OFFICIAL REPORT
AITHISG OIFIGEIL

Meeting of the Parliament

Tuesday 17 January 2023

Session 6

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Pàrlamaid na h-Alba

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Scottish Parliament

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

Time for Reflection

The Presiding Officer (Alison Johnstone): Good afternoon. The first item of business is time for reflection, and our time for reflection leader today is the Rev Tom Kisitu, a Church of Scotland minister.

The Rev Tom Kisitu (Church of Scotland): I thank you, Presiding Officer; my sponsor, Gordon MacDonald; and the staff and members of the Scottish Parliament for this special opportunity to share in your time for reflection.

Last week, a friend and fellow Ugandan warned me, “Tom, take time to choose your words in your reflection—remember that another Ugandan visited Scotland and loved it so much that, several years after his visit, he crowned himself the last king of Scotland.”

However, I come to you as a Leither, a minister at St Nicholas church in Sighthill, a community missionary and a reverse missionary. I refer to myself as a reverse missionary because, 144 years ago, a graduate in engineering at the University of Edinburgh called Alexander Murdoch Mackay went to Uganda to serve as a pioneer missionary. He turned down the invitation to serve in places where, as his friends believed, his skills and knowledge could have been put to better use. He ended up in Uganda and made a positive difference. His spiritual depth and practical skills in farming, carpentry and engineering were valued and admired for generations in the places where he lived and worked.

It is the community missionary spirit and work that excite me and all the members and friends of St Nicholas church in Sighthill. We believe that our church, at its best, must be local and exist also for the benefit of the non-member. Churches and other institutions that exist for the good of all must endeavour to meet people at all their points of need through synergistic partnerships with like-minded champions for good in the community.

As a local church, we, like Alexander Mackay, seek to model Christ and his love in action in everything that we say and do. We are learning not to provide answers to questions that have not been asked. We use items that everyone likes, such as food, to build community and lasting friendships. We share food after our time of worship and during the week at events such as our community meal and the “Let’s Eat Together” food share. We get beautiful food from Marks and Spencer handed to us, and we pass it on. We are reminded of the day when Jesus, surrounded by a crowd of 5,000 hungry men, did not use that moment to launch his manifesto or to build a great big church. No—he fed them using a kid’s packed lunch. When you invite me again, we will talk more about that. He challenges us all to take good care of everyone around us, to place other people’s interests before our own and to meet people at all their points of need.

I ask God’s choicest blessings on you as you continue to love, care for and serve his people well in all the places where you live and work. Thank you, and may God bless you. Asante sana.

Topical Question Time

14:05

Prostate Cancer

1. **Carol Mochan (South Scotland) (Lab):** To ask the Scottish Government what its response is to comments by Prostate Cancer UK regarding reported figures showing that men in Scotland are more likely to be diagnosed with prostate cancer too late for it to be successfully treated than in any other part of the UK. (S6T-01104)

The Cabinet Secretary for Health and Social Care (Humza Yousaf): We have noted that Prostate Cancer UK research, and we are discussing it with clinical experts right across NHS Scotland. Staging prostate cancer is often complex, and, although Prostate Cancer UK's data from across the United Kingdom nations shows apparent variation, we are investigating that further. It is important that we understand the data in greater detail. I have asked my officials, in that vein, to reach out to Prostate Cancer UK for dialogue in that respect. When we compare survival rates—arguably the most crucial measure for any patient—we see that Scotland's five-year survival rate for prostate cancer is 84.3 per cent, which is very similar to the rates in other UK nations.

Carol Mochan: It is important that we look at the figures. The figure for individuals being diagnosed too late to be successfully treated is 12.5 per cent in London. In Scotland, the figure is not far off three times as high, at 35 per cent. The cabinet secretary must accept that that is an extremely concerning gap, creating a picture that the chief executive of Prostate Cancer UK has called "particularly shocking" in Scotland. Does the cabinet secretary accept the Government's responsibility for addressing health inequalities in Scotland and that failures by the Scottish National Party Government are now leading to unnecessary and avoidable loss of life?

Humza Yousaf: I do not accept that characterisation, partly because of the response that I gave to Carol Mochan's first question, about survivability rates. She is asking about the impact of potential late diagnosis, and we know—she is absolutely right—that late diagnosis can affect the outcome for somebody in relation to any cancer type, let alone how important it is in relation to prostate cancer. However, when I look at those five-year survivability rates, I see that Scotland's is 84.3 per cent. She is right in saying that England's rate is slightly higher, at 86.6 per cent, but we are not far off kilter in relation to other UK nations. Of course, we want to see an improvement in that rate.

Where I agree with Carol Mochan is that there is no doubt of the link with inequality, whether that is in relation to wealth or socio-economic inequality, which clearly also impact health inequalities. That is why we are focused on addressing the equality gap. I have good dialogue with Prostate Cancer UK in Scotland, and I was at its march for men event a number of months ago. I will continue that dialogue and we will continue to invest in reducing the equality gap that currently exists.

Carol Mochan: I laid out the figures, which are quite stark. Public Health Scotland data that was released in 2021 highlighted:

> "There was convincing evidence that socio-economic deprivation increased the likelihood of being diagnosed with more advanced cancers of the ... prostate."

In further data, published in 2022, there was a 10 per cent fall in the number of people diagnosed with prostate cancer, which was linked to underdiagnosis caused by the pandemic. It is absolutely essential that the Scottish Government acts decisively to ensure that men across the country are made aware of the options that are available to them in terms of tests, checks and online tools, which can both protect their health and combat the impacts of health inequalities.

The Presiding Officer (Alison Johnstone): Can we have a question, please?

Carol Mochan: Does the cabinet secretary accept that he must take those figures seriously and make sure that those items are in place?

Humza Yousaf: We are, of course, taking those figures seriously. That is why, as I said in my first response to Carol Mochan, I have asked a variety of national health service experts to give us clinical advice on the data. We do not by any stretch of the imagination dismiss the figures, and I hope that nobody has got that impression. We want to understand the detail better.

Where there is no argument between Carol Mochan and I is that we know that inequalities lead to worse health outcomes. That is why our focus is on detecting cancer early and getting into communities in which we know there is inequality, such as those in areas of higher deprivation.

Carol Mochan will know about the excellent work that we are doing on rapid cancer diagnostic services, and she might have seen the interim evaluation that was conducted, which shows that it is having more of an impact in areas of higher deprivation. We will continue to invest, and she will know that we are rolling out another couple of rapid cancer diagnostic services in Scotland.

We will continue to engage with Prostate Cancer UK. Indeed, for our new detect cancer early public awareness campaign, which is due to publish in spring this year, we are already in dialogue with Prostate Cancer UK to source case studies to support the campaign.

Emma Harper (South Scotland) (SNP): Research has shown that the burden of cancer is not felt equally across society. The cabinet secretary has noted that people living in deprived areas are more likely than folk who live in less deprived areas to get cancer and, sadly, to die from the disease. Will the cabinet secretary reaffirm what steps the Scottish Government is taking within its powers to tackle the root causes of poverty and associated health inequalities?

Humza Yousaf: I associate myself strongly with Emma Harper's remarks. She is absolutely right: the Government's focus should be—and is—on dealing with the problem at source, which means dealing with the poverty and inequality that exist in our communities. We are targeting our actions to the areas and communities that are most in need, and we will look to see what more we can do. We have provided free school meals; we have increased the number of hours of free childcare; we recently increased the Scottish child payment to £25 a week; we have supported 1.85 million households with council tax reduction; we have uprated by 6 per cent all the benefits that we deliver; and we continue to deliver free prescriptions, concessionary travel and free personal care. We will continue to do what we can to reduce poverty and inequality within the constraints of the current devolution settlement.

Jackson Carlaw (Eastwood) (Con): Being candid, I admit to having had a significant prostate cancer concern at the start of the pandemic, which had a bearing on decisions that I made in my personal and professional life at the time. Notwithstanding the constraints of the pandemic, the treatment that I received was comprehensive, professional and timely. I think that the key thing—I hope that the cabinet secretary agrees—is that men who have any of the symptoms that are associated with prostate cancer must not be concerned about any embarrassment that they might feel arising from that, and that they must present themselves to the health service at the earliest possible opportunity. By doing that, I hope that they can, like me, expect to survive safely. [*Applause*.]

Humza Yousaf: I absolutely applaud and am grateful to Jackson Carlaw for sharing his personal story. He did not owe that to anybody. I hope that, in his doing so, people who are listening will have heard what he had to say. That is why I made reference to the detect cancer early programme and our dialogue with Prostate Cancer UK.

Jackson Carlaw is right about the stigma around prostate cancer. I was at a men's group at the Maggie's centre in Edinburgh, where the men said that the group was a huge source of comfort, relief and support for them because they were able to talk about issues that were quite intimate. They were able to make light of it in certain regards and to have conversations with other men that they felt they could not have even with their partners, let alone with anybody else in their families.

I return to the fact that—I know that Jackson Carlaw will take this in the spirit in which it is intended—we really need to focus on areas of higher deprivation. Jackson Carlaw is well educated and knows about these issues. He has been involved in politics for a long time, and I suspect that his general understanding of the issues is of a very high level. As a Government, we really need to focus on areas of higher deprivation, where we know that public awareness of the issues is not at the same level. That will be our continued focus.

I end where I started, by thanking Jackson Carlaw for sharing his experience. I wish him all the very best in his health.

Police Officers (Domestic Abuse)

2. **Jamie Greene (West Scotland) (Con):** I associate myself with the cabinet secretary's comments on my colleague's very welcome recovery.

To ask the Scottish Government what its response is to reported comments by His Majesty's chief inspector of constabulary that some Police Scotland officers lack empathy and show outdated attitudes in domestic abuse cases. (S6T-01103)

The Cabinet Secretary for Justice and Veterans (Keith Brown): Police Scotland undertakes excellent work in dealing with domestic abuse incidents, but the recent report by His Majesty's chief inspector of constabulary and comments about the victim experience highlight that more must be done.

Although operational matters are for the chief constable, we remain fully committed to using the available resources to support the delivery of effective and responsive policing. We continue making changes to make it easier for people to report incidents and for perpetrators to be appropriately dealt with, helping us to realise our vision of Scotland as a place where women and girls live free from violence and abuse.

Jamie Greene: More needs to be done, because the police are the first point of contact in 85 per cent of domestic abuse cases. The survey was quite clear about people's overall perceptions of those experiences, which were described as "not very positive" by 60 per cent of respondents to the survey. Many felt that the police had not responded appropriately to initial reports and, worryingly, 50 per cent of respondents said that they felt that the police had not taken their complaint at all seriously. It should worry us that many victims said that they had not bothered to report later instances of abuse because of that initial bad experience of reporting.

The cabinet secretary said that the lives of many vulnerable women are at risk; what discussions has he had with the chief inspector since the report shared those worrying findings? Given that the police are often doing the jobs of other emergency service workers and are already overstretched and overworked, what is his Government doing to support them as they deliver support to domestic abuse victims?

Keith Brown: I agree with much of what Jamie Greene has said. I am happy to acknowledge his point about the progress that is still to be made, as would the police. I think that the chief constable would say that, when he started, the police response to domestic abuse was to send a constable. He would say that there has been massive progress. There used to be a closed door, beyond which the police would not go. That has fundamentally changed.

However, I acknowledge, and the police would acknowledge, that there is a cultural issue that must also be dealt with. The police are dealing with that issue through training and through the leadership that we have seen over a number of years from deputy chief constable Fiona Taylor and from the chief constable. That is the main thing that can be done.

The inspector's 14 recommendations touch on issues that the police are well aware of. They know that they must do more. We will have further discussions with the chief constable and senior officers at our next meeting in two or three weeks' time.

The Presiding Officer: There is much interest in this subject, so concise questions and responses would be appreciated.

Jamie Greene: The reality is that, in the past two years, we have recorded the highest number of domestic abuse incidents in Scotland since records began. It is unclear whether that is due to a rise in reporting, a rise in cases and incidents, or both. That data is lacking.

That number makes clear the vast demands that are placed upon our police. One victim said that it took two days for police to arrive after the initial report was made; another waited two weeks before the police spoke to the abuser.

Does the cabinet secretary share my genuine concerns that, although victims of abuse need fast and empathetic responses to reports of domestic abuse, that is clearly not happening for far too many victims in Scotland? What is his direct message to the victims of those crimes who were brave enough to report abuse but who have now—quite understandably—lost faith in the system?

Keith Brown: My response to victims is that we, and the police, are aware of those shortcomings. The research and the inspector's report are very important, as was the report that came out last week on early implementation of regulations in the Domestic Abuse (Scotland) Act 2018. It showed that progress has been made and that people are more likely to report domestic abuse because of that new and world-leading legislation.

We know that we have more to do. The policies are in place: we must see further progress in dealing with those. We will continue to fund the police in order to ensure that they do that. If I am correct, there was a 1 per cent reduction in instances last year, but we know that many incidents are not reported and that we are seeing the tip of the iceberg. We will continue to tackle that.

Katy Clark (West Scotland) (Lab): Has the cabinet secretary had the opportunity to look at the report published earlier this week by the University of Edinburgh, which reviewed the experiences of victims and witnesses in domestic abuse cases since the passing of the Domestic Abuse (Scotland) Act 2018? The report found that, despite that legislation, domestic abuse victims still find the justice system traumatic. What further action does the cabinet secretary believe can be taken to reduce the trauma that domestic abuse survivors experience in the justice system?

Keith Brown: I acknowledge the report that Katy Clark mentions. I think that it is the report from last week, which has a small sample of around 69 people. It says very good things about the introduction of the new legislation, but it also points out where else we have to go.

If we look at the recommendations, we can see what has to be done to improve things. For example, it is very important to make sure that the gender of interviewing officers is right for the victims and that those officers are trained in how to deal with domestic abuse situations. The biggest challenge perhaps relates to prevention. This is a very hard matter to deal with, but if we can get to a situation where prevention can happen, especially in relation to possible repeat offenders, we will make massive progress.

I think that, between us, the police and what is happening in the Scottish Courts and Tribunals Service, where real priority is being given to dealing with this during the recovery from the pandemic, we can make further progress, and so we should.

Pam Gosal (West Scotland) (Con): The recommendations in the HMICS report suggest that Police Scotland's domestic abuse training should adopt a trauma-informed approach that recognises the lived experience of victims. Similarly, the Domestic Abuse (Scotland) Act 2018 interim reporting requirement finds that increased training and understanding and a more informed approach on domestic abuse by justice professionals could improve victims' experience of the criminal justice system.

What action is the Scottish Government taking to ensure that victims' entire journeys through the justice system are person centred, trauma informed and responsive to their needs?

Keith Brown: Pam Gosal makes a very important point. We have dealt with this through the victims task force, whereby all the different groups that are involved in the area have said that we have to ensure that everyone who is involved in every part of the justice system has undergone trauma-informed training to make sure that they provide a trauma-informed response, as Pam Gosal mentioned. I have done my training, such as it is so far, and I am sure that I will do further training.

Pam Gosal is right to say that, for the victim, it is about the entire journey through the justice system. If they find that one part of the system is working very well and everyone is very well trained and informed, but they then get moved on to another part where that is not the case, their experience is going to be a bad one.

I am not saying that this is going to be done quickly. It is part of a justice vision that will take years to bring about. However, the biggest change that we can make with the justice vision is to get to a situation where the entire system is trauma informed and person centred, and where people get a trauma-responsive reaction from the agencies. That is what we should be trying to achieve and that is what we are setting out to do.

Education and Life Chances of Children and Young People

The Presiding Officer (Alison Johnstone): The next item of business is a statement by Shirley-Anne Somerville on improving the education and life chances of all children and young people. The cabinet secretary will take questions at the end of her statement, so there should be no interventions or interruptions.

14:22

The Cabinet Secretary for Education and Skills (Shirley-Anne Somerville): I am pleased to provide this statement to Parliament today. It is a timely opportunity to take stock of our work to recover from the pandemic and to accelerate progress on attainment.

Before I do so, however, I will directly address the current industrial action. As I have said before, the teachers strikes are in no one's interests—not those of pupils, parents or carers, who have faced significant disruption over the past three years. We are continuing to work closely with our union and local government partners to try to reach a deal that is affordable and fair for all concerned. As part of that, I have spoken again to the general secretaries of the teaching unions over the past few days. Talks will continue over this week and we will continue to focus on areas of compromise. While those constructive talks are on-going, we continue to urge education unions to suspend their industrial action.

It is also important that while we work through that we maintain our work on excellence and equity. In December, we published the latest achievement of curriculum for excellence levels—ACEL—statistics, the 2023 national improvement framework and plan, and the stretch aims that each local authority has now put in place for closing the poverty-related attainment gap. Together, those set out the latest evidence for progress and set out our plans, which have been shared with local government, for substantially eliminating the poverty-related attainment gap by 2026.

There is much to be proud of and to celebrate in our early learning and childcare settings, schools, community learning and development activity, colleges and universities. That is demonstrated by young people's achievement of qualifications and awards that recognise their knowledge and skills, and their moving on to employment and starting new apprenticeships or courses in our colleges and universities. They are a credit to themselves and to those who have supported them through an extremely challenging period, and their resilience is an inspiration to us all.

I also want to pay tribute to the dedication, commitment and hard work of our early years practitioners, our teachers, our community learning and development practitioners, our college and university lecturers, and all those who work alongside them. The challenges of the pandemic are not yet over, and I recognise that we need to continue to support and nurture children and young people.

Pre-pandemic, the poverty-related attainment gap was closing, but the negative impact of the pandemic cannot be ignored. Lost learning resulting from the pandemic is not unique to Scotland, and the attainment gap in other parts of the United Kingdom remains wider than it was pre-pandemic. For example, the UK Government's Department for Education has said that the attainment gap in England is the widest it has been since 2012, which suggests

"that disruption to learning during the Covid-19 pandemic has had a greater impact on disadvantaged pupils".

It is therefore reassuring that the latest ACEL data, which was published on 13 December, demonstrates that the approaches to Covid recovery in education in Scotland are working. As 2023 begins, we are in a strong position to make further headway. The percentage of pupils who achieved the expected CFE levels in 2021-22 is higher than it was in 2020-21 for all primary school stages, and includes the largest single-year increase in primary school literacy and numeracy since 2016-17, which is the first year for which comparable data is available.

There are also promising signs that the attainment gap is, once again, narrowing, with the biggest single-year decrease in the gaps in primary numeracy and literacy levels since records began in 2016-17. For example, the gaps between the proportions of primary pupils from the most-deprived and least-deprived areas who achieved their expected levels have narrowed in both literacy and numeracy from 2020-21, and are now more similar to those that were seen before the Covid pandemic.

However, there is no room for complacency. Attainment levels are still largely below pre-pandemic levels, and the attainment gap at secondary 3 has widened since data was last collected, in 2018-19. That will, of course, be monitored carefully. However, it is important to note that this is the first year that the impact of the pandemic has been visible at that level, because no data was collected at that level last year, so improvements that have been made in the past year are not yet visible.

There is still work to do to support education recovery and to accelerate progress in closing the attainment gap. That is why we have implemented a new accelerated approach for the Scottish attainment challenge programme, which includes record investment of £1 billion over this parliamentary session. Those figures show that local authorities are well placed to make further progress in the coming year, as is set out in the local government stretch aims for tackling the attainment gap that I announced on 8 December.

Alongside health and wellbeing, literacy and numeracy are the recognised responsibility of all who are involved in education, and are priority areas for the attainment challenge and our national improvement framework. The national response to improving mathematics partnership board is identifying opportunities to improve leadership and enhance the professional learning of teachers, in order to improve the learning experiences of children and young people. A parallel national response to improving literacy is at an early stage of development, with the aim of implementing similar improvements for literacy.

There is also across local authorities an established network team of attainment advisers, who are providing improvement support on numeracy, literacy and health and wellbeing in every local authority. There is a strong focus on parental engagement via the Scottish attainment challenge and the "Read, Write, Count" initiative in early primary school. Regional improvement collaboratives, supported by dedicated Education Scotland staff, are focused on improving literacy and numeracy through collaborative work that empowers the system at school, authority and region levels.

Nevertheless, I recognise that, although we are seeing progress on some measures, we are not yet where we need to be on all the indicators. I am the first to acknowledge that there is still work to do. That is why we have implemented a new accelerated approach for the Scottish attainment challenge, including the record investment of £1 billion.

As we set out in 2016, the Government is committed to closing the poverty-related attainment gap and to substantially eliminating that gap by 2026. I stand by that. That remains the policy and the objective of the Government, and there has been progress. I have previously set out the details of our refreshed approach to the challenge in the chamber. In addition, just last month, I published the local stretch aims that local authorities have now put in place for the coming year. In the ACEL figures that have been published we see evidence that local authorities and schools are already making progress and are well placed to go further.

We know that a ground-up approach works best in embedding improvement, so the stretch aims have been developed by local authorities, using local knowledge, data and expertise, and they express each local authority's own ambitions for their learners.

Ultimately, of course, what matters is progress in schools through implementation of local plans, supported by strategic equity funding, that underpin the stretch aims. That is a shared responsibility; I do not expect teachers to achieve on their own the progress that we need. Schools and education services must collaborate across services and with local partners to make progress.

By introducing a requirement for local stretch aims we are ensuring clear local ownership of progress and creating opportunities for learning and partnership working, which will help us to address variation in attainment and to make progress in closing the poverty-related attainment gap between schools and local authorities.

Collectively, the core stretch aims that have been set by local authorities show a great deal of ambition for recovery and for acceleration of progress. I welcome that level of ambition. Achieving the local stretch aims will require local government, central Government and Education Scotland to work together to ensure that progress on attainment and outcomes continues and accelerates.

The national discussion on Scottish education has provided an unprecedented opportunity for young people, parents, carers, teachers and practitioners to contribute to setting a long-term vision for Scotland's education. I am delighted by the positive response from the public and stakeholders to that consultation, which ran between September and December last year. The views of those who took part will help us to develop a compelling and, I hope, consensual 20-year vision for Scottish education. It will provide a further opportunity to enforce our shared endeavour to close the poverty-related attainment gap.

Our vision for Scottish education will be launched in the spring and will be accompanied by a call to action setting out short-term, medium-term and long-term goals, which will build on the areas where we are performing well and make the changes that we will require in order to prepare learners for the economy, society and culture of the future.

The national discussion will also help to inform Professor Hayward's independent review of qualifications and assessments. Her final report in May will pave the way for future reform of the qualifications and assessment system to ensure that it meets the needs of learners and society in the 21st century.

We will continue to ensure that the development of the new national educational bodies supports our vision of a world-class education system that continues to adapt to change and is based on equity and excellence.

Improving the education and life chances of all our children and young people is an ambition that is shared across the education system, and it remains central to our improvement agenda. The attainment challenge is a significant commitment within a much bigger programme of investment. Our spending plans for 2023-24 allocate £4.85 billion of funding across the education and skills portfolio, including on measures to address the cost of living crisis and to support a range of measures to help children, parents and carers with the costs of the school day.

I am committed to ensuring that all children and young people in Scotland have the same opportunities through their education. We know that we have the right curriculum in place for Scotland's children and young people. In its 2021 report, the Organisation for Economic Co-operation and Development found wide support for curriculum for excellence, and highlighted that it

> "continues to be a bold and widely supported initiative, and its design offers the flexibility needed to improve student learning further."

In the programme for international student assessment's 2018 global competence assessment, which measured knowledge of international and sustainability issues and ability to apply that knowledge, Scotland's average score was higher than the average of all participating countries.

The latest evidence is encouraging—it shows that we are on the right track. Statistics that were published in December showed that the gap in respect of entering positive destinations between school leavers from the most-deprived areas and those from the least-deprived areas fell to 7.5 percentage points in 2020-21—the smallest gap on record—which shows that excellent progress has already been made in terms of outcomes for school leavers.

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

Stephen Kerr (Central Scotland) (Con): Before Christmas, the Opposition parties requested a statement on the latest set of data that had been released, but I wish that we could feel a greater sense of passion, energy or urgency from the cabinet secretary. That might be too much to ask, because what we have had in the statement is an exercise in spin. We have had an exemplary demonstration of cherry picking and straw clutching, but the reality is that it is just spin. Frankly, if that is what success looks like in the eyes of the cabinet secretary and the Scottish National Party Government, heaven help us. What would failure look like?

The truth of the matter is that the more data we get, the more we can see that the cabinet secretary and the SNP Government are failing Scotland's children and young people and their parents and carers, and it just will not wash.

Central to improving the education and life chances of children should be ensuring that we have first-class learning environments in schools. Teachers are at the front line in all of this. Such is the cabinet secretary's inaction that teachers have been led to do something that is against their nature as professionals: to take strike action for the first time in 40 years.

The cabinet secretary said last week that she was

> "exceptionally disappointed"

to see

> "a reduction in teacher numbers."—[*Official Report*, 12 January 2023; c 54.],

because that is what the statistics show, but being disappointed, frankly, does not cut it. What action is the cabinet secretary going to take to increase the number of teachers, to increase the number of teachers on permanent contracts, to increase the number of classroom assistants and to reduce class sizes? I ask the cabinet secretary, in answering that question, not to pass the buck to the local authorities. Is the Government really not bothered any more about teacher numbers and classroom sizes, because if it is bothered, where is the energy and where is the urgency?

Shirley-Anne Somerville: Not for the first time, we have heard a critique of my delivery in the chamber and the way in which I preside over these matters. It would appear that Stephen Kerr wants me to be more like him in the way that I act. I will politely decline the offer of being as passionate and energetic as Stephen Kerr is because, quite frankly, what we do not see from him is much development of the opportunity to take the discussion forward.

In my statement, I went over how the ACEL data shows the impact of the pandemic, but it also shows signs of recovery. That is very important. As I also said in my statement, the pandemic has had an impact not only in Scotland and the rest of the United Kingdom but further afield. It is not surprising, although it is exceptionally disappointing, that we have seen a reduction in attainment and a widening of the attainment gap during the pandemic. Very importantly, though, we saw signs of recovery in the ACEL statistics in December and, within the stretch aims, a real determination in local authorities to carry that through for another year. The Scottish Government and Education Scotland will ensure that we deliver our support to local authorities.

On teacher numbers, I point to the context that we are in. Research by the Education Policy Institute found that Scotland has more teachers per pupil than anywhere else in the UK. The overall pupil teacher ratio remains at 13.2, which is its lowest since 2019. I am exceptionally disappointed that, despite the baselining of further additional funding to local government and an agreement with local government that that money would be used for additional teachers, we did not see that happening.

Mr Kerr talks about passing the buck. It is not about passing the buck; it is about accepting, realising and moving forward on the fact that local authorities are the employers. I will be meeting the Convention of Scottish Local Authorities to ensure that, in the coming years, the funding that is given to local government leads to additional teachers and, in particular, to an improvement in the number of teachers who are on permanent contracts. I would hope that local authorities, as the employers, use that funding accordingly.

Michael Marra (North East Scotland) (Lab): The cabinet secretary was right to begin with a focus on the first national teachers strike in 40 years and, frankly, the huge disruption that that has caused to pupils and families right across Scotland. Teachers do not want to be out on strike—we all know that—but it is now eight weeks since the last offer, and 22 more days of strike action have just been announced. What is the cabinet secretary going to do to change her approach to the negotiations to get the breakthrough that we need, because more of the same is clearly not going to cut it?

I have a specific question about the attainment gap at S3. The cabinet secretary will be very aware of the issue, too, and I have raised it previously with her. I am aware, from the conversations that I have with teachers, headteachers and pupils in secondary schools when I travel across Scotland, of the very particular problem that the S3 cohort has because of the huge disruption that those children experienced in their transition from primary school to secondary school. It is not good enough to say that that will be monitored closely. What will be done? What action, help, assistance and resource will be provided, or will those children—that cohort—just be another regrettable statistic for the rest of their lives?

Shirley-Anne Somerville: I will begin by addressing the question about industrial action. I have said in recent media reports, and I say again now, that we are some distance apart on what is affordable to the Scottish Government and local government and what the unions see as being acceptable. I have been clear all along that the 10 per cent pay increase that the unions have requested is simply unaffordable for the Government. The Convention of Scottish Local Authorities has now made four offers to the unions. I totally acknowledge that those have been rejected, but we need to see compromise on the issue from all sides. The only way to reach a resolution will be by achieving compromise not only within the Scottish Government or local government but among our union colleagues. We have had such discussions over the past couple of weeks in particular, and I look forward to those continuing in that manner.

Michael Marra is quite right to point to the particular concerns around the S3 cohort, which we have discussed previously. I have mentioned the £1 billion-worth of Scottish attainment challenge funding, which is an increase from £750 million in the previous parliamentary session. We are also considering carefully what can be done through the local authority stretch aims, through the network of attainment advisers in Education Scotland, through the universal support that is provided by that agency and through specific targeted support, where that is required.

It is important that when it comes to our approach of providing targeted support, where necessary, through our agencies, which is the best way for national government to address the challenges within the S3 cohort, we work with our agencies and local government to ensure that we deliver that support.

The Presiding Officer: Before we go on to the next question, I advise members that it has taken eight minutes to get through the first two questions and that 10 members still wish to ask questions. I would therefore be grateful if we could pick up the pace.

Graeme Dey (Angus South) (SNP): Contrary to Stephen Kerr’s spinning, local authorities are the bodies that are responsible for school-age education, so they have a pivotal role to play in tackling the attainment gap in our schools. Across the country, there is variation in performance on overall attainment and on closing the poverty-related attainment gap. What work is being done to address such variation? For example, how is best practice being shared with councils whose performance might benefit from such an approach?

Shirley-Anne Somerville: I have already mentioned the stretch aims, which are set by local authorities but on which Education Scotland works closely with them to provide support. Education Scotland and the Association of Directors of Education in Scotland are undertaking collaborative improvement work to consider what more can be done to tackle such variation. I have also mentioned the further work—which, again, is being done through Education Scotland—to provide universal, targeted and intensive support where that is needed. I hope that those are examples of how we are attempting to tackle variation and assisting our local authority colleagues to do so.

Meghan Gallacher (Central Scotland) (Con): It is groundhog day. We have heard yet another statement in which the data is stacked against the Government, which has no meaningful solutions for improving education and the life chances of all children and young people. Questions must be asked about Scottish education reform funding. Gillian Hamilton, the chief executive of Education Scotland, has warned that it

> “does not have capacity and/or capability to carry out this additional, very important work”,

which will have

> “a significant detrimental impact on some key policy areas”,

including the Government’s flagship policy to close the

> “poverty-related attainment gap”.

How serious is the Scottish Government about education reform?

Shirley-Anne Somerville: I am quite incredulous that I am being attacked by Opposition parties on this area. Previously, I have always been criticised on the ground that too much was being done by Scottish Qualifications Authority and Education Scotland staff; it would now appear that I am being criticised for not giving those agencies more money to allow more of their staff to be responsible for the reform package.

We will continue to ensure that, within the agencies, there are sufficient resources to enable them to carry out the necessary work, but we will also continue to ensure that the reform process is driven by the Scottish Government and—because I am responsible for that process—by the decisions that I will take to achieve the reform process that I want to see, which will be radical.

Karen Adam (Banffshire and Buchan Coast) (SNP): I welcome the latest achievement of curriculum for excellence levels statistics: the statistics show a positive improvement in achievement for pupils with a recorded additional support need. However, it is clear that there is much to do. It is essential that children and young people with neurodiverse conditions go through an education system that is responsive to the needs of their conditions. How will the Scottish Government ensure that children and young people with neurodiverse conditions are included and that their unique perspective is front and centre when planning for any progressive improvements?

Shirley-Anne Somerville: Karen Adam raises an important point on the work that we are doing. We are working closely with the young ambassadors for inclusion, including those who are neurodiverse. They are closely involved in the delivery of the additional support for learning action plan. Those ambassadors will be consulted in the national discussion on the future of education in Scotland because, as we look to future progress, it is important that everyone is involved in that discussion, including our young people who are neurodiverse.

Martin Whitfield (South Scotland) (Lab): I agree with the cabinet secretary's commitment to ensure that every child and young person in Scotland has the same opportunities through their education.

There are 15,324 school-age children and young people who have been identified as having additional support needs. However, on figures from 2020-21, 17.4 per cent of pupils with learning disabilities did not achieve a national qualification at level 2 or better, compared to 0.9 per cent of pupils without learning disabilities. I thank Enable Scotland for those figures. What will the cabinet secretary do to narrow that gap by 2026?

Shirley-Anne Somerville: That follows on in part from the question from Karen Adam. I point Martin Whitfield to the work on the additional support for learning action plan and the work within that to recognise that success and achievement for those with additional support needs may vary. It is important that we work with those children and young people to ensure that we are setting our actions in the right way so as to ensure that they are achieving what they can deliver within Scottish education.

I hope that the work on that action plan will give the member some reassurance. I would be happy to meet the member and work with him if that is an area of concern to ensure that we are including the thoughts of children and young people and their requirements in order to see their success being recognised in a suitable way.

Fulton MacGregor (Coatbridge and Chryston) (SNP): As the cabinet secretary said, all local authorities have set their stretch aims for the years ahead, outlining their local ambition to tackle the poverty-related attainment gap. Should the local ambitions be realised and if the rate of progress that we have seen in recent years continues, what impact will that have on the poverty-related attainment gap in constituencies such as mine and across Scotland more generally?

Shirley-Anne Somerville: Collectively, local authority stretch aims indicate significant ambition to drive accelerated progress in closing the poverty-related attainment gap. For example, for literacy and numeracy in primary schools, collective local ambitions are to close the gap by more than 7 percentage points compared to 2021, with data from 2022 showing real progress towards that.

I welcome that level of ambition. I look forward to seeing progress towards those stretch aims, recognising that meeting them is more important than setting them. We will do everything that we can as the national Government and through our agencies to continue to support local authorities to do that work.

Willie Rennie (North East Fife) (LD): Before Christmas, in response to my question, the education secretary said:

> "we will be on track to substantially eliminate the poverty-related attainment gap in primary schools".—[*Official Report*, 8 December 2022; c 58.]

She failed to mention secondary schools. Will the election manifesto promise for secondary schools be met?

Shirley-Anne Somerville: There has been no change in the extent of our determination in relation to primary and secondary. Although I point to the success that we are having in primary schools, I also recognise that there is more to do in relation to secondary school. However, nothing has changed in our determination to deliver a substantial reduction in the poverty-related attainment gap by 2026—exactly as we set out in the programme for government.

Emma Roddick (Highlands and Islands) (SNP): It is obvious that the poverty-related attainment gap—it is important to give its full name—cannot be tackled by schools on their own. Will the cabinet secretary outline what steps are being taken by the Scottish Government to tackle the cause—the drivers of poverty—at its root and mitigate the damaging actions of the Tories in Westminster?

Shirley-Anne Somerville: The member rightly points to the fact that tackling the poverty-related attainment gap is best done at source, by tackling the drivers of poverty. Frankly, it is exceptionally frustrating and disappointing that we continue to try and do that with one hand tied behind our back, because of the changes that the UK Government has made to welfare, and the continuation of those changes will push more and more children into poverty over the coming years. We will continue to do what we can through the Scottish child payment and the Scottish welfare fund, but it is exceptionally difficult when the UK Government makes life harder rather than easier for our children and young people.

Ross Greer (West Scotland) (Green): We now have two sets of national qualifications results from years when exams did not take place and pupils were graded based on continuous assessment and the professional judgment of their teachers. In those two years, the attainment gap was considerably narrower than in years when grades were based on high-stakes end-of-term exams. Without pre-empting Professor Hayward's independent review, could the cabinet secretary reflect on the difference in the attainment gap between those two models of grading?

Shirley-Anne Somerville: Mr Greer is right that I will not pre-empt Professor Hayward's work. I am sure that she will be looking not just at what happened when we had exams but at the fact that our experience over Covid has shown that there are different ways in which we can measure attainment and achievement in our schools, all of them credible, as agreed by universities and employers. That presents us with opportunities for change should that be the right thing to do. I look forward to reading Professor Hayward's report and recommendations in due course.

Natalie Don (Renfrewshire North and West) (SNP): I welcome the Government's mission to tackle the poverty-related attainment gap at all levels of our education system. Will the cabinet secretary set out some detail on what measures are being taken by the Scottish Government to widen access to universities?

Shirley-Anne Somerville: We recently announced the appointment of the new commissioner for fair access, Professor John McKendrick, and I welcome him to his post. His experience in tackling poverty and inequality in Scotland is vast, and I look forward to hearing what he has to say. I point to some of the parting words of the previous commissioner for fair access, who said that

> "Scotland continues to set the pace"

when it comes to widening access to university, and who described the Scottish Government's approach as an "unambiguous success".

Pam Gosal (West Scotland) (Con): Central to improving the educational life chances of children and young people should be ensuring first-class learning environments in schools. In the past academic year, there were more than 20,000 physical or verbal attacks against schoolteachers and other members of staff. The former president of the Educational Institute of Scotland, Heather Hughes, said:

> "Teachers often feel unsupported when reporting these issues. All too often they are made to feel that the blame lies with them".

It is therefore disappointing that there was no mention of such a serious issue in the cabinet secretary's statement. The Parliament has enough evidence that shows that teachers are not reporting those attacks and disruption, so the real scale is unknown. Will the cabinet secretary commit to mandatory reporting of violence in the classroom so that the issue can be dealt with once and for all?

Shirley-Anne Somerville: The statement was, as I think Opposition parties wished, mainly based on the statistics that came out in December, and that is where I focused my remarks. The member is right to point to the important issue of violence against staff. There is absolutely no excuse for violence, intimidation or threats against our staff in schools. We work very closely with local authorities as the employers to ensure that we are doing everything that we can, and there are a variety of ways in which we could look to strengthen that work. I would be more than happy to look at any proposals on what can be done, and I would do so in conjunction with local authorities as the employers, who take the issue, as we do, very seriously.

Foysol Choudhury (Lothian) (Lab): I have spoken in the chamber previously about the importance of educating children on Scotland's ties with colonialism and the role that black and minority ethnic people have had in Scotland's colonial past. Currently, it is not compulsory for schools in Scotland to educate students of any age on Scotland's colonial past and its role in the British empire and the transatlantic slave trade. Mandatory primary education on such matters would ensure that, from a young age, children have a realistic understanding of Scotland's history, what has been done to overcome that, and how we can strive to improve that in the future. Does the cabinet secretary agree that a mandatory primary curriculum on Scotland's history of colonisation, slavery and empire is essential to ensure that all children receive an education that redresses historical inequality and supports the growth of our progressive and diverse nation?

Shirley-Anne Somerville: Foysol Choudhury will forgive me if this is not correct, but I think that we have been trying to get some time in the diary to discuss that issue in particular and have kept missing each other. I am more than happy to find a time to discuss the issue in greater detail than I can today.

Although we do not have a compulsory curriculum in Scotland—and I do not think that we should have—we are, of course, working consciously with our anti-racism in schools works to look at how the curriculum can be changed and what changes can be made so that the issues that Foysol Choudhury has raised are dealt with. As I have said, I hope that we will get the chance to have a proper conversation soon to explore that in further detail.

Surgical Mesh and Fixation Devices

The Deputy Presiding Officer (Liam McArthur): The next item of business is a committee debate on motion S6M-07487, in the name of Jackson Carlaw, on petition PE1865, which is on suspending all surgical mesh and fixation devices. I invite Jackson Carlaw to speak to and move the motion on behalf of the Citizen Participation and Public Petitions Committee.

14:57

Jackson Carlaw (Eastwood) (Con): Colleagues across the chamber will not be surprised to hear me speak on the subject of mesh in the 10th anniversary year of that issue first being raised in a public petition to the Parliament by Elaine Holmes and Olive McIlroy. However, I do so today on behalf of fresh petitioners. Roseanna Clarkin and Lauren McDougall have lodged a petition for the Parliament's attention on behalf of all those affected by the issues raised. Members will recognise the similarities between the issues raised in that petition and those raised in our previous debates in the chamber on the subject of transvaginal mesh. I hope that they will appreciate, and be patient with, the need for plain and uncomfortable discussion of the facts.

Our previous discussions focused on the experience of tension-free vaginal tape and women's health. Roseanna Clarkin and Lauren McDougall have highlighted significant additional concerns about the wider use of mesh, and they have made it clear in their petition that our attention should also be focused on the use of mesh in other surgical procedures—for example, hernia repair—and the effects that that has had, is currently having and will continue to have if the use of mesh continues for men, women and children throughout Scotland.

In raising the issue, Roseanna Clarkin and Lauren McDougall have urged us to be cautious about the use of surgical mesh until more information is gathered and we have a better understanding of the complications and adverse outcomes resulting from those procedures. In their view, that should include investigation of the concerns about potential cancer risks associated with the use of titanium staples to secure the mesh.

In considering the issues raised by the petition, the Citizen Participation and Public Petitions Committee heard from individual members of the public, including members of the Sling the Mesh campaign. We have been able to explore the experience that they have shared by gathering further information from the Scottish Government and from clinical specialists who are familiar with the alternative options for hernia repair. I will say more about that shortly. The committee is also grateful to colleagues who joined us at various points in our consideration to offer contributions on behalf of their constituents. I see several of them in the chamber this afternoon and look forward to hearing further from them.

We also heard from the Minister for Public Health, Women's Health and Sport, who, in the Government's initial response to the petition, said that she did not believe that there was evidence to justify a pause in the use of relevant devices. She stated that

> "using mesh resulted in lower rates of recurrence, lower rates of serious adverse events and similar or lower risk of chronic pain."

It struck me, at our first consideration of the petition, back in September 2021, that that was almost exactly the same as the testimony that we had heard in relation to the previous petition, on transvaginal mesh. In that case, people had been dealing with their issues individually; information on their experiences and outcomes was not centrally gathered, held or reviewed; and, until people knew that there was a wider issue to speak out about, there was not much information available in the public domain.

Since then, the committee has received more than 85 written submissions. The majority of them are personal testimony from individuals detailing the life-changing effects that mesh complications have had on them.

Alex Cole-Hamilton (Edinburgh Western) (LD): Jackson Carlaw mentions the symmetry between the committee's considerations on the use of mesh that we are considering today and the previous use of it for transvaginal therapies. Does he also agree that there is symmetry in the fact that knowledge of the risks was not imparted to patients in advance of those procedures being undertaken and, similarly, there was a stigma around their experience of pain because they sometimes were just not believed?

Jackson Carlaw: Yes, that is a fair summary of the position. It is redolent of the experience of those who suffered because of transvaginal mesh, who were told that it was a psychological condition and not a real expression of pain and discomfort.

Figures from Public Health Scotland and the Scottish Health Technologies Group suggest that around 10,500 hernia repairs are carried out in Scotland each year—for all I know, there may be some people with them in the chamber—with mesh being used in approximately 62 per cent of those procedures. Official statistics also suggest that there are, on average, 32 procedures to remove mesh from previous hernia repairs each year. What is not yet available is data on the reasons why the mesh has been removed. In comparison with the number of hernia repairs that are being carried out, those numbers may appear small, but we must keep in mind the fact that individual patients are behind each of those statistics.

The committee also heard from the chief medical officer that the complex mesh surgical service deals only with TVM removal and that there is no similar service for the removal of other types of mesh. We heard of difficulties in getting mesh removal surgery on the national health service, which were attributed to a lack of knowledge about the issue in primary care and the complex mesh surgical service accepting only gynaecological referrals. Some individuals resorted to going private to get their mesh removed and some travelled abroad to have that done. We heard that there is no clear pathway for patients and that general practitioners are not aware of where to send them.

The testimony that we have received details the pain that many individuals who had mesh implanted during hernia or rectal prolapse repair surgery have experienced. The people behind those statistics have told us that their symptoms occurred very quickly after surgery and have worsened over time. They have been left in constant pain—I apologise here—and have nerve damage, sexual pain, issues with their bladder and incontinence. One patient described the pain as feeling like

> "a cheese grater rubbing against my groin."

Another patient told us that the pain feels like they are

> "wearing a tampon dipped in acid."

Some people told the committee that they had been told that the hernia or rectal prolapse mesh had eroded into their vagina wall, bowel and bladder or had adhered to their bladder, ovary, fallopian tube or bone. The committee heard that complications had led to mobility issues and had significantly reduced people's mental health and quality of life. Some people reported improvements after mesh removal surgery, but others were told that the mesh was too enmeshed in their body to be removed without causing serious ramifications, such as the loss of their rectum or testicles.

A Scottish Government-commissioned review on hernia mesh stated that most common adverse events following mesh-based hernia repair are pain, infection, hernia recurrence, scar tissue forming between separate surfaces of the body and blockage of the bowel. The complications that people are being forced to live with mean that they have had to give up working, their relationships have broken down and even something as simple as going out for a meal with their family has become impossible due to the pain that they experience.

They have told us of their concerns about informed consent—the point that Mr Cole-Hamilton raised—and the challenges they faced in having their pain taken seriously. In one case, we heard that a patient was not given any other choice of treatment, was not informed that the surgery would involve mesh and, despite reporting pain in their hips, legs and pelvic area, was met with a dismissive response from the surgeon.

Similar stories have emerged throughout the submissions. Over and over, people have told us either that they were not informed that mesh would be used or, if they were informed, that they were told that the only risk was that the mesh could be too tight, which could be resolved by snipping it. Unfortunately, the testimony that we have heard clearly and, at times, graphically demonstrates that that has not been the case. People have told us about having developed autoimmune diseases, which they believe was linked to having mesh inserted into their bodies.

Those are all themes that we have explored with the Minister for Public Health, Women's Health and Sport during two separate evidence sessions.

It was encouraging to hear from the minister and the chief medical officer about the progress that is being made on embedding shared decision making as part of the patient journey. The CMO indicated that a

> "shared decision-making approach has ... been whole-heartedly embraced by the profession"—[*Official Report, Citizen Participation and Public Petitions Committee*, 8 June 2022, c 5.]

and is supported by education delivered by the NHS. He told us that part of that approach includes sending letters to out-patients, encouraging them to engage with the clinical team and to ask questions about the benefits, risks and alternatives, as well as about what happens if no action is taken.

Daniel Johnson (Edinburgh Southern) (Lab): I am very grateful to the member for giving way, especially as I will not be able to speak in the debate.

Jackson Carlaw has clearly outlined that the issue goes much wider than transvaginal mesh, and the motion refers to the use of polyester and other materials. Like other members, I have been contacted by women who have had Essure devices fitted and have had similar complications. Do the reassurances that the member has been hearing from ministers and medical officials extend to broader categories of devices?

Jackson Carlaw: Mr Johnson raises a valid point. The evidence that we have taken has related more directly to the issues that have been raised by the petition, but he raises an important consideration. I would be interested to hear the Cabinet Secretary for Health and Social Care address that point.

The committee heard that surgical mesh has become the preferred method for hernia repair worldwide, with evidence suggesting that using mesh in hernia repair reduces recurrence. Nonetheless, a small minority of surgeons prefer to use natural tissue repair and will use mesh only as a last resort.

During our deliberations, we heard from experts at Shouldice hospital, in Canada. For those who may not be familiar with that unique hospital, I highlight that it is the only licensed hospital in the world that is dedicated to hernia repairs. We are particularly grateful to Dr Fernando Spencer Netto, who is a surgeon at Shouldice, for taking the time to meet the committee during a virtual evidence session last May.

Anyone who views the evidence that we heard from Shouldice hospital cannot fail to be impressed by its results. Dr Spencer Netto told us that the hospital carries out 6,000 to 6,500 procedures each year, around 99 per cent of which do not use mesh. The specialist focus on natural tissue repair has resulted in Shouldice having one of the lowest rates of hernia recurrence. Indeed, its recurrence rate is around three times lower than that of the hospital with the second-lowest rate of recurrence.

Presiding Officer, I see that I am very close to the time by which I must finish. I will conclude with the words of one of the petitioners. Roseanna Clarkin told us:

> "We feel the Scottish Government have completely ignored us over the past 8 years."

That is how the petitioners feel. She continued:

> "We have campaigned alongside the transvaginal mesh women ... We always knew we would have to fight for better healthcare together ... This petition is our last chance to get what we feel should have already been in place."

I am pleased that the Citizen Participation and Public Petitions Committee can play a part in ensuring that Roseanna, Lauren and all those who continue to campaign with them will have their voices heard.

I move,

That the Parliament notes public petition PE1865 on suspending the use of all surgical mesh and fixation devices while a review of all surgical procedures which use polyester, polypropylene or titanium is carried out, and guidelines for the surgical use of mesh are established.

15:08

The Cabinet Secretary for Health and Social Care (Humza Yousaf): I thank Jackson Carlaw and members of the Citizen Participation and Public Petitions Committee for their work on the petition, and, most important, I thank Roseanna, Lauren and the other petitioners for their involvement in the petition.

I am grateful for the opportunity to speak on behalf of the Government in the debate. I know that most members of this Parliament are familiar with issues that are associated with surgical procedures involving the use of transvaginal mesh, whether that is from our constituents, the press or the Sling the Mesh campaign, which has been running for 10 years, as Jackson Carlaw mentioned.

We have heard about many distressing situations that those with complications have experienced. Those have caused us all great concern and I am genuinely grateful to all who have taken the time to speak openly about their experiences, which is not at all easy, given the deeply personal nature of what they have faced. We have heard some of that in the personal testimonies that Jackson Carlaw read out.

As I said, many of us in the Parliament first heard about mesh and surgery involving its use through the campaigning of those who had transvaginal mesh implants. I remain grateful to that group of patients for making their voices heard, and I continue to engage with them. The Government has taken a wide range of actions to assist the women who have been affected, and I hope that they have seen some progress, particularly over the past 12 to 18 months.

In my remarks today, I propose to focus on people with experiences of other types of mesh. It goes without saying, but I will say it nonetheless: I am always very sorry to hear of instances of complications and adverse side effects, and the impact that they have had on individuals as well as their wider families.

In Alex Cole-Hamilton’s intervention a moment ago, he made the point that one striking common theme that has come out of engagement with women who have been affected by transvaginal mesh is that they simply were not believed. We have heard testimonies from those who have been affected by hernia mesh or other uses of mesh, who have spoken powerfully about the pain that it has caused them. I do not want them to think for one second that the Government does not believe them or does not believe that their pain is real. If they have ever felt that a clinician has not believed them, that is not the trauma-informed and compassionate NHS that I believe in.

Jackson Carlaw: I think that politicians across the chamber, including those in the Government, accept that patients who have suffered in this way need to be believed. Rona Mackay, who is the convener of the cross-party group on chronic pain, has, along with me and others, heard repeatedly from individuals that, unfortunately, that is not always their experience when speaking to clinicians.

Humza Yousaf: Yes, of course, and I have heard that, too, when I have engaged with those who suffer from chronic pain or other conditions. That is why some of the trauma-informed and compassionate leadership work that we are doing is so important. If there are particular services where that approach is not being taken, I am always open to MSPs or members of the public writing to me or communicating that to me directly, and I will ensure, for the Government, that that particular health board or service is investigated. I reiterate on behalf of the Government that, regardless of how mesh is used and the procedure that it is used for, individuals who suffer from side effects, pain or complication should get the care and treatment that they need.

As has been referenced, after hearing the concerns of patients, the Government commissioned the Scottish Health Technologies Group to look into the use of mesh in hernia repair. That led to the publication of not one but two reports on the subject. Those reports are based on information from peer-reviewed published evidence, much of which is from comparative trial data. Both reports support the continued use of mesh in most abdominal wall and groin hernias.

We have discussed those findings with professional bodies such as the relevant royal colleges and the British Hernia Society, and we will continue to work with them on this important issue. It is fair to say that they support much of what is in the reports from the Scottish Health Technologies Group on the continued use of mesh.

Work is also on-going with regard to establishing registries and encouraging better data collection, which was a theme in Jackson Carlaw’s contribution. That will provide important surveillance and outcome information in years to come.

I realise that the petitioners would like an independent review of all surgical mesh and fixation devices to be undertaken, which is entirely understandable in light of their experiences. However, given the conclusions of the Scottish Health Technologies Group reports as well as the action that we are taking in response to those reports—I will touch on that in more detail in a moment—and the various reviews that have been carried out in relation to transvaginal mesh, I do not believe that a further review is warranted. We will, though, remain focused on available evidence, including new information as it emerges—including from the data collection that I spoke about a moment ago—and we are of course committed to acting on it.

Daniel Johnson: I note what the cabinet secretary says about the efficacy of a further review, but there is a growing sense globally that there is a broader issue surrounding medical devices. Will he comment on whether we need a revision of the approach that is taken to medical devices that use polyester or other materials, as cited in the motion, or more broadly, given the global concern about such devices, and not just particularly about mesh?

Humza Yousaf: The Scottish Health Technologies Group looks at the global evidence that is available. There is a lot of value in working on some of these issues on a four-nations basis, which is why making progress on Baroness Cumberlege's report is important. We have the Scottish Health Technologies Group to review any global evidence that emerges on the various devices and the potential complications associated with them. I am happy to take away the specific issue that Daniel Johnson has raised and to see whether we can do anything further in that regard.

I am not making as much progress in my speech as I would like, but I will reiterate a couple of points for emphasis. I understand the reasons for the suspension of the use of mesh that have been given by people, particularly the petitioners. However, some 100,000 hernia repairs are carried out each year in the United Kingdom, and approximately 11,000 such repairs were carried out in Scotland in the year before the pandemic. That number includes elective procedures as well as those presenting as emergencies. Surgery must be available for all, and establishing a specialist centre, which is one of the petition's suggestions, might not be conducive to that, as it could pull resources into one health board area and mean that patients have to travel.

There will, of course, be hernia repairs that are more complex, and it is for that reason that the chief medical officer has asked medical directors to consider the development of local clinical groups and broader clinical networks for the management of more complex cases. We will continue to work with clinical colleagues on that. In the interim, however, it is a patient's right to request a second opinion if they are in any doubt about the treatment that is being offered to them.

I will now address the continued use of mesh in other areas. In comparison with the use of mesh in hernia repairs, such procedures, including those involving the use of mesh in reconstructive surgery and its continued use in gynaecology, are not performed frequently. In those cases, it is recognised that there are currently very few—if any, frankly—viable alternatives, so to suspend the use of mesh in the very wide way that is anticipated by the petitioners would, unfortunately, leave quite a large cohort of people with limited or, indeed, no treatment options, which I am sure is not what the petitioners want.

I will end on one of the points that Jackson Carlaw made. In the Scottish Health Technologies Group's reports and reviews, it made a number of recommendations about ensuring that any procedure is done in conjunction with, and in collaboration with, the patient involved, that the patient is fully apprised of the potential risks that there might be to any surgery, particularly surgery that involves mesh, and that alternatives are explored if they are clinically safe and viable. Potential alternatives to mesh, particularly for hernia cases, are being explored.

The Parliament has, quite rightly, called on the Government to take steps to help those who have been harmed, most notably in relation to transvaginal mesh. The Government has responded positively to that, but I have concluded that a further suspension—in the wide sense that is sought by the petitioners—or review is not warranted. In saying that, I completely understand the disappointment that some people will feel, but I hope that the actions that I have set out, which I will expand on in my closing remarks, give some reassurance that we are listening, that we are making progress and that we are absolutely committed to ensuring that people get the care that they need in the best way.

15:18

Sandesh Gulhane (Glasgow) (Con): Petitions from members of the public have brought about changes in the law and in Government policy, have helped to revise guidelines on issues and have even changed decisions. Even just raising awareness of an issue in the Parliament can be a success. We recognise the hard work of petitioners, of the people who are called to give evidence and of the members of the Citizen Participation and Public Petitions Committee.

Although we often chide the Scottish Government for its lack of transparency or its avoidance of scrutiny, because transparency and scrutiny are essential to the functioning of our parliamentary system, we are also well aware that the petitions process is important for our democracy.

Petitioners Roseanna Clarkin and Lauren McDougall have called on the Parliament

> "to suspend the use of all surgical mesh and fixation devices while"

a full

> "review of all surgical procedures which use polyester, polypropylene or titanium is carried out; and guidelines for the surgical use of mesh are established."

The petition is not about transvaginal tape—TVT—or pelvic mesh implants. We spoke about mesh implants in the Health, Social Care and Sport Committee today, and the cabinet secretary intimated that he might be able to give us a bit of an update. If it is possible, it would be great if he could do that in his closing remarks.

However, the petition is about mesh and other devices and fixations that are used in surgery elsewhere in the body—in particular, in hernia repair. The petition raised awareness of complications that have arisen from use of synthetic mesh in surgical repairs. The petitioners also drew attention to concerns that are associated with titanium ProTacks that are used with hernia mesh, because they carry a cancer warning.

Between May 2021 and June 2022, the committee heard evidence and received written submissions from a lot of people, including the chief surgeon of Canada's Shouldice hospital, which is the only hospital in the world that is dedicated to hernia repair, and performs up to 6,500 surgeries annually. We heard Jackson Carlaw talk about the complications rate, but it is very important to say that the more one does one type of thing, the better one gets at it and the less likely one is to have complications.

I cannot help but wonder how long patients have to wait to be seen at the Shouldice hospital. I am assuming that it is less than they wait in NHS Grampian, where the longest recorded wait for a diagnostic test in 2022 was 258 weeks.

As for surgery, while Shouldice hospital is performing over 6,000 surgeries annually, in our country's largest health board, NHS Greater Glasgow and Clyde, all non-urgent surgery is now paused—likewise, NHS Ayrshire and Arran and NHS Borders, and we understand that NHS Fife is also reducing its elective surgical capacity.

As a former registrar in a busy surgical department, I can say that surgery involves risk, and that the risk increases if the patient's health is compromised, which includes their being overweight or obese. Therefore, it is important to examine the data from the outcome of many surgeries that used a particular technique in order to evaluate any potential risk.

Let us take the example of hernia repair. A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding wall. Hernias usually develop between a person's chest and hips. An inguinal hernia repair can be carried out either as open surgery, which is essentially just a big cut, or laparoscopic, or keyhole, surgery. Once the anaesthetic has taken effect, the surgeon makes a single cut over the hernia. The incision is about 6cm to 8cm long. The surgeon then places the lump of fatty tissue or loop of bowel back into the abdomen and mesh is stapled or glued into the weakened area of the abdominal wall, where the hernia came through, to give it temporary strength while the body heals.

There have been reports of issues associated with the mesh that is used in hernia repair. They include infection, pain and adhesion. However, the Scottish Health Technologies Group reports that men who were operated on with mesh were less likely to have their hernia return than were those who had surgical stitches. Also, use of mesh meant that the men were less likely to suffer urinary retention or injury to nerves, blood vessels or internal organs. They were more likely, however, to develop a build-up of fluid or a swelling soon after surgery, which is common. There was no difference between stitches or mesh being used in respect of their developing chronic pain.

Only a tiny percentage of people who have had hernia repairs involving mesh have had to have their mesh removed. Between 2013 and 2018, there were about 70 operations in Scotland to remove surgical mesh after hernia repair. That represents 0.3 per cent of the 25,188 patients on whom mesh was used.

In January 2020, the Scottish Health Technologies Group recommended that NHS Scotland use mesh when repairing hernias in adult men. It also stressed the importance of robust data collection and the importance of data on long-term outcomes from hernia repair in Scotland being recorded at national level to inform future decision-making.

Emma Harper (South Scotland) (SNP): We are talking about mesh. There is so much choice of mesh that is implanted. Does Sandesh Gulhane agree that the data that we would get from that might—based on the properties of the mesh that is used, such as the type of filament, the tensile strength and the porosity—help us to determine which mesh leads to specific complications such as pain?

Sandesh Gulhane: It is almost as though Emma Harper has read the rest of my speech. Yes—I agree.

The National Institute for Health and Care Excellence, which we all know as NICE, has found that post-operative complications from mesh surgery are rare. In my experience in hospitals, mesh complications were rare, and I am probably the only member to have actually implanted mesh into hernias.

Emma Harper: I have, too.

Sandesh Gulhane: Emma Harper has put them in, as well.

From a systematic review of the literature, covering 37 randomised controlled trials with a total of 5,560 participants—which is quite a lot—10 per cent or less experienced persistent pain from either procedure and 23 per cent or less experienced persistent numbness.

Jackson Carlaw: I have now heard Dr Gulhane say that he has inserted mesh into other people. Were he to be diagnosed with a hernia and told that it must be repaired, would his preference be to have mesh inserted into him or to have a natural tissue repair?

Sandesh Gulhane: My preference would be to have what the surgeon deemed to be most appropriate for me. [*Interruption*.] No—if that involved the surgeon saying that he or she thought that mesh would be the correct procedure, I would whole-heartedly go forward with that. It would depend on the hernia that I had. I would not have a problem with having mesh implanted into me or my family.

NICE guidelines recommend future research into chronic pain and numbness, as well as the setting up of a registry to monitor adverse events and recurrence rates.

As for the petitioners' cancer concerns, the US Food and Drug Administration reviewed early epidemiologic studies on implant-related haematopoietic cancers and found conflicting evidence, with only two studies suggesting that there was an increased risk of lymphoma or leukaemia.

This is important to note: no medical or surgical intervention is without its side effects.

Having considered the evidence that has been taken by the Citizen Participation and Public Petitions Committee, we do not support the petition. I will explain why through another example. Earlier today, Andy Murray won in the first round of the Australian open, which is, quite frankly, amazing, given that he has a metal hip. However, he does not have a total hip replacement; he has had hip resurfacing. When I was working in London under Professor Haddad, there was a scandal around hip resurfacing, with calls for the procedure to be banned completely. However, we have discovered that it is a fantastic piece of kit if it is inserted by the right surgeon on the right patient. Andy Murray shows us the value of the procedure when it is done right.

What I am saying is that not all kinds of mesh are the same, that not all patient indications are the same, and that most evidence points towards hernia mesh being much safer than transvaginal mesh. However, we support calls from the Scottish Health Technologies Group—the Presiding Officer will tell me to wrap up, at this point—to strengthen data collection on hernia outcomes and from NICE to monitor adverse events.

I declare an interest as a practising GP.

15:28

Jackie Baillie (Dumbarton) (Lab): I apologise to members in advance because, with your permission, Presiding Officer, I need to leave the chamber briefly during the debate to give an interview. I will return and ensure that I catch up on my colleagues' contributions.

I thank the Citizen Participation and Public Petitions Committee for its work on the petition, and I commend Roseanna Clarkin and Lauren McDougall for lodging the petition with the Scottish Parliament.

The petition is about suspending the use of mesh, other devices and fixings that are used in surgery and, in particular, in hernia repairs. Some 11,000 hernia procedures were carried out in a recent four-year period, which is five times as many as were carried out for pelvic or transvaginal mesh. Problems that have been reported include infection, pain and adhesion to other parts of the body. There are clear similarities between the experiences of people who have had hernia operations and those of women who have had transvaginal mesh implanted.

There are lessons that the Scottish Government must learn from the 2014 campaign to suspend the use of transvaginal mesh and from the unacceptably long time that campaigners have been forced to wait for treatment and solutions. People who have experienced problems with mesh are often left in crippling pain; they have suffered from multiple organ trauma and extensive nerve damage, despite being told that the mesh that caused them the pain was safe. We know that their pain went ignored by some health professionals because they have told us so; it was dismissed as being all in their minds.

Many of the circumstances, and much of the language, from the fight against transvaginal mesh are replicated now in discussions about the use of all surgical mesh and fixation devices.

People with lived experience have spoken about the excruciating pain that they are forced to endure and about how that has led to depression and sometimes to suicidal thoughts. They tell of how they have been ignored and shrugged off by doctors when reporting their symptoms or attributing pain to their mesh implants. That pain impacts on their ability to work or to enjoy any quality of life. In the evidence that they gave to the Citizen Participation and Public Petitions Committee, patients detailed how the prolapse mesh that they have been fitted with has eroded into the walls of their body, or even adhered to their organs.

In line with the experience of women who were fitted with transvaginal mesh, there are currently few processes in place for addressing and removing defective surgical mesh. There is also a lack of process for tracing the product, which makes it hard to retrieve faulty mesh that has been fitted. Although I welcome the establishment of a medical device information system, it is concerning that such a system is still not in place almost 10 years after transvaginal mesh survivors brought those issues to the fore. The Scottish Government must work to rectify that as a matter of urgency.

I give a cautious welcome to the two Scottish Health Technologies Group reports that make recommendations about the conditions for the continued use of mesh, but I believe that patients must be able to make choices about their treatment and note that some countries, such as Canada, where mesh has been banned since 2019, no longer use mesh at all. What do they know that we do not?

I also agree with the petitioners that there must be a specialist mesh removal service. The complex mesh surgical service deals only with the removal of transvaginal mesh. The waiting time to be seen is currently 42 weeks and patients must wait for treatment after that. I have a constituent, Maureen, who faced months of cancelled appointments before finally being scanned at the Glasgow clinic in November 2021. She had been told that there were no issues with her mesh, yet a private scan, which she organised for peace of mind, confirmed that it was twisted and was the cause of her pain. Maureen lost her job due to the complications from her mesh surgery. She has been failed multiple times by the Government.

The minister cannot tell us how many people have been referred to specialists in England or the US, or how long that will take. I understand that Dr Veronikis has treated only 10 women and that his contract runs out this summer. There appears to be a reluctance to refer women for their preferred choice of operation.

I previously raised the case of Anne, who has been to America for treatment with Dr Veronikis. Ministers said that there was no cap on the amount that could be claimed from the reimbursement scheme, but Anne's experience was entirely different. Despite the minister saying that there was no cap, Anne is still fighting to be compensated for the full cost of her flights. The service established to address the serious problems faced by transvaginal mesh survivors is welcome, but it is not adequately resourced. If we are to include other types of surgical mesh removal, its operation must be urgently reviewed and its scope expanded. We have a duty to get this right for all those who have experienced negative side effects because of surgical mesh

The experiences and stories that the committee heard are not isolated—they are widespread and real. The Government must learn from that testimony and must prevent history from repeating itself.

15:33

Alex Cole-Hamilton (Edinburgh Western) (LD): It gives me pleasure to rise for my party in support of the committee's motion.

I have raised this subject several times in debates about the use of transvaginal mesh implants and have said that we need to expand our debate and discussion to include the use of mesh in other parts of the body. I am very gratified by the work that the petitioners, Roseanna Clarkin and Lauren McDougall, have done to get us to this point—it has been a long time coming.

Last year, I shared the story of my constituent Cathy, whose account echoed those of hundreds of other women who were referred to GPs and physiotherapists to receive mesh implants. Cathy was given very little information, other than being told that the procedure would alleviate the mild incontinence that she was suffering. What followed was five years of crippling pain. Her mobility, mental health and intimacy with her partner all suffered. To put it simply, her quality of life was devastated.

My party and I were proud to back the legislation that the Parliament passed almost a year ago to reimburse the victims of transvaginal mesh implants for the surgery that they would have to undergo to have it removed privately. Although nothing can take away from the trauma that they have had to endure, at least they did not have to bear the hefty financial cost of having implants removed, and at least their plight and their injuries were recognised by this place. However, that legislation was far from a panacea and it was incomplete. The reimbursement scheme did not include the victims of other mesh implants—for instance, those who have suffered complications with hernia mesh. We have heard some graphic descriptions of those cases. That is why I was one of the first to raise hernia mesh in the chamber, along with a number of other MSPs. We have probably all met constituents to whom that has applied. One of my constituents was in effect left crippled by her hernia mesh.

There are harrowing accounts of the impact of hernia mesh implants, including a patient being left with a gaping wound in the side of her stomach that cannot be healed properly and which prevents her from going out and travelling to visit her children, who live far away. Despite such accounts, however, hernia mesh implants are still widely used. The petition that we have before us today seeks to address that and looks towards the suspension of the use of surgical mesh and fixation devices while a review is conducted of the use of all surgical procedures that implant any form of polyester, polypropylene or titanium products.

Sandesh Gulhane: As the member well knows, lots of people are waiting for hernia treatment. Their cases are not emergencies, but they need treatment. What would we do for them?

Alex Cole-Hamilton: An anxiety that I have about the approach of the medical profession in some cases is that it involves rushing into a decision and bouncing patients into treatment without fully informing them of the risks and possible side effects of the intervention. If mesh is not a safe intervention, it is not a solution to the problems that Dr Gulhane outlines.

I have met many survivors of both transvaginal and, now, hernia mesh, and having heard so many tragic and life-changing stories, I have an immediate and visceral problem with that or similar material being implanted into anyone’s body. Personally, I would like to see compelling evidence of the safety of any mesh implant before I would ever be comfortable recommending it to someone that I knew or receiving it myself.

I am aware of the reports of the Scottish Health Technologies Group that support the continued use of mesh in abdominal wall and hernia situations provided that there is shared decision making and an informed consent process with an awareness of the risk being imparted to the patient, but I am not persuaded that that is happening. I intervened on Jackson Carlaw to say—and he agreed with me—that that does not always happen. Informed consent, with patients being given agency and provided with the facts and the risks, is not always happening. Were it to happen, I think that several people might take different decisions and we would see a shift in the balance away from the use of mesh.

I am mindful of the concern that suspending the use of hernia mesh could leave some people with no or very limited treatment options. We have to be cognisant of that and it needs to be taken into account, as is reflected in the petition. I give credit to the petitioners for the elegant way in which they have put it to us. There are of course some life-or-death cases where the use of mesh or some surgical implant is essential.

What many cases involving the use of transvaginal mesh had in common was the failure of those who provided treatment to make the patients fully aware of the risks that were involved in using those implants. Informed consent is one of the key principles or pillars of our health service, or at least it should be, and it is right for every patient to be given all the information about what their treatment involves. That is realistic medicine. That is treating people as grown-ups. That information must include the potential risks as well as the benefits, and patients must always be offered reasonable alternative treatments wherever possible.

In this case, it is also important that we ensure that health boards are provided with all that they need to ensure the availability of non-mesh surgery and that any skills gaps that impact the treatment of complex cases are addressed.

I also agree with Jackie Baillie, who made an excellent point about the urgent and pressing need for mesh removal care pathways in the Scottish NHS. We need to build in the capacity and expertise to make that happen here in Scotland.

I am not a clinician—that is clear—and it is of course right that scrutiny is provided and decisions are taken by specialists. The first step in that process is to hear the lived experience of those who have suffered from complications.

We must remember that many survivors of vaginal mesh implants describe not being taken seriously and even being told that they were imagining their pain. That theme has echoed throughout the debate. In fact, Roseanna, one of the people who brought forward the petition, has a similar story, sadly. She even had to deal with her GP’s suggestion that the pain that she was experiencing was all in her head. It is only by listening to people such as her that we will do the necessary due diligence on the long-term effects of those materials on the body and get a full picture to ensure that nobody else is harmed.

The Deputy Presiding Officer: We move to the open debate.

15:40

Rona Mackay (Strathkelvin and Bearsden) (SNP): The issue that we are debating has been highlighted in the chamber many times over the years—we have been debating it for 10 years, as Jackson Carlaw said—and I have taken a keen interest in it.

Now, thankfully, there is a ban on the use of transvaginal mesh implants, which was brought in by former health secretary Jeane Freeman and warmly welcomed by campaigners and their families.

Jackson Carlaw, whose motion we are debating, and former MSPs Neil Findlay and Alex Neil were at the forefront of the fight for justice for women, and they spearheaded the campaign for women victims of mesh.

Last year, the Scottish Government passed legislation to establish a £1 million fund to support women who were affected by mesh complications, who had received implants on the NHS but had to travel abroad to have them removed by an experienced clinician. Now, thankfully, we have a facility in Glasgow, with specially trained surgeons, where mesh removal can be carried out.

The scandal of women in Scotland—and, indeed, globally—whose lives have been ruined by transvaginal mesh will go down in history as one of the worst medical injustices for decades. However, in all honesty, the debate surrounding petition PE1865 has left me a bit confused. I am sympathetic to the petition, but I probably feel more confused, having listened to Jackson Carlaw and Sandesh Gulhane, who, it is clear, do not agree on it. However, good points have been made in the speeches of everyone who has spoken so far.

Essentially, the petition calls on the Scottish Parliament

> “to urge the Scottish Government to suspend the use of all surgical mesh and fixation devices while—
>
> a review of all surgical procedures which use polyester, polypropylene or titanium is carried out; and guidelines for the surgical use of mesh are established.”

It acknowledges that

> “mesh must be used in life or death situations”

but adds the caveats that

> “mesh is only used when essential; patients have alternatives to mesh; and mesh is only used with the fully informed consent of the patient.”

The petitioners want the use of mesh devices and stitches

> “to be suspended while a review of all surgical procedures which implant any form of”

the materials that I have just mentioned—

> “for example hernia mesh, rectomesh, mesh used in hysterectomies—is carried out and guidelines for the use of surgical mesh are established.”

They call for the suspension of the use of titanium ProTack devices, which, they claim, carry a cancer warning.

Crucially, however, the petition also recognises and supports

> “women with TVT or pelvic mesh implants”

and acknowledges that

> “the mesh that we are talking about is not the same.”

I am not a clinician, nor are the majority of MSPs—with notable exceptions. My opposition to women receiving mesh implants was based on hundreds of testimonies from women who had suffered life-changing injuries. However, as I have said, even the petitioners acknowledge that the type of mesh that is the subject of the petition is different from TVT. The fact is that many people have successfully had mesh inserted for hernia, and I do not know the data for those who have reported ill effects. Data is absolutely key to the issue, and I hope to learn more about that.

The obvious statement is that a review would cause delay for patients in getting treatment, at a time when, as we all know, delays are prevalent due to the intense and unprecedented pressure on the NHS. A review would take time to set up and to come to a conclusion. That would surely leave medics and patients in limbo.

The petitioners ask that

> “mesh is only used when essential”,

but surely a surgeon would not use it unless he deemed it essential. They ask that

> “patients have alternatives to mesh”.

I am unclear—how many of us know?—what options are available to surgeons to treat hernias and other conditions.

The petitioners also ask that mesh is

> “only used with the fully informed consent of the patient.”

One of the stipulations since the scandal of TVT mesh is that patients have fully informed choice. That should be the norm for any surgical procedure that is undertaken. However, I take on board what Alex Cole-Hamilton has said.

The petitioners also acknowledge that

> “mesh must be used in life or death situations”.

I suggest that only clinicians know the severity of any situation, and that they would make the correct choice to keep their patient alive.

The mesh scandal has been a long and difficult journey for the many hundreds of women in Scotland, and many more throughout the world, who have been affected by the devastating and life-changing symptoms and side-effects. We have come a long way in 10 years—although admittedly at a much slower pace than should have been the case—to stop women being affected in this way, and that has been acknowledged by the medical profession.

My issue with the petition is that, although it is undoubtedly well intentioned and heartfelt, I simply do not know whether there is justification for it. I am not sure whether the majority of us do. I am simply saying that there is uncertainty and that there could be unintended consequences. I agree with previous speakers. We must listen to the petitioners on what they have experienced, but my concern is that many patients would face delayed or less effective treatment if the petition were to be upheld.

15:46

Meghan Gallacher (Central Scotland) (Con): I begin by recognising the many women and men who have come forward to discuss deeply personal accounts of the life-changing and lifelong consequences that mesh surgery can cause. Reliving that trauma must be difficult, but it gives MSPs the opportunity to pause, reflect and review treatments that are offered to people across Scotland. I also recognise those who have campaigned vigorously to ensure that any procedure involving mesh is low risk and appropriate.

In all our considerations of the use of such devices, people’s health, safety and wellbeing must be our first concern. The petition that we are debating, if approved by this Parliament, would suspend the use of all surgical mesh and fixation devices. I have some sympathy towards those who submitted the petition to the petitions committee, given the serious implications that the use of transvaginal mesh has had for many women globally.

Mesh was previously used to treat stress urinary incontinence and pelvic organ prolapse in women. However, in 2014, a petition was submitted on behalf of the Scottish Mesh Survivors’ hear our voice campaign. We have all heard from women who have bravely told their harrowing stories about how they were told that they were just experiencing “women’s problems” and that there was nothing seriously wrong. Taking the time to read some of their accounts helped me to understand the distrust that women felt towards the Government and our NHS for not being believed.

It was right that the 2017 Scottish independent review of transvaginal mesh implants recommended stopping the surgery after concerns were raised by women who suffered debilitating, severe and painful consequences. Thankfully, there are now specialised services in Scotland for women who have experienced complications from mesh implant surgery, and the Scottish Government officially signed a contract that allows women to have painful mesh implants removed by a specialist surgeon in the United States free of charge. The deal allows NHS patients in Scotland to travel to Dr Veronikis’s clinic in Missouri for transvaginal mesh removal surgery. Earlier this year, a contract was also agreed with Spire Healthcare, where Professor Hashim Hashim operates, which gave women the option to go to Bristol for the surgery.

However, the points that Jackie Baillie raised in her speech were concerning, and I will not be the only MSP in the chamber today who wishes that the Government had acted sooner and more efficiently to support women who have had such surgery.

One takeaway from the whole debacle was that MSPs from across the chamber rallied together to ensure that mesh survivors not only had a clear route to treatment but were compensated if they had spent thousands of pounds of their own money to have their implants removed.

As my colleague Dr Sandesh Gulhane and others have articulated, there is more than one type of surgical mesh. With other kinds of mesh, such as that used for hernia, there appears to be evidence of issues arising that are similar to those that arose in relation to the use of transvaginal mesh. Potential complications include chronic pain, bowel obstruction, hernia recurrence and infection.

Given that those concerns have been raised, the need for data and evidence is essential when investigating the link between cause and treatment. For example, only a tiny percentage of hernia repairs involving mesh has resulted in mesh having to be removed. The National Institute for Health and Care Excellence found that post-operative complications from mesh were rare, so we need to be careful when looking at the use of mesh and any side-effects of having such surgery.

Emma Harper: Does Meghan Gallacher agree that anyone who is experiencing complications of inguinal hernia repair or any mesh implant should be looked after by a caring, compassionate, kind and competent multidisciplinary team? We need to consider that issue and move forward on it.

Meghan Gallacher: Anyone experiencing any kind of pain should be treated with the utmost care, respect and dignity. Any patient who approaches any service in the NHS should expect that. I agree with Emma Harper that we should always look at those scenarios and make sure that we are moving in a positive and forward-thinking direction.

Moving on to the petition, the foundation behind the campaign is that the petitioners believe that the use of surgical mesh can lead to cancer. The petition also calls for mesh to be used only in life-and-death circumstances and for a full review of how surgical mesh is used. That is why I and other members have outlined the importance of evidence-based arguments. My colleague Sandesh Gulhane mentioned that earlier. Official sources such as the US Food and Drug Administration have said that they are sceptical of mesh leading to cancer. More evidence is needed, therefore, before we consider the petition further.

Having said that, I will not speak against any individual's personal experience of mesh complications. However, I believe that all avenues must be investigated, should someone experience any of the issues that have been identified by transvaginal and hernia mesh victims.

I want to mention hospital waiting lists, because they will undoubtedly impact people who are experiencing any symptoms that could come with mesh surgery. At present, many people cannot see a GP, be seen at accident and emergency within four hours or get through to NHS 24 on the phone. That, combined with budget cuts and NHS staff shortages, is deepening the crisis that has emerged in our healthcare service. If the Government does not get to grips with hospital waiting times, people will continue to suffer unnecessarily due to the pressures on our NHS and the lack of action from the Government.

Conservative members will continue to hold the Scottish National Party-Green Government to account to ensure that improvements are made to our healthcare service.

15:51

Emma Harper (South Scotland) (SNP): I am speaking in the debate because there are two points that I want to make. I also have some additional information that I want to share after hearing other members' contributions.

First, as a former operating room nurse in Scotland, England and California, I have experience of inguinal hernia repairs and other hernia surgery using surgical mesh, and I have seen the amazing results achieved with repair of anatomical defects using mesh. Surgical mesh is a crucial tool in surgery.

Secondly, and notwithstanding that, I completely understand the chronic, serious and total distress that some women experience as a result of transvaginal mesh. I was a member of the Health and Sport Committee in the previous session, when the mesh legislation was being taken forward. The testimony from women who had had complications was extremely powerful, as were the campaigning efforts of mesh survivors. Again, I put my thanks to them on the record. Anyone experiencing mesh complications must be listened to with kindness, compassion and care, and they need a great team of health professionals. It distresses me to hear that some folk have had their pain ignored.

I welcome the steps that the Scottish Government has put in place to allow women to take whichever course of action is most suitable to them for their mesh complications, so that they can be rectified. I look forward to updates from the cabinet secretary on how the complex mesh surgical service is progressing.

Recent studies, including from the Royal College of Surgeons, suggest that the risk of chronic pain following an inguinal hernia repair is similar, regardless of whether mesh is used. Prior to the use of mesh in hernia surgery, recurrence rates of herniorrhaphy were extremely high—10 to 20 per cent in some studies—and there is little doubt that mesh use has dramatically improved statistics and outcomes for patients. According to the Royal College of Surgeons, most of the negative coverage of surgical mesh has focused on post-operative pain issues. The RCS says that there is a danger that the coverage of the issue may be taken out of context.

The original reports of mesh complications featured gynaecological surgery, which is entirely different from patients having a groin or other abdominal hernia repair. In a report published by the Scottish Health Technologies Group, there are a number of recommendations for NHS Scotland, which are underpinned by evidence.

The clinical evidence supports the continued use of surgical mesh as an option for elective repair of primary ventral, incisional and primary inguinal hernias in adults in Scotland. Although patient preference might be for a non-mesh or suture-only hernia repair, access to alternative hernia management options should be available. Those will depend on the patient, the size of the defect—or even the size of the patient—the assessment, the diagnosis and the specific surgical or non-surgical recommendations that need to be made.

The report makes it clear that all elective hernia repairs should be preceded by detailed discussion between the patient and the surgeon as part of an informed consent process. I agree with Alex Cole-Hamilton on that. It is important to ensure that such discussions include the benefits and risks of surgical and non-surgical approaches to hernia management, including the fact that neither mesh nor non-mesh repairs such as the suture method are risk-free procedures. It is also necessary to ensure that the risk of developing chronic pain following hernia repair, especially for patients with pain as their main presenting symptom, is put to patients. Such communication is absolutely crucial in enabling them to make informed consent decisions on their treatment options. The decision to use laparoscopic or open mesh repair should be based on the patient's medical history, the characteristics of their hernia and the level of the surgeon’s expertise.

In addition, it is crucial that we monitor the effectiveness of surgical mesh data. Data on long-term outcomes from hernia repair in Scotland must be recorded at national level to inform future decision making. It must be aligned with the UK medical device information system—MDIS—and should include collection of patient-reported outcomes. I would welcome an update from the cabinet secretary on whether such data will be collected and, if so, how it will be reported.

It is also worth noting that the NICE guidelines recommend laparoscopic surgery as one of the treatment options for the repair of inguinal hernia. I underline that the choice between unilateral and bilateral methods involves assessment and diagnosis of the patient. Section 1.2 of the NICE guidelines states that to enable patients to choose between open and laparoscopic surgery by either the transabdominal preperitoneal or the totally extraperitoneal procedure—the latter is my favourite, by the way—patients should be fully informed of all of the risks. The international guidelines for groin hernia management, which have been developed by the HerniaSurge Group, show that it conducted a thorough review of hernia repairs, leading to 136 statements and 88 recommendations on best practice for hernia repair. It is worth exploring its evidence and guidelines.

Last Thursday, I spoke to Mr David Sanders, consultant upper gastrointestinal surgeon at North Devon district hospital in Barnstaple, who is also president of the British Hernia Society. He gave me lots of information to take away. When the deputy convener closes the debate, I will be interested to hear whether the committee will go on to seek the input of the society, one of whose members is right here on our doorstep in Edinburgh.

I thank the petitioners for bringing the issue to the Parliament. I underline that any decision that we might take in future must be based on the best available clinical data and evidence.

15:54

Katy Clark (West Scotland) (Lab): I thank the petitioners: Roseanna Clarkin, a mesh-injured woman who has suffered chronic debilitating pain and life-altering injury after a procedure for a hernia; and Lauren McDougall, whose mother Michele McDougall suffered 18 years of pain as the result of a surgical mesh procedure before dying of a rare cancer. Neither Roseanna nor Michele had given their assent to mesh being used. Having met both Roseanna and Lauren, I know the pain and damage that mesh has caused in their lives and why they now seek the support from the Scottish Government that they deserve. Roseanna and Lauren have met a number of politicians, but they have not yet met the cabinet secretary. I ask that he consider meeting them to hear of their experiences at first hand. I asked Roseanna Clarkin what her top ask from the debate would be. She said that it was for patient pathways to be provided for all those who have been injured by mesh, rather than each individual having to fight for medical support.

The petition that they lodged in the Scottish Parliament is backed by powerful testimonies from more than 70 mesh patients and their families. It is clear what action they are asking from the Scottish Government. We need to accept that people are still having mesh implanted in Scotland. The Scottish Government must suspend the use of all surgical mesh and fixation devices while an independent review takes place.

Mesh is a cheaper option, but there are other options—the petitioners believed that pig skin should have been used in their procedures. The Scottish Government must provide greater healthcare support for patients who are mesh injured. It must increase access to specialist care, including mesh removal surgery and alternative treatments.

Emma Harper: I am busy on my feet this afternoon, Presiding Officer—it is a really interesting subject for me.

Does Katy Clark agree that it might be worth exploring what they are doing with the one-stop-shop clinic in Barnstaple, Devon, which has a whole pathway sorted for the management of chronic pain from mesh repairs?

Katy Clark: I thank the member for that helpful intervention. Yes, we should look at what is happening there and around the world. Jackie Baillie already mentioned the decision in Canada to suspend the use of mesh.

The Scottish Government must apologise for its failure to date to act on the concerns of mesh patients and should establish a compensation scheme to support those individuals as they attempt to overcome the pain and damage that mesh has caused them. Many of the campaigners on the issue now live with life-changing conditions that are directly linked to the mesh procedures that they underwent.

Although transvaginal mesh and its complications affected the lives of so many women, as we have heard, the use of other products to treat conditions such as hernias affect women, men and sometimes children, too. However, despite the testimonies that the Citizen Participation and Public Petitions Committee received from patients affected by the use of mesh, the true extent of the damage caused by those products remains unclear. Indeed, there have already been several calls in this debate for more data and for evidence to be obtained.

In her evidence to the Citizen Participation and Public Petitions Committee back in June, the Minister for Public Health, Women's Health and Sport admitted that it was not easy to trace what products had been used in all procedures and which were causing harm. However, despite the lack of regulation on its use, NHS Scotland continues to use mesh in surgical procedures. From 2016 to 2020, 62 per cent of all hernia repairs carried out by NHS Scotland used mesh. That is why I join campaigners in their call for an independent review of mesh and fixation devices.

We cannot establish the true scale of the damage that those mesh products have caused to the lives of so many patients across Scotland until we get the data and the evidence. Until that review is completed, the Scottish Government must order health boards to suspend the use of surgical mesh and fixation devices and to use other procedures instead.

We need to put protections for patients in place. There needs to be clear guidance governing the surgical use of mesh. I believe that we need to suspend the use of mesh, but there may well be situations where its use is essential and no other alternatives are available. That must happen only when patients have given their informed consent to its use. It is disturbing that so many of the patients who contacted the Citizen Participation and Public Petitions Committee did not give their consent.

I am very grateful to the Citizen Participation and Public Petitions Committee for giving us the time to explore the issues today. I hope that the cabinet secretary will agree to meet the petitioners to take forward the issues that have been raised in the debate.

16:04

Siobhian Brown (Ayr) (SNP): I have mentioned in the chamber numerous times the experience of a constituent of mine who received a transvaginal mesh implant. She shared with me her story, which she described as a "12-year nightmare" of excruciating pain. Her continual pain had a knock-on effect on all aspects of her life, including her career and her family.

I note that the petition that we are considering today is not explicitly about transvaginal mesh but is about mesh used in surgery elsewhere in the body. The reason that I mention the experience of my constituent is that the story of Roseanna Clarkin, one of the petitioners, echoes what my constituent went through. That all-encompassing pain can have a devastating effect on a person's life.

I thank Roseanna and Lauren McDougall for bringing the petition to Parliament, because it gives us a chance to speak about this very important issue and hear other people's stories. It is clear that the Minister for Public Health, Women's Health and Sport and the Cabinet Secretary for Health and Social Care are taking the issue seriously and are listening to concerns as well as to the evidence.

Given the statements that the Scottish Government has issued and the scientific research that is available, it would not be wise to call for a suspension of the use of surgical mesh in other parts of the body. As we have heard, mesh is routinely used in hernia surgery, and, in Scotland, around five times as many hernia mesh procedures have been carried out as pelvic mesh or TVT implants. Furthermore, hernia repairs are among the most common surgeries carried out globally.

As with any surgery, it carries risks and can have side effects. The Scottish Government commissioned research into the use of mesh in a commonly performed hernia repair, which resulted in the publication of the Scottish Health Technologies Group's report on the use of mesh in primary hernia repair in adult males. The report concluded that, compared to non-mesh procedures, using mesh resulted in lower rates of recurrence, fewer serious adverse events and a similar or lower risk of chronic pain. A further report by the group found that evidence supports the continuation of using surgical mesh in hernia repair as an option. As the minister has previously stated, the use of mesh in operations is long established, and in many situations there are few—if any—viable alternatives. Therefore, the suspension of mesh treatments would leave people with no option.

Informed consent is a very important point that has been raised by the petitioners, the Government and research bodies. It has been reported in the media that Roseanna was not told that her operation would involve the use of mesh and that she did not find out until much later that mesh had been used. I obviously cannot comment on the specifics of the case, but it is unthinkable that something like that could happen.

I agree with the minister and healthcare professionals that, with the exception of emergency procedures, the use of mesh should be carried out only with the fully informed consent of a patient who understands the potential risks and the other options that are available to them. I know that the then chief medical officer wrote to health board medical directors in 2018 to highlight the importance of informed consent. I ask the cabinet secretary, in his closing speech, to confirm that the need for informed consent in relation to mesh surgery is still being highlighted across health boards.

I will draw my remarks to a close. I completely understand that some members of the public who signed the petition will be disappointed that mesh surgeries are still going ahead. I trust that communications from the Scottish Government and healthcare professionals will give reassurance on the reasons behind that.

Fundamentally, it is crucial that we listen to those people who are suffering from mesh surgery complications. My constituent was not listened to, and Roseanna Clarkin was dismissed at first and told that her pain was "in her head". I am sure that many others will have had similar experiences. Only by continuing to listen to people with lived experience can we start the important process of supporting anybody who needs this type of surgery and ensuring that the best possible care is in place for the future.

16:09

Brian Whittle (South Scotland) (Con): I welcome the opportunity to speak in the debate. The mesh issue has been on the agenda of petitions committees since my arrival in the Parliament, and it is fair to say that it has delivered some of the most harrowing evidence sessions that I have been involved with in my time here. It has certainly focused my mind on the fact that what we do in the Parliament, amid all the other white noise of political discourse, has a profound effect on the lives of people in Scotland. In the case of today's debate, the topic has had a far wider reach and far wider implications than just within our borders.

In a particular evidence session, the sight of the cabinet secretary and the chief medical officer being cross-examined in committee room 1 by committee members and former members, with many women affected by the procedure sitting behind them—many of them were in wheelchairs—was a vivid one. I remember that picture every time that I step into committee room 1. The fact that the then committee was joined by Jackson Carlaw, who is now the convener of the Citizen Participation and Public Petitions Committee, Alex Neil and Neil Findlay highlights the cross-party support for the campaign. I put on record that the undaunted pursuit of the issue by my colleague Jackson Carlaw and my previous colleagues Alex Neil and Neil Findlay was very important in arriving at a solution for a petition on such a harrowing issue. Without their determination and effort, it is unlikely that we would have got to where we are now.

We should consider the time that it took to get here. It should be remembered that I have been involved for nearly seven years, which is way short of the time for which my colleagues have been involved. It seems ridiculous to me that it took so long to make the Government move on such an acute issue and accept that there was a major problem. Yet, here we are again, discussing similar issues and trying to ensure that similar required outcomes are realised. Having said that, and given the recent political discourse, it restores a bit of my faith in the Parliament that we can effect change for the good of the country if we come together across the chamber.

Again, I express my sincere gratitude to Scottish Mesh Survivors for its hear our voice campaign, for its unrelenting and resolute campaigning to ensure that what mesh survivors have had to endure was spoken about in a public forum, and for its desire that no one else need have their life devastated by potential repercussions of the use of mesh. That campaign highlights the national and international impacts that a public campaign can have through the vehicle of the Citizen Participation and Public Petitions Committee.

Back then, there were questions to be answered. How could a former health secretary—Alex Neil—take the robust action of imposing a moratorium on the use of transvaginal mesh only for certain health boards to continue to use the procedure to treat stress urinary incontinence? I think that some 400 women have undergone that procedure since that moratorium. Who was ensuring that the moratorium was adhered to? Who was responsible? Rules cannot be set if there is no system of enforcement. It was news to me and, apparently, many other MSPs as well as the campaigners that a moratorium called for by the Government is not binding. That has to be an area of concern, and it is something that the Parliament still has to address. If that moratorium had held, I do not think that we would be in the position that we have found ourselves in.

The involvement of the Medicines and Healthcare products Regulatory Agency was absolutely shocking. A body in which we place a great deal of trust and responsibility has been exposed as inadequate and incapable of applying any degree of logic or care. In fact, it claimed that the sufferers' pain could by psychosomatic. There was no duty of care or candour. It was also painful to watch the chair of the review squirming in her chair under questioning during the evidence session. Her answers caused gasps from the women who were seated behind her. A lack of empathy and understanding was all too evident.

Given the language that was used at the time by certain clinicians around "It's all in your head", as was highlighted by Jackson Carlaw on behalf of the committee, and the way in which such language slowed up the process of getting to the moratorium in the first place and the subsequent positive results for the transvaginal mesh petitioners, it is a worry to hear that such language is creeping back into similar concerns about men who have had or are considering mesh implants for hernia repair. As we know, men are not as good at talking about health issues, and they are certainly more reticent about organising themselves in the way that women mesh survivors did and pushing for justice in the way that they did. We all want to avoid a similar situation further down the line, in which we take evidence from a group of men suffering from the misuse of a similar procedure.

For me, a key element that came out of the initial petition was the lack of discussion about available options for treatment and the possible repercussions. Furthermore, the subsequent way in which the international community has communicated and delivered better medical solutions must be applauded, and further cognisance must be given to co-operative working continuing as we develop the right solutions.

I listened with interest to what my colleague Sandesh Gulhane said. Obviously, he has massively more experience than I have. He talked about the right procedures being conducted by the right surgeon, which brings us to the crux of the matter. As the committee considers a pause, I ask that the pathway of treatment reflect the desire to have the best treatment by the best surgeon.

I once again thank the petitioners for their courage and persistence. I assure them that they will be heard through the committee. I also ask the cabinet secretary to learn from the mistakes that were made in dealing with transvaginal mesh. It is entirely reasonable to note that the Citizen Participation and Public Petitions Committee is considering the use of surgical mesh and the potential for a moratorium until such time as a full review of all the relevant surgical procedures is carried out and more comprehensive information detailing all treatments is available. We must avoid at all costs having another committee session when it is too late to prevent such painful complications.

I look forward to further deliberations by the Citizen Participation and Public Petitions Committee.

16:15

Emma Roddick (Highlands and Islands) (SNP): I enjoyed hearing from Jackson Carlaw earlier about the history of campaigning in the Parliament on the use of mesh. I was interested to read up on his committee's work on the matter over the past few years. My reliable source of pre-2021 parliamentary gossip has had to pop out for a moment, but Christine Grahame tells me that he has been a stalwart in this very cross-party issue.

I, like many, am pleased with the progress that was made last year on transvaginal mesh, which ensures that mesh-injured women can access treatment in Scotland or elsewhere with an independent provider if that is what they want to do. I will repeat something that I said back then and encourage any of my constituents in the Highlands and Islands who would like a referral to any of those services to make their wishes known to their clinical team. They should be able to access the best possible treatment for them as quickly as possible.

One strong theme during that debate last year, which is reflected in what I just said, was the importance of choice for patients—the choice to see the specialist they want and not have a particular pathway prescribed by the Scottish Government in exchange for supporting the necessary removal of mesh. That is my concern—probably my only concern—about the petition.

There has to be choice for patients. It must be informed choice and I am certain that, despite the steps forward in realistic medicine in Scotland, there is work to be done in making sure that patients feel empowered to understand their treatment, ask questions and request alternatives, even through what is undoubtedly a power imbalance between them and their doctors. We have all heard of people being laughed off for consulting Dr Google, but patients should be encouraged to find out more about their own needs and treatment.

Mesh is still considered suitable in some situations and it would not be reasonable to remove that choice from patients here and now when the medical guidance is still that it can be the most effective treatment. That would be particularly concerning where there is no obvious alternative and, certainly, no risk-free alternative.

I understand that the Minister for Public Health, Women's Health and Sport told the committee last year that the chief medical officer had written to health boards to encourage them to consider the availability of non-mesh alternatives and address any skill gaps. That certainly needs to happen alongside, if not before, efforts to cease the use of mesh altogether.

If the Medicines and Healthcare products Regulatory Agency were to come out and say that mesh is not suitable, the petition's ask would absolutely be the right move. At the moment, the guidance is that it is still suitable in some situations. We have heard that echoed by other members with medical backgrounds. In the meantime, it is right that the NHS be particularly vigilant with procedures in which mesh is still used. I understand that protocols are in place to ensure that. We all have a responsibility in Parliament to ensure that lived experience is heard and that mesh is not being used inappropriately or carelessly.

I am glad that the issue is still being given deserved attention. It is right that the Scottish Government keeps an eye on on-going work and forthcoming research, as well as any emerging patterns in complaints from patients who have experience of mesh. I am sure that many members across the chamber will ensure that eyes are not taken off the ball on that.

I also thank those who lodged the petition and contributed to the debate surrounding it. I share their concerns and I completely sympathise with their position. I have read submissions to the committee. It is always devastating to hear of people—usually women—feeling dismissed by doctors when they experience complications or symptoms. There is no doubt that mesh was used when it should not have been and that women have not been listened to when they should have been. As a young woman with a chronic illness, I completely understand that feeling and I am all too aware of the possibility that seeking medical help can mean facing condescension or even being ignored and then suffering further harm as a result.

My heartfelt empathy goes out to all those who are brave and passionate enough to use their stories to influence us and to help others. I hope that, regardless of how long or whether mesh is used, the petitioners know that they have made a strong contribution to the discourse around mesh, the need for specialist mesh removal services and the wider issue of informed consent.

We have heard some considered contributions today. I hope that the impact that the petitioners have had on all of us is clear to them. It would be very helpful to hear from the Scottish Government how the use of mesh will be monitored.

The Deputy Presiding Officer (Annabelle Ewing): Before we move to closing speeches, I express disappointment that we seem to have two members who have not shown the courtesy—[*Interruption*.] Oh! We now have only one member who has not shown the courtesy of being here for closing speeches. Presumably that message can be communicated and an apology to the Presiding Officer given.

I call Paul Sweeney to wind up on behalf of Scottish Labour.

16:21

Paul Sweeney (Glasgow) (Lab): I am grateful for the opportunity to speak in this afternoon's debate on the suspension of the use of surgical mesh, both as a member who is representing survivors of mesh repair and as a member of the Citizen Participation and Public Petitions Committee. That committee and its predecessor committee have considered this extremely important matter in various forms over 10 years. The member for Eastwood has ably convened discussions about the petition in the current committee with great diligence, and with great sympathy for and empathy with those who have been affected.

Dealing with the petition has shown Parliament at its best. As a new member to this institution, I have been impressed to see how accessible and effective it is at addressing serious concerns of marginalised groups in society and I commend the committee for its work.

Like Katy Clark, I extend my gratitude to Roseanna Clarkin and Lauren McDougall in particular for their tireless work in keeping the issue on the parliamentary agenda by sharing their harrowing experiences of mesh repair, as Mr Carlaw described in stark detail earlier, with parliamentarians and the public alike. Constantly reliving and sharing that trauma is not easy. It is not easy to listen to and it must be even harder to talk about. I commend their courage in sharing their stories to the committee and for serving the public interest so well. I hope that the cabinet secretary has heard those remarks today and that he will consider the reasonable request that he meet the women so that they can describe that to him in detail and can seek redress not merely through the committee but through the machinery of Government

Transvaginal mesh is an issue that has been raised in Parliament on a number of occasions, but this petition focuses on the use of surgical mesh and fixation devices elsewhere in the body—that is a crucial distinction—particularly in relation to hernia repair, which has continued to cause pain and discomfort for survivors.

The petitioners have rightly raised the complex problems that mesh can cause, including infection, pain and adhesion. A lack of specialist services for survivors to explore treatment and removal is an issue that we have seen with transvaginal mesh and, unfortunately, the lack of treatment options is a key issue for survivors of hernia mesh repair, too.

Mesh specialists are scattered throughout Scotland, but their number is scarcely enough and many survivors' referrals to those professionals are rejected, especially if their mesh repair was used for hernia treatment and was not transvaginal.

Medical professionals are trying their best to be of support to mesh survivors, but the simple reality that we have heard in evidence to the committee is that there is not a clear pathway for referral and treatment for their patients who are left feeling alone, isolated and reliant on emotional support from other survivors and their families in the absence of specialist medical treatment.

It is not sustainable or acceptable to deprive mesh hernia repair survivors of options to treat or remove mesh, forcing them to live in chronic pain. Therefore, I am dismayed that the Conservative spokesperson for health and social care said that his party will oppose the petition today. That is deeply harmful to those people, most of whom are women, who have said that they have suffered acute pain.

Sandesh Gulhane: It is the suspension that we would be against but, as you heard in my speech, I am very much in favour of data gathering and further investigation.

The Deputy Presiding Officer: I remind members to speak through the chair.

Paul Sweeney: I thank the Conservative spokesperson for that clarification. Suspension in this instance is about addressing real harms that have been experienced, and that should be considered. The Conservative shadow minister makes a point about evidence gathering, and he described the low rate of defects and low requirement for repairs, but how can the evidence be valid or reliable when so many women are denied agency in the healthcare system? That is the issue that the petition seeks to address.

We have a kind of circular logic here. We are short-circuiting the issue and we are not addressing the reality of the evidence and picking up on the lived experience of the individuals involved. That is the issue for which the committee is seeking to provide a remedy. I hope that the Conservative shadow minister and the cabinet secretary might consider that, although there is a need to gather more evidence, those witnesses' voices have not been heard thus far, which is simply not acceptable. What are the Parliament and the Government going to do to address that?

Canada provides a stand-out example of what can be done with national specialist centres for surgical repair for mesh and fixation devices, and survivors have expressed their desire for that to be delivered in Scotland. The Shouldice hospital is specifically devoted to hernia repair and holds the largest single database of hernia patients in the world. Each surgeon performs 600 to 700 hernia surgeries per year. The Shouldice repair technique has the lowest rate of recurrence, as Mr Carlaw described. Although in the short term we should enhance services that already exist in Scotland to better treat and remove mesh, the long-term goal should be to establish a similar national specialist treatment centre where survivors can access the support and treatment that they need from specialist medical professionals.

Emma Harper: Will the member give way?

Paul Sweeney: Do I have time in hand, Presiding Officer?

The Deputy Presiding Officer: Yes—if we have a brief intervention and a brief response.

Paul Sweeney: Thank you for your generosity, Presiding Officer. I will give way.

Emma Harper: The Shouldice clinic has caveats around issues such as weight loss and stopping smoking and alcohol—it is very selective about the patients that it takes for its non-mesh repair. Do you not agree that it is kind of difficult to compare that with the patient population in Scotland?

The Deputy Presiding Officer: I again point out that members should speak through the chair.

Paul Sweeney: I thank the member for that reasonable intervention. We heard that point in evidence, and it is certainly an important clarification that is, for sure, useful to have on the record. Those are important caveats but, nonetheless, it was explicit and clearly expressed in evidence that having that concentration of medical professionalism and skill is critical to achieving low recurrence rates and that doing high volumes in a focused national centre is absolutely important.

The Conservative shadow minister mentioned the need for evidence. Let us look at the structure of the medical service provision and the treatment pathways. We heard compelling evidence about that concentration in a national centre.

As the Labour shadow minister in this area has said, and as has been put to the committee—indeed, as a minister has put to the committee—it is important that that model is supported, and we should consider delivering it. The Government does not think that it is workable, but I think that it merits further investigation. If the issue of people living in chronic pain and illness due to mesh repair anywhere in the body is to be tackled, we need ambition, not abdication. These people deserve much better.

16:28

Alexander Stewart (Mid Scotland and Fife) (Con): I am grateful for the opportunity to close the debate on behalf of the Scottish Conservatives. I strongly welcome the opportunity for Parliament to have the debate. As a member of the Citizen Participation and Public Petitions Committee, I commend our committee convener, Jackson Carlaw, and my fellow committee members for the way that they have conducted themselves throughout the process. Today's committee debate is an excellent example of what can be achieved.

I really hope that the petitioners have seen the debate and have taken from it many of the views that have been expressed. A common theme throughout scrutiny of the petition has been that campaigners feel that their views are not being heard and that they have not been listened to. Following the many passionate contributions that we have heard this afternoon, I hope that one of the things to come out of the debate will be that campaigners feel that the issue is being looked at and addressed by the Parliament.

The issues relating to use of transvaginal mesh have been documented extremely well. Many members have talked about the opportunities and flexibility in that regard. However, wider use of mesh and fixation devices has received much less scrutiny than has use of transvaginal mesh, so I thank the petitioners for their courage in lodging the petition and giving us the opportunity to debate it today.

Many of the themes and concerns that have been encountered will be widely recognised, given the long-running debate around transvaginal mesh. Many members talked about the work of Jackson Carlaw, Alex Neil and Neil Findlay in the previous parliamentary session on ensuring that concerns were listened to. Once again, that shows how the Parliament can, when we work together, achieve great things for the people whom we represent.

We have heard distressing accounts from individuals who have had their lives turned upside down due to mesh-related complications. Some people wrote of how they undertook having the procedure in good faith; they were not necessarily aware of many of the risks. It is to their credit that, through the pain following their procedure, they decided to talk publicly about the process. It is widely recognised that many individuals suffered in extreme ways, and continue to suffer. We have a role to play in ensuring that that is recognised in the Parliament. We should be their voice, and today has shown how that can be achieved.

What many members have said about the process is vital. We have heard that the Scottish Health Technologies Group continues to support use of mesh in hernia procedures, but there have been many mesh-related complications. Many members spoke about that in relation to constituents with whom they have had personal contact.

We have the opportunity to ensure that there is greater clarity when it comes to certain types of devices that are used in procedures. That said, our experience of dealing with transvaginal mesh and the technology associated with it shows that many people have experienced problems. Members have talked about that.

It is important to consider pathways of alternative treatment to mesh. Those have been discussed today. Dr Fernando Spencer Netto, from the Shouldice hospital in Canada, gave evidence to the committee and made suggestions; it has been useful to hear from other members about what has been happening at that hospital. When it comes to managing treatment, Scotland's healthcare system is, of course, different from Canada's, and it has different population demographics. Nevertheless, the Government should seriously consider the lessons that can be learned from what is happening in Canada.

As expected, a number of important and passionate contributions have been made in today's debate; I would like to dwell on them for a moment or two. Our convener, Jackson Carlaw, talked about the life-changing effects of the procedures. He said that the Scottish Health Technologies Group suggests that 10,500 hernia repairs take place in Scotland each year. Of those procedures, 62 per cent use mesh, and there are 32 procedures to remove mesh each year. However, there is not enough data to find out the reasons for that.

In his opening speech, the cabinet secretary acknowledged the distress that is caused to patients and the adverse effects that they have suffered. That is vital. He talked about issues regarding data collection and said that there should be local clinical groups rather than a national centre, as the petitioners have suggested.

My colleague Dr Sandesh Gulhane, who has expert knowledge and experience in relation to the matter, talked about the need for such petitions so that we have the opportunity to debate and discuss issues. He spoke about what is happening in Canada and the risks and complications relating to patient size, infections, chronic pain and numbness. It is vital that we consider all that in order that we give the best treatment to everyone.

Jackie Baillie gave a very strong and passionate speech, as she always does on health topics, and I enjoyed it greatly. She talked about how the Scottish Government must learn lessons, which is important. She also talked about people's lived experience and said that pathways are needed, which is vitally important, and she talked about how there were 10 years when nothing happened. I hope that the cabinet secretary will take on board all the comments that she made.

Alex Cole-Hamilton spoke about the risks, the side-effects and the tragic stories that we have all had to deal with. That is the crux of the matter; we have all heard about and seen the lived experiences of constituents.

Meghan Gallacher, too, spoke about data and the evidence-based approach. She also talked about the waiting times that everyone is experiencing at present and about how the knock-on effects could have a real impact on the way forward.

Emma Harper, who is a nurse, spoke about how mesh is a crucial tool. She also said that people should be treated with kindness, compassion and respect. We hope that that would be the case for all individuals, but we have seen and heard that many people have found it not to be the case.

Brian Whittle spoke about how affected he was and what he saw during the transvaginal mesh situation.

Today, we have had a real opportunity to hear about mesh at first hand. I hope that the cloud of all our warning signals ensures that we do not see the same mistakes as were made in the past being made. We owe it to everyone who has suffered due to mesh in the past, and those who risk it still in the future, to do all that we can to ensure that they are listened to, understood and respected as a result of the report.

I commend the petitioners for what they have done so far.

The Deputy Presiding Officer: I call Humza Yousaf to wind up for the Scottish Government, for around eight minutes.

16:36

Humza Yousaf: I thank all members from across the chamber for their contributions. It has been a very good debate. Common themes have been raised throughout, again from members across the chamber. There have also been diverging opinions on what the next steps should be. That has not detracted at all from the debate. Sometimes, we can assume that only consensual debates are the best debates, but that is not always the case.

However, there is consensus on a number of points, and perhaps I should start at that place. There is absolute consensus that we are all grateful that the petitioners who are raising the issues have shared their stories and the stories of their loved ones, and there is consensus that the pain that they are describing, be it on their own behalf or on behalf of a loved one, is very real. Nobody here doubts that and, as I said already, I would be greatly upset and, frankly, angry and annoyed, if stories are brought to my attention involving issues around pain and chronic pain being dismissed by clinicians. I do not think that that is the experience of a majority of people, but I accept, from some of the testimonies that we have heard, that that has been the experience of some people. As I say, I am very open to members of the public—or, indeed, members of the chamber—writing to me directly in relation to some of those concerns.

Where else do we have consensus? I think that we have consensus on the fact that the Government—mainly—should be learning from the journey that we went on in relation to the women who were affected by transvaginal mesh issues. I do not take away from what was said by critics when they argued that perhaps—well, definitely—it should not have taken 10 years to get to where we eventually ended up. That is fair, and it is imperative that the Government learns from that. I am absolutely committed to doing that.

The points of difference really centre on what happens next. Some members are arguing very passionately for a complete suspension of the use of mesh and hernia mesh; others are saying that that would not be the right approach. I think that I would be right to say that the majority of contributions said that that is probably not the right approach, at this stage, but it is one to be kept under continual review. All that being said, I hope that, although they will be disappointed, those who have called for a suspension of the use of mesh will, at least in part, be reassured by the fact that we are aiming to improve data collection, which was another common theme.

What will that look like? Some work has already been undertaken by the British Hernia Society, of which a number of members will be very aware. In our work on data collection, the aim is that the NHS Scotland scan for safety programme will improve patient safety in acute care; it will provide electronic traceability, linking patients to implantable devices so that we can get real-time data electronically in relation to any issues that might crop up. As I said, that work comes in addition to the work that is being done by the British Hernia Society, which has made progress in establishing its own registry that it will begin piloting shortly. We will watch that closely, and we will work closely with the society, where appropriate.

I want to address some of the other issues that have been raised by members from across the chamber. I thought that Sandesh Gulhane's speech and, more so—if he does not mind me saying—his exchange with Jackson Carlaw was very interesting to watch. Dr Gulhane made it clear in his response to Jackson Carlaw that the clinical advice that is provided should be listened to, although we all agree that there should be discussion between patient and clinician. He also said that he would have no issue with a mesh implant in himself or a family member. From his clinical perspective, we can see that there continues to be a high level of confidence in mesh, and what Dr Gulhane expressed has been expressed by many clinicians right across and up and down the country. We have seen that from the Scottish Health Technologies Group, too. There is a high degree of clinical confidence in the continued use of mesh.

Where alternatives can be explored, they should be, if that is what the patient wishes, and, as for any surgery, the potential complications and risks that are inherent in the use of mesh should be made very clear.

Informed consent was raised by many members, and Siobhian Brown asked specific questions on it. I give her and other members an absolute guarantee that I take informed consent seriously; I have discussed it with the chief medical officer, and he takes it very seriously, too. I am encouraged to hear from patient groups that informed consent processes have improved quite significantly, and shared decision making and informed consent are the centrepieces of realistic medicine. Government ministers often talk about realistic medicine, but it is also close to the heart of the CMO.

We want people to be fully involved in decisions about their care. That is why we encourage people to ask their healthcare professionals questions to help them to make informed choices. Equally, we encourage clinicians to ask questions when they are in discussions with their patients.

Jackson Carlaw: Will the cabinet secretary give way?

Humza Yousaf: I will, shortly.

The questions that we expect clinicians and patients to ask one another are, “What are the benefits, risks and alternatives?” and, “What if I do nothing?”.

Jackson Carlaw: Does the cabinet secretary agree that, although this would have been impossible 10 years ago and unlikely five years ago, we have had a substantive informed debate on the subject of mesh this afternoon, with contributions from all across the chamber? Is that not the perfect tribute to all the campaigners who, over the past 10 years, have worked so hard to ensure that members of this Parliament understand the issues that underpin mesh as well as they now do?

Humza Yousaf: Not for the first time in the debate, I agree whole-heartedly with Jackson Carlaw. I am beginning to doubt myself, thanks to the number of times that I have agreed with him this afternoon. I say that in jest only, because, as he knows, he has my admiration, as well as that of the Government, for the excellent work that he has done on mesh—both transvaginal mesh and wider mesh issues. I have been in front of the Citizen Participation and Public Petitions Committee, which he convenes, and I know how seriously he and other committee members take the issues.

I hope that the testimonies and stories of the women who have been affected by transvaginal mesh and the bravery that they have shown give confidence to other people to speak about complications in relation to their own health, whether due to mesh or other matters. That should be seen as a good thing. There might be disagreements between members on the way forward, but it is important that people speak openly about their health and raise issues about complications or the harmful impacts of a procedure, because it is important that the Government and the health service know about that.

Brian Whittle: Would the cabinet secretary agree that it is really important that people who are encouraged to speak up are listened to and that, as happened previously with cases involving transvaginal mesh, we are keen to hear what people have to say?

Humza Yousaf: I agree whole-heartedly. That was a common theme in the cases of the women who were affected by transvaginal mesh.

I will try to make progress on some of the other issues that members raised.

A couple of members have asked whether I will meet with the petitioners. I do not know if I have had a request to meet them; I will double check that. I will, of course, give that my absolute and full consideration. I am not necessarily convinced that that will change my opinion, given the reviews and reports by the Scottish Health Technologies Group, but there is nothing to be lost by meeting with petitioners and members of the public about their experiences and those of their families, so I will consider that when a letter or any other correspondence to that effect comes to me.

Jackie Baillie and a couple of other members mentioned Canada and other international examples that we should look to. It is fair to say that we should look to other jurisdictions and countries. I may have the wrong information, but I am not sure that Canada has entirely suspended or halted the use of mesh. I think that Canada has done so for transvaginal mesh, but I am not entirely sure whether that has been done for all mesh procedures. I will double check that and, if that is the case, we should link in with our health colleagues in Canada.

Paul Sweeney: Will the minister accept an intervention?

Humza Yousaf: Do I have time?

The Deputy Presiding Officer: I can allow a brief intervention and a brief response.

Paul Sweeney: The issue of the structure of the specialist surgical centre was a key aspect of the evidence from Canada. Would the minister consider replicating that in Scotland?

Humza Yousaf: We have considered that. The points made by Maree Todd when she was asked about that by the committee still remain. We are talking about two very different health systems. I said in my opening comment that having a specialist centre for hernia operations might involve people having to travel to one particular centre when they could be seen closer to home. However, let us not dismiss issues concerning pathways and special centres.

I know that I am already running vastly over time. Allow me to reflect. I recall a debate when we were taking forward the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022. I commented that our work on mesh had shown this Parliament at its very best. I end on the point made by Jackson Carlaw in his intervention, which is that I hope we can continue to work in that spirit when considering what more can be done for patients. Although they may be disappointed that the Government is not suspending the use of mesh in hernia operations, I am listening. We are listening and we are committed to ensuring that people get the care that they need.

The Deputy Presiding Officer: I call David Torrance to wind up the debate on behalf of the Citizen Participation and Public Petitions Committee.

16:47

David Torrance (Kirkcaldy) (SNP): I am pleased to close this extremely important debate on behalf of the Citizen Participation and Public Petitions Committee. I thank my fellow committee members and the committee clerks, whose support, hard work and guidance for elected members is vital and is very much appreciated by the committee. I also thank colleagues who have contributed to today's debate.

After what the convener, the cabinet secretary, Alex Cole-Hamilton and many of my colleagues have said throughout the debate, we can be left in little doubt about the devastating impact that surgical mesh has had on patients from across Scotland or about their fight to be believed about their condition. In our consideration of the petition, the Citizen Participation and Public Petitions Committee gathered a wide range of evidence to assist our understanding of the use and impact of surgical mesh. I place on record my thanks to the petitioners, Roseanna Clarkin and Lauren McDougall, and to all those who have shared their experiences of the issue with the committee in the past 20 months.

This is not the first time that we have debated the effects of mesh treatment; Parliament has been speaking about the use of surgical mesh in one way or another for almost 10 years. Jackson Carlaw and I were members of the petitions committee when the issue of transvaginal mesh was introduced. I am honoured to stand here today as deputy convener of the committee, with Jackson Carlaw its convener, as we debate this petition.

Although we recognise the progress that has been made for those suffering complications caused by the use of transvaginal mesh, the issues that are raised by Roseanna and Lauren's petition are still to be resolved. It is for that reason that I will focus my remarks on finding solutions to the concerns that have been raised.

Since the petition was submitted to Parliament for consideration, the Scottish Health Technologies Group has published two reports on the use of mesh in hernia repair. The first report provided an assessment of the use of surgical mesh for hernia repair in male patients. Dr Gulhane mentioned the findings of that report, one of which was that the use of mesh meant that men were less likely to have their hernia return. The report said that the use of mesh meant that men were less likely to suffer urinary retention and injury to nerves, blood vessels or internal organs, but it said that patients were more likely to develop a build-up of fluid or swelling soon after surgery.

The SHTG has recommended that all elective inguinal hernia repair should be preceded by detailed discussion with patients to help to manage their post-surgery expectations. We heard from patients that it is vital that those discussions take place ahead of any surgery to ensure that they can reach a fully informed decision about their health.

As we have heard, the recommendations were further developed in the second SHTG report, which explored the use of surgical mesh in repairs of abdominal and groin hernias in all adults and not just male patients.

Although both reports conclude that evidence appears to support the continued use of surgical mesh in hernia repair, I highlight the recommendation that patients should be able to express a preference for a non-mesh repair and access to alternative hernia management options. The report mentions that patients should be provided with detailed information on hernia repair in a variety of accessible formats.

Anyone who has been to a hospital appointment to discuss treatment options will know how challenging it is for a patient to absorb all the relevant information and feel confident that they are making a fully informed decision, so the provision of that information in other formats, both written and verbal, would certainly be a positive development.

The committee heard that the chief medical officer wrote to all health boards in December 2021 highlighting the SHTG report and asking them to consider the availability of non-mesh surgery. In an evidence session in June 2022, one of the Scottish Government's senior medical advisers, Terry O'Kelly, stated:

> "it is critical that, when appropriate, patients have access to non-mesh surgery, which might be provided by their health board or by another health board somewhere else in Scotland."—[*Official Report, Citizen Participation and Public Petitions Committee*, 8 June 2022; c 18.]

As Paul Sweeney said this afternoon, the committee heard from patients that it is critical to ensure that there are patient pathways for those who, having been made aware of the risks, want to pursue the option of non-mesh treatment.

Emma Harper: We have talked about mesh this afternoon, but we havnae really talked about titanium fixation devices, which are also part of Roseanna Clarkin and Lauren McDougall's petition. Does David Torrance agree that further discussion might be necessary and further evidence might need to be taken on that? We now have biodegradable fixation devices, which are being used more often.

David Torrance: The committee is still taking evidence on what is raised in the petition, so I think that there is scope for us to look at what Emma Harper has suggested.

A key aspect of ensuring that patients have access to those alternatives will be to identify any skills or training gaps. As the committee convener mentioned, we look forward to seeing the findings of the Scottish Association of Medical Directors report on the availability of non-mesh surgery in health boards across Scotland.

It may feel as if they have been a long time coming, but we welcome the steps to support patients in making informed decisions before any surgery takes place. It is important to get things right at the beginning of the patient's journey. We heard a lot during the committee's deliberations—and indeed we have heard a lot this afternoon—about the complications that arise when mesh does not work as patients and clinicians had hoped.

There is a small minority of surgeons who prefer to use natural tissue repair and who use mesh only as a last resort. The committee was interested to hear more about that approach and, as the convener touched on at the beginning of the debate, and as Alexander Stewart and several other members mentioned, we took evidence from the Shouldice hernia hospital in Canada. It is the only licensed hospital in the world that is dedicated to hernia repairs and it has been a steadfast supporter of natural tissue hernia repair for over 76 years, performing more than 400,000 abdominal wall hernia repairs. To date, it has used mesh in less than 2 per cent of cases—I note that mesh is still used in Canada—and its surgical outcomes remain the gold standard in abdominal wall hernia repair.

The committee held a virtual evidence session with Dr Fernando Spencer Netto, the chief surgeon at Shouldice hospital, to discuss its work. Given his views on the use of mesh, we asked him,

> "Would a ban of the use of mesh in hernia repairs be a good thing?"

His response was:

> "In some situations, there is no possibility other than to close the opening with mesh. Sometimes, the hernias improve, and surgeons' knowledge of how to treat hernias also improves. The stats from today are probably very different from the stats on patients who were operated on five to 10 years ago. In relation to hernia repairs, it is not possible for there to be a ban, because, in some situations, using mesh is the only way to do a good repair."

Given the success of the Shouldice hospital with natural tissue repair, which has resulted in a low recurrence of hernias, it was extremely helpful to speak with as experienced a surgeon as Dr Netto. Nonetheless, although, undoubtedly, much can be learned about the skill, training and techniques that are used in the Shouldice hospital, it is important that its successes and achievements are taken in the context of our own healthcare system and culture.

The pre-operative preparation and post-operative care for hernia repair surgery in Scotland differs greatly from the treatment of patients at Shouldice, when it comes to the application of strict criteria for selection. Shouldice hospital applies selection criteria such as weight loss before admitting patients. In addition, it does not take patients who might have more complex medical needs, such as back-up from cardiology or intensive care units.

Dr Netto told us:

> "if the patient in question is too obese and wants to undergo weight loss, that is okay. Sometimes there are patients who need to lose, say, 50 pounds; indeed, there have been patients who had to lose 100 pounds or more to

> have the operation. Sometimes we also change the estimated ideal weight a little bit.
>
> One of the suitability criteria is the patient's medical condition. If they have a chronic condition, it needs to be stable before they can have the operation. With obesity, though, it is questionable whether we can do tissue repair, because the operation is a lot more difficult: the incision has to be bigger, the wound can get more infected, there can be more hematomas and, frequently, one complication will lead to another. That is why we always try to get patients to the correct weight. Unless some very specific things happen, most of them reach the correct weight—or at least get very close to it—and they have the operation. I am 100 per cent sure that that makes a difference to the final result for individual patients."—[*Official Report, Citizen Participation and Public Petitions Committee,* 12 May 2022; c 9, 6.]

That raises an important question about restricting access to treatment because of personal criteria, and about whether such criteria could be brought into play here and would be acceptable to members of the public.

For some patients, the use of surgical mesh may be the most appropriate option available. It is important to note that the petitioners have called not for a permanent ban on the use of mesh but for the suspension of its use until we understand the complications better and ensure the establishment of robust guidelines.

The evidence that our committee has gathered indicates that work is still to be done to track the outcomes of the use of surgical mesh. As the minister has mentioned in evidence, there are challenges in tracing what products have been used and which of those are causing harm. Although we recognise that the regulation of medical devices is a reserved matter, the committee has also noted cross-party support in this Parliament for the Scottish Government's efforts to make progress on the regulation of such devices.

Our committee has had powerful testimony from individuals who are living in constant pain following the use of mesh; we have heard from the experts on the alternatives that could be used; and we have heard about the need to improve patient pathways and embed a culture of informed consent. What has been clear, as we heard all that evidence, is that we cannot wait for another 10 years for solutions to be developed and implemented.

The Presiding Officer (Alison Johnstone): That concludes the debate on petition PE1865, on suspending all surgical mesh and fixation devices.

Urgent Question

16:58

Gender Recognition Reform (Scotland) Bill

Monica Lennon (Central Scotland) (Lab): To ask the Scottish Government what its response is to the Secretary of State for Scotland making an order under section 35 of the Scotland Act 1998, preventing the Scottish Parliament's Gender Recognition Reform (Scotland) Bill from proceeding to royal assent.

The Cabinet Secretary for Social Justice, Housing and Local Government (Shona Robison): The decision by the United Kingdom Government to make an order under section 35 of the Scotland Act 1998 preventing the Gender Recognition Reform (Scotland) Bill, which was passed with an overwhelming majority, from proceeding to royal assent is a dark day for trans rights and for democracy.

I question why the UK Government has chosen for the very first time to use a section 35 order, against the clear will of this Parliament, on an issue that is within this Parliament's competence rather than, for example, a section 33 order, if there were issues with reference to reserved matters. I also question what the implications are for the future legislation of this Parliament.

The secretary of state has said that he wants to find a constructive way forward. The UK Government had multiple opportunities to provide constructive comments during the extensive consultation on the bill and during its passage, but it did not do so. It does not agree with the bill, so it has blocked it. The decision that it has taken is political. This is a sad day for democracy and for devolution.

However, I want to be very clear to all trans people—who, I know, will be incredibly upset by this decision—that this Government will seek to uphold the democratic will of this Parliament.

As the statement of reasons was made available only just over an hour ago, we will now take time to consider it fully, and I will return to the Parliament to update members on the next steps.

Monica Lennon: The cabinet secretary is correct in saying that the Scottish Parliament passed the GRR bill by a significant majority, and we did so because we believe that trans people should be able to live, work and die with dignity. That is what the bill is about. It is about dignity, fairness and equality for a marginalised group of trans citizens.

The secretary of state may hide behind legal advice, but the truth is that the Tories at

Westminster have proven that they are no friends to trans people—and, as they are the architects of the rape clause, we know that they are no friends to women and girls. Does the cabinet secretary agree that this is a cynical and dangerous power move by an out-of-control UK Government that is determined to wreck the bill at any cost?

Shona Robison: Yes, I would agree with that. The strength of the legislation is in the fact that it had support from members of all parties, who came together to provide support and improve the bill through the amendments that were made at stages 2 and 3.

I fear the truth is that, whether the Parliament had passed the legislation in December, this month or in February, we would always have ended up here, with a section 35 order, because the United Kingdom does not like or want the bill and it will do everything to block it. However, I want to be clear that we will do everything that we can to uphold the democratic will of this Parliament, and I hope that those who supported the bill will work together with us to achieve that.

Monica Lennon: I am pleased that, in her original response, the cabinet secretary set out that trans people are at the centre of this. They need our support and friendship at this time.

We are seeing political reaction across the UK. Our Labour colleague and the First Minister of Wales, Mark Drakeford, rightly said today that this is a "dangerous" situation. He said that it could be a "slippery slope" in terms of devolution. Many of us are concerned that the UK Government, which is a bad actor in this process, could strike again on other legislation that we seek to pass. This is a direct attack on not only self-identification for trans people but Scottish devolution.

What discussions can the Scottish Government have with the UK Government and other Governments to defend our democracy, devolution in Scotland and people's human rights?

Shona Robison: Monica Lennon is right to point out that at the centre of this is one of the most marginalised groups in society. The bill was designed to make their lives that bit better—that was all.

It is quite telling that Mark Drakeford has made those comments about the danger of this step and the slippery slope that it could lead to, because, whether it is in the setting aside of the Sewel convention or other attacks on devolution and the powers of this Parliament and that of Wales, a pattern of behaviour is clearly there for all to see. When we hear the Secretary of State for Scotland put forward the defence that we cannot have divergent systems in the UK, that rather questions the other divergent systems that are put in place to make the lives of people in Scotland better. It is very much a slippery slope.

As for working with others, I absolutely want us not only to work together across this Parliament but to reach out. We work with Mark Drakeford and the Welsh Government on a number of issues, and I would be pleased to work with him on this—and, indeed, with members of the UK Parliament, where some very probing questions were asked on what was a very thin statement with a very late, rushed-out statement of reasons. We want to work with all those who want to uphold democracy and, importantly, improve the rights of transgender people.

The Presiding Officer (Alison Johnstone): There are many requests to speak, and I would like to get through as many questions as possible. Concise questions and responses would be helpful in that regard.

Joe FitzPatrick (Dundee City West) (SNP): The Gender Recognition Reform (Scotland) Bill was passed overwhelmingly by this Parliament, with a two-thirds majority. It had the support of members from all parties, and it was passed after months of extensive scrutiny.

Six years ago, when the bill process started, all parties agreed that reform of the Gender Recognition Act 2004 was needed, as did the UK Government until a couple of months ago. At the Equalities, Human Rights and Civil Justice Committee, we heard lots of evidence, but we did not hear from the UK Government regarding its views on the bill or what changes it wanted. Did the cabinet secretary?

Shona Robison: To be clear, the UK Government at no point raised its concerns with me until a reply was finally received months after my letter of October last year, when I wrote to the UK Government seeking further discussions on cross-border issues. In reply to my letter, a meeting was finally established with Kemi Badenoch on the day before stage 3. At that meeting, no mention was made of a section 33 order or a section 35 order being considered. Those are the facts. Parliament will judge for itself whether the UK Government has made any efforts to be constructive around the bill.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): The Secretary of State for Scotland has acted on legal advice taken on the cross-border implications of the Gender Recognition Reform (Scotland) Bill. Legal experts arrived at the conclusion that the bill would have consequences for the operation of UK-wide equalities protections. That is a reserved matter that falls outside this Parliament's devolved competence. We have also heard Monica

Lennon's Labour counterparts at Westminster agreeing with the Secretary of State for Scotland.

However, the secretary of state has recognised that the intention of the bill is to respect, support and understand the needs of transgender people who are going through the process of changing their legal sex, and he has offered to work with the Scottish Government to create a bill that is legally competent and that falls within the devolved powers of the Scottish Parliament. Will the cabinet secretary accept—[*Interruption*.]

The Presiding Officer: Let us hear Ms Hamilton. Ms Hamilton, I could not hear your question and I would be grateful if you would repeat it.

Rachael Hamilton: Will the cabinet secretary accept the secretary of state's offer to work with him?

Shona Robison: It would have been better if the secretary of state had made contact at the start of the process instead of through a section 35 order.

As I said this morning, I am always up for discussions with the secretary of state or anyone else. However, I thought that it was quite telling that, in answer to one of the questions during his statement, the secretary of state said that there cannot be

"two different gender recognition regimes in the UK."

I am struggling to understand what amendments would need to be made to the bill and what amendments would be "allowed" to the bill in order to avoid having two different regimes for gender recognition. Does that mean that, in essence, we just have to revert to the 2004 process? The secretary of state was unable to answer any of the questions from across the chamber asking for specifics on what amendments would be required. I am all up for discussion, but the onus is on the secretary of state to make his position clear and explain what he means by that.

Pam Duncan-Glancy (Glasgow) (Lab): Let me be clear: I am proud of reform and the work that many of us across the chamber did on the Gender Recognition Reform (Scotland) Bill. I continue to support the bill and hope that it gets royal assent as soon as possible, because at the heart of this is trans people's lives.

In response to a letter that I sent, raising concerns about potential cross-border issues, the cabinet secretary confirmed that the Scottish Government had committed to working with the UK Government on a section 104 order. Can the cabinet secretary give Parliament an update on those discussions? Does she admit that the Scottish Government knew that there could be potential cross-border issues with the bill prior to stage 3 although she reassured Opposition parties that that was in hand?

Shona Robison: First, I say to Pam Duncan-Glancy that it is important that we come together over this issue. We must work together to ensure that the bill that all of us passed collectively and worked together to amend is the one that is finally enacted.

With reference to the section 104 order, every piece of legislation has cross-border issues, and ensuring that those are resolved often involves the making of such an order. Officials have been talking to their counterparts in the UK Government about such issues for many months. However, despite all that work having gone on, behind the scenes there were obviously plans afoot for a section 35 order.

Let us therefore put the blame where it lies. We passed the bill in good faith, in order to improve the lives of trans people. I do not think that that is the motivation of the UK Government here. Let us work together to ensure that the expectation that the legislation will be enacted is met.

Alex Cole-Hamilton (Edinburgh Western) (LD): The cabinet secretary will share my confusion at Rachael Hamilton's line of questioning, given that the reasoning published this afternoon suggests that no amendment to the bill would satisfy the UK Government's concerns and that no divergence in the process for obtaining a gender recognition certificate would ever be legally competent, yet Conservative members of the Scottish Parliament were still offered a free vote on the bill.

Throughout the process, Conservative members in both Parliaments have said that the bill is a danger and is riddled with holes, yet their spokespersons on health and justice and their respected former leader Jackson Carlaw all voted in favour of the bill. Does the cabinet secretary agree that the allowing of a free vote and the division among Conservative members suggest that those legal arguments do not carry any weight at all and that a swift application for judicial review in the UK Supreme Court would demonstrate that, offer reassurance to the general public and deliver much-needed reforms for our trans constituents?

Shona Robison: Yes, I agree. Alex Cole-Hamilton is right to suggest that it is a false idea to suggest that simple amendments could be lodged whereby, if we simply amended the bill around the fringes, it would be acceptable to the UK Government. None of the statements made today by the secretary of state gives me any confidence in that whatsoever. Whether we call it a smokescreen, a fig leaf or anything else, the UK Government has no intention of allowing the bill to proceed. That leaves us with no option but to take the action that we need to take to ensure that that will happen.

Alex Cole-Hamilton made the important point that the bill was supported by members of all parties in the chamber. I pay tribute to the Conservative members who voted for the bill, because I am sure that they did so against much pushback from the powers that be in the Conservative Party.

Let us go forward on the basis that this Parliament has spoken and has made its position very clear. We now need to work together to ensure that we can enact legislation that, as I have said, will, for a small number of people, make an important difference to their lives.

Maggie Chapman (North East Scotland) (Green): That the UK Government has chosen an equalities issue on which to use its section 35 powers for the first time speaks volumes. The Scottish Government has—rightly, in my view—said that no nuclear energy power will be developed here, and the UK Government has confirmed that it would not impose nuclear reactors on Scotland. Energy is a reserved matter. The Scottish decision on that issue has an impact on the energy market of the whole of the UK.

It is interesting, therefore, that it is an equalities issue that the UK Government uses to attack the Scottish Parliament's powers. Does the cabinet secretary believe that that is part of a cynical and despicable culture war on trans people and other minorities? What will it mean for other equalities and human rights issues in Scotland?

Shona Robison: A number of MPs from across the chamber at Westminster made that very point: the UK Government is in its death throes and is looking to distract people's attention from some of the serious issues that it faces, and the culture war is a convenient way of doing that. That is what others have said, and there is a lot of evidence to support that contention.

Maggie Chapman also makes an important point about a pattern of behaviour. We are seeing increasingly draconian behaviour from the UK Government on this issue, in undermining the right of people to take strike action and in threatening to roll back on human rights protections. There is a pattern of behaviour of attacking people's fundamental rights. We need to be really clear that this is the thin end of the wedge in relation to the powers of the Scottish Parliament. We need to stand united to push back on any attempt to undermine the powers of the Parliament and devolution.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): According to the list on the UK Government website, as of 21 December 2022, there were 41 countries from which the UK does not require medical reports in relation to applications for gender recognition in the UK. I presume that that does not impact on the Equality Act 2010. Can the cabinet secretary advise members why breaching the Equality Act 2010 applies only when the Scottish Parliament, by an overwhelming cross-party majority, merely does what many other countries have done, or will the UK Government's position result in the UK removing 41 countries from that list?

Shona Robison: Christine Grahame makes a good point, which is that, for years now, the UK Government has recognised gender recognition certificates from countries that have a similar system to the one that we were seeking to introduce. That speaks volumes. We have not seen any evidence that that approach has caused any difficulties in the United Kingdom. Indeed, the processes used in the self-declaration systems in so many other countries show that there is no evidence of any of the harms that have been alluded to by the UK Government.

Donald Cameron (Highlands and Islands) (Con): I refer to my entry in the register of members' interests: I am an advocate.

Prior to the passing of the bill, many people—most notably, the Equality and Human Rights Commission—raised with the Scottish Government the specific issue of the bill's cross-border implications and the impact on UK equality law. Did the Scottish Government obtain legal advice on those particular matters and, if so, was that advice followed?

Shona Robison: We have taken legal advice on various aspects of the bill throughout its passage. Let me say two things about that. I have already said in response to Pam Duncan-Glancy that we accepted that, as with many pieces of legislation, there would be some practical issues that would need to be resolved and that a section 104 order would be the settled way of doing that. Officials had been working in good faith—I think—to make that happen.

The Equality and Human Rights Commission has given its views on several aspects of the bill. I point out that it was the Equality and Human Rights Commission that was the biggest advocate for the proposed change to the process—it actively lobbied all parties in advance of the 2021 Scottish Parliament election to make the reform of gender recognition a top priority for parties. We are delivering on that request from the EHRC.

Gillian Mackay (Central Scotland) (Green): The move by the UK Government is as cruel as its reasons are flimsy. It weaponises the lives of trans people as part of a culture war on equalities. As many others have said, there are real people at the heart of this.

Can the cabinet secretary outline what we can do to ensure that trans people do not face further hate and prejudice? Will she meet me and colleagues to discuss what additional support we can provide for trans people in the light of the increasing bigotry that they face?

Shona Robison: Gillian Mackay makes an important point. The work that Christina McKelvie has been leading on tackling hate crime is very important in that regard, because we know that hate crime towards the trans community has been increasing, which is partly down to some of the public and media discourse around these issues. I do not think that that has helped at all.

The trans community is one of the most marginalised groups in society, and it is important that we reassure trans people that we will collectively fight for this piece of legislation, and that we will work together to do that.

John Mason (Glasgow Shettleston) (SNP): As the cabinet secretary knows, I was opposed to the bill and remain opposed to it. However, a democratic decision has been made by the Parliament, so does she agree that Westminster is, in effect, telling Scotland that we are second rate and should get back in our box?

Shona Robison: John Mason makes an important point. I have seen a lot of commentary from people who are not in favour of the bill and have made that position clear but who are in favour of Scottish democracy and the right of the Parliament to decide. The Parliament was not established on the basis of only being able to legislate if one happened to agree with the legislation. People from all parties who have been elected to the Parliament come to conclusions about proposed legislation, and whether or not we agree with every aspect of it, once a decision is made, the democratic decision of the Parliament should be respected. That is why it is so important that we draw a line and say to the UK Government, “This far and no further.”

Pam Gosal (West Scotland) (Con): The First Minister told the BBC that the Scottish Government will inevitably end up in court over the Gender Recognition Reform (Scotland) Bill and that it will vigorously defend the legislation. If the matter ends up in court, will the cabinet secretary commit to respecting the court’s decision, regardless of the outcome?

Shona Robison: Perhaps the member and the UK Government should have respected the decision of this Parliament. That is where respect starts.

We will vigorously defend the legislation and our democratic process—of course we will; it would be a democratic outrage not to. Perhaps there are questions for Tory members about the position that they find themselves in, because they are being told to have warm words about amending the bill and bringing it back, but the reality of what Alister Jack said in his statement to the Westminster Parliament makes it clear that that could not be on the cards, because there could not be two different systems of gender recognition in the UK. That is a very cynical approach and, as I said earlier, it is a fig leaf and entirely disingenuous.

Given that we saw the section 35 order details only this afternoon, I will come back to Parliament with our next steps in due course. I am happy to meet Opposition members who support the legislation and to work together with them to ensure that the democratic will of the Parliament prevails.

The Presiding Officer: That concludes the urgent question.

Committee Announcement (COVID-19 Recovery Committee)

The Presiding Officer (Alison Johnstone): The next item of business is an announcement by the COVID-19 Recovery Committee on its inquiry into long Covid. I call the convener, Siobhian Brown, to make the announcement.

17:23

Siobhian Brown (Ayr) (SNP): As convener of the COVID-19 Recovery Committee, I wish to highlight the committee's inquiry into long Covid, which was launched last week.

Figures from the Office for National Statistics estimate that around 2.1 million people in the United Kingdom are experiencing self-reported long Covid, and in Scotland it is estimated that 187,000 people have self-reported long Covid, which is around 3.5 per cent of the population.

Our inquiry will focus on three issues; it will explore awareness and recognition of the condition, examine whether there is adequate therapy and rehabilitation services and consider what further research may be needed to better understand long Covid. We plan to speak directly to those impacted by long Covid over the coming weeks and take evidence on what additional steps the Scottish Government could take to support people who live with the condition.

I am sure that I am not the only member with a mailbox full of inquiries relating to long Covid. I encourage members to share details of the inquiry with interested constituents, whose input would be greatly valued.

Our call for views will run to 10 February. We will then take evidence during February and March. We also aim to hold a parliamentary debate in the chamber on our findings prior to the summer recess.

Business Motion

17:25

The Presiding Officer (Alison Johnstone): The next item of business is consideration of business motion S6M-07545, in the name of George Adam, on behalf of the Parliamentary Bureau, on a change to this week's business.

Motion moved,

That the Parliament agrees to the following revisions to the programme of business for Wednesday 18 January 2023—

after	
followed by	Scottish Labour Party Debate: Addressing the Crisis in the NHS and Social Care
insert	
followed by	Ministerial Statement: Scottish and UK Government Selection of Green Freeports
delete	
5.10 pm	Decision Time
and insert	
5.40 pm	Decision Time—[*George Adam*].

Motion agreed to.

Decision Time

17:25

The Presiding Officer (Alison Johnstone): There is one question to be put as a result of today's business. The question is, that motion S6M-07487, in the name of Jackson Carlaw, on behalf of the Citizen Participation and Public Petitions Committee, on petition PE1865, which is on suspending all surgical mesh and fixation devices, be agreed to.

Motion agreed to,

That the Parliament notes public petition PE1865 on suspending the use of all surgical mesh and fixation devices while a review of all surgical procedures which use polyester, polypropylene or titanium is carried out, and guidelines for the surgical use of mesh are established.

Fundraising for Cardiomyopathy UK (Ferrier Family)

The Deputy Presiding Officer (Liam McArthur): The final item of business is a members' business debate on motion S6M-06325, in the name of Evelyn Tweed, on the Ferrier family raises £30,280.90 for Cardiomyopathy UK. The debate will be concluded without any question being put.

Motion debated,

That the Parliament congratulates the Ferrier family from Doune and Deanston on their incredible efforts raising £30,280.90 for Cardiomyopathy UK, which will assist the charity in providing support advice and nursing support; understands that the Ferrier family began fundraising following the death of Callum Ferrier on 12 February 2008, and that Callum, a 6-foot-tall rugby player, aged 16, went to bed complaining of a headache and was found the next day by his dad, having died from cardiomyopathy, something the family had never heard of; further understands that, since Callum's death, the family has focused on fundraising for Cardiomyopathy UK through arranging ceilidhs, treks of the Sahara, Machu Picchu and the Great Wall of China, coffee mornings, Tough Mudder competitions, running the Stirling and London marathons and the Great British 10k Run, kids treasure hunts, a skydive, funeral collections, online collections, a Gargunnock songster concert and supper, selling wristbands, raffles, a fashion show and dinner, barn dance and many more fundraising efforts; understands that the family has had assistance from a number of individuals and businesses to help in their fundraising including Craig Johnstone, Craig Mair of Skelpit Lug Ceilidh Band, St. Modan's High School, Souters, Gargunnock Songsters choir, Graeme Morgan of Natural Choice, Doune, Woodlane of Doune and McLaren Rugby Club; notes that cardiomyopathy is a disease of the heart muscle, with "cardio" meaning heart, "myo" muscle and "pathy" disease, and that it is not a single condition, but a group of conditions that affect the structure of the heart and reduce its ability to pump blood around the body, and understands that it affects around 1 in 250 people in the UK.

17:27

Evelyn Tweed (Stirling) (SNP): Callum Ferrier was a tall, happy young man. He played shinty and had just taken up rugby. With hopes of becoming a motor mechanic, he had his whole life ahead of him. In 2013, 16-year-old Callum went to bed with a sore head. He was found the next day by his father, having died in the night. His tragic and untimely death devastated his mother, his father and his three brothers.

Callum had cardiomyopathy—a condition affecting the shape of his heart. The Ferrier family, from Doune and Deanston in my constituency, have gone on to fundraise more than £30,000 for Cardiomyopathy UK, which is a national charity for those with the disease. Through ceilidhs, treks all over the world, sky-dives and concerts, Callum's family are honouring his legacy and raising awareness. The charity is working to extend its offering in Scotland, but it needs volunteers to develop peer groups and provide advocacy.

Cardiomyopathy is a group of conditions, and various forms affect the heart in different ways. Dilated cardiomyopathy leads the walls of the heart to become stretched and thin, while hypertrophic cardiomyopathy leads to the enlargement of muscle cells in the heart, thickening the heart walls. With arrhythmogenic cardiomyopathy, cells in the heart muscle do not stick together properly, so the heart wall can become weak. Those conditions have a range of causes, but in many cases, they are genetic. They can all reduce the heart's ability to pump blood around the body and can lead to heart failure.

At least one in 250 people in the United Kingdom have cardiomyopathy, but for many it remains undiagnosed. The story of Callum, who was young, active and a keen rugby player, is sadly not unique. According to the British Heart Foundation,

> "at least 12 ... people ... under 35"

in the UK

> "die from an undiagnosed heart condition"

every week. Members will probably think, as I do, that that is quite a high number and that we need to be concerned about it.

With diagnosis and treatment, those tragic deaths can be prevented. However, Dr Steven Cox, the chief executive of Cardiac Risk in the Young, says that there are no signs or symptoms in 80 per cent of cases of cardiomyopathy because, for many, the first indication of the condition is death. Awareness and access to screening programmes are therefore vital.

Just weeks before Callum's death, Phil O'Donnell, the captain of Motherwell Football Club, died on the pitch. Mr O'Donnell also had cardiomyopathy. Such high-profile deaths led to a rise in screening programmes, which at first were for young athletes but are now available for many young people through charities such as CRY. Their activities are funded mainly through the efforts of those who have lost relatives. CRY screens around 27,000 young people every year for free. Free screenings are, however, booked up quickly, and with well over a million people in Scotland aged 14 to 35, a more sustainable and far-reaching screening strategy is required.

Although cardiomyopathy is frequently undetected, it is possible to diagnose it. Doctors use scans and tests such as electrocardiograms, echocardiograms and magnetic resonance imaging, and once the condition is diagnosed, it can be managed through lifestyle, medication or surgery. Diagnosis for family members is also available on the national health service due to the genetic nature of the condition.

Symptoms can go unnoticed or remain mild, or they can get worse over time. They include breathlessness, chest pain and feeling faint or light-headed; the abdomen, legs or feet may become swollen; and the rhythm of the heart may be abnormal. However, Cardiomyopathy UK found that

> "73% of patients"

with symptoms

> "did not associate their symptoms with a heart problem at the time of diagnosis."

The charity also highlights that those with symptoms spend a long time in primary care before diagnosis, which suggests that we need greater awareness among healthcare professionals.

I tried searching for the common symptoms online. When typing in "swollen legs" on NHS Inform, I found that heart failure comes up only on page 3, and the site mentions cardiomyopathy only in passing; the condition is not mentioned under "chest pains" or "breathlessness" either. There is plenty of information on cardiomyopathy out there, but only for those who know to look for it.

A page on NHS Inform to highlight the condition to parents and young people who may be googling symptoms would go some way towards bridging the gap. The Scottish Government's "Heart Disease Action Plan 2021" sets out heart disease as a priority. However, cardiomyopathy is mentioned only in passing. A more robust outline of the plan relating to the condition would be welcomed by many. I look forward to hearing how the Government will ensure that raising awareness of cardiomyopathy and providing pathways for screening is built into the strategy. Morag, Callum's mum, said:

> "If as family we do nothing else, we are raising awareness of this silent killer."

The family say that they hope that their work

> "prevents other families from going through the heartache"

that they still feel

> "with Callum's untimely death."

I am grateful, as I know that the Ferrier family are, for the interest and engagement in this debate, and I look forward to a future in which cardiomyopathy is diagnosed and treated for as many young people as possible.

17:35

Alexander Stewart (Mid Scotland and Fife) (Con): I am grateful for the opportunity to contribute to the debate and congratulate Evelyn Tweed on bringing it to the chamber.

I, too, convey my most sincere condolences to the Ferrier family on their deeply tragic loss of Callum. Although I acknowledge that that awful event happened almost exactly 15 years ago, I know from personal experience that no number of years can cushion that type of loss in such terrible and unexpected circumstances.

Many colleagues will know that, in the previous parliamentary session, I was pleased to be a co-convener of the cross-party group on heart disease and stroke. During that time, fellow MSPs, together with patients, health professionals, consultants and the British Heart Foundation as the secretariat, along with Stroke Association Scotland and other charities involved, achieved a great many objectives in the research and treatment of the myriad heart conditions that sadly affect so many people across Scotland and the wider United Kingdom. When I was invited to do similar for the new cross-party group on heart and circulatory diseases, I was more than delighted to take up the opportunity.

As we have already heard and as the motion explains, cardiomyopathy is a disease of the heart muscle that is manifested in many forms. In essence, it makes it harder for the organ to pump blood to the rest of the body, which can tragically lead to heart failure. Young Callum was one of many people who have suffered from the condition. There can be no real symptoms at all and individuals can feel completely well before a tragic situation occurs. Indeed, that scenario renders the effects of subsequent heart failure even more devastating.

That makes the Ferriers’ fundraising achievements even more substantial and extraordinarily. To raise in excess of £30,000 is a phenomenal achievement. The way that they have dealt with such a terrible loss, appalling grief and undoubtedly dark times, and have turned those round through time into a superhuman example of courage, determination and the wish to help others is truly exceptional.

The target of such determination and focus is Cardiomyopathy UK. It is the only UK charity dedicated to providing support and information to everyone who is affected by the condition. The charity relies entirely on donations for its work on prevention, to ensure prompt diagnosis and to provide information and treatment to save lives and improve quality of life for people who are affected by the condition. It is all about trying to ensure that the message is put across. The debate is an example of what we can all do to try to highlight the circumstances and situations.

I wholeheartedly commend what the Ferriers have done and Cardiomyopathy UK for all that it has done. I also congratulate the local businesses, clubs, organisations and schools that are mentioned in the motion on their tireless and unstinting endeavours to benefit all levels of research, treatment and wellbeing for everyone affected by the devastating and often silent condition.

We need to raise awareness and we are privileged to have the opportunity to do so. We can fight the corner for many individuals who do not have that opportunity. We need to take that on board.

Thank you for the opportunity to contribute to the debate, Presiding Officer.

17:39

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): I am pleased to speak in the debate in support of my colleague Evelyn Tweed and all who have campaigned over the years to highlight cardiomyopathy and the need for defibrillators.

I note that you, Presiding Officer, have taken part in previous debates on the issue. This will be my fifth. The first was in 2001, and the subsequent debates took place in 2010, 2014 and 2021.

I put on record my condolences to Mr and Mrs Ferrier, even while I congratulate them on their fundraising efforts following their tragic circumstances.

I first became engaged with the issue of cardiomyopathy when I met Kenneth and Wilma Gunn, who were then constituents of mine in Selkirk. After their son died from hypertrophic cardiomyopathy many years ago, they established the Borders-based charity Scottish HART—which stands for Heart At Risk Testing—which is also known as the Cameron Gunn Memorial Fund. Since then, over the decades, Mr and Mrs Gunn have worked tirelessly to promote awareness of cardiomyopathy and to encourage the testing of young athletes.

Back then, they were endeavouring to raise the £0.25 million that was required to provide a mobile echocardiogram that could be used at sports clubs and schools to test young people. Cardiomyopathy is a disease that is usually more recognisable under the headlines that we unfortunately sometimes read, such as “Sudden Death on Sports Field”, “Heart Condition Kills Youth” and “Teenager in Mystery Death”.

Cameron Gunn was playing five-a-side football with workmates, practising for a charity game, when he suddenly dropped down dead. He was 19; it would have been his 20th birthday the next day. Young people are still dying in similar circumstances, so I pay tribute to other members of the Scottish Parliament who have raised awareness of cardiomyopathy and of the work of Scottish HART.

Euan Robson, the former Liberal Democrat MSP, first lodged a motion on the issue in 1999, followed by former Labour MSP Johann Lamont in 2001, myself in 2003 and former Scottish Socialist Party MSP Rosemary Byrne in 2004. The issue has huge cross-party support.

I recognise the campaigning by outside organisations that are involved in cardiomyopathy prevention—it has made progress, and all parties have responded to it. Malcolm Chisholm, who was then Minister for Health and Community Care, and subsequently Nicola Sturgeon, met Wilma and Kenny Gunn, and both gave up a lot of time to discuss the issues with them. That shows that, with determination and a heartfelt commitment to an issue that requires attention, ordinary people such as the Ferriers and the Gunns can change things in the Parliament. It also shows that politicians listen, and that there are results.

Following the Gunns' petition to Parliament, and further meetings with and representations from Kenny and Wilma Gunn and Scottish HART, the then Cabinet Secretary for Health and Wellbeing launched a pilot screening programme, in conjunction with health professionals and the Scottish Football Association, at Hampden park. It involved screening amateur athletes aged 16 or over for life-threatening conditions. The cabinet secretary put in a further £150,000 of funding to extend the screening pilot over the coming years, and the pilot subsequently found 400 youngsters who exhibited risk factors that ranged from mild to serious. Even one life saved is excellent, so the programme was invaluable.

The Gunns also campaigned for the placement of defibrillators in public areas such as large supermarkets, airports, and train and bus stations, and over the years that has happened—there has been movement on that.

I fast-forward to 2021, when I said in the chamber:

> "From 1997 onwards, Wilma Gunn and her husband Kenny have been fundraising; raising the organisation's profile, even in Parliament; and campaigning not only for early testing of young athletes but for accessible defibrillators. Back then, not many people knew what a defibrillator was—I include myself in that. The profile was raised here, with debates and petitions in ... the Parliament, and in 2014 Wilma was deservedly awarded an MBE.
>
> Today, we have defibrillators at many points—in trains, bus stations, airports and supermarkets, and in the Parliament and some workplaces—but Kenny and Wilma ... have not stopped campaigning, and they are keen for even more ... to be distributed. The new ones are easy to use—you cannot hurt the patient by using them. In fact, it is better to use a defibrillator"

than have the patient die in front of you for lack of action,

> "as you cannot do any more harm than if you had done nothing. I have practised on defibrillators, in the Parliament and elsewhere, and if I can use them—because I am hopeless"

with anything practical—

> "anyone else certainly can. Those invaluable minutes on the defibrillator will mean life or death until the medics arrive. That is especially relevant in rural areas such as my constituency, where paramedics cannot simply arrive within eight minutes."—[*Official Report,* 14 December 2021; c 98-99.]

I wanted to take part in the debate to remind members of others who have, just like the Ferriers, through their own tragic circumstances, tried to move the debate forward and tried to bring to the forefront the need for defibrillators, and testing where necessary, to save so many young lives. I congratulate the Ferriers, as I remain forever congratulating Wilma and Kenny Gunn, who are still campaigning after all these years, and I say to them: keep on campaigning, as it does produce results.

The Deputy Presiding Officer: I call Claire Baker, who joins us remotely.

17:44

Claire Baker (Mid Scotland and Fife) (Lab): I thank Evelyn Tweed for bringing the debate to the chamber, and I join other members in paying tribute to Callum Ferrier, who sadly lost his life to hypertrophic cardiomyopathy in 2008. The grief experienced by a family for the loss of a loved one is significant and, for the Ferrier family, the loss of Callum must have been devastating. To experience the death of a healthy and fit young person with their life ahead of them is a tragedy, so it is testament to the Ferrier family that they have invested time, effort and resources into fundraising for Cardiomyopathy UK, and it is fitting that their dedication is recognised in a parliamentary debate.

The family's fundraising efforts and their continuing work in raising awareness of cardiomyopathy and supporting Cardiomyopathy UK should be praised. The breadth of campaigning and fundraising, which Evelyn Tweed highlighted, is impressive, and the family's ability to galvanise others is evident. I hope that, by having this debate today, we can contribute to increasing awareness of the conditions, the importance of testing and the treatment and support that are available.

As the motion stresses, cardiomyopathy is not a single condition; rather, it is a group of conditions that affect the structure of the heart and reduce its ability to pump blood. Some people might get cardiomyopathy as a result of another condition or risk factor that they have and, for others, it is a genetic condition that can be passed down. However, for many, the cause cannot be found. The NHS estimates that the condition affects one in 500 people, and that figure is reflected in the number of members who know a family who have experienced such tragic loss.

I know how devastating it is for a family to lose a young son or daughter in such circumstances. The sudden death of a young person in that way is a huge shock for everyone, as the condition often goes undiagnosed, and the young person can often be athletic and active in sports.

At least 1,600 people across the UK are living with cardiomyopathy. Some people may be aware of it as a result of symptoms such as feeling tired, dizzy or light-headed or experiencing breathlessness, chest pains or swelling in the legs or stomach, but others will have no symptoms at all. Most of the people in the UK who live with cardiomyopathy are undiagnosed.

Evelyn Tweed mentioned Phil O'Donnell, who died during a football match in 2007. That was the first time that many of us had heard about cardiomyopathy and how it can cause cardiac arrest without warning. Only a few weeks later, Callum Ferrier lost his life to the same condition. Although there is no cure for cardiomyopathy, there are effective treatment options, and most symptoms can be controlled through medication, devices such as pacemakers or surgery. That is why raising awareness of cardiomyopathy is so important. If people are aware of the symptoms and know of any family history of heart disease or sudden unexplained death, they can talk to their GP about their risk and, if required, take steps to manage it. With the right treatment and support, people with cardiomyopathy can lead healthy and full lives.

Increased testing for cardiomyopathy would help to allow people with risk factors to be assessed and, if they are found to have the condition, to take steps to manage it. In 2017, the British Heart Foundation launched a UK-wide genetic testing service, which allows an additional 800 people a year to be screened for hypertrophic cardiomyopathy, with test centres across the UK, including at the Queen Elizabeth university hospital in Glasgow.

The CureHeart research project, of which Cardiomyopathy UK is a part, recently won an international competition, the big beat challenge, securing a £300 million research grant. The project was recognised as the one with the most chance of delivering a revolutionary advance in cardiovascular health and disease. The CureHeart team aims to develop a treatment that targets and silences the faulty gene that is responsible for cardiomyopathies.

I will close on that positive news. Although the Ferrier family have experienced great loss, their actions and dedication to improving outcomes for future generations send a message of hope that I applaud and very much welcome.

The Deputy Presiding Officer: I call Fulton MacGregor. You have around four minutes.

17:49

Fulton MacGregor (Coatbridge and Chryston) (SNP): I had not intended to speak until I heard Evelyn Tweed's powerful opening speech, which reminded me of a situation in my constituency. Therefore, I might not take up the whole four minutes, but I appreciate your allowing me to speak in the debate, Presiding Officer.

As I said, Evelyn Tweed's speech was powerful, and it was a great tribute to the Ferrier family and to Callum. It must have been very difficult to get up and speak in the way that she did, but she did the family proud. She put on record the work that the family are doing to continue to raise funds. She and Claire Baker also mentioned Phil O'Donnell, who was, of course, a Motherwell player.

Evelyn Tweed's speech brought to mind something that I have raised before in the Parliament, in motions and in the chamber: the similar story of young Kieran McDade, who died on 26 August 2016—which was not long after the election in that year—while training with Dunbeth Football Club in Coatbridge. He was just 13 years old. Following Evelyn Tweed's speech, I thought that I should mention him again, and pay tribute to him and his legacy.

Kieran was known as being dedicated to Dunbeth Football Club, which is a well-known team in the Coatbridge area. The team had won the youth championship, and it was training when he, very sadly, passed away. He was a massive Celtic fan, and I think that one of the players in the Celtic game against Aberdeen that followed paid tribute to him when he scored a goal—I think that that was Leigh Griffiths. The player removed his top to pay tribute to young Kieran. That would have been a poignant moment for Kieran's family.

The incident resulted in the football club helping to found the Kieran McDade Foundation, which was launched a year later, in 2017. The foundation now runs an annual tournament, which is very well attended and involves teams from throughout central Scotland. The purpose of the foundation is to raise money for defibrillators. According to the most recent update that I have, it has given out around 115 defibrillators, but I am sure that the figure will be more, as that update did not include the most recent tournament. The defibrillators are given to grass-roots football teams, particularly in Scotland but also in England and Ireland. They are given to local organisations. One was placed at the West End bar in Airdrie—I lodged a motion on that—and it recently helped to save an individual's life. That young person continues to leave a very big legacy.

The Dunbeth team regularly posts about Kieran and, obviously, it posts a lot about the Kieran McDade Foundation. It is keen on defibrillators being in every town and village in Scotland. There is a lot of cross-party support in the Parliament for that, and I know that we want the legacies of that young boy and Callum Ferrier to be continued so that we get to a place in which routine screening for young people—particularly those who are active—is a reality. I hope that those sorts of incidents will become things of the past, and that the legacies of those individuals will continue to do good.

Thank you for letting me speak, Presiding Officer, and I thank Evelyn Tweed again for inspiring the debate.

17:53

The Minister for Mental Wellbeing and Social Care (Kevin Stewart): I offer my condolences to the Ferriers on the devastating loss of Callum. As we have heard, Callum, sadly, died in his sleep aged 16 as a result of hypertrophic cardiomyopathy. From the accounts that I have seen, Callum was a young man who loved sports. He was a rugby player and a football fan. He supported Rangers and the local side, Doune Castle AFC. Evelyn Tweed's debate has been an opportunity for members across the chamber to recognise his life and the on-going impact of his loss.

The debate also raises the issue of the importance of quality care and support for people with cardiomyopathy and the issue of out-of-hospital cardiac arrest. I will touch on both of them.

It is important for us to recognise that, in the 15 years since Callum's death, his family have carried out exceptional fundraising efforts in his memory. They have raised more than £30,000 for charity, which has been achieved by carrying out a number of quite incredible challenges. To mention just a few, they have climbed Machu Picchu, trekked the Sahara and the great wall of China, gone sky-diving and run multiple marathons. The result of those efforts has gone to providing support for Cardiomyopathy UK, which is the specialist national charity for people affected by cardiomyopathy.

The charity provides support and information, campaigns for better access to quality treatment, saves lives through raising awareness and provides hope through shaping research. Third sector partners, including Cardiomyopathy UK, play an important role in driving improvement for people with cardiac conditions in Scotland. The Scottish Government is grateful for their continued work and engagement in that area.

Cardiomyopathy UK has outlined the importance of early detection and diagnosis, improving specialist treatment, access to genetic and family testing and on-going care and support. At this point, I should explain that cardiomyopathy refers to a group of conditions that affect the structure of the heart and impact its ability to pump blood around the body. There can be a number of different causes for that, but in many cases it is a genetic condition that can be passed down through families. That might also be referred to as an inherited cardiac condition.

The Network for Inherited Cardiac Conditions Scotland is a national managed clinical network that supports improvement in the detection, diagnosis, treatment and outcomes of people with inherited cardiac conditions including, but not limited to, inherited cardiomyopathies. NICCS brings together healthcare professionals, people affected by inherited cardiac conditions and relevant third sector organisations, and together they are supporting the delivery of quality patient care across our country. A number of helpful patient resources and healthcare professional guidance are available on the NICCS website for anyone who might be interested in learning more about its work. I take this opportunity to recognise and give my thanks to everyone involved in NICCS.

Before closing, I will touch on some of the wider work of the Scottish Government that is of relevance to the debate. We recognise the scale and impact of heart diseases in Scotland and continue to deliver our heart disease action plan. The priorities and actions within that align closely with much of what Cardiomyopathy UK has identified as important areas for improvement. The action plan has a focus on early detection and diagnosis, improving specialist treatment and ensuring access to on-going care and support for people who are living with a cardiac condition.

Further to that, our reflections on the loss of Callum are a difficult reminder that, each year in Scotland, more than 3,000 people experience a cardiac arrest in the community.

Christine Grahame: In my speech I focused on defibrillators, on which we have come a long way. I just wonder whether we know where they are located. For example, do we know where they are in local authority areas? Could local authorities map where there are defibrillators, so that if somebody is in an emergency they know where to get one?

Kevin Stewart: I know that in some areas the defibrillators are mapped, but I will see whether we have a national mapping system in place. I do not have that information to hand, but I will certainly get back to Ms Grahame on that.

We are working in partnership with Save a Life for Scotland to deliver the out-of-hospital cardiac arrest strategy. That includes a focus on ensuring that, in instances where a cardiac arrest is witnessed, people have the skills and confidence to intervene. The overall aim is to increase CPR—cardiopulmonary resuscitation—and defibrillation rates, leading to increased survival rates.

However, it is important to highlight that, beyond that, the strategy recognises the significant impact of witnessing a cardiac arrest or sudden cardiac death. That is why the Scottish Government has recently provided funding to Chest, Heart and Stroke Scotland and the Resuscitation Research Group at the University of Edinburgh to deliver a pilot project of aftercare support for people who have had that experience.

I am grateful for the opportunity to speak to the motion. It has reminded people in the chamber of the importance of efforts to improve early detection, diagnosis and access to care for people with cardiac conditions across Scotland. It has also served as a reminder of the importance of on-going work to increase survival of out-of-hospital cardiac arrest, and of providing aftercare to support those folks who have been impacted.

I reiterate my thanks to Cardiomyopathy UK for its vital work in supporting people with those conditions across these islands, and to NICCS, which plays such an important role in ensuring that people who are affected by cardiomyopathy in Scotland have access to quality care.

To close the debate, I put on record a remembrance of Callum Ferrier, and I give my sincere congratulations to his family on all that they have achieved in his memory.

Meeting closed at 18:01.

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