OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 11 January 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 11 January 2022

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

1st Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O’Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Hazel Borland (NHS Ayrshire and Arran)
Greig Chalmers (Scottish Government)
Heather Connolly (British Psychological Society)
Mary Glasgow (Children 1st)
Kirsty-Louise Hunt (Barnardo’s Scotland)
Terry O’Kelly (Scottish Government)
Jacquie Pepper (Social Work Scotland)
Suzanne Shields (Royal College of Occupational Therapists)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 11 January 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the Health, Social Care and Sport Committee's first meeting in 2022. I take this opportunity to wish everyone a happy new year. I have received apologies from Stephanie Callaghan, but all other members are here.

Agenda item 1 is to decide whether to take items 5, 6 and 7 in private. Do colleagues agree to take those items in private?

Members *indicated agreement.*

Inquiry on Health and Wellbeing of Children and Young People

09:00

The Convener: Item 2 is the first evidence session in our inquiry into the health and wellbeing of children and young people. I welcome Professor Hazel Borland, interim chief executive of NHS Ayrshire and Arran; Heather Connolly, health psychologist, from the division of health psychology Scotland of the British Psychological Society; Mary Glasgow, chief executive of Children 1st; Kirsty-Louise Hunt, senior policy and public affairs lead with Barnardo's Scotland; Jacquie Pepper, chief social work officer for Perth and Kinross Council, from Social Work Scotland; and Suzanne Shields, occupational therapy and care group lead for occupational therapy for children and young people, from the Royal College of Occupational Therapists.

The clerks have allocated one member as a lead questioner on each of our themes. If other members want to come in, they should put an R in the chat box—I will try to take as many supplementary questions as time allows. It would be helpful if members, particularly when asking supplementaries, could direct their question to one of our panellists in the first instance so that everyone is clear as to when they should speak. If panellists want to come in on anything, they can let me know by putting an R in the chat box. If we do that, everything should work beautifully.

I will start by asking a question for all the panel members. What issues are children and young people facing with regard to the impact on their mental and physical health and wellbeing at this point in time? At the start of 2022, we have had two years of the pandemic, but we are right in the middle of it, with omicron on the rise.

I will go round everyone in the order that I introduced you, starting with Professor Borland.

Professor Hazel Borland (NHS Ayrshire and Arran): Many thanks, convener—it is much appreciated.

That is an enormous question. My colleagues across Ayrshire have pulled together a range of topics. We are concerned about a number of developmental delays in infants, the impact on childhood obesity, the interaction with dental services and the possible impact on the broader health and wellbeing of children of all ages. There is a significant impact on their mental health which, tragically, is resulting in an increase in suicides across the country. There is a range of other issues, such as ensuring that we deliver person-centred services, the stigma that can be connected with being care experienced and the impact of poverty. There are concerns that, at times, we seem to be compartmentalising poverty in our language. We talk about child poverty, period poverty and food and fuel poverty but, actually, it is all just poverty and we need to tackle it in that way.

We need to tackle the impact of Covid-19 on education and the attainment gap, and we need to look at the broader issues in relation to social media. We need to think about all those things and their impact on our public health priorities such as breastfeeding, smoking in pregnancy and gender-based violence, and the impact that all that can have on young people, with a particular focus on young girls.

There is a whole range of issues there and I am more than happy to answer questions on them in more detail. I did not want to go into too much detail at the beginning, but I am more than happy to respond to any questions that members may have.

The Convener: I appreciate that it is a very wide question. Colleagues are ready to dig into the detail. Our inquiry is on a big theme, but we have a short timescale. I hope that it will be a springboard for some more focused work and that we will invite you back when we do that.

Heather Connolly (British Psychological Society): I represent the division of health psychology, which focuses on the health and wellbeing of the general population and health and wellbeing at an individual level. It is also about support systems, and we try to be more psychologically informed in the way we provide support to people. It is less about the specialised mental health aspect.

Professor Borland gave a broad array of the difficulties and challenges that children and young people face, which emphasises the wider determinants that impact our children and young people, and all humans, particularly during the Covid-19 pandemic. I reiterate what Professor Borland said: a lot of things around mental health and wellbeing for children have been impacted significantly, including obesity, diet, nutrition, physical activity, social connectedness and relationships. The relationships that we have with children have been impacted; they might not have been attending school or nursery as much and some children have been taken out of school because of the fear of Covid-19. It comes back to our relationships with children and young people and how we engage them. All the fantastic services that we have out there are important.

Again reflecting on what Professor Borland said, the biggest issue is child poverty. It is one of the biggest difficulties in our society and, unfortunately, it will only get worse given the energy crisis and everything else. Trying to tackle child poverty gets down to the core of the difficulties that children and young people have growing up, such as access to certain services and the ability to go to community groups and have relationships with other children and younger people.

Tackling child poverty and poverty in general is very important, because poverty sits in the middle of all the wider determinants that impact our health and wellbeing. Not having the ability to access stuff and having the stress and burden of worrying about financial difficulties impacts on all our health and wellbeing.

The Convener: That point will come out strongly in the questions about child poverty. As you say, the outside determinants that affect household incomes add additional stressors.

Mary Glasgow (Children 1st): Thank you for the opportunity to submit written evidence and the invitation to speak on behalf of the children and families who we support at Children 1st. As colleagues have already said, the themes of the inquiry are broad by any measure; every aspect of children and young people’s development has been impacted by the pandemic and the associated restrictions. We hear and see children, young people and their families who are isolated and struggling with general levels of anxiety. We take a whole-family approach and we know that, when parents and carers are anxious about money, restrictions, relatives and what is happening in a broader context, children pick up on that. There has been a huge increase in the levels of anxiety and pressure on families, which often means a rise in children’s levels of anxiety.

That sits alongside the loss of peer and social relationships and of time at school. For many of the children we support, school is a place of safety, when home and family relationships are not always safe. Children have lost out on sports and community activities so, over the past two years, normal developmental milestones have been lost for a whole generation of children and young people, whatever stage they have been at. Teenagers have had fewer opportunities to take risks and mix with others outside of home. They have lost opportunities to go off and do Duke of Edinburgh awards or experience other normal things that children and young people need to do, so general aspects of their development have been delayed.

We have seen a very specific increase in the levels of distress, anxiety and harm that children have experienced because of the losses that they have come across. One of the biggest things that children and young people and their families talk to us about has been the difficulty of reaching out and getting support in a timely fashion. That was difficult before the pandemic, because there was a lack of support to recover from the impact of trauma, and it was difficult to access quickly good-quality support for children who were experiencing emotional distress or mental health difficulties, but it got a lot worse through the pandemic, and children's challenges around their anxiety and mental and emotional health have been exacerbated and made worse. Parents and carers are very distressed; they are at the end of their tether and do not know where to turn. When universal services are not available as a first step into support, they have been at a loss to try and access timely help for children, so that situation has got worse. One of my big concerns is that the situation was bad in that sphere before the pandemic, and now it has been made a lot worse.

Of course, as other colleagues have said, the biggest thing is the growing impact of poverty and the anxiety, uncertainty and difficulty that that places on family relationships. We always say that children and young people do well when families and parents do well and feel safe and secure. Right now, we are seeing an incredible amount of anxiety, pressure and worry about poverty and the impact of poverty on families generally. There is a general issue and there are very specific issues for some of the children and young people we support at Children 1st.

Kirsty-Louise Hunt (Barnardo's Scotland): Thank you for the opportunity to speak to the committee today on behalf of the children and families that Barnardo's Scotland supports.

I echo a lot of what has already been said, particularly what Mary Glasgow said about the concerns about the impact of poverty. Over the past 18 months—almost two years now—especially since children have returned full time to school after the disruption of lockdowns, we have found that there has been a lot of anxiety and concern about children's mental health. We put out a survey to Barnardo's Scotland staff who are based in schools on what they are seeing in the children and young people they work with. The vast majority of staff—94 per cent—said that they feel that children and young people have a lot more worries than they did pre-pandemic. There was also a great level of concern about the impact of the financial hardship that has been made worse over the course of the pandemic. I echo and highlight to the committee that a lot of those issues are perhaps not new. We knew about those issues before, but the pandemic's impact on developmental milestones and the social isolation that it has caused have made the situation much worse. In the survey that I mentioned, more than 83 per cent of our staff said that they see more families with financial hardship now than they did prior to March 2020, and that is a key concern for us.

Mary Glasgow also picked up on the fact that children and young people get overwhelmed and stressed if the adults who are caring for them in their lives are also experiencing difficulties, so a key thing that we want to see is a whole-family approach to supporting families and children and young people. We would like to see much more investment and focus on that early intervention and the whole-family supports that are available.

09:15

Jacquie Pepper (Social Work Scotland): I am grateful for the opportunity to speak to the committee.

As well as being chief social work officer for Perth and Kinross Council, I am representing Social Work Scotland as chair of its children and families standing committee. The standing committee has met monthly throughout the pandemic, and more often if that has been required. There has been close monitoring of the issues that families face.

I echo all the comments that have been made, but I would like to pick up on some key issues for particular groups of children, such as those with caring responsibilities. In the initial phases of the pandemic, with lockdown and the withdrawal of universal services, there was a significant impact on the mental health of young carers. Those are young people who face isolation and who often lack the support with which other children can engage. That has been a concern for us.

I also highlight the position of care leavers—young people who are care experienced and are living independently, often without the support of families and key relationships. The isolation and the lack of support that young people who have left care have experienced have had an impact on their mental health, with the result that there has been an increase in the likelihood of self-harm. As we heard earlier, there has also been an increase in suicide attempts and suicide, and a high demand for mental health services at an acute level.

Reflecting what other contributors have said, when the mental health and wellbeing of parents is affected, that is likely to have a direct impact on children and young people. When family circumstances are impacted by drug and alcohol misuse, depression, poverty and poor mental health, that correlates directly with an impact on the wellbeing of children.

In addition, I highlight the needs of children with disabilities. We are seeing a link to poor mental health in parents of children with disabilities because their packages of care have been withdrawn or they have withdrawn themselves from such support, with the result that they have become more isolated. Although those services are beginning to be reintroduced, they are tired and are still experiencing the distress of everything that they have experienced over the past 18 months.

From seeking information from our members, we have learned that there has been an increase in the number of young people who require care or residential school provision because their parents are unable to manage or because the young people are unable to be managed within mainstream provision. There has been an increase in concerns and, in some cases, an increase in young people moving into care provision.

I echo the comments that have been made about the need to look at the whole family in order to tackle issues of poverty and health and wellbeing, because anything that positively impacts on families will positively impact on children—their outcomes are inextricably linked.

The Convener: Thank you. We are very aware of the fact that the issue that we are talking about is not just a health issue but one that goes across a range of disciplines. With that in mind, we have reached out to other parliamentary committees to work with them on all the different drivers that affect the mental and physical health of children and young people.

On the initial question that I posed, we come finally to Suzanne Shields.

Suzanne Shields (Royal College of Occupational Therapists): Good morning, convener. Thank you for giving me the opportunity to speak to the committee. I am occupational therapy lead for children and young people in Lanarkshire, although today I am representing the Royal College of Occupational Therapists.

I echo what everybody else has already said, but a key point to make from an occupational therapy point of view is that, over the past year, we have all experienced the loss of our roles and our occupations. We have lost our routines, activities and things that we take for granted, and that is no more so than for our children. They have lost access to education and the opportunity to play, meet, socialise and learn the things that they need in order to progress through life. From an occupational therapy point of view, we already support the children who have a level of need from a range of disabilities including life-limiting conditions, developmental needs and autism. The range is vast. There were already children with a level of need, and that has been compounded by the Covid pandemic.

We know that children thrive on a stable start. We know that there are issues around poverty, poor housing, lack of education and the lack of support that education gives to young people and their families—the routine of getting up every day and going to school. We want children and young people to have access to play, which is a main occupation for them. We want them to have access to green spaces, outdoor activities, leisure facilities and everything that has been stopped. However, even before the pandemic, there were issues for children accessing some of those things as a result of poverty issues such as access and travel, and they have been compounded.

One of the key things for us in the national health service is the threat of redeployment. We are beginning to see the significant fallout for the children whose services were stopped when all our services were suspended and staff across the whole of occupational therapy were redeployed into acute sites. That was essential, but we need to prioritise the needs of our children and young people going forward.

We are seeing evidence of developmental delays in children who did not have good nursery time and are now already in school. They lost that opportunity to develop those early social skills. We need to make sure that we support the parents around those children. We work very hard to empower parents to self-manage and support their children as best they can, but that is difficult when, as we have all said, those parents are struggling with their own activities, routine, levels of stress and anxiety, and poverty.

That probably covers everything from an occupational therapy point of view that has not been covered already.

The Convener: I thank all of you very much for giving the committee that overview.

Sue Webber has put an R in the chat box. Do you want to ask a supplementary on a particular point?

Sue Webber (Lothian) (Con): Yes, please. It is directed to Jacquie Pepper. You spoke at length about how some of the drug and alcohol issues that parents may have impact directly on the children. To what extent are you getting a sense that young people are, or have been, more at risk of adverse childhood experiences, whether that be physical abuse or any other sort of ACE?

Jacquie Pepper: We could probably spend the whole session on that topic. [*Interruption*.] Can you hear me okay?

Sue Webber: Yes.

Jacquie Pepper: One of the things to look at is trends and patterns. It might be helpful for the committee to be aware that what we saw across

Scotland in the first six months of the pandemic, and probably into the first nine to 12 months, was a higher referral rate into social work services. Once universal services started to return and families were being seen, many more concerns were referred to social work services in the first instance, primarily from the education and police services. That gives you an indication of what has been happening.

I do not think that we have seen that level of referrals go down; it is continuing. It has not necessarily worked through the system in a way that means that more children are being entered in the child protection register, but it has meant that there is much more activity at the investigatory stage. All services are working around families as best they can to provide the intervention that is required to ensure that those children do not end up in child protection or the statutory system in terms of care.

My own perspective is that the vast majority of those children will be affected to some degree by parental mental ill-health, parental substance misuse and domestic violence. Those three aspects feature significantly in the lives of those children. Because families have been less visible for a period of time, it is difficult to quantify what that has meant, but they are certainly significant features and it is an area for the committee inquiry to look at in a bit more depth. I am happy to see what I can do to provide a bit more information.

Sue Webber: That is great; thank you.

The Convener: Sue, you want to lead on the theme of person-centred services. If you want to, you can continue with that now.

Sue Webber: Thank you, convener.

We have heard a lot today about the whole-family approach that is needed. In our previous session with Audit Scotland, NHS Ayrshire and Arran was held up as a beacon of good practice, so I will ask Professor Borland to respond first. How could services be organised to provide a more joined-up experience for children and young people, and can you give examples? I suppose that the question is relevant to any of our witnesses today, but could we start with Professor Borland?

Professor Borland: Thank you very much for that—no pressure!

I am proud of the work that is being done right across NHS Ayrshire and Arran. Our children’s services are working in an incredibly integrated way, so that the relationships that we have between health and social care and other multi-agency partners, such as Police Scotland, are very strong, which has given us an incredibly strong foundation.

We are keen to support the voices of children and young people, and enshrining the United Nations Convention on the Rights of the Child has given us a base on which we can build, and we welcome that.

We have established a strategic corporate parenting group that works closely with the corporate parenting agencies and groups across our local authorities. Obviously, we have taken account of the Promise and developed a corporate parenting promise that takes us from 2021 into 2024. As part of that promise, we have a dedicated workstream that aims to ensure participation by and consultation with, for example, our care-experienced population of children and young people in an on-going and systematic way. Rather than using ad hoc, one-off elements, we really want to take a systematic approach.

Our public health teams have aimed to undertake some bespoke local research to inform our needs assessment, and again they have been working really closely with our local authorities.

Our three local authorities have mature mechanisms for getting the voices of children and young people heard, so working across them has been beneficial. We are working with our champions boards, and we are connecting closely with our child and adolescent mental health services colleagues, as you would imagine. All that means that we have been able to come up with a corporate parenting action plan that sits underneath our parenting promise and enables us to think about our priorities from 2022 onwards. As colleagues have described, we also need to sharpen the focus on the pandemic. Some of the things that we are aware of are not new. Colleagues have described the things that we are already aware of, but the pandemic has absolutely highlighted them and escalated a number of them.

One of the things that we will pay close attention to is a piece of work that I am not sure that the committee is aware of by the national children and young people service improvement group, which is run through the Scottish public health network, which is part of Public Health Scotland. In 2021, that group undertook a piece of work that will result in a paper to be entitled “Ensuring our Future” and which will address the impact of Covid-19 on children and young people and their families. We would commend that piece of work to the committee once it has been completed. I am not sure when it will be finished or what the publication date is, but I think that it will prove to be incredibly valuable.

We also aim to focus on a whole-family approach, as colleagues have described. It is impossible to look at children and young people in isolation. Colleagues who have more experience than I do have described the importance of the impact of parental mental ill health, stress and distress on children and young people, and the need to ensure that we support families. The question of how we do that brings us back to the subject of poverty.

09:30

That is one of our foundational approaches: supporting whole families, and gradually beginning to unpick the situation to consider any bespoke needs assessment that may be required in order to target particular interventions.

I hope that that is helpful.

Sue Webber: Yes, thank you. I do not know whether anyone else wants to add to that.

The Convener: I remind our witnesses that if they want to come in on anything, they can use the chat box. I see that Jacquie Pepper wants to come in.

Jacquie Pepper: I agree with everything that Professor Borland said. Ensuring that an integrated approach is taken, and that services are working together, is key.

Sue Webber asked for some examples. From a Perth and Kinross perspective, I highlight the work of our youth service. We have an integrated youth service that works alongside social workers and others to provides holistic support for young people, irrespective of their circumstances, in a targeted way. The service is low key and non-stigmatised; someone can walk in off the street, speak to somebody and receive support. It has been invaluable throughout the pandemic and we certainly want to hold on to it. That type of holistic integrated support is important for not only young people but families.

We are also working with the Wellbeing Economy Alliance, which is a global initiative, and with partners to test out the “Wellbeing Economy Policy Design Guide”, which is about designing our budgeting for wellbeing. The piece of work that we are doing in Perth involves engaging with families about what works for them. Professor Borland articulated well that we need to think about what works for families. Some of that is not new—it is what we already know works best for families. I am sure that other witnesses will articulate that, too.

When we speak to families and to children, we find that it is very much about what is in and around their community, and what supports them holistically in their community. We must ensure that services are easily accessible to people in their own street and neighbourhood, and focus on locality. We need to wrap services around families and provide holistic family support.

Heather Connolly: I echo what colleagues have said—the whole-systems, whole-family approach is important. However, while it looks great on paper, how do we embed it in services? What does that look like? What are some of the barriers to that, and to multi-agency interconnectedness?

The complete stress, burden, burn-out and moral injury that our workforce is experiencing just now will impact on their ability to deliver person-centred care. One of the cornerstones of person-centred care is delivering services with compassion. If those in the workforce have no compassion for themselves because they are working under conditions of extreme stress and burn-out, we will have real difficulty in delivering a person-centred service.

When we think about taking a whole-systems holistic approach, we also need to think about the workforce that is delivering services and how we can provide the workforce with effective skills and techniques, and support, to enable them to deliver a person-centred service.

Mary Glasgow: To build on the theme of person-centred planning, our experience, which is very much informed by the children, young people and families whom we support, is that pre-pandemic—the situation was made worse during the pandemic—many of our systems and support services were complicated to understand for family members who tried to reach out and engage with them.

We use professional language, which is often heavily weighted towards the jargon that we understand, and we can often design processes and systems that actually feel quite stigmatising, or blame and shame inducing, although nobody intends that.

A strong message from families is that a key thing that good person-centred services could offer is more time. We heard from Heather Connolly about compassion. It is about giving more space and more time to really get to know children and young people and their families and to listen to their stories from their perspective, so that we have the space and time to understand what has led to the current difficulty and to start where the family is rather than with what the professional or agency can spare.

One thing that was really heartening at the beginning of the pandemic was that we spoke about needing to review our systems and make them much more human, much more person centred and much more about getting alongside and being with people rather than doing things to people. That is a theme that we may lose if we are not careful. We need to hold on to that original intent.

To highlight one example, we have worked alongside two health and social care partnerships to design and develop multi-agency family wellbeing teams. We began to test that model pre-pandemic in response to a concern held by many parents, carers, children and young people. When they presented at universal services such as the general practitioner, who is often the first point of contact, with concerns and anxiety about children's wellbeing—really significant worries around anxiety, eating disorders or self-harming—the response from their GP was often that their needs could only really be met through CAMHS and through very clinically based services, and there were long waiting times for those services.

At Children 1st, we have designed services and we have learned from those services that often what is required are whole-family support services. You have heard a lot about that this morning. When we really listen to what is going on, we learn that many children are distressed not because they have clinical difficulties—although a small number do—or a medical need but because social and family relationships are fractured and under pressure, as we have heard. Children often carry that weight of worry, anxiety and concern and it manifests itself in all the ways that we have heard about: they become withdrawn, they stop eating, they stop going to school and they become very anxious.

We designed a service to offer very quick, early help and preventative support to children and families. The GP can refer them directly to our wellbeing team and we make a commitment to make contact with the parent or carer and family within two weeks. We have offered a whole-family support response, which has led to children not needing to be assessed by CAMHS, and to parents and carers feeling much more confident because they have support and they feel heard. They have somebody that they can talk to who is skilled in understanding the impact of poverty, adverse childhood experiences and trauma, and who can take a very recovery focused and social approach. That can have a real impact.

One of the challenges that we have is that these test, learn and develop initiatives, which can produce good evidence, are really difficult to take to scale because of a lack of funding or because funding is very short term. We need to fill that gap between universal services and very specialist services such as CAMHS with that whole-family support and community-based offer that any parent or carer, without stigma or shame, can reach out to and access quickly to get the support that they need.

Many parents talk to us about feeling that they are funnelled through a system where they are often offered labels and diagnostics for their children, but they are very rarely offered practical or strategic help to overcome some of the difficulties. Many children and families go through that process. They get a myriad of labels for their children but they are not left with long-term support to help them to manage those difficulties and recover from them.

Person-centred themes are really important. We need to humanise systems, put the needs of children and families at the centre of things, build in time, give skilled professionals the space and time to build relationships and allow them to focus on long-term recovery and improvement for children and families instead of having to deal with short-term issues such as getting people off waiting lists—which, as we know, leads to a revolving-door situation. If we do not get to the heart of the matter and address what is going on, people will simply re-present, and we need investment in early health, prevention and whole-family support services that is consistently applied right across the board in Scotland in order to understand what has happened and to help with recovery.

The Convener: Before I move on to Kirsty-Louise Hunt, I remind everyone that we have a number of themes to get through and that committee members will want to delve into the detail. We have an awful lot to cover in this evidence session.

Kirsty-Louise Hunt: There is so much to talk about that we could be here all day, convener, but I will be brief and simply highlight again the need for practitioners to have space and time. Indeed, that is what families tell us that they want. Family support is about getting alongside families and building up relationships, and I think that it is worth highlighting the challenges in ensuring that services are person centred, given the funding pressures, the short-term nature of funding and the insecurity that arises from having to think about the next year. That is a real challenge, and the situation could be improved.

I would therefore echo the comments made by Jacquie Pepper and others about the need to co-create change with families. We should also keep in mind the importance of The Promise and the need to ensure that the voices of children, young people and families are central to what we are doing.

Suzanne Shields: I will be brief, too, convener, and echo the point that a child or young person does not function without a family or support mechanism around them. The question from an occupational therapy point of view is: what can the family manage? We offer a practical solution to things that some young people find challenging and, as Mary Glasgow has suggested, we talk to young people a lot about some of the wellbeing issues that would routinely be referred to CAMHS.

The focus in occupational therapy is on, for example, ensuring that some of those children can return to school, and we are able to offer support in light of what the families themselves can manage. As occupational therapists, we provide support to get children to school every day until parents and young people are able to do that on their own. By working in that kind of graded way through analysing the various challenges and so on, we can give parents and carers of those young people a mechanism for addressing and breaking down the next challenge or task that they have to face to make it more manageable.

The Convener: Sandesh Gulhane has a quick question for Mary Glasgow.

Sandesh Gulhane (Glasgow) (Con): Thank you, convener. I could not agree more with the point about the need to fill the gap between universal and specialist care, but GPs like me struggle to know of all the organisations that are out there and all the forms of specialist care that are available. How can we ensure that people in primary care, health visitors and anyone else who might make referrals know that your organisations exist and can be accessed?

Mary Glasgow: That is a really good question. The first point that I would make is that there are just not enough of those services. There are two or three whole-family wellbeing services in Scotland, which is not enough. We get many calls from very distressed and anxious parents in other areas—particularly through parentline Scotland, which is our online, phone support and digital service—saying, “We’ve been to the GP, but they can’t refer us anywhere. Do you have any services to support families like ours?” The fact is that, although we can offer emotional support over the phone or online, we do not provide services in every community across Scotland.

We must ensure that those preventative first-step and early-help family support services exist. We welcome the Government’s plan to invest in whole-family support. However, that needs to be applied universally across the country. Organisations such as mine work closely with partnerships. We co-create partnerships with families, and work alongside schools and universal services so that professionals such as GPs and health visitors are aware of us. The onus is on us to ensure that those services exist, and that we co-create them, talk about them and publicise them.

09:45

In one of our services in East Renfrewshire, we are linked to every GP practice in the area. We have spent a long time getting to know the GPs and building relationships with them. From the perspective of an organisation such as ours, which takes a social approach to our work with families, it is reassuring that colleagues from the medical profession understand that what is required for some families is social support and not all those children will require clinical interventions.

We design those services, but one of the challenges that we face is that the funding, which we access from trusts and foundations, is usually very short term. We learn, develop and test new ideas, and we are dependent on evidencing that they make a difference. We then engage with our HSCP partners to get much-needed funding to take those services to scale and sustain them over time. It is not short-term work.

I know that the question was about ensuring that colleagues in other agencies know about the services, but the truth is that there are far too few of those services—they do not exist and that is why you do not know about them. The first thing that we need to do is to scale up the innovations that have made a real difference. We then need to engage with families, communities and local agencies to ensure that they know where the services are, how to access them and then build them together.

The Convener: We have to move on. I am sorry that I cannot let members back in to ask supplementary questions, but I am prioritising the evidence from our witnesses, which is fantastic, to give them more time to tell us their views.

Let us move to the issue of stigma, on which Emma Harper has a question. I ask members to direct their questions to particular witnesses as much possible. Witnesses should put an R in the chat box if they have something to add.

Emma Harper (South Scotland) (SNP): I have a couple of questions about stigma, which was one of the issues that Professor Hazel Borland mentioned in her opening comments. It is good to see you here this morning, Hazel.

I will cite one example in our committee paper relating to stigma. There is a summary from the Promise in August 2020, which talks about the language that we use and explains how we should not use stigmatising language. There are also specific examples of how to act, such as not showing up in branded cars wearing lanyards or in uniforms outside people’s homes or schools. Can Professor Borland talk a little bit about what actions could or should be taken to continue to tackle stigma so that families feel confident that they will not experience stigma when accessing help?

Professor Borland: Thank you for the question, Emma. It is lovely to see you, too.

Locally, we agree that it can feel as though we are at the beginning of the journey in turning around the issue of stigma and rectifying it. We need to consider our use of language, which is one part of a portfolio of areas where we are tackling stigma. We recognise that the narrative that surrounds care and care-experienced young people can be incredibly negative and, at times, can impact on the improved outcomes that we want to achieve for children and young people and how they connect with their support network and their families. We aim to use the Each and Every Child toolkit to turn that around. We are at the beginning of rolling that out. That has not happened in the way that we would have liked it to because of the impact of the pandemic and the need to reprioritise some of our universal services at this time. The toolkit will be instrumental in how we report the difference that we will be able to make.

We are closely focused on The Promise and the actions that sit underneath that. We are keen to make Ayrshire and Arran the best place in Scotland to grow up in, and that is about working really closely across services on health inequalities.

Poverty is a topic that we have touched on throughout the meeting. Poverty is incredibly stigmatising for families because it reduces choice. It reduces options and means that a child, young person or family cannot say yes to things that they might want to say yes to. Therefore, their world becomes much narrower, which can ultimately create incredible stigma around them. That can affect how they feel about themselves and how others perceive them.

How we tackle poverty collectively will be incredibly important. Although each local authority, NHS board and health and social care partnership will do what it can locally, I think that we would all agree that a national focus is needed.

How we approach care experience and care-experienced young people is also important. We need to hear their voices and understand what their needs are. We must also work with the champions boards to reduce the number of children and young people who need to be taken away from where they live to get that care, which is incredibly stigmatising and impacts on a child or young person's mental health, which then impacts on their physical health.

We are not as far along on the journey to reduce stigma as we would like to be. For me, that is because of the impact of the pandemic; we have had to prioritise activity. However, we are firmly focused on the issue, probably because we are now seeing the impact of the pandemic on all those things as well. That has made it even more important that we aim to prioritise the issue. I hope that has helped, Emma.

Emma Harper: It has—

The Convener: Heather Connolly and Kirsty-Louise Hunt want to come in on that question.

Emma Harper: Sure; thank you.

Heather Connolly: To reiterate Professor Borland's point, the language that we use is so important. When we are thinking about a multi-agency whole-system approach, we all need to use the same language when engaging with children and young people in the services to reduce that stigmatisation. Professor Borland is completely right. If children and young people feel stigmatised, that impacts on their basic need to feel safe and secure. If we lose those basic psychological principles, we will find it really hard to engage people in our services again.

Going back to an earlier point about solutions, we can overpathologise and overdiagnose children, young people and families. What we see is often just a normal human response to experiencing things such as poverty. We need to be aware of how we interact and engage with people in our services. That is really important in reducing the stigmatisation that people feel.

That links into person-centred support and care in services. We need services that are much more person centred. We need to allow people to tell their story and narrative, and we must really listen to them and validate them. Life is horrendous; there are so many difficulties. Trying not to overpathologise somebody—to see them as having mental ill health or being in mental distress—but listening to them and engaging with them in that way is so important in reducing stigma.

Kirsty-Louise Hunt: A really important point has been raised about stigma, particularly around the use of language. We would like to see a truly trauma-informed approach embedded throughout services that are supporting children and young people, particularly in education settings.

Barnardo's Scotland teamed up with Public Health Scotland a couple of years ago, just before the pandemic, to work on a video in which we asked education staff for their views on wellbeing and mental health, and for practical examples and tips that we could use for talking generally about that. That discussion needs to be done in a setting where people feel comfortable and are not being put in a tick box or, as Heather Connolly said, being pathologised or sectioned off and told that they have a particular issue and therefore they need a particular service. We need to see the whole person.

I will highlight an example from one of our family support services. Our nurture service in Inverclyde takes a "no wrong door" approach. We provide non-stigmatising holistic support, which is about seeing the whole person. The support is from pre-birth right up to the age of 18; we support parents and families, too.

The idea behind the approach, which is so important for tackling stigma, is that it is not about focusing on one particular issue. If someone feels stigmatised because they cannot afford to feed themselves as they have gas bills to pay and uniforms to buy for their children, we do not single out that aspect and say that we will look only at that particular issue. Our approach is to see the person, and the family, as a whole and not stigmatise them by putting them in silos.

We take a holistic approach: families will receive support and that relational aspect however they need it and for however long they need it. Similarly to Mary Glasgow, we want to see that service being scaled up, because there are family support services in certain areas but, unfortunately, they are not available to everyone universally across the country. That type of approach would really help in tackling poor mental health and wellbeing.

The Convener: That is great to hear, including that point about having no wrong door; it takes an awful lot for somebody to go through a door in the first place.

Mary Glasgow: This is such an important issue. One of the things that children, young people and parents talk to us about is the labels that different agencies give them. Parents will say, "If I go to the GP or the health service, I am a 'patient'. If I go to other services, I can be a 'service user'". Sometimes, they are just called "Mum". They describe feeling quite dehumanised by that, as they are not seen as an individual or a person.

There are simple things around language—I say that it is simple; I know that it is not simple. We are in the middle of redesigning our platform for hosting information and measuring the difference that we make to families. We are paying careful regard to the language that we use. In our systems, we are so used to using language that other people do not understand. What does it mean to be "referred", "assessed" and "reviewed"? That is not human language. It does not imply that people have agency within their own stories.

We need to start thinking about using much more humanised, kind and compassionate language. We also need to think about seeing access to support and services as a right. If we take a rights-based approach and say to people, "You are entitled to get support with some of these really complicated and understandable difficulties that are beyond your control," we remove stigma. With the children and families whom we support, much time is spent overcoming the shame and guilt that they feel about needing to get help.

When your child is not doing well—when you have a child who is anxious, distressed or not coping—those of us who are parents will recognise the need to ask ourselves: "What did I do wrong? What did I not do?" Feeling that way tends to be the first port of call. Parents carry that shame. Sometimes—inadvertently, without intent—our systems, our agencies and even our professionals can reinforce that shame because of the language that we use, as a result of our being under pressure and not taking the time to really listen to and reassure people.

One of the biggest things that has a significant impact is when you say to children and young people, and even parents and carers, "No wonder you feel like this—there is nothing wrong with you; this is an entirely appropriate and understandable response to some really stressful and difficult circumstances. There is nothing inherently wrong."

It is absolutely okay to express emotion and to feel distress and anxiety. One of the things that we need to get better at with children and young people from the minute they are born and from the minute we engage with parents and carers is helping people to name and share their feelings. If you can help children to say out loud what it is that they feel, they automatically feel slightly better and you can begin to move on. The shame, the stigma and the guilt need to be removed.

I echo the point that has been made about learning and development opportunities for professionals and about helping staff. One of the first things that we need to do is to think about how we feel and think about the people we support. We need to stop othering people and get right alongside them. They need and want the same level of respect, engagement, kindness and compassion that we do. One of the biggest barriers for people is being made to feel that there is something wrong with them or that they have done something wrong.

10:00

The Convener: I invite Jacquie Pepper to contribute, and we will then move to questions from Carol Mochan.

Jacquie Pepper: I will speak briefly, as I am aware of the time constraints that you are working to.

On the point about stigma, and thinking about this very complex landscape from a social work perspective, there is an entire continuum of support and protection, from very early intervention through to the management of complex risk, statutory intervention and the removal of children from their birth families. Stigma has a place there, too.

I echo what Mary Glasgow said: becoming a parent or a carer is one of the most difficult things that people can ever do, and there should be a recognition of that. It is a matter of having empathy with parents and with the family and of recognising that a continuum of support is required right through the system. How do we have strong, trusting relationships throughout the process? The relationships with families are key to that.

The Convener: Carol Mochan will now discuss health inequalities.

Carol Mochan (South Scotland) (Lab): I thank the panel for coming along. Much of what has been discussed has involved things that need to be done and support that needs to be given to address inequalities and prevention.

I want to pick up on a couple of things. In their evidence to us, young people said that lots of support is available when they are in crisis but there is not so much support available on the journey or on the way towards crisis. What do the witnesses think about that? Have you experienced that, and is there some way of looking into that?

I am also interested in hearing from the panel about how we deal with poverty and take a whole-family approach. I have heard about that before, but I would like a wee bit more information on that.

We talk a lot about Government investment, funding and finances, and I am sure that people have views on what we need to do there. What things do we need to do differently that are not just about the financial provision? Could the panel give a wee bit of feedback on that, too, please?

The Convener: Is there anyone you would like to pose that question to first? There is a lot in there.

Carol Mochan: I would be particularly interested in hearing from Kirsty-Louise Hunt about what kind of things people say they need before they are in crisis.

Kirsty-Louise Hunt: That is a really important issue. We hear quite a lot from young people and the Barnardo's Scotland staff who support them. It is at the tiers before people get to a crisis intervention level where support needs to be available. From recent engagement through the survey of school-based staff, which I mentioned, the clear feedback is that more investment in or better resourcing of early intervention is needed.

You also asked about the whole-family approach. We are talking about holistic family support. For example, Barnardo's Scotland has family support workers based in schools, and we are taking a wraparound approach. We want to be where children and families actually are. It is not necessarily about someone going to their GP and then getting referred, which can feel quite clinical and not rooted in their lives. What we want is investment in support at the early intervention stage to ensure that issues and problems do not escalate to a point at which more crisis intervention is required.

Obviously, we welcome the Scottish Government's plans for a whole family wellbeing fund over the course of the parliamentary session, but what Barnardo's Scotland really wants is an urgent action plan for getting that funding to front-line services, to ensure that we build up the intervention approach. As other colleagues have made clear, there is probably a lot of agreement about which approaches best support families. Indeed, families themselves have told us as much. It is not that we do not know what works; instead, the question is what action can be taken, particularly with regard to the impact of the pandemic and our response in that respect. As we continue to move through this pandemic and look to fulfil our promise to children and young people over the rest of the decade, we must focus on the actions that are needed to put in place the infrastructure and scaffolding that The Promise talks about, which will properly support the people who are themselves providing support to children and young people.

I am conscious of the time, but I hope that that addresses some of what you were asking about.

Suzanne Shields: We, in allied health professional land, work under the "Ready to Act" transformational plan, which the Scottish Government brought out in 2016. That is partly about ensuring that children and young people access services at the right time and in the right place, as well as what the right opportunities for them might be. It also sets out a much more tiered approach, with universal, targeted and specialist services. That is where we can look at having early intervention and prevention before families, children and young people reach crisis point.

With regard to universal services, for example, we are able to offer different workshops that parents can tap into across Scotland, which cover some of the common difficulties that children and families might experience. If parents can access that sort of thing quite quickly, as Mary Glasgow has said, it does not have to be a referral. In the new language, it would be a request for assistance, but the question is how that assistance looks to families.

There is also the opportunity to work with children and young people in schools and in education without the need for formal paperwork, and all the allied health professions—although I am obviously talking about occupational therapy today—can be used to support staff in educational establishments in providing interventions. That is one of the ways in which we can provide support before children and young people reach crisis point, because staff and parents are more aware of what is going on.

It is also about building a relationship with and ensuring direct access to the professionals around the young people in order to provide support before the crisis point is reached. They will know who they need to talk to, which will hopefully not only prevent any crisis but support the children and young people's long-term wellbeing.

Heather Connolly: With regard to health psychology and how our services can become a wee bit more psychologically informed to support engagement, we know how important early intervention and prevention are. Without them, we get a downward spiral and it becomes 10 times more difficult to engage with people and support them through the lower tiers. We must meet people's basic needs, including their basic psychological needs, before we think about the other services that are needed.

We also need to think about health-promoting environments. Children do not live in a vacuum. They might have had a fantastic conversation with a lovely and compassionate person, but they then have to go back out into a world that might be hitting them with stigma, discrimination and inequalities.

We need a whole-system approach to how we support people and to be a bit more psychologically informed about how we engage people, how we support behaviour change and how the system can change itself. We are talking about a massive system and, in itself, it is complex to support that to change and adapt to meet the needs of children and young people at an early intervention and prevention level. We need to get to people at that point. If we capture them too late in their distress or the difficulties that they experience, they end up in a revolving door, as Mary Glasgow said.

What everybody has said is important. I am aware of the time, so I will not talk too much.

Jacquie Pepper: The question about what more we can do on early intervention and to avoid a crisis is great. I will give two practical examples.

I am thinking of a transformational service redesign that moved away from providing residential care for young people who could not be held in their families or their own communities. That piece of work created a team to provide intensive family support for 12 to 18-year-olds. That support was provided 24/7 but primarily in the evenings and at weekends, and it was about providing support when families and young people most needed it. That is a practical example of thinking about what more we need to do and not necessarily continuing to provide services in traditional ways. If we are really listening to families—through both what they tell us and how their needs present—we need to design our services in a way that best meets their needs and not just continue to provide them in traditional ways.

I mentioned the increase in concerns that has come about as a result of the pandemic. A small example of that relates to providing immediate access to family support workers—that is, family and parenting support—in the family home through the child protection and duty team. All that was required to refer families for whom such support was relevant to a family worker was two part-time workers working with 30 families who would otherwise have gone through a risk assessment and through the child protection procedures. Only one of those 30 families has moved on to a referral to the children's reporter. That gives you a sense of the scale and value of putting one family support worker into such a high-end crisis intervention and what it can result in.

Those are examples of what more can be done, thinking about what works with families and where we perhaps need to put in additional resource.

Mary Glasgow: I will make a couple of brief points. The case for the links between poverty and health inequality is well made, but we have not made the shift to prevention that we should have made, and we need to think seriously about that. As far back as the Christie commission, we identified the need to shift away from crisis management and take a public health approach to ensure that we address the pillars of inequality, which include poverty. Moreover, for many of the children we support, the adverse childhood experiences that their parents and carers have experienced lead to stresses before they are even born that, without a focus on recovery, just make things worse.

We are also seeing particular concern about growing inequality for children and families with additional support needs such as mental health needs and disability. That is particularly the case for black children and families or families of colour, whose needs must be better represented and understood. There also needs to be better connection to their communities about their specific wants and wishes for the type of support that they have. Scotland's population is growing more diverse, but that diversity is not always reflected in the way that we design services. So, on inequality, I would highlight a couple of those specific needs.

The Convener: Thank you. That is helpful.

I apologise to Carol Mochan, but we have to move on. I thank her for rolling all her themes into one question, which was helpful. With that in mind, we move on to dig deeper into child poverty issues. Does Evelyn Tweed want to pick up on some of the points that have been made in that regard?

10:15

Evelyn Tweed (Stirling) (SNP): Yes. Good morning, panel, and thank you for all your contributions so far.

Last week, the Office for National Statistics said that the gap between the rich and the poor is the largest for more than a decade. We have an energy crisis and food prices are rising. What does that mean for child poverty and for our children's health and wellbeing? I pose that question to Mary Glasgow.

Mary Glasgow: Thank you for that question—it is incredibly important, and I totally concur with the view that child poverty is going beyond anything that we have ever seen before. It was a problem before the pandemic, but the pandemic has exacerbated it.

Quite simply, the impact on children and families is like nothing that we have ever seen before. I have been a social worker for 30 years, and I have never known children and families to be in such dire circumstances. They simply do not have enough money in their pockets to manage a decent standard of living. We need to get money into the hands of children and families quickly.

Over the pandemic, support from the Government was going directly to organisations such as Children 1st, enabling us to give parents direct payments in cash. We have talked about a revolving door. The shame of poverty can be distressing, and the challenges in our security system, given the way in which it is built, can make the system very difficult to navigate. We find that, through the money wellbeing services that we provide, our money advice workers, who are trauma informed and trauma responsive, can very quickly help families to access huge amounts of benefit that they are entitled to but have so far not been able to claim simply because the system is so complex. That amounts to literally hundreds of thousands of pounds' worth of additional benefits going into the hands of families, which is what makes the biggest difference. Despite the rhetoric that we often hear in the media, parents and carers, when they have money, make really good choices to ensure that children are provided for.

We have to address poverty in a sustainable way. It is getting worse—it causes terrible distress for parents and carers, and it impacts directly on the experiences and opportunities of the children and young people who are living in poverty. They do less well in school, as it is very difficult for children and young people to go to school and concentrate on learning if they have not had breakfast and they are worried about what they are going to eat when they get home. It is very difficult for parents and carers to be available and to give their children all the warmth, love, support and care that they need if they are really anxious about their ability to pay their utility bills, to buy enough food or to pay the rent.

We are seeing significant and growing concerns, so we need to make some progress. We welcome the measures that have been taken, but they are simply not enough. We need to design a system that does not make children and families jump through all sorts of hoops to get access to money. We have been able to give payments to families directly to enable them to clear debt, which immediately reduces distress and puts more money in their pockets to buy things like new fridges or washing machines when an appliance is broken and to put petrol in their cars in order to get to medical appointments. Those are really significant things.

One of the challenges that we face is that Children 1st has five money advice workers based in our services, which is not enough. We need community-based, trauma-responsive and trauma-informed, and well-trained money advice workers in every community across Scotland to ensure that families get the help that they need and to get the money to which they are entitled in their pockets as quickly as possible. However, we also need to address the other issues around child poverty. We understand that those issues are complicated, but we need to do much better. The problem is that what we are seeing is beyond anything that was experienced before, which is a real concern, particularly this winter, with the rhetoric around increased utility bills. We know that families are really worried about that.

The Convener: I heard this morning that gas bills are going up by 500 per cent, which is shocking. Whatever the Government is doing to mitigate that, it will not be enough to cover such an increase.

Heather Connolly: I was thinking about how people's basic needs require to be met for them to have the flexibility and space in their brain to engage with services. If we do not target poverty and child poverty, all the other money that we are spending on services and early interventions will not work as well. People will not be able to engage with those services, because they will still be too worried about getting food on the table or getting clothes for their kids in order that they can go to school. They will not feel safe and secure or a sense of hope that things will get better; therefore, they will be unlikely to engage with services or professionals.

We need to consider that issue. There is no point in having all the other interventions without the cornerstone of supporting people and meeting their basic needs—including their basic psychological needs—to enable them to thrive and flourish.

Professor Borland: Colleagues have articulated very well some of the points that I would have made. In Ayrshire, the most recently published data says that we have nearly 16,500 children living in poverty, and two of our local authority areas have the second and fourth highest rates of child poverty. Across all three local authorities, the rate ranges from just under 25 per cent to just under 28 per cent, so it is a significant issue.

The pandemic has had an unprecedented impact. Colleagues in public health have described Covid as a disease of deprivation and poverty. If someone was already on that journey and in that sphere, unfortunately, Covid will have exacerbated the situation beyond all belief. Prior to the Covid pandemic, child poverty levels were forecast to increase significantly, with relative poverty reaching 38 per cent by 2027-28. We have a short timeframe in which to make a difference, and the pandemic has brought the issue into sharp focus.

Our local authorities in Ayrshire and Arran are focused on the issue in the way that Mary Glasgow described. The community-based advisers work closely with third sector colleagues and families across some of our localities to ensure that families, children and young people are accessing anything that can make their lives better and easier in the way that they should expect. It is not a favour that we are doing for families, children and young people; it is what they should be able to expect in terms of their right to a certain standard of living. Therefore, it is about taking a rights-based approach. The issue is a significant worry.

The Convener: I will go to Kirsty-Louise Hunt and then back to Evelyn Tweed for a quick question.

Kirsty-Louise Hunt: I am conscious of the time, so I will be brief. Others have articulated the points exceptionally well, and I agree with everything that they have said.

I will highlight a couple of examples. Evelyn's question was about what the situation really means for children, young people and families. It is not shocking to us, although it should be, that, on many occasions, parents come into the service having not eaten for the past few days because they just did not have the cash. Therefore, measures to increase incomes are very important. As others have mentioned, that aspect is crucial and it underlies a lot of the other issues due to the stress that it causes, the stress that it puts on family relationships and the mental health problems that it causes.

My other point relates to a piece of research that Barnardo's Scotland did in partnership with the NSPCC. The research was carried out pre-pandemic, which is concerning, because, in a 2019 survey of our family support services, we found that, since 2014, the level of support had decreased while the level of need had increased. Poverty was a core issue for families, and the level of destitution had increased. From our services and the families we work with, we are finding that the pandemic has made the problem all the more acute.

I want to drive home the point that poverty is a core issue that affects the children and families we work with.

The Convener: Thank you. Evelyn—you may ask a quick question.

Evelyn Tweed: Thank you for your patience, convener. I have one very quick question. I am conscious of the recent cut to universal credit. I want to know whether it, too, has exacerbated child poverty. That question goes to Mary Glasgow.

Mary Glasgow: Yes, absolutely. I totally concur that the cut has exacerbated child poverty. Removing financial support from families who are already struggling gives them, first, a clear message that their poverty is not important and, secondly, makes their life a lot more difficult. So many of our families who are queueing up at food banks and are waiting to get enough food to eat are coming to us through our parentline service, which is available online and over the phone and is accessible to all parents and carers in Scotland. We often receive calls from parents who say that they do not have any food in the cupboard; we are able to get vouchers to them or to send out workers with bags of shopping.

The cut to universal credit has made a huge and significant difference. It has not only made a material difference to the amount of money in people's pockets, but has sent a message to children, young people and families about how society views their needs. Showing that society takes that view of them has increased shame and guilt for families who are reliant on benefits or are in need of extra support—often for very complex reasons.

The way the money was withdrawn was brutal and unfair and has had a huge impact on the children and families whom we support—not only practically and financially, but emotionally. The parents whom we support are not immune to that, and it induces more shame, guilt, embarrassment and, often, reluctance to ask for help. We see parents who regularly do not eat in order that they can feed their children, and parents who do not have the money to buy basic things, such as children's coats and shoes. Especially when there is cold weather, we hear a lot from families about their inability and reluctance to put the heating on, because they are absolutely terrified about the increased bills that will come.

The Convener: From the committee's perspective, health outcomes also suffer as a result, so the point is very well made.

Sandesh Gulhane is having problems with his connection, but I hope that he is here.

Sandesh Gulhane: I am here and I hope that my connection keeps working.

We could spend the entire time that we have on the topic of Covid-19, but I know that time is short. At the start of the evidence session, we heard about the loss of socialising for kids and the loss of the ability—which we all had—to make mistakes and errors as children. We know that there has been a huge impact on all services. I know that this will be hard to answer. What impact will Covid have on our young people's current and future development? What should we do to mitigate that? What services should we set up in the future? Those three questions go first to Heather Connolly and Jacquie Pepper.

Heather Connolly: Social connectedness has been lost to all of us, not just children and young people, throughout the pandemic. However, the closure of schools and nurseries on children and young people has made it really tough and difficult for them to learn how to make friends and deal with the difficulties of social interactions. I have a one-year-old and a four-year-old, so I see the impact on them of the lack of social contact—not just with friends, but with family members—during the pandemic. That inability to engage has impacted harder on the children and young people who have the most health inequalities and are in most poverty.

10:30

We are seeing delayed development and delayed social skills; we have all spoken throughout the meeting about the need to understand the whole system and about how we can use it to approach, engage and interact with our children and young people to support and build those skills to combat that delay. The early intervention framework includes a lot of psychologically informed evidence-based interventions around how to support children in the early years to build on those skills and to build confidence and self-esteem—the basic psychological principles that we need in order to grow and to flourish.

As services and as communities, we need to think about how we can engage with the people whom Covid-19 has impacted on most in terms of social skills. We also need to think about the whole system and the whole environment around how we support people and how we become a wee bit more psychologically informed about how important acceptance, trust and normal relationships and the impact that they have are. Social contact is so important to us as humans, so it would be beneficial to think about how we can build confidence and self-esteem—as well as awareness of all the emotional and psychological impacts—through our systems and our interventions.

Suzanne Shields: Heather Connolly has spoken about the social aspects. From an occupational therapy point of view, we see the physical impact of children not being able to participate in activities. We have children who are at risk of physical limitations and children with more complex neurological conditions, so we need to consider what missing basic things such as running around the gym hall does to children generally. Children have now been back in education for quite a while. However, they have been in small bubbles and have been mixing with only five or six other children, or maybe up to 10, and have been missing out on things like running around the gym hall, which sounds like a simple thing, but it develops balance and co-ordination. You need balance to get dressed—you need to be able to stand on one leg to put a sock on or to pull up your trousers—so that lack of physical development has an impact. People need to practise the gross motor movements that we then develop and refine into finer motor skills. Children need to be able to handwrite and to use cutlery. The developmental sequence means that they have to do all the gross motor activities before they are refined into finer tasks.

We are not yet seeing the full impact on some young children, but we will see it as we go further down the line. We see a lot of children and support them through occupational therapy already; we will see more and more children who would not normally have come through our door. They will come to our services through having difficulties with movement, co-ordination, handwriting and the activities of daily living, including how they get dressed and how they access things. There has been a big impact from lockdown lack of activity, lack of meeting others and lack of going to school. That is just a small snapshot of the developmental concerns that have been highlighted.

Mary Glasgow: One way to look at this, as people have said, is to look all the way through the developmental life course, from pre-birth to adolescence, and moving into young adulthood. Children and young people have been hugely impacted. We hear of babies who were born during the pandemic who have only seen people out and about with masks on and are unable to read facial expressions and do not really know that other people are warm and friendly. There are babies and toddlers who are reluctant to go to nursery or to begin to move through important social stages because they have been so closely cared for by their parents and carers at home. We will be seeing the impact of the pandemic for a long time to come in relation to socialisation and the ability to move through development stages.

We also know that the major issue for us all, and for children and young people in particular, is loss. We have lost many normal opportunities to socialise and be together, and to develop and test our skills as humans. We need to think about how we can invest in a whole programme of social and emotional recovery focused activities that will enable us to spend time with children and young people, and with families, reflecting on what has happened, identifying the impacts and working with them to think about what would help.

Children 1st finds that some of the young people whom we support, whose families are living in poverty, face complex additional challenges including drug and alcohol issues, mental health problems and challenging relationship problems or domestic abuse, which have been exacerbated by the pandemic. We need to think about a raft of supports being available and easily accessible to help people to think about repair and recovery—not just from the pandemic but from all the challenges that they were already experiencing.

One of our biggest concerns as we move forward is the country's ability to continue to invest in important services. That is a big worry; we are really worried and are hearing some worrying things about funding. Some support services were already underfunded; they were already limited and hard to reach, and they are almost the first things to go. We continue with the cycle of investment in crisis intervention because that feels like the most important thing, but we need to think about prevention, and about repair and recovery for children and young people.

We need to invest in youth work and in ensuring that every child and young person, regardless of their family circumstances or economic situation, can access local community groups. They need to be able to join sports clubs and go to the scouts or the brownies—the things that help children and young people to develop independence, skills for adulthood, confidence and all the ways in which we operate as humans when it comes to getting jobs and making the country work.

We need to focus on repair and recovery, and we need massive investment in social opportunities and activities to ensure that we help children and young people to feel less isolated and more connected to their peers and communities.

Professor Borland: Mary Glasgow has just articulated the situation beautifully. In Ayrshire, we are focusing in particular on developmental delays in our infants. Data from 2019-20, just before the pandemic, demonstrated that, at the 27-month to 30-month review stage, 17 per cent of infants who were reviewed were found to have a developmental delay in at least one domain.

There is no doubt—for all the reasons that colleagues have described—that developmental delays across all domains will have increased, so we need to look at how we provide support and make things better. We need to think about the ability of our universal services to pick up on developmental delays—for example, through our health visitors and family nurses—and we need to ensure that we have in place the mechanisms through which to support improvement. In the main, that involves the allied health professions. Speech and language therapy, occupational therapy and physiotherapy for children and young people are ways in which we can exert an influence. It is all very well to identify developmental delays, but we then need to provide the support to ensure that delays are minimised and we need to bring about improvement. That is my key point.

Jacquie Pepper: We have all spoken about isolation and social connectedness. From the social work perspective, there was a focus during the pandemic on ensuring that children who were seen to be at risk and highly vulnerable were seen face to face. That was measured weekly by the Scottish Government and the Society of Local Authority Chief Executives and Senior Managers. Our practice across Scotland has shown that, through the lockdowns and restrictions, social workers in particular made extreme efforts to see children face to face, either in the family home while using personal protective equipment, or by going out for walks or making garden visits. Relationships have been strengthened as a result of that.

However, other opportunities have been less available to children and young people as they move towards independence, so we need to think about what that means for them. I refer the committee to a number of pieces of research. CELCIS—the centre for excellence for children's care and protection—produced "The impact of COVID-19 on children and families in Scotland: Understanding needs and services through local social work data". That report indicated that, despite all the on-going work that I have mentioned, 77 per cent of care-experienced children and young people who responded to a survey by Who Cares? Scotland said that they felt

"that they had received less support".

That included support from teachers, college lecturers, social workers and doctors—whoever it might be. That was the experience of children and young people; we are hearing that very clearly. They describe feelings of worry and anxiety, vulnerability, depression and being tired. My point is that it will take some time for those children and young people to be ready to move into group activities.

That brings me back to the previous comments about what that means for the workforce. Across the whole children's services workforce, in its broadest sense, we need to enable staff to spend time with families and young people. We also need to think about the longer-term impact and how young people recover from that. For example, we need to consider how we support for longer—in order to enable them to recover and heal from their experiences—young people who are furthest away from universal support and from opportunities such as the Duke of Edinburgh's award scheme, which are highly motivational and successful in ensuring that young people achieve and move on in life. That is the question.

The Convener: Sandesh Gulhane has a very short question directed to one of our witnesses. I must move on after that, Sandesh, or else we will disadvantage two of your colleagues.

Sandesh Gulhane: Thank you, convener. I will go straight back to Jacquie Pepper. When we are teenagers, we do silly things. We have all made little mistakes and errors, but that is how we learn, so that when we become adults, we do not make the same errors. Teenagers have lost that opportunity. What do you think the impact will be on that age group?

Jacquie Pepper: As we moved into spring and summer last year, we saw young people beginning to gather together and get involved in what might be described as antisocial behaviour, because they were using alcohol and so on. There is a real concern, not only for me in Perth and Kinross but nationally, about what the situation means for young people's interaction and how they engage with each other positively and meaningfully and avoid difficult situations.

We saw such behaviour in some of the cities, but we also saw it in rural areas like Perth and Kinross. We developed a detached youth work team to go out and engage with young people on the streets, in parks or wherever they were gathering, because they were drinking and getting into difficulties as a result. We tried to turn that around and provide diversion by engaging young people in activities, including physical activity such as football.

We need to think about young people who have been more distanced from positive experiences, and ensure that they are re-engaged in activities and do not head off without such experiences. I think that that is what Dr Gulhane is suggesting. There are ways in which that can be done, but we are heavily dependent on our workforce to do it all, and they are under pressure. They are dealing with greater demands, but we are also experiencing recruitment difficulties in some areas.

10:45

The Convener: We have only about 15 minutes left, and there are two remaining themes to cover. Therefore, I ask colleagues not to ask a question followed by a supplementary but instead to roll everything up into one question, if they can.

David Torrance has a question about online content and social media.

David Torrance (Kirkcaldy) (SNP): Good morning. How does the amount of time that children and young people spend on social media affect their health and wellbeing? Online bullying has an impact on young people's mental health. Has that increased during the pandemic? What more can the Government and public services do to highlight the dangers of social media to young people?

Kirsty-Louise Hunt: Again, those are important questions. I do not have to hand specific data on whether there has been an increase in online bullying. However, the surveys that we have conducted with staff in schools who work with young children reflect the fact that there has been an increase in online activity during the pandemic, because of social isolation.

Obviously, social media and online communication are tools and, although it is important to ensure that children are safe, there can be positive aspects to them, such as the ability that it gives children and young people to use video calling to keep in touch with friends when they are isolated during lockdown.

Barnardo's, as a UK-wide organisation, has some concerns about the forthcoming online safety bill. We are looking for further strengthened safeguarding protections for young people in relation to their ability to access harmful online content. We want to ensure that proper and robust age-verification processes are in place so that young people do not access age-inappropriate material.

There is a lot that the Scottish Government can do to raise awareness about internet safety, and it can ensure that it speaks to parents about that.

The surveys that we conducted following the return to school showed that teachers felt that young people are spending more time online than they were before the pandemic. More research needs to be done to establish whether that is leading to harmful impacts in terms of bullying, which you mentioned.

It is widely documented that, although social media can be a positive thing, there are negative aspects around peer pressure, children comparing themselves to others, the use of social media photo filters and so on. We want young people to be equipped with the knowledge that will enable them to differentiate between the online world and the real world.

I hope that that answers some of your questions. I would be happy to follow up with details of some of our research.

The Convener: That is always helpful. If anyone wants to add anything in writing afterwards, we would welcome that.

Suzanne Shields: I think that social media have their place. They are how children and young people make connections and communicate—that is a fact of life. I suppose that the issue that we face is about making it safe for them.

We want to ensure that children and young people receive trusted and safe information. Our organisations have a responsibility to provide up-to-date and relevant information to people who come to us with questions. I think that young people and their parents are unlikely to do vast Google searches and might end up getting information that is not up to date. Therefore, across Scotland, we have looked at creating bite-sized pieces of information that parents and young people can access if they have questions about, for example, how to reduce their anxiety or about practical tasks such as how to do up their buttons. The hope is that, if they can access information in a place and at a time that suits them, they will be less likely to go and look for other sources of information.

That kind of thing is about trying to make the online world safe for young people by providing trusted sources of information. Certainly, however, there needs to be more scrutiny of the area, and online safety legislation might help to secure the safety of children and young people. We need to quickly address the problems that young people have so that they do not go and get information that is not up to date and might be irrelevant or harmful

Mary Glasgow: To build on what has just been said, I note that, for many children and young people, the ability to connect online through social media was a lifeline during the pandemic. That was how they connected with each other and how most of the ones we were supporting were able to connect with us. It was also how we were able to keep eyes on children we were worried about in the early days of the pandemic. Social media have their place, and have been really useful.

We have to measure and balance what we are saying to children and young people about their social media use, given that we are talking to them in a context in which, for good reason, we expected them to engage with online learning and be looking at screens for many hours of the day in relation to many aspects of the pandemic.

One of the things that we have got to do now is to wean children and young people off social media by giving them exciting alternatives. They have nothing else to do; that is why they spend all their time on social media. Many of the children who we support live in poverty and do not have parents who can pay for enjoyable but expensive outdoor activities. We need to think about how we support children and young people to make better choices. We need to help parents to do that, too. We do whole-family support work where family relationships are breaking down. That usually involves teenagers, but the age range is getting younger. Most eight, nine and 10-year-olds now have their own mobile phones or iPads. We spend a lot of our time with parents and young people helping them to negotiate social media use and screen time in a way that does not break their relationships.

We need to help parents to find ways to talk to children and young people. We also, as adults, need to model better behaviour around social media. We all probably spend far too much time on our phones now because that was all we had during the pandemic. We need to find balanced, positive ways to support children and young people to access better alternatives.

There is definitely an increase in social media use. It is almost like an addiction for lots of children and young people now. For many whose social skills and confidence have been impacted, using social media is an easier and more comfortable way to have some sort of social interaction. Again, we need to think about what sort of alternatives we can build for children and families.

On online safety, particularly when it comes to sexual exploitation and what children are exposed to, we need to place a much greater responsibility on social media companies—they need to take that much more seriously. It is literally everybody’s job to make sure that children are safe and social media companies are not doing enough. We hear of very young children accessing harmful information or seeing things that they are not necessarily looking for but which they come across. That is a concern, and we must find ways of addressing it.

The Convener: We must move on. Paul O'Kane has questions on public health priorities. Paul, you can take us up to 11 o'clock, and I might be able to give you a couple of extra minutes. I am sorry that you are coming in at the tail end of a long session.

Paul O'Kane (West Scotland) (Lab): Thank you, convener. In some ways, ending the session on the subject of public health is quite helpful, because a lot of what we have spoken about this morning is about the need to make interventions in the lives of children and young people. This committee is focused on what positive interventions in terms of policy and legislation can make the most difference.

From a public health point of view, I am keen to understand what interventions the witnesses feel will make the most difference to tackling obesity, drugs and alcohol misuse and non-communicable diseases later in life. How do we get to a place where those interventions are not stand-alone or in a silo but provide holistic family support and work across themes? Someone mentioned there being no wrong door. That is key to the situation. Perhaps we can consider those themes to take us up to our time.

Mary Glasgow: As we have heard, one of the biggest challenges that we have and one of the measures that will make the biggest difference is addressing poverty. Poverty underpins all the other public health challenges and inequalities that we have talked about, so an important place to start would be a real drive to address it and to ensure that we do not forget the links between health inequalities and challenges that cost us in the long term but are started and underpinned by poverty.

We have talked a lot about the importance of normalising the need for support with child rearing. Many of us have many supports on which we can call, whether in our communities or in our extended families. Those really help us to raise our children, because it is challenging at times for most families. However, many of our families and communities do not have such existing networks, so the investment in what we have described as whole-family support is crucial to address public health inequalities. It is crucial to ensure that that support is informed by understanding poverty so that it gives practical offers to families that enable them to access early help and support easily without stigma or having to jump through hoops or be bounced around different agencies and systems.

It is also crucial to ensure that professionals understand the impact of childhood adversity and trauma on parents and family life. People are recognising that many of the reasons that parents and carers use drugs or alcohol or have mental distress are rooted in childhood experiences from which they have not had the opportunity to recover.

Good-quality whole-family support is practical, emotional and financial help to strengthen family relationships. The biggest message that Children 1st wants to give on behalf of the families that we support is that the parents and carers we support love their children. They want their children to do well. They just have many more challenges than the rest of us to overcome and there are no easily accessible supports to help them to overcome them.

We need to focus on, and get passionate about, delivering The Promise. We need to take a rights-based approach through the UNCRC. We also need to ensure that every child, young person, parent and carer can ask for help in a non-stigmatised way and get support in a way that makes sense to them, is kind and compassionate, is child centred but family minded and recognises that children live in families, families make up communities and communities are the backbone of our society.

We need to invest massively in the whole-family support that we described.

Heather Connolly: I will fly my little health psychology flag, because what we have all spoken about is really behaviour. Whether it is the behaviour of the workforce, who are trying to engage and deliver person-centred care, of the systems that are trying to change and adapt to meet the needs and requirements of children and young people, or of policy makers, who are making the decisions about what policy and interventions are best to deliver certain changes, it is all behaviour change.

If we can pull on a lot of information, knowledge, theories and models from behavioural science and health psychology, we will be more psychologically informed about how we deliver services. We will be more likely to see positive outcomes because that pulls on the basic principles of how we listen to, support and collaborate with people rather than telling them what to do, how we support them to problem solve and think of their own solutions to the problems that they experience and how we instil hope, acceptance, trust, security and safety in the systems that support people. If we can do that, people will be more likely to thrive and flourish within those systems.

That is a little bit of self-promotion. I am sorry.

11:00

The Convener: Paul, we could maybe round off by asking the panel members what to focus our efforts on in particular as a result of everything that we have heard today—are you happy for me to pose that question on your behalf?

Paul O’Kane: Yes.

The Convener: Thank you. Obviously, it has been a broad session. What can we do as a committee to drill down with regard to children and young people’s health outcomes? Where can we add value?

Professor Borland: That is an excellent question. We have heard from everybody today how poverty impacts on everything, so my key messages are about doing whatever we can to tackle poverty and the way in which it impacts on children, young people and families and about taking a whole-family approach.

Heather Connolly: My response is very similar, and it is probably very similar to what all my other colleagues will say. Tackling poverty is key. All our basic needs, including our psychological needs, need to be met in order for us to develop and thrive—that is so important.

Mary Glasgow: I would highlight poverty, first and foremost; the need to underpin that investment in whole-family support; and the need to bridge the gap between universal services and acute services for children who are emotionally distressed. Most importantly, the committee can add value by scrutinising the delivery of the Promise. The Promise is a thing of beauty; it makes a strong commitment to the children and young people of Scotland. It needs to be delivered and it needs investment for that to happen. One way in which the committee can add value is to make sure that we deliver on The Promise that was made to children and young people that, where they are loved and safe, they must stay within their own families and that the country must do all that it can to ensure that parents, carers and families get all the emotional, financial and practical support that they need in order to fulfil that commitment. We also need to maintain a focus on repair and recovery from the pandemic, which has been a collectively traumatising event. Those would be my key asks.

Kirsty-Louise Hunt: I would echo what others have said, particularly on the issue of poverty. One issue that we have talked about throughout the session is the need for properly resourcing early intervention and investment in family support, which is key to shifting our focus towards prevention. Also, as Mary Glasgow just articulated so well, we need to focus on making sure that The Promise is kept. The committee could have some good input on making sure that that remains a focus for this parliamentary session.

Jacquie Pepper: From all those contributions to your insightful question, I would just echo that the approach should be to strengthen families within the community; it is about securing children within the families they live with and the communities they live in. Also, there needs to be that focus on doing what really works for families, in a non-stigmatised way.

Suzanne Shields: I think that poverty is the issue, but let us give children and families access to free physical and leisure activities, with support in place. Let us give children and young people somewhere to play, to have fun and to thrive with support, so that they can recover from the pandemic.

The Convener: Thank you all for everything that you have told us this morning. As usual, we could go on for a lot longer, but we must break now. We will suspend the session until 11.15, when we have more evidence to take on another issue.

11:04

Meeting suspended.

11:17

On resuming—

Transvaginal Mesh Removal Reimbursement Scheme

The Convener: Our third item is an evidence session with the Scottish Government on the draft transvaginal mesh removal reimbursement scheme, which the Cabinet Secretary for Health and Social Care sent to the committee in December 2021, and which, of course, comes off the back of our scrutiny of the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill.

I welcome back to the committee Greig Chalmers, head of the chief medical officer's policy division; Terry O'Kelly, senior medical adviser; David Bishop, mesh team leader; and Ailsa Garland, solicitor. I thank you all for your offer to come back to take us through the scheme and some of the issues that we raised in our stage 1 report.

I will start by asking you to take us through the crowdfunding issue, which came up when we took evidence on the bill. Some of the women affected crowdfunded for their surgery, and we had questions about how people who had gone down the crowdfunding route might be dealt with.

I am not sure who I should go to first. Perhaps Terry O'Kelly could explain how crowdfunding will be dealt with. However, if you want to defer to anyone else, please do so.

Terry O'Kelly (Scottish Government): Thank you very much, convener, and welcome from Aberdeen. If it is not unreasonable to say so, as that is a policy rather than a clinical issue, I think that it probably best that Greig Chalmers responds. I do not want to steal his thunder.

The Convener: Over to you, Greig.

Greig Chalmers (Scottish Government): Good morning and happy new year. I am very pleased to come back to speak to the committee about the bill and the reimbursement scheme.

I will turn directly to crowdfunding, which was one of the issues that the committee raised in its stage 1 report. We gave consideration to the different circumstances in which individuals will have received money from other people to help meet the costs of mesh removal surgery. The Government's conclusion was to distinguish between private arrangements and arrangements that were, in essence, public. I recall that the committee discussed that with the cabinet secretary.

In relation to arrangements that were private—for example, between family members—it seemed to the Government most sensible not to get involved and to allow those family arrangements to be dealt with privately and for any moneys granted to be distributed privately between family members. Families come in all shapes and sizes and have different arrangements. That was our view on that aspect.

In relation to public and quasi-public arrangements, as is addressed in the reimbursement scheme, where moneys have been raised publicly through a recorded, quasi-public route such as a crowdfunding website, we thought it reasonable to expect applicants to declare that they have received moneys through such routes.

That is in part because crowdfunding websites will generally have recorded what has happened. Even if individuals did not retain the receipts or documentation at the time, that information is recoverable—it can be got from the organiser of the website. In those circumstances, we think that it is reasonable for those moneys to be declared.

It is also partly because, where private people made voluntary donations to the costs of somebody whom they know—albeit perhaps distantly or through social media—the Government considered that it is reasonable that those individuals did not expect to get the money back and that it was a purely charitable donation. That is the balance that we came to on that aspect. That is recorded in paragraphs 17(1) and 17(2) of the scheme.

The Convener: Of course, people might have raised funds from various sources.

Before I allow my colleagues to come in, I have a question. How will we make sure that the process is not overly burdensome for individuals, some of whom are recovering from surgery? How will you facilitate the process so that they do not find it a burdensome task?

Greig Chalmers: That is a very fair point. One thing from which we take encouragement is the fact that NHS National Services Scotland, which will operate the scheme, has a fair amount of experience in that area. I will give an example. When individuals have been making applications to the existing Scottish Government mesh fund, there have been occasions when applications were, for one reason or another, incomplete—possibly for the reason that the convener gave. In those circumstances, NSS has worked with people to get additional information to make sure that the application is complete.

We and NSS certainly plan to proceed in the same way with the scheme. The applications will be made in good faith and sincerely. If it so happens that there are issues with the information that is provided, whether in relation to the aspect that has been mentioned or whether in relation to something else such as travel receipts, we will make best endeavours to support people to find, or to help us to find, the information that they need

The Convener: Okay; thank you very much. I will pass over to Gillian Mackay, who has questions on the scheme's flexibility.

Gillian Mackay (Central Scotland) (Green): Can the witnesses provide more detail on the exceptional circumstances provision at paragraph 16? Can you provide an example of circumstances that may require that provision to be used?

Greig Chalmers: The purpose of paragraph 16 is to give the administrator—NSS—the scope for flexibility that it needs in relation to all the different circumstances that will have transpired with regard to people travelling some way to get their surgery, whether in the United Kingdom or internationally.

On specific flexibilities, as the committee would expect, we specify in the scheme that reasonable travel costs are, generally speaking, economy-class travel or standard-class hotel rooms that one would ordinarily use. However, one cannot know all the circumstances that will be involved in each situation.

For example, if it so happens that, for one reason or another, there was no standard-class room available in the hotel in the United States during a particular period, or that it was necessary for somebody who was in particular pain or discomfort to upgrade their air transport so that they did not travel by what we would all understand as economy class, NSS would, if the circumstances were reasonable and the explanation made sense, have the flexibility to pay that bit more.

The provision is to give NSS the commonsense flexibility to take account of things that have happened outwith the applicant's control.

Gillian Mackay: Given that many of the women who travelled did not expect to be reimbursed, do you believe that there is sufficient flexibility to address the many different situations that may arise, to ensure that anyone who claims under the scheme will be covered?

Greig Chalmers: We certainly hope so. For example, we are conscious that it is very likely that individuals will not have kept receipts—why would they?—for meals, taxis and other items that, although they are small individually, will add up in aggregate over a few days, or up to a week, when people are travelling. We hope that, for smaller items for which people will not have kept receipts, the provision for exceptional circumstances will be wide enough.

It is reasonable to expect that, even if people did not keep plane tickets—indeed, people do not get plane tickets these days—or receipts, they will, for large expenditures, be able to draw on bank statements. Given that we know where the surgery has taken place, if it so happens that people have not kept receipts for the surgery costs—I expect that they probably will have—we would be able to get that information from the surgery provider. In general, we would hope that there is sufficient scope to cover exceptional circumstances.

One point to make is that, because the scheme is administrative, we would have scope, if something transpired that we did not anticipate, to remake the scheme or add to it, as we did in the case of the Scottish Government mesh fund.

11:30

After the mesh fund had been operating for a while, it transpired that some women had had mesh implanted in a private hospital. We had not been aware of that at the outset. However, because the scheme was administrative, we were able to amend it very quickly and bring those women within the scope of the existing fund. We would have that option with this scheme, too.

Gillian Mackay: That is great—thank you.

The Convener: We move to questions from Sue Webber on medical issues arising from mesh surgery.

Sue Webber: I am a bit confused—it might just be because it is the first day back, or the first committee meeting—about the other costs. Can someone explain the rationale behind allowing only treatment for complications arising directly from the mesh removal surgery to be reimbursed, whereas medical issues arising as a result of mesh removal surgery will not be reimbursed? What is the difference? Why are we reimbursing one and not the other?

Greig Chalmers: I am happy to start on that, and then I will hand over to Terry O'Kelly, if he does not mind, to address the more clinical aspects.

We are trying to make a distinction in relation to issues immediately arising from the surgery. I should say in that regard that we are not aware of any issues immediately arising. In essence, if something has happened during the surgery—if, to put it in layman's terms, something has gone not quite right—and that needs immediate attention afterwards, we want to draw a distinction between that and the healthcare that we would offer patients on their return to Scotland—that is, the continuing care that all individuals can access from the NHS. We would expect individuals to access that care through the NHS, as everyone else does.

I will let Terry O'Kelly come in to better explain the distinction.

Terry O'Kelly: The scheme specifically addresses reimbursement for mesh removal, and therefore it is entirely appropriate to think that, if there is a complication or an issue relating to that procedure—for example, a surgical site infection or some other issue resulting in the patient returning to theatre or having to have an additional length of stay—that will be reimbursed.

For a number of women, there will be on-going problems. We have seen from correspondence and requests from the women themselves that they are linked to local services and the national multidisciplinary team so that their future care will be taken forward in a coherent and seamless fashion. That will involve pain management, if that is appropriate; care for psychological and psychosexual issues; and perhaps further urological surgery.

The reimbursement is about the primary procedure to remove the mesh and what surrounds it and any expenses related to that, rather than about additional issues that might have been taken care of beforehand or subsequently.

Sue Webber: Okay—I think that I have got that now. The language is very subtle, is it not?

Terry O'Kelly: I absolutely agree. As Greig Chalmers described, the issue is the way in which the scheme is applied. We hope that the application will be as flexible as possible, and that each individual case will be assessed on its own merits, because cases will undoubtedly differ.

Sue Webber: Is it acceptable that long-term care is not reimbursable under the scheme if such care was required because of the original mesh surgery? I am talking about the implantation surgery, not the removal.

Terry O'Kelly: The bill specifically addresses mesh removal rather than other aspects of care for these women.

Sue Webber: Are you suggesting that, if a patient has significant issues resulting from their original surgery, the treatment would be carried out under the new Scottish mesh service?

Terry O'Kelly: Yes, that is absolutely right. Treatment will be accessible locally, but we hope that it will be accessible through the service. Now that we have a centre, which is aligned with the other centres in the United Kingdom, it will act as a hub and spoke. Patients will attend the centre and be consulted with as needs be, but we hope that they will be able to access as much care as possible locally.

With regard to long-term issues such as psychosexual and psychological issues, the centre will, over time, develop expertise on specific aspects of care. Nonetheless, those areas of care are, and have been, accessible through the NHS, throughout Scotland and the rest of the United Kingdom.

What we have added to that is—[*Inaudible.*]—centres for the act of mesh removal. I appreciate that there are issues around that, such as reconstructive surgery and so on.

Sue Webber: Thank you—that is great.

The Convener: We move on to questions from David Torrance.

Apologies, David—I have just realised that Emma Harper has asked for a supplementary on the points that Sue Webber raised.

Emma Harper: It is just a quick question to ask Dr O'Kelly to clarify a matter. If a person needs anticoagulant therapy, which would require them to have an extended pre-operative assessment and may even affect their post-op recovery, leading to a delayed discharge to enable the anticoagulants to be managed, that would be covered as part of the mesh removal procedure. Is that correct?

Terry O'Kelly: That would be my understanding, yes. It would be very difficult not to support that.

Emma Harper: My other question is on the flipside of that. If somebody acquires a complication because of mesh removal surgery, such as urethral transection or something in the ureter that requires additional surgery, such as a urostomy, is that covered as something that happened because of the removal surgery?

Terry O'Kelly: My understanding and belief is that that would not necessarily be covered, unless it was an immediate problem that required urgent or emergency care.

With regard to the longer-term aspects of urinary diversion or other major urological reconstructive surgery, I am not sure how much of that surgery goes on in the private sector, but I think that one would expect to be given that care. When I gave evidence to the committee previously, I think that I highlighted that such care is for the major centres, with all available resources. We would anticipate that such care would have been picked up by the NHS, and that, in future, it will be given under the auspices of the NHS.

If there was a urethra or urological injury at the time of mesh removal, and it had to be corrected at that time, that should be reimbursed for sure. That would not necessarily involve the care that you have suggested. It might do, but I think that that would be a very rare occurrence.

David Torrance: My question is for Greig Chalmers. Some of the women will have taken out loans or used credit cards, or even remortgaged houses in some cases. Will they be eligible for reimbursement of costs that they have incurred through interest payments on the loans?

Greig Chalmers: In general, yes—that is the policy intention. We would look to the cumulative—actually, "cumulative" is a big word. We would look to an individual's circumstances and the way in which they had raised the money, which might well involve interest payments.

As Terry O'Kelly said, our general approach is to maintain as much flexibility as we can in the administration of the scheme. Where individuals entered into credit agreements and other financial instruments, the cost to the person will be considered. That will be within the broad scope of reasonableness, which is a point that I should always add. As the cabinet secretary said in his evidence to the committee, we need to keep a balancing eye on the use of public funds. Nevertheless, I fully expect that the actions that people have taken in such circumstances will have been reasonable.

The Convener: As I do not see any other member wanting to ask questions, I thank all the witnesses for their time this morning, and once again thank them for giving us sight of the draft scheme.

Subordinate Legislation

Abortion (Scotland) Amendment Regulations 2021 (SSI 2021/457)

11:41

The Convener: Item 4 is consideration of a negative instrument. The regulations amend the Abortion (Scotland) Regulations 1991 to enable the notice of termination that is sent to the chief medical officer to be given electronically and to extend the deadline for giving notice. They also reduce the amount of information that must be provided as part of the notification.

The Delegated Powers and Law Reform Committee considered the instrument and made no recommendations, and no motions to annul have been received in relation to it.

I see that no member wishes to make any comment. Therefore, I propose that the committee makes no recommendations in relation to the instrument.

As no member objects, we agree to that approach.

At our next meeting, on 18 January, the committee will take evidence from stakeholders as part of our inquiry into the health and wellbeing of children and young people. We will also take evidence from the Cabinet Secretary for Health and Social Care on the provisional common framework on public health protection and health security.

That concludes the public part of today's meeting.

11:42

Meeting continued in private until 12:02.

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