OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 16 May 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 16 May 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

17th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Greig Chalmers (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 16 May 2023

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 17th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Paul Sweeney and Emma Harper. James Dornan joins us remotely.

Agenda item 1 is a decision on whether to take item 3 in private. Do members agree to do so?

Members *indicated agreement.*

Complex Mesh Surgical Service

09:30

The Convener: Our second agenda item is follow-up scrutiny of the complex mesh surgical service. I welcome Jenni Minto, Minister for Public Health and Women's Health, and Greig Chalmers, head of the chief medical officer's policy division at the Scottish Government.

We move straight to questions. Minister, there are plans to create a single patient leaflet that will be available to women at the point of referral to the service. Why is that leaflet not already being designed, given the length of time that the service has been in operation? How will the leaflet clearly explain the various elements of the whole referral and treatment journey, whether patients opt for surgery with the service, NHS England or a private provider?

The Minister for Public Health and Women's Health (Jenni Minto): First, I thank the convener and the committee for inviting me along and for recognising the quite dramatic experiences that women have had as a result of transvaginal mesh surgery.

It is clear that, when we started setting up the surgery system for women who have been impacted, we wanted to design the processes with those women in mind and ensure that we did the right thing for them. There have been lots of discussions and surveys with women who have been impacted to find out how they feel the service should operate. Taking that learning on board has been incredibly important.

There is some advice on the NHS Inform website, but creating pamphlet literature to support women is incredibly important. We have listened to the women in order to ensure that it contains the right information, whether it is about the pathways for the referral system in the NHS Greater Glasgow and Clyde service or the independent service.

I am pleased that we have listened to the women and are able to provide them with the information that they have highlighted is needed.

The Convener: Can you give a timescale for when the leaflet will be available to women?

Jenni Minto: I am afraid that I cannot, but Greig Chalmers might be able to.

Greig Chalmers (Scottish Government): Convener, you are quite right that, as Dr Alan Mathers confirmed in his note to you, which I saw this morning, NHS Greater Glasgow and Clyde has been developing a patient information leaflet. We do not have a date for when it will be available, but we will seek to confirm that with GG&C after today.

As you no doubt know, convener, and as others will know, when patients attend the service, they are provided with a range of information about their surgery and a range of other conditions that might be relevant, and they receive a telephone call beforehand from a psychologist. You make a valid point about continuing to improve that information, and I am sure that, if it was represented here, GG&C would agree with that. It is one of a number of things that GG&C helped with, including keeping improving the website.

The Convener: Thank you.

Sandesh Gulhane (Glasgow) (Con): Minister, when was the bill passed?

Jenni Minto: The bill was passed in 2021-22.

Sandesh Gulhane: Between the time that it took to come into force, with all the planning that went into it, and now, why have we not seen a clear pathway for women to get referred to the service? Why is there confusion?

Jenni Minto: My understanding is that there is a clear pathway. I saw it when I was on the NHS Inform website this morning. I have a copy of it here, and it is described as the complex mesh surgical service pathway. I would be happy to submit it to the committee after this evidence session.

Sandesh Gulhane: We heard from a number of people that general practitioners are making direct referrals and that the pathway is a secondary care referral pathway. If the people who are coming to the committee are not being absolutely explicit, how can we expect other people to know what the pathway is and the way to follow it?

Jenni Minto: If I recall correctly, the evidence that the committee received two weeks ago indicated that the pathway is clearly laid out and that there is an electronic referral to the GG&C complex mesh surgical service. That is the clear pathway that has been introduced. Greig Chalmers would like to comment on that.

Greig Chalmers: In this discussion, it is important not to conflate the number of things that are going on. The Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022, which gained royal assent in January or slightly later than that from my recollection, is about the reimbursement of private expenditure that has already been spent by women who went for mesh removal surgery, generally in the United States but also in Bristol. That process is separate from the commissioning of independent surgery through the NHS from the NHS Greater Glasgow and Clyde service.

As the committee might know, after the 2022 act was passed, we published the administrative scheme that underpins the 2022 act, and an information leaflet is available through National Services Scotland, which administers the scheme on our behalf. The date of royal assent—

Sandesh Gulhane: You are, of course, correct, but when we are thinking about a reimbursement scheme and talking about pathways for women who have suffered and are struggling, everything goes hand in hand. I was under the impression that the Government was looking at what to do with women who are struggling, who are in pain and who were unable to get the help that they required during the passage of the bill. That is why my question was framed in that manner.

My final question is also on the referral pathway. Is it possible for a GP to directly refer into that pathway?

Jenni Minto: My understanding is that the GP refers women to their local health board, which then refers them to the complex mesh surgical service, which is managed by NSS and NHS Greater Glasgow and Clyde.

The Convener: Tess White has questions on this theme, and she is joining us remotely.

Tess White (North East Scotland) (Con): I have two questions for you, minister. We have heard that one mesh-injured woman who has debilitating pain has been waiting for 82 weeks for an urgent referral. What guidance is being given to health boards to manage women who have mesh-related complications?

Jenni Minto: NSS has been sending out information to health boards, each of which has an individual who has been tasked with the responsibility of ensuring that there is an understanding of the complex mesh service in their health board area.

Greig Chalmers: I should say that we had hoped to be joined by our clinical adviser, Dr Terry O'Kelly, but unfortunately he was taken rather ill last week. I therefore apologise if we are not able to answer any explicitly clinical questions this morning. If that happens, we will take the matter away with us, but I hope that we can be as helpful as possible.

On Ms White's question, as you would imagine, the Government becomes aware of particular cases from time to time, and I think that we are aware of the situation to which the member referred. I think that it is the case that the individual has been contacted by their health board, which is following things up as a matter of urgency and has arranged a telephone appointment with the consultant. Obviously, that period of waiting will have been profoundly distressing and difficult for the individual involved—that would, of course, not be disputed by the Government.

In general, however, GG&C is, in its specialist mesh centre, taking steps to reduce waiting times from a position that, as all involved will acknowledge, required improvement. As things have developed and as the service has, we hope, been progressively improved, the gap between referral for surgery at the centre and the surgery itself is getting closer and closer to 12 weeks, as Dr Lamont and Dr Mathers said on 2 May. That is still a significant wait for the person involved, but it marks, I hope, a degree of improvement since the service was established.

Tess White: [*Inaudible.*]—health boards to manage women with mesh complications?

The Convener: I am sorry, Ms White, but we missed the beginning of your question.

Tess White: I appreciate the acceptance that an 82-week wait is not acceptable, but what guidance is being given to health boards to manage women with mesh complications?

Jenni Minto: I refer the member to my earlier answer about the responsible officers in each health board, who have direct contact with NSS and the complex mesh surgical service.

Tess White: That was my first question. Secondly, at the committee meeting on 2 May, there was significant confusion about the referral pathway, so I would like to clear up that issue today. What work is being done to ensure that health boards follow the same referral pathways when mesh is identified as a factor?

Jenni Minto: That question is along the same lines as that asked by your colleague Dr Gulhane. I have offered to send the committee the complex mesh surgical service pathway. I am aware of the evidence that you received on 2 May. I felt that Dr Mathers clarified in that meeting that an electronic referral from the health board to the service is required. As I said, we will send the complex mesh surgical service pathway to the committee so that you have sight of it.

Tess White: Thank you.

09:45

The Convener: Carol Mochan has a brief supplementary question.

Carol Mochan (South Scotland) (Lab): I want to be clear on some of the points that you have made, minister. From parliamentary questions on outpatient appointments, we know that the median waiting time between referral and appointment at the complex mesh surgical service in Glasgow is 236 days and that the longest waiting time is 448 days. I just want clarity on exactly how you have been approaching that issue with the health board. Those waiting times are absolutely unacceptable, and, as members have indicated, this is about a longstanding commitment to women. What discussion have you had with the health board about that? What reassurances do you have for those women that we will get appointment times closer to referral times?

Jenni Minto: I agree that waiting times of that length must be incredibly difficult for the women who are waiting for the referral and for the discussions to find out what their best pathway is—the best course of action that they can be offered for what is a very debilitating and pretty awful situation to find themselves in.

My officials correspond and meet regularly with the health boards and NSS to ensure that everyone is across the pathways and understands the need to ensure that this is done with the patient at the centre of it, which is how we would hope to achieve any improvement in waiting lists. As Greig Chalmers indicated earlier, the whole system has been improved by listening to those who are waiting in order to improve their experiences while they are waiting. We have introduced a waiting well plan, and, in my role as women’s health minister, I am looking at how that can be connected into the women’s health plan.

Carol Mochan: I suppose that people will want to hear about very practical things. Will there be any extra clinic times? Will there be extra resources? Will there be more nurses to give out that kind of advice? You might not be able to give answers to those questions now, but it would be helpful for the committee to know those things for the women.

Greig Chalmers: The member makes a very a reasonable point about the range of issues on which patients will be interested to see how the service is developing. As members know, the service has developed quite significantly since it was established, in 2020. As Dr O’Kelly and Dr Mathers said to the committee the week before last, it now has a wider range of staff, including psychologists and physiotherapists as well as the clinical and nursing staff.

To come to the member’s direct question, we, in the Government, have a relationship directly through National Services Scotland, which commissioned the service. It does that commissioning through a service-level agreement, which was originally for two years and will be renewed shortly. It is through that instrument that the Government will, working co-operatively with GG&C, continue to seek improvement in all the issues that are waiting.

I think that it is reasonable to say that improvement in waiting times has taken place, but there is clearly still more to do, and the minister—and we, as her team—will be seeking to do it, together with NSS.

If it would be helpful to the committee, we could provide you with the service-level agreement when it is renewed. Perhaps it would be useful for you to see the types of measures, metrics and plans that GG&C has in place to continue that improvement, some of which I explained to you a couple weeks ago.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Greig, you said that systems have developed significantly since 2020, and I agree with that. However, women still find things confusing, misleading and inadequate. They have certainly described the service as that in the past, and it is not the one-stop shop that they expected it to be.

In relation to that growing knowledge and expertise, is there a place for the national service to devise national guidance on managing symptoms locally, particularly while women are waiting for long periods for appointments?

Jenni Minto: Stephanie Callaghan brings an important idea to the table. For any women approaching any healthcare, a one-stop shop helps because we have incredibly full lives, so it is helpful if we can get all the information in one place.

We have great learning from other areas in the women’s health plan, and, very importantly, we have fantastic information from the women who have been through the centre to make decisions on whether to go for surgery to reverse the procedure or to go for more conservative and less surgical ways forward. We have a responsibility to enable women to make the best-informed choices with regard to that and to make the process clear, open and helpful so that they can make the best decisions.

As I said, we need to look at that in relation to the women’s health plan. Greig Chalmers and I have had conversations about how we integrate that.

Greig Chalmers: I will come in on the integrated service at GG&C and on joining up the different parts of the healthcare system, which is something that the committee talked about on 2 May. We have tried, with GG&C and NSS, and with the accountable officers, to see whether that chain of information and guidance is working as best it can.

At the committee’s previous evidence session, on 2 May, Dr O’Kelly mentioned that we were in the final stages of putting together and using a package of training for GPs. I am conscious of the number of things that GPs have to look at, but I hope that that will be of use in increasing awareness.

A number of times this morning, we have alluded to the accountable officers. I emphasise that that group is not just an email distribution list but a place where the accountable officers come together regularly to share experiences and thoughts about how to communicate with their primary care networks and other people. Through joining up the national service with boards, primary care networks and GPs, we are seeking to disseminate the best possible information so that, when GPs meet patients with relevant symptoms, they are attuned to what they are likely to say. We hope that the websites and information leaflets that we put in place are all good and positive, but we come to the issue in the spirit of knowing that we need some improvement and that there are steps still to be taken.

Stephanie Callaghan: I appreciate that the website has been updated recently and that a number of things have shown improvement. I hope that that will be pushed and will continue to move at pace.

I will ask a slightly different question on that issue. I am interested in data capture. I am not sure whether there is a definitive record of how many women are affected by transvaginal mesh. Is there is a comprehensive system in place for data capture, or is data spread around? Has that data been effectively collated?

Jenni Minto: I will hand that over to Greig Chalmers, because he has been involved for much longer than I have.

Your last point was about GP training. When Dr O’Kelly was with you two weeks ago, he spoke about work that is happening with NHS England. There is a four-nations approach, and a lot of work has been done to connect NHS Scotland support for GP training with what is available in England. That is really positive for women, because we are looking at how we can get the best resources to support them and how we can enable GPs to support their patients.

Stephanie Callaghan: That is really helpful. I know that some of my colleagues will have big questions to ask about GPs later.

Greig Chalmers: In that case, I will try to be as brief as possible. On the issue of information, there are two things in our minds. As the minister has suggested, information about the performance of the specialist service, about the number of referrals and surgeries and about waiting times should already be available and will continue to be so. Those expectations will be set out in the service level agreement that I mentioned to Ms Mochan.

Looking to the future, we have been working with a number of health boards to develop a pelvic floor registry, with information about the relevant procedures that are being undertaken in health boards and the types of devices that are being used. That is one way in which the Government has been trying to respond positively to the recommendations of the Cumberlege report.

We have been working with the other three countries in the UK to develop clinical outcome registries, and that work continues. Within NHS Scotland, we have been developing our scan for safety programme. It would be useful to have Dr O’Kelly here to describe this correctly, but I will try. The implantation of specified types of implantables will be recorded, with that information linked to patients and clinicians. We are seeking to put systems in place so that the sort of circumstances that led to this very unfortunate situation can be more quickly detected in the future and so that clinicians can respond appropriately.

The Convener: I invite David Torrance to continue with the theme of communication and information.

David Torrance (Kirkcaldy) (SNP): In evidence to the committee, Dr O’Kelly acknowledged that communication and information could be improved. Why is the website for the national service, which has been running for a number of years, still a work in progress, and why is there no hyperlink from the NHS NSS website to the website for complex mesh surgical services?

Jenni Minto: To go back to answers to earlier questions, it is important to get the website right and to get support for the women who are in this situation right. There is currently a good amount of information on the website, but it could be improved. There is an argument that a lot of the websites could be improved to ensure that people get the right information and support.

That work has been continuing in parallel with work to ensure that the women who are referred get the best service. Improvements include the move to the new Victoria hospital, where the welcome, support and environment have been improved. Everything depends on priorities and resources, and it is right that some of the attention has gone on the location where women are first given support.

However, I take on board that the website needs to be improved. Just yesterday, we were talking about the hyperlink and I said that I expect it to be a quick win to add a link to the service so that, as soon as someone goes on to the NHS Inform website or the NSS website, they get directly to the service that they are looking for.

10:00

David Torrance: What more work is required to be done for women who are following the NHS route on communication with their GPs about appointments, surgery and follow-up treatment? Is a standard letter enough, or can that be improved?

Jenni Minto: To be fair, we are learning from the women who have experienced the situation that a lot of services could be improved. That is why I know that a lot of listening has been done. I appreciate that, at the start of this process, the women did not feel as though they were being listened to. So, to support them even more, listening has been absolutely key.

If anyone has experienced surgery, they will know that the best information that they can get is as much information as can be given, and a simple letter is sometimes not enough. That is why post-surgery phone calls to women have been introduced. That is incredibly important. I have suffered some surgery, and I know that you really do not take on board what people are saying during the first 24 hours after surgery. So, we need to find ways of keeping women more informed after their surgery.

It is also important to keep their families informed, because that is where the women’s main support will be once they have left the hospital environment. Improvements can be made, and I hope that that will happen. We have talked about the accountable officers in the health boards and how sending additional information to GPs should provide the level of support that women rightly expect.

David Torrance: Thank you. I have no further questions.

The Convener: Sandesh Gulhane has a supplementary question.

Sandesh Gulhane: David Torrance asked you about the website, and I believe that he said that it needs to be improved. I went into Google and I put in “NHS GGC complex mesh”. The hyperlink came up and it said, “It seems that we can’t find what you are looking for.”

Jenni Minto: Dr Gulhane, that is what I said yesterday. I did the same thing. We have taken that away and will find out why that is happening.

Evelyn Tweed (Stirling) (SNP): My question is about preventative guidance for women and girls. Stress urinary incontinence is a huge issue. When I had my children, I was lucky enough to be given immediate guidance about pelvic floor exercises, what to do after having a baby and so on. Do we need to standardise the information that is given to women and girls? Should it start in schools and be disseminated, to make sure that everyone knows what to do?

Jenni Minto: Sadly, I did not get the same training as you got. I do not have children, but I do recognise the conditions and their results.

Giving information on different exercises in primary and secondary schools would be a strong way forward. Emma Harper raised that concern during the evidence session on 2 May. This summer, I hope, the women's health group website is set to launch some short animations and support to help women to understand the importance of exercising muscles in their pelvic area.

That is a really positive way forward, and it reflects the importance of having the women's health plan, which can react and respond positively when women see a specific need. I would love yoga teachers or Pilates teachers to come into schools to give women support. That is a good suggestion from Evelyn Tweed.

Evelyn Tweed: Is any programme being considered for schools to talk about that to girls from an earlier age, before they even think about having children?

Jenni Minto: This week or early next week, I will have a meeting with Natalie Don, the Minister for Children, Young People and Keeping the Promise. We can talk about what solutions we might put in place.

The Convener: I am aware of the recent appointment of the women's health champion. I absolutely appreciate why menopause, heart disease in women and endometriosis have been prioritised within her role, as those are very important areas that the Scottish Government is working on. However, I am keen to hear how you see the women's health champion's role in promoting good pelvic health, if I can put it that way, when it comes to the education that Evelyn Tweed spoke about. I am also keen to hear about the Government's plans for reviewing the incontinence strategy.

Jenni Minto: I was pleased to meet Professor Anna Glasier very early after she was appointed. Her skills and personality embed exactly what women would like to see in their health champion. As you indicated, we have prioritised the menopause and endometriosis. I will have further discussions with the women's health team about how we can expand on those. It is important to say that, although Anna Glasier is the champion, we also have a group of officers who are working further on the plan. Greig Chalmers leads the group specifically on this.

We have a lot to do. In a meeting last week, I said that, until we can say "health" without having to put the word "women's" before it, we have a long way to go. However, I am confident that, with Professor Glasier's leadership and the wealth of groups of women who want to get involved in women's health and to raise it to the headlines, that can only be welcomed.

I am afraid that I have no information on the incontinence plan. I apologise.

Greig Chalmers: Convener, we will come back to you on that in writing.

The Convener: That would be really helpful, given that we want to move to a preventative strategy as opposed to treatment and to give women and girls the information that they need about looking after the pelvic floor. That is important for the committee to hear about.

Stephanie Callaghan: I could not agree more about stress urinary incontinence. Often, it is very treatable, but a lot of women think that they just have to live with it. I, too, would love to see something like that coming along into our schools.

However, my question is about peer support. Does the minister recognise the need for formal mechanisms for the provision of peer support? There is Scottish Mesh Survivors, but not every woman wants to be involved in a lobby group. Peer support is formalised in other countries. Will you look at that?

Jenni Minto: If I am being honest, I have not looked specifically at peer support for mesh survivors. However, I have had really positive experiences of groups getting together. We talked earlier about menopause, and there have been amazing support groups around that—even St Mirren Football Club has created a menopause chat group. I would like to see that happening for mesh survivors.

The other way of offering support is perhaps through third sector organisations. As an MSP, I have quite regular conversations with the chief officer of Argyll and Bute health and social care partnership about how it is supporting women's health in that health board area. It is about considering what connections could perhaps be made with the third sector interface or other women's health groups that could be of support. I am interested in looking at that theme, because I have seen great success through self-help groups in other areas.

Stephanie Callaghan: Our colleague Emma Harper, who is not with us today, suggested that creating something like a Maggie's centre could be a great idea. I just put that on your radar, minister.

The Convener: We will move to the next theme, with Carol Mochan.

Carol Mochan: I am interested in the link with GPs, which is so important because GPs are maybe the first port of call. Women have found the matter quite difficult, for two reasons. First, we know that GPs are under enormous stress, so I am interested to know what is out there to help GPs around transvaginal mesh issues.

Secondly, an important point about medical records was raised in our previous evidence session: why are GPs unable to easily ascertain whether women have had mesh implanted? Do we have an understanding of how we might resolve that issue? Some of the women have reported that they went to their GP with the symptom and that either the GP was unaware of it or the diagnosis was delayed. Do GPs get good information about the symptoms so that women can get a diagnosis and a referral?

Jenni Minto: I have read some of the reports from women who really struggled to explain to, and be listened to by, their GPs in the years leading up to 2015—when the issue was given front-page billing in media reports—and I can only imagine how frustrating that must have been for the women.

The work that has been done in Scotland and the cross-party work that Parliament has done has really improved everyone’s knowledge of the impact of vaginal mesh on women. As I indicated earlier, the fact that we have set up that specialist service and that specialist services are being set up in NHS England, too, with options to go abroad, is really helpful.

In an earlier answer to a supplementary question from Stephanie Callaghan, I indicated the training that NHS England has created for GPs and the importance of the work that Dr O’Kelly is doing to ensure that Scottish GPs can access that training, which is absolutely key to getting it right. I also refer back to the individuals in each of the health boards who are there to provide support.

Can you cover the point about medical records, Greig?

Greig Chalmers: Of course. The committee discussed that point on 2 May. I might refer back to what I mentioned earlier, which is the development of the pelvic floor registry that is being trialled in four health boards. That will allow for the recording of all treatments for pelvic organ prolapse and stress urinary incontinence as well as mesh removal procedures. We hope that the registry will be an important development in that area.

As the member says, clinicians, GPs and others are under significant daily pressure. They need to be able to access quality information about particular procedures and devices and about particular NHS settings quickly, and they need to be able do so without having to send away for records.

10:15

We can make a potentially powerful improvement in the coming years. We are working on that with four health boards as part of the wider scan for safety programme. It is not for me to talk about the legacy, but we are trying to do something positive by understanding and improving a situation that has had an impact on so many people.

We now have more ways in which more NHS staff—GPs and others—can access information that can give an advance warning. That applies both to individual patients and at a system level, so that a number of incidents occurring in a number of places would become obvious far more quickly. If we can make that improvement through the scan for safety programme, that will be an important change.

Carol Mochan: We have heard about the need to learn lessons and the need to have easy-to-access registry systems for other devices, such as hernia mesh. Has the Government considered that as a way of giving GPs easy access to information? Other people have raised that issue with us in the past.

Greig Chalmers: I will confirm this in writing, because I should be careful in talking about clinical matters. I do not think that the pelvic floor registry deals with hernia mesh—I commit to confirming that later in writing.

Carol Mochan: That would be helpful.

The Convener: We move to questions from Sandesh Gulhane.

Sandesh Gulhane: As a practising GP, I can say that access to records is shocking. It is not good enough to say that you are going to create a new system and that GPs might be able to access that, because I already log into three different systems and it takes forever to search for things. How will the new system that you are creating be linked to the records that already exist for GPs?

Greig Chalmers: Let me be straightforward: I do not know the operational detail. That is under development and we will be happy to speak to the four health boards involved in the pilot.

You make the important point that, when new systems are developed—whether by the Government or by health boards—integration with what is there already will be critical for success. I agree with you, and that is something that the pilots will have to reflect on and draw conclusions from. The idea of access is an important aspect of the work in progress.

Sandesh Gulhane: Carol Mochan asked about GPs accessing information. I often do not know what surgery a patient who is in front of me has had and patients often do not know the details of the surgery that they have had. You can send me all the information you want to send about what women who have mesh might experience, but, if I do not know that a person has had mesh implanted, how can I put two and two together?

Jenni Minto: That is a very fair question. Some of what I read in preparation for this meeting included responses from women who gave the kind of examples that you have given. Some articles also say that women had not been told, or did not know, or could not remember exactly what had happened to them.

I would hope—speaking very much as a layperson and someone who goes to a doctor for advice—that doctors' training and knowledge would allow them to ask the appropriate questions of their patients. I am sure that that is the case for the vast majority of GPs. I hope that they would therefore be able to eliminate something or say what the next step might be, such as a referral for a scan to see what has happened.

I am only a patient, but that is what I would hope for if I went to a GP to explain some of the symptoms that I had. As I indicated earlier to Carol Mochan, the increase in knowledge of this issue, and the support for GPs that I believe that health boards have put in place, plus the training, will move things to allow for better diagnosis. However, I absolutely get what you say about the fact that, historically, that information was perhaps not captured.

Sandesh Gulhane: Forgive me, but you are not just a patient; you are the minister in charge. It is very important to have a safety mechanism to ensure that that occurs. In relation to GPs' ability to co-ordinate patient care, when we have a scenario in which a GP would refer someone to a service, which would then refer the person to NHS GG&C, and there are multiple players involved, it is impossible to keep track of where things are. Would a simplified method be better in such circumstances?

Jenni Minto: You are absolutely correct that I am the minister. However, I am also a patient, and the experience that I was giving you was my own. One strength of a lot of MSPs and everyone sitting round this table is that we all come to discussions, debates and policy with our experiences. Therefore, it is important that I reflect that in answering questions, as you reflect the fact, which I respect very much, that you are a practising GP. Therefore, I absolutely take on board what you have said.

Yes, it would be wonderful to have a simple system that allowed everything to be accessible, but we must recognise that there are requirements around the general data protection regulation, which is high on a doctor's list of considerations when it comes to confidentiality and suchlike. However, on the premise of your point, yes, a simplified system would be helpful.

Sandesh Gulhane: Forgive me, minister, but are you saying that GDPR is an issue when it comes to referrals?

Jenni Minto: No—not at all. I was referring to how information is stored and made accessible.

Gillian Mackay (Central Scotland) (Green): Good morning. Obviously, at the moment, we have the complex mesh surgical service, and there will undoubtedly be women who need surgery further into the future. Many will have surgery that might not resolve their symptoms but that might remove the mesh. Therefore, I am interested in how that service will evolve as women go through the process of surgical intervention.

Will the service evolve to treat some of the symptoms, such as pain? I do not think that it is entirely appropriate for some of the women to end up in generalised pain clinics, because of the issues that they have faced. What should the next evolution of the service look like, and how long should the service be in place?

Jenni Minto: From the reading that I have done and the way that I have seen the service change over the past couple of years, I think that it has absolutely moved to being that holistic service. Early on in this evidence session, I mentioned that the service must be based on the person—the patient—so I strongly believe that the way that we can provide the best support for the women in this situation is by understanding their needs.

In about a third of referrals, I think, patients end up not choosing to go for surgery but looking for holistic support such as physiotherapy or support for pain or wellbeing. The service has to be aware of the possibility that that number could increase. I hope that the service will evolve to support women in the way that they feel is most appropriate to their circumstances.

I see that Greig Chalmers is nodding—he may want to add something.

Greig Chalmers: I agree with the minister. As she indicated, the service has evolved to include a wider range of clinical and other colleagues, which has been broadly welcomed. As I mentioned, NSS will renew the service level agreement shortly, and it will want to reflect that evolution. Gillian Mackay made the important observation that the service continues to evolve. The judgment will be difficult, and careful thought should be given to which services should be provided at the specialist centre and which provided locally. People who are referred from the islands or the north-east of

Scotland have a long way to go. There is a balance of pros and cons.

Gillian Mackay: Absolutely—you have pre-empted my next question wonderfully. We want a lot of care to be delivered in the community but, as you have said, much of the service has to be delivered in certain places due to its specialism. Is thought being given to how women who have had surgery and been discharged, but who feel that they need some of that wider non-surgical holistic support, can be referred back quickly so that they do not have the sorts of wait that there have been for accessing the service in the first place?

Jenni Minto: That is a natural follow-on. Given that the service is improving its support for pre-referral and post-referral people, there has to be an indication on the patient's records that that has happened, so that GPs and local health boards and their officials recognise that additional support may be required.

I have had meetings with groups that have concerns about treatment for other women's conditions, and they have talked about that issue as well. I do not want to increase the pressures on the women's health plan, but there is something to think about more holistically across health delivery for women in Scotland, to ensure that their aftercare is appropriate to their surgery and the support that they have had around it.

The Convener: Tess White has a supplementary question.

Tess White: I am reminded of the woman who had to wait a year and a half for an urgent referral, so here is just a thought. Sometimes, GPs are unable to help women who require mesh removal. Would it be better for GPs to be able to refer directly to the CMSS, or is there another way to get through the seeming bottleneck?

Jenni Minto: We have to strike a balance. On 2 May, the committee was given clear evidence about the importance of having one route that everybody understands and that would avoid any confusion or cluttering of the landscape.

What I take away from your questions is that we need to ensure that GPs are absolutely clear about the pathway, perhaps by writing directly to the health boards and their officers who have responsibility for the matter. However, adding another pathway might cause confusion, and it might not be the best way of supporting women who are in desperate need of this support.

10:30

Tess White: Thank you. I hope that we will monitor the situation closely.

The Convener: The committee has heard evidence on the curriculum and framework that the Royal College of Obstetricians and Gynaecologists has published for specialist training in mesh complications, and I am keen to hear about the clinicians who have been through that training. Can you give us any numbers? Have all the surgeons involved in mesh removal in Scotland been through that training?

Jenni Minto: I know that Dr O'Kelly has talked about credentialling across the four nations. I am not clear how far those discussions have gone, but I know that the surgeons who operate in Scotland have been trained to very high standards.

I do not know whether Greig Chalmers has anything to add, but it is probably best if we come back to you with an indication of progress that has been made in credentialling across the four nations and with the numbers of those who have been trained.

The Convener: That would be helpful, minister. I think that Sandesh Gulhane has a question on this theme.

Sandesh Gulhane: What is the Scottish Government's position on credentialling?

Jenni Minto: As we have said, Dr O'Kelly is not here today, and I would have asked him to answer that question, as it is on a specifically clinician-led area. That said, I think that setting a high standard is a positive way forward, and that is what credentialling will allow us to have across the four nations.

Sandesh Gulhane: Do you envisage credentialling moving into general practice?

Jenni Minto: I do not feel qualified to answer that question.

Sandesh Gulhane: Can you write to us with a response?

Jenni Minto: I am sure that we can.

Sandesh Gulhane: Okay.

Obviously, a key member is missing from the clinic; it has no urogynaecology specialist, which is causing a bit of angst among a lot of women who have written to me. There has been a lot of talk about issues of continence in women—and I just want to say very quickly that it is a real shame that women do not go to their GPs about such issues, as there is a lot that we can do. It is certainly not wasting my time for women to come and see me about those issues but, sadly, that is what a lot of them feel, I think. When do you envisage such a specialist being in place in the clinic?

Jenni Minto: I am aware that you asked that question two weeks ago, and the response was that active recruitment is happening at the moment. I should point out that there are urology specialists in Scotland, and they can provide support as and when required. I am afraid that I cannot give you a timeframe, but I have been informed about the situation and it has been underlined that this is a key appointment that people are working to progress.

I agree with you that women should be able to approach their GPs regularly with whatever concerns they have and get the right support, which I know GPs can provide.

Greig Chalmers: Perhaps I can add something for clarity. The minister and the member are entirely right to say that no person of this type is employed directly in GG&C at the moment, but I emphasise that the service has access to such support through another health board in Scotland. That advice is there, although we understand that such a person is not presently employed in GG&C.

Sandesh Gulhane: I have a final question. When I was training to be a GP at the Royal, Dr Ros Jamieson was one of the trainers in obstetrics and gynaecology. I understand that she is no longer within NHS GG&C. You certainly cannot comment on individual consultants but, in such a specialist clinic, which already seems to be a little under strain, what can we do to protect the service when consultants move and there is turnover of other staff?

Jenni Minto: I am not sure that I would categorise the service as being under strain. As you have heard in our evidence and in the evidence that you received two weeks ago, it is clear that the service is improving and is listening to women. As I said in answer to Carol Mochan's questions, waiting times have reduced, and the NSS survey responses show that women perceive an improvement in the service. However, it is appropriate to raise the point about availability of people to work in that specific area and other specialist areas. That is why we have to continue to ensure that the NHS in Scotland can get the right access to good people and employ the best people that we can. I hope that the importance of NHS surgery and support for women is recognised and that we can employ the appropriate consultants.

To look at it from the other perspective, putting care in one specific centre gives us a centre of excellence. In his evidence, Dr O'Kelly said that the service is well thought of and well perceived in the wider United Kingdom. It is important to have that centre where all the skills are in the one place, as opposed to perhaps having them more spread out across Scotland. I think that I am right in saying that we have one centre in Scotland and there are nine in England, which reflects population need. Given that the service is seen as being of such a high standard, I hope that we will continue to attract the right people to work there, so that women get the health support that they need.

The Convener: Thank you, minister. I am aware that we have taken you over the allotted time, but Stephanie Callaghan has one brief question before we finish.

Stephanie Callaghan: Thank you, convener, for allowing me in.

The minister is aware that the Patient Safety Commissioner for Scotland Bill is currently making progress through Parliament and that Professor Alison Britton's case review on transvaginal mesh is also coming through. Once the patient safety commissioner for Scotland is appointed, will the minister highlight the need to have learning and improvement work taken forward from the transvaginal mesh situation?

Jenni Minto: Thank you for raising that point. That is a really important piece of legislation that is going through Parliament just now—you certainly highlighted that in your contribution to the chamber debate on the bill last week. As was mentioned in that debate, if the bill is passed and becomes an act and the patient safety commissioner is in place, it will be up to the commissioner to decide what areas they will work on. From my perspective, there is a huge amount of learning that we have to get on record and understand from the transvaginal mesh situation. I do not want to put something into that person's in-tray straight away, but I think that it should be there.

The Convener: I thank the Minister for Public Health and Women's Health and Greig Chalmers for their attendance this morning and for their evidence. The committee looks forward to seeing the written responses that the minister and her official have committed to sending to us.

At our meeting next week, we will continue our scrutiny of NHS boards, as well as taking further formal evidence as part of our inquiry into female participation in sport and physical activity. That concludes the public part of our meeting.

10:40

Meeting continued in private until 11:14.

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