OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 26 October 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 October 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
8th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Bishop (Scottish Government)
Greig Chalmers (Scottish Government)
Ailsa Garland (Scottish Government)
Terry O'Kelly (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 26 October 2021

[The Convener opened the meeting at 10:48]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the eighth meeting in 2021 of the Health, Social Care and Sport Committee.

Our first item is to decide whether to take agenda items 3 to 6 in private. Do members agree to do so?

Members *indicated agreement.*

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

10:49

The Convener: The second item is an evidence session with the Scottish Government on the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill. The Scottish Government officials from the bill team, who are all participating remotely, are Greig Chalmers, head of the chief medical officer's policy division; David Bishop, mesh team leader; Terry O'Kelly, senior medical adviser; Ailsa Garland, solicitor; and Kate Walker, solicitor.

I have a note of the questions that members want to ask.

My initial questions to the bill team are about the specialist mesh removal service. I would like to get an idea of where we are with that. The committee has reached out to mesh survivors, who have asked questions about the service. I am not sure who to call on. Is the question for Mr Chalmers?

Greig Chalmers (Scottish Government): Good morning, convener. On that question, I will defer to my medical adviser Terry O'Kelly, who has been closely involved in the service.

Terry O'Kelly (Scottish Government): Good morning. Welcome to a rainy Aberdeen. The specialist mesh service in Scotland was established following work that was undertaken by a short-life working group that consisted of accountable officers and representative parties. For its first three years, the service is being funded by additional money from the Scottish Government. The centre is housed in NHS Greater Glasgow and Clyde and has operated for more than a year.

Members will appreciate that the unit's work has been inhibited to an extent by the Covid pandemic, but considerable progress has been made in establishing a fully functioning multidisciplinary team, with the recruitment of new medical and non-medical clinicians. We can now offer a truly holistic service for women with mesh-related complications.

The work is on-going. We will have a service review next month, and we are looking for updates on the patient experience and early outcomes, which are important. We have had a lot of input into the service level agreement that is in place.

Across the United Kingdom, where other such centres are being established—in England, Northern Ireland and Wales—the Scottish centre is seen as leading because of the clinical expertise

that is on offer and because of the public and patient engagement. We are grateful not only to colleagues in Glasgow but to the Health and Social Care Alliance Scotland, which is taking work forward.

As everyone does, we appreciate the sensitivities that are involved in such care. The women who have suffered need to have confidence re-established, and we are working towards that not only through looking to provide a good experience and good outcomes but through ensuring that our surgeons' skills are credentialled, which involves a process that is being established through the Royal College of Obstetricians and Gynaecologists, the Royal College of Surgeons and the General Medical Council. We have been actively engaged in promoting that and ensuring that the work moves forward as quickly as possible.

Previously, a major problem related to information and shared decision making. With the background of realistic medicine, we are and have been intimately involved in developing the new GMC guidance on consent, and we have been engaging with services across the United Kingdom to ensure that we have information and patient decision aids that are acceptable and are seen to be so for patients.

The Convener: Over the years, since Scottish Mesh Survivors first began petitioning, there has been a lot of testimony as to what happened to the women and where trust in the people who had been removing the mesh had dissolved. How has that informed the way in which the services are being taken forward? You talked about the clinicians and surgeons who are involved in the work that you are doing, and the expertise that you have. What learning has come from the mistakes and practices of the past to lead us to where we are now with the bill?

Terry O'Kelly: We have very much drawn on the experiences of patients. That information has been used to craft and mould the service, and it will continue to do so as we move forward. We heard the voices of the women in Scotland. One has to recognise their bravery in coming forward and continuing to press their points, often when their views and pleas for help were not being listened to. That was the perception and, given the numbers of patients who were involved, there must be a lot of reality in it. The reality was borne out not only here in Scotland but in the experience of Baroness Cumberlege in undertaking her review at the Westminster Parliament.

We have heard those voices, and we recognise that there are lessons to be learned. If we look across the policy areas that are being developed with regard to mesh, we can see that those lessons have been learned and that the learning is being applied.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in issues around total versus partial mesh removal. Some of the procedures are quite complicated and subsequent surgeries might be required. Does the bill cover the wider requirements of women who need concomitant surgeries?

Greig Chalmers: Perhaps I might start on the bill and then defer to Terry O'Kelly on the clinical aspects of the question. The bill does provide for reimbursements when there has been more than one surgery. We are aware that, as the member says, successful surgery can require more than one surgery; we cover that at paragraph 10 of the explanatory notes. Terry O'Kelly might want to comment on the surgical aspect.

Terry O'Kelly: For some women, the issues and complications relating to mesh and the on-going care that might be required are very complex. Speaking as a clinical surgeon in Aberdeen, I can tell you that those issues are not really the domain of private practice in private hospitals; they are the domain of major national health service centres, with all the infrastructure and services that can be offered to women.

We raised that point through the accountable officers short-life working group, and it was echoed by Baroness Cumberlege. The care for the women is dependent on a multidisciplinary team, and we have to be able to offer them holistic care. The bill covers primary assessment and removal of mesh. Women who have subsequently had further care might come forward, but the bill's principal aim is to reimburse women who have had mesh removed. It is about the act of removal, rather than on-going management.

The referral possibilities that are being established for care outwith the NHS will predominantly involve physical removal of mesh, rather than any reconstructive or additional procedures or clinical interventions that are required, such as chronic pain management, psychosexual counselling and so on, which are the domains of the multidisciplinary team and of major NHS centres.

11:00

Ailsa Garland (Scottish Government): I will add to what Greig Chalmers and Terry O'Kelly have said. I would like to clarify that the bill gives power to ministers to make a scheme. As is set out in the bill, the costs to be reimbursed will include the cost of the removal surgery itself, but ministers will have power to cover other costs—for example, if more than one surgery was needed to remove mesh. There is quite a broad power in the

bill to have those things in the scheme, and they can be considered as the scheme is drafted.

Emma Harper: We heard earlier about a person who needed additional time because of a pre-existing condition that needed to be managed with constrained thrombolytic therapy. If somebody required additional time because of additional health conditions, would that be included, too?

Ailsa Garland: Again, we can consider in the scheme itself what costs could be included in addition to the main mesh removal surgery. I do not know whether the additional time reflects a longer period in accommodation, while treatment is being carried out, but such things could be taken into account as we consider the shape of the scheme itself.

The Convener: We have heard from many women, and they have all said that there should be a degree of flexibility, because every person's case, when they have gone for surgery—be it in Bristol or in the States—has been different. There have been different circumstances and, as Emma Harper has mentioned, women have had different health complications. They want to see that recognised and, if someone does not fit into a particular box but has still incurred a lot of costs, they want flexibility. Do you believe that the bill as it stands allows for that?

Ailsa Garland: The bill certainly allows for flexibility in setting up the scheme. I do not know whether there has possibly been a slight misunderstanding over the costs that were set out in the financial memorandum, which were estimated costs that were used to estimate the overall costs of the bill. I do not think that the intention is for there to be a specific cap for things such as the mesh removal surgery—that would be covered in full, and we might look to set out what would be considered reasonable by way of accommodation and travel costs and so on.

There is certainly that degree of flexibility in the bill. For example, the £20,000 estimate for surgery was just to get an idea of what the total costs of the bill would be; it was not about the scheme saying that, overall, we are going to cover up to that £20,000 limit.

The Convener: Okay. We might dig into that later. Some members have questions on the financial memorandum, so it is good to have that point to dig into later.

Evelyn Tweed (Stirling) (SNP): I very much welcome Terry O'Kelly's comment on our moving towards a holistic approach. How will you assess the success of the specialist service here? How will patients' reported outcomes be collected and reported?

Terry O'Kelly: When it comes to holistic care, we can look at the process of management of a patient's episode, such as a hospital admission or some other practice of care. A pathway can be set up and measured. That is reasonable for things such as pain management. I am sure that that could be done. The same applies to psychological inputs and so on.

It comes down to patient experience and patients engaging with the centre. What were the expectations at the start? How were those expectations addressed? What was the patient's final opinion? That is really important, and we should be able to measure that relatively early.

There are early outcomes, which can be patient orientated, and there will be later outcomes. What is the legacy of the care? That is being looked at and addressed across the United Kingdom by an oversight group, which is setting up a database that will, over time, morph into a registry. NHS Digital is leading that work. We are engaged with that, and we have pilots running in Scotland.

The patient reported outcome measure is an issue. There are some established PROMs that are validated. Unsurprisingly, mesh survivors would like a bespoke one for mesh and mesh complications. One of the difficulties is that PROMs take some time to establish and a longer time to validate. As we go forward, it is important that we have an eye on creating something that might be bespoke but that we also apply something that currently exists so that we can get an early handle on patient reported outcomes, in order to be sure that what we are doing is correct and addresses not only what women want but what they need. That is vital.

Sue Webber (Lothian) (Con): My question is also for Terry O'Kelly. We have heard a lot from witnesses about the logistical challenges in managing the private sector experience in the US and England, and the challenges facing the NHS service in gaining trust. Obviously, an NHS-based service will be much better at managing the anticipated and unplanned outcomes of the complex surgery. What is being done to benchmark and reassure people that in Scotland we will have among the best mesh removal specialist services?

Terry O'Kelly: That is very much in the forefront of my mind and actions. We want to change the narrative but, to do that, we cannot just say to women and mesh survivors that we have a great service and so on. We have to demonstrate through evidence that we have a centre that is as good as any in the world and is—we hope—world leading. To do that, we need credentialling as soon as possible. We need the skills of our surgeons to be accredited, and we need robust

evidence of excellent patient experience and outcomes.

We can look at the very early experiences from the centre. The outcomes will be based on initial measures rather than the long-term legacy. We will be able to change the narrative and lead women to want to use our centres in Scotland through providing them with hard evidence. I absolutely appreciate that there is a lack of trust and issues with competence. We have to do our best to restore trust in services in Scotland and across the United Kingdom. That is not within my gift. We have to provide the information, and it will be for women to judge and value the experiences of their peers who have gone through the service.

However, initial measurements of experience are encouraging, and I encourage women to look at them, to speak to our clinical teams and to open their eyes to what is available in Scotland before they decide to go anywhere else.

Sue Webber: In one of your earlier statements, Terry, you spoke of new staff coming on board. Where are they being recruited from? What multidisciplinary areas of expertise do they cover that the team did not cover previously?

Terry O'Kelly: Some removal surgeons are working in Glasgow, but they have been augmented by colleagues from the rest of the United Kingdom. We are now up to complement with surgeons. If a woman chooses not to have contact with a surgeon who might have been responsible for her care in the past, she can state that and elect to have her care managed by another colleague.

We have also recruited pain management nurse specialists, who are very important additions to the clinical team.

Gillian Mackay (Central Scotland) (Green): I am interested in how we can support women's mental health and in whether consideration was given in the bill to reimbursing private medical costs related to that. In our private round-table session this morning, we heard that some of the women had lost confidence in the centre in Glasgow, and some will probably have lost confidence in the Scottish NHS as a whole. They might want to be seen privately for what has been for many of them a traumatising event. Has consideration been given to paying for or reimbursing women for private counselling and other services, aside from mesh removal itself, that might help them to recover?

Greig Chalmers: Ailsa Garland referred to the scheme that is set out in section 1 of the bill that is concerned with mesh removal surgery in the first place. That will be clear to committee members. As Ailsa said, there is scope in the scheme to refer to other costs. Our intention is that the main focus should be on the surgery, the necessary preparatory steps for the surgery, and the accommodation of and arrangements around the surgery. The reason for that focus goes back to the bill's primary motivation, which is the commencement of arrangements to procure surgery in the independent sector, as the Government has decided and as committee members know. The purpose of the bill is to reimburse people who paid private costs while not knowing, and having no reason to know, that the Government was about to do that.

The mental health and other important services that Gillian Mackay refers to have been and will continue to be available as normal through the NHS, whereas in the past the mesh removal surgery was not available in the independent sector. There is scope for matters that are connected to the surgery to be included in the scheme, but in general it is not the Government's intention that it will cover the whole scope of a person's health needs. I hope that that is helpful.

11:15

The Convener: How do you propose to make clear to the women who present the options that are available to them? The bill allows for patient choice. Women can opt to have their surgery in Scotland or in another part of the United Kingdom, and they can opt to have it done privately. How will the options be made clear to women? To what extent will the approach be patient centred and respect patients' choices? How will all that be communicated, not just to patients but to general practitioners, given that we have heard from women that there is sometimes a lack of understanding on the part of GPs about mesh complications. Will you also cover that?

Greig Chalmers: I am happy to do so, and your question usefully highlights what is and is not covered in the bill. The bill is focused on surgery that has taken place in the past, meaning things that have happened, so it is about reimbursement of money that has already been spent.

The bill does not cover what you correctly described as the range of services and surgery options that are and will be available to patients in the future. As Terry O'Kelly explained, a primary element in that regard is the mesh removal centre in Glasgow. There is also the developing option of surgery in NHS England and, potentially, other parts of the UK, and work is under way to make arrangements for the independent sector's involvement. Those three options are separate from the bill. Of course, the issues are connected, but the bill is very much focused on the past, to ensure that the people who entered—

The Convener: I asked because the committee also wants to know about specialist mesh removal services. That is why we are asking about those services as well as the reimbursement scheme.

Greig Chalmers: That is completely understood, convener. This might be a convenient moment for me to ask Terry O'Kelly to talk about the sort of conversation that you asked about, which will inform the choice that people go for.

Terry O'Kelly: We have to be clear that the needs of a number of patients are complex and it would be foolish to divorce the surgical procedure from a care pathway that must involve services near to home as well as services that are perhaps further away. It is important that patients who have problems are seen by their local clinical teams. I accept that there are potentially issues in that regard, but being seen locally is really important, because the local team will pick up problems if they occur or present as an emergency.

In discussion with colleagues in the local teams—and we have been working with the boards—onward referral will be made to the specialist mesh centre in Glasgow. It is reasonable that patients are assessed here in Scotland. There will then be a conversation with the patient about what they want. I speak as a clinician who has been involved in managing similarly complex problems with inflammatory bowel disease, when patients have wanted to go to various places.

There has to be a discussion about what is in their best interests, and we must ensure that we do not prejudice care by acting in a certain way. We have been clear that the management of any patient must be linked to a competent multidisciplinary team for appropriate discussions and that our primary aim is to encourage and show patients that the best care that they will get is in Scotland. However, if we are unable to reconcile issues with their care so that we can go forward in Scotland, we will advise an appropriate referral to a mesh centre in NHS England, Northern Ireland or Wales. That can be discussed and a decision made about it. All those centres in England will provide similar services to the centre in Scotland, linked to a credentialling measurement of experience and outcomes, to benchmark the outcome of the care pathway. The process of care will also be benchmarked and categorised and identified.

After all that, if a woman feels that she just cannot undergo surgery in our NHS—that is a tragedy, but we recognise the reality—surgery outwith the NHS might be possible. Discussions are on-going, but there are two places for that, one of which is in the United Kingdom and one in America. However, that care must be tied into a competent multidisciplinary team. It cannot be that the woman embarks on management that is not overseen by the multidisciplinary team. We recognise that that is important as did Baroness Cumberlege and the clinical teams, and I am sure that the women also do.

It is important to ensure that any intervention is part of the care pathway and does not prejudice what might be necessary and what is in place going forward.

Gillian Mackay: I have one more question on that before we move on to talk about the bill.

If a woman who has had mesh inserted that has caused problems is nervous about the surgeon who put the mesh into their body also being the surgeon who might remove it, is that taken into account and respected?

Terry O'Kelly: Yes, although as I said, it depends on where the woman had surgery. In Scotland, if the woman engages with our mesh removal service, there are clinicians who were there previously, but we have also recruited new surgeons who are well trained and well supported and credentialled. A woman has the absolute right to elect to have her care undertaken by one of those individuals.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Earlier, we heard about the importance of trust and there was mention of the fact that there is now a full complement of staff with the required expertise at the specialist centres. We heard from women today—some of whom have been treated by Dr Veronikis—that NHS imaging often cannot see mesh because it is placed behind the bone, and that Dr Veronikis has designed and developed new specialist surgical tools. Have our specialist centres considered those issues and developments? Have lessons been learned and incorporated into the processes? That would be a step in the right direction in re-establishing trust.

Terry O'Kelly: I have been involved with mesh since 2014 and Dr Veronikis has been an important figure in the development of surgery. There is no doubt that he has gained the trust of women in America, in the United Kingdom, and elsewhere across the world but I do not think that his techniques are unique. Surgeons will inevitably develop the ability to undertake his procedures. The published evidence shows that the process and the outcome of care that is offered by Dr Veronikis are no different to those of other surgeons who specialise in this type of surgery, including our surgeons in Scotland.

Dr Veronikis is a high-volume surgeon, and I am sure that he is highly competent. We need to make sure that the care that we offer is at least as good as if not better than that which he offers, and that it is supported by all the other services that women need.

We also need to offer a service that is responsive to women's wants and needs and can demonstrate that those responses have taken place. Certainly, the initial experience with the new service in Glasgow is that women are being listened to and responded to in words and in actions. That is tremendous.

The process is an iterative one. As something important changes and is improved, something else comes along. The service is evolving. We would like it to be an exemplar for how services are developed across Scotland for women's medicine and surgery as well as for other specialties. It is, after all, the people's service.

The Convener: David Torrance has questions on the reimbursement scheme.

David Torrance (Kirkcaldy) (SNP): Good morning. How long will the scheme last and will there be a time limit for reimbursement? If there is a time limit, how will it be decided?

Greig Chalmers: I will start and might ask David Bishop also to contribute.

It goes without saying that all the rough timings that I am about to mention are dependent on the proceedings of the bill. Our current intention is that the scheme will open soon after royal assent has been granted, and that it will be widely publicised to interested people. It will not surprise the committee, although it might encourage you, to hear that we have what we hope is a reasonably well-developed system of consultation of interested people through the Health and Social Care Alliance, which has been very useful in developing policy, and through NHS National Services Scotland, which—as the committee knows—has been leading on implementation of the current mesh fund that has been in operation for a while.

We expect the scheme to open only a few months after royal assent and then to be available for a period. We expect that there will be a closing date, but we have not come to a final view on the duration of the scheme—it could be about a year, for example. We hope that, during that time, it will be practicable to bring it to the attention of everyone who is potentially eligible, and to give them a reasonable period to submit an application.

As is the case with the Scottish Government's current mesh fund, there will, of course, be circumstances in which an application needs to be added to or explored a little so that particular circumstances can be confirmed. However, we hope that that will be possible under the new arrangement, as well—not least because, as has been said, there are a variety of circumstances to address. Of course, the bill provides that a copy of the scheme must be laid before Parliament after royal assent is granted. I hope that that is helpful.

11:30

David Torrance: How will reasonable costs for individuals be defined in the bill? I think that I heard earlier that there will be no cap on surgery costs, but will there be a cap on daily costs?

Greig Chalmers: I will start, if I may, and then I might bring in my colleague David Bishop, who was involved in the financial memorandum. I hope that the reasonableness assessment will look at the evidence of the situation. We will look for reasonable proof of the costs of surgery and for intelligence around rough costs.

In relation to reasonable costs for travel and accommodation, we considered the reality of somebody planning travel on their own using their own budgets—the access that you, I or anyone else would have to travel and accommodation on the internet or as advised by the centres that they attend. Perhaps David Bishop will say a little about our estimates in the financial memorandum.

David Bishop (Scottish Government): It is important to say at the outset that the figures are estimates. They were based on the intelligence that we had at the time from correspondence and so on. In the period since, we have, via the Health and Social Care Alliance Scotland, been getting evidence from women who have lived experience of the surgery. We will take it into account as we draw up the scheme, which we are still working on.

The question was about capped rates. We are engaging with women on what evidence they can practically provide to support their applications. It might be that they have not kept evidence for smaller amounts, but probably have evidence for the big-ticket items—the treatment and so on. We are considering such things in relation to reasonableness, the caps that might be applied and whether caps are appropriate at all. The scheme is very much a work in progress; we will continue to engage with women as we draw it up.

David Torrance: Many of the women have had to take their husbands, partners or family members with them for support. Will the bill include reimbursement of those costs?

Greig Chalmers: Yes, it will.

Sue Webber: From what we heard this morning before the meeting, the biggest issue appears to be women having the money up front to fund the surgery; the bill is about reimbursement. We also heard that there could be significant on-going costs that are not planned for regarding surgery for removal of mesh and complications—particularly when women access surgery through the private sector. Is there something that we can do to help with that? It will not be a very equal service if there are women who do not have the

resources to pay up front then claim it back and therefore cannot access what the bill is, ultimately, trying to achieve.

Greig Chalmers: I apologise for repeating myself, but I highlight that the bill is concerned with things that happened in the past when people spent their own money. We are trying to make sure that they can be appropriately and reasonably reimbursed for that.

On what is happening now and what will happen in the future, the focus is on continuing to improve the specialist centre in Glasgow, as Terry O'Kelly and others have said. As Terry also said, it is not just about surgery; it is about having a broad range of services of different types, which will be provided free through the NHS, as usual. I should have mentioned earlier that the current continuing Scottish Government mesh fund is providing help for people who have been affected by mesh complications. That fund remains open.

Sue Webber: Thank you for clarifying that—it was very helpful. What is the position for women who have had mesh removal surgery that has not gone as they expected? When surgery has not been as successful as it was hoped it would be and there are on-going issues, how will that be covered or addressed by the bill?

Greig Chalmers: That is a very fair question, but it is not the subject of the bill. Terry O'Kelly will address what happens when surgery that is carried out now is not as successful as the patient and surgeon hoped for.

Terry O'Kelly: As Greig Chalmers said, the reimbursement bill is about care that happened previously. We are addressing through the work of NSS, and the NHS more broadly, care for women going forward. If a patient has had remedial surgery that has not achieved their expectations and further management is required, that is absolutely the domain of the multidisciplinary team. It is about engaging with patients, understanding their issues and what they want, and identifying how that can be achieved.

In reality, it is unlikely that further remedial surgery will be the domain of out-of-NHS care. The truth is that we could then get into pretty complex engagements that might in themselves be associated with risk. That said, there might be cases of residual mesh that might appropriately be cared for elsewhere, but that would have to be determined through discussion that is centred on what the patient wants and—this is important—which takes into account their true needs. It is about trying to align opinions.

I recognise that that might not be what every woman wants to hear or what the committee wants to hear, but it is the truth. We have to make sure that, in managing patients, we absolutely take into account what they want, but also that we align that with what is required and what is reasonable.

Sue Webber: Is that the realistic medicine that you referred to earlier in the discussion today?

Terry O'Kelly: Yes—absolutely. That is dominating how we are going forward with the health service in Scotland.

People sometimes say that realistic medicine is cheap medicine, but it is about addressing what people want. Clinicians seldom ask that question, but it is empowering for patients. There are lots of experts involved. The clinician knows about the disease, the process and the treatment, but the matter is also about the patients, who are the experts on themselves. Patients' expectations and wants might sometimes be unrealistic, but we should try to find some way to give them as much as possible of what they want and need.

The Convener: Evelyn Tweed and I have questions about what reimbursement might cover and about proof of eligibility.

I am not clear about something. Suppose a woman had surgery involving mesh in Scotland but then opted to have the mesh removed privately when she was not resident in Scotland, although she might be resident in Scotland now. Am I correct in thinking that, if she was not resident in Scotland at the time of the mesh removal surgery, she would not be eligible for reimbursement of what she had paid?

Greig Chalmers: I will take care to check the record to ensure that I have understood the question correctly. I think that what you say is correct. Section 1(3)(b) says that surgery that qualifies for reimbursement is surgery

"in relation to a person who was, at the time the surgery was arranged, ordinarily resident in Scotland".

The surgery that we are talking about is the removal surgery. That is what is being reimbursed. Ailsa Garland may want to say more about that.

The Convener: So, if a person was not resident in Scotland at the time when they had mesh removal surgery, that is not included in the scheme.

Greig Chalmers: To be absolutely precise, it is

"at the time the surgery was arranged".

There will be a gap between the surgery being arranged and it happening, but if the person was not "ordinarily resident in Scotland" at the time when the mesh removal surgery was arranged, that would not be within the scope of the possible scheme. Ailsa Garland may want to clarify what I have said.

Ailsa Garland: Greig Chalmers has set that out correctly. The key point is when the surgery was

arranged. If the person was "ordinarily resident in Scotland" at that point, they would be eligible for reimbursement.

The Convener: David Torrance said that a person who had the removal surgery a few years ago might have had some smaller expenses such as taxis and meals and might not have kept the receipts because they never thought that they would be reimbursed. I understand that there will be some flexibility about that. If someone took out a loan to raise money to pay for their surgery, interest will be an additional cost. Will that sort of thing be covered by the reimbursement scheme?

Greig Chalmers: We want to consider that aspect of the scheme carefully. We will reflect on your question. Our explanatory materials discuss the fact that, in some cases, people may have received donations through crowdfunding. That is relevant and should also be taken into account. There will be a need for reasonable documentary evidence about the overall financial cost to the person if that involves a large amount of money. We will reflect on that in drawing up the scheme.

11:45

The Convener: If a person has applied for reimbursement and is not satisfied with the level of money that they have been given as a result of the application, what avenues might be open to them to challenge that?

Greig Chalmers: The potential to cover that in the scheme is addressed in section 2(1)(h). It is intended that the scheme will include a route of review. David Bishop might be able to clarify this, but I think that there is a route of review in relation to the present Scottish Government mesh fund.

David Bishop: There is, yes. We are working through the detail of the reimbursement scheme and how an appeals process might work. We are considering including one in this case as well.

The Convener: Evelyn Tweed has some questions on that.

Evelyn Tweed: I have one question left, convener, because you have asked quite a lot of them.

If a woman came forward to use the scheme that is set out in the bill and was unhappy with the outcome, how could she get redress? Where would she go to say that she was not happy about what had been offered and how could we help with that?

Greig Chalmers: As David Bishop indicated, we intend that the scheme will include an explanation of how review can happen. We will explain it in detail in the scheme. I imagine that, in the ordinary course of events, the process of review will be through the body that considered the application, which will in all likelihood be NHS National Services Scotland. The scheme will establish a route for somebody to ask for a review or, indeed, make a complaint.

The Convener: We are running out of time, but some members have questions on the financial memorandum.

Paul O'Kane (West Scotland) (Lab): Analysis of the financial memorandum so far suggests that there are known unknowns. We do not have clarity on how many women might come forward to use the scheme, so the finances are somewhat estimated at this stage. I am keen to understand what contingencies there are in the financial memorandum to account for any unanticipated increase in the number of women coming forward.

Greig Chalmers: That is a fair question. Knowing all along that we do not have confirmed official information about the number of women who have sought mesh removal surgery, we are trying—in the hope that it will be helpful to the committee and the Parliament—to measure the cost on a per diem basis. There might be variation in the number of nights' stay or the number of people who were accompanied against those who were not, although our base assumption is that almost everybody going for the surgery will have had a husband, partner or companion with them because of the practical circumstances. To help the process, we have tried to make it as simple as we can to cope with variation as information becomes available.

I suppose that it is best to be straightforward and honest in the circumstances. As policy officials, we have had a number of conversations with a number of people in different fora over the last little while, and we have been offered a similar overall picture on the number of potential applicants. Of course, we cannot know for sure that there are not people out there who are hidden from us because they have not been involved so far. That is definitely a risk.

However, in all the estimates, we have tried to provide for variation and to ensure that, where there is a plausible risk that someone will not have receipts for a taxi or for lunch, which is perfectly understandable, we come to a standard approach, whereby a person will be fairly reimbursed for such reasonable expenses.

Carol Mochan (South Scotland) (Lab): Thank you for the information that you have provided so far. Leading on from Paul O'Kane's question, I am interested in ensuring that information is provided to any women who do not know about the scheme or about how to apply to it. We must ensure that that information is very accessible and that women

feel at ease in applying, should they have to do so. Has any work been done on that?

Greig Chalmers: Yes. As Terry O'Kelly and others have said, we wish that it was not the case, but we recognise that there is a nervousness about interacting directly with the Government on the issue, because of the circumstances. Therefore, throughout the process, we have sought to work with the Health and Social Care Alliance Scotland. It is for others to judge, but I think that it has a lot of expertise in engaging with groups who are sometimes hard to reach and who are ambivalent about working directly with the Government. The alliance has held a number of focus groups over the last little while to inform the development of the scheme and the bill, and on other points.

We will continue to work in that way and to work through NHS National Services Scotland, which has the established routes. We know that many hundreds of people have already applied for the Scottish Government mesh fund. Although we cannot be certain of this, we would imagine that people who apply for the mesh fund will include those who might be relevant under the bill. That route will be available as well. Of course, it goes without saying that, if the bill gains royal assent, the Scottish Government will use all its channels to publicise the scheme—it will bring it to people's attention through social media and other steps.

The Convener: Emma Harper has a short question, which I think will be the final question of the morning.

Emma Harper: Greig Chalmers has already alluded to this issue. The financial memorandum says:

> "It is expected, upon establishment of a scheme, that all applications will be made within one year of the scheme opening."

I presume that that is because the scheme will be advertised on social media and because you will know who has had mesh implant surgery. Is the one-year timeframe narrow, or do you think that it is reasonable?

Greig Chalmers: We hope that it will be reasonable. We will want to ensure that we align our activity in such a way that we open the scheme after we have made people aware of it. We hope that a year will be sufficient. Instinctively, it feels that a full calendar year after the scheme opening will provide enough time.

It is worth saying that that will be the period for applications. As a number of members have said, because of the complexity of the circumstances, there will, I am sure, be a number of cases where the determination of any grant or payment will continue after that year. There is no date specified for that—that will be based on the circumstances of each case.

I do not know whether Ailsa Garland would like to qualify anything that I have said.

Ailsa Garland: No, thank you. I am very happy with everything that Greig Chalmers said.

The Convener: That completes our questions. I thank you all for your time and for clarifying certain aspects of the bill and the scheme.

At our next meeting on 2 November, the committee will continue its scrutiny of the bill and will consider some subordinate legislation.

That concludes the public part of our meeting.

11:55

Meeting continued in private until 12:15.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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