OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 2 November 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 2 November 2021

CONTENTS

	Col.
INTERESTS	1
DECISION ON TAKING BUSINESS IN PRIVATE	2
TRANSVAGINAL MESH REMOVAL (COST REIMBURSEMENT) (SCOTLAND) BILL: STAGE 1	3
SUBORDINATE LEGISLATION	45
NHS Education for Scotland Amendment Order 2021 (SSI 2021/330)	45
National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2021 (SSI 2021/335)	45

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
9th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Greig Chalmers (Scottish Government)
Paul Hornby (NHS National Services Scotland)
Dr Ros Jamieson (NHS Greater Glasgow and Clyde)
Dr Anna Lamont (NHS National Services Scotland)
Roseanne McDonald (NHS National Services Scotland)
Marie McNair (Clydebank and Milngavie) (SNP) (Committee Substitute)
Terry O'Kelly (Scottish Government)
Mark White (NHS Greater Glasgow and Clyde)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 2 November 2021

[The Convener opened the meeting at 09:02]

Interests

The Convener (Gillian Martin): I welcome everyone to the ninth meeting in 2021 of the Health, Social Care and Sport Committee. I have received apologies from Evelyn Tweed and Paul O'Kane. Marie McNair and Jackie Baillie are here as substitute members. I welcome you both.

Our first item is to invite Jackie Baillie to declare any interests that are relevant to the committee's remit.

Jackie Baillie (Dumbarton) (Lab): I have no relevant interests, convener.

Decision on Taking Business in Private

09:03

The Convener: Agenda item 2 is to decide whether to take items 6, 7 and 8 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill: Stage 1

09:03

The Convener: Agenda item 3 is an evidence session with NHS Greater Glasgow and Clyde and NHS National Services Scotland on the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill. All our witnesses today are remote.

I welcome Dr Ros Jamieson, who is clinical lead for the complex mesh national surgical service and clinical director for obstetrics and gynaecology at NHS Greater Glasgow and Clyde; Mark White, who is director of finance at NHS Greater Glasgow and Clyde; Dr Anna Lamont, who is interim medical director in procurement commissioning and facilities at NHS National Services Scotland; Roseanne McDonald, who is associate director in procurement commissioning and facilities at NHS National Services Scotland; and Paul Hornby, who is head of strategic sourcing and commercial in national procurement at NHS National Services Scotland.

I want to ask about the current status of the service—I should probably direct my questions to Ros Jamieson. Is the service operating with a full multidisciplinary team? I would like an overview of the specialists who are part of the team and are available for any onward referrals.

Dr Ros Jamieson (NHS Greater Glasgow and Clyde): The funding that we have received from the Scottish Government via NHS National Services Scotland has allowed NHS Greater Glasgow and Clyde to consolidate and expand the mesh treatment service for Scotland. That has ensured that we can provide a smooth and consistent journey for women who are experiencing mesh complications, from assessment through treatment and into follow-up.

We have increased our cohort of urogynaecology specialists to four. That is important, because women have expressed the desire to have a choice of surgeon, and we are now able to provide that. We have dedicated colorectal surgeons, who are vital in providing complex surgery. We also have in place experienced radiologists with an interest in, and experience of, gynaecology imaging, which is vital to the planning of that complex surgery.

We have put in place other specialists to support women through their journey. Specialists who can provide pain services are available at the clinics that women attend to discuss their issues and plan any treatment that they wish to progress with. To provide further support to women, we have recruited a clinical psychologist who is dedicated to the mesh service to provide that critical level of care.

We have also recently appointed two whole-time equivalent CNSs for the mesh service. They will provide a vital role in the pathway. One of the pieces of feedback that we got from women who are currently going through the service was that they would like to be able to contact the service in between planned appointments to discuss any issues that they have. Those CNS posts will provide women with the ability to do that.

Another piece of feedback that we received was that women would like an increase in the physiotherapy aspect of their care. We have increased our physiotherapy capacity so that physiotherapists are also able to attend the planning clinics and see the women through their journey in the wards and also through follow-up.

To support the service in other ways, we have recruited a data manager for the mesh service. We feel that that will be important. It will enable us to provide and make available the outcomes of our treatment, which will be helpful to us.

I think that that completes the overview. I am happy to answer any questions that you might have.

The Convener: Thank you. First, is a CNS a clinical nurse specialist?

Dr Jamieson: Yes.

The Convener: I just wanted to clarify that for the record, because we had a bit of a confab about what that meant when you first mentioned it.

The issue of the choice of surgeon has been very much a focus of the mesh survivors. In our open session last week, I asked about the fact that women might not want the surgeon who put their mesh in or who partially removed some of the mesh to come back and be their surgeon again, because they have not had a good experience with them. Can you tell me whether the surgeons who were involved in the historical mesh removal procedures that the women have an issue with would be part of the team or whether you have got in new people with new experience and new training as a result of some of the things that have arisen over the past few years, since the women have brought the topic to public attention?

Dr Jamieson: Absolutely. As I said, we have increased the cohort of specialists to four: two specialists who have been with us over the longer term and two holders of additional posts. That will bring in a choice for women and make it possible for them to see someone who, historically, has not been involved in their care.

Gillian Mackay (Central Scotland) (Green): Good morning, everyone. How is Covid-19 impacting the service from the point of view of staff absence or redeployment, or people's ability to access a referral because of capacity issues in primary care? That question is probably for Dr Jamieson.

Dr Jamieson: I am happy to answer that.

Unfortunately, as you will be aware, Covid has affected the whole of the national health service and all its services. Therefore, the mesh service has been affected.

Because of a reduction in our capacity to access theatres, we have not been able to do as much surgery as we would have liked, but we are still able to perform mesh surgeries. To date in the financial year 2021-22, we have performed 20 mesh removal surgeries. The number varies from between two and five such surgeries per month.

We have a waiting list of 20 women who have been through the pathway and are waiting for mesh surgery. We hope that, as Covid is reduced, we will get more theatre access and be able to treat those women in an appropriately timeous manner.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in how the fact that the specialist mesh removal service exists has been communicated to the health boards. How do they know that it exists?

Dr Jamieson: That is a really important issue.

I point out that, when I am speaking, I can see only Mr Hornby; I cannot see who asked the question. However, that is okay—I will carry on.

It is important that the service is seen as a national mesh service. We have communicated information about the service to the boards. We have provided information on referral criteria, what should be done locally, and what can be done locally. We have also developed a referral form so that as much information as possible can be sent with the referral, the process is streamlined, and we do not have to go back to ask for more information.

In addition, we have distributed a pathway so that the different boards can see what happens on the women's journey. When they have finished their treatment, we aim to communicate with the boards on what the follow-up treatment is and what can be done locally. That is one of the things that we are trying to improve. The physiotherapists are communicating with local physiotherapists to ensure that the women concerned get appropriate treatment and management in the period after their surgical treatment, regardless of where they live.

Emma Harper: I have a couple of wee follow-up questions. Last week, we heard that some general practitioners might need help to diagnose mesh complications. What help is being provided to primary care to enable GPs to know that the service exists? What help and support will be given to GPs so that they are better able to refer?

Dr Jamieson: I agree that that is really important. As a group, the women are appropriately aware and will help their GPs to make appropriate referrals to secondary care. There is on-going work to ensure that our service is known throughout Scotland and that GPs are aware of it.

09:15

Marie McNair (Clydebank and Milngavie) (SNP): Good morning. I have a follow-up question. Can someone directly self-refer to the service?

Dr Jamieson: No. The initial referral needs to be through secondary care. However, once they are known to the service and are in the process, we have contact ability through the specialist nurses.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): What health professionals will be part of the multidisciplinary team? How wide will that go, depending on women's needs?

Dr Jamieson: We are following the National Institute for Health and Care Excellence's guidance on membership of the multidisciplinary team, which is really helpful in that it is clear about what types of professionals and specialists should be in it. That includes urogynaecology specialists, dedicated colorectal surgeons and anaesthetists. That is a really interesting part of the development. Quite often, women progress quite far down the pathway then hit a hurdle just before their surgery, when we realise that we have not done appropriate pre-operative work. We hope that bringing anaesthetists into the pathway much earlier will prevent some of the disappointment that can—[*Inaudible*.]—with physiotherapists, as I mentioned, and pain specialists. The group is multidisciplinary, and it is functioning well.

It is also important that specialists are in the mesh clinic so that women have access to them and can speak to them. Putting them in place and women being able to speak to a colorectal surgeon, for example, to discuss what is involved in complex surgery will help to inform them and enable them to make the appropriate choice.

Stephanie Callaghan: Thanks very much. That is really helpful.

I want to ask about the team making decisions and whether the best care and treatment available can be delivered within the specialist service. Is

that completely down to the team? What choice will women have in relation to onward referral?

Dr Jamieson: On decision making, we have adopted NICE's patient decision aids. That is worked through with the women in their initial consultation. We have extended the consultation appointment time to one hour; it is important that women have time with specialists to discuss what can be very complex treatment. A decision is not made during that appointment. The woman goes away and has time to consider and discuss matters with family members or people who have gone through treatment. A second consultation in which questions can be answered is then arranged.

Stephanie Callaghan: Just to be clear, are women given options to consider when they go away? Does that play a big part in the decision in the second consultation? Do they have real input in that?

Dr Jamieson: Absolutely. We have developed our patient information based on the feedback that we received. We listened to women, who told us that they needed more information; therefore, we have improved our patient information. An hour is not enough time to make a decision, so they can go home and make the decision using the information, then come back with queries.

Sue Webber (Lothian) (Con): I have a quick question for Dr Jamieson. What is the time period between the first and second consultations? That will have a big impact when you are planning your service.

Dr Jamieson: Absolutely. There is usually about four weeks between the two appointments. After that, it is important that the decision is rubber-stamped—if that is the right word—as it goes back to the multidisciplinary team. Initially, the referral is presented to the MDT and the range of options are discussed. Those are then discussed with the woman and a decision is agreed, which then goes back to the MDT for final approval.

Carol Mochan (South Scotland) (Lab): My question is probably also for Dr Jamieson. I am interested in the clinical nurse specialist role. I have read that, in other services that have such a role, it can be quite successful in developing patients' confidence right through the care pathway. How will the role work, and how early will the women meet a clinical nurse specialist to go through the information?

Dr Jamieson: I agree that clinical nurse specialists will be absolutely crucial to the success of the service, because they can give women time and clinical expertise. We have recruited two whole-time posts consisting of three people. I do not think that I included them in the list, but they also attend the MDT. They will be at the initial consultation and the clinics.

We did a patient-experience exercise with women who are currently going through our service, and comments included that they felt that follow-up needs to be more consistent, so the follow-up role is a vital one for specialist nurses to play. They will see the women in the ward, then arrange a follow-up telephone call for one week later. They will also be available between then and the next planned follow-up, which is with the surgeon.

Carol Mochan: That is helpful. Thank you.

Jackie Baillie: My questions are also for Dr Jamieson.

I will go back to timing. You said that 20 people are waiting for surgery. How long is it anticipated they will wait?

Dr Jamieson: As I said, our goal is to be within the Scottish Government's recommended treatment time, which is 12 weeks. We are not within that timescale at the moment, but that is understandable.

We estimate that we will, when we are running at full capacity, be able to do two mesh surgeries per week, which is eight per month. That will depend on when we are given access to our dedicated theatres again. As you are aware, currently, NHS GGC is prioritising operating theatres for cancer treatments. The pressure on the service is easing, so we hope that it will not be long before we are able to get back to a full service.

Jackie Baillie: You are suggesting that it will not be long, but we are all aware that winter pressures are coming. Would not it be more realistic to plan on the basis that it will not be until after the winter that you will be back doing full surgery on the 20 mesh women?

Dr Jamieson: I am not able to predict that. Although the majority of elective surgery is not going ahead at the moment, we have still been able to deliver some mesh surgery in recent months. We are grateful to NHS Greater Glasgow and Clyde for allowing us to do that. Although numbers have been reduced, we are still able to provide some treatment. That has been recognised as a priority.

Jackie Baillie: That is good news for the women. How many have been referred to the service so far, and how long are they waiting?

Dr Jamieson: Give me a second to bring up the figures.

Jackie Baillie: The committee has received written evidence from some women. One went to the gynaecology service in Paisley, which is in the

same health board area, but it has taken two years for her to be referred to the mesh service. Another woman reported having a magnetic resonance imaging scan in September and being told that she would get an appointment with the mesh service, but that appointment is for July 2022, which is 10 months away. I am trying to drill down into how long people are waiting before they even get to you.

Dr Jamieson: I do not have the exact figures with me today. I am aware that our waiting times for consultation are longer than we would like. I have some figures that show that 64 women were reviewed by the MDT service in September, which is 26 more than were reviewed in August. There is turnover, but some women wait longer. Part of our job is to ensure that health boards in other areas are aware of the service so that the delay in referrals is reduced as much as possible. As we progress, more boards will become aware, so I hope that delays in women being referred to the service will reduce.

Jackie Baillie: Is the delay the responsibility of the referring health board? It sounds as if referrals are made but there is pressure on your service that prevents you from seeing people as quickly as you would like.

Dr Jamieson: The increase in our team of specialists and the expansion of the whole service will be adequate for the future. I do not mean to keep blaming Covid, but it is a fact that a significant part of the delay has been due to it. We had to redeploy clinicians to deal with the pandemic.

I am confident in the way that we have expanded and set up our service. We have also moved into new facilities. Women told us that when they came to their clinic appointments, the outpatients area was shared with other services. We have moved the mesh service into the New Victoria hospital, which is a nice new building that has a dedicated area for the service. We have also increased the number of rooms. We are developing, and will deliver, a service that is fit for purpose. We will meet demand, although at the moment waits are longer than we would like.

Mark White (NHS Greater Glasgow and Clyde): In response to Jackie Baillie's question about waiting times, I note that the board is currently operating at 40 to 45 per cent of our pre-Covid level of elective activity. The figure was as high as 60 to 65 per cent as we came out of the summer, but the much-publicised current pressure has brought us back down to about 40 to 45 per cent. I doubt that we will have much respite from that in the next few weeks. Much of our capacity is taken up with emergencies and urgent cases.

We are doing everything we can to get the level of activity back up, although Jackie Baillie is probably correct that it is unlikely to increase within the next few weeks. However, we hope that, through the winter and certainly as we come out of it, we will get back up to the rates at which we were operating at the end of the summer, then ramp them back up again to pre-Covid levels as we move into next spring and summer.

09:30

The Convener: We will move on to the reimbursement aspect of the bill, which is its main focus; it is about reimbursement for women who have had surgery privately or who have arranged surgery privately. We want to drill down into the eligibility criteria. Stephanie Callaghan will lead on that line of questioning.

Stephanie Callaghan: What further detail is required on eligibility for the scheme? Is there anything more that we should look at?

Mark White: I think that the details that are outlined in the bill are quite comprehensive. I guess that every case will be different in terms of its merits. The majority of the information that is proposed in the bill is probably at the correct level. One question that has been alluded to is about funding that patients have received to go abroad. If someone has used crowdfunding or whatever, it will be critical to establish that before the claim is processed. However, that can probably be covered in the application.

The bill is pretty comprehensive, and the information that will be required is pretty much as it is documented in the bill.

Stephanie Callaghan: Does it seem to you to be reasonable that women who might be back living in Scotland now but who were in England at the time of mesh removal will be excluded from eligibility?

Mark White: That does not sound fair to me. I am not sure whether there is any clinical background to that, but from a financial point of view, I would not imagine that that would be a ground for exclusion. However, I am not aware of the background of previous decisions on that, including clinical decisions. Perhaps my clinical colleagues can help with that.

Dr Anna Lamont (NHS National Services Scotland): On the specific question of eligibility for reimbursement for previous surgery, I defer to my colleagues in the Scottish Government. We are primarily here to speak about commissioning of services and the external provider, and the current provision in NHS Greater Glasgow and Clyde. Our understanding is that the bill is specifically about reimbursement for previous surgery that was

substantively organised while a person was resident in Scotland. We will be administering the reimbursement, but who is to be reimbursed and the exact criteria for that will be established through co-ordination with our Scottish Government colleagues.

Jackie Baillie: I want to ask Dr Lamont about the group of women who would describe themselves as the in-betweeners: those who are in the process of arranging private treatment while the bill is going through the Parliament. Should they be covered by the bill? Will the setting up of the specialist service have any impact on them? Could they be asked to start at the beginning and then be referred through the specialist service, or should they be covered by the bill?

Dr Lamont: As I said, the requirements are for the Scottish Government to specify, and we will be working with our colleagues there. However, the bill is specifically about cases where the substantive arrangements were made prior to 12 July. My understanding is that, if the substantive arrangements were made prior to that, whether surgery has or has not occurred by this time, the issue is to do with where the arrangements were substantively made.

The issue was raised at the previous evidence session. Following the cabinet secretary's announcement on 12 July, the expectation was that women would be aware that free provision of the surgical removal of mesh was available through NHS Scotland at the specialist centre in NHS GGC—as people were already aware—and through providers in NHS England, as well as through the option of external providers, for which we were developing commissions.

Jackie Baillie: Is 12 July quite an arbitrary date? Equally, could another date be picked?

Dr Lamont: The choice of 12 July reflects the decision-making process and the commissioning process in National Services. The initial commissioning panel was established in June, but the invitations to tender were sent out much earlier in the year. The commissioning panel agreed in July that two providers would be allocated to the framework, which led to the announcement on 12 July. We would typically expect a process of about six months from the announcement of an award to a commissioning framework to having eventual contracts for women to be provided with surgery, although that period varies and we have a continuing process of working with private providers to establish the surgical service.

The Convener: I will follow that up. Women who do not want to go to the NHS mesh removal service may have the option to choose a private provider. Where do you stand on helping women to do that? How will the pathway work?

Dr Lamont: Having the option of private providers is an important aspect, but such options must align not just with informed choices but with women's needs. My colleague Roseanne McDonald will speak about the referral pathway, which she has been very involved in.

Roseanne McDonald (NHS National Services Scotland): As Anna Lamont said, we have been working with two independent providers to progress the contract for Scotland. It is important for the specialist MDT in Glasgow to oversee the pathway for referral out of Scotland, because women who go forward for mesh removal need to be assessed and taken through the decision process before being referred to an independent provider. We expect that we will work up a relationship between the MDT in Glasgow and the independent providers.

As Anna Lamont said, the approach is intended to ensure that informed choice and the women's needs are closely aligned. We expect that, when women are referred to Glasgow, they will meet the team, have a choice of surgeon in Glasgow and go through the consultation. An NHS provider in England could then be considered and, if that was not an option for the women, we hope that there would be an option of independent providers, once we have progressed the contract.

The Convener: We will now ask for your views on how appropriate the costs that the bill outlines are, given your experience.

David Torrance (Kirkcaldy) (SNP): Last week, we heard from witnesses that costs have varied, especially when women have sought treatment during the pandemic. One witness incurred higher costs because of other medical conditions. Should more costs be specified?

The Convener: I am not sure who would be best to answer that. We are asking for your opinion, but those of you who are in procurement might be best placed to answer.

Mark White: I am not in procurement, but from a finance angle it is clear that the costs will vary, and the bill acknowledges that. The bill sets out a range of assumptions and estimated costs. I would assume that, if costs vary from the benchmark or guide costs in the bill, they will be treated on their individual merits. I would assume that, provided that the costs are not too far from those in the bill, there should not be a problem in processing them. Our procurement colleagues in NHS NSS would have to tell us what parameters they have set within those contracts.

Paul Hornby (NHS National Services Scotland): There are several types of surgical interventions that we can ask for costs for in our requests to the independent providers. The range of costs varies between £12,000 and just over

£17,000 for the provision of those surgical interventions. There are lots of other costs involved, but I am referring to the range of costs for the provision that we have engaged from the market.

David Torrance: Should the same criteria and standard rates apply to women who have already had treatment as will apply to any woman who is referred for private treatment in the future?

Paul Hornby: As Dr Lamont outlined, we are in the process of finalising that. We have an agreement with the providers, but those costs that I have just shared will be the ones in place for one year, plus a year's extension. Again, those are the costs just for the operation and there are other costs that are indicated as part of the whole service. Those are the costs that will be in place for at least two years.

Dr Lamont: I differentiate between the funds allocated for the bill and those for the on-going commission of service. The costing of commissioning surgery from an external provider refers, as Mr Hornby has described, to the on-going costs. In reference to the previous question about the refunding of additional costs, as was outlined in the previous evidence session, additional costs will be accounted for, including those relating to travel, subsistence and insurance. The exact details of how those costs are refunded, what is eligible and what will be covered is a question for my colleagues in the Government.

For the future, it is important to recognise that we must commission wraparound care. Although we are focusing on a surgical service, people need more than that—it is about ensuring that we have holistic wraparound care that ensures that patients can attend surgeries safely, can be cared for before, during and after the surgery, and can travel home and receive that important aftercare.

The women who have been harmed by mesh are looking for a flexible and personalised service that recognises that everyone is different. We have to ensure that the surgical service that is commissioned and provided does not just provide for those people for whom it works well and have low surgical risks but also allows for those women who have additional surgical risks. As my colleague Dr Jamieson has described, the involvement of the multidisciplinary team and our anaesthetic colleagues is so important in that. Those are the factors that we are continuing to explore with the private providers.

09:45

Roseanne McDonald: Dr Lamont covered my point nicely. As part of the independent provider for procurement and commission, we are working up a travel and subsistence policy. It is our intention that travel and daily subsistence for the woman and a partner would be covered in that. That is very much in line with our intentions.

David Torrance: In evidence given to the committee last week, the bill team said that there would be no cap on costs. Why do you think there should be a cap?

Dr Lamont: I draw a distinction between the costs of the services that we are commissioning and the costs that are in the bill. It is important to draw that distinction. The bill that is being discussed today is about refunding the costs of previous surgery. Exactly what will be provided and refunded is a matter for my colleagues. An indicative cost has been provided, but they have also said that each person will be considered as an individual case and their personal circumstances will be taken into account.

On future costs, we are commissioning a surgical service, so the costs that we are looking at are the costs of providing surgery in the future. There will also be additional costs, as have been spoken about, for the wraparound holistic care that carries them from Scotland, through their surgery and back safely.

The Convener: On the administration of the scheme, do you think that the number of women who have had surgery or have applied for surgery that is estimated in the financial memorandum is realistic? You are obviously having to look at your resources and finances in response to the situation, and you are administering the scheme. The estimate is for around 20 women and it could be up to 40, but we really do not know yet. Do you think that the estimate in the financial memorandum is realistic?

Dr Lamont: The issue here is the historical surgery that has already been provided. We are therefore reliant on understanding how many women have sought private surgery, who arranged that in Scotland, and who will then seek reimbursement. There are circumstances in which women might choose not to seek reimbursement, and that has been recognised as a particular issue, especially perhaps when crowdfunding has been involved and reimbursement might be more difficult.

That is why there is significant uncertainty about the numbers who will seek reimbursement under the proposed legislation.

Gillian Mackay: In its response to the consultation, NSS said that reimbursement should be made only when the outcome of the mesh surgery was fully successful and requires no further treatment on the NHS. Can you expand on that? Is it fair to exclude women who might have

suffered complications or had unsuccessful surgery through no fault of their own?

Dr Lamont: It is important that each person is considered independently. We are not talking about excluding women. If surgery has been undertaken and further surgery is required, it is important that those people do not feel excluded and that we recognise that further surgery and costs might be incurred. The exact eligibility for what is within and without refunding is, as I have said, a matter for my colleagues, but the bill certainly does not seek to exclude women just because some surgery has not been as successful as intended. On the other hand, it recognises that additional costs might be incurred and that they will need to be taken into account.

My colleague Mr Hornby might be able to provide you with more detail.

Paul Hornby: I am not quite sure what else I can add to the position that has been painted. As Dr Lamont has pointed out, we need to take a case-by-case approach as these cases are presented and reviewed along with the information from our Scottish Government colleagues. The most important thing is to find out how the patient's situation can be resolved and how they can be helped to get where they want to be.

Sandesh Gulhane (Glasgow) (Con): I should first of all put it on the record that Dr Jamieson was the clinical supervisor for my own work.

I have a question for Dr Lamont about costs. I know that we are talking about reimbursement here, but what do you think the indicative costs will be for women going to the NHS, Spire Healthcare in Bristol or the United States?

Dr Lamont: As you have said, the bill is about reimbursement, and future costs are not part of it. They will be an issue for the service that is being established.

The first choice that we would always offer would be the NHS Greater Glasgow and Clyde specialist service, and it is important that we try to explain to the women who have been harmed that the expertise and skills are now available in Scotland, as is the credentialling to demonstrate them. We will also be able to provide those services through NHS England through the NHS commissioning service, and there is the third option of a private provider. All that is not part of the bill.

My colleague, Mr Hornby, has provided a range of indicative costs. The exact costs that we have at the moment relate only to individual surgical procedures, but those costs are still being developed, because we must cover any complications that might arise, as well as insurance and safe travel to and from the place of surgery. Our focus is on ensuring not just safety but that the same key and informed shared-and-cared decision-making that is available in NHS Greater Glasgow and Clyde or an equivalent service is available through the commissioned private providers.

Carol Mochan: I have a question about the third option, which has been referred to a couple of times now. I have to say that I am unclear about the timeframes, but are you clear about them? When will we get an answer to that?

Paul Hornby: Perhaps I can start off. We have identified two providers who can provide the service, and we are working closely with each to understand how the specific surgical interventions will work with the patient pathway that my clinical colleagues have described.

We have been working with those providers since July, and will continue to do so. As Dr Lamont has indicated, it normally takes some time to award the commission to clinical service providers and then work through the detail of the different potential patient journeys and the different types of care that need to be provided on a continual basis.

The point that Dr Lamont made is key. There are contingencies because things might not go exactly to plan, so the question is how those are managed through the pathway journey. Work is being done with clinical colleagues and the suppliers on that detail. Dr Lamont indicated a period of about six months from the award of the contract to contracts for operations. They are on that journey just now and the work is quite well developed. It needs to be finalised so that the service is ready and the referring clinical staff can be confident that it gives the patients as good an option as they would have if they remained within the NHS.

Roseanne McDonald: We are awaiting formal confirmation that the lead surgeon for Spire Healthcare is a member of an NHS England mesh centre. That was part of the specification. We anticipate that that formal notification will come through shortly and that we will be able to move forward with the Spire Healthcare contract soon.

We are working closely with Dr Veronikis and the company that he oversees—Gynecologic & Reconstructive Surgery—to understand the contract that he has with the hospital where he operates to ensure that we have covered all the bases not only for mesh removal but for any incidental complications. It is extremely important that we consider those facets because the mesh removal is only one aspect. We have to ensure that we have cover for people in case they have something like a clot or a heart attack.

We are working closely with Dr Veronikis on that so that we can proceed with the contract. We do not have any timescales at the moment but we will be happy to update the committee, and we hope to be able to do that soon.

The Convener: Thank you. That is helpful. It goes to show why individual patient experience is important. There is no way that we can say that only one type of procedure is involved because everyone will be different.

Sue Webber has some questions on the administration of the scheme.

Sue Webber: Roseanne McDonald said that you are seeking to assess whether the clinician who will carry out the procedures in the Spire hospital in Bristol has an affiliation with an NHS trust in England. Is that because they work only privately at the moment?

Roseanne McDonald: I cannot comment on that surgeon's position at the moment, but the clinical advisory panel that oversaw the specification for the independent provider recognised that it was important that the lead surgeon had a volume of reportable mesh outcomes and that they operated within an NHS mesh centre. That is the information that we are waiting on. I am not sure of the individual's working arrangements.

Dr Lamont: One of the key elements that we look to establish with any external provider is that, when women attend that provider, they can expect to experience care that is at least as good as the wraparound holistic care that NHS Scotland can provide. In particular, we look for standards of shared decision making and competent multidisciplinary team input that is able to have the shared discussions that my colleague Dr Jamieson described. At NHS Greater Glasgow and Clyde, women can have the conversations, then go away and come back, and we are looking for a similar level of engagement.

Similarly, there are issues with volumes and understanding the skills that are involved. At the previous committee meeting, there were conversations about credentialling. We are working to establish that credentialling to give those women whom mesh has affected the confidence that the services that can be provided in Scotland are of the highest quality. Although we will provide an assured external provider, we hope that women will understand that their first option, and the best service for them, is a local service that offers wraparound care.

10:00

Sue Webber: I have two questions: one about the reimbursement process and one on service commissioning for the future. We will deal with the reimbursement element first. Mr Hornby has spoken about it being a case-by-case process. We have heard from many of the witnesses about how complicated the issue of what we call wraparound costs is—we already know that the surgery is complicated, that no two cases are the same and that unexpected costs occur.

The administration of the reimbursement scheme sounds like it might be quite complex. At the same time, the payment will not be made until everything is concluded, but women will want to be reimbursed as quickly as possible. What extra resources has NSS put in to administer the scheme successfully to tie it all in for the women at the end of a traumatic period of their lives?

Dr Lamont: I will come in briefly, and you can then speak to Mr Hornby. I want to clarify that, with regard to the reimbursement bill, the women would already have experienced those costs. Again, I draw the distinction between the reimbursement bill and the commission service.

The reimbursement is for costs already experienced by the women who were in surgery prior to 12 July this year. As we go forward, services will essentially be free, as we will look to provide a contract that pays for those services up front. Incidental costs are likely to occur that will require refunding, but we will pay the substantial costs of the commissioned service, such as surgery and travel, up front, so we will not reimburse women for those. The idea is similar to that of providing surgery through the NHS or any other provider; one would not be expected to pay for that service and then claim its cost back.

I defer to my colleague, Mr Hornby.

Paul Hornby: The question was about the extra resources that are required in NSS. The commissioning side of NSS has resources to administer and deliver a number of services, so the reimbursement scheme would be included as part of those services.

I am not sure whether additional resources are required. We are at the stage of getting the bill through, of understanding the number of payments that will be made, and the level of detail of the scheme. If NSS is appointed to administer the scheme, we will then have to resource it accordingly. On Roseanne McDonald's side—commissioning and procurement—we would just allocate the resources to ensure that the reimbursement of patients who need it can be administered as quickly as possible. We have not yet identified the number of people that we will need to do that job.

Sue Webber: Thank you; that answers my specific question.

Can you clarify whether all women will still have to refer in via NHS GGC, whether the commissioned service be the Glasgow mesh service, the site in NHS England, the potential site at Spire Healthcare, or overseas? With regard to the hierarchy—that word might not be correct but you will understand it—is there a preferred route? If the women do not want to go to Glasgow, will we encourage them to take up the service in NHS England because it is an NHS service and the wraparound care might be more definable there, or are those choices patient driven? The matter is complicated.

The Convener: I wonder who can best answer that question. I will go to Dr Lamont first.

Dr Lamont: It is important that we also hear input from my colleagues Roseanne McDonald and Dr Jamieson.

The pathway in is through the patient's GP referring them to their local service, with—as we have heard—subsequent referral on to the specialist mesh service within NHS Greater Glasgow and Clyde.

I emphasise the vital involvement of shared decision making and the multidisciplinary team, which was also recognised by Baroness Cumberlege. The multidisciplinary team is a vital part of the service in relation to understanding the specialist needs of all those women and their particular circumstances. It is not a case of selecting a surgical process from a menu and saying that is what is required. It is really important that we take into account and understand the women's choices, and also that we consider what their needs are and what can provide a positive contribution to their life.

I will defer to my colleague Dr Jamieson.

Dr Jamieson: I—again—draw the distinction between the women who need to be reimbursed for surgery that they have already had and the women who are now coming through the service. I hope that I have been able to explain and demonstrate that the service that we are currently providing will constantly be improving. I also really hope that it will be valued and seen as a quality service by the women who are coming through it, and that they will trust in it and want to stay in our Scottish service.

It is my job—and our job as a team—to deliver that while accepting that it is appropriate to offer choice, whether that is in England or with a private provider. Women need to have explained to them the pros and cons of that, including the travel away from home. That will all be done to the best of our ability.

The Convener: I will bring in Roseanne McDonald, who wanted to come in on the substance of the initial question as well.

Roseanne McDonald: The principle is about women having trust and confidence in the surgeon. Our primary aim is that women should feel confident in their choice of surgeon. It is also our absolute ambition and intention that the Glasgow service is seen as a first choice. We are setting up an exemplary service. The Glasgow service is recognised as one of the leading centres across the United Kingdom and it has been established longer than NHS England centres. We very much want to set that up so that people see the value in it and want to use it.

On the pathways, we intend that the women should remain in the NHS and that their care should be given by the NHS, because it understands the credentialling and what we are offering women. However, it is really down to the women. If, after they have gone through the shared decision-making process, they decide that they want to go to an independent provider, that will be respected.

The Convener: I will take a last question from Sue Webber. I will then go to Emma Harper, then we will have to round up.

Sue Webber: Thank you for those answers. However, going back to what Jackie Baillie said earlier on and the correspondence that we received last night, that trust and confidence are still not there. That binary choice, and the one route into referral via Glasgow, will be an issue.

Although the choice of surgeon is significant, another factor is that, for whatever reason, the Glasgow service has a bad reputation among mesh survivors. What, specifically, are we doing to give women the confidence to come into the service, knowing that they will get a good outcome, wherever it might be, for whatever treatment and whatever the approach might be needed at the other end?

The Convener: I will bring in Dr Lamont on that.

Dr Lamont: It is important that you also hear from Dr Jamieson on this, but I emphasise that the surgical service that is being provided at NHS Greater Glasgow and Clyde is not just a single surgical service; it also involves the multidisciplinary team, as we are emphasising. The team there is unique in what we can provide in Scotland, and it is recognised by colleagues as being a specialist service.

It is sad, but we recognise that there is a significant confidence issue for women who have been harmed by mesh. It is part of our job to be clear in establishing that the service that can be

provided in Scotland is exemplary and the best service that the women can be given.

However, if women are still of a mind that the service that is provided in Scotland is not what they want to have, even if they have a different surgeon and even with a choice of surgeon and the involvement of a wraparound team, if they do not wish to engage with that, we will provide NHS services through NHS England. If they decide that they do not want to be involved with those services, there will be options for the provision of surgical service that is still local to the UK. If they do not wish to engage with those services, there will be further options for an external provider, which we are trying to develop in the US.

Although the single point of contact remains the MDT in Scotland, when it comes to all the risks and the wraparound care that we have spoken about, it is important to establish that we can address the mental health concerns and other concerns that the women have.

It is important to recognise that the surgical process that a woman undergoes on one particular day is only one part of her journey to recovery. We must take cognisance of the need to provide more than just that one day of surgery. We have the single entry point through Glasgow so that we can provide a personalised service. However, I will defer to my colleague, Dr Jamieson, for more details about the pathways for the NHS Greater Glasgow and Clyde service.

Dr Jamieson: I go back to the point about trust, which is a priority for our Scottish national service. We hope to maintain the trust of current users and, if possible, to regain the trust of users who have had bad treatment in the past. We understand the difficulty and challenge of that.

We are doing that in several different ways. We recognise the importance of publishing our data and making it available. That will be a priority. We are engaged with the other accredited mesh centres in the UK. One of the purposes of that is to agree the outcomes that all the mesh centres will make available so that they are the same, and so that women have opportunities to see them and to be reassured that the outcomes of the Glasgow centre are as good as, if not better than, those at the other mesh centres in the UK.

The other way that we are hoping to maintain trust in our service is by listening to women. We have had valuable feedback via the Health and Social Care Alliance Scotland, to which we have responded. That has helped us to form and shape the service in the past few months. We value that interaction, and we hope that it will continue.

Dr Jamieson: We are also talking to the women who are going through the service. We carried out a questionnaire at the start of the year and got some helpful feedback about where we are doing well and what we need to improve. We are doing that again for women who had treatment in July and September. I am sure that different things will come out of that. It is another way of ensuring that women feel that their voices are being listened to and that they can trust what we provide.

10:15

Emma Harper: The bill is about reimbursement for women who have already paid for surgery. You represent the specialist mesh centre in Greater Glasgow. I read that 20,000 women had mesh implants in Scotland in the past 20 years and that some 600 have suffered agonising or debilitating complications. Can you assure the women watching this meeting that the specialist mesh centre will take a clear, person-centred approach? That would address some of the issues. Jackie Baillie mentioned one woman whose appointment will not be until July 2022. Is there a way to expedite that, so that there will be a truly person-centred approach?

The Convener: I will go to Dr Jamieson first. Anyone else who wants to come in before we wind up should put an R in the chat box.

Dr Jamieson: The Scottish Government has recognised the number of women who have been treated with mesh and who may have problems with it. The service has been funded to allow us to cater for that need. The specialists spend years learning their skills. That is important. We anticipate that the service will be needed for years, not just for the next 18 months or two years. We anticipate that more women will come forward and will need the treatment that we can provide.

The Convener: I thank everyone for their time; it has been helpful. We will take a short break before we move on to our next agenda item.

10:17

Meeting suspended.

10:30

On resuming—

The Convener: Agenda item 4 is an evidence session with the Cabinet Secretary for Health and Social Care, Humza Yousaf, on the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill. I welcome the cabinet secretary, who is with us in person. He is supported by our other witnesses, who are participating remotely. We have from the Scottish Government Greig Chalmers, who is head of the chief medical officer's policy division; Terry O'Kelly, who is senior medical adviser; David Bishop, who is mesh team leader; and Ailsa Garland, who is a

solicitor. We heard from all of them last week. Thank you for coming back.

The session is the last part of our scrutiny of what is a very narrow bill. However, as you can imagine, members might have questions on some of the issues around it as we go forward.

Eligibility is one of the main issues on which we would like some clarity. We know that reimbursement is for women who, historically, opted to go to other countries to get private treatment outwith Scotland's mesh services or women who arranged for such private treatment within a certain timescale. Why have you excluded women who had their mesh fitted during surgery in Scotland but were not resident in Scotland when they had private treatment to remove the mesh, even though they might now be resident in Scotland? Why has that exclusion been made?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Thank you for the invitation to give evidence.

You are right that the bill is narrow in scope, but the interest in it from members of the Scottish Parliament and the women who have been affected and their families is huge. I have met a number of those women, some of whom are my constituents, and I am dealing with an active constituent case. Therefore, we know that the interest is huge.

From the outset, we want to acknowledge the real pain and suffering of the women involved and their fight for not only justice, but—this is important—relief from the pain that they feel. That is at the top of our mind. Given the pain and suffering of those women, convener, I am pleased that you have been able to deal with scrutiny of the bill as quickly as possible. I just wanted to acknowledge that before I go into the detail of your question.

Throughout this session, I hope that we make it clear that we want to be as flexible and open as we can be. Before we get to stage 2, we will look closely at the evidence that you have taken and the report that you have produced as a result.

The issue has enjoyed good cross-party working—indeed, I would argue that, maybe more than many other issues that I can think of, it has shown the Parliament working at its best. A number of MSPs have been involved in the work to highlight the plight of the women, but it is worth while again putting on record the efforts of Jackson Carlaw as well as those of the former MSPs Neil Findlay and Alex Neil.

To come to the detail of your question, convener, you are right: under the current eligibility criteria, the women who are eligible are those women who paid for mesh removal surgery to be carried out by an independent provider and who were ordinarily resident in Scotland at the time that that treatment was arranged. That goes back to our view that the state has a responsibility for such individuals who are ordinarily resident in Scotland, regardless of whether they had the mesh implanted by the NHS in England or any other part of the United Kingdom, or, indeed, overseas. When such individuals are ordinarily resident in Scotland, the state has a responsibility towards them. We recognise that, if a woman was ordinarily resident in Scotland when she had her mesh removal procedure—regardless of whether she is a Polish Scot, an English Scot, a Pakistani Scot or a Scot whose family has been in this country for 10 generations—it is the state's responsibility to reimburse her for the cost of that procedure.

If we opened up the eligibility criteria to anybody who had transvaginal mesh implantation carried out by NHS Scotland, we might get into difficult territory, because we would exclude women who might have had a mesh implant carried out elsewhere but who were ordinarily resident in Scotland and who felt that they had to pay for private mesh removal.

Our approach to the entire scheme is to try to be as open and as fair as we can be.

I do not know whether my officials, who are participating virtually, wish to add to what I have said.

Greig Chalmers (Scottish Government): Good morning. I am happy to add a few points to what the cabinet secretary has said.

The scope of eligibility as it is presently defined in the bill reflects one of the primary motivations for introducing the bill, which is that the Government has now decided, as the committee heard in the session with the first panel, to procure surgery from independent providers, and that process continues. One of the primary purposes of the bill is to reimburse people who are resident in Scotland who decided to pay for the surgery in question themselves and who, if the policy that ministers have now chosen to adopt had been in place, would have had that surgery provided to them free of charge. That is the essential reason for the eligibility criteria as they are.

Obviously, we will consider the committee's report but, as the cabinet secretary said, somebody who is not ordinarily resident in Scotland would not be able to take advantage of the range of options for surgery treatment that will now be available. That is the primary reason behind the position that we have taken.

For the sake of completeness, I add that, as I mentioned in my letter to the committee of 29 October, over the years in which the team has

been involved in the mesh situation, although we have received a lot of correspondence, as you can imagine, we have not received correspondence from somebody in the situation that was described in the convener's letter to me of 27 October. It goes without saying that, if the committee has heard from someone in such a situation, we would be interested to know about that.

That is the background.

The Convener: I missed what you said. Did you say that you have not received any correspondence from any women who might fall into that category?

Greig Chalmers: That is right.

The Convener: That is very interesting. I was going to ask what the potential impact would have been if you had done but, given that you have not received any such correspondence, that is very difficult to quantify.

I hand over to my colleagues, who have further questions on the theme of eligibility.

Marie McNair: Good morning, cabinet secretary, and thank you for your time at committee this morning.

It is envisaged that there will be a deadline for applying to the scheme. How flexible will that deadline be? Will there be reasonable grounds for accepting late applications?

Humza Yousaf: I go back to my opening remarks to the convener. We recognise the suffering of the women involved, and we should try to apply as much flexibility as we possibly can. We must balance our public finance and funding obligations, but we should be flexible.

If the bill passes the appropriate parliamentary process and gets royal assent, we hope to be able to open the scheme as soon as possible, which should be in the summer of 2022, and initially keep it open for a year. However, I give the assurance that that does not mean that people will have to wait for a year. There will be a rolling process for reviewing applications, but the scheme will be open for a year because it might take people a bit of time to get the appropriate invoices from the independent providers or to contact the airline that they used a year or two years ago to get the required proof.

If it was necessary to extend the deadline, we would look at that favourably. We want to take a flexible approach, because we realise that people do not keep airline stubs from five years ago. We will try to be as flexible as we can while being mindful of our public finance obligations.

Marie McNair: The cabinet secretary will have seen the correspondence from women that raises the issue of the in-betweeners, or those who started the process by pursuing surgery themselves. How will they be accommodated and supported?

Humza Yousaf: That is a good question. I will keep emphasising the point about trying to be as flexible as we can. We chose 12 July as the cut-off date for eligibility for the scheme because that is when we made the announcement about the independent providers. In all the communications that have followed from 12 July, we have been keen to say to the women that we are working as hard as we possibly can with those independent providers to finalise the contracts and to put the appropriate pathways in place and, if they can hold off from arranging any surgery with independent providers until the scheme is in place, that would be favourable.

Some women had arranged their surgery prior to 12 July, but it would not have taken place until after 12 July. In those cases, they will be reimbursed when the scheme is open.

To go into the granular detail, what we mean by "making an arrangement" is something for us to consider. If the patient, the surgeon and the clinical team that was to perform the surgery understood that it would take place on a certain date, that would be an arrangement. If an initial preliminary inquiry had been made but nothing had been booked, that would not count as "making an arrangement". Again, however, we will look at each circumstance and each individual on a case-by-case basis.

The Convener: Does Jackie Baillie want to come in?

Jackie Baillie: Yes. I hoped to question the cabinet secretary on that area.

Given that, in all honesty, only a small number of women may be affected, why are you sticking rigidly to 12 July? You could make it the date when the bill was introduced, for example, or the date of stage 3 and the passage of the bill. We are not talking about a huge number of women. I am thinking about the consequences of women not being reimbursed and then having to go through the mesh service right from the beginning when they are already making progress.

Humza Yousaf: It is important to separate what we are doing in relation to the complex pelvic mesh removal service and the pathways for the independent providers, and what the bill seeks to do. The issues are clearly interlinked but, to answer your question, I will separate them out.

There has to be a cut-off date in the bill. If I was really being pushed hard on it, we could absolutely consider where the flexibility lies.

10:45

I hope that contracts will be finalised relatively imminently, but there are no contracts of that nature, particularly given that we are dealing with providers overseas so, naturally, working through where those services are different from the NHS services will take a bit of time. Once they are finalised, there will be a pathway for women that will include, for example, a multidisciplinary team that will include Dr Veronikis and Professor Hashim from Spire Healthcare in Bristol. They will be part of the MDT process that will decide what the best pathway for those women is.

I would not see a reason, when that pathway is up and running, to have to reimburse because, if the MDT decides that the procedure provided by Dr Veronikis is the best route, that is provided free of charge anyway. I do not think that it would make sense to have eligibility criteria at the end, when the bill receives royal assent.

I can see that Ms Baillie wants to come back in.

Jackie Baillie: I am not suggesting that we need something once those contracts are in place. The key point is that there is a gap between 12 July and when those contracts are established. Given that it is unlikely that a huge number of women will be involved—we are talking about only a small number of women—why can you not close that gap so that they are covered by this reimbursement bill?

Humza Yousaf: The reason why I referenced when the bill will be passed and receives royal assent was that you asked about waiting until the bill has been passed and receives royal assent. I do not think that we should, so it seems that we are on the same page in that respect.

On the gap between when I made the announcement and the contracts being finalised, I do not think that it is an unreasonable point. I am happy to take that away and look at whether there is flexibility. As you said, probably a small number of women are involved. That said, if we made that change, we could get a rush of women who all decided that they wanted to be seen by Dr Veronikis, for example. I understand that, of course, because he is such an expert in his field. That could complicate matters, given that we are in the midst of our contract negotiations. What would happen with those women, and where would they be on the list? There is an MDT process that we want women to go through, because that will help with pre-operative care, post-operative care and so on. That is where the nervousness comes in.

Jackie Baillie has asked me to look at that in good faith. Some of the women involved whom I have spoken to have asked me to look at that in good faith. I will consider the issue of the gap between 12 July and contracts being finalised but, as I said, there is some nervousness about the unintended consequences that that might have and about what it might do in terms of the current contract negotiations.

Carol Mochan: It is really important that we are clear with the women—the people who describe themselves as in-betweeners—about what we mean by entering into arrangements. Having spoken to some of the women, I think that any movement towards going for that surgery was quite a trauma to go through, so we need to be clear.

To go back to Jackie Baillie's point, in the previous evidence session, we heard that we are not clear about when people might have the option of going to Dr Veronikis. It did not seem clear in the previous session when that date might be settled. A small number of women are involved. Can we be clear with them, please? It is very important for those women to be able to move on.

Humza Yousaf: Yes is the short answer. As Ms Mochan might be aware, we have arranged some consultations with the women through the Health and Social Care Alliance Scotland, which is an excellent organisation and is well respected by the committee.

We have tried to be as clear as we possibly can about arrangements. It is difficult, but I am happy to look at whether we can be clearer in our communication. Generally, if it is understood by the patient and the consultant or clinical team that a surgery will be taking place on a specific date, that is, to me, an arrangement. Again, a preliminary call inquiring about the services that a particular provider provides is, to me, not an arrangement. If there are specific cases in which someone is in doubt about that—I say this very openly, because I know that many of the women involved will be watching this session—please contact the Scottish Government. We would be happy to be as explicit and clear to you on what we mean by an arrangement, and we will also be entirely flexible, as best we can.

At this stage, the message remains: "Please do not make your own arrangements. We are very close to finalising those contracts with Professor Hashim and Dr Veronikis, and we hope to have that pathway up and running very soon." I know that that can be a bit of cold comfort, given everything that the women have gone through in the past and the fact that there have been some false starts for them, too. However, we are making progress.

I take Ms Mochan's point about doing all that we can to be clear in the language around arrangements.

Emma Harper: Good morning, cabinet secretary, and thank you for giving us your time this morning. Given that the bill is on cost reimbursement for mesh removal, I am interested in women who have been affected and have already paid for surgery. Would women who raised the money through a crowdfunding platform still qualify for reimbursement?

Humza Yousaf: That issue was raised in previous committee sessions. In my view, the answer is no. If a portion of the money was crowdfunded, that portion would not have had a cost for the women involved. We are looking to reimburse women for the costs that they would have had to pay out of their own pockets. If we were to open it up to donors and crowdfunders, we would get into very difficult territory when it comes to public finance and the surety of that money going to the places where it is meant to go to. I do not mean that there would be any malicious intent on the part of the women in that regard at all, but as some people donate to crowdfunders anonymously, how would we know who the money should go to, for example?

At this stage, I would not open up the scheme to cover situations in which money has been given through crowdfunding or by donation, because those costs are not incurred by the women involved. However, we are hoping that the scheme will cover all reasonable costs for the women involved and anyone who went with them to support them in having the surgery.

Emma Harper: Are you saying that women would not be excluded if they had been partially funded through a crowdfunder but were able to supply evidence that they had paid for a flight or transport or whatever from their own means?

Humza Yousaf: Yes. Let us say that the cost of surgery overseas was £20,000, and £10,000 was covered by a crowdfunder and £10,000 was covered by the woman. In that case, the £10,000 that the woman had paid would be eligible—in fact, it would be the woman's right to seek reimbursement for that money, as long as it was for reasonable costs attached to the surgery. Those costs could be for flights, accommodation, travel to the surgery and any reasonable costs for food and drink and so on. I am sure that we will get into the detail of that later. The portion that was non-crowdfunded would be eligible for reimbursement.

The Convener: A couple of other questions have been raised about eligibility and reimbursement under the bill. I understand your point about crowdfunding, but many women will have had family members give them substantial donations and will want those family members to be reimbursed, too. Is that being taken into account? If someone has been loaned or given thousands of pounds by family members or someone else, will they be able to give that back?

Humza Yousaf: I understand the point well, but it would be really challenging for us to reimburse a woman for a loan from a family member and to square that against our obligations under public finance rules, which we have to follow rigorously. Ultimately, we are using public money. However, I will take that point away and I will speak to colleagues in economy and finance to consider whether there is any flexibility on that.

Again, that takes us into difficult territory. If a woman gets a loan from a family member, I am sure that all of us around the table would have some sympathy with the person wanting to reimburse that family member. However, what if it is a loan from a friend, a work colleague or even—if the person was in desperation—a classic loan shark, as they were called back in the day? Such borrowed money takes us into really difficult territory. Therefore, at the moment, the eligibility criteria are for reimbursing women who have had to pay out of their own pockets, and they cover all reasonable costs that have been incurred.

That said, I ask the committee to let me take the issue away. I can see why the situation in which someone has been generously gifted money by family and friends would be of interest to members.

The Convener: Some of the women we have spoken to also raised the issue of the interest on loans that have been taken out.

Humza Yousaf: As far as I am concerned, you would be more able to evidence that sort of thing as a reasonable cost. It is slightly different from getting a loan from a family member; I know that all families are different, but you are unlikely to be charged interest by someone in your family. I realise that I am thinking of my own family, though, so I suppose that I should not take that for granted.

However, you are absolutely right to say that interest would be applied to any bank loan. If a person can evidence that loan and the associated interest, I do not think that it would be unreasonable for them to ask for that cost to be reimbursed.

The Convener: Sandesh Gulhane has some more questions on the theme of eligibility.

Sandesh Gulhane: Thank you for your response to the convener's questions, but I would say that it is not an either/or issue. It would be nice if we could add to the list those women who had their mesh implanted here but who had to pay privately for the surgery to get it removed after they had moved away from Scotland. After all, it was the NHS in Scotland that implanted the mesh

in the first place, and those women should be reimbursed for any out-of-pocket expenses. I understand from Greig Chalmers that you have not as yet been contacted by anyone in that respect, but even if reimbursement in those circumstances could help just one woman, it would be good for us to do it.

Humza Yousaf: You have reiterated and re-emphasised an issue that the convener asked about, and I commit to going away and looking at it. As other countries will have their own schemes to help women who have had transvaginal mesh implants, women in those circumstances might be able to access that support rather than the support that is available here.

I take your point, though, about women who had mesh implanted in Scotland but who now live in other parts of the UK or, indeed, overseas. Given that, in some respects, the pain that they are suffering is a direct result of an implant that they received from NHS Scotland, is there a fairness argument to be made with regard to whether we reimburse them for any corrective procedure that they might have had? I am not shutting the door on that and will go away and look at it, but we do not think that it is necessarily a significant issue, given that we have not had any correspondence on it. As you will imagine, we regularly get correspondence on the general issue of mesh.

However, you make a fair point. If reimbursement in such circumstances can help even just one woman, that is one woman whose life will have been utterly transformed. As I have said, I am not closing the door on that, and I will take another look at eligibility in that regard.

Sandesh Gulhane: Thank you. Will you also be writing to and contacting everyone who had mesh implants in Scotland to highlight the scheme and say, "If you received your mesh here and are eligible because you've had private surgery to remove it, we will reimburse you."? I did not see that as something that you are doing to promote the scheme.

Humza Yousaf: At the moment, women who had their mesh surgery through NHS Scotland but who are not ordinarily resident in Scotland and live elsewhere are not eligible. If we looked at changing the eligibility criteria, we would also look at the appropriate communication that would accompany such a change. In short, those women are not eligible at the moment, but if we change the criteria, we will, of course, look at the appropriate way of communicating with and reaching out to them.

The Convener: We move to David Torrance, who has questions about costs and the bill's financial memorandum.

David Torrance: Good morning, cabinet secretary. Last week, witnesses gave evidence on the costs and how they varied. For example, one witness had personal medical conditions that needed to be taken into consideration, while others incurred costs as a result of having to seek treatment during the pandemic. If they are needed, will additional resources and funding be made available to reimburse those costs?

11:00

Humza Yousaf: Yes. We have taken what we think are the reasonable costs into account. Those include the reasonable costs for corrective surgery overseas or in the UK and for reasonable costs such as taxis, hotels, food and subsistence.

Our detailed engagement over a number of years has given us an idea of how many women we think have been affected by mesh surgery and would be eligible for reimbursement. That is how we got to the figure in the financial memorandum. There may be women who have not yet come forward, although I told Dr Gulhane and the convener that we are regularly contacted by women who have been affected. If there are women who have not previously contacted us but who do so after the bill has been passed, we will look to make more resources available.

David Torrance: Will NHS NSS have the required staff and resources to consider each application properly?

Humza Yousaf: Yes. We think that the number of women who will be eligible for a reimbursement scheme—if not the overall number of women who have been affected by mesh—will be relatively small, so we do not think that the application scheme will require huge resources. To go back to Marie McNair's point, it is important to get the right balance between having a quick application process for women who may have been waiting years for reimbursement and giving those women enough time to gather the required evidence of their costs.

David Torrance: Will the scheme give detail about the proof of expenditure that is required so that staff do not feel that they might face litigation if they make a wrong decision?

Humza Yousaf: Once we have the final details of the scheme—obviously, that will depend on Parliament passing the bill—we will make those clear to staff. We are keen to get the balance right and to ensure that the scheme is as flexible as possible. It must be like that: we cannot have a rigid scheme for women who may have had surgery a number of years ago. We cannot expect them to have kept taxi or dinner receipts. That is not going to happen. It would be unreasonable to

demand that women find bank statements from years ago.

We must be flexible in that respect. That is why we are looking at what public finance manuals suggest as an appropriate level of subsistence per person. We are trying to be as flexible as we can, while being mindful of our public finance obligations, which we cannot veer away from. There should be no pressure on staff who are deciding on the eligibility of applications or the level of costs to be recovered to work within a particular financial envelope.

The Convener: The bill does not give detail of the application process, but it is worth mentioning that some of the women who will apply will have undergone surgery very recently. They will still be in recovery and might be quite unwell. Notwithstanding what you have said about our obligation to audit the public finances, I hope that the application process will not be onerous or overly bureaucratic.

Humza Yousaf: My officials and I are not getting pressure from finance colleagues or from anyone else in Government. No one is sitting on a pot of money and saying that we cannot spend a penny more than that. We want to keep spending within the scope of the financial memorandum, but if we have underestimated certain reasonable costs that people can demonstrate, no one will be constrained in that respect. You are right that we must have an application system that is user friendly and not onerous for the women involved, but which is also mindful of and aligned with our public finance obligations.

Gillian Mackay: Good morning, cabinet secretary. In the past few weeks, we have heard some of the women say that they have lost trust in the mesh services, and some of them have lost trust in the Scottish NHS as a whole. The event will have been traumatising for many of them. Earlier, you broke down one of Jackie Baillie's questions and spoke about the bill and the position going forward. What consideration has been given to women who have already paid out of their own pockets for other wraparound care, such as mental health support? What on-going consideration is being given to women who may not feel able to undertake any form of mental health support or physiotherapy, for example, in NHS services because of their mistrust?

Humza Yousaf: Those are excellent questions. Nobody in the Government—certainly not me, as Cabinet Secretary for Health and Social Care—will have any issue with women who wish to be seen by a provider that is not the NHS. We went out to contract because it was recognised in Government that some of the women do not have trust in the NHS because of the process that they have been through. I am deeply sorry about that. I regret the fact that they do not have that trust and accept that that is not the fault of the women involved; they do not have that trust because of the failures that they have been presented with. That is why we have gone out to providers outside the NHS. If a woman wishes to be referred to an NHS England specialist centre, she can be. That option exists at the moment, even before we get into the contracts with Spire Healthcare in Bristol and, we hope, with Dr Veronikis.

I do not know whether I understood Ms Mackay correctly—she can tell me if I have not—but, once we have the clinical pathway up and running, the multidisciplinary team that will consider each woman's case on a case-by-case basis will absolutely consider the pre and post-operative care, including mental health support, physical health support, physiotherapy and anything else that is needed. I cannot speak about the clinical space, but any pre and post-operative care will absolutely be considered.

In our dialogue with a number of the women in a recent consultation that was arranged by the alliance, a number of them said that, even if they had surgery elsewhere, they would expect their post-operative care to be in Scotland and we would have to make arrangements for those who did not want that and wanted their post-operative care to be somewhere else. The multidisciplinary team would absolutely consider that. That would be a clinical decision for it to make.

If Ms Mackay's question was about reimbursement of costs, such costs would, to me, fall into the bracket of reasonable costs if they were to do with the woman's procedure. If the woman did not have the procedure and there were costs that resulted as an effect of her transvaginal mesh implant, those costs would not be considered at this stage, because the costs that are being reimbursed are those that are related to the surgery for removal. However, I am happy to take that issue away. It has not been raised directly with me, and I do not know whether it has been raised with my officials, who may wish to come in on it. If the question was about that, I am happy to take that away.

Stephanie Callaghan: It is good to see you, cabinet secretary. It was reassuring to hear many of your answers to the questions from Sandesh Gulhane, Gillian Mackay and David Torrance, and it was good to get reassurance on David Torrance's question about additional funding being available if required. I would like to confirm the position and to be clear. Some of the on-going treatment costs for women are for multiple corrective procedures that are required. I take it that they would also be covered and that it would be ensured that those costs were reimbursed.

Humza Yousaf: In short, yes. If women needed to go through multiple surgeries to remove mesh, that would be covered.

Stephanie Callaghan: That is great. Gillian Mackay mentioned trust, which is a huge thing for the women. It is important for their views and their expertise in their condition to be taken seriously. I know that you have engaged with the women, but are engagement and discussions with them continuing as we go through the process?

Humza Yousaf: Yes—that may involve me or my officials. I have referred a couple of times to the alliance, which has expertise in the area and has been exceptionally helpful in assisting us to engage with the women involved.

I detect from the women a bit of frustration about the next steps and about the fact that we are in November—they ask what has been said and done since we made the announcement on 12 July. That is difficult, because we are in a challenging space of contract negotiation. In general, that is always complex, but it is particularly so when we are dealing with independent providers that are not NHS Scotland providers. We must get everything tied up. It is no fault at all of Professor Hashim or Dr Veronikis, who we thank for engaging well in the process. We hope to tie that up soon but, understandably, the women involved are desperate to hear what the pathways will be for them to get the corrective surgery that they require.

Stephanie Callaghan: That is great. I thank you for the huge amount of compassion that is coming through today, which is incredibly important to the women. I hope that that will be reflected in the decision-making process, when we come to that point.

If women are unhappy with decisions about eligibility or cost reimbursement, what processes will be available for them to make a challenge or ask for a review?

Humza Yousaf: That is a really good question. I do not think that we have considered what the appeal process will look like, but there should be one. It is necessary for any such application scheme to have a process for individuals to question why certain costs have not been reimbursed. However, I hope that we would not get to such a position and that, if a cost was questionable, we would go back to the woman to understand more about that before an absolute decision was made.

My direction to those who operate the scheme will be to be as flexible as possible, within the public finance rules. It is understood that none of us would keep certain receipts for years and years, so it is important for us to take a fairly liberal view of what a reasonable cost is, although I am mindful—I can almost feel Ms Forbes's eyes on the back of my neck—of our public finance obligations, which are important when we spend even a single penny of the public's money.

Stephanie Callaghan: It is good to hear that, although you do not think that an appeal process will be necessary, it will be there to reassure women that there is some comeback, if it is needed.

Humza Yousaf: There should be a process for women to challenge decisions.

The Convener: I will bring in Greig Chalmers, who wanted to come in on a previous point.

Greig Chalmers: I apologise for pressing the wrong button, which is why I missed my moment earlier, but my comment is also relevant to a question that Stephanie Callaghan has just asked.

In relation to administration of the scheme, NSS has for some time administered the Scottish Government's mesh fund, which is available to a wider group of people. NSS has a lot of experience of working with the women who are affected and knows a lot about the background, so I hope that we are starting from a position of quite a high level of informed decision making for the patient group.

To add to what the cabinet secretary said, I reiterate the point about consulting the women. Our most recent consultation event with them was on 19 October, when we got into quite a lot of technical detail about receipts and processes—all the things that the committee has touched on. I hope that that will inform the drafting of the scheme.

Finally, the bill provides for a system of review, which Stephanie Callaghan asked about, in section 2(1)(h). Again, I am sorry for coming in late.

11:15

The Convener: That is fine. Thank you for that clarification. Emma Harper has questions about reaching out to particular groups, after which I will go to Marie McNair for questions on costs.

Emma Harper: Cabinet secretary, in your opening comments, you talked about Polish Scots and Pakistani Scots. What work will be done to help to engage women whose first language is not English and who might have experienced complications from mesh implants?

Humza Yousaf: Without going into detail, I am dealing with a case to which that question is relevant. The NHS is well versed in dealing with people whose first language is not English. Once the eligibility criteria have been decided, which the Parliament will do in passing the bill, that will allow

us to engage in the process around eligibility. When that process is well defined, it will be important for us to ensure that we communicate through all possible channels and reach out to communities whose first language is not English. Because of the pandemic, we have good experience of how to do that. We have made good progress on that engagement, with the help of many organisations, such as Black and Ethnic Minority Infrastructure in Scotland, or BEMIS. We will continue to use those networks.

A good question is what we can do now, because the issue is not just about the eligibility criteria for the scheme, although that is why we are discussing the bill today. There are also the pathways, which can be complex to explain and understand. We can maybe do a bit more work with our networks on explaining the pathways when the contracts are finalised, which I hope will be soon. We will explain the pathways for women to the complex pelvic mesh removal service in Glasgow and the pathways thereafter in terms of the multidisciplinary teams and women who want a referral to independent providers. Emma Harper has raised a good point. After this committee session, I will double check on what networks we are reaching out to.

Marie McNair: I go back to the issue of trust. The cabinet secretary has acknowledged how difficult the unsatisfactory experience has been for the women affected. What they have endured is appalling and there is no doubt that there is now a lack of trust in the service. How confident is the cabinet secretary that confidence in the service can be re-established? What lessons can we learn from this whole process?

Humza Yousaf: We are working hard to re-establish trust. However, we are not making any judgments about those who wish to use the services of a provider outwith NHS Scotland, because they have the right to do that, particularly given all that they have been through. We are trying our best, though, and one way in which we are doing that is by adapting our own service, which is the complex pelvic mesh removal service in NHS Greater Glasgow and Clyde. We have made changes to the service since its inception by, for example, changing the site of the service. We did that because of feedback from women, who wanted a more private location. We have also made other changes around the service's arrangements.

How do I know whether trust is being regained by at least some of the women affected? I hope that that is shown by the fact that the mesh removal service has been used by a number of women. Between April and September of this year, 19 mesh removal surgeries were carried out in Glasgow and, in September, more than 64 patients were reviewed by the MDT. That was an increase of 26 from the previous month, so I hope that that suggests that there is trust in the service. A number of patients are on the waiting list and, since the service was designated, 32 mesh removal surgeries have been carried out. Those numbers suggest that there are women who trust the service that we have in Glasgow, but I absolutely accept that, for a number of women, trust has broken down and might be damaged beyond repair, and we will keep reaching out and doing our best to rebuild and regain that trust.

The Convener: We move on to discussing the fundamental need for the bill, on which Sue Webber will lead.

Sue Webber: Thank you for coming along, cabinet secretary. You mentioned the cross-party support for the bill, but given that the NHS has always had the ability to refer patients for services between Scotland and England, can you see any reasons why you might not need to establish the reimbursement scheme?

Humza Yousaf: No; from the feedback that we get from women, I think that the reimbursement scheme is essential. We absolutely need the scheme, and the costs are reasonable.

On the related issue of pathways, although Ms Webber is right that there is already the ability to refer to providers outside of NHS Scotland—for example, to NHS England—we heard back clearly from women that they wanted independent providers to be available. There is a lot of faith and trust in Professor Hashim and Dr Veronikis—rightly so, because they are leaders in their field.

Sue Webber: You have spoken at length, and we have heard much, about the complexity of the wraparound care that the women need. Are you satisfied that the bill and the provision for procurement of services from the private sector will not undermine the NHS in any way?

Humza Yousaf: Yes. Again, it is an exceptional situation, as everybody around the table will recognise. All of us have probably met some of the women who are involved and, in our limited experience, we understand as best we can how much they have suffered as a result of what has happened. We need the bill and the pathways in question because of the unique nature of the issue. I do not think that the bill will irreversibly damage trust in the NHS. Again, I hope that the figures that I read out in response to Ms McNair's question give the sense that, although some women have been affected by the implantation of transvaginal mesh, many are seeking surgery and treatment through the NHS in Scotland.

Sue Webber: NHS National Services Scotland has expressed concern that the bill might set a precedent for other groups in a similar position.

What have you and your team learned from the experience to ensure that we will not have to consider similar provision for other procedures in the future?

Humza Yousaf: That is a very fair question. That is why, in my previous answer, I was keen to stress that the plight of women who have been harmed by transvaginal mesh is exceptional. We are not setting a precedent; we are recognising the unique nature of what happened to those women, for which there has to be a unique solution. The very obvious point is that the way to avoid setting a precedent is to make sure that we do right by people at the beginning of their treatment, so that there is no need for such a situation to unfold in relation to any other procedure. As Sue Webber is aware, if people believe that there has been NHS negligence or a misdiagnosis, there is a process for them to seek a claim in that respect. The figures are published at least annually about the number of claims that are made and the value of those claims.

People have the ability to seek redress, but I hope that the good faith that we are showing by introducing the bill restores some of the faith in Scotland's healthcare system that the women concerned have understandably lost.

Greig Chalmers: We had an opportunity to talk about this important matter last week. To add to what the cabinet secretary has said about ensuring that such circumstances do not arise in the future, last week we had a good discussion about the importance of realistic medicine and fully informed consent, and of patients asking clinicians about the benefits and risks, whether alternative treatments are available, and the option of no treatment. In taking forward those steps in the chief medical officer's realistic medicine initiative, we have to have those fully informed conversations in which the patient feels empowered to ask questions and to challenge or to think about alternatives. We sincerely hope that the situation that has arisen here, which Baroness Cumberlege described in some detail in her report, is not repeated.

From the point of view of the officials who are supporting the cabinet secretary and developing those initiatives, although some important progress has been made in realistic medicine, we do not underestimate in any way the fact that substantial steps are still to be taken, as much with the public and patients, whom we need to encourage to feel empowered to have those conversations, as with clinical staff. We know that considerable progress is still to be made with that, which is why we are keen to continue working with the alliance and other representatives to make sure that, as patients go through the pathway that the cabinet secretary has described, they feel able at all times to present their point of view and to describe their preferences.

I know that Dr O'Kelly is very focused on the fact that this example, which has been tragic and regrettable in so many different ways, sets us the challenge of making sure that everything possible is done to ensure that nothing like it happens again.

The Convener: We will move on to discuss the specialist service. We had a useful session earlier with NHS Greater Glasgow and Clyde and NSS on some of the issues, but there are still some questions that members would like to ask you, cabinet secretary.

Jackie Baillie: Gillian Mackay raised the fundamental issue of trust. Although we would all welcome the mesh service that has been set up in Scotland, there is almost a perception that it could be a gatekeeper to the services that are available, and that there is somehow a hierarchy of choice, with the Scottish mesh service being the first port of call, followed by the Spire mesh service with Professor Hashim and then Dr Veronikis in the US. Can you clarify absolutely whether, if a woman wishes to receive treatment privately, that will be supported from the outset, or whether she will have to go through that hierarchy?

Humza Yousaf: To be absolutely clear, such a hierarchy does not exist. I know that Ms Baillie understands this, but it is always worth reiterating it for the record: the decision will be one that neither she nor I will make; ultimately, it will be one for an MDT to make. My expectation, which I will communicate clearly in whatever form is necessary or appropriate, is that a woman's choice will be a primary consideration.

Although I cannot give Ms Baillie a 100 per cent cast-iron guarantee that if a woman wants to go to a particular independent provider, she will be able to do so, because the clinical team might decide that there is a good clinical reason for going for one provider over another, I can absolutely assure Ms Baillie that Professor Hashim and Dr Veronikis will be part of that MDT discussion. They will not be sitting in a different room when the people who are involved in the complex mesh service make decisions on where a woman should go for surgery. Dr Veronikis and Professor Hashim would be involved in that MDT discussion.

It is absolutely the case that a woman's choice must be one of the primary considerations.

11:30

Jackie Baillie: That is helpful and clear.

I would like to ask a question that is not directly linked to the bill but is about a matter of concern that we have heard about and discussed this

morning. It has been raised by the women who are affected and relates to waiting times. We heard that 20 women were waiting for surgery. Dr Jamieson rightly pointed out that it was unlikely that the 12-week treatment time guarantee would be fulfilled. For reasons of elective surgery being cancelled because of Covid, that is perfectly understandable.

There are 64 women who have been reviewed, but the suspicion is that many more have been referred—we do not know how many and I would welcome it if the figures were provided for that—and some are waiting for up to two years. I will read you a couple of quotes. One woman said:

"Just had a letter today from my gynaecologist in Paisley that it's taking two years for referral to the Mesh Service",

which is part of the same health board. Another comment that was made was:

"I had an MRI in September which showed inflammation around mesh. I was told they would send me an appointment to discuss it with the Mesh Service. My initial appointment is July 2022, ten months after the MRI."

What can you do to improve those waiting times? I am sure that you agree that those women have waited long enough.

Humza Yousaf: I agree with Ms Baillie's last sentence in particular. I received the same letter that she received; I was cc'd into the letter from some of the women involved. I read those quotes last night and was taken aback, so I will ask my officials to make contact with those women. Obviously, we would respond anyway because we received the letter, but I am keen to make contact with them.

I will not rehearse and reiterate too much of what Ms Baillie said. Because of the direct and indirect impacts of the pandemic, there is a challenge, but being told that you will have to wait two years for a referral is not acceptable. I will respond to the women who wrote the letter as quickly as I can. If they are able to provide the particular circumstances, we will look at how some of the issues that they raised can be resolved.

Jackie Baillie: Thank you.

Sue Webber: Our papers say that, when we called for views on the bill from the health boards, we received responses only from NHS Highland and NHS Greater Glasgow and Clyde. That is an indicator that the health boards are perhaps not aware of what is going on despite the publicity that the matter has had. What work is under way to publicise the service to the various NHS boards throughout Scotland? What is the timeline for them to receive guidance on the referral routes to make the process as clear as possible for women who will access the service via their local health boards?

Humza Yousaf: I cannot speak for the health boards that did not respond, although I suspect that that might have happened because of some of the pressures that they are under at the moment. I would not take it as any of them suggesting that they do not take the issue seriously and I know that that is not what Ms Webber is suggesting.

If Ms Webber does not mind, I will ask one of my colleagues who are online to give the detail on the guidance on referral pathways. Dr O'Kelly might be the best placed to do that.

Terry O'Kelly (Scottish Government): Good morning, convener and committee. As I mentioned last week, we have been working with one accountable officer from each of the health boards throughout the process, not only on the reimbursement but previously on the establishment of the complex mesh centre and other initiatives.

We have another meeting coming up at the beginning of December. We would like to take the matter to that forum to discuss with the accountable officers what they think is required and how best we can ensure dissemination of information in their boards.

I am very sorry to learn of the difficulties with waiting times. Ros Jamieson, who was giving evidence earlier this morning, said that she wanted the complex mesh centre to be as open as possible in sharing information. It is important that, as we look into the cases concerned, we try to understand why issues have occurred. I can only reiterate what has already been said about waiting times of two years. I am disturbed by that, and we need to look into what exactly has gone on.

Sue Webber: Thank you for that answer. We know that the first point of call is often with the woman and her GP, but there are many GPs across the country. What wider publicity and training are being provided about the national mesh service, and particularly about the GPs linking into it and understanding the complications that arise from the surgery, so that they can refer women quickly and effectively into the service?

Humza Yousaf: We have written to general practices through NHS NSS, not just about the importance of any referral pathways but about the fund that was open previously to support women who had gone through transvaginal mesh complications. We would expect anybody who had those complications to present to their GP for help in the first instance, with the referral pathways made clear. I am happy to take up that point with NHS NSS and colleagues at health board level, in case there are any gaps. In the communication and correspondence that we have received, that

has not presented itself as a significant issue, but I am happy to take it away.

Stephanie Callaghan: This is not directly related to the bill, but it is important for the women concerned that we learn from what has happened. This is not the first time that women have felt like they have not been listened to, believed or respected. Looking at the situation from that point of view, and thinking about the impact on the mental health of professionals and their families, which can be devastating, will there be an opportunity later to take a holistic view of all the learning points and possibly to embed them into learning, including for health professionals during their initial training and for their development?

Humza Yousaf: That is an excellent question. I can assure you that some of that is happening right now, as you would rightly expect to be the case. All of us should say, however, that those women should not have had to take the time and make the effort to bravely come forward, campaign and fight hard while they were still suffering the complications with their transvaginal mesh implant to get a solution in place—I hope—to help with that suffering. I appreciate, however, that many of those women will continue to suffer until the contracts are signed, they go through the pathway and they get the corrective surgery. Some of that learning is taking place now.

The process is evolving. I have referred to the complex mesh removal service in Glasgow, which has had to evolve and develop as we have continued to receive feedback from the women involved. To me, that is the crux of the issue, and that is the promise that I will certainly make, as cabinet secretary. I know that my officials also understand that. We will continue to listen to the women. It is not a case of introducing the bill, which I hope will pass, and putting a pathway in place, then once the contracts are signed, that will be the end of the engagement with the women. Far from it. We will continue to engage, listen and hear what the women have to say, and we will continue to evolve our processes and practices, where possible.

That does not mean that we will be able to do 100 per cent of what is being asked of us. I will always try to ensure that we do as much as we possibly can, understanding the suffering that the women have gone through. However, some matters involve clinical decisions, as I referred to in a previous answer. Generally speaking, however, we should be open to listening to the feedback that we get from the women involved.

The Convener: I think that Greig Chalmers wishes to come in on this.

Greig Chalmers: I do, convener, but Terry O'Kelly might want to come in before me on the point around training.

The Convener: I am happy for Terry O'Kelly to come in.

Terry O'Kelly: The impact of realistic medicine should not be underestimated. For doctors who are going through their training now, it is an important component of their learning, and it couples with the new General Medical Council's guidance on consent. A part of it is about the empowerment of patients, and expecting them to be joint participants in meaningful conversations. Aligned to that is a greater understanding of our knowledge and lack of knowledge in certain areas, and a need at all times to be kind and empathetic. Those are the big issues for clinicians that have come out of the exercise.

I would like to think, and I have been involved in trying to ensure, that, going forward, we will not hear again some of the criticisms that have been levelled at clinicians.

The Convener: It is worth mentioning that, on the back of its discussion with us, the alliance sent us a letter. The letter highlights some of the experiences that women have had, both at primary care level and when they were seeing a consultant, and some of the issues that they were not happy about. The cabinet secretary got a copy of that letter.

I will go back to Greig Chalmers.

Greig Chalmers: Thank you, but Terry covered the points that I was going to make.

The Convener: I am not seeing any other member wanting to come in. Cabinet secretary, thank you for your time this morning.

Subordinate Legislation

NHS Education for Scotland Amendment Order 2021 (SSI 2021/330)

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2021 (SSI 2021/335)

11:42

The Convener: The next item on our agenda is consideration of subordinate legislation. We have two negative instruments, the first of which is the NHS Education for Scotland Amendment Order 2021, which creates additional capacity and capability in NHS Scotland to provide healthcare-related digital services. In doing so, NES will become one of the delivery arms of the Scottish Government's digital health and care strategy, with a focus on enabling the development of national patient-facing digital products and services.

The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2021 amends the 2011 regulations for prescription charges applied to English prescription forms if presented for dispensing in Scotland. It increases the amounts charged in line with increased charges in England.

The Delegated Powers and Law Reform Committee considered the instruments and made no recommendations. No motions to annul have been lodged.

As members have no comments, I propose that the committee make no recommendations in relation to those negative instruments. Do members agree?

Members *indicated agreement.*

The Convener: At our next meeting on 9 November, the committee will take evidence from the Minister for Public Health, Women's Health and Sport on session 6 priorities, followed by an evidence session on seasonal preparedness and winter planning. That concludes the public part of our meeting today.

11:44

Meeting continued in private until 12:39.

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