OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 16 November 2021

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
11th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Donna Bell (Scottish Government)
Kevin Stewart (Minister for Mental Wellbeing and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 16 November 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the 11th meeting in 2021 of the Health, Social Care and Sport Committee. I have received no apologies.

Agenda item 1 is a decision on taking business in private. Do members agree to take items 4 to 6 in private?

Members *indicated agreement.*

Session 6 Priorities

09:00

The Convener: Agenda item 2 is an evidence-taking session with the Minister for Mental Wellbeing and Social Care on his priorities for session 6. I welcome Kevin Stewart, who is supported this morning by Donna Bell, director of mental health and social care, and Gavin Gray, deputy director for improving mental health services, with the Scottish Government.

I believe that you have a short opening statement, minister.

The Minister for Mental Wellbeing and Social Care (Kevin Stewart): I do, convener. Good morning to you and the committee, and thank you for the opportunity to appear today.

I welcome the opportunity to set out for the committee my strategic priorities for the current parliamentary session. Right now our national health service and social care systems are under more pressure than they have been at any point in the pandemic, and the Government has responded with a comprehensive programme of investment in and action on our mental health and social care sectors to address the challenges and to build a health and care system that is fit for now and the future. Such a system must focus on people and on meeting their needs in a holistic way that is informed by their experience.

I will start with a brief summary of my vision for mental health and wellbeing. I want our work to focus just as much on supporting and creating the conditions for everyone to have good mental wellbeing as on transforming our mental health services. Our transition and recovery plan, which outlines the breadth of our work, contains more than 100 actions, and we are determined to build on some of the amazing work that has happened across Scotland during the pandemic. That work includes, among countless other things, the establishment of mental health assessment centres and the roll-out of computerised cognitive behavioural therapy.

The plan requires similarly ambitious investment, which is why it is being supported by record levels of funding for mental health. Compared with the previous financial year, we have doubled the mental health budget, with the core budget now standing at more than a quarter of a billion pounds. That includes our £120 million recovery and renewal fund, which is the single largest investment in mental health in the history of devolution. Over £80 million has already been allocated from the fund this year, with £43 million of that for improving the mental healthcare that is received by children and young people, including

£40 million for child and adolescent mental health services.

Additionally, we have committed to increasing the direct investment in mental health services by at least 25 per cent, thereby ensuring that by the end of the parliamentary session 10 per cent of our front-line NHS budget will be invested in mental health. Together, those investments will be truly transformational for mental health and wellbeing, and we will continue to work with our partners, stakeholders and people with lived experience to ensure that our response evolves as we continue to recover from the pandemic.

As for social care, I see my priorities falling under three broad headings, the first of which is improving access to care. The pandemic showed and continues to show us the need for a significant improvement in access to care and support for people, and for that work to be done now. For example, I know the pressure that unpaid carers are under, and that situation cannot wait for the national care service to be established. We have therefore committed to overhauling the current eligibility criteria mechanism. We plan to extend to March 2023 the support in the right direction programme, with funding of £2.9 million. We have invested an additional £28.5 million for local carer support.

Secondly, we recognise that the workforce is absolutely vital in delivering our ambitions for social care across Scotland. We must ensure that the principles of fair work are adopted as standard across the sector, and we must improve pay and conditions and career progression for social care workers. Last month, we took a step forward by investing in the social care sector to ensure that front-line care workers receive a minimum of £10.02 per hour, but there is more left to do on that front.

The Government is committed to increasing public investment in social care by 25 per cent during the current parliamentary session, equating to an increase of approximately £840 million. The recent investment to relieve winter pressures will maximise the capacity of care-at-home services, enable more social work assessments to be carried out, and support social care staff.

Finally, we will take forward our commitment to establish a national care service. We have already consulted on our proposals in that space. The independent review of adult social care was clear that, if we are to improve people's experiences of social care, we need to create a comprehensive system that cares for and supports people in a holistic way that empowers them to thrive. Human rights must be at the heart of all that we do here.

We will introduce legislation for the national care service by the end of this parliamentary year, and aim to establish the national care service by the end of the current parliamentary session.

Convener, I look forward to working closely with you and the committee as we implement this very important agenda.

The Convener: Thank you very much, minister. We will look at the mental wellbeing part of your portfolio first, and then we will move on to talk about social care in the second half of your session with us.

The drivers and implications of mental health issues are found in many areas of Scottish society, so I am interested in how you, as minister with responsibility for mental wellbeing, work across other portfolios. Mental health is important in areas such as education and justice, for example. How do you make sure that the drivers of mental health issues and the response to people who have them are taken into account across all Government portfolios?

Kevin Stewart: That is absolutely vital. Let me give you examples of some of the cross-cutting work that we have done in the past couple of weeks. The committee will be well aware that, the other week, I held a joint debate with Angela Constance, the Minister for Drugs Policy, to look at how drugs policy and mental wellbeing work together. In the past couple of weeks, I met the Cabinet Secretary for Justice and Veterans on a number of issues but, at our most recent meeting, we looked primarily at what we need to do to improve mental health and mental wellbeing services for veterans in our community. Again, in the past few weeks, I met Jamie Hepburn in his further education role to see what more we need to do to support university and college students.

Mental wellbeing is a cross-cutting issue. The First Minister has made it clear to all her ministers that we should all work together to break down silos so that we are doing our level best for people. Although I have overall responsibility for mental wellbeing, every minister in the Government recognises that they have a role in ensuring that we do our level best for folk as we move out of the pandemic period.

The Convener: As you alluded to several times in your introductory remarks, for many people during the pandemic, their mental health went from something that they were managing to crisis point. Do you plan to carry out a review of the "Mental Health Strategy: 2017-2027", taking into account some of the issues that have arisen in the past 19 to 20 months?

Kevin Stewart: At this moment, we need to see what is required in the here and now. Many members of the committee will have heard me say in my present role and in my previous ministerial role that the way that we should conduct ourselves

in that regard is that we should listen to the voices of lived experience. Therefore, over the past six months, I have spent a large amount of my time listening to people out there talk about their current experience of services. Some of that is good, some of it is not so good and some of it is indifferent. What we need to do in the here and now is ensure that the best practice that is out there is exported across the country.

I will give the committee an example, because I think that that is always the best way. The other week at the health awards, NHS Grampian won an award for the Grampian psychological resilience hub, which has been extremely beneficial for lots of people over the pandemic period and in the here and now. A week past Thursday was the first time that I had met anyone from the hub, but I had heard a lot about its work by talking to folk with lived experience.

I know that the committee is soon to do an inquiry on perinatal and infant mental health, which is an area that I have a great interest in. The other week, I met women from the convener's constituency who are in Let's All Talk North East Mums—LATNEM—which is the voice of lived experience of women in that corner of Scotland. They told me what was working well and what was not. Everyone there said that the Grampian resilience hub had been a lifeline for them during the pandemic period. We need to ensure that such service delivery happens right across the country.

We know that face-to-face services have not been provided for a long while, although such provision is starting to return. We need to look at what works for people. For the women I spoke to, the resilience hub worked for them. Let us see what we can do to export that best practice beyond Grampian to other places and to do our level best for folk right across the country.

The Convener: Is there anything that you want to flag up that is happening in your portfolio on mental health when it comes to the nuts and bolts of the legislative programme?

Kevin Stewart: A number of things are going on, as is always the case. The Scott review is taking place, which is looking at the legal aspects of how we deal with folk with mental health difficulties. That will be extremely important. As always, there are folk who are saying that we need to look at various bits and pieces of legislation. In connection with the Scott review, there are folk who are saying that we should look at aspects of the adults with incapacity legislation now, but I think that we should allow the review to take place and do all that work in the round.

As we move forward, as I said in my introductory remarks, we need to take a human-rights based approach in all that we do. I know that many members have taken a great interest in embedding human rights in legislation. There must be more of that no matter what challenges are posed by the fact that the UK Government took to the courts the previous attempts by the Parliament to embed human rights in Scottish legislation. We must continue in that vein. The Scott review is also important in that regard.

09:15

The Convener: Those answers give me a good basis to turn to my colleagues, who wish to dig deeper into some of those issues.

Evelyn Tweed (Stirling) (SNP): Good morning, minister. What effect do you think Covid has had on the wellbeing of Scotland's population?

Kevin Stewart: It has had a huge impact. From talking to folks, it is clear that the difference that Covid has made to some people's lives is quite horrendous. We have all faced the stress of the pandemic period, but for some people, such as those who have lost income or have been bereaved during the pandemic, it has been much worse than for others. For some people, the lifeline things that they were able to do previously, which kept them in fairly good fettle, went by the wayside as a result of the lockdowns.

We should not underplay the impact that the pandemic has had on people across the country. We can see from the survey work that has been undertaken across the piece that almost everyone has been affected by what has gone on.

Evelyn Tweed: What action is the Scottish Government taking to deal with the long waiting lists that we have heard about?

Kevin Stewart: Waiting lists are a worry, and we are taking action on that. In my opening remarks, I mentioned the important investment that we are making in child and adolescent mental health services. We can already see the difference that the investment is making in certain parts of the country as new folk are being recruited into post. On Thursday last week, I visited the youth unit in Dundee and I heard from staff about the difference that the investment will make.

On some of the pressures on the folk who work in and with the youth unit, I should say that, at one point during the pandemic, the unit—which covers the north of Scotland—was 19 staff down because of Covid and the pressures around it. Those folks have worked immensely hard during the course of the pandemic and have behaved admirably. They were extremely enthusiastic not only about the current investment in CAMHS, but about our ambition to move towards more preventative measures, including school counsellors and putting mental health link workers into general

practices, and about the investments that we are making in communities.

I understand why the focus is on acute services, waiting lists and waiting times, but the best thing that we can do as we move forward is to prevent folk from having to enter acute services by putting in place the right preventative solutions for folks. I am determined to do that.

Sandesh Gulhane (Glasgow) (Con): Good morning, minister. I declare an interest as a practising NHS doctor.

The health improvement, efficiency and governance, access and treatment—HEAT—target for starting psychological therapy is 18 weeks after referral. Psychological therapy is vital in dealing with patients who have mental health issues. When was the last time the HEAT target was achieved?

Kevin Stewart: I do not have that information. I am more than happy to write to the committee with any detail that I do not have in front of me.

It is our ambition to ensure that we get waiting times and lists down, but Dr Gulhane must recognise that we are going through a very difficult period because of Covid. I am sure that he will come back at me and say that some of the problems existed before Covid. That is fair enough, but the pandemic has exacerbated difficulties for people and has put a huge amount of pressure on services.

We have put in place a national standard for child and adolescent mental health services. In co-operation with stakeholders, including the Royal College of Psychiatrists, my officials will do exactly the same for psychological therapies. That is important and we are going to be extremely ambitious as we move forward with that.

Sandesh Gulhane: The target has not been achieved since 2017. Through the amazing adaptations and digital appointments that have been offered through the Covid pandemic, there has been an increase to 82.7 per cent of people being seen within 18 weeks. Covid is not the reason why we are missing the target, so how could we improve access to psychological therapies and address the fact that we have not hit the HEAT target since 2017?

Kevin Stewart: I disagree profoundly with Dr Gulhane that Covid has not had an impact: it most definitely has. He should spend some time talking to folks with lived experience and the folk who work in front-line services about the impact that it has had.

His point about digital services is important. During the past period we have adapted quickly, and digital services are among the things in which we have invested. Cognitive behavioural therapy has been provided, which has worked well for many folk. We will continue to invest in digital services.

There is no doubt that digital services work well for many people, but there will still be a need for group therapies and individual face-to-face consultations, as we move forward. We can learn a lot from what we have gone through, so we are considering how to embed that in services in order to create hybrid provision where it is required. However, as always, we need to take a person-centred approach and to see what is best for the individual. Much of that is down to what clinicians think is best for the individual.

Without a doubt, lessons have been learned from the pandemic: we will take full advantage of the technological changes that we have made to get treatment right for people.

Emma Harper (South Scotland) (SNP): I have a quick supplementary question. There has been a lot of work done on tackling stigma; it is now less stigmatising for a person to say that they have anxiety or a mental health disorder. Has that contributed to the challenges? Has the fact that more people are coming out and saying that they have struggles affected the ability to tackle the issue? The Government has done a lot of work on support for mental health in that way.

Kevin Stewart: Over the past number of years, even pre-Covid, there has been a rise in the number of people coming forward with mental health conditions. A lot of that is down to the fact that we are changing how folk think about their mental health. Much of the destigmatisation is down to a lot of hard work on the part of many stakeholders, but it is also due to the amount of investment that the Government has made through the see me campaign. Just the other week, in order to ensure that the campaign continues to thrive, the Government—this is also down to the Parliament, through the budget process—agreed to provide the campaign with £5 million over the next five years so that it has the comfort of knowing what it will be able to do over the piece.

It is a really good thing that we are destigmatising mental ill health, but we still have a long way to go. Let us be honest: there are still a lot of folk who will not discuss mental health issues or their own mental health. There are aspects that folk are still wary of discussing. The best example is probably the unwillingness on the part of many folk to talk about suicide and suicide prevention. The work that has been done here in Scotland by the national suicide prevention leadership group has been recognised by the World Health Organization. We need to go further, however, so we have said that we will double the suicide prevention budget during the course of this

parliamentary session. We need to get folk to start speaking about the issues, which are often still taboo.

I will continue, if I may; I know that I have rabbited on for a fair while. A number of organisations and groups have major parts to play in helping us. The other week, I went to an event at St Mirren Football Club—which George Adam would, of course, say is at the centre of the universe, although I do not know that I could agree with that. For—if I remember rightly—the seventh year, St Mirren ran a conference day. It was initiated by a local lad who had seen some of his mates die by suicide and thought “Enough is enough.” That event was immense. It was heart rending and difficult, but it made people think about what is going on, what some folk are going through and what we need to do to help folk in their time of greatest need. That community-based approach is the best way, in some respects. The event brought a lot of footballers together for a very good competition, but that message was at the heart of it. We need to do more such things.

The Convener: Gillian Mackay has a question, after which we need to move on to the topic of children and young people.

Gillian Mackay (Central Scotland) (Green): The mental health benefits of social prescribing are well known. Does the minister have a sense of the impact of the pandemic on social prescribing? As pressure has increased on primary care, do healthcare staff have reduced time to engage with social prescribing?

Kevin Stewart: It would be fair to say that time is precious, at the moment. I do not have with me evidence to give Ms Mackay about that impact. We are examining those things very carefully.

I know that Ms Mackay has a great interest in data. I have freely admitted to Parliament that some of our data collection is not the best. In some regards, there is duplication in data gathering—not just by the Government, but by a number of agencies. We need to do a wee stocktake—as I have called it—or audit. This is one area in which we probably need to do a little bit more.

I do not want to pre-empt Ms Mackay’s next questions, but she knows from my answers to her in the chamber that we also lack data on some minority groups. We need to do much more work on that.

09:30

The Convener: Carol Mochan has questions on children and young people’s mental health.

Carol Mochan (South Scotland) (Lab): The minister briefly mentioned CAMHS, which is very important for young people and their families. We know that waiting times have been quite long. I wonder whether you can give us some information on three aspects relating to CAMHS. The first is waiting times, which you have touched on. We need to get it right for people by getting waiting times down.

Secondly, there are a number of rejected referrals to CAMHS. The Government has acknowledged that and has said that more work needs to be done. What can be done for those young people?

The third aspect relates to unmet need. We know that when schools were closed because of Covid there was a drop in the number of referrals to CAMHS. Medical staff have identified that young people might have missed a window, so we should ensure that they get any support that they need at this time.

Kevin Stewart: I know that Ms Mochan has a real interest in community-based services and preventative measures. As I said earlier, I want to move much more towards those so that folk do not have to enter acute services.

Let me give a wee flavour of the CAMHS situation. Some of the statistics are not brilliant, and some show that things are, without a doubt, on the move. We cannot forget that each number in the statistics is a person with a family; I will certainly not forget that.

The statistics that I will give were published on 7 September. During the quarter prior to that, 4,552 children and young people started treatment. That is an increase from the previous quarter, when the figure was 4,096. The figure was up by 28.3 per cent on the figure for the same quarter in 2020. Therefore, we are getting back to clinicians being able to see more folk. That is good, but we still have a way to go.

In the quarter prior to the report on 7 September, 72.6 per cent of CAMHS patients started treatment within 18 weeks. That percentage was ever so slightly up on the percentage in the previous quarter, when the figure was 72.4 per cent. However, it was up dramatically on the percentage for the same quarter in 2020, which was 61.7 per cent. We have to understand that there was a massive impact from the pandemic at that time.

In the quarter prior to the report, 10,193 children and young people were referred to CAMHS. That was an increase on the number who were referred in the previous quarter, when the figure was 7,883, and on the number in the same quarter in 2020, when the figure was 4,052. As has been pointed out, there was a dip in the number of folk being referred during the pandemic.

In the quarter prior to the report, 22.2 per cent of referrals to CAMHS were not accepted, and the figure was similar in the previous quarter. I know that Ms Mochan believes that there should be more interrogation of that; I agree with her, on that front. We will look at that.

That gives a flavour of the situation. I have a lot more information in front of me, but I am sure that the convener does not want me to take up a huge amount of time with all that. If you wish, I can send all the statistics to the committee in writing so that you have all the information at your disposal.

The Convener: That would be very helpful.

Carol Mochan: I want to ask a wee bit more about unmet need. Do you have a plan? Have you spoken to any organisations about what we might do to identify young people who have been missed?

Kevin Stewart: In all this, I see it as being my job to ensure that we are doing our level best for everyone. I make no bones about the fact that I think that long waits are unacceptable. We, as a Government, remain committed to meeting the standard that 90 per cent of patients begin treatment within 18 weeks of referral.

I hope that folk will excuse me for this, but I will be a little bit parochial for a minute. When I was first elected to Parliament, CAMHS in Grampian were pretty poor, and I used to get a fair amount of correspondence in my mailbag and inbox about that. Those services have been transformed. Even during this very difficult pandemic, I have had no real complaints about CAMHS in Grampian. If you look at what has happened there during the pandemic, you will see that things have been pretty stable, given the circumstances. The transformation has made a real difference to service delivery. The service is much more community based and is, in some respects, less reliant on acute services.

Our ambition is to ensure that that change happens across the country. It would be fair to say that different health board areas are at different stages in making the change. I am concentrating on speaking to health boards that have not made the shift because, in order for us to meet need, we have to make the change. It is fair to say that quite a lot of my time has been spent challenging health boards about what they can do to make the change.

Some of what is needed might not be so easy to do at the moment, but some of it should be easy to do now, and would make things much better not only for patients, but for staff. Again, I would be more than happy to write to the committee about our ambitions and the standards that we have set. I would even be willing to go down to the level of saying whom I have been speaking to, if that is what you require.

The Convener: Again, that would be very helpful. Stephanie Callaghan will ask about young people.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I have a couple of wee questions. Thank you for being here this morning, minister. I want to ask you a little bit more about prevention. Earlier, you mentioned school counsellors and mental health link workers in general practices. We have heard quite a lot of evidence on various topics about how it can be quite difficult for professionals to focus on prevention. What measures are you looking to put in place to ensure that prevention is prioritised on the ground, and that it has an impact?

Kevin Stewart: You have picked a good example of prevention and how we are trying to keep folk out of acute services. School counsellors, which are quite new, are already making a difference. A report was published—Oh, gosh! Do not hold me to this because I am not so sure about times at the moment—a month, six weeks or two months ago on what school counsellors are finding and the difficulties with which young folk are coming to them. The report also gives details of referrals, which are not necessarily just to acute services.

In addition, I have been getting pen pictures of other things that were going on with regard to signposting young folk to the right help. For some young folk, a listening ear is enough; having someone recognise that we are facing a challenge is often all that we need in this life. How many of us actually go to somebody and say, “This is my problem at the moment?” Telling someone and getting a wee bit of advice is cathartic in itself and can be immensely helpful. The huge amount of work that is already going on in the service is quite incredible. Again, we can provide the committee with a link to that work. I think that it is public—I am looking at Donna Bell, here.

Donna Bell (Scottish Government): Yes, it is.

The Convener: It would also be helpful to know how counselling has been rolled out across each local authority. It would be good for us, as individual MSPs who speak to our local authorities, to see where everyone is.

Kevin Stewart: Sure. Each local authority has done things slightly differently. There will be a lot of learning from that, because we will be able to see where performance is better, and to export and share best practice.

We have also provided local authorities with moneys for prevention work with young people. I have been keeping a close eye on that. Some

local authorities have moved quickly to support services and to establish new services where they are required, while others are lagging behind; I am afraid to say that a few local authorities have not done very much at all. We are keeping a close eye on that, because I want to ensure that investment reaches the community groups that were—and still are—at the front line during lockdown. They have done great work in preventing young folk from entering acute services.

The Convener: We need to move on. Sue Webber has a question on health inequalities.

Sue Webber (Lothian) (Con): I hope that my question will follow on nicely from those of Stephanie Callaghan and Carol Mochan.

I want to ask you about health inequalities across Scotland, minister. You mentioned the established and successful CAMH service in Grampian but, in Lothian, it is quite a different story for the many young people who are trying to access services. The counselling is being rolled out quite differently across local authorities—some are lagging behind or doing very little. As taxpayers, we want to ensure that every single penny is spent well and reflects the intended purpose of the investment. What actions are you taking to address those inequalities in the delivery of mental health services across the country?

Kevin Stewart: I will come to the issue of inequalities in delivery in a moment, but as I have said previously and will continue to say, the main driver of health inequalities in the population, including mental health inequalities, is poverty. We all have to recognise that. Some of the difficulties that people currently face have been exacerbated by some of the decisions that have been taken in recent times, including the cut in universal credit, which has had a major impact on individuals and families across Scotland. I will not go on too much about that, because—I will be honest with you—I could go into a rant that would last all morning.

Let us look at the difference in delivery. I spoke earlier about the standards that we have put in place for CAMHS. I expect those high-quality standards in delivering for people to be met across the country; that is one of the things that we need to do. Ms Webber is right. There is a stark difference in service delivery between Grampian and Lothian. We must transform services and do our level best to follow the example of the north-east.

09:45

The CAMHS standards are already making a big difference to thought processes, but we need to go further. That is why officials and stakeholders are working up new standards for psychological therapies. We will do something similar in other business areas so that everyone—those who deliver those services and those who receive them—will know what is to be expected.

I cannot emphasise enough that, where services work well—even if they do not work perfectly—the voices of lived experience are at the heart of shaping those services. That is where we need to get to. We should listen much more to service users to find out what works for them and what does not. Although the service in Grampian is not perfect and folk have gripes about things that did not work well for them, folk mostly have a good feeling about that service and feel that they are listened to.

I might be accused of parochiality for bigging up Grampian. Grampian has not done so well with perinatal and infant mental health. I think that a key reason for that is that the voices of lived experience have not been at the heart of those services. The committee will find out more about that during its inquiry. Other areas, such as Lothian, do well on that, whereas Grampian and the north do not do so well.

The Convener: You have hit on something that the committee wants to do in our inquiries: we want to speak to people with lived experience.

Sue Webber: Scotland has only 13 health boards, but many more local authorities. There is a small cohort of healthcare providers. What can the Scottish Government do now to be more forceful and to ensure that best practice, such as in Grampian, is not just spoken about but is consistently implemented across the country?

Kevin Stewart: I think that I have answered that in what I have said about standards. We have set standards for CAMHS, we will set standards for psychological therapies and then we will move on. That will give folk a framework and a foundation with regard to what is expected of them in service delivery for people in their areas. It will also give service users and patients knowledge of what they can expect.

The Convener: Emma Harper has some questions about healthcare workers in the mental health sector.

Emma Harper: As a registered nurse, I have been participating in the vaccination programme. Colleagues have told me about how they have been coping or not coping with their mental health. I know that a lot of work has been done, for example through the national wellbeing hub and programmes such as clear your head, to support staff in healthcare and social care. How are we monitoring and evaluating the way in which people engage with those programmes?

Kevin Stewart: With regard to what we have done, the proof of the pudding is in the eating. We

know that staff are accessing the mental health and wellbeing hub and the services around it. As the committee knows, we have invested more money in that, but it would be fair to say—this goes back to your earlier point about stigma—that some staff feel stigmatised in using those services. We have to get folk over that hump.

In talking to folk in health and social care, I have always said that we must continue to signpost those services; indeed, at times, we must cajole folk to use them. Once they use them, those services can make a real difference. In some cases—although, obviously, not in every case—that can happen in a fairly short time. The other week, I talked to somebody who had used the services, and they felt that, even in the initial calls, the burden had been lifted, to use their words.

Folk are under a lot of pressure, and I want those services to be used. It is absolutely vital that all of us—whether in the Parliament or out there on the front line in health and social care in the NHS, in health and social care partnerships or in third sector organisations—highlight that those services exist and that folk should access them if that is needed.

All of that shows that we still have a lot of work to do in destigmatising.

Emma Harper: I know that we have asked our NHS and social care staff to work through these unprecedented times, often in unfamiliar settings, and that many have been asked to learn new skills and to work in new roles and in unfamiliar teams, for instance. Are we tracking how staff might be retained so that we can address all of that and not lose staff because of poor mental health?

Kevin Stewart: I will maybe write to the committee to give the details of access to the mental health and wellbeing hub and other services in more depth, and to give the committee an indication of what those services are doing and the kinds of difficulties that folk are going to them with.

I will answer Ms Harper's question without giving her the in-depth statistics that she wants. I am spending a lot of time speaking to folk on the front line, and it is quite clear that a lot of them are under a lot of strain. Sometimes that is because of work, and sometimes it is because of home pressures as a result of the pandemic. A lot of different things are going on out there. We all need to be aware that there are folk out there who are not feeling at their best at the moment, and we—not just as a Government, but as individuals—need to do what we can to support people in the best ways. We have had suggestions from staff about wellbeing issues, which we have acted on. Why would we not do that if a difficulty has been highlighted to us? We increased investment because it was suggested that we needed to go further in some cases.

Beyond that, there are individual health boards that have gone even further in meeting the needs of staff during these times. For example, Fife Council received a substantial donation from a member of the public that went to supporting staff. Sometimes that support comes in the form of the simplest things, such as free hot drinks or free food. All that can make a difference and take the pressure off. I am open to suggestions on the issue, as is the cabinet secretary.

The Convener: I will take a short supplementary question from Gillian Mackay before we move on to questions from Paul O'Kane, who will ask about suicide prevention.

Gillian Mackay: During the pandemic, there were times when a member of staff was the only person with someone who was dying and whose loved ones could not get in to see them—that happened during the lockdowns. That was probably quite a traumatising event for some staff. As part of the wellbeing hub, is any specific support provided for people who might have experienced those particular situations?

Kevin Stewart: Yes. You have hit on a really good point. Some folks have seen some very traumatic scenes happen before their eyes. I have heard some pretty bleak stories as I have been doing the rounds and talking to folk. We must ensure that we do our level best for such people.

A number of folk have seen difficult situations, including deaths, in the past but, for many, the pandemic has been so much more than that. We must take cognisance of that and provide the wraparound support that is required.

Paul O'Kane (West Scotland) (Lab): I appreciate that the minister touched on suicide prevention in his earlier answers, which were very informative. Currently, Scotland has an increasing suicide rate. When we take that as a comparator across the UK, we see that our rate is higher than those in England, Wales and Northern Ireland. Are we engaging with other parts of the United Kingdom to understand their experience and what has been done in them? How can we share best practice? Notwithstanding the work that is already being done, I think that we can learn from other people.

Kevin Stewart: I will be brutally honest with the committee: I am happy to nick good ideas from anyone, anywhere. We are doing some pretty groundbreaking things in Scotland, and we owe a debt of gratitude to the national suicide prevention leadership group, which was recognised by the World Health Organization in its most recent report. That report is worth reading. It contains

some good tips from across the globe that I am more than happy to nick as we move forward.

We saw a small decrease in the number of suicides in Scotland last year, but one suicide is one too many as far as I am concerned. Therefore, we have a fair amount of work to do.

The committee might also be aware that we have a lot more to do when it comes to self-harm. That is why I have said that we will develop a separate self-harm strategy. A lot of work has been done on that issue by stakeholders and academics in Scotland. We have more to do, but we can do that. I stand to be corrected, but my understanding is that, by moving in that direction, we will be the first country in the world to have a separate but connected self-harm strategy.

10:00

Paul O'Kane: All of us on the committee would want to associate ourselves with your comment that one suicide is one too many and to welcome any decrease in the figures.

On "Scotland's Suicide Prevention Action Plan: Every Life Matters", the outcome of the review in March was that progress was perhaps slower than expected in some areas. Indeed, I think that you alluded to the need for us to go further and do more. Notwithstanding the challenges that we have all experienced through the pandemic and lockdown and the fact that they have exacerbated the situation with services and people's lived experience, I am keen to understand how we will drive towards the plan's very ambitious target of reducing the rate of suicide by 20 per cent by 2022. How achievable is that target? What further actions need to be taken to reach it?

Kevin Stewart: We need to look at a number of things. I have already mentioned that we will be doubling the budget over the course of this parliamentary session, and we have to ensure that every penny is well spent. At the moment, we have pilots going on in Ayrshire and Highland to support folks with experience of suicide. I think that the findings from those pilots will be very important and that they might well lead to a national roll-out.

I am also really keen to explore how much more we can do in communities. I have already mentioned the St Mirren event, but I have recently come into contact with a lot of small groups that are doing sterling work. The question is how we can build on that work.

Yesterday morning, I met the family of Chris Mitchell, who are trustees of the Chris Mitchell Foundation. Chris was a footballer whose professional career ended because of injury and who then carried out suicide. Some of the work that the foundation has been doing with football clubs could be expanded. Indeed, the Scottish Professional Football League has been carrying out other work that we should be building on. The fact is that we need to reach certain areas of the population that our normal health messaging sometimes does not get to, and we have to continue to adapt and think outside the box with regard to what is required in order to get this right.

There is work to do, but we should also recognise the immense partnership involving the Government, the Convention of Scottish Local Authorities and the national suicide prevention leadership group.

The Convener: Paul O'Kane has another brief question.

Paul O'Kane: I will be brief, convener. I just want to welcome the minister's comments about grass-roots organisations in communities, which I think all of us will have experience of. Does the minister feel that there is space to fund some of those organisations at a more localised level and move that sort of thing forward where required?

Kevin Stewart: One of the reasons for establishing the communities mental health fund, which we announced the other week, is to ensure that those kinds of groups can access funding. There is plenty of detail on the fund, and there will be more such detail that we will share with the committee. To be honest, I want those grass-roots groups to apply for that funding. That is why it is there.

The Convener: Sue Webber has a supplementary question about that.

Sue Webber: Minister, you have mentioned a number of times the importance of listening to the voices of those with lived experience. As we heard from Paul O'Kane, the suicide prevention action plan from 2018 was reviewed back in March. The plan stated:

> "Our vision is supported by our key strategic aims of a Scotland where ... people at risk of suicide feel able to ask for help, and have access to skilled staff and well-coordinated support".

I have been contacted by a friend who knew two ladies who, tragically, both committed suicide very recently and who had cried out for help many times. Both were looking for access to rehabilitation services. One woman was told that she could not be helped because she was not on benefits and "looked amazing". She took a paracetamol overdose when drunk, and she died four days later sober. I am emotional—I am sorry. Her other friend lost her job of 33 years. She was in the system and well known, and she was desperate for help. She hanged herself and left her young family behind. They were both able to ask for help, but it was denied. That is the harsh

reality of what is happening again and again in our communities.

What is the Scottish Government doing now to help these people? Those suicides could have been prevented. Today, I want to make sure that we acknowledge that their lives mattered. I want those in decision-making positions to be able to do something about that.

The Convener: Minister, I know that you cannot respond on particular instances, but would you like to respond to Ms Webber?

Kevin Stewart: I think that Ms Webber knows that I cannot respond on individual cases—that is not possible—but she should feel free to contact me about those situations.

Ms Webber hit upon a point that came up in discussion yesterday morning. There is something that we all need to recognise, and we need to build it into the action plan and how we deal with folk on the front line.

It was said to me yesterday that, for many folk on the outside, it looks as though some folk have the perfect life—they are pretty wealthy, and they have a nice hoose and a good job—but we never know the turmoil within. You might have all those things and still not be happy and still be unwell.

Ms Webber made a point about folks who make judgments that are based on a person's external aspects. That is wrong, and we have to put a stop to it. We have to listen more. Again, it comes back to a person-centred approach. Work needs to be done on that. That is another kind of stigma, is it not?

The Convener: I was going to say that. It fits into the idea of stigmatising people.

Kevin Stewart: It is another stigma that we must get rid of. Although I canna comment on the individuals, I get that point completely. It is a very good point to make, and it was made to me just yesterday. We have got to get over that and get rid of that stigma, too.

The Convener: Yes. There will be people watching this meeting who have their own lived experience and who find that that resonates very much.

Minister, I am letting the session run on, as you can probably see from the clock. Are you able to stay for an additional 15 to 20 minutes, so that we can give the social care aspect of things a good airing, as well? We are coming to the end of talking about mental health, and that is our final theme for today.

Kevin Stewart: I am in your hands, as always, convener.

The Convener: That is good news, but I always like to ask.

David Torrance (Kirkcaldy) (SNP): How have pathways to primary care and community services been improved since the publication of "Mental Health—Scotland's Transition And Recovery" in October 2020?

Kevin Stewart: There is much that we need to do there. I touched on that earlier with regard to our ambition and vision for this parliamentary term to put mental health link workers into GP surgeries. I know—as others around the table will know—that, where that has happened already in pilot schemes, it has made a huge difference in relation to linkages. There is absolutely no doubt about that. That will make a big difference as we move forward, and we will talk more about that in the very near future.

David Torrance: The third sector plays a vital role in delivering services. What representation does it have on the bodies of the Scottish Government and NHS boards in relation to providing mental health services?

Kevin Stewart: Third sector representation is better in some places than it is in others. On how we as a Government interact with the third sector, I speak to the third sector all the time, and it is represented on many of our strategic groups and bodies. With regard to health and social care partnerships in particular, it is fair to say that there is pretty good dialogue with, and representation of, the third sector in some of them—although that is without votes at the table—and not so much in others.

Sandesh Gulhane: In your first answer to me, you asked me to talk to people on the front line. Yesterday, I was a GP talking to patients and staff on the front line.

In 2017, we were promised 250 link workers by the end of the parliamentary session in 2021. That was backed by evidence given to this committee in 2019. As of a Scottish Government publication in October 2021, only 218 link workers are in post. Most concerningly, there are no link workers in Aberdeenshire, Forth Valley, Midlothian, north Highland and the Western Isles. Why are those five areas without link workers? We are all aware of the vital role that they play.

Kevin Stewart: As I think that Mr Gulhane knows, those are not mental health link workers but community link workers. I do not have the detail of all that in front of me. As he said, 218 link workers are in post, and I will get colleagues to write to the committee around about other aspects of that. However, those are community link workers and not mental health workers.

The Convener: I will go back to the cross-portfolio point. What has been the difference for accident and emergency, the police and any of the front line services from having mental health specialists? How well covered are those first responders? I am thinking particularly of the justice system and police with regard to having that mental health expertise. People can often be advised to phone the police when they are, in fact, presenting with a lot of mental health issues. What has been the difference there over the past few years?

Kevin Stewart: There has been a huge difference through some of the things that we have done in recent times. Again, it would be worth the committee's while to talk to other organisations about what different interventions have meant in different places.

To give the committee an example, distress brief intervention work is happening in a number of parts of Scotland. It has been expanded and we will no doubt also roll that out further. If you talk to the folks working in that area, you can tell the difference that it can make. Let us take the police, for example. Pressure comes off them if they can get others in to help folk at time of need, rather than officers being tied up, often for long periods of time and often without having the skill set to deal with the difficulty that the person is facing at that point—although, let us be honest, most of our officers are pretty immense. Those things therefore make a huge difference.

Another example, although not quite so recent, is work that went on at the Victoria hospital in Fife as part of a joint partnership between Shelter, NHS Fife and the Scottish Government, which focused mainly on housing but also on dealing with mental health. Getting folk housed and getting them support took pressure off the accident and emergency department.

10:15

There are a lot of things going on and a lot of learning is happening. We have to consider what is working, what is working well and how we can export that elsewhere. The co-operation that exists in many places is beneficial for all those organisations, but the outcomes can be immense for individuals who are vulnerable and in a lot of distress.

The Convener: We must move on to talk about social care.

Paul O'Kane: I declare an interest as a councillor for East Renfrewshire.

I think that this is the first time that the minister has had the opportunity to talk about the national care service with the committee and I am sure that it will not be the last as the proposal progresses in legislation.

We are coming to the end of the consultation phase and I want to start my questions by asking about scope. The scope of the Government's consultation goes further than Feeley did. There has been a degree of commentary about that. For example, Fiona Duncan, chair of the Promise Scotland, said that she was puzzled as to why children's services were in the consultation and she expressed some concerns about how we deliver the Promise if it becomes part of the national care service.

I was at the cross-party group on learning disability and lots of folk were concerned about the consultation's scope and the particular needs of adult social care getting lost in that. What was the rationale for arriving at the scope in the consultation and why does it go beyond Feeley? How do you envisage the bill in comparison to the consultation, once we have processed the responses? I appreciate that there is a lot in those questions.

Kevin Stewart: Are you giving me half an hour, convener? [*Laughter*.] I will try to be quick.

Our ambition for the national care service is that it puts people at the heart of the new arrangements, that it is holistic and that it enables people to have the life that they want to lead.

Derek Feeley answered a lot of questions about adult social care—that was his remit—but he also said that there were a lot of unanswered questions. Mr O'Kane asks why we enhanced the scope. Folks have told me about some of the difficulties that they face and it is recognised in the proposals that transition periods are often very difficult for folk. That is also recognised by Pam Duncan-Glancy's proposed member's bill.

In all of that, we decided to ask the questions about bringing everything together and getting rid of those transition periods, and seeing what folk out there think. Mr O'Kane mentions learning disability groups being wary about it all coming together. I have talked to a fair amount of folk from the learning disabled community and only a very small minority expressed concerns.

I know that, for some, change is threatening. However, we have a huge opportunity to get it right. That is why we have asked some of the questions in the consultation. We will analyse the responses—there are some 1,300 of them, although some may be duplications. We will also consider all that we garnered from all the meetings that were held and then we will come to a conclusion on the way forward.

We have to get it right. It is all about people. Some of the responses that I have seen focus

almost entirely on people and others do not. If the committee goes out and talks to folk—as I am sure it will do over the piece—it will find that they want change. People do not feel that the delivery of social care is right in many places. They think that the postcode lottery that clearly exists is unfair and they feel that there is a lack of accountability. We have to get that right.

The Convener: Paul O'Kane is right that we will have the minister back to go into the detail.

Kevin Stewart: As many times as you like, convener.

Paul O'Kane: I thank the minister for that response. I am sure that he will be keen to come to the cross-party group on learning disability as well, so I will book him in for that.

The minister said that people want change. My experience from talking to people is that there is a desire for change but it is perhaps about cultural change rather than being solely focused on structural change.

My next question is—

Kevin Stewart: Can I tackle that point, because it is a big question, although it was a shorter sentence than Mr O'Kane's previous point.

Paul O'Kane: I am verbose if nothing else, minister.

Kevin Stewart: I know that folk will be looking at the framework of regulation, but Mr O'Kane is right that there needs to be cultural change as well. There is no doubt about that. We need to have a human-rights-based approach and listen to what people have to say. That has not been happening in many places throughout the country. Some things that are going on or have gone on in terms of delivery are ludicrous. The consultation talks about getting it right for everyone. That is what our ambition should be but, from some of the stories that I have heard, you would think that, in some cases, the ambition was how to get it wrong for folk, with silly situations that should not happen.

I do not want to go into depth in case I end up identifying circumstances, but we can provide the committee with some of the contributions that were made at the consultation events which, to be frank, show ridiculous instances in which folks have not been held accountable. We have to have accountability to be able to change the culture.

Paul O'Kane: The point has been made about accountability. We have had structural change already in social care with the introduction of integration joint boards and seven years, I think, of work on the integration of health and social care that has not yet been well analysed.

Local authorities are concerned about the changes that are proposed to accountability, because it will move to ministers rather than being with them. It would be helpful for the committee to understand what discussion is going on with local authorities about their role. COSLA has been critical of the proposal, so it would be useful if the minister could explain what discussions he is having before we get to the publication of a bill.

Kevin Stewart: Accountability for all that will ultimately rest with ministers, but local accountability is also important and is sadly lacking in various places at the moment. Local accountability is as important as, if not more important than, the accountability of whichever minister is in the chair at a particular point in time. Let us not shy away from that, because some folks say, "Oh, all of this is going to be nationally run." We absolutely need a framework of quality standards that are matched across the country.

It is also about local delivery and adaptability. Whoever will be sitting in my chair in the future will not be running the entire show day to day. It is not the case that there will be diktats through centralisation—it canna be. It is about local delivery and local accountability, but it is also about having a set of standards that folk should expect to be delivered.

The Convener: That comes back to what you said about mental health. It is about having national standards but also about what people on the ground can expect, no matter where they are in Scotland.

Kevin Stewart: Absolutely. Some of the anomalies in delivery are really stark. Five miles down the road from where you are, the level of service can be totally different or, in some cases, non-existent. People do not think about the boundaries of local authorities, health and social care partnerships and health boards; they think about the service that they need. We have to get that right across the country. That is why the change is vital.

The Convener: Sue Webber has a very short supplementary question.

Sue Webber: The level of local service being X in one place and non-existent in another is relevant to the earlier discussion about mental health.

Is economic modelling under way to cost the proposals? I am looking at a chart that shows the number of care homes in Scotland. There are 1,069, 63 per cent of which are privately owned and 23 per cent of which are run by the voluntary or not-for-profit sector. That means that the balance—142 care homes—is under local authority control. I apologise for giving a lot of numbers. In relation to the economics of funding

something or the reforms that might happen, what economic modelling is taking place?

Kevin Stewart: There will be a huge amount of modelling in various areas. Some of that work is on-going, and we will continue to look at the results from the analysis. Obviously, a huge amount of work needs to be done in looking at the 1,300 or thereabouts responses and everything else that has come in from consultation events. I can assure the committee that a lot of work is going on, because we have to get it right.

I can also reassure the committee that—as was the case in my previous role—I am happy to come back to the committee to deal with such issues subject by subject if necessary, because that is how we get good legislation. I say to Ms Webber and every member around the table that there will be a lot of hard graft, because I am determined to get this right.

The Convener: We will move on to questions on winter preparedness in the care sector.

Emma Harper: We have our winter preparedness plan for 2021-22, and there is a parallel health and social care winter overview. We have in front of us a short list of the challenges this winter: recruitment and retention, which links back to my previous question; nursing staff in care homes; infection control in care homes; staff wellbeing; services and support for unpaid carers; and delayed discharges.

I know that there are challenges, and that there are complexities in how we manage our health and social care system. Could you could give us a brief overview on how the plan will practically assist providers and social care services in meeting the challenges in the sector over the winter?

10:30

Kevin Stewart: I dinna ken if I can give a brief answer to that, as Emma Harper has covered a lot of ground. As the committee is aware, the cabinet secretary announced £300 million of funding specifically to support winter pressures. There was equity between health and social care on that front. That includes £62 million for enhancing care-at-home capacity, £40 million for interim care, £20 million for enhancing multidisciplinary teams and up to £48 million for the pay increase that I mentioned earlier.

The investment in the plan itself being published does not mean that the work stops there. The cabinet secretary and I have been in discussion with a number of health boards, health and social care partnerships and local authorities over the past number of weeks to hear from them what the pressures and challenges are and to see what other help we can provide. That will continue as we move forward.

Without doubt, this is the most precarious time in the pandemic. In some areas, there is a difficulty with staffing, often because of Covid outbreaks and often because of other illnesses. Frankly, many folk on the front line are shattered. They are tired. We must take cognisance of all that in how we get all of this right.

In some of the meetings that have taken place with health boards, health and social care partnerships and local authorities, we have been considering together—and I emphasise together—what else can be done to take pressures off. That includes how everybody works in partnership and in tandem in reducing delayed discharges. What can we do through the multidisciplinary team approach to plug gaps? If there are Covid outbreaks or other things that are keeping staff off, how can we plug those gaps? Some good thinking and some good action is taking place in some places, which we are advising other places to consider and do if necessary. That will be on-going—Ms Bell has probably been on more calls than anyone else—and will continue on a daily basis.

The Convener: Emma Harper can ask a very short question; I will then need to move on.

Emma Harper: Thanks, convener—it is very short.

I believe that cognisance will be taken of an approach dealing with rural areas such as Dumfries and Galloway and the Scottish Borders in my South Scotland region. Am I right in thinking that? This can be a yes-or-no answer.

Kevin Stewart: Yes. Some of the thinking obviously has to be different in rural areas than it is in cities. Sometimes it is not so easy to plug a gap if there is illness in a remote rural place. Some places have considered having flying squads—which is their expression, not mine—so that they can deal with care at home in places where a gap has been created because of illness or whatever.

Many people are thinking out of the box around how we do our level best for folk, and that needs to continue. We need to continue to push that. What we require—some of the folk on the calls with me are probably sick fed up of me of saying this—is collaboration, co-operation and a lot of communication in order to get that right over the piece.

The Convener: We move to questions about unpaid carers.

Evelyn Tweed: Minister, are you confident that all unpaid carers who require practical or respite support are able to access it?

Kevin Stewart: No—at the moment, I am not confident that everybody can access respite support. I should say that I want to get away from using the word “respite”; I prefer the phrase “short-term breaks”, which is a much better way of describing it. As somebody said to me, “respite” implies that care is seen as a burden, and we need to get away from that kind of thinking.

I want to ensure that, as we move forward, short-term breaks become a right, as they should. That is why the national care service consultation contained questions on that subject. I would be telling porkies if I said that, at this moment in time, everybody can access what is required, because I know that that is not the case.

I was talking to managers of carers centres only yesterday, and it is clear that there is a combination of things going on that add to the pressures. In some areas, day services have not fully opened up. That is sometimes down to space difficulties, or they have been in the same position in the past. We need to continue to open those centres up safely.

Equally, as was said to me yesterday, some carers are still afraid to send their loved ones to daycare services or on short-term breaks because they are still feart about the pandemic. As we move out of the pandemic, we will have a job of work in regaining folks’ trust and helping them to get back into their previous routine. That will take a while.

I cannot say that we are doing everything to meet those needs at this moment in time. However, as we move forward, we need to ensure that we do that, which is why that part of the national care service consultation is very important.

Evelyn Tweed: What statutory services are available to support unpaid carers directly?

Kevin Stewart: The Carers (Scotland) Act 2016 provides for a number of statutory services to meet the needs of carers. However, we know that delivery of the provisions in the 2016 act is better in some parts of the country than in others, and we need to make further changes to the situation. The 2016 act is grand, but the moneys that we have given to local authorities—substantial amounts of money—are not necessarily reaching carers services in every area.

Again, we need to change that as we move forward. That may mean making changes to the national care service legislation, or looking at what we need to do to secure—I do not use that word lightly—the money so that it goes directly to carers and carers centres as anticipated. The correct term to use is “ring fencing”. It would be fair to say that, in some areas, where all our investment is going is not open and transparent.

Stephanie Callaghan: I think that we can all agree that unpaid carers such as family, friends and neighbours are the backbone of looking after people. There has already been talk about the ethos and the culture and how they have to change. It is time that we started valuing caring roles much more.

You spoke about the pressure on unpaid carers and how they cannot wait, and I agree strongly with that. You also talked about how professionals in the front line are shattered and tired. Carers are also in that position because they had to pick up when services closed. That is not a criticism—we had to prevent the spread of the infection and save lives—but that burden fell on carers, and it was a physical burden as well as a mental one. What practical, hands-on support is there for carers, bearing in mind that they cannot wait? What can they expect to see on the ground right now and over the next few weeks? Some of them are reaching the point at which they cannot cope and they will not be able to continue in their caring role if they do not get that support.

Kevin Stewart: I know that folk canna wait, and that is why we have already made additional investment. I will just run through some of that, if you do not mind, convener.

We invested an extra £1.1 million in the short breaks fund through Shared Care Scotland last year, and £300,000 in our Young Scot young carers package to support carers of all ages to enjoy some time away. As we know, however, some folk will not do that, so we need to encourage it. This year, we have already committed an extra £570,000 for the short breaks fund.

We also recently launched the £1.4 million ScotSpirit holiday voucher scheme for tourism businesses to sign up to help low-income families, unpaid carers and disadvantaged young folk to take a break from caring.

The other thing that I want to do in the short term will require co-operation from partners including the Convention of Scottish Local Authorities, and it is to get rid of eligibility criteria, particularly some of the local eligibility criteria that have cropped up. That is of major importance to delivery.

As Ms Callaghan rightly points out, unpaid carers have seen a decline in their mental health during this time. The national wellbeing hub that I talked about earlier is also open to carers. Yesterday we talked with managers from carer centres and, although a lot of work is being done to signpost folk to the hub, we still need to do more on that front. The national wellbeing hub also has a dedicated section for unpaid carers, and we are developing a dedicated page for young carers.

Those are some of the short-term things that we have done, are doing and will do.

The Convener: I am moving on now to questions from David Torrance on the remobilisation of social care support services, which I find a bit of an anomaly because nobody has not been mobilised—they have been ultramobilised. That might not be the wording that we should be using.

David Torrance: The pandemic has seen a reduction in and even an end to some care-at-home services, and many community-based and third sector organisations have been unable to provide services or they have been forced to close because of pandemic restrictions. Is there a co-ordinated social care remobilisation plan? Who are the key stakeholders involved if there is?

Kevin Stewart: I turn to Ms Bell to talk about the folk who are involved in the remobilisation plan because I cannot remember off the top of my head.

Donna Bell: There was a wide range of partners involved on the original group from across the NHS, health and social care partnerships, integration joint boards, COSLA, the third sector, professional bodies and so on. We are now in the implementation phase of that, so we are working individually with local partnership areas. Again, that involves a wide range of local partners including NHS boards, integration joint boards, local authorities, the third sector and organisations that represent people with lived experience. The phases are changing. We continue to engage with national bodies, but we are also at a point where we are engaging with local partnerships.

10:45

Kevin Stewart: Convener, you are right to point out that we are talking about remobilisation here, but folks have put in a hard shift over the course of all of this. Some services were disbanded during Covid, but the vast bulk of folk who were in those services moved and worked elsewhere. We owe a huge debt of gratitude to those who have kept our most vulnerable folk cared for during these very tricky 20 months.

I am sorry to repeat myself, but we are in a precarious time. In fact, it is the most precarious time. It would be fair to say that, in many areas, there are staff shortages. Some of that is down to illness and some of it is down to the fact of Brexit. One service that I spoke to had lost 40 per cent of its staff, who returned to their home countries after Brexit. That is inevitably going to have an impact.

We also know, because we have heard the stories, that other folks have left social care for the moment because they are tired and they have gone into what they see as easier jobs in hospitality. I hope—I think that we all hope—that those folks come back, and the national care service proposal gives us an opportunity to consider national pay bargaining for them, with a real hard look at pay and conditions and, beyond that, at opportunities for career progression.

We all have a duty to recognise that care is a profession. We have a wee bit of education to do with some folk around that, but we should continue—and I hope that the committee will continue—to refer to it as a profession as we move forward.

The Convener: Those issues came through loud and clear last week, when we spoke to care organisations.

We move on to questions from Sue Webber on delayed discharge and interim care facilities.

Sue Webber: I understand the rationale for the interim care facilities, but surely they are just going to result in more of the most vulnerable people making multiple moves over a short period of time from one facility to the next. What will happen if there is no care package in the community after the six weeks? If the community care issues could be solved in six weeks, why has that not happened already? This is all the stuff that is going round in my brain. Also, delayed discharge is not new. If anything, during Covid, we had some rapid discharges from hospitals into care facilities and we are now looking back and being a little bit reticent about those decisions.

I am trying to figure out what will happen if, after the six weeks, nothing is in place in the community. Also, how many people are currently in what are classed as interim care facilities? Where is that data recorded? Are they still classified as delayed discharges? I ask those questions so that we can get a sense of how things are progressing.

Kevin Stewart: There was a huge amount in that question. Ms Webber said that it is all buzzing about in her head, and I think that it is probably all buzzing about in our heads at the moment, as well.

I explained to the committee earlier the level of engagement that we have with partners around getting all of this right as we move forward. At the moment, we have a significant number of folk in hospital who should not be there, and it is best that they are not there. Some of the solutions will be interim ones, but the ambition is to get folk back to living independently, with support, if that is possible and as soon as we can.

Rather than going on about all of the possibilities, we will write to the committee about

what we are doing. We do not have some of the information that Ms Webber is asking for regarding people in interim situations. I will write back to the committee in more depth to explain how we are handling that.

Sandesh Gulhane: Hospital at home was first introduced in NHS Lanarkshire in 2011. It has had great results. In March 2020, Jeane Freeman announced £1 million of funding for the programme. Why, 10 years after hospital at home was first introduced and a year after £1 million was invested, do 10 health boards not have adequate hospital at home resources to prevent admissions?

Kevin Stewart: The cabinet secretary, Humza Yousaf, recently announced additional resources for hospital at home. It is a great way forward. I recently had the pleasure of meeting teams in Edinburgh and Lanarkshire. The deputy chief medical officer, Graham Ellis, is from Lanarkshire and has been a great advocate for hospital at home. That is why we are investing to expand the programme further, which is a good thing.

Stephanie Callaghan: I remind members that I am a councillor on South Lanarkshire Council. Just as Sandesh Gulhane has done, I will mention NHS Lanarkshire. I was at the health board briefing last Friday, where we were told that there was a 30 per cent to 35 per cent increase in demand for supported discharge from hospital. So, despite a 30 per cent improvement in discharges from hospital, the situation there is standing still.

The third sector is critical to that situation. What further support could be offered to it?

Kevin Stewart: Some solutions have to be found locally. That is why we are having conversations with partners across the country to mobilise everything and to ensure that we do the right thing.

We do not have the luxury of not involving everyone. There must be collaboration and co-operation between Government, local authorities, health and social care partnerships, NHS boards and the third sector so that we can do our level best for everyone in these precarious times.

Carol Mochan: My question is about rights for care home residents. We know what happened during the pandemic. Does the minister feel that the opening up of care homes to visitors provides adequate access for family and friends to ensure the wellbeing and health of residents?

Kevin Stewart: Every week, I get a report on how the guidance "Open with Care—Supporting Meaningful Contact in Care Homes" is working, and where it is not working. There are still some difficulties with outbreaks in certain places, but "Open with Care" should allow greater access for relatives. Even when there is an outbreak, there are still ways for relatives to have access to their loved ones in care homes.

The committee will know that we have had two consultations that have now come to an end. I cannot remember how many responses we have had.

Donna Bell: I do not have the figure.

Kevin Stewart: We are both losing our memory on that, but we can send you the figure. There has been a significant response.

I should say that Anne Duke, whom Anne's law is named after, passed away at the weekend. I give my condolences to her family. We will move forward on Anne's law. I think that there is cross-party support for getting that right for people as we move forward. That will be Anne's legacy. I pay tribute to her daughter, Natasha, and her husband, Campbell, for their efforts in getting it right for their family and for everyone in the future.

The Convener: Sue Webber wants to put something on the record.

Sue Webber: Thank you, convener. In the question on the theme of delayed discharges, I should have declared that I am a City of Edinburgh Council councillor. I apologise.

The Convener: The minister will be pleased to hear that we have come to our last theme for questioning in this extended session with him. That will always happen when a minister comes in front of us for the first time: we will go through absolutely everything in their portfolio.

Gillian Mackay: We heard from last week's panel about the role of golden hellos in recruitment. It was made clear that any such initiative would need to be funded across the board, otherwise some providers would not be able to afford them. Will the Scottish Government consider funding an incentive for people to be recruited into social care?

Kevin Stewart: That is a question and a half. Introducing golden hellos, or golden handcuffs, is a very difficult thing to do, and it could end up creating more problems than it resolves. I will be honest with Ms Mackay and the committee. I am pretty pragmatic about many things, and I do not automatically shut doors on suggestions. We could look at that but, in some regards, I do not think that it is necessarily a solution.

Gillian Mackay: I have one more question, which is on social work. Social workers have maybe been the only front-line workers whom we have not discussed. Like many other services, social work has come under increased pressure during the pandemic, but we hear very little about the impact that it is having on social workers. Does

the minister have a sense of the wellbeing levels in the profession and how they might be impacting on retention? We know that the average working life for a social worker is around seven years.

Kevin Stewart: I cannot give the retention numbers off the top of my head, but we will furnish the committee with that information.

I have spoken to a lot of social workers. Last week, I spoke to criminal justice social workers, and I have spoken to social workers in children and families services and adult services over the past few weeks and months. It would be fair to say that there is a lot of pressure on them, as there is on everyone else, and things have been very difficult for them at points, particularly during the lockdown periods, because of the way that they work. However, folks have behaved admirably, and they have done amazing things over the piece.

In conversations with social workers, one of the key messages from them is that front-line staff should be more empowered. We must do that. Social workers sometimes feel that they are the poor relation of other professions, and we have to change that. Part of the conversation in the consultation is about whether we should move to a social work agency, which was Derek Feeley's suggestion. There is that issue to consider, and we will look at the analysis on that issue.

One big bugbear of social workers is that they feel bound by the eligibility criteria, which are often set locally. As I said, we must work with COSLA in the short term to eradicate some of that, because we are not doing good by the professionals and front-line staff, or by the individuals and families whom they serve.

The Convener: I thank colleagues for their questions, and I thank the minister and his officials for their time. We will, of course, be seeing you many times over the next year, minister.

Kevin Stewart: I am sure that that will be the case, convener.

The Convener: We will take you up on your offer to come back to the committee whenever we want to drill down into any particular aspect of your remit. You have provided us with an excellent overview of your priorities for the coming year.

I suspend the meeting briefly before we move on to our next item.

11:00

Meeting suspended.

11:06

On resuming—

Subordinate Legislation

National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2021 (SSI 2021/367)

The Convener: The third item on our agenda is consideration of a negative instrument. The instrument amends the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 to allow for the provision of dispensed medicines at premises that are not a registered pharmacy. That is in line with the exception that was created by regulation 248 of the Human Medicines Regulations 2012.

The Delegated Powers and Law Reform Committee considered the instrument and raised no issues, and no motions to annul the instrument have been lodged.

As members have no comments, I propose that the committee does not make any recommendation in relation to the instrument. Do members agree?

Members *indicated agreement.*

The Convener: At the committee's next meeting, which will be on 23 November, we will take evidence on data and technology in health and social care.

That concludes the public part of our meeting.

11:07

Meeting continued in private until 11:54.

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