Public Petitions Committee
Thursday 5 November 2026
5th Meeting, 2026 (Session 7)

PE2240: Improve Gynaecology, Fertility, Early Pregnancy and Maternity Care in Scotland

Introduction

Petitioner	Elizabeth Crammond
Petition Summary	Calling on the Scottish Parliament to urge the Scottish Government to improve gynaecological, fertility and early pregnancy and maternity services throughout Scotland by reinstating a duty of care on GPs to provide transitioning care for gynaecology, fertility and maternity care and support, and by introducing a reactive auditing process to minimise delays and ensure the safe delivery of accessible, uniform services across health boards.
Website	https://petitions.parliament.scot/petitions/PE2240

1. This is a new petition that was published on 4 August 2026.

2. A full summary of this petition and its aims can be found at **Annexe A**.

3. Every petition collects signatures while it remains under consideration. At the time of writing, 922 signatures have been received on this petition.

4. A SPICe briefing has been prepared to inform the Committee's consideration of the petition and can be found at **Annexe B**.

5. The Committee seeks views from the Scottish Government on all new petitions before they are formally considered.

6. The Committee has received a submission from the Scottish Government and two submissions from the Petitioner which are set out in **Annexe C** of this paper.

Action

7. The Committee is invited to consider what action it wishes to take.

Clerks to the Committee
November 2026

Annexe A: Summary of petition

PE2240: Improve Gynaecology, Fertility, Early Pregnancy and Maternity Care in Scotland

Petitioner:

Elizabeth Crammond

Date published:

4 August 2026

Petition summary:

Calling on the Scottish Parliament to urge the Scottish Government to improve gynaecological, fertility and early pregnancy and maternity services throughout Scotland by reinstating a duty of care on GPs to provide transitioning care for gynaecology, fertility and maternity care and support, and by introducing a reactive auditing process to minimise delays and ensure the safe delivery of accessible, uniform services across health boards.

Background information:

The existing early pregnancy and maternity care system in Scotland, which removes pregnancy care from GPs and mandates self-referrals, is inadequate, resulting in delays, preventable pregnancy losses, and instances of medical negligence all damaging the lives of expectant mothers and families.

In my experience, there appears to be a significant issue with the level of communication between different services and across health board boundaries. There also seems to be a lack of appreciation or awareness within services about any potential risk factors that should require increased diligence when supporting expectant mothers.

Delays in understanding and addressing any risks can have devastating consequences for expectant mothers. I would like to see these delays minimised through a triaging system and an effective and reactive auditing process. There should also be a role for GPs in co-ordinating the initial provision of services.

Annexe B: SPICe Briefing

Scottish Parliament Information Centre
Ionad Fiosrachaidh Pàrlamaid na h-Alba

Briefing for the Public Petitions Committee on petition PE2240: Improve Gynaecology, Fertility, Early Pregnancy, and Maternity Care in Scotland, lodged by Elizabeth Crammond

Brief overview of issues raised by the petition

PE2240 calls on the Scottish Parliament to urge the Scottish Government to improve gynaecology, fertility, early pregnancy, and maternity services throughout Scotland by reinstating a duty of care on GPs to provide transitioning care for gynaecology, fertility and maternity care and support. Additionally, the petition calls for the introduction of a reactive auditing process to minimise delays and ensure the safe delivery of accessible, uniform services across health boards.

The petition was lodged by Elizabeth Crammond, whose experience was raised during First Minister's Questions on 10 September 2026. Elizabeth tried on multiple occasions to access early pregnancy care after experiencing bleeding during the early stages of a high-risk pregnancy, but was not seen. She experienced a miscarriage after waiting for nine days to access her local NHS early pregnancy service.

Current gynaecology, fertility, early pregnancy, and maternity care pathways in Scotland, and the role of GPs

In the context of the petition, "transitioning care" refers to the care and support offered to women when they transfer between gynaecology, fertility, early pregnancy, and maternity services. For example, a woman who undergoes in-vitro fertilisation (IVF) and becomes pregnant would experience a transition of care from her fertility clinic to maternity care.

In 2025, the Royal College of Nursing created guidance to support women who transition from fertility to maternity care. The guidance noted that for many women who undergo fertility treatment and become pregnant, the wait of several weeks between being discharged from the fertility clinic and having their first appointment with a midwife can create anxiety, particularly when symptoms such as bleeding are experienced. The guidance stated that access to early pregnancy units is therefore crucial to the mental and physical wellbeing of women in early pregnancy.

Each NHS Board in Scotland has an Early Pregnancy Unit (EPU), a specialist department that provides care to women in the first trimester of pregnancy. Women who are less than twelve weeks pregnant can self-refer to their local EPU if they need advice, or experience symptoms such as bleeding.

Each NHS Board is responsible for developing its own access arrangements for early pregnancy care, in line with the relevant section of the Scottish Government's

Miscarriage Care in Scotland Delivery Framework. For example, the petitioner's local health board, NHS Fife, states that it aims to offer an appointment within seven days of a patient making contact, depending on their symptoms and appointment availability.

Some women may be asked to monitor their symptoms at home, and others may be given an urgent appointment if their symptoms suggest that they require immediate attention. The Miscarriage Care in Scotland Delivery Framework details the care arrangements that should be offered to women who experience their first, second, third, and any subsequent miscarriage.

The role of GPs

GPs do not currently have a specific defined role in the provision of these aspects of care. However, they would be responsible for referring patients for gynaecology and fertility care, in addition to treating and referring women who present with pregnancy concerns as appropriate. As the Scottish Government noted in its written response to the petition, the overarching duty of GPs to provide care to patients in need would apply in the context of gynaecology, fertility, and pregnancy care.

Oversight and inspection of services

The petition calls for the introduction of a reactive auditing process to minimise delays and ensure the safe delivery of accessible, uniform services across health boards. Currently, each NHS Board is responsible for developing its own internal audit procedures, informed by the Scottish Government's NHS Scotland blueprint for good governance. Additionally, Healthcare Improvement Scotland (HIS) conducts planned and unplanned inspections of acute hospital services.

As of January 2025, Healthcare Improvement Scotland also has a specific responsibility to conduct inspections of maternity services in Scotland. In March 2026, HIS published a set of standards for maternity care, against which maternity services in Scotland will be assessed. These standards apply to maternity care delivered in all settings, and are applicable to:

- all women and birthing people experiencing maternity care in Scotland
- all babies receiving core newborn care, until their care is transferred to the universal health visiting service, usually at ten days old
- care partners, where appropriate, of people experiencing maternity services.

The National Maternity and Perinatal Audit (NMPA), led by the Royal College of Obstetricians and Gynaecologists, is a large-scale clinical audit of maternity services in Scotland, England, and Wales. The NMPA has been in progress since 2016, and a range of audit reports, papers, and other resources have been published.

Scottish Government actions

In its written response to the petition, the Scottish Government stated that it does not consider the introduction of a specific duty for GPs to be necessary, as GPs already

have a responsibility to provide care to any patient in need, including those presenting with fertility or maternity-related concerns.

The Scottish Government introduced its delivery framework for miscarriage care in September 2025. The framework aims to standardise miscarriage care and early pregnancy services across Scotland, and includes guidance on provision of early pregnancy services.

Scottish Parliament actions

The issues discussed in this petition were raised by Jackie Baillie MSP during First Minister's Questions on 10 September 2026. The First Minister apologised to Elizabeth Crammond and others who had shared similar experiences with Jackie Baillie MSP, and offered to explore Elizabeth's case.

Key Organisations and relevant links

- The National Maternity and Perinatal Audit
- The Miscarriage Care in Scotland Delivery Framework

Sarah Swift
Researcher
22 September 2026

The purpose of this briefing is to provide a brief overview of issues raised by the petition. SPICe research specialists are not able to discuss the content of petition briefings with petitioners or other members of the public. However, if you have any comments on any petition briefing you can email us at spice@parliament.scot

Every effort is made to ensure that the information contained in petition briefings is correct at the time of publication. Readers should be aware however that these briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

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Annexe C: Written Submissions

PE2240/A: Improve Gynaecology, Fertility, Early Pregnancy and Maternity Care in Scotland

Scottish Government written submission, 19 August 2026

Does the Scottish Government consider the specific ask[s] of the petition to be practical or achievable? If not, please explain why.

The Scottish Government does not consider it necessary to reinstate a specific duty on GPs to provide referral or "transitioning" care for gynaecology, fertility, early pregnancy or maternity services, as GPs already have responsibilities in relation to the assessment, management and referral of patients who present to them requiring care.

Under existing General Medical Services arrangements, GPs are responsible for providing services for patients who present to them with a health concern or care need. Care is delivered in a manner determined by the practice in discussion with the patient and includes making appropriate referrals to other NHS services where clinically required.

In relation to maternity services, access arrangements vary across Scotland. NHS Inform's Ready Steady Baby! guidance explains how women can access maternity services in their local area. In some Health Board areas, women contact their GP for referral to maternity services, while in others women can self-refer directly to midwifery services. The Scottish Government considers that these locally agreed arrangements support timely access to care while reflecting local service models.

The Scottish Government therefore does not consider that there is a duty which requires to be reinstated. Women seeking access to gynaecology, fertility, early pregnancy or maternity services can already access care through established NHS pathways, with GPs continuing to play an important role in assessing, supporting and referring patients where appropriate.

The Scottish Government recognises the importance of ensuring safe, high quality and accessible gynaecology, fertility, early pregnancy and maternity services, and supports continuing scrutiny and improvement activity across NHS Scotland.

What, if any, action is the Scottish Government currently taking to address the issues raised by this petition, and is any further action being considered that will achieve the ask[s] of this petition?

The Scottish Government continues to work with NHS Boards and national improvement bodies to support the delivery of safe and effective maternity services across Scotland.

Healthcare Improvement Scotland (HIS) has expanded its routine Safe Delivery of Care inspection programme to include all 18 obstetric maternity units in Scotland. Since 2025, these inspections have been conducted independently and without notice. Following publication of inspection reports, HIS reviews progress against NHS Board action plans at 18 weeks and again at 12 months.

The Scottish Government expects NHS Boards to address all requirements identified through the inspection process and implement necessary improvements. HIS operates a clear escalation process where it is not satisfied with a Board's response or progress. Scottish Government officials receive notification of inspection outcomes and subsequent reviews and will advise Ministers of any significant concerns.

The current inspection programme focuses on obstetric maternity units and does not presently cover routine antenatal or postnatal care delivered in community settings, nor neonatal services. HIS has indicated that expansion of inspection activity into additional services is expected to begin in 2027.

The Scottish Government also supports the provision of information to women and families through NHS Inform and Ready Steady Baby!, ensuring that clear guidance is available on accessing maternity services and understanding the care pathway from early pregnancy onwards.

Is there any further information the Scottish Government wish to bring to the Committee's attention, which would assist it in considering this petition?

The Committee may wish to note that access arrangements for maternity services differ between NHS Boards. Information published through NHS Inform's Ready Steady Baby! resource sets out local routes into maternity care, including where women should self-refer directly to midwifery services and where GP referral remains the entry point into care.

The Scottish Government considers that existing GP contractual arrangements already require GPs to appropriately manage patients' care and make referrals to other NHS services when clinically necessary. As such, there is not currently a specific gap in responsibility for referral into specialist gynaecology, fertility or maternity services.

In addition, independent oversight of the safety and quality of maternity services is provided through Healthcare Improvement Scotland's inspection programme, which includes follow-up reviews and escalation processes where concerns about improvement activity remain. This provides a mechanism for identifying and addressing quality and safety issues within maternity services across NHS Scotland.

GP Contracts Policy Team / Maternal and Infant Health Policy Team

PE2240/B: Improve Gynaecology, Fertility, Early Pregnancy and Maternity Care in Scotland

Petitioner written submission, 25 September 2026

This petition did not arise from a disagreement with a clinical outcome. It arose from concerns regarding access to care, continuity of care, accountability, risk recognition and the effectiveness of existing safeguards within Scotland's healthcare system.

The petition was born out of my own experience of navigating the healthcare system during a high-risk pregnancy following two previous miscarriages. During that pregnancy, I experienced ongoing vaginal bleeding and repeatedly sought medical

assistance. Over a period of nine days, I made more than 60 telephone calls in an attempt to access appropriate care and support. Despite my documented history of recurrent pregnancy loss, my high-risk pregnancy status and persistent symptoms, my care remained predominantly managed through telephone triage rather than face-to-face clinical assessment. Parliament's own briefing records that I repeatedly attempted to access early pregnancy care and waited nine days before receiving NHS assessment.

Ultimately, I suffered an early pregnancy loss and was left to give birth to my baby at home without clinical support. It is difficult to reconcile those circumstances with a healthcare system that is intended to identify vulnerability, provide timely intervention and protect patients at increased risk of adverse outcomes.

This petition is therefore deeply personal. However, it is not solely about my experience. It is about ensuring that no woman or family is left facing similar barriers, delays, uncertainty or a lack of support during one of the most vulnerable periods of their lives.

I welcome the publication of the SPICe briefing because it independently validates many of the concerns that led to the petition being lodged. The briefing acknowledges the challenges women can face when transitioning between fertility, early pregnancy and maternity services. It recognises that delays and uncertainty can arise during these transitions and highlights the importance of timely access to Early Pregnancy Units for both physical and psychological wellbeing.

Those findings are significant because they mirror the concerns I have consistently raised. Parliament's own research acknowledges that women can find themselves in a period where responsibility becomes unclear and support becomes fragmented between services. If Parliament's own evidence identifies these vulnerabilities, it is entirely reasonable to question whether existing safeguards are sufficient to protect patients when complications arise.

Importantly, these concerns have already been recognised at the highest level of government.

During First Minister's Questions on 10 September 2026, the First Minister addressed my case directly and stated:

> "She should not have had that experience."

He went on to acknowledge:

> "When there is any vulnerability whatsoever in relation to a pregnancy, the earliest possible intervention is provided. That is what the maternity framework is designed to offer. It has clearly not delivered that in this case."

Most significantly, the First Minister stated:

> "We must understand why that is the case and provide a remedy."

These statements are highly significant. They represent an acknowledgement by the Scottish Government that the maternity framework, which was specifically designed

to provide early intervention and protection for vulnerable patients, did not achieve its intended purpose in my case.

The First Minister further recognised the importance of transparency and accountability when services do not function as intended, stating:

> "Part of what we must do when things do not go as they should is to be transparent and open about that and ensure that all steps are taken to ensure that the situation is not repeated in the future."

He additionally acknowledged that:

> "The framework for the delivery of maternity care should address the circumstances that Ms Baillie has put to me. It has clearly not done that."

Those statements are not observations made by a petitioner or campaigner. They are admissions from Scotland's First Minister that the framework designed to protect vulnerable women in pregnancy did not deliver the intervention or support that it was intended to provide.

The SPICe briefing further notes that each NHS Board is responsible for determining its own arrangements for early pregnancy care and records that NHS Fife aims to offer an appointment within seven days of contact, with urgent appointments available where symptoms indicate a need for immediate assessment.

Yet the same briefing records that I waited nine days to access care despite reporting bleeding during a high-risk pregnancy and despite a documented history of previous pregnancy loss.

This contradiction lies at the very heart of Petition PE2240.

If local pathways, national frameworks and escalation mechanisms were operating as intended, how could a patient with recurrent pregnancy loss, ongoing vaginal bleeding, more than 60 attempts to seek assistance and a recognised high-risk pregnancy status remain without timely assessment?

The issue is not whether policies exist.

The issue is whether patients can rely upon those policies in practice.

My concerns are further reinforced by the responses received from NHS Fife and NHS Tayside.

NHS Tayside acknowledged that following my miscarriage in November 2025 there was no documented evidence that a referral to recurrent miscarriage services had been considered. It accepted that such a referral could have facilitated specialist review and consideration of progesterone treatment prior to my subsequent pregnancy and expressly apologised that this referral was not facilitated. NHS Tayside also identified learning in relation to pathways spanning maternity and early pregnancy services.

In contrast, NHS Fife concluded that the care I received was consistent with local pathways and that no delay had occurred despite confirming that NHS assessment did not take place until 24 March 2026 following repeated reports of bleeding. NHS Fife further concluded that triage decisions were consistent with local guidance and identified no breach of established pathways.

Taken together, these responses demonstrate precisely why independent scrutiny is required.

One Health Board identifies missed opportunities, pathway weaknesses and learning requirements. Another concludes that existing systems functioned as intended. Yet both responses concern the same patient journey and the same outcome.

A high-risk patient repeatedly sought help, experienced ongoing bleeding, struggled to access assessment and ultimately lost her baby.

That inconsistency should concern Parliament because healthcare systems should not be assessed solely on whether procedures were followed. They must also be assessed against whether those procedures achieved their intended purpose.

PE2240/C: Improve Gynaecology, Fertility, Early Pregnancy and Maternity Care in Scotland

Petitioner written submission, 25 September 2026

Further to my written submission, the SPICe briefing also highlights a significant inconsistency regarding the role of General Practitioners. It notes that whilst GPs do not currently have a specifically defined role within these pathways, they nevertheless remain responsible for referring patients and continue to hold an overarching duty of care in relation to fertility, gynaecological and pregnancy-related concerns.

However, this does not reflect my experience.

When I sought assistance through primary care, I was advised that I would need to contact the Early Pregnancy Unit myself and that there was little that could be done beyond performing a blood pressure check. As a patient, I was effectively left to navigate the system independently during a high-risk pregnancy whilst actively experiencing complications.

This raises an important issue of accountability.

If GPs retain an ongoing duty of care, why are patients still being advised that responsibility rests elsewhere?

Conversely, if responsibility has effectively transferred to specialist services, then there is a legitimate question as to whether current policy accurately reflects clinical practice.

Patients should never be left uncertain as to who is responsible for coordinating, escalating or facilitating access to care.

Another important issue concerns the treatment of private diagnostic information. NHS Fife confirmed that private ultrasound findings, including evidence of fetal cardiac activity, were recorded within my records but could not be relied upon for NHS clinical decision-making or commencement of progesterone treatment because they had not been verified through NHS imaging.

This raises broader questions regarding consistency, transparency and continuity of care.

If diagnostic information is considered sufficiently credible to be documented, discussed and referenced in clinical records, patients are entitled to understand why that same information is insufficient to influence treatment decisions, escalation or eligibility for intervention.

The issue is not whether governance standards should exist.

The issue is whether current arrangements create avoidable barriers to timely intervention for women experiencing pregnancy complications.

Petition PE2240 also calls for the introduction of reactive auditing. The SPICe briefing outlines extensive governance arrangements already operating throughout Scotland, including Healthcare Improvement Scotland inspections, national maternity standards, internal NHS Board audits and the National Maternity and Perinatal Audit.

However, the existence of governance structures inevitably leads to a fundamental question.

If inspections, audits, standards, governance frameworks and review processes already exist, why do patients continue to report difficulties accessing care, uncertainty over responsibility, fragmented pathways, communication failures and inconsistent experiences between Health Boards?

My concern is not that Scotland lacks scrutiny.

My concern is that serious concerns appear capable of existing despite it.

The purpose of reactive auditing is therefore not to create additional bureaucracy or duplicate existing oversight arrangements. It is to identify recurring problems in real time, detect emerging risks, highlight variations in practice and close the gap between organisational assurance and patient experience.

Current systems largely assess compliance.

Reactive auditing would assess outcomes.

The NHS Fife response partially upheld aspects of my complaint relating to communication, language and patient experience and identified a number of learning actions. However, it also confirmed that no Significant Adverse Event Review was undertaken and that no formal assessment of avoidable harm was conducted.

That raises a question of wider public interest.

If a patient with recurrent pregnancy loss repeatedly seeks help, reports ongoing bleeding, makes more than 60 attempts to access assistance, waits nine days for assessment, gives birth to her baby at home without clinical support and still does not meet the threshold for formal review, how are opportunities for learning, improvement and accountability being identified?

The issue is not necessarily whether wrongdoing occurred.

The issue is whether current governance systems are capable of recognising potential failings when they arise.

These are therefore not questions arising solely from my personal experience. They are questions arising directly from Parliament's own briefing, documented patient experience, formal health board responses and statements made on the floor of the Scottish Parliament chamber.

I remain grateful that these issues were raised during First Minister's Questions and that an apology was offered publicly. However, apologies should be the beginning of reform, not the conclusion of it.

The First Minister acknowledged that the maternity framework *"clearly"* did not deliver what it was intended to deliver in my case. The challenge now is to understand why, to address the causes and to ensure that those failures are not repeated.

The question before Parliament is no longer whether these concerns exist. Parliament's own briefing, the responses from NHS Boards, and the statements made by the First Minister demonstrate that they do.

The question now is whether Scotland is prepared to address the gap between policy and practice, between accountability on paper and accountability in reality, and between what patients are told should happen and what they actually experience when they seek help.