OFFICIAL REPORT
AITHISG OIFIGEIL

Citizen Participation and Public Petitions Committee

Wednesday 8 June 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 8 June 2022

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CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

10th Meeting 2022, Session 6

CONVENER

*Jackson Carlaw (Eastwood) (Con)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Fergus Ewing (Inverness and Nairn) (SNP)
*Alexander Stewart (Mid Scotland and Fife) (Con)
*Paul Sweeney (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Maria Aitken
Gordon Baird
Rhoda Grant (Highlands and Islands) (Lab)
Emma Harper (South Scotland) (SNP)
Terry O'Kelly (Scottish Government)
William Sinclair
Professor Sir Gregor Smith (Scottish Government)
Colin Smyth (South Scotland) (Lab)
Maree Todd (Minister for Public Health, Women's Health and Sport)
Rebecca Wymer

CLERK TO THE COMMITTEE

Lynn Tullis

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 8 June 2022

[The Convener opened the meeting at 09:31]

Continued Petitions

Surgical Mesh and Fixation Devices (PE1865)

The Convener (Jackson Carlaw): Good morning. I welcome everyone to the 10th meeting in 2022 of the Citizen Participation and Public Petitions Committee.

We have a number of interesting evidence sessions this morning, the first of which is on continued petition PE1865. It seems that the committee has been preoccupied with that petition for coming up to a decade. It almost feels like 10 meetings and 10 years of this important issue.

The petition, which was lodged by Roseanna Clarkin and Lauren McDougall, 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 that use polyester, polypropylene or titanium is carried out, and while guidelines for the surgical use of mesh are established.

We have previously met the Minister for Public Health, Women's Health and Sport, Maree Todd. I welcome her again and thank her for attending. We are also delighted to have with us the chief medical officer, Professor Sir Gregor Smith. Terry O'Kelly is back with us, but online. I say good morning to him as well.

We previously considered the petition in an online meeting in which we took evidence from Dr Fernando Spencer Netto of Shouldice hospital in Canada. A number of questions arise from all the evidence that we have heard.

As we have gone along, we have had a lot of evidence that many people have benefited from mesh as a treatment for hernias. However, I will start with a couple of back questions, as this might be the last time that we cover mesh in quite such wide detail.

In relation to the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022, there have been some reports that we are still trying to negotiate—

The Minister for Public Health, Women's Health and Sport (Maree Todd): Convener, I have an opening statement, if you would like to hear it.

The Convener: I very much would. Thank you.

Maree Todd: It might set the context and answer some of the questions that you are keen to put to me.

The Convener: Excellent. Thank you very much.

Maree Todd: Thank you for inviting me and giving me the opportunity to return to this important topic.

I am pleased to say that we have made significant progress in our action on transvaginal mesh. We have established a national service for the management of mesh complications, and women have options with regard to their treatment, which can be undertaken in Scotland or elsewhere in the United Kingdom and with an independent provider if desired.

Most recently, the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022 was introduced, and the associated scheme opened on 6 June—just this Monday. The contract with Spire Healthcare has been concluded, and arrangements are being made for the first patients to attend for surgery. Meanwhile, discussions with Dr Veronikis are progressing.

I am mindful of the concerns that have been raised by campaigners over the years about the use of mesh in other sites, such as in hernia repair. That is what I will focus on. I am sorry to hear of any instance of complications and the adverse effect that they have had on individual patients and their wider families.

As members know, the Scottish Health Technologies Group has looked into the use of mesh in hernia repair and published two reports on the subject, one of which was published shortly after my previous committee appearance. Those reports, which are based on current published evidence, support the continued use of mesh in a variety of abdominal wall and groin herniae. That is, of course, subject to all the tenets of realistic medicine: ensuring shared decision making and informed consent with knowledge of the benefits, risks, alternative measures and the possibility of doing nothing.

We have discussed the findings of those reports with professional bodies, including the royal colleges and the British Hernia Society, and we will continue to work with them on that important issue. Work is also going on to establish the medical device information system—MDIS—which will provide important surveillance and outcome information.

Since I last appeared before the committee, the chief medical officer has—in December 2021—written to board chief executives and medical directors to draw their attention to the SHTG report. In the letter, the CMO asked health boards to consider the availability of non-mesh surgery, how best to address skill gaps, if they exist, and the development of broader clinical networks for the management of complex cases. The actions resulting from that will be discussed at a meeting of the Scottish Association of Medical Directors in August.

I know that the committee has received a report from Shouldice hospital in Canada. Although the results reported are notable, it is important to remember that Shouldice hospital is a specialist centre dedicated to natural tissue repair and that it operates in a healthcare system that is very different from the national health service in Scotland. For that reason, the report should not be considered in isolation; rather, it needs to be considered in the context of the wider available evidence.

As I have said before in front of the committee, there are, of course, still some gynaecology procedures for which the use of mesh has not been halted. In those circumstances, there is a high vigilance protocol in place across NHS Scotland. It is important to remember that some of those procedures are complex and long established with few, if any, viable alternatives. Therefore, to suspend the use of mesh would leave a cohort of people with limited or no treatment options.

I reassure committee members, as well as the campaigners who lodged the petition, that the Government is absolutely committed to ensuring that everyone with mesh complications gets the care and treatment that they need.

I look forward to answering any questions that members have on the matter.

The Convener: Thank you, minister. That is very helpful.

The evidence that we have heard on the second area of mesh concern supports the view that there are nuances that mean that the way in which we might progress in future is different from the prognosis in relation to the transvaginal mesh campaign.

You mentioned the continuing conversations with Dr Veronikis. “Negotiations continue” has been the situation for as long as I can recall—in fact, I might even have been a list MSP when we first heard that said. I recognise that there is a commercial interest in the Missouri facility that Dr Veronikis operates, and I know that, at times, the conversations have been strained. However, inherent in the 2022 act is a belief that the facility would be one of the identified options and that something would be concluded with it. Therefore, naturally enough, expectations are raised that something will be forthcoming that can assist women in the near future. Some people will have thought that it would be even sooner than now. Is it difficult to say where we are in those negotiations and how they are proceeding?

Maree Todd: No. I have to commend NHS National Services Scotland, which is pursuing the conclusion of that contract. It is very close to finalising that. I know that it is frustrating but, if we stop and reflect on the differences in the medical and legal systems in the two countries, we see that it is understandable that there has been a deal of to-ing and fro-ing. However, I am confident that everything is being done to conclude that contract, and I hope to be able to update Parliament on it soon.

The Convener: Thank you, minister. I have one further follow-up question.

We have discussed the nuances in relation to hernia mesh. At times, it seems that the issue has been the need for a proper explanation of options to patients. That is one of the aspects that Professor Alison Britton is looking at in her casework review with regard to the way in which women progressing through the transvaginal hernia mesh issue have been treated. Her inquiry has been going on for some time; a month or so ago, I asked a question about it in Parliament. I wonder whether you are able to offer any update on where we are with the review, as some of what Professor Britton may report might be of interest with regard to the need for patients to be properly notified and made aware of the options that are available to them.

Maree Todd: Absolutely. The review is now well under way. It was established following the serious concerns that were raised by some of the women about whether their case records accurately reflected the treatment that they had received. It is expected to conclude later this year.

In Scotland, we have a system that is based on realistic medicine—I am sure that Professor Sir Gregor Smith will want to come in on this. We want all patients, at all times, to be well informed and to be part of the decision-making process. We use the acronym BRAN to remind everybody who is involved to consider the benefits, risks and alternatives, whether the intervention is needed now, and what will happen if we do nothing. That type of conversation is vitally important when people are considering surgery.

There is no risk-free option when someone has a hernia, and it is important that people are well able to ask questions about, and understand, the proposed treatment—not just the risks in general, but how those risks apply to them—in order to make a fully informed decision on how they want to proceed.

I will let Gregor Smith say more on that.

Professor Sir Gregor Smith (Scottish Government): Shared decision making is at the heart of the relationship between people who receive care and those who provide it. With regard to realistic medicine, when we began to have a conversation with the profession in late 2015, we saw that there was a need to promote a better approach to shared decision making. Personalised care has been right at the heart of realistic medicine, as we try to create a much more equal relationship between patients and providers of care.

Since that point in time, the shared decision-making approach has—I would say—been whole-heartedly embraced by the profession. It has been supported very much through the work that we have participated in with the General Medical Council on refreshing the ethical and legal obligations around consent. In addition, it has also been greatly supported by our education establishments at the undergraduate and postgraduate levels, through NHS Education for Scotland, with several modules that promote the essence of shared decision making.

The four questions that the minister outlined, which are known by the acronym BRAN—the benefits, risks and alternatives, and what would happen if we did nothing—are now at the heart of consultations. We have them as part of the NHS Near Me electronic platform, which has been used extensively over the past two years and has now increased its presence across the country. They are also part of the letters that we send to out-patients. In those letters, we encourage patients to engage with the clinical team and to use the BRAN questions to ensure that they explore those concepts, so that, when they arrive at a decision, it is well informed and underpinned by consent that can be said to be informed. We know that, if that conversation has happened fully, it is associated with much lower levels of treatment regret afterwards.

The Convener: I think that the evolution of that exchange and how shared decision making has materially progressed are great. Such a process was historically meant to be in place, but we discovered, in exploring the transvaginal mesh issue, that it was not really in place. If that change has happened, it is a very positive development.

I should say, Mr O'Kelly, that we have a very good video feed for you, so if at any time you feel that you would like to say something, you can just raise a hand and I will know immediately that you are trying to come in. You should not feel that you have to do anything more—I can see you well.

09:45

Minister, on the last occasion we met, you said that it would be very difficult to quantify the extent to which there was a valid underpinning for the petitioners' concerns, because there was no basis for evidence gathering that would allow for a material judgment to be made about the extent to which any experience was real. Has any thought been given to undertaking some sort of limited sampling or anything like that, just to get an understanding of how many people may be experiencing genuine post-hernia mesh complications?

Maree Todd: I am not sure that I entirely understand your question, convener. Do you mean a sampling of records or of data? There is a recognition that, where medical devices in particular are used, they need to be more traceable. More clarity is needed on which devices were used where, and we need a system of retrieval in place. We are working closely with the United Kingdom Government on that aspect, so that, in future—I guess this answers your question, as we found ourselves in a situation in which it was quite difficult for us to tell precisely what had happened—that data should be gathered much more routinely. Where there are issues with a product, it should be perfectly straightforward to find out where that product has been used, and there should be a strong audit trail in a patient's notes.

Alexander Stewart (Mid Scotland and Fife) (Con): Minister, you talked about the risks and the benefits, but, in all this, the word "complications" seems to be the problem. Many individuals have given us their testimony that they took the information that they received in good faith and went through the process but then, three, four or five years on, their situation became so difficult that they ended up with a real problem. You talked about consent in the process, but communication is an issue. I believe that anyone who goes in and gets medical support and advice will take it on board, but they may not realise what complications could occur perhaps three, four or five years later, and the damage that could be done.

We have seen the same thing with the hernia situation. People believed, in good faith, that having the mesh put in was the right thing to do because that is what they were advised to do at the time, but it ended up not being the right thing, and that has put them in a really difficult and dangerous situation.

It would be good to get clarity as to how that aspect is communicated, in order to ensure that individuals make the right choices and are not steamrollered by a doctor or clinician who says, "We believe that this is the best treatment for you." People take such advice in good faith, but, years later, as I said, they may find that that treatment should not have happened.

Maree Todd: I see that Mr O'Kelly is raising his hand—I am sure that he is very keen to contribute, as a practising surgeon who has to go through such issues with patients time and time again, day in and day out.

You are absolutely on the button, Mr Stewart—it is really important that these decisions are shared, and that is what we are talking about with regard to realistic medicine. We are moving away from what has happened in the past, when we had a paternalistic style of medicine. Back then, the doctor was all-powerful and told the patient what to do, and their advice was almost always taken as law. We now recognise that health is much better when it is delivered in a shared way. People are much more likely to attain good health if the decision making is shared.

The individual has to be party to a decision, and they must be able to discuss it with their clinician. As I said, that discussion should cover not just the general risks, but how those risks apply to that person as an individual. It should be a very individual discussion, and a patient should feel that, instead of having to access the internet in order to find and assess the data themselves, they can, as they make their decision, talk to their own health professional and have the risks explained as those risks apply to them specifically.

Patients are often in a very difficult situation in which there is no risk-free option. If someone has a hernia, continuing to live with it is not a comfortable situation for them to be in, but the options for treating it are never going to be risk free. As you said, an honest, transparent and well-documented discussion about those risks is a very important part of the process.

Secondly, you raised the point that there is sometimes a sense that people are not listened to. As a politician, I—and we all, as politicians—probably hear about that more than it actually happens, through a select few, or even many, stories. We hear from people who have been to see their health professional and have felt that their concerns have been dismissed or their health problems minimised. Again, we are working hard to improve that situation so that people, when they present to a healthcare professional—often, five years on, it will not be the same surgeon who operated on them—will receive a response that is more empathetic and understanding. We want to ensure that they are suitably directed to people who might be able to help them to disentangle whether what they are experiencing is related to the surgery that they have had.

I am sure that Mr O'Kelly will want to come in at this point.

The Convener: Yes—I think that Mr O'Kelly would like to contribute.

Good morning, Mr O'Kelly—over to you.

Terry O'Kelly (Scottish Government): Good morning to you, convener, and to the committee. I may well have raised my hand too early. It involves a very good explanation of—[*Inaudible*.]

The issue of complications is difficult. In explaining complications, we do not want to flood patients with data and cause anguish or a feeling that something dreadful is inevitably going to happen, given all the things that can happen. Within that, we need to try to allay their fears. Although the risks are relatively small in that they may affect less than 5 per cent or 2 per cent of people, for the person whom the complication affects it is not a negative concept. In that case, there is not a risk of less than 1 per cent—it is a 100 per cent risk, because it has happened to them. There is a notion of the importance of trying to ensure that patients understand the nature of the risk to which they are exposing themselves.

We know, from the work that has gone on around realistic medicine, that health literacy in Scotland is by no means ideal. There is a need, therefore, for clinicians to spend time with patients to ensure not only that they have given them the information, but that it has been assimilated and truly understood. In that respect, it is always a good idea to check and to ask patients to attend with a supporter or advocate if required, particularly when one is engaging in a more invasive and perhaps more risky procedure. That is very important—it is probably the crucial point.

Another important point to consider takes me back to the comments from Donald Rumsfeld, which members may remember. There are the knowns—we know the complications and we have looked at them—and there are the known unknowns: we cannot tell people about what is going to happen in 10 years, because the products have not been available for that period of time and we do not know what the outcome is going to be, so there is a risk there.

However, as Donald Rumsfeld said, there are also the unknown unknowns, and those are the ones that always catch us out. I am not suggesting at all that my colleagues have, in the past, always dressed themselves in glory, but we now need to recognise that we have to be absolutely honest with patients. We need to say that we do not know what is going to happen in 10 years' time, because a particular device, product or drug has not been available for that length of time, so it is impossible for us to know. We have to tell the patient that, nevertheless, we recognise that, at that moment, given our experience of the timeframes, something will be of benefit to them. We can say to them, “These are the reasons and the risks that we know of, these are the alternatives, and this is what might happen if we do nothing.”

There is quite a lot there—for the patient who is sitting in a doctor’s surgery, that is quite a lot to take on board. However, as Gregor Smith said, an important aspect is not only the questions, but flattening the hierarchy. We need to have the right attitude and give the patient the right environment, which is one in which they feel able to speak up and ask questions.

Alexander Stewart: Following on from the comments from both the minister and Mr O’Kelly, do we have some understanding of mesh itself? Different types of mesh may well undergo different processes. How have we been investigating and taking steps to analyse some of the mesh products themselves, to look at what defects they might have?

Has the Government, or have clinicians themselves, had a look at any of the history to find out whether there are defects that occur with specific types of mesh products, which might be more susceptible or more problematic for individuals? If we are aware that certain products might be more susceptible than others, that might reassure people in the future that the mesh that is being put in will be better, because it is not of a type that has a track record of causing issues in the past.

Minister, perhaps you can answer first.

Maree Todd: I will let Mr O’Kelly answer the bulk of that question. He can certainly give you a picture of what clinicians are doing to understand those issues. As with medicines, it is possible to do randomised controlled trials with these medical devices in order to learn more about them. It is also possible, as the unit in Canada has done, to collect anecdotal and observational evidence. That happens on an on-going basis in this area of medicine as in any other.

I go back to your concern about how we find out about different types of mesh and which types may have defects. The Cumberlege report focused on the regulation of medical devices, and it found the UK environment wanting in that regard. As a Government, we are absolutely committed to taking forward the recommendations that were made by Baroness Cumberlege and her team, and we have made significant progress on them since the report was published, last year.

Alexander Stewart: Mr O’Kelly, do you want to answer some of that question?

Terry O’Kelly: The base material, polypropylene, has been used in surgery for 80 years—I think that it was introduced at the time of the second world war, or perhaps just afterwards. It has been found to be very safe and effective, and it is well tolerated by patients. In vascular surgery, in particular, it is the product of choice. We have learned over time that there have been no major safety issues raised with its use as a suture material.

Mesh itself has evolved over time. The Medicines and Healthcare products Regulatory Agency has looked at hernia mesh. I know that there have been issues with MHRA representatives sitting in front of this committee, but the mesh has been scrutinised very carefully, as the committee will appreciate, both in this country and by similar organisations abroad, such as the Food and Drug Administration in the States. It is recognised that mesh is an implanted product, and it is important that patients understand that, but there does not seem to be an intrinsic issue with the product itself. There are some reports in the press and the published literature of patients having some reactions, but those are very rare.

Given the number of meshes that are used each year and the period of time for which they have been used, going back to the late 1980s, we see very few patients—or, rather, a very low percentage of patients—coming back. As these procedures are common, even rates of less than 1 per cent will mean that a number of patients will appear to have problems related to their surgery. Yes, they have a foreign body—-the mesh—inside them, but it is not necessarily the mesh itself that will be the problem. Modern mesh construction is probably as good as we are going to get it; the base material allows for the ingrowth of fibrous material and scar tissue, which causes a fibrous scar and strengthens repair. Problems can occur over time with shrinkage or contraction of the fibrous scar, which can in turn lead to other problems. It is important that the mesh is inserted in a tension-free fashion so that there is a lesser possibility that it will cause injury. It is also important that, if it is used in a position where the bowel might come into contact with it, steps are taken to avoid that as much as possible.

Alexander Stewart: We have heard that, in some situations, individuals had one mesh for a hernia put in but it had to be removed; they then had a second one put in and, since the second attempt, things have been better. They have not experienced the same complications since the first mesh was removed and the second one was implanted. Is there evidence, in your experience or that of others, of that happening when one mesh is removed and then replaced with a new one? Is it common or just an ad hoc situation that occurs with certain individuals?

10:00

Terry O'Kelly: I suspect that that is an ad hoc situation; I do not know the individual circumstances relating to the case that you cite. If, let us say, a mesh was put in and it was too tight—which can happen, as it is a technical exercise—the answer might be to remove that mesh and put in a tension-free mesh. It is possible that, if the mesh is inserted and held in place by sutures, a suture could entrap a nerve—it is very likely that one would not be able to see that at the time. Physically removing the foreign body from the vicinity of the nerve might alleviate the patient's symptoms, but it might be necessary to remove the mesh to do that.

In the case that you described, it may be that the second mesh that was inserted was self-adhering or was inserted and held in place with tissue glue. There may be other such reasons. Why, in a car, does something not work, but, when you get it changed, it then works? It will be difficult to know precisely what the issue was in every circumstance, but such a situation is not common.

The Convener: Minister, to go back to the Cumberlege report, I note that this committee was alert to the shortcomings surrounding the MRHA regimen, and I think that all parties in this Parliament endorsed the report's recommendations. Did I understand you to say that you believe that the discussions that are taking place in relation to the report are constructive and are progressing to a positive outcome?

Maree Todd: We in the Scottish Government are certainly working with the report and taking positive steps. There is still work to be done to ensure that patients' voices are heard and listened to—that is why we proposed a patient safety commissioner in our programme for government; it was also a manifesto commitment. We consulted on that recently. The consultation has now closed, and we recently published a report that provided an analysis of the results. We are going to take that into account as we continue to work with patients and experts to develop the commissioner role. We are keen to do that in Scotland, and we are keen to deliver what patients are asking for on that front.

With regard to UK-wide discussions with the MHRA, there has been slow progress—as has often been the case over the past couple of years—which is understandable, given the situation that we are in. Nevertheless, we are pretty keen to pick that up as a priority and to make UK-wide progress on these issues.

The Convener: MHRA regulation is reserved, but I think that there was a very strong feeling across all parties in this Parliament that, wherever support could be given to efforts that the Scottish Government was making to progress issues around the regulation of these devices, it would be forthcoming. I am sure that all parties are still willing and able to offer whatever support the Government feels that it might need if it is struggling to make the progress that we all want to see.

Maree Todd: I will bear that in mind, convener, and I will take up your offer if necessary.

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for their contributions so far, which have been very interesting. I have some questions around mesh removal procedures and protocols. We have had a number of written submissions from members of the public—patients—who have experienced adverse outcomes and complications. Martin O'Neill commented that his life is improving now that he has had the mesh removed. He said:

> "I'm still mesh afflicted due to the device being left so long in my body that pain and damage is permanent. BUT I have hope. It's out! There is at least a possibility of me doing something with life rather than taking pills that don't allow basic functioning, coupled with pain that still doesn't stop sleepless nights and an overwhelming sense of wanting to die than live in that horror of pain that mesh causes."

In other cases, individuals were told by surgeons that the mesh was too enmeshed in their body to be removed without causing serious consequences such as the loss of their rectum or testicles. Individuals have resorted to private surgery to get the mesh removed, with some even travelling abroad to do so.

In another written submission, Carole Coutts described difficulties in getting her mesh removed on the NHS in Scotland. She said:

> "My GP ... discussed my case with other GPs. She said none of them knew much about mesh. She tried referring me to the Scottish Complex Mesh Surgical Service"—

which is a service for women who are considering specialist surgical mesh removal—

> "and I also emailed them"

as a patient.

> "They refused my referral as they only accept gynaecological referrals."

In 2018, your predecessor as chief medical officer wrote to the health board medical doctors in Scotland on the use of mesh in sites other than the vagina. In that letter, she said:

> "The management of patients with mesh-related complications must follow agreed pathways which should involve a multi-disciplinary team of clinicians with appropriate skills and experience."

In the light of all that, can you talk us through the "agreed pathways" for non-gynaecological "mesh-related complications" that your predecessor referred to in 2018? Do you believe that those pathways are operating as they should?

Professor Sir Gregor Smith: When the stories and the terrible symptoms that some are suffering as a consequence of some types of surgery are recounted, as you have recounted them, it is always very difficult, and you cannot help but be moved by their experience.

Terry O'Kelly will be able to say a little bit about the detail of some of the pathways, but you are absolutely right to suggest that we have created an expectation in boards that they should be developing pathways that not only offer alternatives to mesh surgery for patients who would prefer to explore other options but allow people who might have complications necessitating further revision surgery to explore that in a place of a specialist nature.

Each health board has what are called exceptional referral protocols. What happens just now—and, indeed, what has happened for many years—is that, where particular specialist services that require a high degree of competency are not available in a local board area, local staff are able through the exceptional referral protocol to refer outside that board to places that can provide them, either in another area in Scotland or even beyond Scottish borders. That has traditionally been one of the ways of trying to deal with this issue. Many surgeons in Scotland have a high level of competency in addressing some of the issues that you have described, particularly at the more complex end of mesh removal, but I would like to see greater consistency across Scotland in developing more localised services to provide that type of care. Indeed, that is why my predecessor and I have written to health boards.

As I have said, Mr O'Kelly might be able to say a little bit more about progress in that respect. We have heard that, later this year, there will be more detailed discussions with the Scottish Association of NHS Medical Directors on the progress that has been made following the letter that was sent to them towards the end of 2021—in December, I think.

Terry O'Kelly: I just want to make a couple of points. First, it is not only for the clinician to recognise the need for a second opinion—it is actually the patient's right. If they are not receiving information or opinions that they are satisfied with, they should be able to ask to see somebody for a second opinion themselves. As a practising surgeon, I think that there is a great deal of security in asking somebody else to review a case; it helps not only me but the patient, and it is something that we need to support.

Pathways are germane to each circumstance. Because the hernias and complications that have occurred are not that common, the mesh procedures will be bespoke. It is important that care is individualised so that it is very much centred on the particular patient.

It is also important that clinicians form networks. That is certainly the case in my own health board area. Networks need support—especially administratively. It is essential that any conversations that occur are recorded and discussed with patients and that the outcomes of all deliberations are entered into the electronic patient record that will go forward in perpetuity. A bit of work still needs to be done to ensure that such a process is embedded into the work of every health board in Scotland.

With regard to private healthcare, it is a real shame that there is still a perception that, if I pay for something, I will get it done better. State services are often provided by the same people. We need to be able to provide exemplary care within our national health service for all patients, and I think that we are all committed to doing that.

The Convener: Mr Sweeney, do you want to come in? Mr O'Kelly has slightly anticipated the question that we might have asked.

Paul Sweeney: Thank you for that contribution. The point about there being such a small number of cases in the national scale of things requires us to reflect on how best to address it. The pathways perhaps need consideration of how we might establish learning curves so that defects can be addressed by a network of people who are robustly capable of doing it rather than it being a lottery.

Could the NHS consider establishing a protocol for investigating such cases so that it could understand, for example, why someone has gone for a private surgical solution, what the outcome was and what could have happened differently? Is there a way of addressing the concerns that are expressed in the patients' submissions that we have received, such as by conducting a deeper analysis of what has gone wrong in their journey to identify whether there are opportunities for improvement?

Professor Sir Gregor Smith: Audit is an incredibly important part of learning in medicine or surgery. The ability to reflect on practice and to obtain evidence of how practice has affected people and the outcomes that they have experienced—whether those are positive or, as has happened on the occasions that we are considering, negative—relies on the availability of good data. Some of the issues that we have heard about today—such as the scan for safety approaches, where we are able to have much greater information about the types of devices or materials that are used in different types of surgery—help us to better understand, over time, and through that data, the outcomes that people are experiencing.

Where care transcends the division between the NHS and private facilities it sometimes becomes a little more difficult to obtain such data and to be able to use it in a way that allows proper understanding. However, the point that you make is still critical. We rely on using such data to be able to understand the outcomes that are associated with it. The new protocols that will come into play will allow us to do that an awful lot better in the future.

Paul Sweeney: Okay. Thank you very much. I want to follow up on an instance that was mentioned earlier. It is in one of the submissions from a patient. The national complex mesh removal surgical service in Scotland accepts only gynaecological referrals. Why cannot patients who wish to have other types of surgical mesh removed utilise that service? Why is it restricted in that way?

Professor Sir Gregor Smith: Mr O'Kelly might want to add more to what I am about to say. The service has been set up with surgeons whose focus of training has been the urogynaecological use of mesh. Because that is so specialised and highly specific it would not be appropriate for them to look at the use of mesh in other sites—it is very site specific.

Terry O'Kelly: The centre was set up specifically for the purpose of managing complications from the use of urogynaecological mesh. There is a multidisciplinary team that consists of urogynaecologists, a urologist and colorectal surgeons.

10:15

If it is not yet doing so, the group will, over time, take on the burden of dealing with rectopexy mesh, which is very specialised and crosses the boundary between urogynaecology and colorectal surgery, at the interface between the last part of the large bowel and gynaecological structures such as the vagina. That is certainly the way in which such management procedures will proceed in England.

The centre has not been constructed to deal with other forms of mesh surgery. The clinicians are certainly available to be consulted, but they are not taking referrals for non-pelvic gynaecological mesh surgery, as I have described. That is appropriate for that particular centre.

The Convener: I want to touch on the final area to which you alluded in your opening statement, minister, which is the evidence that we received from and the subsequent oral testimony of Dr Spencer Netto from Shouldice hospital in Canada. David Torrance will lead our questions on that.

David Torrance (Kirkcaldy) (SNP): Good morning. In his evidence, Dr Spencer Netto highlighted how successful Shouldice hospital had been with natural tissue repairs, which have resulted in a low recurrence of hernias. How do pre-operative preparation and post-operative care for hernia repair surgery in Scotland differ from the steps undertaken in that hospital?

Maree Todd: It is probably worth going to Mr O'Kelly on that question. As I understand it, Shouldice has a very specialised unit and patients there are somewhat pre-selected. It is therefore not a population that would be reflective of the general population who seek surgery in Scotland. That aside, its results are impressive and we are very interested in the work that is being done over in Canada. However, as I understand it, if we were to compare the population who use the unit in Canada with that seeking hernia repair in Scotland, there might be significant differences, for example in terms of obesity or ambulation.

I will hand over to Mr O'Kelly, who will be able to give you a better explanation.

Terry O'Kelly: The results and outcomes at Shouldice are very impressive. However, it has said that the relative contraindications and risks with regard to successful surgery are smoking; obesity; diabetes and other pre-existing conditions; the quality of the underlying structures; and the size of the defect. We do not have a great deal of control over some of the aspects that Mr Torrance mentioned in his question, but the build-up to surgery—or prehabilitation, which I think he might be alluding to—could have a significant role in getting patients fitter for surgery by getting them to stop smoking, increase their exercise levels if they can, lose weight, reduce alcohol consumption and so on. All those things are beneficial for patients and we aim to promote them. If surgery is then conducted in a "get it right first time" manner, patients will be in good shape and will benefit not only from the surgery itself but from post-operative mobilisation and return to normal activities at an earlier stage. There are lessons to be learned from the experience of Shouldice and measures that we can apply to improve the lot of patients who are having surgery in this country.

David Torrance: There are very strict criteria at Shouldice hospital, especially on patient weight loss. In fact, Dr Spencer Netto told the committee that some of its patients have to lose between 50 and 100 pounds before the hospital will even see them before going ahead with a natural repair. Could such criteria be brought into play here? Would it be acceptable to do so?

Terry O’Kelly: This is very difficult—are we going to deny patients access to surgery if we believe that they are overweight? I suspect that that would be a subject for parliamentary debate. The other issue is around what problem the hernia is causing. Is it a strangulated hernia? Do we need to engage in life-saving surgery? Is it preventing them from working? We also know that, when patients are a certain size, losing weight becomes almost impossible without some other medical intervention, particularly if they are diabetic.

These are theoretical issues that are profound and worthy of consideration, but you may also have an opinion on that, which might be better than mine.

Professor Sir Gregor Smith: You have raised a very interesting ethical dilemma and it is one that many clinicians would feel uncomfortable with. I feel uncomfortable even talking about it just now. The restriction of access to treatment because of personal criteria is something that many clinicians feel deeply uncomfortable with, particularly when a health need lies at the bottom of it.

However, if we turn this concept around a little bit and look at how we can work with patients on education in relation to the concept of risk, we can then begin to explore an area where there is mutual benefit. It is about trying to encapsulate the risk of certain personal characteristics for people before they enter all sorts of treatment where risk is increased because of those personal characteristics.

The term “prehabilitation” is becoming more familiar to us all: using education, we can work with patients so that they can prepare themselves for surgery in a way that helps to reduce that risk. That is part of the conversation that we spoke about earlier when we spoke about the benefits, risks and alternatives and what happens if we do nothing.

We know that there are many approaches that we can take with patients to discuss that and to work with them. The two most obvious things to talk about are being overweight and being a smoker. Weight loss before surgery is a good thing if you are overweight. It does not matter what type of surgery you are undergoing—if you are more obese, greater risks are associated with surgery and general anaesthesia as a consequence of that. We know that, with abdominal surgeries specifically, such as hernia repairs, being more obese is associated with slightly poorer outcomes. It is a similar case with smoking.

Knowing those characteristics, you can then describe risk in different terms to those individuals. You can begin to calibrate risk for them. They will have their own level of tolerance to risk and they can then make their own judgment and say, “If I go forward and have this treatment that I really want and need to have, these are the things that I can do and can take personal responsibility for to contribute to better outcomes.” However, I think that many people would feel very uncomfortable about methods of restricting access to surgery, particularly when people are experiencing a lot of discomfort.

David Torrance: Are the skills in natural tissue hernia repair techniques being lost in Scotland in favour of teaching surgeons mesh repairs? Could more surgeons in Scotland be receiving training in natural tissue methods?

Maree Todd: Mr O’Kelly will want to come in on this but, as I understand it, there is real interest in improving the expertise within Scotland in natural tissue repair and they are looking at centres that use those techniques in Europe—just because of the ease and practicalities of links with Europe versus links with North America.

I will let Mr O’Kelly tell you a little bit more about that.

Terry O’Kelly: The Shouldice submission said that mesh surgical training is seen as being easier to teach and that is why that aspect of training was germane to training in Scotland. That is a bit disingenuous. There has been an emphasis on mesh training and mesh surgery because of its proven efficacy as revealed in the Scottish Health Technologies Group report.

That said, we need to offer patients choice—that is very important—and there will be some for whom mesh is not appropriate. With each health board, 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.

I cannot tell you how many surgeons we would need to train, but I think that it would be more than one. One of the discussions that we will have when we meet the Scottish Association of Medical Directors will be about the provision of training, and access to training, for colleagues who wish to do it. In my health board, one of my colleagues is keen to take that forward. He has started to make contacts, and he will probably travel with one of the surgeons from NHS Lothian. However, it will not be sufficient for one person in my board to have the necessary training; we need at least two people. The situation will depend on demand.

It is important that individual surgeons will not be performing one procedure per year. There will need to be a sufficient volume for the process to be effective and efficient. Colleagues will need to buddy up—certainly at the start—to make sure that the numbers are correct and that they refresh their skills through practice. One of the successes of Shouldice is that the surgeons there perform 600 or 700 procedures per year. That is 15 to 20 procedures per week, taking into account leave and one thing and another. Doing the same thing every day enables you to become very proficient. That is something that we also need to—[*Inaudible*.]

David Torrance: The example of Shouldice hospital demonstrates the success of a specialised hernia repair unit. Would it be possible to have such a centre in Scotland, taking into account the criteria that would need to be met in order to have such a success rate?

Maree Todd: I understand why you ask that question. I know from debates that have taken place in my constituency that there is a real tension between accessing healthcare as close to home as possible and being able to access national expertise when that is required. I get many more expressions of concern from constituents who have to travel within the constituency to access care than I do from people who want to travel to benefit from specialist expertise.

In NHS Scotland, the way we tend to work is that it should be possible for people to access routine care as close to home as possible. There are lots of good reasons for that. From the point of view of not just the medical model of health but the biopsychosocial model of health, with routine procedures it is important that people are treated close to home, have support around them and are able to recover well within their family and their community.

However, with particularly challenging or complex procedures, we need to build in expertise. We will have to work in a networked way across Scotland to deliver that. We have said that there are challenges with volume. If people are to train in natural tissue repair, they will have to see enough people to maintain that training. We will certainly consider what is the best model for Scotland but, at the moment, I am not minded to reconstruct the unit in Canada here in Scotland.

I will hand over to Mr O'Kelly, who is keen to come in.

The Convener: We are quite short of time, and we still have a couple of questions to come.

Terry O'Kelly: With the creation of the national network of treatment and diagnostic centres, there will be some migration of patients in their locale to those facilities. That will provide an opportunity to concentrate colleagues who have particular expertise and interest in such fields. It may be that, as their careers develop, they will choose to have a more scheduled workload, instead of providing unscheduled care in the way they do at the moment. If they did more hernia lists, that would increase the numbers and would result in a move towards more of a Shouldice-type model. However, for most of our colleagues, I am not sure that doing one thing all the time is a very attractive way of spending their professional life.

The Convener: Thank you. We are very short of time now, although we are grateful for the time that you have given us. I invite Alexander Stewart and Paul Sweeney to ask their supplementary questions, and then the minister can round up the discussion with any final comments in response.

10:30

Alexander Stewart: Minister, you touched on the need to try to create facilities to support individuals. Canada gives us a good example of what can be achieved. I appreciate that you want to ensure that medical support is given to individuals at the closest point, but some degree of specialisation may still be required, perhaps by creating a unit or expertise in the field for clinicians. That should be considered, as it could help to iron out some of the difficulties that we have seen. It would be good to get your views on that.

Paul Sweeney: I want to build on the point about the Scottish complex mesh surgical service being the opportunity to evolve the model. Given that there is such a small volume of defects in the national population base, combined with Scotland's relatively small geography and population base, the idea of a concentration of skills to deal with and rectify complex defects could provide a way to build the service to include some of the examples that Dr Spencer Netto has called for as key takeaways. Building that national centre would not be to say that everyone has to get a surgical mesh repair for a hernia in a national centre in Glasgow—for example, if they live in Lerwick. However, if there are complex or high-risk cases, that might be the most appropriate solution. Do you agree that we should look at that?

Maree Todd: Certainly. The Shouldice hospital deals with more routine operations and at quite high volume. In order to give people options in highly skilled and trained surgeons who are using those techniques, that is something that we need to explore on a national basis, although we can also build up local expertise.

I agree that there needs to be a national multidisciplinary team to look at those particularly complex cases. Clinicians from all over the country need to be able to access that expertise. It is difficult to understand how challenging it can be to communicate across boundaries in the NHS. That is a theme that comes up time and again. We are very keen to bust those boundaries to ensure that clinicians can access the expertise that they require for their patients, wherever they live in the country.

We are also mindful of developing systems that mean that patients, wherever they live, can access the right level of expertise. People in Lerwick are probably more comfortable with travelling than people on the mainland because they travel all the time. Patient choice needs to be part of it. We need to make shared decisions with patients about what is the best option for them.

Professor Sir Gregor Smith: One of the concepts that were explored in the extant clinical strategy for the country is the tension between competence for any given procedure or approach to care, and the volume of patients likely to be seen. There is a recognition that sometimes we need to look at ways where, nationally, we can provide care for the low-volume procedures. All clinicians would sign up to that. However, there are different ways to achieve that.

Mr O'Kelly has spoken about the informal and formal networks that develop around care that can provide that highly specialised approach when it is required. That underpins much of our clinical strategy. Occasionally, there is a need to develop that further to create centres of excellence where there is a much more formalised structure and approach. The difficulty is gauging the best method to provide support to people when they need it.

Terry O'Kelly: That point is well made. An issue that Sir Gregor might want to take to the medical directors for discussion is how we can ensure that the best opinions and skills are applied when they are required, on all occasions. That means engagement between the board networks. The question is how we improve liaison and allow that cross-fertilisation of ideas.

The Convener: I do not know whether you saw any of our evidence session with the Shouldice hospital. I understand that there are questions of geography but, in principle, Dr Spencer Netto said that he would be very happy to facilitate any access to the expertise that they have developed with their clinicians to benefit Scotland's NHS, were that thought to be useful. They would be happy to explore that further if the Scottish Government wanted to pursue that.

I thank all three witnesses for giving evidence this morning.

10:35

Meeting suspended.

10:39

On resuming—

The Convener: I welcome everyone back. For confirmation, are members content to consider the evidence that we heard on the previous petition at a future meeting?

Members *indicated agreement.*

Rural Scotland (Healthcare Needs) (PE1845)

Rural Healthcare (Recruitment and Training) (PE1890)

Caithness County Council and Caithness NHS Board (Reinstatement) (PE1915)

Women's Health Services (Caithness and Sutherland) (PE1924)

The Convener: We now bring together, in one session, four petitions that the committee has been considering. PE1845, which was lodged by Gordon Baird, calls for an agency to advocate for the healthcare needs of rural Scotland. PE1890, which was lodged by Maria Aitken on behalf of Caithness health action team, is on finding solutions to recruitment and training challenges for rural healthcare in Scotland. PE1915, which was lodged by Billy Sinclair, is on reinstating Caithness community council and Caithness NHS board. PE1924, which was lodged by Rebecca Wymer, calls for the completion of an emergency in-depth review of women's health services in Caithness and Sutherland.

Maria Aitken and Rebecca Wymer are joining us as we consider those petitions—good morning to you both. We also have with us Gordon Baird and Billy Sinclair, who are online, I believe—these screens are very helpful if you have good eyesight but not so helpful from a distance. It is good to understand who you both are. I welcome you all.

We also have with us a number of interested colleagues from the Scottish Parliament. I welcome Rhoda Grant MSP, as I seem to do at every meeting—it is nice to have you with us again, Rhoda. I also welcome Emma Harper MSP and Colin Smyth MSP, who both have rural healthcare interests in their constituencies. We will return to our parliamentary colleagues when we have heard from our petitioners, as I know that they are keen to speak in favour of the petitions.

Committee members have a number of questions that they would like to explore, so we will move to the first of those if the panel is happy to do so. I should explain to those petitioners who are joining us virtually that, if you would like to come in at any point, you can put an R in the chat box, or, if you put up your hand, I will probably see that—I can now see you both on the screen in front of me—and I will be happy to bring you in.

For our petitioners in the room, if you can catch their eye, one of the clerks will ensure that I know that you are keen to intervene in response to one of the questions. I should say that there is absolutely no obligation on any of you to feel that you have to jump in and answer questions; you may be content to hear the evidence that is given and to understand how we will proceed.

We move to questions in relation to the petitions. I invite Fergus Ewing to lead off.

Fergus Ewing (Inverness and Nairn) (SNP): Good morning to all our witnesses. I am very grateful that you have, collectively, brought to Parliament the issues around health in rural Scotland, as they are very important.

I start by posing some questions to Mr Baird in respect of his petition, which urges the Scottish Government to create an agency to ensure that health boards offer fair and reasonable management of rural and remote healthcare issues.

Mr Baird, I am sure that you are familiar with the broad arrangements in Scotland, whereby there are 14 regional NHS boards and, since their establishment in 2014, 31 integration authorities. More recently, in 2020, the remote and rural general practice working group published its report on “Shaping the Future Together”. The Scottish Government accepted all the report’s recommendations, including the recommendation—perhaps the most relevant one—to commit to the development of a national centre for remote and rural healthcare in Scotland.

I mention that because it is important to give a backdrop. Following on from that, I have two questions for Mr Baird. I will put them both together.

First, how could the Scottish Government reform the way in which the NHS and social care are currently organised so as to better address the needs of remote and rural constituents and populations? Secondly, will the development of a national centre for remote and rural healthcare for Scotland help to address some of the issues that you raise in your petition?

10:45

Gordon Baird: The current structures are very effective in delivering healthcare in many aspects of clinical care. The problem concerns the inequities that occur in respect of access. In the past, that has been dealt with through an advocacy process, primarily through general practice.

In the 1980s, Richard Smith, the then editor of the *BMJ*, wrote an article with the headline “Dumfries and Galloway: where the NHS works well”. He stated:

> “Most of the doctors in the region know the senior administrators and can find their ear without difficulty; so much so that one doctor suggested that the advisory committees were redundant.”

In short, at that time, the ability to represent local issues was embedded in the system through mutual respect and an advocacy process.

In 1989, Richard Smith followed that up with another specific article in the *BMJ*, with the headline “To flourish or fade”. At that point, 10 years later, he was describing an institutional view of Wigtownshire as the wild west. By 1999, he was describing the Dumfries and Galloway health board as “straining but optimistic”. That series of articles highlights that there is a long-standing issue.

The current structures alone fail rural patients. As Paul Sweeney said to this committee,

> “the elephant in the room”

is

> “the role of NHS health boards”,

which

> “are meant to be the democratic voice of stakeholders in those regions”,

and are clearly

> “not performing that role effectively”.

He went on to say:

> “There needs to be consideration of how effective those health boards are at representing the interests of those areas.”—[*Official Report*, *Citizen Participation and Public Petitions Committee*, 8 September 2021; c 29.]

We need to alter the capacity of rural clinicians even to influence management thinking, much less create further change. Instead of mutual respect, we have to deal with antagonism and rancour. Even with the best evidence, we are gaslighted and stonewalled. All that is currently going on in the system, and the boards are not particularly accountable. That is true throughout Scotland—I think that you will find that it is the same in Caithness.

Our view is that independent advocacy agencies such as the Office of the National Rural Health Commissioner in Australia and the Children and Young People's Commissioner Scotland have proven to be invaluable. Such agencies have to be established as separate structures—they need to be completely independent. There are other, similar agencies but, broadly speaking, we need an advocacy agency role embedded in healthcare management, and it should be externally imposed.

On the establishment of a national centre for rural health, I cannot argue against that; it is a good thing. However, it strikes me that it would be likely to have a significant provider role, and that would create a barrier to its engaging in an advocacy process.

Secondly, a centre, generally speaking, always seems to be situated in Inverness and Aberdeen and serves people who are near those places. As a general practitioner with 40 years' experience, every time that I hear the word "centre", I rather cringe and think, "Here we go again." We need local engagement and advocacy from the bottom up, rather than a centre that becomes yet another silo, as was described in the Sturrock report.

A national centre will be very useful, and I cannot argue against it, but it will not provide the advocacy role that we are proposing. Furthermore, such an advocacy role would help the national centre to deal with the issues that it would face.

I am sorry that I have taken so long.

Fergus Ewing: Thank you for your answer—you have covered a lot of territory. I will pursue some of the points that you made. Your petition calls for an agency—presumably, that means one agency, if I have understood it correctly. How is one agency going to deliver the kind of advocacy that would be required from the bottom up?

As I understand it, you are suggesting the establishment of an agency not to deliver or procure service provision, but to advocate that services be provided more effectively to people who live in remote and rural areas, and to ensure that inequities in access are addressed and not ignored, with no stonewalling or gaslighting. If that is the case—I put this to you as a devil's advocate, I suppose—would it not be more efficacious, in respect of achieving what you wish to achieve, to have an advocate for the rural voice on each health board?

Would that be perhaps be a different way to proceed, rather than the establishment of one presumably centrally based agency, or wherever it is based? It would have to be based somewhere. Would that be an alternative model that would not change the way that health boards operate, because they would include an advocate among their number with a specific remit to make sure that remote and rural issues are not overlooked and are addressed? I put that to Gordon Baird and the other petitioners, because you are all covering interlocking aspects of the issue. Would that be a better model than having one agency that would inevitably operate on a high level?

The Convener: If any petitioners other than Gordon Baird want to comment on that, they should let me know.

Gordon Baird: I have considered that possibility, but various rural areas have the same issues. For example, we in Dumfries and Galloway have a lot of deprivation; we have the worst 1 per cent of deprivation in Scotland, the worst 1 per cent for cancer access in Scotland and probably at present the worst community maternity care provision in the UK. Caithness and other areas throughout Scotland have the same issues.

The problem has always existed in rural and remote areas, and I was chair of the Royal College of General Practitioners rural and remote practice subgroup. The problem with rural and remote practice is that it is disparate, and is rarely seen as a holistic thing. It is interesting that Professor Sir Chris Whitty, not having much to pass the time with in 2021, chose to consider health in coastal communities as NHS England's priority. It is a big health issue.

If you join up, there is strength in numbers, and the issue becomes a big problem that Government and boards cannot ignore. Secondly, you can develop shared solutions and create a better understanding of where the solutions lie. It is about sharing information and solutions and gathering information and data. For the past 30 years, I have provided data, in an advocacy role when I was working and when I retired, to try and persuade our health board that we do not belong in the east of Scotland—we are 40 miles west of Glasgow—but I have been profoundly unsuccessful. A specific advocacy taking a national view would help in that regard.

You spoke about having someone on the board. When I was concerned about some local issues I tried to contact the whistleblowing champion on our board, and their response was:

> "It isn't appropriate for me to meet with your group at this stage".

In our group, we have 100 years of experience in the NHS and public service between us. That response was not particularly the fault of the board member; it was the fault of the system. However, the whistleblowing champion was set up in response to the Sturrock report.

I would like there to be national oversight of the issue, and that would be much more easily achieved by a national committee.

Fergus Ewing: I did not quite understand why you did not find acceptable the suggestion, which you say that you had already considered anyway, that each board should have a member whose role would be thus. Why do you not want that? Although that might not be the whole solution, I would have thought that it might be part of it.

Gordon Baird: That sums it up. The Government decided that there should be a whistleblowing champion on each board following the Sturrock report. We are trying to provide advocacy for our patients, but the whistleblowing champion said:

> "It isn't appropriate for me to meet with your group".

That approach does not work.

Fergus Ewing: I do not think that you said you welcomed the national centre for remote and rural healthcare—or perhaps you did—but you said that it was a step in the right direction. Could that new body be set up in such a way that its remit could take up the issues that you have raised? We can raise that with the Scottish Government following this meeting, if you and your colleagues think that that would be a good idea. Would that be a step forward?

Gordon Baird: It would be a step forward, and a national centre for remote and rural healthcare is a good thing, but I do not know whether it would solve the issues that I have concerns about. For example, I did quite a lot of work with NHS Education for Scotland before I retired, and during visits or telephone conferences it was commonplace to be asked what the weather was like in Dumfries. Those people are embedded in rural healthcare through NES and they did not even know that not only is Dumfries far away; it is not even in the next county. I have concerns about a lack of focus if such a wide-ranging view is taken. I should say that I am talking specifically about clinical access.

Fergus Ewing: I am putting to you that that new body could be tasked specifically, in law, with the remit of addressing the access issues that you raised. It may not operate perfectly in practice, but if we clearly define the remit, duty and tasks that the new body should perform when setting it up then, surely, if we task it to address inequities of access for people who live in remote and rural Scotland, that would at least give the opportunity for things to improve.

Gordon Baird: We already have those bodies; they are called health boards. The problem is that they are not listening to rural and remote issues.

The Convener: David Torrance is keen to ask a supplementary question that relates to that. Some of our other witnesses might feel they can also comment on it.

David Torrance: What do you think are the recurrent issues that impact on recruitment of health and social care staff in rural areas?

Maria Aitken: We lodged this petition after a meeting with our local midwifery team at which we discussed its worries and disappointment about not being able to recruit midwives in the Caithness area and the impact of the shortened midwifery course that was being delivered at the time by the University of the Highlands and Islands. That course was centralised to Edinburgh and the Scottish Government withdrew the funding for it.

My petition has two aspects. The first aspect is the need for rural communities to be able to access local training for professional healthcare qualifications and to gain skills locally wherever possible. The second is the need for an agency or overseer to ensure that rural communities are not disadvantaged and are given equity in training for qualifications.

A lesson that we learned from the Covid pandemic is that distance should not be a barrier to access training because technology can effectively be used to ensure inclusion and accessibility for remote and rural communities. Our students should not have to travel hundreds of miles from their homes to access training. They should not have to take on large student loans to pay for accommodation to access a university. They should have a choice to suit their life circumstances. That is important for inclusion and the sustainability of our communities, as research suggests that where a student trains is often where they continue to stay.

Higher education providers should provide inclusive distance learning methods to support rural education and recruitment, using technology to enable remote learning. Wherever possible, they should provide the clinical skills locally. Those are the main issues.

We have worked with health boards for several years following the downgrading of our maternity model. We have found that health boards are not accessible to the public and we have experienced many of the issues that have been raised in previous reports. If someone was to be on the health board to represent our needs and to be a voice for rural and remote communities, it would need to be someone who is independent because they would need to be very strong in order to have the voice to support those communities. That is very difficult to do in a very big health board.

11:00

William Sinclair: At the moment, we know that NHS Highland does not work for the rural areas. We know what works because we had it before and Orkney has it. We would like Caithness to be reinstated using what we would call the Orkney model or what Caithness had before NHS Highland took over. I have a wee comment prepared. May I go through it, convener?

The Convener: Yes.

William Sinclair: Prior to 1995, Caithness was in control of its own council and national health service. There were shared, consultancy-led maternity services in the towns of Wick and Thurso and a first-class general surgeon in the Wick hospital. Other than for highly specialised treatment, there was very little requirement for patients to travel out of the county to access the national health service.

Caithness had its own council, so it had control over the budget and could make sure that the money was spent where it was needed. Over a period of six years, Caithness lost all control over its council and health services, when the Highland Council and NHS Highland came into being—both of them are based in Inverness. From that point on, at a local level, there has been a deterioration in the services provided in Caithness by both those agencies. The bullying culture in NHS Highland is well documented in the Sturrock reports. Unfortunately, Caithness has been at the sharp end of that culture for years.

Prior to removing our consultancy-led maternity service, there was a public meeting, which NHS Highland attended. Unfortunately, the board did not listen, the concerns expressed at the meeting were ignored and it went ahead and removed the service anyway. NHS Highland stated that there was no clinical objection to the downgrading. That is untrue, but typical of NHS Highland's culture.

NHS Highland did not even listen to its own staff. One staff member said:

> "the geographic distance and transfer times between Caithness and Raigmore is greater than that accepted for a primary birthing unit."

He also said that Raigmore was not suited to the additional workload generated by the proposed changes. The consequence of the change to a midwife-led unit had an enormous impact on Caithness mothers and babies. Eventually, it resulted in babies' deaths.

After the babies' deaths, a report was commissioned, and "The Safe Provision of Maternity & Neonatal Services at Caithness General Hospital: A Public Health Review" was published in 2016. One of the findings of the report was that the babies died due to "suboptimal care". Not being the smartest cookie in the jar, I had to look up what "suboptimal care" meant—it means care that is not up to standard. The report also stated that, as an area, Caithness is socioeconomically deprived. That is what NHS Highland left us with when it "redesigned" the service. What a damning indictment of NHS Highland. On a side point, no one was held accountable.

One of the recommendations made in the report was that first-time expectant mothers should travel 120 miles to give birth at Raigmore hospital in Inverness. The report completely ignored the risk to mothers and babies travelling that distance. It also stipulated that no caesarean operations should be carried out at Caithness general hospital. What happens if someone requires an emergency caesarean?

The people of Caithness are desperate for the situation to change before we have another fatality.

The Convener: I just want to cut in here. I think that in response to all our questions, your solution is going to be the reinstatement of that entity, which perhaps does not develop our discussion in a way that might be helpful.

Rebecca Wymer, do you want to respond to the question that David Torrance put?

Rebecca Wymer: I agree with a lot of what the previous petitioner has said.

To go back to the recruitment issues, those of you on Twitter—I am new to Twitter, but I know that this is not the most politically damning evidence—may know that Humza Yousaf tweeted yesterday that NHS staffing levels are now "at a record high" in Scotland. The argument that I heard from him a few months ago was that recruitment for the area was almost impossible. He has either done an enormous U-turn or lots and lots of staffing is happening very centrally and not in rural areas.

From campaigning and talking to people in the past year, I have heard that when the maternity unit was downgraded, we also saw the loss of the gynaecology department because obstetrics and gynaecology are linked so closely. Our gynaecological services have been picked away to become more and more central and now we have hardly anything. We do not have an emergency gynaecologist, which means that we have no emergency women's healthcare. It is pot luck whether you get a junior doctor who has done a rotation in gynaecology—that is about as good as it gets.

Many people have said to me that they have been put off moving up to take up professional positions, despite the fact that they are very well qualified—I am talking 10 years in a surgical position. They will not move up here because they and their families cannot access women's healthcare or maternity services to the standard that they are used to and should expect. If they were to move to the area, they would still live in Scotland and they should have the same quality of care, no matter the postcode.

Humza Yousaf's post on Twitter is either poorly timed or slightly out of touch. I am looking forward to meeting him in person when he comes up in the summer to discuss the issue further. Time and time again we have seen people move away from professional positions to seek better healthcare or deciding not to move up because they cannot access the healthcare that they should have. Perhaps that sheds a tiny bit of light on why the positions are not being filled. That goes for many different sectors. Hospitality is struggling and the nuclear industry sometimes loses good members of staff because staff will not risk their pregnancy or, like me, they have a condition such as endometriosis or polycystic ovarian syndrome and they cannot access the emergency care that they need.

The Convener: Emma Harper, I know that you have been listening and are keen to come in on some of the themes that have been developing.

Emma Harper (South Scotland) (SNP): Rather than making a statement, I want to ask Dr Gordon Baird a question that might help us to understand why we should consider an agency to advocate for patients. If we were to have members on each health board that were rural, they might then become embedded in the culture of that health board, rather than having a voice with which to advocate. That is why I would support having an independent agency.

Dr Baird, I am interested in pursuing what you said about the rancour or confrontational issues. When I try to represent constituents in Dumfries and Galloway on health issues, it seems to be perceived as confrontational. That is the last thing that we need when we are trying to secure the best healthcare support as we emerge out of the pandemic. How would an agency that can advocate help to reduce the perceived confrontational stance of MSPs or anyone who is not engaging with a whistleblower? How would an agency help to support that?

Gordon Baird: The Sturrock report was excellent and gave a clue as to the way forward. It talks continually about mediation.

Local people, inevitably, have a focus on local issues, but that is not always the best way to deal with things. In the past decades, I have tried to use science to support the argument and to make reasoned, rational, clinical arguments. That is not always popular. The solution that I would offer to Caithness if I were king might not be acceptable, but I hope that it would be based on best evidence and shared best practice and that it would be equitable throughout the area. Such an approach is not happening.

The issue to do with being independent as opposed to part of a national centre needs to be thought through very carefully. A national centre will almost certainly be a provider unit, in that it will provide education and services. You would not get Ofgem run by SSE—that is not going to happen; the provider and the purchaser must be separate.

Let me go back to recruitment. In the 1980s, before the purchaser/provider split, I advertised a job in my practice and got 80 applicants. A practice in the Lake District got 220 applicants. As Richard Smith said in the *BMJ*, we were able to advocate for our patients. Richard Smith mentioned the connection between the health board—executive and non-executive members—and rural doctors. We knew that when we went to someone on the health board, it worked really well. Today, a practice in a remote and rural area would be very lucky if it got a single applicant.

A commissioner would take over the advocacy role, but he or she would have to be independent and not part of the embedded structures in the political and managerial system. That is my view, which is based on my experience, my research of the literature and my time as chair of the rural practices subgroup at the college.

Emma Harper: One of the challenges that I and my colleagues Finlay Carson and Colin Smyth have had is that Dumfries and Galloway is part of the south-east cancer network although nowhere in Dumfries and Galloway is in the east of Scotland. It is a challenge to look at that and to engage. The health board says that it is up to the Government and the Government says that it is up to the health board. We do not want to dictate how cancer care is provided, but we need people to have a choice of whether to have their radiotherapy in Edinburgh—which might be better—or Glasgow.

That is just one example. Folk fae Stranraer are not given a choice about making a 260-mile round trip. We are told that they are given a choice but we do not really have evidence of or feedback on that. I am interested in pursuing an advocacy approach, whether we do that through a commissioner or an agency, so that we can look at the challenges in rural health care.

The Parliament’s Health, Social Care and Sport Committee is undertaking an inquiry into health inequalities. Many of the issues that we have been talking about in this meeting are coming to light.

I am hearing from the other petitioners that there are challenges for remote and rural areas, whether we are talking about Caithness, Galloway or the Borders, and it would be great to be able to join up all the work that has been done and see how we can take it forward to address the needs of our people. I will stop there.

The Convener: We have two other parliamentary colleagues listening to the discussion today. Now that all the petitioners have spoken, they might want to comment.

Rhoda Grant (Highlands and Islands) (Lab): The petitioners have made it very clear what the issues are. There is a huge distance to travel to access healthcare, and they are not being heard.

Let me give the example of maternity services in Caithness. I have been asking the health board for a risk assessment of the journey between Caithness and Inverness for someone who goes into labour early, for example. I know that there are people who are more likely to be induced or to have an elective caesarean, but there are people who go into labour and need to drive down that road. The road is horrendous in winter and can often be blocked.

11:15

As we were discussing before the meeting, expecting someone to drive down there with a partner who is in labour is unacceptable. It is an offence for someone to use a phone while driving a car. Imagine what it is like for a driver to have someone in active labour beside them while they are trying to concentrate on a really difficult, dangerous road. No one will risk assess that journey. I have asked the same question in relation to routes in Moray. I hope that the committee would at least request that a risk assessment is done on transporting people in emergency situations where there is no local healthcare.

When this situation started in Caithness, there was not enough ambulance cover. Quite often, if one person was being transported by that means, the area was left without an ambulance. That problem has been resolved to an extent, but the situation is still not ideal.

I support the petitioners’ argument that the healthcare service that they have received is not equitable.

Colin Smyth (South Scotland) (Lab): My interest is primarily in the petition from Dr Baird, who is a constituent of mine. However, his proposal is pertinent to all the petitions that we are discussing—the common theme being inadequate healthcare provision in rural areas. The fact is that no one appears to be advocating on behalf of such communities and they are not being listened to.

Emma Harper highlighted the example of cancer care in Dumfries and Galloway, where our constituents in Stranraer have to travel to Edinburgh for treatment when there is a hospital in Glasgow that could provide it. Neither the health board nor the Scottish Government is tackling that problem.

In our discussions, a number of ideas have been suggested for how we could do so—in particular, by Mr Ewing, who said that we should have on health boards people with rural interests. I would hope that people who are appointed to a health board in an area such as Dumfries and Galloway would already have knowledge of rural healthcare. To reinforce that point would not do any harm.

However, we are failing to recognise that we have a Scotland-wide problem in rural healthcare. There will be commonality between the challenges in Caithness and those in Dumfries and Galloway, so there should be Scotland-wide solutions. When it comes to finding such solutions the problem is often—but not exclusively—the health board.

It was also suggested that the proposed national centre for remote and rural health and social care could have an advocacy role. I understand that it will be primarily a delivery mechanism, although crucially it will be part of the NHS, so it will not be independent. It is interesting that, yesterday, the Scottish Government announced that it now supports the proposal for an independent food commission and has rejected the idea that Food Standards Scotland could take on that role—I presume that is because it is independent of the Government.

It is key to our discussion that no independent national authority is advocating on healthcare on behalf of rural communities. There is a model for that in Australia, where there is the Office of the National Rural Health Commissioner. We should consider that model here in Scotland. I see no harm in carrying out a piece of work on how we could strengthen advocacy for rural healthcare in this country, whether it be through a commissioner or another model. It is absolutely clear that the current set-up is simply not working.

The Convener: I thank our parliamentary colleagues for their interventions. I now want to bring the petitioners back in. Rebecca Wymer is keen to contribute again.

Rebecca Wymer: I will make a quick point. I thank Rhoda Grant for her input on travel times, traffic incidents and the quality of roads. I have asked Mr Yousaf about those issues in correspondence before and during the petition process.

I have a business on the north coast 500 route, so I can tell the committee exactly how busy it is in winter and summer. The road is appalling in the winter. My dad was in the police for 11 years, during which he pulled many people out of smashed cars there. That was before it became one of the busiest roads in the world. It is now one of the top 10 busiest traffic routes; it is incredibly popular.

A worrying trend that we are seeing is groups of eight, nine or 12 young people—under-25s—hiring sports cars and racing each other as though they were going round a track. We can imagine what might happen if they were to hit an oncoming ambulance while they were overtaking, and if there were someone behind those vehicles, trying to concentrate on the road. It is almost impossible to get from Inverness to Wick without some sort of near-miss incident.

Most of you have probably already been to the area or have a similar problem where you are but, for those of you who have not, I point out that the one-way journey from Wick to Inverness, which is the most straightforward route if you live in Sutherland—if you live in Bettyhill, near Thurso, it is slightly longer—is the same distance as the journey from Edinburgh to Newcastle upon Tyne. The mileage for the combined return journey equates to the mileage from Edinburgh to York. However, it is on far worse roads. It would not be acceptable for women in Edinburgh to travel such distances on far better roads for routine scans, appointments, clinics or labour. All miscarriages, including active miscarriages past 12 weeks, are expected to travel on those roads for upwards of four or five hours in the summer and three to four hours in awful conditions in the winter.

I spoke to Mr Yousaf about that and, rather than taking into account the near misses and small accidents, which can still cause harm to patients in emergency stop situations, he decided to focus on road closures. He spoke to Transport Scotland and came back with a bunch of statistics saying that the road had been closed for only less than 4 per cent of the time over the past four years. However, the past four years include two years in which nobody could travel, so the statistics are not necessarily accurate. If that exercise was rerun now, there would be a much clearer and more accurate response on how often the road is closed on one side or both, or there is a diversion that takes on to a very rural track on which one cannot get to hospital anywhere near as quickly.

I will leave it there. I have more to say on the travel situation, but I wanted to back up Rhoda Grant on the fact that it is simply not safe. An assessment of that journey has been skirted around for quite some time and needs to be looked into.

The Convener: Thank you. Your point about distances was well made. Characterising the journey in terms of a journey from Edinburgh is possibly more familiar to members than the one about which you are talking, which means that it is well understood.

William Sinclair: I will follow up on what Rhoda Grant said about the distance and the hazard that is associated with travelling it.

Last year, a Wick lady started a journey in labour and had to stop at Golspie, one hour away from Inverness, where she gave birth to the first of her twins. She was then loaded back into the ambulance and sent off to Raigmore, where she had her second baby. It was a miracle that mum and both babies were well. There was another case of a lady giving birth in a lay-by near Golspie. That could happen again in the current circumstances.

Think about what trauma those ladies suffered at what is supposed to be one of the happiest times of their lives. Is that really the best outcome for Caithness mums? What would members of the committee think if it was their wives, partners or daughters going through that?

The Convener: It is a while since Maria Aitken has had a chance to comment. Is there anything that she would like to say at this point? [*Interruption*.] I think that we have lost the link to Ms Aitken. Perhaps I will come back to her.

Paul Sweeney: The testimony that we have heard has been compelling. The democratic deficit in decision making on health boards, and the tension between the tendency for the medical profession to want to centralise in national centres and build capacity, and the rights of rural patients to access services, have been borne out in discussions that we have had on a number of petitions.

I will ask the petitioners about defining the rights of patients regardless of where they are. Perhaps the advocacy body that has been proposed would be the best way of defining the right of a patient to access services safely, whether in gynaecology or any other context. Examples such as William Sinclair described in relation to Caithness could be identified through data, study and inquiry as unsafe provision. That would mean that the health board would have an obligation to address the situation. The advocacy body could place on the health board an obligation to deal with it.

An alternative to that might be to say that, in instances in which it is appropriate to travel to Glasgow for an operation—in neurosurgery, for example—the patient has the right to have their travel costs covered and the right to accommodation for a companion for the duration of their period of surgery and recovery.

Those are mechanisms by which the rights of patients could be defined and advocated for, so maybe they are the ones by which those rights could be delivered. A national body in which stakeholders from different geographies can come together and define the standards that all citizens should be entitled to in different contexts, and one that can take evidence from clinicians and patients is, perhaps, what we are all driving toward. Would petitioners agree that that is where we need to arrive?

The Convener: Before we hear from Gordon Baird, we will hear from Maria Aitken, who is now back with us after we unfortunately lost her connection.

Maria Aitken: I agree. In 2016, when our maternity service was downgraded rapidly and without any consultation, we went to just about everyone to try to get help and to have our voices heard, but no-one listened to us. We went to the Scottish Health Council—which is now Healthcare Improvement Scotland—and MSPs, who listened, but no actions were taken after what was said. We feel that we have been forgotten and ignored. We are disempowered in decisions that are made about our communities because decisions tend to be made in central Scotland by people who might not have lived in a rural area and who do not know about the challenges and barriers that we face.

For example, most of our medical clinics and so on are at Raigmore, which is a 200-mile journey from us. I think that the amount that we can claim for fuel costs has recently gone up to 15p per mile. When we looked at the rate of subsidies that the Scottish Government gives for attending courses, we saw that you can claim 20p a mile to take your bike to the Scottish Parliament for meetings, while we are given only 15p per mile to access our healthcare. Many people cannot afford that, so straight away they are disadvantaged and must decide whether to have heat, food or access to healthcare. We need people who know about living in rural and remote areas to ensure that we are heard, and that decisions are based on what is best for our communities.

To leave the matter on a positive note, I note that a good example of recruitment practice comes from obtaining of a professional teaching qualification in Scotland. People can study up to masters-degree level through distance learning using technology; they do not have to leave their home, family or community. They can do a year or two of part-time distance training for a postgraduate diploma in education and do a paid year of teaching experience in their local area.

The Scottish Government has also set up a system whereby students who tick the “go anywhere” box can get £6,000—or £8,000 for secondary teaching posts—if they are willing to teach in any area. I spoke to a lot of teachers who have done that and who now live in this area. They have come to rural areas and love living there, so they are bringing up their families in those areas. That is a way to keep our communities sustainable and to encourage professionals to come and live here.

When courses are set up, the independent person should be able to say what can be done remotely. People should not need to attend a central university to get a professional qualification. When people can get a professional qualification, that removes them from poverty. I did it; I would not otherwise have been able to get my teaching qualification, because I had a family and I live up here. I could not have left to get a qualification in Inverness, even. I was able to access training, and my and my family’s life changed because of it. That access is about fairness and equity; such things have a huge impact on communities in rural and remote areas of Scotland.

11:30

The Convener: I turn to Mr Baird, then I will come back to Paul Sweeney, who posed the question.

Gordon Baird: The symptoms of what has happened are perfectly clear, and they are dreadful and disabling. We have all heard from rural and remote agencies that are suffering from a sick system. The system is wrong because of new public management, which has had enormous benefits in technical things such as joint replacements, minimally invasive cardiology and neonatal survival. The reason for that has been the power of the providers. Boards and, I suspect, the new national centre for rural and remote health, will be very focused on provider issues.

That is good, but public organisations that provide telephony, power and water all have independent agencies that look after people who otherwise lack advocacy. All that we are asking is that the NHS, which had a good advocacy system in the past, do what other new public management systems do, which is provide a good advocacy system and minimum standards such as we have talked about.

By the way, I note that neurosurgery and neurology patients—at least, when I was working—went to Edinburgh. That does not suit people with motor neurone disease; it is not acceptable that such people have to travel that far. There has been no advocacy for those people, but the providers are quite happy, because they look at the figures and say that they are okay because they get good results. We are asking for common practice with other public management systems.

The Convener: Mr Sweeney, do you want to come back in on that? This is where we began with Mr Ewing. Having heard all that we have heard, is there anything that you want to ask, finally?

Paul Sweeney: The discussion has been really worth our while, in that it has focused on what the effects need to be. We need a check and balance on health boards and providers to ensure that, where necessary, there is correction, through inquiry into people’s experiences by giving them a proper formal voice and through the ability to put obligations on providers. In that sense, the petitioners' requests are significant and require further advocacy by the committee.

The Convener: Mr Ewing—you posed a lot of questions at the start of the meeting. Having reflected on the evidence as it has unfolded, have any questions for the petitioners occurred to you?

Fergus Ewing: I have listened with interest to what the petitioners have said. I will mention two issues. One is that Mr Sinclair and our two online witnesses call for reinstatement of local provision of services, whereas Dr Baird calls for a slightly different additional model of advocacy. Both arguments have a rationale behind them. I understand that, but our job is, to some extent, to play devil's advocate.

I will put this to Dr Baird to see what his response is. Rhoda Grant, Emma Harper, Colin Smyth and I represent constituencies that are largely or partly rural, so we are performing an advocacy service of a sort in the casework that we do. I expect that we all take that job very seriously. It is a big job, and we each represent tens of thousands of people. How on earth can one centralised body hope to advocate for the interests of people throughout the country who live in a plethora of differing remote communities, each of which has its own particular needs, problems, interests and challenges? How could one centralised body effectively perform such an enormous role? How would it be accessible to people? Is there a risk that it would be just another faceless organisation, adding to the number that exist already?

I am sorry that I am putting it a wee bit provocatively, Dr Baird, but I am trying to make a point, as someone who takes advocacy for the remote and rural areas in my constituency seriously. It takes me a day properly to go over a case with an individual, if I want to do it justice. We need to really listen in order to be able then to represent and articulate that individual's concerns properly. It cannot be done quickly and we cannot cut corners. It is inevitably, and rightly, time consuming. How on earth could a national agency be efficacious?

The Convener: It might take a day to go over a case, but we no longer have a day to discuss the matter, so I ask Mr Baird to make a final comment. I will then invite the other petitioners to make any final points that they would like to contribute to our thinking. If you could be quite concise, Mr Baird, that would be appreciated.

Gordon Baird: I will do my best. It is not my forte.

I did not envisage the agency taking on individual cases. There are plenty of ways in which that can be done. That is the role of all of us around the table, whether as community groups or politicians.

The issue is that there is a systemic failure. We have clearly identified that. Science has not addressed that over the past 30 years. That is the way that I have tried to influence things. If you google me on Google Scholar, you will see the publications that have gone before. They have not worked.

We are looking at systemic failures. Caithness has a problem and we have a problem in Dumfries and Galloway. We become a more accountable issue for boards and politicians if we get together. We also benefit from shared solutions.

I was not envisaging the agency taking on individual cases but, having said that, for new public management, it is pretty common—indeed, it is almost invariably the case—that a formal agency is provided to ensure that minimal standards are applied. The agency would be about minimal standards and not excellence.

The Convener: Rebecca, would you like to make a final comment?

Rebecca Wymer: Yes. Sorry—I was waiting for my microphone to be put on.

The question was raised about having one advocate to address all the issues. There are already advocacy bodies. There are already community groups and people shouting about the problems and advocating. I have a dossier of stories from 42 women, who gave them to me six months ago to pass round Parliament. I have been blocked at every stage of trying to get those stories to the people who need to see them.

An independent advocacy system that listens to the community groups and filters down to members of the public works like the branches of a tree. Those branches exist already; it is just that the trunk is not listening.

The Convener: I invite Maria Aitken to make a brief final comment.

Maria Aitken: To echo what Rebecca Wymer and Gordon Baird just said, the centralisation of professional training and qualifications needs to be governed by someone. The fast track to midwifery course that was funded for the UHI in Inverness—a really good university—had that funding withdrawn. Someone needs to ensure that examples such as that are monitored and assessed for fairness and the equality impact on rural communities. Things like that should not happen.

The Convener: Mr Sinclair, do you have any final thoughts?

William Sinclair: Most of the talk until now has been about maternity services, but we also have

14,000 people travelling to Inverness every year as outpatients. That is a colossal number of people. We are trying to go green these days, are we not? That is 14,000 journeys down to Inverness.

Those people are ill but, if they travel by train or bus, we are talking about eight hours' travel to get down there and back again. That situation must be changed. That is what we are calling for, because what we have at the moment certainly does not work.

The Convener: I ask for a couple of sentences each from the parliamentary colleagues who are with us.

Emma Harper: In Dumfries and Galloway, patients are means tested for the reimbursement of travel costs, whereas in other parts of the country it is a given that people are supported in that way. I think that an agency could advocate to change that model.

I thank the witnesses who are here in Edinburgh and those who have joined us remotely today, because it is really good to hear their input. I am keen for progress to be made with the petition.

The Convener: Maybe we should be offering them an operation while they are here, having made the journey.

Colin Smyth: That might not go down too well in Stranraer, convener, where people are trying not to travel to Edinburgh. They are trying to get the service a bit closer, in Glasgow.

A very powerful case has been made on the need for a further bit of work to look at how we advocate—to be frank, we do not advocate—for healthcare in rural areas. It is not about individual cases, although looking at the issues collectively will probably reveal policy failures; it is about trying to assist. The commissioner model in Australia, for example, is about providing policy advice to Government on how to tackle some of the big rural challenges. It is important that we look at that model and at whether we need an advocacy service to support rural healthcare in Scotland. I hope that the committee will support that—it is certainly something that I very much support.

The Convener: Thank you. Finally, I ask for a comment from Rhoda Grant.

Rhoda Grant: I wonder whether the committee has had any discussions with the Health, Social Care and Sport Committee about whether it will look at the subject. I know that the Health and Sport Committee in the previous session of Parliament looked at some issues to do with rural healthcare. In a way, the problem extends from the very start of the process, with the training of clinicians, right through to how we support them in different areas. They are now all trained to work in huge teams, but when people work in rural general hospitals, they are not in a big team.

In addition, the standards of care, which are written for urban areas, are not transferable to rural areas. One of the lessons that I have learned from my time in Parliament is that policies that are written for rural areas work in urban areas, but that is not the case the other way round. We should be turning this on its head so that we make sure that people have access to the services that they need.

I wonder whether the committee has discussed the matter with the Health, Social Care and Sport Committee, because a light needs to be shone on it and some detailed work is required to make sure that we get the changes that we need. We certainly need to have people advocating for our rural areas, because that is just not happening.

My final point is that, in the Highlands and Islands, we get assistance with travel and accommodation, but it is absolutely inadequate when people get £40 a night to stay in Inverness and they cannot find a room for less than £400 a night. That is impossible, and it is creating a barrier to healthcare.

The Convener: Thank you. The possibility of such a referral is among the options that the committee has considered ahead of today's evidence session. When we consider the evidence afresh, that will be one of the options that are open for us to explore further.

We have gone 20 minutes over the time that we thought we would need to discuss the petitions. I am very grateful to you all, because they are all very important petitions. They are thematically linked, but each has its own individual characteristics, and I very much appreciate the way that the witnesses both online and in the room have advocated on behalf of their petitions.

Historically, we used to hear from all petitioners, but the volume of petitions is now such that we do not hear from everybody. However, we all very much value the opportunity to meet and talk with petitioners and to hear them advocate on behalf of the petitions that they have lodged. It is still quite a big thing for petitioners to come before the Scottish Parliament and present their evidence in that way, probably thinking that they are up against a team of inquisitors. I hope that it has not proved to be too intimidating and that we have encouraged you to contribute as much as possible during the session.

I also thank our parliamentary colleagues who joined us for this morning's session.

11:44

Meeting suspended.

11:46

On resuming—

The Convener: Before we move on to consider other petitions, do colleagues agree to consider the evidence that we have just heard at our next meeting and to review our actions at that point?

Members *indicated agreement.*

Air Traffic Management Strategy Project (PE1804)

The Convener: The next continued petition is PE1804, on which we have taken evidence on a couple of occasions. The petition calls on the Scottish Government to halt Highlands and Islands Airports Ltd's air traffic management strategy project. On 4 May, we took evidence from Peter Henderson, one of the petitioners, and David Avery from Prospect. We subsequently took evidence from Inglis Lyon, the managing director of HIAL.

Rhoda Grant is still with us, and I invite her to speak before we consider how we might proceed.

Rhoda Grant: I echo some of the things that the petitioner said about the Sumburgh radar project in his written response. I share his concerns, and I believe that he has highlighted areas that we need to look at.

When the ATMS project came to light, everyone agreed that something had to change and that safety improvements had to be made, but it was felt that HIAL was going in the wrong direction.

Radar is really important, but my understanding is that there are concerns about the training that is being delivered to the new operators of radar who will be transferred across. In his submission, the petitioner says that training has ceased, so all the work that has gone on has now stopped. The training manual is being rewritten and will need to be approved by the Civil Aviation Authority, which will build in quite a time lag.

It would be good to find out how many people need to receive the training and how many people who were in training will go into the new programme once it is signed off. I also understand that the whole thing might not have been signed off by Transport Scotland. We need to ask Transport Scotland whether that is the case. It might be worth asking NATS, which runs the Sumburgh radar at the moment, what it thinks is happening—it must have a date in mind, because it has a contract and will know when it is supposed to be handing over the radar to HIAL.

Quite a few concerns have been raised with me about the situation, and I wonder whether the committee has given any thought to the suggestion that Audit Scotland should consider the issue. If it does so, perhaps it should also consider the issue of the transfer of radar.

David Torrance: I think that this issue has been well investigated by the committee over two parliamentary sessions. We have taken evidence from everyone we needed to hear from. In our most recent evidence session, we got assurances that the proposal would not go ahead for five years. I do not think that we can take the issue any further—how many of us will be here in five years' time?

I believe that what the petition originally called for has been addressed. I am therefore happy for us to close the petition under rule 15.7 of standing orders, on the basis that the issues that were raised by the petitioner now appear to have been resolved.

The Convener: Having listened to Rhoda Grant, I think that there are fresh issues, but I think that those might be best addressed as the subject of a fresh petition, because I think—looking at the actual terms of the petition—that we have met the objective of the petition.

Paul Sweeney: I think that the substantive issues in the petition have been addressed by the actions resulting from it. If there are subsequent areas of inquiry, there is no impediment to the lodging of a new petition that is focused on those issues, which will be addressed by the committee in due course. If people feel that that would be a tidier approach, I am happy with that. I have no strong feelings either way.

Alexander Stewart: I agree with David Torrance. This petition requires to come to an end, as we have gone through that journey. As we have already heard, over the next three to five years, things will improve, but, as you indicated, convener, there might be fresh issues to be considered and, if there are issues that Rhoda Grant and the community want to explore, that could be done via a new petition.

The Convener: This has absolutely been a substantive petition, and now the mood of the committee is to close it. I suggest that we write to the petitioners to thank them for submitting the petition and to say that we recognise the concerns that they and Rhoda Grant have articulated and that, if they feel that there is a justification for doing so, they could submit a petition that is focused directly on those concerns. Do colleagues agree?

Members *indicated agreement.*

Rhoda Grant: I thank the committee for the huge amount of work that it has done on the issue and for all the evidence that it has taken. In some ways, you are responsible for our being in a much better position than we were when the petition was first lodged.

The Convener: Thank you for that. I also thank you and Liam McArthur for your additional forensic cross-examination of witnesses as we have progressed through the process. Although we might not all be here in five years, I hope that some of us will be—David Torrance has been here for ever—to see whether there has been any progress or any reversal of the commitments given.

Scottish Qualifications Authority (PE1875)

The Convener: The next continued petition is PE1875, which was lodged by Jordon Anderson. It calls on the Scottish Parliament to urge the Scottish Government to order a public inquiry into the Scottish Qualifications Authority. Do colleagues have any comments to make?

David Torrance: Again, I think that what the petition calls for has been achieved. Therefore, I would like us to close the petition under rule 15.7 of standing orders, on the basis that the terms of reference for the Covid-19 inquiry have now been published and will include consideration of the provision of education and certification during the pandemic.

In closing the petition, we might wish to draw the attention of the Education, Children and Young People Committee to the issues that have been raised.

The Convener: I agree that, in some measure, the objectives of the petition have been reached. Are colleagues content that we close the petition on the basis outlined by Mr Torrance?

Members *indicated agreement.*

Council Tax Collection Procedures (PE1897)

The Convener: The next continued petition is PE1897, which was lodged by Richard Anderson. It calls on the Scottish Government to reform certain procedures for the collection of council tax.

The Minister for Public Finance, Planning and Community Wealth reiterated that council tax is a local tax that is set and collected by each local authority, with every council being financially and administratively accountable to its electorate. He states that the Scottish Government has no plans, at this stage, to review the processes that are set out for council tax regulations. We have also heard from the Convention of Scottish Local Authorities that it has nothing further to add to its previous submissions.

Do members have any comments or suggestions for action?

David Torrance: Considering the position of COSLA and the fact that the Scottish Government has no plans to review the processes, I think that we have no option but to close the petition under rule 15.7 of standing orders.

The Convener: Are colleagues minded so to do?

Members *indicated agreement.*

The Convener: That concludes this morning’s meeting. We will meet again a week today, on 15 June, when we will hear from the Minister for Parliamentary Business and the Minister for Public Finance, Planning and Community Wealth.

Meeting closed at 11:54.

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