill sets are required in the system and in the hub, which will be designed specifically to reach out to experts in adjacent professions to move forward applications in the planning system that are taking longer than they should.

The Presiding Officer: I am very keen that all members who have pressed to put a question have an opportunity to do so. I would be grateful for slightly more concise responses, minister.

Evelyn Tweed (Stirling) (SNP): Today's statement made reference to potentially expanding permitted development rights, but in England that has led to inappropriate conversions that have often resulted in the creation of poor housing. How will the minister ensure that such outcomes are avoided here in Scotland?

Ivan McKee: The member makes a valid point. We recognise the issue. We are open to considering more development rights, but I know that that can be a blunt instrument and that a careful approach is required to avoid unintended consequences, as the member outlines.

We can learn lessons from the experiences in England. We absolutely do not want the experience of homes in industrial areas, overcrowded conversions and poor-quality living accommodation to be replicated here. Instead, our starting point will be to explore how PDRs can help us to deliver town centre living, reuse empty buildings in a sustainable way and support rural communities.

Willie Rennie (North East Fife) (LD): The minister knows that change is essential, following the housing conference that he and I spoke at recently. It seems sensible to progress a more pragmatic way of making the current policy work more effectively, but I am concerned about the availability of usable development land, which is clearly a problem in certain parts of the country. Is the minister prepared to look again at the policy to ensure that sufficient land is available?

Ivan McKee: It is important to recognise that there is a balance between the need for housing development and the need to ensure that developments are in the right place. Developments should not be on prime agricultural land that is without infrastructure and not adjacent to transport links, or in places that do not meet planning authorities' local development plans—that is not the direction that we want to take.

I have outlined the numbers. There is already a significant amount of land with planning permission and significantly more land that is in local development plans but has not yet been brought forward for planning permission. We have a lot to go at there.

The member would agree that we do not want to be in a position where land that is being brought forward for planning permission runs counter to our need to maintain good-quality agricultural land or is challenging in terms of biodiversity, climate change, flooding provisions or other very important aspects of NPF4.

Stuart McMillan (Greenock and Inverclyde) (SNP): There is a need to encourage registered social landlords to build the new properties that are needed and wanted by tenants, including in my Greenock and Inverclyde constituency. How will today's announcement support an acceleration in the provision of social housing, and how will the Scottish Government ensure that registered social landlords buy into the aim to speed up delivery alongside planning authorities and developers?

Ivan McKee: Clearly, that work happens at a local level. Local authorities are the statutory housing authority, with a responsibility for assessing housing requirements locally and for working with RSLs and others to identify priorities for affordable housing delivery as part of a strategic housing investment plan.

My colleague the Minister for Housing works closely with local authorities and RSLs through Scottish Government area teams to oversee delivery of affordable housing programmes. It is important to recognise that the Scottish Government has a strong track record in housing, through its support for the delivery of more than 133,000 affordable homes since 2007, with more than 94,000 of those being for social rent.

Graham Simpson (Central Scotland) (Con): The problem is that council planning departments have been hollowed out for many years. It is a question of funding, but I do not see anything in the statement that addresses that. The minister seems to be pinning his hopes on a rather vague planning hub, but that will work only if it has the ability to deliver. Will it have any powers to do that, and will it have a budget?

Ivan McKee: It is interesting that Graham Simpson asks about the resources going to planning departments. The member who is sitting

next to him was complaining just a minute ago about us increasing fees.

Graham Simpson: That was not my question.

Ivan McKee: —and it is important to recognise—[*Interruption*.]

The Presiding Officer: Let us hear one another.

Ivan McKee: It is important to recognise that, on average, only approximately 65 per cent of the costs of council planning departments are covered by fees that are collected from planning applicants. We recognise that increasing fees, alongside improving services, will be critical to providing the resources that are required.

The hub itself will have a budget and will focus on unblocking the stalled sites around the country that already have planning permission. In particular, it will focus, as I described, on working through what is preventing applications for sites that are in the planning system from proceeding more rapidly through that system. It will be targeted and focused on working with planning authorities in local councils, which are the statutory providers in delivering that process.

Again, I note that if the member has spent any time at all talking to those in the sector, he will recognise that they have absolutely been calling for the planning hub.

Paul Sweeney (Glasgow) (Lab): Planning authorities and planning committees in local authorities often have to make decisions on applications on the basis of evidence that has been commissioned by the applicant. That can be particularly problematic in contentious cases that involve, for example, the demolition of listed buildings.

Would it be possible for the minister to look at options to enable planning authorities to commission independent adjudication or advice on things such as structural condition surveys, which can then be billed to the applicant? That would ensure that there is integrity in the planning process and that we do not have people shopping around to get the outcome that they want, which can lead to the unnecessary demolition of our national heritage.

Ivan McKee: The member makes an important point. Again, that is among the many aspects that have to be considered in the round—in NPF4, there are 33 different policies. National heritage, and the cultural importance of historic buildings, is an important part of considerations.

I think that it is true to say—if I am not mistaken—that planning authorities already have the ability to commission independent advice as required. When applications come to the Scottish Government on appeal through the reporter process, work is done to consider the independent advice that has been brought forward as part of the process in order to ensure that all sides have been considered. Nevertheless, I take on board the member's point, and it is important that we ensure that our national heritage is considered as part of the process.

John Mason (Glasgow Shettleston) (Ind): In his statement, the minister referred to net zero, nature and building stronger communities, all of which suggests the use of more brownfield sites and fewer greenfield sites. As it is, the minister's constituency and mine have a number of brownfield sites, and yet we see building going on and on to the extent that, one of these days, Glasgow might even get to Coatbridge.

Can the minister reassure us that brownfield sites will be used even more through this statement?

Ivan McKee: Absolutely—the member is right to identify net zero, biodiversity, nature and building communities as policies in NPF4, and those need to be considered in the round. There is a presumption in favour of brownfield sites, and I recognise what the member identifies with regard to our constituencies in that respect. That is critical to our focus, and as the hub works through those sites that are stuck in the planning system, or which already have permission but have not been taken forward, I have no doubt that many of those will be on brownfield sites. Work to join up different partners to help unlock those sites will be a key part of what the hub takes forward.

The Presiding Officer: That concludes the ministerial statement.

Women's Health Plan 2021 to 2024

The Deputy Presiding Officer (Liam McArthur): The next item of business is a debate on motion S6M-15382, in the name of Jenni Minto, on progress and next steps on the women's health plan 2021 to 2024.

14:55

The Minister for Public Health and Women's Health (Jenni Minto): I am extremely passionate about women's health, so I warmly welcome this debate and the opportunity to bring this important topic back to the chamber.

We know that women's health is not just a women's issue. When women are supported to lead healthy lives and fulfil their potential, everyone benefits. Women make up 79 per cent of our national health service workforce, 89 per cent of our teachers, 80 per cent of our social care workers, 59 per cent of our unpaid carers and 92 per cent of single parents. To prioritise women's health is to prioritise the health of Scotland.

However, we know that women and girls face inequality and disadvantage because they are women. That has to change, and we are determined to create the conditions that we need to improve health outcomes for women and girls.

In August 2021, Scotland became the first nation in the United Kingdom to publish a plan for women's health. The plan's ambition—and, I hope, the ambition of us all here today—is for all women and girls to enjoy the best possible health throughout their lives.

The first phase of the plan focused on a set of priorities to address particular inequalities for women, such as heart health, and on areas in which women told us that improvements were needed, such as action on menopause and menstrual health. Healthcare professionals, academics, third sector colleagues, researchers and, most important, women came together to inform the plan, and I am pleased that we have been able to make progress in implementing the actions in it during what has been and continues to be a challenging time for NHS Scotland and for all our public services.

Three years on from the plan's publication, it is right that we take stock and reflect. In doing so, I will highlight just a few of the achievements of the past three years. In January 2023, we appointed our women's health champion, Professor Anna Glasier OBE, which was an important milestone in the progress of the women's health plan. I am very pleased that Professor Glasier joins us in the chamber today. Professor Glasier has had a long and distinguished career in women's reproductive health and, as the women's health champion, she plays a pivotal role in raising the profile of women's health, sharing her unparalleled expertise and challenging the status quo. I thank Professor Glasier for being our women's health champion and for her leadership and her passion for driving change and innovation. I am delighted that she has agreed to remain our women's health champion to ensure continuity into the next phase of the women's health plan.

In addition to our women's health champion, we now have a women's health lead in every NHS board. The leads are able to highlight issues that impact women across Scotland, which enables national responses to be taken. Most recently, they have focused on improving access to longer-acting reversible methods of contraception.

During the plan's development, we heard consistently from women that they wanted a reliable source of information on women's health. In response, in May 2022, we launched the women's health platform on NHS Inform, which provides new resources on menopause and menstrual health. The platform offers women and girls access to comprehensive and reliable information, including myth-busting videos, information on symptoms and options for care. As of last month, there had been more than 2.95 million views on the menopause pages alone.

The importance of information on menopause was particularly illustrated to me in April this year when I visited the Maggie's centre in Edinburgh. I met a group of women experiencing treatment-induced menopause, and they described their personal experiences of menopause during their cancer journey and the importance of good-quality information on treatment-induced menopause. It was a privilege to spend time with those women, and I am very grateful that they felt able to share their experiences. As we move to the next phase of the women's health plan, I hope that we can continue to learn from women's experiences and the work that organisations such as Maggie's do to go even further in our support for women and girls.

We know that endometriosis affects one in 10 women, which is why tackling it featured as a key priority in the women's health plan. Last year, the national centre for sustainable delivery published the endometriosis pathway for Scotland to improve women's access to diagnosis and care, and I was delighted to visit the endometriosis specialist centre in Aberdeen a couple of months ago to learn more about how the pathway works in practice.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): The minister met me and endometriosis campaigners last April. She looked at a policy paper from the Scottish Conservatives

regarding ways to improve access to endometriosis treatment, and she committed to reducing waiting times, which are currently, on average, eight and a half years. Can she provide any updates to the chamber on that?

The Deputy Presiding Officer: I will give you the time back, minister.

Jenni Minto: I thank Rachael Hamilton for her work, specifically in the Borders, on endometriosis diagnosis times. I recognise that diagnosis times for endometriosis are too long and that we need to find ways to address them. That was one of the benefits of my meeting the staff at the centre in Aberdeen and across the health board, because they are passionate about supporting women who live with that challenging condition to access high-quality care. As part of our work, we have jointly funded a £0.25 million research project with Wellbeing of Women, which aims to develop a new treatment option for endometriosis-associated pain. We still have work to do—I recognise that—but the issue is certainly on our radar.

There has also been progress in a range of other areas. A specialist menopause service has been established in every mainland health board, and a buddy support system is in place for island health boards. We have worked with the University of Glasgow on groundbreaking research that asked women who work in NHS Scotland about their experience of menstrual health and menopause in the workplace. Based on that research and the views of more than 6,000 women, we published a menstrual health and menopause workplace policy for NHS Scotland. The recently published final report on our women's health plan provides more detail on the three years of implementation. Importantly, the report has been published alongside two companion pieces: a review of the data landscape and a report by the Health and Social Care Alliance Scotland on its lived experience programme. That is a key part of the delivery of the women's health plan, which will ensure that women's voices are at the heart of our work.

Once again, I note my thanks to everyone who has been involved in delivering the first phase of the women's health plan. It has been a nationwide, collective effort. I particularly thank those in the chamber who continue to advocate for the health of women and girls. I really value the input that we have had from many members, and I hope that we can continue in the spirit of collaboration and joint effort as we move into the next phase of essential work.

It is important to highlight that the women's health plan does not exist in isolation. Women make up the majority of our population, at 51.4 per cent of it, and women and girls have particular needs that must be addressed across the breadth of health policy. Work is being undertaken across the Scottish Government and the NHS to progress improvements in women's health and access to healthcare services. Maternity services have a key role to play in supporting women's health throughout and after pregnancy. The best start programme is our plan for putting women, babies and families at the centre of maternity and neonatal care. We want all women and their babies in Scotland to receive the best and safest care possible at all times. Working in partnership with NHS boards, including Healthcare Improvement Scotland, clinicians and women, we are committed to continuous improvement in maternity safety.

Jackie Baillie (Dumbarton) (Lab): It is clear to say that, when it comes to specialist neonatal services, the consultants, all the clinicians and the women who are involved are opposed to the minister's determination to withdraw specialist services from maternity provision at University hospital Wishaw.

Jenni Minto: We have received advice from clinical experts in the field, and they, as well as the charity Bliss, which advocates for parents, all support the reduction in neonatal intensive care units in Scotland.

Sadly, pregnancy does not always go the way that we would want it to, and the loss of a baby, no matter at what stage of a pregnancy, is a traumatic experience that can have a profound impact on families. Improving miscarriage care and support for women across Scotland is a key priority for me, and we will shortly publish a miscarriage care delivery framework to help NHS boards to drive progress and focus on areas where improvement is required.

Last year, we launched a memorial book and certificate for those who have experienced pregnancy or baby loss prior to 24 weeks, because we know that, for many parents, formally recognising the baby that they lost provides some comfort and validation during an incredibly painful time. The service is free of charge and completely voluntary, and historical applications are welcome. More information on how to apply can be found on the National Records of Scotland website. I thank baby loss charities such as Sands, Held In Our Hearts and others for their considered support on that.

The Government is also determined to see the end of cervical cancer. The World Health Organization director general has announced a global initiative to eliminate cervical cancer, and we are dedicated to supporting that vital cause. As I set out in Parliament in January this year, we have already taken positive steps. We have established an expert group, chaired by Professor Glasier, and three working groups, which will focus

on human papillomavirus vaccination, cervical screening and cancer treatment.

Good progress is being made through the HPV vaccination programme, and recent research undertaken by Public Health Scotland, in collaboration with the universities of Strathclyde and Edinburgh, shows that there have been no cases of cervical cancer in fully vaccinated women who received their full course of HPV vaccination aged 12 and 13 years old. The message to girls and young women is clear: get vaccinated. Elimination of cervical cancer is within our grasp.

I will move on to abortion. On 24 September this year, the Abortion Services (Safe Access Zones) (Scotland) Act 2024 came into force. The Government was pleased to support the bill that became that act, which was introduced by Gillian Mackay, and I am sure that women across Scotland were encouraged that it won support from across the Parliament. It has long been the Scottish Government's ambition to ensure that Scotland is a place that people can look to as a beacon for women's rights. The women's health plan committed to a review of abortion services in Scotland to ensure that services are meeting the needs of women. We want abortion to be seen first and foremost as a healthcare matter and as a way by which women make their choices over their health.

That is just some of the work that we are doing to improve the health of women and girls. I am proud of what we have achieved together, and I look forward to what will come next. Supporting women and girls to enjoy the best possible health throughout their lives will continue to be our guiding principle as we develop the next phase of the women's health plan. We know that it is still the case that many women and girls do not enjoy the best possible health. We know that there are women and girls living in poverty, where inequalities are even greater, and I acknowledge here today that we must do more to address them. That is not something that I have shied away from, and therefore I am happy to support Carol Mochan's amendment.

To further achieve our ambition for women and girls in Scotland, we will look at what has changed in Scotland, both positively and negatively, since August 2021; build on the plan's existing priorities; and reflect on where additional focus is needed. We will consider the many factors that make up a healthy life, asking what we can do better or differently to support women and girls of all ages and at all stages of life. Over the coming months, we will continue our conversation with women and girls, healthcare professionals and academics, as well as the third sector across Scotland to ask what they want to see in the next phase of the women's health plan. We will review and update our evidence base, ensuring that any future work is grounded in the most up-to-date research.

Early discussions indicate that women would like to focus on pelvic health; bone health; postmenopausal health and ageing well; and waits for gynaecology care and treatment. However, we are just at the beginning of that work, and I look forward to hearing proposals from members from across the chamber today.

It is a huge privilege to hold the position of minister for women's health and to be able to listen to women and girls across Scotland and hear about their ideas and ambitions as to what can be done differently so that all women and girls experience the best health and healthcare throughout their lives. I look forward to today's debate and hope that, across Parliament, we can find common cause to support that ambition.

I move,

That the Parliament acknowledges the longstanding health inequalities faced by women and believes that it is vital that services and health outcomes are improved for women and girls; notes the progress made through implementation of the Women's Health Plan as a first step towards addressing these inequalities, in particular the appointment and work of the first Women's Health Champion; thanks hard-working NHS staff and all those who have contributed to the progress to date; welcomes the commitment from the Scottish Government to work with women and girls across Scotland in developing the next iteration of the plan, and thanks everyone who has contributed their lived experience to the priorities of the Women's Health Plan.

The Deputy Presiding Officer: I invite Annie Wells to speak to and move amendment S6M-15382.1.

15:09

Annie Wells (Glasgow) (Con): I begin by thanking the many organisations that have provided briefings for the debate. Health is one of the biggest issues in the minds of people across our country, and that is no less true for women, who have their own unique health challenges and needs.

The women's health plan was first published in 2021 by the Scottish National Party Government. It set out to address women's health inequalities and the serious barriers that were preventing women and girls from accessing the healthcare services and support that they needed.

The plan included 66 actions focusing on heart health, postnatal contraception, menopause, endometriosis, menstrual health, abortion, and contraception. We all know that women's health needs such as those are present and evolve throughout each woman's life, from adolescence to their later years and that, because each woman is different, health policy must be aimed at

adopting an approach that accounts for the disparities and barriers that women face in accessing sufficient healthcare services.

In the SNP's manifesto in 2021, several commitments were made to improving women's health. Those commitments ranged from reducing endometriosis diagnosis waiting times and establishing a new Scottish institute for women's health to improving access to services helping women through menopause diagnosis and management. I welcome the £250,000 of funding that the minister said is being provided to address endometriosis.

However, despite the SNP's manifesto commitment and the women's health plan, healthcare services, support, and—most importantly—health outcomes for women have shown a downward trend under 17 years of SNP mismanagement.

How are women being failed by the SNP Government? Let us simply look at the numbers for some of the most crucial areas in the women's health discussion. There are on-going failures in addressing issues surrounding endometriosis, women's heart health and cancer care, which have devastating impacts on the women that they affect.

For example, 58 per cent of women said that they saw their general practitioners 10 or more times prior to getting an endometriosis diagnosis because of symptoms, with 53 per cent also doing the same with accident and emergency visits. As my colleague Rachael Hamilton pointed out, even when a woman is finally diagnosed with endometriosis, it has taken an average of nearly nine years to get a diagnosis in Scotland. We are talking about women waiting almost a decade just to receive a proper diagnosis—that is not even including the time that it takes to begin treatment.

On the issue of women's heart health, the situation is no better. The British Heart Foundation notes that 2,600 women die each year in Scotland from coronary heart disease. That makes coronary heart disease the single leading killer of women, even more so than breast cancer. Moreover, the charity Chest Heart & Stroke Scotland has found that, for every day that passes, there are 10 women who die from heart disease and heart attacks across Scotland. There are also 95,000 women across the country who are living with coronary heart disease.

I am highlighting those numbers at a time when waiting times for cardiology have hit record highs. That has resulted in fewer than three in 10 Scots being seen within the echocardiogram six-week waiting time target, with 1,200 people even being forced to wait more than a year for an ECG.

That brings me to the failures of the Scottish Government relating to women's health and cancer numbers. Although it said in the women's health plan progress report that it wanted to take an intersectional approach to account for each woman's life in order to ensure the best outcomes, the truth is the opposite. Women from the most deprived areas across Scotland were less likely to get screenings for breast cancer in 2022-23 and for cervical cancer in 2021-22.

On the issue of breast cancer specifically, the charity Breast Cancer Now says that breast cancer is the most common type of cancer in the UK, with almost 4,770 women being diagnosed annually. The charity also said that the Scottish Government women's health plan was an opportunity to improve breast cancer outcomes through doing things such as reaching the 80 per cent screening targets for breast cancer and increasing breast awareness.

However, although the women's health plan was an opportunity to help women overcome barriers and inequalities to receive the highest standards of care and support, that potential has not been fulfilled. The numbers are shameful and they continue into another area that has important effects on women's health: alcohol consumption and misuse, which also impacts on breast cancer health outcomes for women.

According to Alcohol Focus Scotland, in Glasgow alone, 16 per cent of women drink more than the guidelines set out by chief medical officer. That has the potential to significantly affect women's health in relation to developing certain types of cancers. Just drinking about a half pint of beer or a small glass of wine daily can increase a woman's risk of developing pre-menopausal breast cancer by 5 per cent. For post-menopausal breast cancer, the increase is even greater, with the risk rising by 9 per cent. In addition, women often face barriers to accessing alcohol addiction support services, and a good deal of stigma remains around women who misuse alcohol.

Adding to that, in 2022-23 in Glasgow, only 26.5 per cent of people with learning disabilities who were eligible for cervical cancer screenings went to their appointments.

Unfortunately, that grim picture carries over to women's life expectancy. Scottish women have seen that fall to a lower age than it was before the Covid-19 pandemic, standing at 80.9 years from 2021 to 2023, compared with 81.1 years prior to 2021. In fact, not only is Scotland ranked lower than other nations in the UK for female life expectancy, it is now also ranked 22 out of 29 nations for female life expectancy Europe-wide, according to the National Records of Scotland.

The Scottish Government launched the women's health plan 2021 to 2024 with the aim of tackling the health inequalities and poor health outcomes that women face and changing the approach that is taken to women's health. The Scottish Government must acknowledge that the plan is now failing. Not only have the Government's goals not been realised, women have paid the serious price for its long list of failures.

Going forward, achieving the mission of improving women's health services, support and outcomes requires the involvement of all sections of society—private individuals, public bodies and individuals who are dedicated to helping address women's health issues and inequalities. Just as importantly, women need to be heard, healthcare in Scotland needs to see women's health issues as distinct, and each unique aspect of each woman's life must be acknowledged and considered.

In my new role, I will work with colleagues from across the chamber and in the Scottish Government to ensure that women finally receive the services that they so desperately need to lead the fullest and healthiest lives that they can.

My colleagues Tess White and Brian Whittle will highlight some other areas, from menstruation and menopause to maternity and neonatal issues. I urge the Scottish Government to work with us to avoid those failures in the future on behalf of the women and girls across our country.

I move, as an amendment to motion S6M-15382, to leave out from "acknowledges" to end and insert:

"agrees that 17 years of Scottish National Party (SNP) administration mismanagement of healthcare in Scotland has worsened longstanding health inequalities faced by women and girls, while challenges facing women's health services continue to go unaddressed; notes that thousands of women across Scotland have missed out on life-saving screenings for breast and cervical cancer, and that some breast cancer screening centres are at risk of being downgraded or closed entirely under drastic NHS budget cuts by the Scottish Government; further notes that women in the west of Scotland have been forced to pay for their own ovarian cancer treatment due to long and unacceptably high delays; believes that the Scottish Government has failed to recognise and address the underlying preventable factors that contribute to poor mental health for women and girls; notes that the SNP administration made the decision to cut the mental health budget by nearly £20 million for 2024-25, despite the number of people in Scotland who reported to have a mental health condition doubling between 2011 and 2022; acknowledges that women's life expectancy is lower than it was before the COVID-19 pandemic, with Scotland ranked 22 out of 29 European nations for female lifespan in the 10 years up to 2022; urges the Scottish Government to restore the provision of consultant-led maternity services in rural areas, such as Moray and Caithness, so that women are no longer forced to travel hundreds of miles away from home to give birth; believes that the Scottish Government should abandon its proposed centralisation plans for specialist neonatal units in NHS Scotland, which includes downgrading services at University Hospital Wishaw, Ninewells Hospital in Dundee, and Victoria Hospital in Kirkcaldy, potentially endangering the lives of vulnerable babies and placing additional stress on new and expectant mothers alike; calls on the Scottish Government to prioritise women's reproductive health, as it currently takes an average of 8.5 years for a woman to get an official diagnosis for endometriosis, despite the fact that one in 10 women in Scotland live with this debilitating condition; believes that the Scottish Government should take steps to reduce cardiology waiting lists, which are at a record high in Scotland, as women are more likely than men to receive the wrong cardiac diagnosis and will receive half as many heart treatments; criticises the SNP administration for continuing to put gender ideology before the safety of women and girls by backing Rape Crisis Scotland, despite an independent review discovering that survivors were being let down, and calls on the Scottish Government to address the specific healthcare needs of women, ensuring that Scotland's NHS is efficient, reliable and accessible for all women, always."

The Deputy Presiding Officer: I call Carol Mochan to speak to and move amendment S6M-15382.2.

15:17

Carol Mochan (South Scotland) (Lab): I am so pleased that Government time has been given to debating women's health today. We will support the Government's motion tonight.

If we have learned anything from the women's health plan, it is that every target in the next women's health plan must have attached to it a clear action plan and a pathway to deliver it. Otherwise, it will just be more words to women in our communities. When our population desperately needs action, it is incumbent on us to ensure that we have a delivery plan. I am very pleased that the Government will support our amendment at decision time.

Since the introduction of the women's health plan, it has always been my intention—and, indeed, the intention of the Scottish Labour Party—to scrutinise it fairly, with the genuine hope that it would be a success and that access to and quality of women's health services would improve across the country.

As the minister indicated, securing a women's health champion was a significant step forward, supported by Scottish Labour, in achieving some form of progress for women. I welcome Professor Glasier's account of what the plan has achieved so far and what she hopes it will achieve in the future. Nonetheless, she and others continue to identify where there are problems and where we must strive to do better.

What we all agree is that women's health must continue to be a priority if we are to have any hope of getting on top of the backlog of pain and

misdiagnosis that so many women continue to suffer.

We will all have had meetings or phone calls with women who are unable to access diagnosis and treatment. As other members have said, we must mention those with endometriosis, in particular. I am sure that other members will cover it in their speeches today, but I note that women have suffered over many years, as there has been an absolute void in service for that condition. I welcome the changes, but there is much more to be addressed in the coming years.

We are all pleased with the achievements in women's healthcare during this session of Parliament in areas such as the introduction of buffer zones to ensure that women can access healthcare free of intimidation and with the roll-out of the human papillomavirus vaccine as part of our fight to eradicate cervical cancer. I have been desperately pleased to see the progress in those areas.

I also want to mention, as the minister brought it up, the online women's health platform, through which factual information is now available to young girls and women in Scotland. As we go through our life cycle, we can go back to that at the points when we need it. Professor Glasier spoke to us about that at one of the cross-party meetings that the minister pulled together.

However, it is undoubtedly the case that, in other areas, progress has been far too slow and that health inequalities have deepened and are very real for many people in our most deprived communities. All members have a responsibility to acknowledge that and to scrutinise the Government to ensure that the dial can finally be moved on the issue. We cannot have a debate such as this without understanding that life expectancy in our most deprived communities is falling and is far lower than it is in our most affluent areas. Of course, we are all more aware of the issues around unhealthy life expectancy.

Tess White (North East Scotland) (Con): Does Carol Mochan agree that there needs to be a separate road map for women and that the women's health plan needs to be sex specific?

Carol Mochan: Yes, of course.

I return to my point about unhealthy life expectancy. Not only do our poorest neighbours die younger, they live life in a much poorer state of health for longer. That plays out for women in many ways. They live in poor health, and they care for others in poor health. It is often the case that a heavy weight is placed on the women in our population.

As is the case for other areas that impact directly on women, the issue of rural maternity services has been debated in the chamber many times. However, that has been in members' time rather than in Government time. The Government's inadequate response to that cannot be overstated. The health of pregnant women in rural areas is in particular peril, because they are often transported multiple miles at various stages of pregnancy or labour. That must be a women's health priority in Scotland. Despite the genuine concerns of patients and staff throughout the country in communities such as Wishaw, the Scottish Government has continued with its policy of downgrading key neonatal units at the heart of our most deprived communities. The impact of that on women should be a concern for us all.

In waiting times for cancer treatment, hysterectomies and reproductive healthcare, women in Scotland are waiting far too long to receive the support that they need. We often hear of the lack of training opportunities for staff, which limits development in our services.

Inequality is most pronounced when it comes to cancer screening. As we know, women from the most deprived areas are less likely to attend breast screening—about 20 per cent less likely. The rates of women who are up to date with their cervical cancer screening continue to fall. I am sure that I do not need to remind the Government of the importance of improving those statistics. Many lives will be lost if we do not get on top of that. Again, we cannot debate the issue without some reference to the significant lower uptake of screening by women from more deprived areas.

Although I do not want to dwell too much on this, I cannot contribute to the debate without mentioning the impact of strong cross-departmental working on women's health services and outcomes. It is absolutely imperative that the Government does better on that. I have raised the issue before in the chamber. All Government departments must see women's health inequalities as a priority, but there is no clear evidence that that is currently happening—or certainly not in the way that it should.

In many ways, no matter how many iterations of the women's health plan are brought before Parliament, I argue that a lack of Government willingness to acknowledge its own responsibility plays a big part in the on-going suffering of many women across Scotland. I am glad to hear the minister acknowledge that responsibility here today; that is very welcome.

The lack of urgency from the Government compounds that and it is not unfair to say that the Scottish Government appears to believe that publishing a policy paper completes a task and that it places very little importance on the delivery or outcomes of its plans. We must address that significant issue together. Without serious reform

and a change of direction—which we have heard that the First Minister is not committed to—delivery in this policy area will remain largely untouched, and if we debate this again in another three years, we will find the same challenges still being faced by women up and down the country.

Therefore, although the Government will concentrate on the areas where it considers that progress has been made—as we saw in the opening speech—I urge serious caution. The Government is supporting our amendment, which we welcome, and should use that to show that it can be serious about setting out a route to delivery.

I say that because, as all parties will say today, health inequalities still have a stubbornly high impact on women. When it first published its plan, the Scottish Government referred to a British Heart Foundation report that said:

"in Scotland there are inequalities at every stage of a woman's medical journey".

As we review the plan and look towards its next iteration, we must ask ourselves whether that has really changed.

The next women's health plan must set out not only targets but the action plans that will achieve those targets. I look forward to playing my part in making that happen and I know that my party is committed to doing that so that we can change the health outcomes, and the health inequalities, that are seen by women in Scotland today.

I move amendment S6M-15382.2, to insert at end:

"; is concerned by the slow progress in addressing stubbornly high health inequalities experienced by women, and calls on the Scottish Government to ensure that the next plan sets out concisely when and how each of its actions will be fully implemented across Scotland."

15:27

Gillian Mackay (Central Scotland) (Green): The women's health plan that was launched in 2021 marked a significant commitment to addressing the distinct health needs of women across Scotland and aimed to close gaps in care, improve health outcomes and promote health equity. The very existence of that plan has brought much-needed attention to issues that have historically been sidelined and significantly underfunded.

The plan recognised that taking a dedicated approach to women's health is essential for the wellbeing of women and of our wider communities. It also acknowledged that there is an urgent need for societal and cultural shifts in attitudes to women's health and that much more must be done to address the long-standing health inequalities that women face. It set out a way to achieve those lasting changes, and I welcome the updates that we have received throughout the life of the plan. The final report that is the topic of today's debate sets out the important progress that has been made and raises the areas in which work is still to be done.

A number of commitments, and the significant progress that has been made towards them, should be celebrated. I am a little embarrassed to say that, when preparing the "progress" section of this speech, I forgot to mention my own act of Parliament. That might be because it is in my nature to want to move on and do the next thing. I thank the minister for her kind words about my Abortion Services (Safe Access Zones) (Scotland) Act 2024. I also thank the Minister for Social Care, Mental Wellbeing and Sport for her kind words when she had the women's health role, as well as thanking the ministerial teams, the campaigners, and those with lived experience who gave evidence.

No one will be surprised to hear that I welcome the Scottish Government's commitment in the plan to review abortion law and its recognition of the importance of having a legal framework that reflects both current practice and the needs of patients and healthcare professionals. Parliament has rightly acknowledged abortion as part of healthcare for those who need it. Law reform is not the only area in which abortion care must progress: late-stage abortion and the recruitment of staff who can carry that out must also be addressed.

I hope that the law review will carefully examine the gaps and inadequacies in current legislation, assess the need for changes and consider how to bring about concrete change. However, that process must be urgent. There is no room for delay, and I hope that we will see progress and a clear path being set out to achieve that before the end of the session. Scotland needs a responsive and timely approach to the issue.

I feel that, so far, the plan has involved a genuinely collaborative approach. The meetings that we have had with ministers and the women's health champion, Professor Glasier, have been informative, but they have also felt like a genuine dialogue. Although I will move on to discuss some things that we should be doing better on or looking at, I will do so in the context of genuine collaboration and making progress for women. I am pleased to hear that Professor Glasier has agreed to stay on as the women's health champion.

Tess White: I would like to ask you whether you—

The Deputy Presiding Officer: Through the chair, please, Ms White.

Tess White: Sorry. Does the member agree that we benefited from working collaboratively in the work that we did as a committee on the buffer zones?

Gillian Mackay: Absolutely. It very much helps us all if we work collaboratively in the sphere of women's health. I hope that we will have a similar level of conversation in the next stage of the abortion law review, which will take us into a slightly different space from the question purely of access. I thought that the conversation that we had on safe access zones was quite grown up and even tempered, and I hope that that can be taken forward on the next issue.

Although I recognise the strides that have been made between 2021 and 2024, I also want to shed light on some critical areas that remain unaddressed or that require more attention. It is important to highlight issues such as access to fertility services, comprehensive support for endometriosis and systemic inequalities in health outcomes for women from minority and disadvantaged backgrounds. The report demonstrates that a stronger focus is also needed on addressing delays in diagnosis for conditions that uniquely or disproportionately affect women and on ensuring equal access to healthcare services across urban and rural areas. There also remain significant data gaps that act as a barrier to understanding and addressing women's health needs comprehensively. Conditions such as polycystic ovary syndrome, premenstrual dysphoric disorder, endometriosis and other underresearched areas still suffer from a lack of robust data, which impedes progress on effective diagnosis and treatment.

Several organisations that are directly involved in improving women's health have reached out to us, and I will use the short time that I have left to highlight some of their very important observations and asks. #MEAction Scotland highlights that myalgic encephalomyelitis or chronic fatigue syndrome is a complex chronic illness in which 80 per cent of patients are women. It is thought that there are approximately 58,000 cases in Scotland, but that remains an estimate because we continue to lack robust data. There are several reports of women being disbelieved and dismissed by doctors, and diagnosis can take years if it happens at all. #MEAction Scotland points to the need for healthcare education to accurately quantify disease burden, along with the urgent need for data to be collated nationally in order to understand the full picture.

As the motion rightly notes, one of the biggest thank yous should go to all those who have spoken to us about their health issues and their often very long journeys to diagnosis. For many, that journey has already happened or concluded. They often give their experience—sometimes at their own cost—to make sure that no one else has to go through what they did. For some, that has been decades of campaigning, and we should rightly take on their wealth of experience from that.

We must continue to build on the momentum of the 2021 plan to increase awareness of women's health. The first phase of the plan has provided a solid foundation to build on, but the rest of the work must not be delayed. Women across Scotland are counting on us to continue advocating for them and their rights. Continued commitment to the unmet goals is crucial if we are to fully realise the vision of the women's health plan and deliver a Scotland where all women can achieve the care that they need.

15:34

Alex Cole-Hamilton (Edinburgh Western) (LD): It gives me pleasure to speak for the Liberal Democrats in what is a vital debate. I am grateful to Jenny Minto for securing Government time to bring the debate to the chamber. We do not speak about the topic often enough in this place, not least given that women make up more than 50 per cent of our society and are vital to our economy, yet many of the health issues that we are talking about today are particularly gendered in nature.

Before I talk about the Scotland-specific picture and the report and plan that we are debating, it would be remiss of me not to recognise the events of last week—in particular, what the election of Donald Trump for a second term means for the reproductive healthcare rights of women in America. That was a dark day. All three branches of Government are now stacked against the freedoms that we take for granted in this country, and we hold those women in our thoughts. I am proud that we have not only resolved to safeguard those rights here in Scotland but committed to enhancing the quality, accessibility and range of healthcare services that are essential to women's bodily autonomy and wellbeing.

Tess White: Alex Cole-Hamilton referenced the US in relation to abortion, but will he also applaud the fact that, even though Donald Trump is a controversial figure, he knows what a woman is?

Alex Cole-Hamilton: I very much regret that Tess White wants to lower the tone of what has so far been a consensual debate. That problem stems from her, and I ask her to reflect on those remarks.

I want to re-foster, if I can, the atmosphere of consensus by paying tribute to Gillian Mackay, who spoke eloquently just before me and who spearheaded single-handedly the bill that she

brought to the Parliament on safe access zones around clinics that offer abortion and other reproductive services. Our commitment must remain steadfast, so that every woman has the right to make informed choices about her health, supported by the highest standards of care and free from abuse, intimidation, stigma and the dog-whistle politics that we have just heard from Tess White.

As we have heard, the women's health plan, which was introduced in 2021, marked a step in the right direction. The plan rightly acknowledges that advancing women's health is about not just reproductive rights but treating women's health needs holistically, giving priority to issues that are often dismissed and stigmatised, and recognising, in particular, the abundant health inequalities that exist in Scotland in 2024. That includes expanding access to menopause care, ensuring rapid support for postnatal contraception and focusing on often-overlooked conditions such as cardiac disease, which affects women differently yet has historically received far less attention and financing than heart disease in men.

I welcome the focus that has been brought by the implementation of the plan and, in particular, the appointment of Professor Anna Glasier as the national women's health champion, but it is important that we do not rest on our laurels. We must recognise the significant work that is still needed. For example, despite increasing awareness, many women who suffer from endometriosis continue to endure years of severe pain before they are even given a proper diagnosis or a pathway to treatment. The delays disrupt careers, education and family life. We know that such delays only compound endometriosis and make it worse, increasing the chances of it spreading and damaging multiple organs. We need to treat it with the same urgency that we offer at the moment for similar conditions. We are failing in that regard.

Similarly, coronary heart disease is a leading cause of death among women in Scotland, claiming the lives of more than 2,500 every year—twice as many women as are killed by breast cancer. I am pleased that the report has focused on that. The proposed new specialist centre in NHS Forth Valley is especially welcome.

However, we need to go further. We need to ensure that those women who are most at risk are given the advice and support that they need. That includes those who are experiencing early menopause or high blood pressure during pregnancy.

We also need to improve access to menopause care more generally, particularly in rural areas. That is something of a postcode lottery and provision remains inconsistent, with services stretched across the board. Menopause is a condition that will affect every woman in Scotland. It is not a surprise; it is something that we can plan for. However, I am struck by the lack of provision—or the patchy provision—in so many parts of the country. Just this week, I was visited by a constituent who lives in our nation's capital, who is going through menopause and is unable to access the basic advice and support that she needs.

It goes without saying that the Government has a duty to ensure equal access to treatment for all women, no matter where they live. We need each NHS board to actively prioritise women's health in its area.

Women's health can be disproportionately impacted at times of financial strain. That is a gendered issue that highlights the need to remain focused, even as NHS budgets are at full stretch. For the plan to succeed, it needs to be backed fully by the Government, and we need to ensure that we have appropriate staffing—safe staffing—and regular updates on progress. Without those, it risks becoming just another set of promises.

Liberal Democrats remain focused on improving primary care, which is essential to women's health—indeed, it is essential to the health of all of us. Quick access to general practitioners, mental health specialists and services such as physiotherapy can make all the difference. We want to have world-class mental health services across Scotland, which could provide much-needed support for women who are facing postnatal depression or who are at risk of postpartum psychosis.

We have come so far, but there is still a great distance to go when it comes to supporting perinatal mental health in Scotland. I raised that issue repeatedly during the previous session, but I am dismayed to see that we have made very little progress on it.

I reflect on the cultural change that still needs to take place. Too often, women's health concerns are met with stigma or outright dismissal, or they are the subject of dog-whistle politics. We saw that clearly in the experience of the survivors of transvaginal mesh, who had to fight for years to have their pain recognised and treated. Health issues that disproportionately affect women deserve to be treated with the same urgency, attention and seriousness as any other condition, and they must be met with dignity and respect. I hope that the health plan that we debate today marks a renewed and invigorated commitment to seeing those changes through, so that we continue to walk the path to a better, healthier future for women in Scotland.

The Deputy Presiding Officer: I note that a member who was looking to participate in the debate has not been here throughout the opening speeches, for which I will need an explanation and, probably, an apology.

We move to the open debate. I call Emma Roddick.

15:41

Emma Roddick (Highlands and Islands) (SNP): I was glad to hear, in the minister's opening speech, about the progress that has been made on endometriosis and, in particular, on managing the pain that comes with the condition. Alex Cole-Hamilton also made some good points about the need for cultural change.

There have been changes since the appointment of a women's health champion. I have felt that change as a member of the Parliament and as someone who keenly listened to debate and discussion in this place on women's health issues before I was elected. I can see that there is progress in the platform that these issues have and in the willingness of a wide group—not just the usual suspects who champion these issues regularly—to accept that there are problems and to enter conversations about how to solve them. That bodes well for the overall aim of using the fact that Scotland has this role to precipitate wider societal and cultural change. It is always welcome to see real leadership being taken across the parties, which can translate to changing minds and cultures outside.

I credit the minister with the impact that her approach has had. I have also enjoyed regular engagement with Opposition colleagues, as well as with the minister, on a wide range of issues related to women's health. She has been open, understanding and willing to take on board expertise and knowledge that exists across the chamber. That is certainly contributing to reaching the cross-party consensus on women's health that Engender and other members who have spoken in the debate have called for.

I will speak about a few issues that will not be new to the minister, as we have had conversations about them already. Mental health remains a significant women's health issue. It is difficult to see in statistics the different experience that women with mental health issues face compared with those of others who access different services. Being a woman impacts the diagnosis that we will get if we have mental health issues. That is borne out in the statistics around mental health and cardiovascular and chronic pain conditions, which show that women and men often present with the same symptoms but are frequently given different diagnoses.

Being a woman impacts how other conditions will be treated if a person has a mental health issue, chronic pain or fatigue. I bet that every MSP has had a constituent raise evidence supporting that at some stage during the past three years. Being a woman also impacts on the treatment that we receive. There are times when that is justifiable, because our needs may be different, but it is not acceptable that my constituents still feel that they are being brushed aside or that their symptoms are minimised because they are female.

Many chronic conditions often go hand in hand with mental health issues. Living with chronic pain will affect someone's mood, often clinically, and mental health issues are frequently diagnosed in people with the likes of endometriosis, myalgic encephalitis, multiple sclerosis and other chronic conditions. We have to get better at drawing a distinction between clinical mental illness and reasonable reactions to difficult situations. Almost every patient with a chronic illness and depression to whom I have spoken has said that, at some point, they have been told something along the lines of, "Of course you're sad—anybody would be."

People with depression understand the difference between feeling sad and having depression, which are completely different in terms of quality of life, hopelessness and the impact on the ability to function. A few weeks ago, one member of Glasgow Disability Alliance told colleagues in Parliament that they had been told, "I would kill myself if I had your life." That is the type of stigma and dismissal that people face. It is a lot harder for someone to get help for mental health issues if the people who are assessing them think that they should be feeling depressed.

Given those cross-cutting issues, which touch on both women's health and mental health, work on the approach to either aspect needs to be done with awareness of the other. North Highland Women's Wellbeing Hub has done incredible work in sharing resources on many issues affecting women. I am sure that the minister is aware of that work, given that her colleague Maree Todd, as the Minister for Social Care, Mental Wellbeing and Sport, and I both represent the area that the group covers.

At a meeting that I had with North Highland Women's Wellbeing Hub earlier this year, Kirsteen showed me the leaflets and resources that the group has made up to support women who have been diagnosed with various conditions. It is a shame that it actually felt quite wondrous to see information on endometriosis, menopause and postural tachycardia syndrome laid out clearly and to imagine people, in the moment that they are diagnosed, receiving such helpful and clear

information. It is a massive step forward, and I hope that the Government will look at the take-up of post-diagnosis support in NHS Highland that has come from the North Highland Women's Wellbeing Hub and consider how that type of information can best be made available and standardised.

It is also fantastic to hear about the impact that having an islander in post has had in the taking of sensible approaches. Accepting that we have to do things differently in different places does not mean that the end result has to be difference. The buddy system that exists to ensure that island health providers can still access quality information is a great way to ensure that, no matter where people are, they can access specialist advice.

Before concluding, I will touch on abortion care, which cuts across everything else that I have spoken about. Pregnancy is more dangerous to some than to others. Mental and physical health conditions, when they are combined with pregnancy, can be life threatening, so it is critical that we continue to strongly and frequently defend the right of Scots to access abortions in the face of attacks on those rights around the world. Nothing that we have won is guaranteed, and we must continue to recognise the necessity of quality and accessible abortion care.

I am proud of the steps that the Parliament has taken to protect people who are accessing abortion services through the Abortion Services (Safe Access Zones) (Scotland) Act 2024, which brought in safe access zones. However, there is work to be done to ensure that there are services available to access for everyone, including—for those who need it—up to 24 weeks, which is currently the limit in Scotland in law but not in practice. No matter where people live, they should not be forced to carry a pregnancy that they do not want to go through with, and I look forward to hearing updates on work that is to be carried out to ensure that that is the reality.

I also look forward to seeing what comes of the next iteration of the plan overall. I am hopeful. It can often feel difficult to feel hopeful about the topic of women's health, so I thank all those with lived experience, who have rightly been at the centre of the work on the plan and of the Government's motion, and colleagues on all sides of the chamber, including the minister, who have put in the work on the plan.

15:48

Tess White (North East Scotland) (Con): As the first women's health plan comes to an end, I welcome the opportunity to take stock. I thank Jenni Minto and her team for the cross-party working that they have undertaken so far. It has been constructive, so I give praise where praise is due.

I also thank Professor Anna Glasier, who is in the public gallery today, for her leadership. I have enjoyed our lively conversations and I have valued Professor Glasier's frankness, expertise and insight. Eighteen months—and just four days a month—was precious little time in which to deliver on the ambitions for the women's health plan, so I am pleased that Professor Glasier will remain in post. If only the SNP had appointed her sooner and had not left the plan in limbo for so long. The minister would probably expect me to say something like that.

Throughout the life cycle, from menstruation to menopause, a woman is adapting and adjusting to major changes in her body. She is also contending with a healthcare system that, as Caroline Criado Perez's "Invisible Women" describes, is

"systematically discriminating against women, leaving them chronically misunderstood, mistreated and misdiagnosed".

Too often, women do not feel heard. Too often, their legitimate concerns are dismissed. We should not have to put up and shut up when it comes to pain. Healthcare cannot be one size fits all. The male default bias has dominated the diagnosis and treatment of women for far too long.

MSP colleagues might want to dodge the bullet on this, but healthcare must be sex specific. That is why women's health needs require a completely separate road map, a dedicated advocate and rigorous oversight in the long term. That is why data in the NHS matters, and it is why objective and immutable biological sex must be recorded on medical records. Terms such as "chest feeders" perpetrate the erasure of women in healthcare in the name of so-called inclusivity.

The Scottish Conservative amendment drills down into the failings in women's healthcare that have occurred under the SNP Government. The reality is that, under the SNP, women's healthcare has worsened. Waiting times for vital services such as women's reproductive health, cardiac care and cancer screening and treatment are unacceptably high. Earlier this year, more than 500 women in NHS Grampian with suspected breast cancer had to travel more than 125 miles for diagnosis because the health board could not meet demand. The centralisation of maternity services in rural areas such as Stranraer and Moray is forcing prospective parents to travel for more than an hour and a half. There is an alarming postcode lottery in the provision of perinatal mental health services, and a simple test for pre-eclampsia is only just being rolled out by health boards, thanks to proactive campaigning by

the charity Action on Pre-eclampsia, years after its roll-out in NHS England.

The SNP cannot reduce the gender health gap if healthcare in Scotland is inaccessible, but that is the stark reality for too many. After two years as the shadow minister for women's health, I recently took on the equalities brief and joined the Equalities, Human Rights and Civil Justice Committee. It is clear from our pre-budget scrutiny that budget decisions are made from a central-belt perspective, without thinking about policy coherence or the bigger picture. The centralisation of NHS services is having a negative impact on women in rural communities, with my constituents having to travel from outlying Forfar to Dundee to have a simple intra-uterine device fitted. Gender and geographical inequalities are becoming further entrenched under the SNP's centralisation agenda.

I have been working with the north-east endo warriors, and I recently met representatives of Endometriosis UK regarding the distressingly long diagnosis time for endometriosis. There is growing awareness of this debilitating condition, but training and education are not enough. I have been told that the waiting list for diagnostic tools such as laparoscopy is two years at minimum. That urgently needs to change—two years is just not good enough.

As we look to the next iteration of the plan, I welcome Professor Glasier's commitment to prioritise pelvic floor rehabilitation. From relationships to participating in sport, the physical and emotional impact of pelvic organ prolapse on women is absolutely horrendous. The minister asked for examples, so I would like her to look at countries such as France, where women are automatically offered pelvic floor therapy as part of their post-natal care. In Scotland, women are told to do Kegel exercises and wear Tenor underwear—it is an absolute disgrace.

This is not just about reducing the gender health gap; it is about how women experience the healthcare system and how that system supports them through their whole life cycle so that they can live happy, productive and pain-free lives. To achieve that, Scotland's NHS must be efficient, reliable and accessible for all women, always. We have a long way to go.

15:55

Kenneth Gibson (Cunninghame North) (SNP): Over the years, I have raised concerns about a range of women's health issues, from endometriosis and pre-eclampsia to cardiovascular conditions and breast cancer. Those important female health issues have long required further action, and I welcome the opportunity to discuss them in the context of the women's health plan.

The plan is undoubtedly a step in the right direction, but I believe that there are still significant gaps to be addressed. I will focus on four key areas that should be central to ensuring that women's health is properly prioritised and supported. First, I will focus on endometriosis, which several members have mentioned. Seven years ago, I led a members' business debate that ultimately resulted in significant progress, with the involvement and solid support of the then Cabinet Secretary for Health and Social Care, Jeane Freeman, and the then Minister for Public Health and Sport, Aileen Campbell, securing the opening in Glasgow of a third accredited endometriosis unit to complement those in Edinburgh and Aberdeen.

Although the women's health plan outlines positive aims through the endometriosis pathway, including improved access to specialist endometriosis centres and reducing diagnosis time, I believe that those actions fall far short of what is needed. In Scotland, it still takes an average of eight and a half years from the onset of symptoms to receive a diagnosis of endometriosis. That is simply not good enough to meet the needs of the more than 100,000 women who live with that debilitating condition.

To truly prioritise women's health, we need more specialist treatment centres. In Ayrshire, for example, we must reduce the burden of long travel times and journeys and make it easier for families and support networks to be involved in care, expanding access to that care closer to home. The added stress of long journeys only serves to make treatment more difficult. That is important not just to improving healthcare access, but to improving lives.

My second point concerns cardiovascular disease, which remains a leading cause of death among women in Scotland, where 95,000 women currently live with coronary heart disease. The condition significantly impacts quality of life and claims the lives of twice as many women as breast cancer. Thanks to British Heart Foundation research, sex-related differences in presentation and management of heart disease are now much better understood. However, women continue to face significant challenges, such as misdiagnosis, receiving fewer treatments and being underrepresented in clinical trials, which, in many cases, contribute to sub-optimal care that is not tailored to their needs.

Although there has been a 14 per cent reduction in coronary heart disease deaths over the past decade, recent trends show an increase, highlighting the need for sustained and focused action. It is alarming that heart disease accounts for a quarter of maternal deaths in the UK, with 77

per cent of the women who died not knowing that they had a cardiac condition. That underlines a critical failure in our health service to identify, let alone effectively manage, heart disease in women.

However, I am encouraged by the progress that has been made through the women's health plan, which takes an important step forward in addressing those challenges. The plan's focus on increasing research funding and recognition of gender-specific health needs, particularly in cardiovascular care, is welcome and much needed. We must build on that momentum and continue to raise awareness of women's heart health across Scotland, ensuring that women receive vital heart health advice and support at every stage of their lives, with health service interaction at every available opportunity.

Recognition of the need for high-blood-pressure management is vital, as hypertension is a key risk factor for cardiovascular disease, which is responsible for around half of heart attacks and strokes. Clinicians, particularly obstetricians and midwives, must be equipped with the necessary knowledge and resources to offer advice and support to women who are at risk. By prioritising women's heart health, investing in early diagnosis and developing tailored treatments, we have a real opportunity to improve outcomes.

Pre-eclampsia affects around 5,000 pregnancies in Scotland each year, but it is noticeably absent from the women's health plan, despite being in the original 2021-24 plan. Perhaps the minister can tell us why it is absent. That life-threatening condition is serious and requires immediate attention, but it remains overlooked in a strategy that is meant to address women's health needs.

However, I am pleased to note that NHS Lothian has taken a positive step forward by introducing targeted blood tests to reduce the risk for pregnant women. The placental growth factor test, which NHS England has used since 2016, is a significant development in helping doctors to diagnose pre-eclampsia. The test not only helps to reduce the number of unnecessary hospital admissions but, more importantly, ensures that expectant mothers receive the care and support that they need. A roll-out is taking place, but it is slower than it should be. Given the severity of the condition, which is manageable with early detection, I ask the minister, as I have asked her predecessors, when PIGF testing will take place routinely across all health board areas in Scotland, which will ensure that every pregnant woman has access to that vital test.

My son died on his due date. My wife's liver ruptured, and she then spent 19 days in an intensive care and high-dependency unit because of a failure by midwives and doctors to diagnose pre-eclampsia.

After the event, women who suffered from pre-eclampsia are twice as likely to have heart attacks and strokes as women who did not, but there appears to be no follow-up whatsoever, which is a matter that I have raised previously with the minister. Instead, there is a suggestion that such women—lay members of the public—self-monitor their blood pressure for the rest of their lives. Even the women's health champion, Professor Anna Glasier, who is in the public gallery, calls that a rather "tall order" in the health plan.

Finally, I turn to primary biliary cholangitis, which is a chronic liver disease that many women across Scotland are living with. Following a round-table meeting at the Scottish Parliament, which Gillian Mackay kindly chaired, a recent report highlighted significant disparities in the experiences of women living with liver conditions. The findings revealed that experiences vary widely, depending on geography, with many women reporting feelings of stigma associated with their liver condition, despite it not being caused by any action of their own, such as alcohol consumption.

The report recommends wider roll-out of the intelligent liver function test, which is currently used routinely to assess liver health in Tayside and Fife. Research by the University of Dundee shows that the test increases diagnosis of liver disease by 43 per cent, which allows for earlier and more effective treatment. Expanding access to the test would improve early diagnosis and care for women living with liver conditions across Scotland. Scottish ministers should also actively raise awareness of PBC.

The women's health plan provides us with a clear path forward, but much remains to be done. By continuing to build on progress, we can ensure that women across Scotland receive the care and support that they deserve when they need it most.

16:02

Pam Duncan-Glancy (Glasgow) (Lab): I thank the Government for bringing forward this debate on such an important issue. Although I welcome the fact that some progress has been made on the women's health plan, as the minister and others have set out, and that the Government is looking forward to the next steps, I fear that many women are still unable to access appropriate healthcare as and when they need to.

Women in Glasgow, especially those from more deprived areas in the region, are less likely to attend breast and cervical screening services than women elsewhere on mainland Scotland. Until very recently, women in Glasgow experienced harassment when attending abortion services, and

I acknowledge the success of the work of Gillian Mackay and Back Off Scotland on safe access zones. However, there remain barriers to accessing abortions in Glasgow, where a lack of information on what is available still prevents timely access to such services when they are needed. As is the case elsewhere, women in Glasgow still wait far too long for diagnosis of endometriosis or polycystic ovary syndrome, which leaves many living in significant pain.

The situation in Glasgow for women must be turned around, and in order for that to happen, we need the Government to take a different direction. In addition, we need a different direction to be taken for specific groups of women, because, as Engender and others have highlighted, minoritised and marginalised women's health experiences are still not fully recognised or addressed. I will use the rest of my speech to speak about the need for that to change.

Women continue to face stubborn inequalities in how they experience healthcare. Engender and others, including me and my party, are concerned by the slow progress in that regard. Years on from the publication of the women's health plan, 65 per cent of respondents to research by the Young Women's Movement in Scotland stated that being disabled is still associated with a lack of healthcare. They cited various reasons for that, including a lack of understanding of the need to treat multiple conditions holistically and, in some cases, bias and discrimination. The women's health plan highlights that issue, and an Engender research report that was published in 2018 described how disabled women in Scotland experience specific barriers to accessing a range of health services, including a lack of accessible facilities, specialist equipment and accessible information.

The plan acknowledges the importance of considering how sex, gender and disability intersect, and the specific needs and experiences of marginalised disabled women. It concluded:

"It is important for healthcare professionals, and health policy makers, to recognise that a failure to take an intersectional approach can lead to further discrimination or disadvantage."

I am concerned that many disabled women still face the same problems that were identified in that 2018 report. It has been brought to my attention that access facilities are not being prioritised as part of the development of new health centres. In fact, it appears that those facilities are deemed to be unimportant, as they are the first thing to be cut when health and social care partnerships are looking to reduce costs. The promised Changing Places toilets, for example, and hoists in GP surgeries were not installed in new healthcare centres in my region. I would have thought that the development of new buildings is the perfect opportunity to ensure that access for disabled women is assured, rather than being something that is considered later. However, that opportunity is being missed.

There also seems to be a lack of awareness among healthcare professionals where specialist equipment is in place. For example, in one of the health centres in the Glasgow region, a hoist was available, but none of the GP practices in the building was aware of it.

A report by Glasgow Disability Alliance that was published in 2022 found that the global pandemic has made it even harder for disabled women in Scotland to access women's healthcare, because many have more complex needs than can be met through their GP surgery. The report also found that some disabled women felt unable to seek healthcare due to a mix of reasons, including the guilt associated with the need for additional things from an overstretched system. Disabled women should not feel guilty for having more complex needs, which—I should not have to say this—they did not ask for.

The report found lengthy delays in accessing health services and that those have

"significant health and life implications, including loss of function and mobility, missing potential problems or conditions and opportunities for preventative interventions".

The report recommended that disabled women should have the option to be

"accompanied at medical appointments including on admission to hospital for communications and/or support",

and that disabled women should have access to the equipment that they require.

Given that access to healthcare is a fundamental human right, it is extremely concerning that that was still a recommendation in 2022 and that, as demonstrated by the examples that have been outlined, it still applies today. Disabled women are being failed, and lives are being lost as a result. I was made aware of a situation in which one of my constituents was sadly unable to receive a smear test due to the fact that no hoist was available when she attended her appointment. Heartbreakingly, my constituent later lost her life due to a rare female cancer. I am cognisant of the fact that, if the correct equipment had been available, that outcome could have been different. My thoughts are with my constituent and her family, who have been failed by the current system.

Something must change. The women's health plan outlined Government plans to launch a wider programme of work to specifically target inequalities across all screening programmes. However, three years on from its publication, not

enough progress has been made. In Scottish Labour's 2024 manifesto, we recognised that and said that, despite the publication of the plan, women continue to face inequalities. We committed to ensuring greater uptake of and ease of access to screening services, including the roll-out of cervical screening self-sampling. We recognise that local GP surgeries are the first port of call when a health problem starts, and we are committed to ensuring that they provide a range of services and to growing multidisciplinary teams, which are crucial.

Those are some of the ways in which we could ensure that disabled women no longer face barriers to basic healthcare. The next plan must be clearer in setting out solutions for improving all women's healthcare, including unambiguous timescales for delivering the required change. In the words of Glasgow Disability Alliance's report,

"Our society must be one in which disabled women participate and have our voices heard, on a full and equal basis, in all aspects of our lives, communities and wider society, with choices equal to others and our human rights upheld."

16:08

Clare Adamson (Motherwell and Wishaw) (SNP): I am pleased to contribute to what has been an informative and excellent debate. I will begin by following on from Pam Duncan-Glancy's thoughtful contribution on access for disabled women by mentioning that, so far this afternoon, we have perhaps not examined some of the cultural barriers for our black and ethnic minority groups. We know that accessing mental health services can be particularly challenging in some cultures, and the birth mortality rates for black women have been well documented in the UK and abroad.

There needs to be a better understanding of all the cultural barriers for women who are seeking help to get the support that they need. Those need to be examined in further detail. I thank Annie Wells for highlighting the poverty-related aspects of some of the challenges that women have, particularly as she represents a constituency such as mine that has historically low life expectancy for both men and women. I thank my colleague Kenny Gibson for his very personal reflection on his own experience, and not for the first time in the chamber. It is important that we hear about the lived experiences of women and their partners, and the impact that very difficult circumstances can have on the whole family.

I am glad that we are joined in the gallery by Professor Anna Glasier, who has been mentioned on many occasions in the debate for her lead in the area of women's health. It is worth remembering that the women's health plan was the first in the world to be published by a Government and it is the first attempt to examine the inequity that women experience in healthcare. It is also worth noting how much we now understand of the risks, many of which have been mentioned in the debate. Alex Cole-Hamilton touched on heart issues, and the risks presented by endometriosis, polycystic ovary syndrome, the mental health challenges associated with menopause and postnatal depression. He also mentioned postpartum psychosis, which can be devastating for the women and families who are affected by it.

The women's health pathway runs from puberty through to old age. We now know about some of the other issues that may face women beyond menopause, such as osteoporosis. Screening, which is so important, has been mentioned in the debate, includes breast screening and ovarian screening, as well as access to the HPV vaccine, which can now do much to prevent cervical cancer.

It is interesting that we are having this debate and that these issues are commonplace in the media and in our debates in the chamber. I thought that I would look back to see when we first started to talk about such issues, given that the first women's health plan covered the period 2021 to 2024. In the first session of the Parliament, from 1999 to 2003, there were four mentions of menopause. Three of those were mentioned as ancillary to the main issues that were being discussed, and one was mentioned in relation to men's health week. Very little changed during the few years after that. In the second session, the word "menopause" was recorded in the *Official Report* a couple of times. Between December 2003 and 2013, there were only seven entries in the *Official Report* that mentioned menopause, including in relation to other areas that did not focus on women's health issues.

In 2017, we had the first real mentions of menopause as having been a cause for women to be dismissed for other health issues, and a petition on thyroid and adrenal issues was lodged. The issue of incontinence was mentioned, and that menopause had been a reason for women's health problems to be dismissed, which has already been mentioned.

In sessions 1 to 4 of the Parliament, the word "tampon" was mentioned once. We now have the groundbreaking Period Products (Free Provision) (Scotland) Act 2021, which legislates for period products to be provided for free to those who are in need in Scotland. That was another first for Scotland.

From May 1999 to 2016, menstruation was mentioned five times, and three of those times were in the context of female genital mutilation.

Most women experience menstruation around once a month and millions of us go through it, so it seems incredible that we were not discussing women's health issues long before then.

I am really pleased that we have moved on from that. We have a long way to go to address women's health inequity, but I think that it is worth recognising how far we have come. The debate and the contributions that have been made show that we are taking it seriously, that we understand the challenges and that there is a lot more to do. I am delighted that the women's health plan is in place and that it has established a pathway. I look forward to hearing how the Government intends to implement it and about the work that has already been done under the current stewardship and leadership of the minister.

16:15

Audrey Nicoll (Aberdeen South and North Kincardine) (SNP): Like my colleagues, I am pleased that we are taking time to debate the subject of women's health. It is an issue that regularly appears in my constituency postbag, and a number of important points have been raised in the course of the debate.

The motion does not detract from the fact that there is still much work to be done to develop women's health services further, but the women's health plan is an important first step towards addressing the inequalities that impact half the population of Scotland. Nowhere are the long-standing health inequalities that impact women more evident than in the justice space, and I will focus on that a little later in my speech.

I am enormously proud of a health system that has, in the past few months, seen me receive my flu jab, my Covid jab, my cervical screening, my free eye test, my well-woman check, my mammogram, my asthma review, my audiology referral and a free prescription for antibiotics. Those are all effective and important preventative approaches that are part of the wider programme of activity to keep women in good health and that intersect with the priority areas in the women's health plan, which include menopause, menstrual health, pregnancy, contraception and endometriosis.

A few months ago, I had the pleasure of visiting the women's health services team at Aberdeen Royal infirmary, where I heard about the significant progress that is being made to develop health services for women, including endometriosis services and breast screening. I heard about the fantastic progress that is being made by NHS Grampian, alongside the University of Aberdeen and Kheiron Medical Technologies, to develop Mia—or mammography intelligent assessment—which is a promising artificial intelligence technology that can identify minuscule traces of breast cancer that can be missed through conventional practice. As one of the team acknowledged, even doctors are human, so they get tired, they might have been up all night with a crying baby or they might be full of the cold.

I have a number of constituents who are interested in seeing the women's health services model extended further to that of a hub. I am grateful to the minister for her previous engagement with me on the issue, with specific regard to menopause services for women. I welcome any further update that she can provide on progress in hub provision in the north-east. I was interested to hear Emma Roddick's reference earlier to the Highland hub.

The issue of urinary tract infection has been raised with me, and, although the women's health plan makes reference to recurring UTI, it does not refer to chronic UTI, which we know has a significant impact on women who experience it.

Typically, we are probably all members of the worried well population in society—thankfully, more well than worried—but I welcome that the plan acknowledges what is commonly known as the inverse care law, whereby those, including women, who most need healthcare are often least likely to access it. I commend the work that has been done recently by the universities of Glasgow and Edinburgh on how to tackle the inverse care law in general practice in Scotland.

That brings me to my final point, which is the challenge that women in the justice system face in their health and wellbeing. The women's justice leadership panel report, "The Case for Gendered and Intersectional Approaches to Justice", outlines how women typically enter the justice system in different ways from men and for different reasons. Scotland has a relatively high incarceration rate for women compared with other countries, including those in Europe, and it is commonly accepted that the health needs of women in prison are often not met due to a complex layer of factors, including domestic abuse, addiction, trauma and compromised mental health.

For women who have family members in prison, the practical harms that are associated with reduced household income, stigma, the loss of the practical and emotional support that they previously relied on from the imprisoned family member and even the cost of travel for prison visits can take a significant toll on their health and wellbeing, which further drives the health inequalities that we know disproportionately impact women who are caught up in the justice system. To a great extent, women serve a hidden sentence of their own in that regard.

The priorities that are set out in the plan apply equally to women in prison, who do not stop having periods, having the menopause or even being pregnant, so humanising healthcare in that space will help women to be well and more resilient when they leave prison.

Across Scotland, the establishment of trauma-informed community custody units for women, such as the Bella centre and the Lilias centre, is leading the way in preparing women to leave prison. Such units provide a real opportunity to insert even better healthcare services at that crucial release point.

I would be very interested to hear any update that the minister can provide on what opportunities might exist to insert some more focus on women's health in prisons into the next stage of the women's health plan. I very much look forward to following, and even contributing to, the plan's future development.

The Deputy Presiding Officer (Annabelle Ewing): We now move to closing speeches. I call Gillian Mackay to close on behalf of the Scottish Greens.

16:21

Gillian Mackay: This has been an interesting debate and I will reflect on some of the contributions. In her opening statement, the minister laid out how important it is to look after women's health because, in doing so, we are looking after the nation's health. It is important that we point to factors outwith the minister's portfolio and the women's health plan that have an effect on women's health. The minister mentioned unpaid carers—that is the perfect example of how factors in many other portfolios can drive health inequalities, or otherwise. The rate of carers allowance, access to carer support plans and the ability to get respite to attend appointments all have an impact on carers' health.

Another area that the minister mentioned is pregnancy and baby loss. Several friends have pointed out to me that they found it interesting that, during their pregnancies, almost every symptom that they asked healthcare providers about was described as normal, even when the symptoms were complete opposites—for example, having a higher-than-normal appetite and being concerned about that, or having no appetite at all when they believed that they should have. Both symptoms were totally normal, and I think that we need more information and clear explanations in those areas.

Many women have been told to just battle on with debilitating symptoms in pregnancy that we would not expect anyone else to battle on with, purely because there is a stigma around how early it is okay to tell people about a pregnancy. I know some friends who, after a loss, regretted not telling their family earlier. They had a bereavement without having had the celebration of their happy news. We need to assess whether some of those norms are making losses harder, and I commend Kenny Gibson for sharing his personal experience in that regard.

We need to ensure that employers are aware of all the ways in which they can support pregnant women and that women are supported to reveal their pregnancies whenever they are ready to do so, not when tradition dictates that it is okay, especially if they feel that they need support.

I am glad that the baby loss memorial book is open to those who have historically had a miscarriage. I am sure that many of us have had meetings with those who have historically lost a pregnancy and have heard them speak about the sense of validation of their experience.

Alex Cole-Hamilton, Clare Adamson and others have mentioned postpartum depression and postpartum psychosis, among other issues that are hugely important to address. The Health, Social Care and Sport Committee has undertaken work on perinatal mental health, and it would certainly be worth repeating such work in a future parliamentary session.

Emma Roddick mentioned chronic pain and how not being believed about a multitude of symptoms, but pain in particular, is devastating for many. Why the default is not just to believe that women are experiencing pain and then try to find out what is causing it to manifest, rather than not believing that the pain exists in the first place, boggles my mind.

Kenny Gibson kindly mentioned my chairing of the PBC event last week. Primary biliary cholangitis, which is not easy to say at this point on a Tuesday afternoon, is an autoimmune liver disease that predominantly affects women—women account for around 90 per cent of all cases. The symptoms of PBC, such as itch and fatigue, can have a profound impact on a person's quality of life and mental wellbeing. Those affected often feel misunderstood and sometimes stigmatised, because, unlike many other liver conditions, PBC is not the result of alcohol or drug consumption. Instead, risk factors may be gender, older age, genetics and where a person lives.

In my opening speech, I spoke of my awe for those women, who shared raw experiences of how PBC has affected, and continues to affect, their lives—how it has affected their families, their experience of transplant and their own mortality. They spoke with passion about what they want to see and how they see their own care. I encourage

others to engage with the groups that were represented at that event.

Kenny Gibson and others also mentioned cardiovascular health. We know that heart attacks often manifest with different symptoms in women. Many of us try to raise awareness of those symptoms, but their not being accurately defined in women is potentially a big problem. That is why I will not stop going on about data, and it is why I was really pleased to see a review of the data landscape published alongside the women's health plan report. Some of the data that we need to see is not just more things that the Government should collate, but specific funded academic work that is done to ensure that we better understand many of the symptoms and causes.

Organisations have asked for other issues to be raised that I did not have time to address earlier, so I will try to race through them now. Breast Cancer Now has underscored the need for a stronger emphasis to be placed on a life-course approach when women interact with the healthcare system. More should be done to provide women with information on how to check their breasts, to remind them when they will be invited for breast screening and to provide them with the tools to make an informed choice to attend.

That organisation also points to the fact that the Scottish Government's major review of breast screening in 2021 recommended that bringing high-risk screening within the remit of the national screening programme be considered. That project is outside the programme board's scope and would require a specific business case and funding. Breast Cancer Now advocates for the next iteration of the women's health plan for Scotland to provide an opportunity to fulfil the review's recommendations and to conduct a larger piece of work to fully assess the potential advantages, feasibility, benefit and cost of integrating high-risk surveillance with the national screening programme.

Engender has highlighted the need for more details to be provided on how Covid-19 has impacted women's health outcomes and affected the implementation of the women's health plan, including whether it has limited the scale of change that has been delivered. Engender has also renewed its calls for future work on women's health to focus on an intersectional approach that recognises and addresses the health experiences of minority and marginalised women.

I look forward to working with and learning from Professor Anna Glasier on the next iteration of the plan, as well as working with the minister and the rest of Government to achieve the aims that we all hold dear. I hope that we can continue in the largely constructive tone that we have had today.

The Deputy Presiding Officer: I call Jackie Baillie to close on behalf of Scottish Labour.

16:27

Jackie Baillie (Dumbarton) (Lab): I welcome the debate and I welcomed the plan, but I have to say that progress has been slow. The report was launched three years ago, yet we have not shifted the dial on the inequality that continues to plague women's health. I know that it will not happen overnight, but we need to make more progress.

I strike a note of consensus and agree with the minister's comments that to prioritise women's health is to prioritise the health of Scotland. That is why the agenda is so important. However, I fear that women's health is too often treated as an afterthought. Although the Government took more than a year to appoint the women's health champion, I very much welcome the work that has been undertaken by Professor Anna Glasier. She has certainly been hands-on in her approach and she has a hugely important role in making change, but leadership and resourcing from the Scottish Government are needed.

We are very welcoming of progress on issues such as self-sampling for HIV and sexually transmitted diseases, but what about cervical self-sampling? That was promised in the first year of the plan, but three years on, it appears that only Dumfries and Galloway has a pilot. In the report that was published last week, there is no mention of cervical self-sampling.

When the health plan was published, colposcopy waiting times were so bad that women with a suspicion of cancer were waiting more than 300 days to be seen. It was a real postcode lottery. If someone lived in Lanarkshire, it was fine—they were seen timeously—but if they lived in the NHS Greater Glasgow and Clyde area, they had to wait for up to a year, which simply was not good enough. I understand that matters have improved, and that is welcome, but there is still a long way to go to ensure consistency across Scotland.

I welcome the progress on the HPV vaccine. In fact, my daughter was in the first cohort of young women to receive it, which is great. However, the plan also promised to address wider health inequalities in cancer screening and, as others have mentioned, Public Health Scotland statistics still show a stark inequality in the uptake of breast cancer screening by women from the most and least-deprived backgrounds. There is a shocking 18.8 per cent disparity between the proportions of the richest and poorest women attending routine breast cancer screenings, and Cancer Research UK has estimated that approximately 4,900 cancer cases in Scotland each year can be attributed to

deprivation. We must make more progress on that, because thousands of women are being overlooked or put in danger due to their socioeconomic position, which is a shocking indictment of any Government.

Annie Wells was right to talk about waiting times for endometriosis treatment. I recognise the positive steps that have been taken and welcome the new pathway, the research and the specialist centre in Aberdeen. However, women are still waiting as long as nine years for diagnosis and treatment. I cannot begin to imagine the pain and suffering that they experience; I simply note that if that condition affected men, action would have been taken before now.

I do not underestimate the scale of the challenge. Women continue to have the highest levels of poor mental health and more women—45 per cent of women compared with 29 per cent of men—suffer from limiting, long-term conditions. Women are more than twice as likely to die from heart disease as from breast cancer and are also more likely to be given the wrong diagnosis, which means that they receive only half as many heart treatments as men. In part of my constituency, sexual health clinics have been withdrawn and centralised because of a failure to plan for the retiral of a clinician—you really could not make that up. We must do better in all those cases.

Yesterday, I met a number of very impressive women who, because of pregnancy outside marriage, were subject to forced adoption. Some were mothers who had to give up their babies, and some were babies now grown into adulthood. It was a very emotional meeting. I absolutely welcomed the public apology that the former First Minister, Nicola Sturgeon, made to them because of what happened, but there has been no action since and not even any provision of trauma-informed counselling. I know that it is hard to say sorry and I do not in any way diminish the impact of the apology, but to do so little in the way of follow-up shames us all.

I do not want to disrupt the cosy consensus but I must express my disappointment. The SNP cut £10 million from women's services and reduced funding for the removal of transvaginal mesh. Women who have endured years of crippling agony are the last people who should be paying for the SNP's mismanagement. The cuts do not stop there, because there will also be cuts of almost £3 million to early years care, breastfeeding and young patient family funds. Those are the very same funds that women have been told to rely on should they give birth to the most premature babies. Some women will be forced to travel for more than three hours to get treatment because of the SNP's plan to remove specialist neonatal services from Wishaw, which goes against the views of expert clinicians and of families in Lanarkshire.

My mother always used to tell me to follow the money. If something is important, we put resources behind it, so the fact that the SNP has cut funding tells us all that we need to know. The Scottish Government will receive the largest block grant from the Labour Government in the history of devolution. Every single penny given for health must be spent on health, and on women's health in particular.

I offer the SNP an early win. One of the biggest problems with menopause services is the waiting time for referral to a specialist clinic, which is largely down to the fact that many women have multiple GP appointments before their symptoms are diagnosed. We know that 90 per cent of menopause cases can be dealt with in primary care and that community pharmacies have a key role to play. I am therefore genuinely disappointed to see that that is only a long-term goal when there is already a menopause service on a digital community pharmacy platform that would deliver a better integrated service for women within six to 12 months and would be far more cost-effective for the NHS. I have no idea why the SNP is not interested.

I turn to the comments of Engender, which provided us with a very helpful briefing. I want to pick up on two issues that it has raised. First, we should understand what funding and investment has been provided to help with delivery of the plan and what accountability measures and monitoring are in place. That is the essence of our amendment, and I welcome the fact that the Government will accept it.

The second issue is that a new Scottish institute for women's health was promised in the plan but it has not been delivered. That body could drive change to improve women's health outcomes. I ask the minister to consider that, together with Kenny Gibson's suggestions on local clinical provision for women. Both of those are important.

While the NHS and social care in Scotland remain in crisis, women are overwhelmingly paying the price. We know that one in six Scots is on an NHS waiting list, that long waits at A and E put lives at risk, and that delayed discharge is at a record high. We need to do better. I agree with Professor Glasier that we must make the health of women central to every area of healthcare, but that will be achieved only with the proper levels of planning and funding.

The Scottish Government should also commit to addressing the large data gaps in reproductive health, endometriosis, menopause and contraception. There is no silver bullet for undoing years of inequalities in women's health, but the

pace of change needs to be picked up. Carol Mochan is right. We need more than words—we need delivery. Policy papers do not mark the end of the task. We need reform, and we need to get on with the job. I think that we can all agree that the women of Scotland deserve better.

The Deputy Presiding Officer: Before I call Brian Whittle, I advise members that we have a wee bit of time in hand between now and decision time, so I can be extremely generous.

I call Mr Whittle to close on behalf of the Scottish Conservatives.

16:36

Brian Whittle (South Scotland) (Con): I am very grateful, Deputy Presiding Officer.

First, I declare an interest in that I have a daughter who is a midwife.

This has been an excellent debate, with much agreement across the chamber. It is obvious that we all want faster progress towards parity for women's health. I was struck by the World Health Organization's statement that

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

We need to consider that against the backdrop in Scotland, where we have significant poor health issues. Despite the SNP's claim that it spends more on health per head of population than the rest of the UK, we have much poorer outcomes, and that is what matters. Scotland is the unhealthiest country in Europe. We have the highest obesity numbers, the highest drug and alcohol deaths, comparatively low and falling life expectancy, and so on. That impacts on women's health, of course, which already suffers from significant inequality.

Tess White made a powerful speech. I am paraphrasing, but she said that we know less about how best to treat diseases in women. I am also grateful to Alex Cole-Hamilton for mentioning the fight of the transvaginal mesh women. If anything highlights the inequalities in women's health, it is that. My overwhelming memory of the previous session of Parliament is sitting in the Public Petitions Committee questioning the CMO and the cabinet secretary while, behind them, sat some 40 or 50 women in wheelchairs, in unimaginable pain, searching for a solution. As I said, if we want to highlight the inequalities in women's health, that is where we should start.

ME affects four times as many women as men, and it is only fairly recently that we have started to get doctors to recognise the condition. As many members said, coronary heart disease kills twice as many women as breast cancer, and it kills more women prematurely. We know that a third of eligible women did not have a smear test in 2021-22 and that women from deprived areas are significantly more at risk from missing a smear test than those from the most affluent areas. It is the same for breast cancer. That thread has run right through today's debate.

If the women's health plan is to be successful, we must consider how the message reaches out to women and, crucially, how we ensure easier access to services. It cannot be right that, as Tess White highlighted, women have to travel for up to 125 miles to access screening, as they do in NHS Grampian, because local services cannot cope. We have a service that is underutilised yet cannot cope with the numbers who are trying to access it.

Rightly, Annie Wells highlighted the fact that the continuing shameful alcohol figures have a significant impact on breast cancer numbers, as well as on other cancers.

As Carol Mochan, Annie Wells and others highlighted, it takes on average more than eight years to get a diagnosis for endometriosis—a condition that will affect one in 10 women. That is not progressive women's health, in my book.

Given the impact of sport and physical activity on physical and mental health, it would be remiss of me not to mention the disparity between numbers in women's and men's participation. Early opportunities to get active are more difficult for girls than boys, and a stigma still exists around girls playing sport, especially around the age of menstruation. Much of that has to do with perception and access to safe and adequate changing and shower facilities.

That situation has not improved much in recent times, despite its being highlighted consistently. Society has not caught up—as is evident from the back pages of any newspaper, in which women seem to be, at best, an afterthought. At the weekend, two netball international matches were played, and I did not see any coverage in the media. You have to be able to see it to believe that you can do it. I know about those matches only because my daughter, who happens to be a netball ex-international, mentioned them to me. Women's football, cricket, golf and rugby are moving forward globally, and it is time that we in Scotland caught up. However, I note that, in my own sport of athletics, Scottish women are more prominent. It is good to see them buck the trend, and it shows that that can be done. Participation must be tackled and developed to impact the general overall health benefit, which is both physical and mental.

Before entering the Parliament, I worked in a healthcare technology company, developing communication and collaboration platforms for

healthcare. One target was to allow a global reach in new medical trials, taking into account the effectiveness of those drugs across different ethnic groups. However, globally, the uptake was in the region of 80 per cent male. To back Tess White's call for a women-specific treatment plan, the big issue is the efficacy of medicines for women. It is a fact that, mostly, medicines are tested on men, and then the dosage is extrapolated from the results to define dosage and effectiveness for women. However, not only is that an inexact science when it comes to dosage; it does not necessarily take into account the different biology in women, such as their bone density, muscle mass, fat content and menstruation. Mirroring society, whether in its male-female split or in variations in ethnicity, must be a significant goal for medicines, if we are to tackle women's health inequalities, and I would appreciate the minister's suggestions on how the Scottish Government might take steps to address what is a long-standing issue.

I listened to the minister discussing the neonatal services at Wishaw. Carol Mochan took that further, into rural neonatal units. I also listened to what Jackie Baillie had to say, and I think that she would agree that we spoke to a different cohort of constituents and healthcare professionals. It seems to me that the downgrading of the services at that maternity unit in Wishaw general hospital, the creation of a specialist unit in Glasgow to the detriment of Lanarkshire mothers, and the fact that the significant specialist skills that were developed at Wishaw are not being used, are based not so much on the delivery of healthcare but on an administrative decision, given the way in which the situation has been discussed many times in the chamber. It is wrong to develop and deliver women's healthcare in that manner.

As I said, this has been an important debate, shining a light on women's health and the inequalities that exist. Across the chamber, there is a desire to improve and impact on the health of women and girls. However, we must accept that we are a long way from parity in that healthcare. The debate is welcome, but change will come about only if the Scottish Government listens to members from across the chamber, acts on those suggestions and develops those plans. After all, better outcomes are what we all want.

The Deputy Presiding Officer: I invite the minister, Jenni Minto, to close on behalf of the Scottish Government. We still have some time in hand. If the minister could take us to as close to decision time as possible, that would be much appreciated.

16:45

Jenni Minto: This afternoon's debate has, once again, highlighted that it is vital to prioritise the health of women and girls. Having listened to the contributions from members, I am greatly encouraged by the progress that we have made, but I am under no illusion that work does not remain to be done. The plan recognises the need for a societal and cultural shift in attitudes towards women's health, to tackle the inequalities that women have faced for generations, as Carol Mochan and Gillian Mackay both referenced. That does not happen overnight—and it should not, because we need lasting change.

It is clear that there are specific areas where renewed and targeted focus is required—long waiting times for gynaecology are a clear example. The first phase of the women's health plan has provided a solid foundation for us to build on, but we are not finished. More work needs to be done to ensure that women and girls in Scotland are listened to, informed and supported to enjoy the best possible health throughout their lives. I and the Scottish Government remain committed to that ambition.

I will focus on a few points that have been made. When I came into this role and Ms Todd came into her role, we both felt that it was important to understand the views of people from across the chamber. We have been very open in how we have connected, and I have very much appreciated the comments from other members who appreciate that. Meeting half-yearly with Professor Glasier and having that space where we can talk about concerns and find responses has been very worth while for us all.

A number of members spoke about the stigma of women accessing healthcare. I was well aware of that at one of my very early meetings in this portfolio, with representatives of the Young Women's Movement, who told me about exactly that. I recognise a lot of the stuff that Pam Duncan-Glancy spoke about, and I recognise, as she does, that that is not an appropriate way to treat disabled women when they are accessing health services. I would very much like to have a further conversation with Pam Duncan-Glancy, to ensure that we incorporate that as well as we can in the next phase of the plan.

On a similar note, I acknowledge Audrey Nicoll's comments about prison services. Like Audrey, I have visited the Bella centre, and I found it a very inspiring place where women are given the opportunity to step back into life outside prison and are provided with suitable healthcare. The final report mentions progress in improving healthcare for women in prisons by providing additional investment to health boards to enable them to deliver trauma-informed healthcare. A

cross-ministerial group is looking at justice and healthcare, and I am very happy to engage further with that group and with Audrey Nicoll to ensure that we have the right connections with women in the justice system as we progress to the next phase of the plan.

Clare Adamson and others mentioned cultural barriers, and I have been very pleased to meet Amma mothers in Glasgow on a couple of occasions to understand the work that they are doing with BAME mothers, whether they are asylum seekers or refugees in the Glasgow area or further afield, to reduce inequalities. I also attended a research outcomes event on maternity care for refugees and asylum seekers, at which some very powerful information was shared that it is helpful for us to consider when we are talking about women's health.

Gillian Mackay's Abortion Services (Safe Access Zones) (Scotland) Bill was a great example of the Parliament working incredibly well together. The committee stages were very probing, as Tess White described. In addition, we were able to have conversations, both at stage 2 and prior to stage 3, in which there was a great deal of openness and understanding with regard to the various positions that members were coming from. That was a really good example of the Parliament working well, and I hope that we can use the same structure when we are looking towards the next phase of the women's health plan.

In that respect, I look forward to engaging with Annie Wells in her new role, and I welcome her along to the six-monthly meetings that we have been having with Professor Glasier.

Gillian Mackay also suggested some ways to move forward, and I am happy to engage with her on those to try to move things on.

I was pleased that Alex Cole-Hamilton recognised the consensus across the Parliament, and he, too, talked about stigma and mental health support. We have taken a number of actions in the "Peer Support in Perinatal Mental Health Action Plan 2020-2023" not only to support practitioners, but to provide peer support in supporting pregnant women, mothers and young babies, as well as partners and fathers, who are facing challenges such as loneliness and isolation. I recognise that we can always go further, but that work is on-going.

Gillian Mackay: I am intervening partly to give the minister a wee minute to get a sip of water. Does she recognise that we need to keep mums well throughout their pregnancy and ensure that they are supported to have the best possible mental health during that journey? In that way, when issues creep up in post-partum situations, there are existing support mechanisms in place for them.

Jenni Minto: Last week, I visited Home-Start Glasgow South, on the south side of the city, and that is exactly what that organisation has been doing. It supports mums from the time when they are about to give birth all the way through to when the children are at primary school. It provides combined support, and I was pleased to listen to, and learn from, some very powerful mothers who told me about the difference that that support had made to their own mental health.

I will touch briefly on the situation with neonatal units and the decision that was made about them. We made that decision in order to give babies who have been born at the extremes of prematurity the best chance of survival, which I believe is what every parent wants. Evidence shows that such babies do best when they are cared for in large, specialist neonatal units that look after a lot of babies and have specialist staff services available on site to give them the best care. As I said earlier, in response to an intervention, that approach is supported by experts and by Bliss, the charity that represents neonatal families.

Tess White: Will the minister give way?

Jenni Minto: If the member does not mind, I will move on to talk about a few other things.

There has been a lot of discussion about remote and rural maternity services. At a national level, we continue to work to address the challenges that are faced by maternity services in rural health boards. The implementation of the best start initiative and the introduction of the continuity of carer model; the development of community hubs; and the increased use of NHS near me, which allows for remote consultations and appointments where appropriate, are all intended to improve the delivery of maternity services in rural areas. I recognise that because I represent Argyll and Bute, which includes a number of islands that use those additional routes. We particularly recognise the importance of patient transport, and work is commencing to develop guidance on pre-hospital maternity and rural interpartum transfers. We will consider any specific needs and challenges that rural communities across Scotland face.

A number of members talked about pre-eclampsia, and I note that it was recognised that the Scottish Government has invested in health boards to ensure that the test, which is an important tool in identifying pre-eclampsia—a condition that can be, as others have said, dangerous or life threatening to pregnant women and babies—is available. Our expectation remains that all NHS boards will work to ensure that the recommendations on PLGF-based testing are implemented effectively and consistently. We are

working with NHS boards to navigate any local challenges to their implementation.

In relation to Kenneth Gibson's mention of PBC, it is later—

Gillian Mackay: Will the minister take an intervention?

Jenni Minto: I hope that Ms Mackay understands that I will not explain PBC. I was very pleased that Professor Glasier attended the parliamentary round-table discussion in October, as we recognise that that liver disease affects predominantly women.

Do you want me to wind up, Presiding Officer?

The Presiding Officer (Alison Johnstone): You have time, minister, if you are content to continue.

Jenni Minto: The group heard personal accounts from patients living with PBC and discussed how treatment and care could be improved for people in Scotland with the condition. We absolutely recognise the importance of hearing directly from people living in Scotland as we look to develop the next phase of the women's health plan. Professor Glasier appreciated very much the opportunity to hear at first hand from people living with PBC and the clinicians supporting them.

I will touch on Jackie Baillie's points about menopause services. When I was in Aberdeen during the summer recess, I heard about the fantastic work that is being done to support women and men who live with migraine. Primary care and pharmacies are working closely together on that. When I said that that seemed like an excellent way forward, I was asked what my next suggestion for that approach would be—and it is menopause. That is absolutely on my radar, and I am having those discussions. Some incredibly important research work on heart health is also happening at Napier University, which I am keeping across.

As everyone said in the debate, it is our duty to ensure that every girl and woman, regardless of their age and background, has appropriate and timely access to the information, support and services that are required to live a healthy life.

Tess White: Will the minister take an intervention?

Jenni Minto: I am just concluding, thank you.

It is a critical part of improving the health of Scotland, so I am very encouraged that we have found some consensus today. I hope that all members who took part in the debate, and perhaps those who will read our contributions after, will continue to work together, because, as we said at the start of the debate, the women's health plan is important for the health of Scotland as a whole.

I would be very happy to meet people to talk further about their ideas, contributions and suggestions, to ensure that the next iteration of the women's health plan is as correct as possible.

Business Motion

The Presiding Officer (Alison Johnstone): The next item of business is consideration of business motion S6M-15430, in the name of Jamie Hepburn, on behalf of the Parliamentary Bureau, on changes to the business programme.

16:59

The Minister for Parliamentary Business (Jamie Hepburn): I will be very happy to move the motion. It seeks to add a statement on Thursday of this week, after the scheduled portfolio questions on education and skills, which have already been agreed. Upon request from other parties, being the accommodating person that I am, I am very happy to add the statement to the schedule.

I move,

That the Parliament agrees to the following revision to the programme of business for Thursday 14 November 2024—

delete

2.30 pm	Parliamentary Bureau Motions
2.30 pm	Portfolio Questions: Education and Skills

and insert

2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Education and Skills
followed by	Ministerial Statement: Ministerial Events

Motion agreed to.

Decision Time

17:00

The Presiding Officer (Alison Johnstone): The next item of business is decision time. There are three questions to be put as a result of today's business.

The first question is, that amendment S6M-15382.1, in the name of Annie Wells, which seeks to amend motion S6M-15382, in the name of Jenni Minto, on the women's health plan 2021 to 2024, progress and next steps, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Con)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Burnett, Alexander (Aberdeenshire West) (Con)
Carlaw, Jackson (Eastwood) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Choudhury, Foysol (Lothian) (Lab)
Clark, Katy (West Scotland) (Lab)
Dowey, Sharon (South Scotland) (Con)
Duncan-Glancy, Pam (Glasgow) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallacher, Meghan (Central Scotland) (Con)
Golden, Maurice (North East Scotland) (Con)
Gosal, Pam (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Greene, Jamie (West Scotland) (Con)
Griffin, Mark (Central Scotland) (Lab)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Johnson, Daniel (Edinburgh Southern) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Kerr, Liam (North East Scotland) (Con)
Kerr, Stephen (Central Scotland) (Con)
Leonard, Richard (Central Scotland) (Lab)
Lumsden, Douglas (North East Scotland) (Con)
Marra, Michael (North East Scotland) (Lab)
McCall, Roz (Mid Scotland and Fife) (Con)
McNeill, Pauline (Glasgow) (Lab)
Mochan, Carol (South Scotland) (Lab)
Mountain, Edward (Highlands and Islands) (Con)
Mundell, Oliver (Dumfriesshire) (Con)
O'Kane, Paul (West Scotland) (Lab)
Ross, Douglas (Highlands and Islands) (Con)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Sarwar, Anas (Glasgow) (Lab)
Simpson, Graham (Central Scotland) (Con)
Smith, Liz (Mid Scotland and Fife) (Con)
Smyth, Colin (South Scotland) (Lab)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Sweeney, Paul (Glasgow) (Lab)
Villalba, Mercedes (North East Scotland) (Lab) [Proxy vote cast by Richard Leonard]
Webber, Sue (Lothian) (Con)
Wells, Annie (Glasgow) (Con)
White, Tess (North East Scotland) (Con)

Whitfield, Martin (South Scotland) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Adam, Karen (Banffshire and Buchan Coast) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Brown, Siobhian (Ayr) (SNP)
Burgess, Ariane (Highlands and Islands) (Green)
Chapman, Maggie (North East Scotland) (Green)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Dey, Graeme (Angus South) (SNP)
Don-Innes, Natalie (Renfrewshire North and West) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Dunbar, Jackie (Aberdeen Donside) (SNP)
Ewing, Annabelle (Cowdenbeath) (SNP)
Fairlie, Jim (Perthshire South and Kinross-shire) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Gray, Neil (Airdrie and Shotts) (SNP)
Greer, Ross (West Scotland) (Green)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (Ind)
Matheson, Michael (Falkirk West) (SNP)
McAllan, Màiri (Clydesdale) (SNP) [Proxy vote cast by Jamie Hepburn]
McKee, Ivan (Glasgow Provan) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP) [Proxy vote cast by Jamie Hepburn]
McLennan, Paul (East Lothian) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
McNair, Marie (Clydebank and Milngavie) (SNP)
Minto, Jenni (Argyll and Bute) (SNP)
Nicoll, Audrey (Aberdeen South and North Kincardine) (SNP)
Robertson, Angus (Edinburgh Central) (SNP)
Robison, Shona (Dundee City East) (SNP)
Roddick, Emma (Highlands and Islands) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Slater, Lorna (Lothian) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stewart, Kaukab (Glasgow Kelvin) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thomson, Michelle (Falkirk East) (SNP)
Todd, Maree (Caithness, Sutherland and Ross) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Tweed, Evelyn (Stirling) (SNP)
Whitham, Elena (Carrick, Cumnock and Doon Valley) (SNP)
Yousaf, Humza (Glasgow Pollok) (SNP)

Abstentions

Cole-Hamilton, Alex (Edinburgh Western) (LD)
McArthur, Liam (Orkney Islands) (LD)
Regan, Ash (Edinburgh Eastern) (Alba)
Rennie, Willie (North East Fife) (LD)
Wishart, Beatrice (Shetland Islands) (LD)

The Presiding Officer: The result of the division on amendment S6M-15382.1, in the name of Annie Wells, is: For 48, Against 67, Abstentions 5.

Amendment disagreed to.

The Presiding Officer: The next question is, that amendment S6M-15382.2, in the name of Carol Mochan, which seeks to amend motion S6M-15382, in the name of Jenni Minto, on the women's health plan 2021 to 2024, progress and next steps, be agreed to.

Amendment agreed to.

The Presiding Officer: The final question is, that motion S6M-15382, in the name of Jenni Minto, on the women's health plan 2021 to 2024, progress and next steps, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament acknowledges the longstanding health inequalities faced by women and believes that it is vital that services and health outcomes are improved for women and girls; notes the progress made through implementation of the Women's Health Plan as a first step towards addressing these inequalities, in particular the appointment and work of the first Women's Health Champion; thanks hard-working NHS staff and all those who have contributed to the progress to date; welcomes the commitment from the Scottish Government to work with women and girls across Scotland in developing the next iteration of the plan; thanks everyone who has contributed their lived experience to the priorities of the Women's Health Plan; is concerned by the slow progress in addressing stubbornly high health inequalities experienced by women, and calls on the Scottish Government to ensure that the next plan sets out concisely when and how each of its actions will be fully implemented across Scotland.

The Presiding Officer: That concludes decision time.

17:07

Members' business will be published tomorrow, Wednesday 13 November 2024, as soon as the text is available.

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