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Tuesday 5 December 2017

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

Time for Reflection

The Deputy Presiding Officer (Christine Grahame): Good afternoon. The first item of business is time for reflection. Our leader today is Fiona Stewart, creative director of Foolproof Creative Arts.

Fiona Stewart (Foolproof Creative Arts): Presiding Officer and members of the Scottish Parliament, thank you for giving me the opportunity to address you this afternoon.

John F Kennedy said:

> “We must never forget that art is not a form of propaganda; it is a form of truth.”

I am a performer, a writer and a director, but above all else I aim to be a truth-teller. Actors in training are often reminded that truth is in the body. The heart and soul of a good performance is about taking a piece of text or an idea and bringing it to life, making it believable to an audience.

As a performer, I strive to communicate as specifically as possible. As a writer, I try to create characters and situations that enable the audience to understand the deeper story running beneath the action. As a director, I want to help actors find ways of portraying character truthfully. The longer I do my job, the more I notice the disconnection that occurs when an actor plays a role untruthfully or glibly, and everything in me is shouting, “I don’t believe you!” Uta Hagen describes the process of performing truthfully thus:

> “Thoughts and feelings are suspended in a vacuum unless they instigate and feed the selected actions, and it is the characters’ actions which reveal the character in the play.”

In other words, there is no point in feeling an emotion unless it is used to prompt the physical action of the performer. People understand who a character is by what they observe them doing.

In real life, the same is true. I may speak certain words, but you will read what I really think and believe by my posture, my gestures and my facial expressions, and you will draw your own conclusion as to where truth lies.

We are in the season of advent—a time of waiting. In John’s gospel, Jesus is described as Immanuel: God with us, the divine made real with human skin and bones, full of grace and truth. People understand who a character is by what they observe them doing. Incarnation—the coming of God in human form—reminds us that God’s character is revealed in his actions. In him we find truth and grace in equal measure, demonstrated in his life, his death and his resurrection. Truth is in the body.

This advent, may you find time to reflect on incarnation, and in so doing may you live, speak and act with grace and truth.

The Deputy Presiding Officer: Before we move to the next item of business, I advise the chamber that the Presiding Officer has selected two urgent questions for answer today. The first one will be taken as the next item of business and the second will be taken following the Public Petitions Committee debate. As a consequence, decision time will be at 5:30 pm. A revised business programme has been issued to all members.

Urgent Question

14:03

European Union (Regulatory Alignment)

Mairi Gougeon (Angus North and Mearns) (SNP): To ask the Scottish Government whether discussions have taken place with the United Kingdom Government regarding Scotland retaining regulatory alignment with the European Union and effectively remaining in the single market.

The Minister for UK Negotiations on Scotland's Place in Europe (Michael Russell): The Scottish Government put forward proposals in December 2016 in its publication "Scotland's Place in Europe", which set out our view that, if Brexit was unavoidable, the UK as a whole should remain within the European single market and customs union. We set out a mechanism through which, in the event that the remainder of the UK chose not to do that, Scotland could continue to benefit from membership of the single market and the customs union.

However, subsequently, in her Lancaster house speech, the Prime Minister, without any consultation or forewarning, ruled out single market and customs union membership. Much of the damage and chaos that have been caused over the past year are a direct result of the red lines that the Prime Minister set out then. After our proposals for Scottish membership were tabled at the joint ministerial committee on European Union negotiations in January 2016, there were limited further discussions between officials in the UK and Scottish Governments. Two months later, the UK dismissed the proposals as unworkable, without giving any convincing reasons.

We fully support the Good Friday agreement, in all aspects, and we welcome the proposals of yesterday that sought to ensure that there would be no return to a hard border in Northern Ireland, and which demonstrated that the principle of a differentiated approach, which we set out in December last year, was viable within the scope of the UK's future relationship with the EU. Although the detail remains unclear, the Irish Government has been clear that it would facilitate free movement of people, goods and services across the border to Northern Ireland. On that basis, we understand that the deal provides for a dynamic regulatory compliance between Northern Ireland and the EU acquis, now and in future, and provides for an agreed form of dispute resolution, which could include the European Court of Justice. We will press for further clarity on those and other issues as a matter of urgency.

Of course, Scotland did not vote to leave the EU. The best solution would be to stay. However, in the case of a continued move towards Brexit, there is overwhelming support in this Parliament and across the country for retaining Scotland and the UK's place in the single market and customs union. Therefore, it is time for all of us, here in Scotland and across the UK, to speak out at this crucial time for what is in everybody's interests and reject a hard Brexit. It is time for Scotland to speak with one voice, and I encourage all who realise that single market and customs union membership is vital to say so and to work to achieve that.

Mairi Gougeon: Given the discussion and debate over the past few days, I do not think that it is fair that there can be one rule for one constituent part of the UK and another rule for everyone else. Last year, the UK Government committed to

> "full engagement with the Scottish Government, the Welsh Government and Northern Ireland Executive on the UK's exit from the European Union",

and the four Governments agreed to work together towards an agreed UK approach to the Brexit negotiations, through the joint ministerial committee. Does the minister think that there has been full engagement with the Scottish Government on the latest developments, or that we have an agreed UK approach?

Michael Russell: I stress at the outset that the situation in Northern Ireland stands on its own, with its own history and its own need for a solution that respects, for example, the Good Friday agreement and the great benefits that that has brought. However, that stands alongside membership of the single market, which has allowed the border to be completely porous with, I think, 275 crossing points.

We are endeavouring to work on solutions that have been made more difficult by the European Union (Withdrawal) Bill, and we have been making progress on those. What yesterday's chaos actually means is a moot point and will have to be factored into the discussions that we are having. There is due to be a meeting of the joint ministerial committee next Tuesday, and we hope that at that meeting we will be able to explore the issues, get some clarity about what the situation is and find a way to move forward.

It is very difficult to negotiate with people who seem to change their position all the time and who do not inform others of their position. What we saw yesterday was a chronic failure to keep everybody informed about what the situation was. We ourselves have, over a period, suffered from not having the information that we required. Maybe this will be an object lesson for the UK Government; maybe it will change.

Mairi Gougeon: What will be the consequences for jobs and living standards in Scotland if the UK leaves the single market and the customs union? In particular, what will that mean for rural constituencies such as mine, Angus North and Mearns?

Michael Russell: I, too, represent a rural constituency, Argyll and Bute—indeed, some people might call it an extreme rural constituency—and I am very worried, as all members of the Scottish Parliament should be about the effects on their constituencies, rural and urban, of our leaving the single market and the customs union.

We published material last year in “Scotland’s Place in Europe” and we have published analysis and other information over the past 12 months. Just recently, we published our evidence to the Migration Advisory Committee, which paints a stark picture of the difficulties that we will have if there are restrictions on migration.

In the circumstances, the best solution would of course be to stay in the EU, but the compromise solution, which we put forward 12 months ago and which seems ever more relevant, is to remain within the single market and the customs union. Such an approach has been widely supported across the Parliament—I am very grateful for that; it is extremely important. Indeed, although I do not anticipate questions from Conservative members today, I am mindful that, just days after the vote, Ruth Davidson said:

> “Retaining our place in the single market should be the overriding priority.”

I do not think that that has changed. If this Parliament were to speak with one voice on membership of the single market and the customs union, I think that that would be very effective indeed.

The Deputy Presiding Officer: We will have to move to the topical question at 2.25, so I ask those members who wish to ask questions to be succinct, so that we can get everyone in.

Jackson Carlaw (Eastwood) (Con): Somewhat unexpectedly, I agree with Mairi Gougeon’s opening remarks. The Scottish Conservatives believe that if regulatory alignment in a number of specific areas is a requirement for a frictionless border, the Prime Minister should conclude that that must happen on a United Kingdom-wide basis.

Yesterday, the First Minister hastily took to Twitter to once again demand a separate Brexit deal for Scotland. We know how that would benefit the Scottish National Party’s political objectives, but can the minister explain how separate arrangements for Scotland and England would be beneficial to the rest of us, given that trade with Britain is worth four times more to Scotland than trade with the whole of the European Union combined?

Michael Russell: I am going to be very constructive in my answer, no matter how much Jackson Carlaw tempts me not to be.

The reality of the situation is that the position that the First Minister has laid out yesterday and today is exactly the same as the position in “Scotland’s Place in Europe”, which we have had for the past year and which I am sure that Mr Carlaw has read, marked and inwardly digested. The position is that our preference is to stay in the EU. If that is not what is to happen—I think that the evidence for doing so grows stronger and stronger—a whole-UK approach to staying in the single market and the customs union is what is required. Whether we call it regulatory convergence, lack of regulatory divergence or continued observance of the acquis, that would be the best solution.

In the circumstances that we are in today, that is also the best solution to resolve the difficulty that has arisen in Ireland and Northern Ireland, because it squares the circle—the impossibility of making one offer to Ireland and another to Northern Ireland. The only way out of that is to make sure that the whole of these islands is in the single market and the customs union. If the Scottish Conservatives would support that—as they have in the past—that would be a considerable step forward. That would resolve the issue.

We also know that there can be no cherry picking of the single market. The idea that appears to be being floated at the moment in Downing Street—there are so many ideas being floated in Downing Street that I am surprised that it is not under water—involves the cherry picking of agriculture, elements of trade and elements of energy regulation, but the reality is that that will not be possible. [*Interruption*.] Adam Tomkins says from a sedentary position that those elements are in the Good Friday agreement. Yes, they are, but the Good Friday agreement goes alongside membership of the single market. Not everything is in the Good Friday agreement, and that is a difficulty.

The solution is single market membership for the whole of the UK. The position that the First Minister has articulated is also in “Scotland’s Place in Europe”. If that is not available, it is axiomatic that those places that can have a different arrangement should be allowed to have that, and that is the position that we find ourselves in. Single market membership for the whole of the UK would be the way out of the incredible mess that has been created by Theresa May, and I urge it on every member of the Parliament.

Lewis Macdonald (North East Scotland) (Lab): What matters here, of course, is to draw the right conclusions from current events, and I hope that the minister will agree that it would be a mistake to use the chaos of Theresa May's failed deal on Northern Ireland yesterday simply to push for a differential deal here, too. Is the right conclusion not to say, "If it's good enough for Northern Ireland, it's good enough for the whole of the UK"? If the proposals that were floated by Mrs May yesterday were indeed designed to protect jobs and business in Northern Ireland, surely we should seek to do the same in Scotland, England and Wales. Should achieving that not be the focus of all the efforts of the Scottish Government?

Michael Russell: I am in the curious position of hearing my own words echoed back in that question. I have just said that a differentiated deal is at the end of the road. We are forcing the pace by saying, "Let's have a deal for the whole of the UK." We should do that, but it is also wise to be prepared—as the member has in the past urged me to be—for any circumstance. "Be prepared" is the motto of the boy scouts; I was never a boy scout, but I recognise the motto. We are preparing ourselves, but we must be realistic and recognise that if the solution of a deal for the whole of the UK is not possible, another solution must be found.

We wish to have a UK-wide solution—in that regard, I commend to members paragraphs 169 to 171 of "Scotland's Place in Europe". We have said that membership of the single market and the customs union would be the best thing for Northern Ireland and the rest of us.

If, however, that is ruled out, it would be wrong to have entirely differentiated solutions in one place and not in another—not least because it would be very damaging to Scotland. The effect of having a differentiated solution in one part of the UK and not in another could be deleterious to the country, and I am sure that Lewis Macdonald would not urge upon the chamber actions that would be damaging to Scotland. However, I agree that the whole of these islands should be in the single market and the customs union. We urge that upon all, but particularly upon the Labour Party. I have to say that if the Labour Party were to adopt that approach—to carry that standard in the campaign—it would move things on very considerably indeed. The First Minister made that point this morning, in a tweet to Jeremy Corbyn, and I repeat it to Richard Leonard.

Patrick Harvie (Glasgow) (Green): It seems that those who angrily assert the difference between differentiated models among parts of the UK and full single market membership for the UK are missing the central point: that those are now the only two credible options. Last week, the cabinet secretary spoke at a meeting of the Finance and Constitution Committee, in positive terms, about the re-energised process in the joint ministerial committee (European Union negotiations). Did the JMC meeting specifically address the question of the extent to which differentiated options are technically achievable? If it did not, will the cabinet secretary ensure that next week's meeting of the JMC does not end without a clear answer to the question of whether such options—or the UK's single market membership—are still on the table?

Michael Russell: There has not been a meeting of the JMC since I gave evidence to the Finance and Constitution Committee, but, of course, John Swinney and I have had a meeting with Damian Green and David Mundell. We were looking at ways in which we could progress discussions on the European Union (Withdrawal) Bill and on frameworks. An hour is a long time in Brexit, and that meeting took place well before we had the current situation with Ireland. In evidence to the committee last week, I said that I thought that it was a pending difficulty that was coming towards us very fast—and so it has happened.

I cannot imagine going to the JMC meeting next week and not making it crystal clear—as I am sure that my colleague in Wales, Mark Drakeford, will—that what has happened in the past 24 hours has changed things yet again and will require to be addressed very seriously indeed. There must be a resolution of that. However, I agree with Patrick Harvie that there are only two possible solutions: one is to have a differentiated solution, but the better one is to have a solution for the whole of the UK. Anything else will not resolve the issue. Again, I am grateful for the support that Patrick Harvie has given, and I urge others to give theirs. Together, we can make a substantial difference on the matter.

Willie Rennie (North East Fife) (LD): We do not really know what the Conservatives and their Democratic Unionist Party allies are doing, and neither, it seems, do they. We have a mounting set of broken promises on Europe: first, on the £350 million for the national health service and now the apparent dismissal of any scaremongering about the Irish border. In that context, does the minister not think that there is a third option, which is that the British people should have the final say on whether it is appropriate to accept this guddle—or should it be left to the Conservatives and their DUP allies?

Michael Russell: As Willie Rennie knows, I have certainly not ruled out supporting that third option. There is a need for people to reflect very seriously on the changed circumstances in which we now are. As he will know, an opinion poll yesterday showed that, in Scotland, there is now a substantially greater majority against Brexit than there was even on 23 June last year. There is some indication that that is also happening elsewhere. On the radio this morning, I quoted the case of Grimsby, which is a town in which 70 per cent voted to leave the EU, but whose fishing industry now says that it does not wish to have the disadvantages of doing so. People are genuinely seeing what the difficulties are. I have been very struck by the number of people who have commented to me on the difficulties that will be caused by the way in which the competition to be named European capital of culture has come to an end. People are seeing the effect of what is taking place. They will wish to reflect on that, and there may be a number of ways in which they can do so.

Willie Rennie is also right that the chaos of the situation is a major factor that affects people's confidence in politics, which is something on which Theresa May needs to reflect very seriously indeed. There is a weekly—sometimes daily—crisis of confidence in the UK Government, which cannot be good for the generality of politics. I say again that it would be an example if the chamber could come together on the issue of the single market and the customs union and be able to say that that is what it wants to be delivered and that that is what it will try to do.

I am still meeting representatives of the other political parties and I am glad to do so. When we meet again—this week, I hope—I hope that we will reflect on that. That stance, which was taken right across the chamber, before and after the referendum, could unite us in a clear view of what should happen now. People are looking for a clear view of what should happen now, because all that they are getting is chaos and confusion from elsewhere.

Daniel Johnson (Edinburgh Southern) (Lab): On a number of occasions this afternoon, the minister has stated his position that a differentiated settlement is one option further down the line, but what assessment has the Scottish Government made of the economic impact of Scotland ceasing to have regulatory alignment with the rest the UK?

Michael Russell: It is quite obvious that we have assessed the difficulties of ceasing to have regulatory alignment with the EU. We are in a position where our own paper and future papers have reflected on all of the issues. However, I ask the member to think about this. I have made it absolutely clear that the best solution is to have regulatory alignment across these islands. That is the work that we have been trying to achieve—it is the position that we have laid out. We are grateful for the support of the Labour Party, frequently, in this chamber, on the issue of the single market. If we focus on what might unite us to achieve that, we would probably achieve more than if we focus on what divides us. Here is an opportunity for the chamber to achieve something and I hope that we can do it together.

Anas Sarwar (Glasgow) (Lab): Does the minister accept that there is a credible alternative to the Tory Brexit shambles that, first, respects the result of the referendum; secondly, resolves the issue of the border between Northern Ireland and the Republic of Ireland; thirdly, challenges the economic deficit that will come from Brexit; and, finally, stops further austerity? That alternative is to support permanent membership of the single market and the customs union for the entire UK. There is a natural majority across the UK for permanent membership of the single market and the customs union.

Michael Russell: We could find ways to disagree but I will not disagree with Mr Sarwar. That is absolutely what should take place. I have described a single market solution as not transition but destination. That would be another way of putting what the member has just described. That is available to us. Contrary to the completely erroneous information given by David Jones on a television programme on which I appeared with him this morning, it is perfectly possible for the UK to say, "We now see that the best result would be for us to stay in the single market and the customs union." There is a mechanism so to do, through European Free Trade Association and European Economic Area membership. I am absolutely sure that a way could be found to do that, which would solve the issue.

It would also create the circumstances in which negotiations become much clearer and easier, because the negotiations would then be about a single market solution; a single market minus solution perhaps, but a single market solution. That is a completely clear path out. Almost uniquely, I am not going to disagree with Anas Sarwar. I am not going to disagree with Daniel Johnson or Lewis Macdonald either. We are as one on that and I am very glad that we could unite on the issue of single market membership.

Topical Question Time

14:23

Royal Bank of Scotland (Branch Closures)

1. **Kate Forbes (Skye, Lochaber and Badenoch) (SNP):** To ask the Scottish Government what impact it expects the branch closures announced by RBS will have on communities across Scotland. (S5T-00811)

The Minister for Business, Innovation and Energy (Paul Wheelhouse): Last week's announcement by RBS that it is to close a further 62 Scottish branches is a body blow to communities across Scotland. That most recent announcement is the latest in a long line of branch closure announcements—a programme that is rapidly accelerating. The closure announcements by RBS and other retail banks are affecting communities the length and breadth of Scotland. I welcome the decision that a members' business debate will be held next week to allow all members to raise the concerns of their constituents.

As members will know, the United Kingdom Government retains legislative and regulatory responsibility for banking and financial services, and is the majority shareholder in RBS. However, although the matter is not a devolved responsibility, the Scottish Government stands ready to work constructively with UK ministers, RBS management, unions and wider stakeholders to support and reassure customers, in the light of the planned branch closures, and to minimise the negative impact of closures on the wellbeing of the communities across Scotland that will be affected.

In our view, the UK Government should not be a passive bystander; it should take immediate action to defend customers and ensure that communities—in particular, the most vulnerable members of those communities—continue to have access to day-to-day banking services, including ATM provision, and that businesses have the ability to deposit their takings safely, locally.

While respecting that commercial decisions have been taken by RBS and acknowledging that the use of online banking is growing, the Scottish Government remains steadfast in its opposition to the planned closures proceeding until such time as a guaranteed minimum level of service provision for essential banking services is in place.

Kate Forbes: I thank the minister for the reminder that banking is a reserved matter and that the UK Government owns a 71 per cent stake in RBS on behalf of taxpayers. Many of those taxpayers—for example in Kyle, Mallaig, Beauly and Aviemore—whose local branches are being closed may now have to travel for over an hour to the closest branch. Has the minister been able to speak to his counterpart in the UK Government about his views on the matter?

Paul Wheelhouse: Yes. I spoke to Stephen Barclay, the Economic Secretary to the Treasury, yesterday afternoon to press the case for a guaranteed level of access to essential banking services. The UK Government has made it clear that it will not, despite its having a majority stake in the RBS, exercise any influence that it may have to support RBS's customers at this time. I appreciate that RBS does and must operate on a commercial basis. However, the UK Government, as the Government with responsibility for regulation for the financial sector, has a duty to ensure that the banking system meets the needs of all users, whether they are in Aviemore, Beauly or other vital local communities across Scotland. Although we respect the commercial relationships that the banks have with Government, we believe that the Government should work to ensure that robust alternative options are in place before it allows the bank-branch closures to take place.

The Deputy Presiding Officer (Christine Grahame): Thank you. I have eight members—

I am sorry. Does Miss Forbes wish to come in again?

Kate Forbes: I will, if I may.

It is worth noting that the announcement by RBS is just the latest in a series of announcements about branch closures in which we have seen banks totally deserting rural communities—including in my constituency—in which elderly people, cash-based businesses and rural residents have the most to lose. How important is it that there is a minimum level of banking services in the most rural dependent communities?

The Deputy Presiding Officer: I apologise again, Miss Forbes. I was ahead of myself.

Paul Wheelhouse: I certainly agree with Kate Forbes and, indeed, with my colleague beside me who represents Argyll and Bute. I know that in communities such as Inveraray, and in communities in the Borders, where I live, the announcements are being very acutely felt. I agree that the closures will have the greatest impact on those who are least able to make use of alternative services. We are aware of customers of RBS in those communities for whom online banking is, depending on their perspective, something entirely new and frightening. Clearly, their ability to use the online services may be limited.

I have been reassured to some extent in conversations with RBS that it will make great efforts to train those customers on how to access services, but we all know that in areas of rural

Scotland there are still challenges in terms of digital access. Progress is being made, but we are aware that there are still households and customers around the country who have limited access to digital services, so we need to ensure that suitable and accessible alternative provisions are made to ensure that no customers are left unbanked by branch closures.

Further to that, I am aware of the work that RBS is doing with the Post Office in looking to expand the services of the post offices that cover areas that are losing bank branches. That is welcome, but I am also aware that there are limits to how much cash can be banked at post offices, which I raised with Stephen Barclay yesterday. There are also challenges in respect of the range of services that are available in post offices, in which there is, in effect, a basic banking service rather than a full-range service. We have also raised that concern with the UK minister.

Although there are commitments by RBS to extend its mobile banking network, we have concerns that it may not have enough vehicles, including vehicles with disabled access, to allow all customers, regardless of their vulnerabilities, to access services. There is much to be done; we want a dialogue with RBS and the UK Government to make sure that those limitations are addressed before the closures take place.

The Deputy Presiding Officer: Thank you. At least eight members want to ask questions, so I respectfully ask the minister to be briefer in his comments—I am sure that they will be duplicated. I will try to get through as many questions as possible, bearing it in mind that there is a debate on the matter next week.

Murdo Fraser (Mid Scotland and Fife) (Con): In his reply to Kate Forbes the minister mentioned internet banking, which is cited by RBS as being one of the reasons for its closing branches. However, as I am sure the minister will appreciate, in many parts of rural Scotland, including in Perth and Kinross, where a number of branches are closing, both mobile and broadband connectivity are such that people cannot do internet banking, even if they want to. Will the minister make those points forcefully to representatives of RBS when he meets them, as I and my colleagues have already done?

Paul Wheelhouse: That is a fair point, which I made it in my response to Kate Forbes's second question. Progress is being made on ensuring digital access, but we are all aware that the reality on the ground is that there are communities in Perthshire, the Highlands and other parts of rural Scotland, and some urban communities, where mobile banking via mobile phones or broadband is still a challenge. We strongly encourage RBS to consider that matter. I have raised—and will continue to raise—that with the bank, and I hope that we will make progress.

Mike Rumbles (North East Scotland) (LD): I have written to the chief executive of the Royal Bank of Scotland asking him to examine the possibility of working with other businesses—even his competitors—to establish shared premises from which to operate. Does the minister support such an initiative, which would include sharing of costs and would allow banks to remain in towns and villages across the north-east, which will be particularly hard hit by the proposed closures?

Paul Wheelhouse: I would certainly welcome that. Mike Rumbles's point is similar to one that I have raised with RBS. He is right to try to challenge the bank on those issues. Is it strictly necessary to close all the branches if there could be collaboration to provide a central facility? As I understand it, changes to primary legislation would be needed to allow that to happen. That is a matter for the UK Parliament: the regulatory and legal powers over banking and financial services rest at Westminster. We have commented on the issue, and I would welcome dialogue with RBS.

Mike Rumbles was right to identify the need for banks to collaborate. Traditionally, they have seen themselves very much as competitors and do not talk about collaboration, whether on ATM or branch provision. There is an opportunity arising from the very strong public concern that has been expressed about not only the latest tranche of closures, but about the previous tranches, for the banks to seek to collaborate to try to address the issue.

We are not blind to the growth in online banking—we accept that it is happening—but the pace of change is catching out customers. That is the key challenge that we all must face.

Joan McAlpine (South Scotland) (SNP): The proposed closures do not affect just small villages. I have calculated that 16 branches across my South Scotland region will be affected, including in market towns including Lockerbie, Annan and Langholm.

Last year, the Royal Bank of Scotland tried to improve its image with a brand campaign in which it called itself the "Royal Bank for Scotland". Does the minister agree that many people will feel very cynical about that and regard it as, at the very least, a breach of advertising standards?

Paul Wheelhouse: Unfortunately, I am not the advertising regulator, but I take Joan McAlpine's point. I point out that the nearest branch in my area—the eastern part of the Borders—is in England, which is ironic, given Joan McAlpine's point about branding.

The closures are a concern. As part of the programme, six of the eight branches that are left in the Borders will be closed. Although, overall, a quarter of Royal Bank of Scotland branches are to close across Scotland, six out of eight branches are to close in one local authority area. Other local authorities—South Lanarkshire, for example—will lose seven branches in the latest programme. The programme has raised so much concern because it has potentially devastating local impacts.

When the previous closures were made, we were reassured that the nearest branch would be in the local town and that villages therefore need not suffer too badly. However, now that those branches are to go, there will be serious consequences for vulnerable customers, as well as for small businesses, which will have to travel lengthy distances in order to bank their cash. That will be a real challenge, given that the economy in much of rural Scotland is tourism driven.

Neil Findlay (Lothian) (Lab): The RBS has bailed out of West Lothian, leaving branches only in Bathgate and Livingston. In each of the places the bank has vacated, we have properties lying vacant in their high street. Many community groups want to take over those properties for community use, but they have been refused by RBS because of its greed. It wants its hands on the cash. Is not it a disgrace that no legacy is being left by it after years of loyalty from customers in those communities?

Paul Wheelhouse: That is an issue. Other banks, and not just the RBS, have had loyal customers for many generations who have supported the banks, although we should not forget that they have been supported by the banks in return.

Neil Findlay makes a valid point about what happens to vacant branches once they close. It need not be a black-or-white situation. Funding is potentially available through the Scottish land fund for communities that are interested in taking over facilities. If there is a willingness on the part of banks to sell to those communities, we can perhaps find a way.

Parliament can make its view clear to the Royal Bank of Scotland and to other banks that we look to them to engage in those opportunities with communities to see whether facilities can be used to house community facilities, credit unions or alternatives. That dialogue with RBS would be welcome, just as it would—because it is not just RBS that is closing branches, unfortunately—with other retail banks.

Donald Cameron (Highlands and Islands) (Con): What reassurances can the minister give to island communities, including Barra where the RBS branch is under threat, that are particularly vulnerable to closures of services?

Paul Wheelhouse: As I have explained, because this Parliament and Government do not have regulatory or legislative powers, unfortunately, there is nothing that we can do directly to force banks to change their minds. Parliamentarians can all make our views and concerns known to the senior management team at RBS.

I recognise the ludicrous situation for an island community such as Barra—the point has been made by Angus Brendan MacNeil, the MP for the Western Isles—that it would probably be easier for someone from Kent to travel to Calais to do their banking than it is for someone from Barra to get to the mainland. Such is the challenge that we face in our most remote and rural communities, which is why it is so potentially devastating to lose our branch network. There needs to be a concerted effort to make sure that there is adequate provision left for communities once those branches go—if they go. We have no direct power to influence the decision, so it is down to UK ministers, who have a controlling stake in the bank, to make their influence felt.

The Deputy Presiding Officer: I am sorry, but that answer must conclude topical questions. I apologise to Alex Neil, Alex Rowley and Richard Lyle because I am unable to take their questions. I hope that they are in the debate next week.

Planning and Inclusive Growth

The Deputy Presiding Officer (Christine Grahame): The next item of business is a statement by the Minister for Local Government and Housing, Kevin Stewart, on planning and inclusive growth. The minister will take questions at the end of his statement, so there should be no interventions or interruptions.

14:36

The Minister for Local Government and Housing (Kevin Stewart): Scotland's economy needs a world-class planning system. We need long-term planning to lay the foundations for inclusive growth and future infrastructure investment across Scotland.

When planning is done well, we get high-quality developments, well-functioning communities and places that we value. Planning in Scotland has had its successes, but there is room for improvement. It is crucial that planning is an active facilitator in the growth of our economy, particularly in light of the challenges ahead of us. For example, the Government is acutely aware of the particular threats to rural Scotland arising from Brexit and the importance of planning as an enabler of development in our rural communities. Planning needs a rethink if we are to realise its full potential as a driver for sustainable growth. Our planning system must take a strong and confident lead in securing the development of great places that will stand the test of time and help us to adapt to long-term climate change.

My first request to planning officials when I became the Minister for Local Government and Housing was for a full report of the independent panel that was set up to review the operation of our planning system. The review was independent of Government—it was not led by the development industry or the profession—and it had a focus on the experience of those people who use the planning system and whose places are shaped by planning decisions. The drivers for the planning review—the delivery of housing and infrastructure, the experience of our communities, and the effectiveness of development planning and management, resources, skills and leadership—were, I believe, the right areas to examine, and they remain the key areas for improvement.

The Government followed up the panel's work with extensive consultation and discussion with a wide range of stakeholders and heard many views from professionals, the development sector and businesses. I was particularly pleased that many individuals and community organisations took the time to share their ideas. Bringing people together has not guaranteed consensus. However, we have listened to all views and I am grateful to everyone who has engaged in the process to date. Planning is important to all of us and the system needs to work for all interests.

Yesterday, the Scottish Government introduced the Planning (Scotland) Bill to Parliament and I take this opportunity to update Parliament on how the bill will change how planning operates in Scotland and how our legislation is supported by a wider programme to promote changes in approach and changes in attitude in planning.

Our communities need investment in development, which is a good thing. It brings much-needed housing, infrastructure and services that we rely on, such as schools, and places for our services and for enjoying our leisure time. Importantly, investment in planning and development also brings much-needed jobs.

The Planning (Scotland) Bill is about inclusive growth. It is about securing investment in all our futures and, at a time when Brexit brings nothing but uncertainties, it is even more vital that we support Scotland's economy. The bill sets out a strong legislative structure for a much more proactive and enabling planning system. It will bring us clearer development plans that will be produced through collaboration without being stuck in process.

Development plans need to provide clarity about where development should take place and how our places may change over time. They should help us to design and deliver places where people can lead healthier lives, move around easily and have access to the homes, services, facilities, education and employment that they need. They should set out a vision for places that are low carbon and resilient to the future impacts of climate change.

We should be focused on delivery rather than a continuous cycle of plan making, so we will simplify the development plan system. We propose to remove the current tier of strategic development plans and ensure that the national planning framework and local development plans provide effective co-ordination and delivery of the infrastructure that we need to support development, including housing. The next national planning framework will provide a clear plan for Scotland as a place and support the delivery of all our policies on the environment, communities and the economy. It will play a central role in realising our climate change ambitions and set the course for the planning system as a whole.

We will empower people to play an active role in shaping the future of their places. The bill will ensure that people in our communities have a real influence over the future development of their places through meaningful early involvement. We will draw a clear, statutory link between community planning and spatial planning so that local development plans capture communities' aspirations for better services and the development that is needed to support them. We will also give communities the opportunity to produce their own plans, which may ultimately form part of the local development plan.

We will ensure that the planning system is properly resourced to lead. There is wide agreement that the planning service has been underresourced and that that is having an impact on performance. We can change the legislation and revise planning fees, but there needs to be a clear and related upturn in performance standards.

The latest set of official statistics on planning decisions was published this morning. Although there has been some moderate improvement in the pace of decision making in recent years, we need to be sure that planning processes and application handling are as swift as is reasonable and add real value. Our bill aims to do that. It will include scope for additional discretionary charging to fund a better service. For example, a higher fee could be paid for faster decision making. We will also consult on further increases to planning fees once the shape of the new planning system is clear. That will be coupled with the bill's proposals for taking a stronger, statutory approach to planning performance assessment and improvement.

Even now that the Planning (Scotland) Bill is before the Parliament, we continue to listen to what people tell us. For example, I am attracted by the prospect of embedding the agent of change principle into our planning system so that we can protect the established and emerging talent in our music industry. Our live music venues should not become financially disadvantaged or have their viability threatened as a result of new development in their vicinity.

I understand the pressure in some parts of the country for new controls over short-term letting of residential properties. The Scottish expert advisory panel on the collaborative economy is currently considering that issue and the panel's report is expected shortly.

We will continue to engage closely with our stakeholders on developing the best proposals. I will be happy to lodge amendments to the bill if that is the right thing to do, but only when there is a robust evidence base for doing so.

I am sure that members from across the chamber will share the Government's aspirations for a well-functioning and effective planning system, as have the many stakeholders with whom we have engaged. However, I accept that people can have differing views on how we should go about that. For example, I fully acknowledge that there is some disagreement around rights of appeal. We agree entirely with the view of the independent panel that better inclusion and collaboration at the front end of the system will bring more positive results than pursuing further options for conflict and dispute resolution at the back end. Our bill does not include a third-party right of appeal. That would run entirely counter to the thrust of the reforms to support inclusive growth, and would introduce significant and unwarranted risks to our economy, but I am equally certain of the need to retain the existing rights for applicants to appeal against decisions to refuse planning permission. As an illustration of why those rights should be retained, it is the case that, since 2014, around 5,500 housing units have been approved on appeal, following refusals by planning authorities.

If we are serious about growth—about securing investment and delivering the homes, jobs and economic growth that Scotland needs—we cannot afford to put unnecessary obstacles in the way. I look forward to the discussions and debates over the coming months, and to us reforming and modernising Scotland's planning system so that it delivers on the investment in good-quality development that our communities deserve and our economy needs.

The Deputy Presiding Officer: The minister will now take questions on the issues raised in his statement. I intend to allow around 20 minutes for questions, after which we must move to the next item of business. As usual, it would be helpful if members who wish to ask a question could press their request-to-speak buttons now and if they could make their questions succinct. I have 12 members who wish to ask questions.

Graham Simpson (Central Scotland) (Con): I thank the minister for advance sight of his statement. The Planning (Scotland) Bill contains some positive steps that we support, but I want to focus on some of the more draconian measures that are being proposed. For example, the proposed infrastructure levy could be retained by Government, not councils. Why, and on what grounds, and why has the Government not decided what sort of levy it wants? The bill would also order councils, which are already cash strapped, to prepare annual performance reports. Will they be given extra money to do that?

Quite separately, there is a power to send in a Scottish Government troubleshooter if a minister decides that a council's planning department is not performing, and there could be fines for non-co-operation. The Scottish Government would even be able to take over a planning department. That runs a coach and horses through any pretence of localism. Can the minister say under what circumstances he would use that power grab, and on what grounds he has brought forward the proposals? How does he define underperformance? The bill certainly does not do so. What is the problem that he is trying to fix?

Finally, councillors would have to pass an exam to take planning decisions. That affects all councillors, whose right to take those decisions is surely determined by the voters who elected them in the first place. Again, the Scottish Government reserves the right to take over if a council does not play ball. What is the justice in that affront to democracy?

Kevin Stewart: As Mr Simpson points out, the bill includes a provision for the introduction through regulations of an infrastructure levy, but that levy would be spent locally and not nationally. Beyond that, as I have pointed out in previous discussions with Mr Simpson, I do not feel that we are currently in a position to knowledgeably introduce that infrastructure levy. That is why we will continue to work on that issue. I draw members' attention to the recent analysis that has been posted on the Scottish Government website. I have asked my officials to continue to work on the issue, and that will be the case.

As I said in my statement, in terms of performance reports and additional costs, I would look to increase planning fees if we see a movement in performance. I have already done so since I took up my post. I have made it clear that I want planning authorities to invest that money in their planning services. Many authorities are doing that and we are seeing much better performance in that regard.

A number of the issues that have crossed my desk since I have been in post have been about performance. The Planning etc (Scotland) Act 2006 contained provisions to look at performance more closely and allow further ministerial intervention if that was required. I would hope not to use that power, but the reality is that if an authority is not performing well, our options should be open.

Mr Simpson's final point was about the training of councillors and councillors having to sit an exam. Councillors who are on licensing boards have to undergo statutory training and sit an exam at the end of it. A number of people believe that that has led to improvements in the decisions about licensing. A lot of people are not entirely happy with the current lack of training for elected members. The bill will allow for such training, and I do not see what problems that would cause. The most important thing is that decision makers should understand the reasons why they take the decisions that they are taking.

Pauline McNeill (Glasgow) (Lab): The Planning (Scotland) Bill aims to give people a greater say in the future of their places and it aims to empower communities. However, it contains no provisions for redress for communities that feel a deep sense of unfairness in relation to planning processes that they feel favour one side over the other. What remedies will communities have if they feel that a decision is not appropriate or that the development plan has been breached? There is no tangible or specific statutory right of any kind in the bill to allow communities to challenge decisions.

Will the minister at least recognise that early engagement under the 2006 act has not worked? Communities can produce a local place plan, but how meaningful is that? Will any resources be allocated to help communities, particularly poorer communities, to achieve the production of that plan, and how will it be incorporated into the final development plan?

Will the higher fees that are proposed for faster decisions not create a hierarchy that means that richer applicants will have an advantage, given that fees have already risen in the planning system? How does that sit with a quasi-judicial system that should be open and transparent?

Kevin Stewart: As I said in my statement, we want to see more communication and co-operation at the beginning of the process. Pauline McNeill has heard me speak previously about linking community planning with spatial planning. We have the ability to use local plans and to join them up with local outcome improvement plans to create better places. In some parts of the country, communities are already putting together their own local plans. That happened recently in Linlithgow. I have not seen that plan myself but I understand that it is a good example of a community coming together to come up with a positive local plan. Many communities will be able to do that kind of thing without much help, and I encourage such communities to do so and local authorities to co-operate with them.

Pauline McNeill is right to point out that some other communities might have a bit more difficulty putting plans together. I expect local authorities to give more help to socially-excluded communities that might face such difficulties. I do not think that that resource will be a huge amount, to be honest, because community planning should already be taking place in those places and that intertwining should bring those services together.

On the point about faster decision making, we will look closely at what is required in that regard. We know that, in many parts of the country, the decision-making process is slow. I continue to keep a close eye on statistics, including this morning's statistics. It is not just about timescale; it is also about quality. Beyond that, we have to reach a point in the system itself where planners become enablers and deliverers rather than people who are just going to say yes or no. If the answer is no, there have to be reasons for that and maybe there should be an opportunity to say, “If you change this, it might make your plan much more viable.”

We need much more co-operation and much more communication. I agree that the early engagement that was set out in the 2006 act has not worked as well as folk hoped that it would but we have a huge opportunity to get folk much more involved in planning through new technology. That is why, alongside the work on the bill, I continue to work with the digital task force that I put in place to make sure that we can use technology to engage people at an early stage.

The Deputy Presiding Officer: I have allowed leeway for the first two questions but I now have 10 people who want to ask questions so can I have short questions, please, and—if I may respectfully ask this of you, minister—succinct answers?

John Mason (Glasgow Shettleston) (SNP): On the one hand, we want economic development, with more homes and other services, but on the other hand, we want the local community to have a real say. Does the minister believe that it is possible to get a balance between those things that will satisfy everybody?

Kevin Stewart: Yes, I believe that it is possible. Our reforms aim to strengthen planning’s contribution to inclusive economic growth through the delivery of the development that we need and to empower communities. We need an effective planning system that helps to create quality places, with the housing infrastructure and investment that current and future generations need.

Giving people a greater say in how their areas will develop is central to our reforms of the planning system. For example, as I have already said to Pauline McNeill, that link from the local outcome improvement plans to the new local place plans is a huge opportunity for communities and will help communities to meet their aspirations.

Beyond that, this bill will help us to achieve our ambition of 50,000 affordable homes during the course of this session of Parliament. No matter where I have gone in Scotland since I have taken up this post, people have said, “We need more housing here.” We have to get planning right for communities and I think that this bill will do that.

The Deputy Presiding Officer: I think that I will have to redefine “succinct”.

Dean Lockhart (Mid Scotland and Fife) (Con): In his statement, the minister acknowledged that the planning service has been underresourced, and that that has had an impact on performance. If that is the case, why has the Scottish Government not acted sooner to address that underperformance, and what additional support and financial resources will it make available to do so?

Kevin Stewart: Earlier this year, as I pointed out in a previous answer, I allowed a rise in planning fees. That means that more resource is going into local authorities and I would expect local authorities to use that resource wisely and to invest in their planning services.

Andy Wightman (Lothian) (Green): I welcome the bill. I remind the minister that the independent review did not include any questions on rights of appeal and that discussions on that topic were banned in stakeholder workshops. Does the minister accept that if we are to have more meaningful, up-front engagement in the system, it is illogical and counterproductive to deny the need to equalise appeal rights?

Does he accept that retaining existing rights for applicants to appeal will inevitably in some cases overturn, frustrate and erode trust in the very community engagement and local accountability that he seeks to promote in the bill?

Kevin Stewart: I said earlier that the independent panel did not support a third-party right of appeal. We do not propose to remove applicants’ right to appeal against planning application decisions. Without a doubt, we want to see early engagement right at the beginning rather than conflict at the very end of the process.

Many folks have given examples of the third-party right of appeal in Ireland. The situation in Ireland has changed dramatically. Special development zones are being put in place where third-party right of appeal is not allowed, in order to allow for the investment that is required. There is also much more judicial review in Ireland than in Scotland. The key in all of this is getting it right at the beginning rather than having conflict at the end.

Alex Cole-Hamilton (Edinburgh Western) (LD): Will the Planning (Scotland) Bill do more to protect areas of green belt and natural heritage, such as the Cammo estate in my constituency, particularly when development in such areas would lead to intolerable pressure on local roads infrastructure and health services?

Kevin Stewart: Mr Cole-Hamilton is being a bit naughty by talking about a particular place. He knows that I will not respond about a particular place in my role as planning minister.

It is up to each local authority to put together its local development plan, taking into account the needs of the community that it serves. It is not for me to say exactly what local authorities should be doing in that regard; it is up to them to put the policies in place. However, local development plans are required to meet the housing need of a particular area and, in recent times, the City of Edinburgh Council has failed to meet that need, with its new local development plan being some 7,500 houses short.

We need to see improvement on that, which is another reason why we require the training of elected members, so that they know exactly what they are doing when they put together local development plans. Of course, they should also take cognisance of the communities that they serve.

Fulton MacGregor (Coatbridge and Chryston) (SNP): How does the Scottish Government intend to strengthen the planning system's contribution to inclusive growth and growing the economy? How will local communities as a whole be able to affect plans for large-scale developments?

Kevin Stewart: The bill will ensure that planners move from regulating development to making things happen. At the moment, when a local development plan is completed, the planners immediately move on to formulating the next local development plan. That does not provide security for communities and does not allow for development. We want development to progress, which will give much more confidence that it will be completed. The bill will ensure that there is a much more consistent approach to performance. Of course, all of that has to be done with communities, who will have a stronger say on and influence over positive changes that are happening to their places. The local plans are extremely important. Interlinking between local plans and community planning is all-important, and I want to see that right across the country.

Lewis Macdonald (North East Scotland) (Lab): I welcome the minister's reference to the agent of change principle, which as he will know is set to be taken forward to protect live music venues in Wales and greater London. If amendments are lodged to add the agent of change principle to the Planning (Scotland) Bill, will they have his Government's support?

Kevin Stewart: I welcome Mr Macdonald's discussions with me on the issue, just as I welcome the discussions with Tom Arthur, Fiona Hyslop—the Cabinet Secretary for Culture, Tourism and External Affairs—and the industry. We all know that there have been difficulties in certain places with live music venues, and we have to do all that we possibly can to ensure that we protect that vital part of our heritage. The Government is aware of proposals in Wales, where the issue is being dealt with through planning policy rather than legislation. I am also aware that the mayor of London is looking at the agent of change principle for the next London plan and that planning policy in the state of Victoria in Australia has something similar in that regard.

As Mr Macdonald is aware from the discussions that I have had with him, I do not know whether primary legislation is necessarily required; it might be that changes to Scottish planning policy are required. However, whatever change is required, he can be assured that I will be positive on the issue.

Ruth Maguire (Cunninghame South) (SNP): In what way does the minister see the Planning (Scotland) Bill as being key in contributing to the delivery of much needed affordable homes and infrastructure in Ayrshire and throughout Scotland?

Kevin Stewart: Members will be absolutely sick to the back teeth of me constantly talking about housing. It is absolutely essential that the bill moves us forward with our affordable housing delivery targets, whether in Ms Maguire's patch in Ayrshire or other parts of the country. Everywhere that I go, people say that they need more housing, so we need to get on with the job of providing warm, affordable homes for people around Scotland. The bill will allow that to happen and there will be areas that can be zoned for housing with permission granted up front. We must also ensure that we get the infrastructure and investment right as we build those homes.

Alexander Stewart (Mid Scotland and Fife) (Con): Will the minister confirm that local place plans that are prepared by local community bodies will not be undermined by Scottish ministers? Will he detail the support that will be provided to community bodies to ensure successful outcomes?

Kevin Stewart: I have already given my view on local plans, which currently have no statutory basis. People in Linlithgow and other places who have come up with their own plans are to be applauded and I am certainly not going to undermine anybody's plan. There might be occasions when communities and others have to agree to disagree, but I encourage communities the length and breadth of Scotland to get involved in spatial and community planning.

Since taking on my role, I have gone to great lengths to encourage people to become involved in planning; in particular, I want young folk to be more involved. There has been great success in Galashiels academy in your constituency, Presiding Officer, where pupils, with Planning Aid for Scotland, are learning about the place standard. They have different ideas from older folk and all those ideas need to come into the mix, so I hope that young folk will get involved in local planning.

The Deputy Presiding Officer: I thank you for the namecheck.

Clare Haughey (Rutherglen) (SNP): How does the Scottish Government intend to encourage stronger engagement with communities earlier in the planning process, rather than at the end, to ensure that the system works for all, including those who want to invest in the quality of our places and our economy?

Kevin Stewart: I know that Ms Haughey has taken a great interest in the issue—particularly in Cambuslang, if I remember rightly—from the engagement that she has had with me.

I want communities, such as those in Cambuslang, to have early engagement with the plans for their places, which the bill encourages. The local planning aspect will give people, such as those in Cambuslang, the opportunity to shape their community.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Will the minister explain what an inclusive growth approach will mean for Scotland's poorest areas, and will he ensure that the new planning process will adequately engage and empower local communities?

Kevin Stewart: Absolutely. I want communities the length and breadth of Scotland to be engaged and empowered. In particular, as I said in my answer to Ms McNeill, I want local authorities to put an emphasis on helping socially excluded communities to fulfil their ambitions for local place and community planning. As a Government, we will continue to do all that we can on community capacity building to ensure that such communities have the same abilities as wealthier communities.

The Deputy Presiding Officer: I thank the minister and members—thanks to the minister being succinct, I managed to get all questioners in. That concludes questions on the statement.

15:09

Meeting suspended.

15:10

On resuming—

Polypropylene Mesh Medical Devices

The Deputy Presiding Officer (Linda Fabiani): The next item of business is a debate on motion S5M-09241, in the name of Johann Lamont, on petition PE1517, on polypropylene mesh medical devices. I call Johann Lamont to speak to and move the motion on behalf of the Public Petitions Committee.

15:10

Johann Lamont (Glasgow) (Lab): I am pleased and privileged to open the debate on behalf of the Public Petitions Committee and to play a small part in the opportunity to bring this critical issue to further public attention. Petition PE1517, on polypropylene mesh medical devices, was lodged in April 2014, receiving more than 1,700 signatures of support and attracting 212 comments. The committee will consider a draft report on the petition in due course and it will reflect on this debate in its deliberations. What is said today will help to shape that important report.

Before I move on to the key themes and concerns raised by the petition, I would like to place on record my thanks, on behalf of the committee, to the petitioners, Elaine Holmes and Olive McIlroy, and all the other women and their husbands, partners, friends and families who have provided their testimony on the impact that mesh has had on their lives. That testimony was often given at huge personal cost. Although, through their courage, we have been given a window into what they have suffered, we do not live with the daily impact of mesh on every aspect of our lives. The testimony is set out in the 80-plus written submissions that we have received on the petition to date. It would be remiss of me not to acknowledge the members who do not sit on the committee but who have joined us in our consideration of the petition. I expect that Jackson Carlaw, Neil Findlay, Alex Neil and John Scott will contribute to the debate, just as they have contributed to the committee's deliberations.

The session 4 committee's consideration of the petition started in June 2014 with evidence from the petitioners. It is an indication of the impact of the evidence that just two weeks later, Alex Neil, then the Cabinet Secretary for Health and Wellbeing, gave evidence to the committee. It was in the course of that evidence session that the intention to establish an independent review and the request for a moratorium on the use of mesh devices were announced. It is worth reflecting on that moratorium, as it transpired that mesh operations continued while that was in place.

We heard during our most recent evidence session from Dr Wael Agur that the cabinet secretary's request was disseminated to health boards by the chief medical officer. The request asked the boards to consider suspending the use of mesh in procedures for pelvic organ prolapse or stress urinary incontinence. However, it became clear that boards retained autonomy over their operations and, as such, were under not under a binding obligation to act upon the request or to confirm whether it was intended that mesh procedures would continue in their area. Although I cannot speak for the members of the session 4 committee, that would not have been their understanding of what a moratorium should entail. That should be reflected on in any future circumstances in which a moratorium may be requested. I would welcome a commitment from the cabinet secretary to ensure that that is done.

With that said, members will understand that I wish to focus most of my opening remarks on the process and outcomes of the independent review. The review group comprised urologists, researchers, public health professionals, patient representatives and representatives of professional bodies, the regulatory body for medical devices and the office of the chief medical officer. Secretariat support to the chair was provided by the Scottish Government. The independent review's published remit was:

> "to evaluate both the efficacy and the extent and causes of adverse incidents and complication rates associated with SUI and for POP".

Its formal title was the Scottish independent review of the use, safety and efficacy of transvaginal mesh implants in the treatment of stress urinary incontinence and pelvic organ prolapse in women.

At our most recent meeting, the petitioners informed the committee that they had to fight to get the word "safety" put in the heading of the review. That certainly gave me pause for thought, as I am sure it did for other committee members.

The independent review group got to work and reached a milestone when it published an interim report in October 2015. Its interim report was tentatively welcomed, in so far as it represented signs of progress and enabled interested parties—not least the Government and mesh survivors—to reflect on the interim conclusions.

It should be noted, however, that the petitioners produced a minority report and that the Scottish mesh survivors group considered that the recommendations should be actioned immediately and that outcomes should be monitored before any further mesh procedures took place.

The interim report produced eight conclusions. They related to the need for robust clinical governance; the need for multidisciplinary team working, with appropriate levels of audit activity to ensure the recording and reporting of adverse events; and the need to ensure that women have the opportunity to discuss with their clinician all the options that are available to them, and the pros and cons of each, so that they can give fully informed consent. There was a "serious concern" that some women who had reported adverse events were not believed. There were concerns about the efficacy of short-term studies of the safety and effectiveness of mesh procedures, given that many adverse effects do not become evident until five, 10 or more years after a mesh procedure.

There were also concerns about the lack of reliable or robust information systems to record the number of procedures that are carried out and, by extension, difficulties in accurately measuring adverse events. There were other concerns around the use of transobturator mesh procedures, rather than retropubic mesh tape procedures, for what was referred to as "routine surgery" for stress urinary incontinence; those concerns were based on information that was produced in chapter 6 of the interim report and accompanied by a number of tables. Similar concerns were expressed in the report about the use of mesh in surgery for pelvic organ prolapse.

It was explained that the October 2015 report was interim because the independent review was awaiting the outcomes and findings from two key pieces of work. The first of those was the final opinion of the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks on the safety of surgical meshes used in urogynaecological surgery, which was published in December 2015. Its recommendations included that

> "Implantation of any mesh for the treatment of POP via the vaginal route should only be considered in complex cases, in particular, after failed primary repair surgery",

and that

> "The amount of mesh should be limited for all procedures where possible."

The second piece of work was the "Prolapse Surgery: Pragmatic Evaluation and Randomised Controlled Trials" study, which is referred to as the PROSPECT study. One of the primary outcomes to be assessed in that three-year study was the quality of life for women who had reported prolapse symptoms. Its final report was published in *The Lancet* in December 2016. It concluded that

> "augmentation of a vaginal repair with mesh or graft material did not improve women's outcomes in terms of effectiveness, quality of life, adverse effects or any other outcome in the short term".

In addition, it found that more than 1 in 10 women—approximately 12 per cent—experienced a complication associated with mesh. The study concluded that follow-up was "vital" to identify whether there were any potential longer-term benefits for women and, conversely, to identify any potential serious adverse effects of mesh procedures for pelvic organ prolapse.

With those two pieces of work completed, the independent review's final report was published in March this year. It would be a significant understatement to say that the final report was not as well received as the interim report. There were resignations from the independent review group shortly before publication of the final report, amid reported concerns that it was not fully independent, was misleading and was a backwards step from the interim report. Indeed, the petitioners were reported by the BBC as feeling "betrayed" and concerned that the report was "a whitewash". Concerns were expressed by the petitioners and members of this Parliament that information had been either omitted altogether or moved to a different part of the report.

Significant concerns related in particular to the removal from the final report of the tables on shared decisions in chapter 6. Those concerns have already been raised in this chamber, both at topical questions and during the cabinet secretary's statement to the Parliament on 30 March.

In May, the committee took evidence from the chair of the independent review and then from the cabinet secretary and the chief medical officer. It was unfortunate that the evidence that we heard seemed to produce more questions than answers. We were unable to establish a clear understanding of how decisions were taken in the independent review. We could not establish whether decisions were taken by sub-groups, the full group or at the discretion of the chair. The committee thought that that lack of clarity could have been avoided through the provision of readily accessible minutes or notes of correspondence.

There was also confusion about the timeline of communications between the petitioners, the cabinet secretary and the chair of the independent review, which extended to decisions that were made following receipt of the petitioners' communications asking for the removal of all their contributions from the report, which did not happen.

The review's final report recommends the mandatory reporting of mesh adverse events. That is welcome, although it appears from the evidence that we heard that that conclusion was reached quite late in the day. A number of other recommendations are also welcome, in so far as they address systems and practices that should be in place as a matter of clinical governance.

I want to focus on two recommendations. First, the recommendation in conclusion 7 of the final report, which relates to stress urinary incontinence, is:

> "women must be offered all appropriate treatments (mesh and nonmesh) as well as the information to make informed choices."

I cannot stress how important it is that when women are considering their options they have the opportunity to discuss them with their clinician and have their views listened to. Discussions must be based on the most up-to-date information available.

Conclusion 8, on the surgical treatment of pelvic organ prolapse, is that a mesh procedure does not provide "any additional benefit" over natural tissue repair. However, that conclusion seems somewhat qualified by the next sentence, which is:

> "Transvaginal mesh procedures must not be offered routinely."

I emphasise the word "routinely".

In evidence to the committee, the cabinet secretary advised that the Scottish Government would establish an oversight group to take forward the recommendations. She added:

> "the key safeguards that are to be put in place ... must be implemented before any procedures using mesh are reintroduced routinely".—[*Official Report*, *Public Petitions Committee*, 18 May 2017; c 24.]

When I sought clarification from the cabinet secretary on whether the moratorium would remain in place until the recommendations have been implemented, she replied that the suspension would not be lifted until medical directors have assured the chief medical officer that all the recommendations in the final report have been implemented.

It could be argued that much of what the petition called for has been delivered. For example, a moratorium was put in place, an independent review was initiated, reporting of adverse events will be mandatory, and progress is being made towards fully informed consent. However, the outcome of the independent review is such that it would be absolutely inappropriate for the petition to be closed at this point.

That is reflected in the fact that the cabinet secretary has commissioned Professor Alison Britton to conduct a review of the independent review. Along with the deputy convener of the committee, I have had the opportunity to meet Professor Britton, to explore her remit and flag up to her some of the concerns and issues that have come to light in recent months as part of our consideration of the petition.

The cabinet secretary has offered her reassurance that the recommendations of the independent review's final report stand, pending the conclusion of Professor Britton's review of the review. However, the overriding concern that has come across during our consideration is people's lack of confidence in the independent review process and therefore in its outcomes. Given people's already fragile confidence in the independent review's governance and findings, if Professor Britton's review finds that the process was significantly flawed, how can the cabinet secretary, this Parliament and, most important, the public be assured that the independent review's outcomes are robust and credible? I hope that today's debate provides an opportunity for that question and others to be answered.

We might, sadly, have to confront the harsh truth that the damage that was done to the petitioners and others cannot be repaired, but we must do what we can to ensure that their experience is not repeated. Believing all those women and responding to their well-founded understanding of what must change would be a good start. [*Applause*.]

I move,

That the Parliament notes public petition PE1517 on polypropylene mesh medical devices.

The Deputy Presiding Officer: I respectfully say to people in the public gallery that it is not appropriate to show appreciation—or otherwise—during the debate. Thank you.

15:24

The Cabinet Secretary for Health and Sport (Shona Robison): I am grateful for the opportunity to take part in today's debate on what is a very important issue and for the chance to give the Parliament an update on the Scottish Government's work in this area. I want to thank the Public Petitions Committee for all its work and deliberations on the issue of transvaginal mesh. Most important of all, I thank Elaine Holmes and Olive McIlroy, who brought the issue to light through their petition.

Members might recall that I made a statement on transvaginal mesh back in March. At the time, I spoke about what had led my predecessor to establish the Scottish independent review of mesh—the brave action of the Scottish mesh survivors, who were patients who had suffered serious complications and had petitioned the Parliament. In doing so, they spoke very openly about the difficulties that they faced on a daily basis. Indeed, it is those actions, as well as the stories that I have heard from women who have written or spoken to me over the months and years, that have led me to continue to treat the issue with the utmost importance.

Given the complexity of the issue, it has proved difficult to reach a consensus. However, what is important is how we move forward and that the improvements that we propose allow us to keep our aim of continuous improvement in NHS Scotland.

Members will recall my commitment to look at concerns that had been raised about the process of the independent review. That is why I asked Professor Alison Britton of Glasgow Caledonian University to examine the course of the independent review. She will produce a report with recommendations about how future similar reviews could be conducted.

Neil Findlay (Lothian) (Lab): The concerns were about much more than the process. Is it not an issue that the women—who feel, quite rightly, that no one was listening—have had to go through the very long petitions process to get to the stage that we are at today?

Shona Robison: Neil Findlay makes an important point. It should not have taken a petition for the issue to be brought out into the light. However, some important changes have flowed from that, which I want to highlight. It is important to record the fact that changes have been made. We must not lose sight of the central issue, which is that we must continue our work to address the issues that have been raised by so many women and to build on the work of everyone who has taken part in the independent review and the process that Neil Findlay referred to.

The review made eight clear key recommendations. The Scottish Government has accepted all of them, and it expects all health boards to take note of future developments, as I will now explain. Officials have been working with the General Medical Council to draft updated guidance on shared decision making, which Johann Lamont made an important point about. The drafting of that updated guidance is now complete and it will be subject to wider consultation, which, it is anticipated, will start in the spring of next year. The emphasis of the guidance is on sharing information, explaining risk and giving choices. The importance of doctors working in partnership with patients and supporting them to make decisions is stressed, and all clinicians are expected to abide by that.

When I made my statement in the chamber in March, I explained that an oversight group would be established. That group is absolutely key, and I can confirm that Healthcare Improvement Scotland has taken forward that work in the months since I made the announcement. The oversight group will regularly review data relating to mesh procedures and will scrutinise adverse event reporting. What is particularly significant is that it will continuously review new studies and new evidence, and will carefully consider how that new evidence can be incorporated into pathways of care. The group will also help to ensure that patient information is relevant and up to date. Indeed, producing a patient information and consent leaflet for pelvic organ prolapse and reviewing the existing leaflet for stress urinary incontinence will be key tasks for the group.

It is important that the oversight group has on board the right people, who have the level of expertise and experience that is necessary to take forward such critical work. That is why I am pleased to be able to confirm that Professor Lorna McKee has been appointed chair of the oversight group. Professor McKee is now emeritus professor of management and health services research at the University of Aberdeen. I wish her well in her role and look forward to receiving future updates on the progress that is being made in achieving implementation of the review group's recommendations.

Neil Findlay: The cabinet secretary mentioned the University of Aberdeen. I do not know the individual involved, but is the Government aware of any allegations of research misconduct on the SIMS study that was carried out in Aberdeen? Has there been any communication between the Government and those who were involved in that study?

Shona Robison: I make it very clear that Professor McKee is absolutely above reproach in the matter. It is very important that she is allowed to get on with the job of chairing the oversight group. I hope that there is no inference from Neil Findlay that she is in any way connected with that study; those issues are completely separate. We should allow her to get on with the important work of the oversight group.

Healthcare Improvement Scotland has well-established procedures for engaging with the general public, through its public partners scheme. HIS will ensure that the oversight group has full representation for patients who have direct experience, in the best way that they feel they wish to be involved. The group will meet for the first time in early December, when it will focus on future planning. The first full meeting of the group will take place in January.

John Scott (Ayr) (Con): Will the cabinet secretary take an intervention?

Shona Robison: I would like to make some progress, if the member does not mind.

As my colleagues will be aware, there was an almost parallel process in NHS England, involving a different group of patients, clinicians and evidence reviewers, which, in July this year, published a report that came to very similar conclusions. However, I wish it to be noted that, in Scotland, the independent review went further and used the language of the regulator—the GMC—stating that mesh procedures

> "must not be offered routinely"

for POP, whereas the NHS England report noted that

> "The use of vaginal mesh in primary procedures to treat POP is not supported by the current evidence and this should not be offered routinely for the first surgical intervention".

Members will be aware that the National Institute for Health and Care Excellence will shortly publish its updated guidance on the use of mesh for pelvic organ repair, as part of its interventional procedures programme guidance. As NHS Scotland is a full partner in that programme, the guidance must—and will—be implemented. Such procedures will be included in patient management pathways and, as I have mentioned, the new evidence for those pathways will be overseen by the new oversight group. I await the revised guidance with interest; however, what we already have in place in Scotland is a clear set of recommendations that place a clear emphasis on patient safety.

I can confirm that the chief medical officer for Scotland has today written to all NHS board medical directors and to the oversight group, drawing their attention to the forthcoming NICE guidance. The CMO has also written to the Medicines and Healthcare Products Regulatory Agency, which after all—as we have discussed many times in the chamber—is the only organisation that can ban mesh. The CMO has pointed to a recent publication by the Australian Therapeutic Goods Administration, and it is important that we hear back from the MHRA about its response to that publication.

I want to be clear, meanwhile, that the request to suspend remains in place, and will do so until the CMO is satisfied that all the recommendations have been implemented, including all upcoming changes to guidance, and that necessary safeguards are in place. In essence, we expect that the consent procedures and other safeguards will be put in place, taking into account all new guidance into pathways, meaning that the situation in future will not be greatly different from that under the current suspension. What we all want to see is a change in the whole approach to the condition.

I hope that, over the last few minutes, I have been able to set out the updated position—

John Scott: Will the cabinet secretary take my intervention before she closes?

Shona Robison: I will do so in my closing remarks, because I am in my last few seconds.

The Deputy Presiding Officer: I can allow the cabinet secretary the time to do so.

Shona Robison: I hope that I have been able to give members reassurance that the Scottish Government takes the issue very seriously, and that we have made progress since the publication of the independent review report. In my closing remarks, I will come back to members on any other issues that they might want to raise.

15:33

Jackson Carlaw (Eastwood) (Con): This full debate, brought to the chamber by the Public Petitions Committee, is long overdue and especially welcome.

It is now nearly some four years since my constituent, Elaine Holmes, visited my constituency office, on crutches; she was anxious about the nature of what she had to discuss and share, but absolutely determined, even then, that she would do all she could to bring a spotlight to mesh procedures and to what has gradually, but inexorably, become a worldwide scandal and in Scotland a devastating tragedy for far too many women.

I do not say “scandal” lightly. Having been born in 1959, I remember my bewildered shock when, as a child in the mid-to-late 1960s, I read newspaper features in *The Sunday Times* on thalidomide. That, too, was marketed as a convenience for women—and a safe one at that. Facts were concealed, lives have been ruined and compromised to this day, and women have been patronised by experts living, practising, operating, researching and preaching from their ivory towers. Mesh is the 21st century’s thalidomide: it is a worldwide scandal that is every bit as devastating.

At the heart of the mesh scandal is the most deeply personal testimony. Who expects to find themselves, without warning, suffering from chronic pain and a loss of sexual function, with mesh protruding through the bladder or bowel—sometimes removed, with horrendous consequences—and with organs trapped and entwined with mesh, shrinking and moving inside the body, and slicing through nerve endings, tissue and those same organs? I have met the women in wheelchairs and on crutches, and who among us cannot appreciate their courage in stepping forward to discuss such intimate details with, in many cases, male politicians?

The Public Petitions Committee led. Alex Neil, as Cabinet Secretary for Health and Wellbeing, led. No one doubted the commitment, too, of Shona Robison, as the review committee established in 2014 went about its business. That is why the sense of betrayal and dismay among all those mesh survivors is so profoundly felt. They thought, I thought—frankly, we all thought—that the Government was on their side. The rest of the world took note. As litigation that has now generated billions in compensation commenced, here was political leadership in Scotland, where the unique circumstance of a smaller national health service made action possible and credible. We were ahead of the rest of the United Kingdom. Due to the many health boards and the lack of co-ordinated patient networks, England was slow to pull everything together. Patients there, too, looked to Scotland.

Throughout, I have listened to many experts, including those who appeared before the Public Petitions Committee. In a risible and dismal performance here at Holyrood, so-called experts, the lamentable MHRA, denied that there was even an issue or that many women were affected, even as those women sat in packed rows behind them. Other experts dared to suggest that women might seek psychiatric help.

Surely the most reasoned and impressive of all those experts was the consultant physician Dr Wael Agur, who is also a constituent of mine. Along with Elaine Holmes and Olive McIlroy, he resigned from the review committee in abject dismay and professional fury at the bowdlerisation of the committee’s draft report—including the travesty of chapter 6—into the shameful and widely despised whitewash of the final report.

The new chair was a deeply unimpressive witness. It was Dr Agur who spoke without artifice and with sincere clarity. As he talked through his journey towards believing in a complete ban, he exposed the fallacy of the informed consent process. Of the 22 women who made use of his health board’s shared decision-making tool to assess whether mesh was appropriate for them, only one—yes, just one—decided in favour of the procedure, and that was because she had not read the leaflet properly. When she did, she changed her view.

I understand and take note of what the cabinet secretary said about the advice and guidance that are under way and which will be subject to scrutiny, and I look forward to seeing the outcome of that.

There was talk ahead of the debate of amendments to the motion to make a much more direct demand of Government. I understand those calls, but I am not yet convinced that the moment has arrived when this Parliament must divide. However, I want to be very clear with the cabinet secretary: this is last chance saloon territory. If decisive progress is not forthcoming, we will, however reluctantly, seek to find common cause with others in this chamber to require and mandate action and change. As the SNP MP Brendan O'Hara stated in the Westminster Hall debate in October,

> "this devastation for women and their families is absolutely intolerable and must never be allowed to happen again".—[*Official Report, House of Commons*, 18 October 2017; Vol 629, c 296WH.]

There must be no interruption to the current ban. There must be a full public consultation on the content of the review that took place, to be published alongside the procedural review led by Professor Britton. There must be sustained engagement with the Westminster Government in respect of the actions and performance of the MHRA. Politicians on all sides will willingly join in that, here and at Westminster, where Owen Smith MP and my East Renfrewshire colleague Paul Masterton MP respectively chair and co-chair the all-party group on mesh. The Scottish Government must act on Alex Neil's proposal to convene an international summit here at Holyrood to allow Scotland to regain the political initiative.

There may be aspects of this scandal that are reserved and other aspects that are devolved, but for pity's sake that can no longer be a defence against the most determined and joint close working and co-operation.

The hourglass has run. Huge legal compensation claims the world over are landing with health services; more than 800 claims are under way in the UK. That, too, is an issue of immense concern.

However, this issue is about more than money, consent and all the most basic issues of a woman's dignity, and her quality of life and that of her family, and that too of the increasing number of men who have had mesh implanted and have experienced complications. Led by Elaine Holmes and Olive McIlroy, these Scottish women are an inspiration. I will confess to being a sentimental sort, but the coldest glass eye could not be in the company of those women, who, compromised in so many ways, have become a joint support network, a hugely entertaining social party and one of Scotland's most effective campaigning groups, and not be moved by their efforts.

I want Scotland to lead again. I want us to prevent mesh from destroying more lives. In all sincerity, I want this Parliament to be able to look to our Government to regain that leadership. We have waited patiently as due process has promised hope, only to thwart it instead. I look to the Government for justice and say to the cabinet secretary, "Please act, and please act now."

15:40

Neil Findlay (Lothian) (Lab): I thank the Public Petitions Committee for bringing the debate to the chamber. It has been a long time coming.

Five years ago, on becoming my party's shadow cabinet secretary for health, I was handed a portfolio of issues by my colleague Jackie Baillie. In it were a few news cuttings about an issue that no one was really talking about—transvaginal mesh implants. Along with Tommy Kane, my researcher, I soon met the then small group of women who had been affected by the product. We immediately struck up a friendship that has been sustained to this day. They are some of the finest people I have ever met, and I am proud to call them my pals.

All of them have been affected by the polypropylene product that was permanently inserted into their bodies in an attempt to address incontinence or prolapse. When mesh is implanted, body tissue grows through its pores, so it cannot be removed without serious nerve and tissue damage; removal has been compared to removing chewing gum from a person's hair. In many patients, the mesh lost its pliability, became rigid and started to break up, dispersing shards and fragments throughout the body.

The past five years of the campaign have been very emotional. Let me tell you why. It is because women—young, middle-aged and older—were told by surgeons and health boards, many of whom had a conflict of interests, that they would be treated by a short procedure that was the new "gold standard" in care, and that after it, all would be well.

Was it "well"? If we call lacerated and ruptured organs "well"; if we call a severed urethra "well"; if we call being forced to use crutches or a wheelchair for the rest of your days "well"; if we call the loss of a kidney, the end of a person's career, the loss or their sex life, the end of their relationship or marriage, and the loss of their house and life savings "well"; and if we call mental ill health "well", then yes—all is well.

The reality is that tens of thousands of women around the world are living with chronic physical and mental pain and a lifetime of hopes and dreams lost, and are forced to struggle against the might of the medical establishment and the cosy relationship between the big medical companies including Boston Scientific and Johnson & Johnson, surgeons, health boards, Governments and the MHRA, all of which denied that there was a problem and told women that they were imagining things or exaggerating.

Month in and month out, my office staff and I worked with the Scottish mesh survivors group, which is led brilliantly by Elaine Holmes and Olive

McIlroy. We took them to meet Alex Neil, the then Cabinet Secretary for Health and Wellbeing, and asked him to ban mesh. At that time, he said that he could not because he feared being sued by the manufacturers. After numerous freedom of information requests, parliamentary questions and much lobbying, we found ourselves coming up against a brick wall, so we advised the women to lodge their petition. I will never forget the day when it was presented to the Public Petitions Committee. Dozens of sobbing women sat hugging and supporting each other in solidarity on what David Stewart, who was then convener of the committee, said was one of the most emotional days of his political career.

The petition forced Alex Neil to suspend the use of mesh, but not before yet more women had been implanted. We then forced the establishment of the so-called independent review, on which Elaine and Olive sat. It met at least 10 times and unanimously agreed an interim report. Then the chair resigned, a new chair came in and no meetings took place for the next 10 months. Well, actually, they did take place—but Elaine and Olive were not told about them and no minutes were circulated. With the new chair in place, the final report was radically changed from the interim report, to the extent that Elaine, Olive and Dr Agur could not sign up to it, and they all resigned.

At that point we met the new Cabinet Secretary for Health and Sport and asked her to ensure that the mesh survivors' contributions were withdrawn from the report before publication. We were assured that that would happen, only for the report to be published with no changes, which was a shocking breach of faith. In the run up to that event, more than 100 MSPs from across parties signed a "No mesh whitewash" pledge. The Scottish mesh survivors group's view is that the report is a whitewash—a deep, big and murky barrel of it.

On the review were four surgeons—doctors Karen Guerrero, Voula Granitsiotis and Wael Agur, and Mr Paul Hilton—three of whom are subject to litigation by mesh survivors. None of them declared that conflict of interests before taking part in the review.

Mr Paul Hilton is one of the main witnesses for the NHS Scotland Central Legal Office in the forthcoming civil action for damages that has been brought by 420 patients. His position—and the position of the other doctors—on mesh was predetermined before he took part in the review.

Mr Hilton also failed to declare that his wife—

The Deputy Presiding Officer: I will stop you there, Mr Findlay. I ask you to bear in mind that those matters may be sub judice.

Neil Findlay: I sought clarification on the matter from the chief executive of the Parliament.

Mr Hilton also failed to declare that his wife, Dr Lucia Dolan, is also subject to litigation in Scotland.

After all that, does the cabinet secretary still believe that the review is independent? Will she allow the report to go out for public comment, as Jackson Carlaw has suggested? Will she agree to the indefinite suspension of mesh? Will she tell the NHS to clear its shelves of mesh, so that it can no longer be used. She has the powers to do that. Will she use her procurement powers to end its purchase? Will she write to the medical companies urging them to settle the litigation cases quickly and to stop their deliberate stalling? Will she instruct a judge-led inquiry, similar to the baby ashes inquiry, into what is the biggest multiple litigation in the history of Scotland's NHS?

Scotland had the opportunity to lead the world on mesh: everyone was watching, and we flunked it. The review was compromised from the outset. The Government has let down mesh victims. This is a tragic tale of corporate power and greed, institutional arrogance by the medical establishment, and Government ambivalence and delay. It is only because we have refused to give up that we have got this far. I say to the cabinet secretary that we are not going away. This is the Government's last chance to make radical changes, or we will introduce political motions that seek to unite the Opposition on the issue.

The Deputy Presiding Officer: We move to open debate. I ask for speeches of about six minutes. I have a bit of time in hand, so I can allow for interventions.

15:47

Alex Neil (Airdrie and Shotts) (SNP): I, too, pay tribute to the work of Elaine Holmes and Olive McIlroy and all the mesh survivors. Their campaign has been absolutely fantastic, well motivated and very effective. I pay tribute to the Public Petitions Committee—in particular, the convener, Johann Lamont, and the deputy convener, Angus MacDonald, who have done an excellent job so far on the petition, although there is still a way to go.

I also pay tribute to the late Chrissy Brajcic, a Canadian campaigner who died last week of sepsis. She was in the process of suing Ethicon over her treatment and was part of the Canadian mesh survivors group. This is not just a Scottish issue; it is a worldwide issue. I thank Jackson Carlaw for reiterating my call for the Public Petitions Committee, with the support of the full Parliament, to call an international conference to take co-ordinated action against the real culprits:

the manufacturers of the mesh equipment that has been neither properly tested nor trialled before it was introduced worldwide.

I hope that Parliament can unite on the matter. This is not about the Opposition against the Government. I think that we all share concerns, and I think that we all need and want to do what is right by the survivors, and to prevent such a situation happening again.

I am going to be open, honest and very transparent. It took me longer to commission the independent inquiry that I might have taken. Why? It was because, to be quite frank, I was—very unusually—not convinced by the information on the matter with which I was provided by official advisers when I was health secretary. On no other matter did I have any reason for doubt, but I increasingly felt that I was not being told the truth, the whole truth and nothing but the truth. I ended up doing a lot of research into the subject myself . The more I researched, the more I became convinced that we had to do something: at the very least, we had to suspend the procedures until we were much more sure about their safety. I am glad that we did that.

Neil Findlay: Will Alex Neil take an intervention?

Alex Neil: I will, if Neil Findlay will make the intervention brief.

Neil Findlay: Were the people who advised Alex Neil the same people who are now advising the cabinet secretary?

Alex Neil: I have no idea. For the record, I was absolutely clear when we appointed members of the independent review group that none of them should have a commercial interest in mesh. That did not happen; I am very critical of that.

John Scott: In Alex Neil's time as cabinet secretary, did he assess potential contingent liabilities in damages due to the Scottish survivors of the mesh implants from the class actions elsewhere in the world.

Alex Neil: We were aware of potential legal proceedings in Scotland, the rest of the United Kingdom and the rest of the world. That was a consideration for my research—rather than relying entirely on the official advice—which reinforced my view that there was something seriously wrong that had to be addressed.

Members have quite rightly addressed the independent review procedure and the very good interim report, which was unanimously agreed. Something happened, however, between the interim report and the final report. In between those two reports, more research came out, but it was never taken into account in the final report. I agree with Jackson Carlaw that one of the best witnesses at the Public Petitions Committee, apart from the women who were the best witnesses, was Dr Agur, who explained why he resigned as a member of the group. As well as reviewing the report process, we need to review the report contents, which are so disrespected. To be frank, there is not universal agreement that we should accept the contents, as they stand.

Fortunately, as the cabinet secretary has outlined, we have made advances. A decision has been made in Australia to which we should listen and learn from. There are also NICE and GMC guidelines available, which we will need to police to ensure that they are adhered to well. However, that will not be enough; we need to do other things. I welcome the cabinet secretary's comments about the establishment of the oversight group, but proper oversight in this case needs patient involvement. A drawback in the whole review procedure has been that patients and survivors feel that they have not been listened to. Such oversight would not second guess or undermine the role of medics; clearly, those of us who are not trained cannot exercise medical judgment. However, patients—particularly the survivors—have a lot of potential input into what to look for in an oversight arrangement. Health Improvement Scotland uses lay members in most of its inspections; we should involve patients in the oversight procedure.

I have mentioned the current state of the leaflets, and I will write separately to the cabinet secretary about their details. There is a clear commitment from her to ensure that the leaflets are up to date and easily accessible and readable.

I have three other points to make quickly. First, there should be an onus on any surgeon who has commercial involvement with the producer of a product that he or she uses on a patient to tell the patient about that commercial interest.

Secondly, it is very clear that the MHRA is not fit for purpose. It is partly funded by the mesh manufacturers, so I do not see how it can be truly independent.

Thirdly, we must ensure that any future independent review is genuinely independent. I look forward to Professor Britton's report. We can never again have such processes tainted by suspicion such as surrounds the outcome of the review.

If we implement those suggestions and those that other members have made—and, no doubt, suggestions that are yet to come—we will, I hope, get the right answer. We will also ensure that no other woman—or, indeed, man; some men have suffered—need suffer what the women who have been affected have had to suffer and will, in some cases, endure for the rest of their lives. [*Applause*.]

The Deputy Presiding Officer: I remind people in the public gallery that neither appreciation nor otherwise should be shown.

15:56

Brian Whittle (South Scotland) (Con): I refer members to my entry in the register of interests, as I have a close family member who is a healthcare professional in the NHS.

I welcome the opportunity to speak in the debate. The issue has been on the Public Petitions Committee agenda since before my arrival in the Parliament and it has delivered some of the most harrowing of the evidence-taking sessions in which I have been involved in my short time here. It has certainly focused my mind on the fact that, amid all the white noise of political debate, what we do in the Parliament has a profound effect on the lives of people in Scotland. In this case, the topic has a far wider reach than, and has implications beyond, our borders. It is not overstating the importance of the debate to suggest that the eyes of other nations are watching to see how the Parliament deals with the continuing issue of polypropylene mesh implants.

The sight of the cabinet secretary and the chief medical officer being cross-examined in committee by current and former committee members, with so many women who have been affected by the procedure sitting behind them, many in wheelchairs, was vivid. It was uncomfortable to watch and listen to that evidence while seeing the reaction from those who sat behind the cabinet secretary—they seemed aghast. The fact that the current committee members were joined by Jackson Carlaw, Alex Neil, John Scott and Neil Findlay highlights the cross-party strength of feeling and support for the campaign. It also highlights the need for the Parliament to come together and end the scandal.

To that end, I add my sincere gratitude to the members of the Scottish mesh survivors hear our voice campaign for their unrelenting and resolute campaigning to try to ensure that what they have had to endure will be spoken about in the public forum and that no one else need have their lives devastated by the potential repercussions of the procedure. The campaign also highlights the national and international impact that a public campaign can have through the Public Petitions Committee.

However, there are questions to be answered. First, how is it that a former health secretary, in the shape of Alex Neil, can take the robust action of imposing a moratorium on the use of transvaginal mesh only for certain health boards to continue to use the procedure to treat stress urinary incontinence, with some 400 women undergoing the procedure since the moratorium was introduced? Who should have ensured that the moratorium was adhered to? With whom does the responsibility lie? Why do we set rules if there is no system to enforce them? It was news to me—and many other MSPs, apparently, as well as the campaigners—that a moratorium that the Government calls for is not binding. That must be a matter of concern and the Parliament must address it. Had the moratorium held in the manner in which I believe it was intended to, we would not be in the position in which we find ourselves today.

Worse than that is the debacle of the initial review and the resignations from the review panel amid allegations of the changing of language and the omission of key evidence and findings from the review. Ultimately, there seems to be clear evidence of an attempt to whitewash the issue. Although we are not trying to be party political, I have to say that the response from the Government and the cabinet secretary in particular has been, at best, sluggish and indecisive. With such a weight of evidence piled against the procedure, action could and should have been clear cut by now. It was obvious to all that all was not well within the review panel.

The involvement of the MHRA, as already mentioned, has been absolutely shocking. A body in which we place a great deal of trust and responsibility has been exposed as inadequate and incapable of applying any degree of logic or care, with experts claiming that sufferers' pain could be psychosomatic. At no point has there been a duty of care or candour, and it was painful watching the new chair of the review board squirm in her seat under questioning during an evidence session, as her answers caused gasps from the women seated behind her. A lack of empathy and understanding was all too evident, and I have to agree with my colleague Jackson Carlaw in his assertion that there must be a full public consultation on the content of the review that took place. I also want consideration given to Alex Neil's proposal to convene an international summit here at Holyrood to allow Scotland once again to lead the way.

Putting an end to this procedure is well overdue. The ban must remain in its entirety, in the way that was originally intended. That must surely be a precursor to an end to this operation for good. I once again thank the petitioners for their courage and persistence, and I close by assuring them that their voices are now certainly being heard.

16:01

Rona Mackay (Strathkelvin and Bearsden) (SNP): Today's very important debate is one that I wish was not happening, because the circumstances surrounding it are shocking and upsetting, particularly for the thousands of women whose lives have been devastated by transvaginal mesh implants. This is not, or should not be, a political issue, as others have said. Since long before I was elected, colleagues from across the chamber, particularly the former health secretary Alex Neil, Neil Findlay, Alison Johnstone, John Scott, Jackson Carlaw and others, have fought tirelessly to help women affected by this issue.

I say that it should not be political because the mesh survivors watching this debate could not care less about party politics. They are simply searching for answers, asking why this has happened to them and why a surgical procedure that was supposed to help them has ruined their lives.

My former colleague, journalist Marion Scott, who has spearheaded the campaign from day 1, along with mesh survivors Elaine Holmes and Olive McIlroy, did not get involved because it was a good story, despite displaying the highest standard of investigative journalism, which is all too often sadly lacking these days. Marion has supported mesh sufferers because their pain and distress is all too visible. Their quest for justice despite their suffering was and is relentless, and they deserve our full praise and admiration. However, mesh sufferers are not looking for praise. Olive McIlroy and Elaine Holmes do not want television cameras in their living rooms; they want answers.

Before they knew each other, Olive and Elaine were trying to cope with the crippling aftereffects of surgery that they had been told would change their lives. Both had been told they were unique. They were not. We now know that thousands of women worldwide have been affected—mothers, daughters, sisters, aunts and grans. The mesh survivors are not campaigning for themselves. They are not doing it for money. They are doing it so that no more women have to suffer as they have—lives ruined, families shattered.

I vividly remember seeing on TV in 2014 the joy and delight on the faces of the women, led by Marion Scott, at the committee meeting as the suspension on mesh implants, introduced by Alex Neil, was announced. However, as I understand it, since the suspension at least 400 women have had a mesh tape implant to treat the very common condition of stress urinary incontinence. Incidentally, if anyone does not know what the tape implant looks or feels like, they should imagine the strong plastic tape that binds a bale of newspapers—the kind of tape that cuts your finger if you touch it in the wrong way. That is what women are dealing with when it is put inside their bodies.

Like everyone else in the chamber, I do not pretend to be a medical expert, but what I do know is that when clinicians cannot agree—as we heard in Elaine Smith’s powerful members’ business debate on thyroid diagnosis and treatment a couple of weeks ago—it is the patient who suffers. As with the thyroid problem, the vast majority of mesh sufferers are women. I leave people to draw their own conclusions on that.

The Scottish Government cannot ban the use of medical procedures, but it can ask health boards to suspend their use, which is what was done. As a result of the petition, some progress has been made, albeit slowly, such as the stipulation that mesh should not be offered routinely to women and that all patients must have access to clear, understandable advice to help them make an informed choice. All appropriate treatments should be made available, subject to informed choice. A helpline has been established. Reporting of all procedures and adverse effects will be mandatory. As we have heard, a new oversight group is being set up to ensure that the conclusions are implemented, so there is progress. We are at last heading in the right direction.

It is, however, the UK body—the MHRA—that decides what medical products are safe. We must now put complete pressure on the MHRA, which has been in denial over this issue from day one. We should ask what more proof it needs that the product is not safe and show it the victims. We should tell the MHRA to tell health boards that the product is not available for use.

Of course, there are clinical risks with every surgical procedure and side effects to all medicine taken, but when hundreds of women are so severely affected, the risk must surely be too great and we must stop doing it.

As a member of the Public Petitions Committee, I am well aware of the serious issues that the report into the review and the review of the review threw up. Time does not allow me to delve into it and other members have outlined the issue very well. However, when those in authority, in whatever field, stop listening to the people at the centre of the issue, the people they are supposed to protect, it is a disaster.

The Scottish mesh survivors hear our voice campaign is an outstanding tribute to the courage and determination of the women who are determined to effect change. Those in power must start hearing their voice, albeit belatedly, before more women’s lives are destroyed.

16:06

Monica Lennon (Central Scotland) (Lab): I am grateful for the opportunity to speak in today’s debate. I add my appreciation to the Public

Petitions Committee for its work thus far on this important petition.

Most of all, I am grateful for the incredible bravery and strength of mesh survivors in Scotland, whose tenacity in campaigning to raise awareness of the issue has led us to the point that we are at today. Like all members, I am totally in awe of the strength and passion of the women I have met who are part of the Scottish mesh survivors group.

Earlier this year, I joined parliamentary colleagues at a meeting with the Scottish mesh survivors that was organised by my colleague Neil Findlay, who has been a long-time champion of the voices of mesh survivors, and who has done some excellent work in raising awareness of these women, as have several other members of the Scottish Parliament from various parties.

Nothing can prepare us for the stories of these women. I can only imagine the pain that they have had to endure over the years. However, I share their rage that this has been allowed to happen to them. All the Scottish mesh survivors, ordinary women who have ordinary lives, have had those lives turned upside down by the implantation of transvaginal mesh.

Intended to address incontinence or pelvic prolapse, the insertion of polypropylene mesh was, for many of these women, a procedure that they had been led to believe was first-class, safe and would make their lives better. For so many of the women who have undergone those procedures, that could not have been further from the truth.

As we now know, in many patients, the mesh began to break up, dispersing fragments throughout the women's bodies and causing incredible damage. Some of the women I met earlier this year told me about ruined relationships and careers, the daily struggle of living with chronic pain, the loss of the full use of their legs, and the unbelievable pain of having to deal with how those changes utterly changed their lives, shattering hopes and dreams for the future.

The implantation of mesh in women across Scotland on the NHS is a national scandal. The way in which those women have been denied, first by their doctors when they first expressed their concerns—they were told that they were imagining or exaggerating their symptoms—then by the medical companies, and now by Governments that are tasked with investigating the whole debacle, is nothing short of an outrage.

During the drive to get MSPs to sign up to the say no to mesh whitewash pledge earlier this year, one of the women I met told me about her experience when she first started having problems following mesh surgery. Her surgeon repeatedly told her that she was a unique case and the only one he had ever known to experience adverse side effects. For months, she was none the wiser. It was only through her discovery of the mesh survivors group and discussion with other women who had gone through the surgery, some with the same surgeon, that she discovered that that doctor had been telling several other women the same thing. It is an absolute outrage that the health of those women has been put so terribly at risk by that procedure. Not only is the implantation of mesh unsafe, some practitioners and medical companies who advocate its use have clearly known about the dangers and have been complicit in misleading women about the effects.

Earlier this year, a few of us launched the cross-party group on women's health; I am the convener and Alison Johnstone MSP is the vice convener. The purpose of the cross-party group is:

> "To inform Parliament and policymakers on a range of health issues which only, predominantly or disproportionately affect women; to consider the impact which gender and inequalities has on women's health and their ability to access healthcare and treatment and to empower women to make informed choices about their health and ensure they are treated with dignity and respect."

In large part, the discussions that I was having with a range of groups as my party's inequalities spokesperson sparked the need for this cross-party group to be established, and the experience of the women from the mesh survivors group absolutely played a role in the desire for these women's health issues to be looked at more closely.

The way in which so many of these women have been brushed off and disbelieved is outrageous; it should never be allowed to happen again. These women deserve justice, so I echo the call of my colleague Neil Findlay that the mesh scandal must be investigated with a judge-led inquiry that is truly independent of the health service and the Scottish Government. I urge the health secretary to give that call serious consideration.

As an MSP who was elected in 2016, I am fairly new to the parliamentary scrutiny of mesh and I am struggling to understand how health boards were able to disregard the moratorium and get away with it without any apparent consequence. I ask the cabinet secretary to give an answer on that in closing.

Mesh survivors in Scotland and across the world have been silenced and sidelined for too long. It is beyond time that their concerns were investigated seriously through a truly independent inquiry, and that the calls of their petition were considered by the Scottish Government. I ask the cabinet secretary to give her whole-hearted commitment to that in closing.

16:12

Alison Johnstone (Lothian) (Green): I, too, thank members of the Public Petitions Committee for their work on this critical issue, MSP colleagues who have supported the women, and—most of all—the mesh survivors themselves, who have campaigned to make the risks of mesh surgery clear, to have the procedures suspended in Scotland, and to protect other patients from harm.

Meeting the mesh survivors when they came to Parliament was eye opening. They are women of different ages and backgrounds who have gained great strength from coming together and realising that, as Monica Lennon has just pointed out, they are not alone and are not unique—unfortunately. I came into a room packed with women who are reliant on wheelchairs and crutches. What chronic condition or illness was responsible for these life-limiting symptoms? Surgery, here in Scotland.

I spoke to women who had worked in high-level roles in justice and in care—in services that we all rely on—who are no longer able to make a living and are reliant on others for help and support. No one appreciates more than the women themselves how debilitating and how life-restricting incontinence can be. Although we all appreciate that surgery can never be guaranteed 100 per cent safe or side-effect free, for a group of patients to have such high hopes of life-improving surgery only to have such devastating outcomes is absolutely unacceptable.

What is clear is that the consent that was given to surgeons by these determined and remarkable women was far from informed. That is why their work and campaigning are so important. Incontinence is an issue affecting millions, yet it is rarely discussed in public. The mesh survivors have ensured that that will change.

I will never forget meeting one of the survivors, who attended with her husband. They explained how their relationship had been changed forever by this procedure. Imagine your partner going to hospital for surgery to treat incontinence and that resulting in their facing the rest of their life in a wheelchair, with their incontinence considerably worsened, their autonomy and self-esteem shattered, and physical intimacy a fading memory. I met a woman in tears because she was no longer able to lift up her beloved grandchildren.

When we discussed with survivors the issue of reversing or rectifying the surgery, I, like Neil Findlay, heard that they had been told that removing mesh could be likened to removing chewing gum from hair.

I appreciate the forthright evidence that Elaine Holmes and Olive McIlroy presented to the Public Petitions Committee in September and the detailed account that Dr Agur gave of his involvement with the independent review. He noted key differences between the interim report and the final published report. Dr Agur firmly believes that the final report did not do enough to reduce harm and was too ambiguous about the risks of mesh surgery, contrary to the evidence that analyses the long-term adverse effects of mesh surgery, including mesh erosion and chronic pain.

From Dr Agur's evidence, it is clear to me that, at one point, the work that was led by the independent review group made it

> "The first authority in the world to formally express concerns about a procedure that many clinicians and surgeons and other authorities around the world considered to be a gold standard."—[*Official Report, Public Petitions Committee,* 28 September 2017; c 4.]

Scotland had an opportunity to show global leadership on mesh. Like other members, I am extremely dismayed that the final report did not reflect that. We missed the opportunity to lead and we let down mesh survivors in the process.

The Public Petitions Committee has reflected that Professor Alison Britton's report on the independent review will focus on the process that was followed and will not revisit the findings and recommendations of the report. In Dr Agur's view, recommending that transvaginal mesh procedures must not be offered routinely does not give sufficient clarity. I, too, believe that the findings of the report must also be revisited.

It has been well reported that draft guidance from NICE will acknowledge the "serious and well-recognised" concerns about transvaginal mesh and recommend that it is not used, or is used only in the context of research. I hope that the cabinet secretary will provide clarity on the Scottish Government's position on NICE's advice and will say whether advice for clinicians in Scotland will follow it, given the challenges that the Government's independent review faced. Will the work of the new oversight group change to reflect any updated advice?

In March, when the cabinet secretary made her statement on the review, she stressed that only the Medicines and Healthcare Products Regulatory Agency has the power to ban the use of mesh implants. However, the forthcoming NICE guidance is clearly another way to restrict the practice of the surgery. Why did health authorities in Scotland not take a similarly protective approach?

Ultimately, I agree with Elaine Holmes and Olive McIlroy that procurement is a matter for the

Scottish NHS and the Scottish Parliament and that the fact that it is a UK-wide body that decides whether medical products are safe does not mean that the Scottish NHS should buy everything on offer. Alex Neil has made clear to the Public Petitions Committee his concerns about the MHRA's independence and effectiveness as a body protecting public health, and I agree. Complete transparency regarding vested interests must be the norm.

Work to improve reporting of adverse incidents related to medical devices is more urgent than ever and the case for imposing a real suspension of all transvaginal mesh procedures is stronger than ever. I urge the cabinet secretary to open up the final report of the Scottish review of mesh surgery to public consultation. We must learn from the mesh survivors and ensure that they realise that we hear their voice. We must leave no stone unturned in delivering justice for them and making sure that not one more life is affected by those implants. We hear their voice.

16:18

Alex Cole-Hamilton (Edinburgh Western) (LD): I am grateful to the Public Petitions Committee for securing time for the Parliament to address something that for every one of the hundreds upon hundreds of women who are mesh survivors in this country is nothing short of a public health disaster. I am proud to add my voice to some incredible and passionate speeches that we have heard.

I put on record my thanks to Neil Findlay for arranging the visit that Alison Johnstone has just described during which members met mesh survivors, many of whom were in wheelchairs and all of whom were in abject pain. The experience prompted me to hold a member's business debate just two weeks ago on the need for a national continence strategy, given that, although 80 per cent of cases of incontinence can be alleviated with appropriate physiotherapy, all too many cases have led to the insertion of potentially devastating implants and devices that, were they pharmaceutical products, might never have even made it out of the trial phase.

I was contacted at the weekend by a constituent of mine called Cathy, who has given me permission to share her story with members.

In 2010, after suffering very mild issues with incontinence, Cathy was referred by her physiotherapist to a consultant, who suggested that she could undergo a marvellous new procedure. Somewhat bewildered, Cathy was asked to sign a consent form then and there. She said that it felt as though she was entering a clinical trial, although it was never spelled out to her quite like that. In fact, nothing was properly spelled out to her. If those fully grown women had been given the facts about what was going to happen to them, they might all have made different decisions. Despite being booked in for the more invasive transobturator tension-free vaginal implant, which is secured via spikes through the obturator muscle, Cathy received very little information other than that the procedure would cure her incontinence.

When Cathy woke after surgery, she could not move. The nerve damage that she had sustained to her obturator muscles radiated pain throughout her abdomen, legs and back. Her condition was so bad that, when she was discharged, she would not allow her son to travel at more than 30mph along the bypass. With no let-up in the pain, she tried to call the hospital from three days after being discharged and throughout the following week, but never received a call back from nursing staff or doctors. To add insult to injury, and in the cruellest twist of irony, her incontinence worsened for a time.

When Cathy visited her doctor, she was told that the pain might be related to the fact that she had stopped smoking at the time of her operation, and that she should try cutting fat out of her diet as a means of helping, but at no point did any medical professional suggest that there could be a physical problem with the mesh implant.

All told, Cathy went a full five years of trying to cope with abject pain before the cause was identified as the mesh implant. A routine check-up with her gynaecologist revealed that the tape was in too tight on the right-hand side and, as such, was constantly tearing at her obturator muscle. On seeking the advice of her surgeon, she received the devastating news that, because her tissue had grown around the implant, it could not be removed without further significant nerve damage. Had someone taken her call at the hospital in the days after her operation, a reversal or correction could have been performed. Imagine her horror at receiving that news, and also consider that she, like several others, had been told at the time of the surgery that the mesh plastic would simply melt away over time.

Once the cause of Cathy's pain was identified as the physical obstruction inside her, she was heavily medicated with gabapentin. The drug had a soporific effect on her, which forced her to retire from the job that she loved way before she had planned to.

Cathy's implant has had a significant impact on her mobility, her intimacy with her partner and her mental health. The mesh implant has devastated her quality of life and she is left with the Hobson's choice of making do or having it removed with potentially far greater nerve damage and resultant pain. As I stated at the start of my speech, she felt rushed into the procedure, she was not clear about her options and, given the lack of understanding on the part of the clinicians who tended to her about possible side effects, she had the impression that she was part of a clinical trial.

Cathy is far from alone in feeling like that. Yesterday, I was contacted by a constituent called Tress who underwent a similar procedure. In her case, it was for a prolapse that resulted from a hernia in 2010. In order to send a message to members this afternoon, she has allowed me to read out a brief passage from the message that she sent me. She wrote:

> "I feel it was an unnecessary operation but was bullied into having it, being told it was my last option. I was not informed of the risks. My life has changed. I suffer from chronic pain, as well as recurring infections, and I have to have antibiotics in the house at all times. I have been for investigations but was told my mesh was safe. No, it's not safe; no mesh is safe, and we have lost several lovely ladies through having a mesh fitted."

It is the human cost, as expressed in Tress's words, that underscores that the situation is a public health disaster. At the end of October, the world lost Christina Lynn Brajcic, a formidable Canadian mesh campaigner, to sepsis from the infections that she had sustained relating to her mesh implant. She is part of a death toll that is increasing. Because of that, I add my voice to those who are calling for the petition to be kept open, for a full and frank assessment of the final review—we can see that there is cross-party consensus that it is unsafe—and for a policy response that protects patients from the horrors of mesh implant side effects in absolute terms with a full and continuing moratorium.

16:24

David Torrance (Kirkcaldy) (SNP): I, too, put on record my thanks to the Public Petitions Committee and to the mesh survivors group. During my time on the committee, in the previous parliamentary session, we heard evidence from a range of women as well as from medical organisations, charities and fellow MSPs. We listened to the opinions and evidence of several patients. We were asked to reconsider the best mechanism for compiling research evidence, and we analysed statistics as well as both patient and expert views to find out more about the nature and scope of the problem. We also listened to women who had undergone the surgery.

The committee travelled to Brussels to give evidence to one of the European Commission's science committees and to the European Parliament's Committee on Petitions to update them on the work that we had carried out on mesh implants. The committee also listened to clinical experts locally and around the UK, while the Scottish Public Health Network, alongside the information services division of NHS National Services Scotland, provided us with an objective review of the research literature. I can, however, say with confidence that the evidence that the committee took from the women was the most emotional evidence that we heard in my time as the deputy convener. Some of them have experienced severe and constant abdominal pain, infections and bleeding, and some have been left unable to have sexual intercourse while others have been left disabled as a result of the procedure.

Early last week, a well-known Canadian campaigner against vaginal mesh procedures became the first woman to die in what has become known as the vaginal mesh scandal. I was deeply saddened to hear that she had had only minor complications, which a simple procedure could have prevented, but she became immune to the antibiotics that she was given as a result of major complications of the procedure. Her death came just a week after NICE's draft report recommended banning vaginal mesh as a routine procedure for prolapse, claiming that the implants should be used only for research and not in routine operations.

More than 400 women in Scotland have gone through the procedure since the health secretary called for the use of the implants to be suspended, in June 2014. Although thousands of women have had the implants over the past 20 years, many of them have experienced agonising and life-changing implications. Three years after the suspension of their use, fierce debate still continues as to whether the devices should be banned completely. However, the MHRA has found no evidence to indicate that mesh implants are unsafe. In a report that was published in 2014, the agency claimed that, although a small number of women had been affected by adverse implications, the benefit of tape and mesh implants outweighed the risks and could help in dealing with upsetting conditions. Nevertheless, although the MHRA announced that only 12 women UK-wide had reported cases to them, more than 3,000 women have undergone repeated operations in an attempt to resolve problems and complications from the surgery.

The debate over the past few years has shown us that there is a serious lack of information in circulation in Scotland regarding the surgery. In line with the NICE recommendations, patients should be provided with the information that they need to make informed choices. It is outrageous that some of the women who had experienced problems told us that they were not aware that the implants were permanent. Informed consent should be introduced fully and uniformly throughout Scotland's health boards, and I will encourage the MHRA to reclassify TVM devices to heightened alert status to reflect on-going concerns not just in Scotland but worldwide.

Informed consent is a fundamental principle underlying all healthcare interventions, and it is extremely important that women know the ins and outs of the procedure before agreeing to it. What is most appalling, however, is that some of the women who experienced adverse effects felt that they were not believed, which added to their distress and increased the period of time before any remedial intervention could take place. Women felt that their voices had not been heard as they raised concerns about the side effects that a number of them had suffered. Many of them eventually felt that the only way to bring the matter to the attention of the Scottish Parliament was to lodge a petition bringing the issue to the attention of the Public Petitions Committee.

There is, without doubt, a serious possibility that the implants will continue to have a profound impact on the lives of many Scottish women, so I am pleased that there is general agreement on the conclusions of the current Public Petitions Committee. We need to revise and enhance governance around the launch of both new medical procedures and new approaches, give women more opportunities to report any adverse effects should they arise and re-evaluate how women are assessed and treated.

The lack of understanding of the effects of the implants means that the Government and key stakeholders must ensure that the guidance that is given to the NHS and clinicians is based on the most robust, up-to-date and accurate evidence. Similarly, good information is essential to good patient care. The women need much more than we are currently providing for them, including adequate time for discussion and reflection, and we must make them aware of patient choice and involve them in shared decision making supported by robust clinical governance.

Ultimately, we need to see the recommendations, as well as the evidence from women who have been affected, reflected in the patient safety and clinical governance strands of the NHS. Although the debate will continue, in order to progress further the Government needs to co-operate with key stakeholders to address information gaps and ensure that the available information is used as effectively as possible to support safe and effective care.

The Scottish Parliament must act under the restraint that it lacks the authority to withdraw the product, but our job as policy makers is to challenge the status quo and represent those women so that their voices are not drowned out. I ask my fellow members to support the continued suspension of TVM implants and to expose some of the false information that is being circulated about this potentially life-altering procedure.

16:30

Michelle Ballantyne (South Scotland) (Con): I echo the sentiments of gratitude towards Elaine Holmes and Olive McIlroy for lodging the petition and for their unyielding courage in sharing their stories with us and the world. I am relatively new to the petition—indeed, I am new to the Public Petitions Committee—but, after hearing of their strength and courage through adversity and their will to stand up and speak out on behalf of mesh survivors across the country, I empathise fully with their resentment and dismay at the review process, not least because I have undergone a mesh procedure myself.

It is important that the women are heard today, because their own words—shaped through pain, angst and frustration—should resonate with us all as human beings and as parliamentarians. They said that their voices had been “drowned out and stifled”. They said that they had endured “adversity and pressure” for “almost three years” as patient representatives on the review group. They said that they had felt “physically sick” upon reading the final report.

Those words encapsulate what we heard at the committee: that the report’s recommendations will not succeed in “reducing harm to patients” from the procedure. Those are not my words but the words of Dr Wael Agur, in his evidence to the committee. He told us, in no uncertain terms, what mesh can do. He spoke of mesh tape procedures causing “chronic pain”, and he expounded on the devastating problems that that can cause for intimacy in a relationship.

Dr Agur has performed mesh procedures—many of them. He speaks from a place of experience and expertise. He is quoted as telling of his “incredible pride” when he joined the review group to protect women in the future. That pride was short lived and supplanted by dejection, however. He now says that Scotland failed to live up to expectations. Since NICE has recommended banning the use of vaginal mesh operations to treat pelvic organ prolapse in England, the powerful words of Dr Agur take on a new profundity.

Of course, hindsight is a wonderful thing. We must remember that the procedure was, at first, whole-heartedly embraced by the profession and by patients as a simple, quick and life-changing solution to really troubling medical problems. It would be wrong to direct all the blame at the surgeons and specialists, such as Dr Agur, who performed the procedures in the expectation of improving their patients’ quality of life.

However, it has become very clear that procedural and regulatory deficiencies have been abundant. It has been acknowledged at the committee that there was no robust framework for ensuring fully informed consent. Indeed, even when the adverse consequences of mesh entered broader medical perception, heads remained firmly buried in the sand. Unfortunately, as my colleague Jackson Carlaw has highlighted, the whitewash of the report indicates that some heads are still there.

Survivors, professionals, experts and politicians are speaking with one voice. With that voice, we ask: did the MHRA have an undue influence in the arrangement of the report? Why was chapter 6 deleted from the final report? Why is the report engineered in such a way as to exhibit the benefits of mesh for incontinence while it obfuscates the potential for mesh erosion?

Damage to reputation does not justify it. A loss of funding from manufacturers does not justify it. Fear of litigation does not justify it. The report does not, should not and cannot justify lifting the suspension of polypropylene transvaginal mesh operations. When we make decisions on the issue, we should be able to look Elaine Holmes, Olive McIlroy and all survivors in the eye and say, honestly and transparently, that this will protect women from the pain that they endure—that this is the right way forward.

I do not believe that the cabinet secretary can do that today on the basis of the report. No amount of whitewash can conceal the facts. At a time when Australia and New Zealand are banning the procedure, legal actions are taking place all over the globe and acclaimed academics are describing the procedure as a “catastrophe”, one must question why the Scottish Government is dragging its feet.

The Scottish Government must set aside obstinacy in favour of engagement. I urge it to act decisively and ban mesh before it ruins more lives. [*Applause*.]

The Deputy Presiding Officer (Christine Grahame): I politely remind people in the public gallery that it is not appropriate to clap. I understand why you are doing it, but it is not appropriate when the Parliament is meeting.

16:35

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Like many members who have spoken in the debate, I was made aware of the issue when constituents made representations to me. I heard their experiences at first hand, in my local surgeries.

I also sat in on a meeting of the Public Petitions Committee that was attended by a number of women who are affected by mesh implants, and who offered their time that day to provide MSPs with more information about the conditions that they endure in their daily lives as a result of undergoing the procedure. Some of their evidence was pretty harrowing, and I have to say that in my 10 years as a member of this Parliament I have not come across many cases like theirs.

The issues that the women face are very challenging. I would not pretend to understand all the medical complexities that are involved, but I hope that the debate at least gives all the affected women hope that their concerns are being heard and acted upon.

The review that the Scottish Government carried out, notwithstanding the disagreement about what was and was not included in the final report, at least went some way towards meeting the petitioners’ initial demands—the suspension of mesh procedures, mandatory reporting of all adverse events, the introduction of fully informed consent and, of course, the establishment of a review.

Health boards must put in place further safeguards before the procedure is reintroduced. As we know, and as members have said, in relation to pelvic organ prolapse the current evidence does not indicate any additional benefit from the use of mesh, and the procedure is not to be offered routinely.

Some of the review’s recommendations could reasonably have been put in place at the outset of the process. In particular, I am thinking of the recommendations on the provision of information, consent and mandatory reporting of adverse events. Why on earth would such an approach not be routine for a procedure in relation to which there are known risks? That is a bit of a mystery to me and to some of the women to whom I have spoken.

I had a look at the report, “A summary of the evidence on the benefits and risks of vaginal mesh implants”, which the MHRA produced in 2014. As members know, the MHRA is the sole UK body with the authority to withdraw products. It concluded:

> “the benefits of the use of these devices outweigh the risks. This means there is no justification for the MHRA taking regulatory action to remove all of these devices from use in UK hospitals.”

I looked through the report to see how the MHRA had reached its conclusion, given the number of reported adverse incidents. It was interesting to learn that the MHRA had no data that showed how many mesh devices had been used. Instead, it was relying on sales figures to get an indication of that. Its data showed that between 2005 and 2013, in relation to SUI, there were 29 variants of devices, around 170,000 devices were sold in the UK and 291 adverse events were reported in England—the MHRA was using English data. In relation to POP, there were 25 variants, about 24,000 were sold in the UK and 110 adverse events were reported.

My point is that I could see no comment in the report on the statistical significance of the data and how it led the MHRA to conclude that the devices were safe. One adverse event is a matter of great regret. More than 400 such events were reported between 2005 and 2013, but no assessment was made of whether such a figure should be expected, statistically. I am still wondering how the MHRA was able to conclude that the devices were safe if it had not addressed the statistical probability of adverse events and dismissed the numbers. Perhaps we can attempt to clarify that point with the MHRA.

Members have already commented on the very sad news from Canada, where Chrissy Brajcic, who was treated for mild urinary incontinence with a mesh device, has recently died. That tragic news will undoubtedly mean that further demands will be made for such procedures to be reconsidered, and a more rigorous assessment of risks and the potential impact on women if those risks should materialise might well be given more prominence.

I said that it is impossible for us as laypeople to analyse and assess the evidence and impact of such mesh devices on the women who have come forward, but we have to listen, offer a forum in which concerns can be heard and expect those on whose professional judgment we rely to get this right. However, that cannot be the end of the story.

The number of women who have been affected adversely by the procedures in question might be small in relation to the total number of procedures that have been carried out, but when they occur, the impacts are particularly severe. Confidence is everything here. We must challenge our clinicians more on the risks that are involved, and we must restore confidence to the women involved before we proceed any further with such procedures.

The Deputy Presiding Officer: We move to the closing speeches.

16:41

Anas Sarwar (Glasgow) (Lab): I thank Johann Lamont and the Public Petitions Committee for securing this important debate and giving Parliament the opportunity to contribute to their deliberations.

Today, we have heard the best of our Parliament. We have heard from across the chamber a story of courage and emotion, strength, and dignity and determination in the face of the might of Scotland’s medical establishment. We have heard about the campaign that has been driven by a group of women who have been forced to struggle every step of the way against a medical establishment that has closed ranks to protect its own.

As every member who has spoken in the debate has done, I pay tribute to all the survivors, many of whom are in the public gallery, for their bravery, determination and courage in not taking no for an answer and pursuing the issue, not just to get justice for themselves but to protect patients in the future. I pay tribute to Elaine Holmes and all the other campaigners for their determination and the dignity with which they continue to campaign.

We have heard how medics closed ranks to protect their own reputation, how the medical establishment closed ranks to protect its relationships with medical companies and how the women affected have had to fight even to have their case heard.

I praise the work of my colleague Neil Findlay in steadfastly supporting the women affected and ruthlessly pursuing the truth. I also thank parliamentarians from other political parties—in particular, I thank Jackson Carlaw of the Scottish Conservatives and Alex Neil, who has continued his passionate and principled campaign on the cause since vacating the office of health secretary. I also thank the women throughout Scotland who continue to campaign. Without their campaigning, women in Scotland would still be having mesh implanted into their bodies, with consequences that are now well evidenced. If it were not for that campaigning spirit within and outwith the Parliament, we would not be debating the use of a procedure and a product that cause so many women to face a lifetime of chronic pain.

Fundamentally, the debate comes down to one word: confidence. The reality is that the survivors of the scandal do not have confidence in what has happened since the scandal. The review is compromised and we must accept that it is compromised, just as the MHRA is compromised and we must accept that it is compromised. I am sorry to say that Government action—I do not mean this to be a party-political point, and I will come on to explain how we can move forward—is also compromised. Unless we can give the survivors of the mesh scandal confidence that their Government, the institutions and the medical establishment are working in their favour and in the interests of justice—for them, rather than against what is in their interests—we will never be able to deliver justice for them. Confidence is crucial as we move forward. We must consider how we create a climate of confidence in the review process, the actions that come out of that review and what happens as regards the long-term use of the product.

There has been a cover-up. For medics to fail to declare a conflict of interests while serving on a review body is simply unacceptable. If parliamentarians were to take part in a committee process in which they had a conflict of interests, they would be hauled before the Standards, Procedures and Public Appointments Committee and rebuked by the Parliament. If it is not acceptable for parliamentarians to behave in that way, it is not acceptable for anybody in any profession to behave in that way while serving in a so-called independent review. The fact is that there is litigation over the use of a product and that the people who face that litigation are serving on the review body and failing to declare that interest. That is shameful behaviour that brings both the conduct of the review and that of medical professionals more widely into disrepute. We should call that out for what it is.

The evidence of the misuse of a product that is not fit for purpose is clear. In the US, manufacturers of the product have already paid out more than £1.5 billion in compensation. The survivors do not want to hear that the situation here might be a cover-up to try to protect money, whether from the public purse or from private companies, rather than a means of seeking justice. That is why what we do in the future will be so important.

The fact that NICE has banned the use of mesh operations in England speaks for itself. The fact that the product is banned in Australia and New Zealand also speaks volumes. The use of the product was wrong, with lifelong consequences. Today, we have an opportunity to put that right. More than 100 members of the Scottish Parliament have already put their names to a call for an honest and transparent review—not one that has been compromised by the actions of the medical establishment, but one that has process at its forefront and which is not tainted by a cover-up. We cannot allow the Parliament to look as though it is part of a cover-up, which is why we need to hear a commitment from the cabinet secretary that there will be a judge-led inquiry to bring this tragic and murky scandal into the full light of public scrutiny. There must be a review that will give women the chance to be listened to and lead to action being taken against those who are culpable. Nothing less than a judge-led review will suffice.

I have some specific and direct questions for the cabinet secretary. I say this in all sincerity: given the way in which the debate today has been conducted, we have an opportunity to bring together all our parties—Opposition and Government—to get to the bottom of the mesh scandal and give justice to people who have been affected by it. Following the debate, the cabinet secretary has an opportunity to unite our Parliament in that process.

I repeat what Alex Neil said about his not having been told

“the truth, the whole truth and nothing but the truth”.

For a former cabinet secretary to say that he did not believe that he had got that from his most senior officials when he was in office as a member of the Scottish Government and this Parliament is absolutely damning, and we should not take it lightly. We have to know whether those people are still giving the same advice to the present cabinet secretary and, if they are, how we can expose that and make sure that the position changes.

We must make sure that, when we have a moratorium, it means just that, and that we review mesh procedures not just in women, but, as we heard from Alex Neil, in men, who also suffer complications when they undergo those procedures. We must consider how a genuinely independent review might work: whether we should open up the report for public comment before final publication; whether the use of mesh products should be indefinitely suspended; whether we should use the Parliament’s procurement powers to end the purchase of the product; and whether we should settle litigation cases quickly and stop deliberate stalling by companies. Anything less than that will be a failure and a betrayal of the women who are sitting in the public gallery. Anything less will be a betrayal of the best of this Parliament and the best of this country.

I hope that, by working together across the Parliament and across all political parties, we can, once and for all, give justice to survivors of the mesh scandal in Scotland and ensure that it never happens again.

16:49

Miles Briggs (Lothian) (Con): I am pleased to close for the Conservatives. The debate has been a useful and thoughtful discussion. Like others, I pay tribute to current and former members of the Parliament’s Public Petitions Committee for their consistent work on this subject over a number of years. This is another good example of the important role that the Public Petitions Committee plays in the political process in modern Scotland. Like others, I commend the petitioners Elaine Holmes and Olive McIlroy, who have done so much to speak up for those who have suffered as a result of receiving mesh implants and tape procedures. I welcome all those in the public gallery who have campaigned so hard. I hope that, today, Parliament has given them a voice and done them justice.

A number of members have spoken in detail about the horrendous health impacts that some women have experienced as a result of mesh implants and tapes for prolapses and stress incontinence. As a newly elected MSP, I, along with many MSPs, first met the mesh campaigners in Parliament following the publication of the draft report of the review group. Those women had, in good faith, desperately sought answers, and I have to say how angry I felt going home that the review group that they had hoped would challenge, and seek answers and the clarity that they had been looking for, had been compromised, and that a whitewash of a report that helped no one had finally been published. Those women have been badly let down. The whole chamber will have sympathy for them, but they do not want sympathy—they want answers and action.

Jackson Carlaw expressed very clearly the frustration and anger of mesh campaigners over the past few years. It took a great deal of pressure before the then Cabinet Secretary for Health and Wellbeing, Alex Neil, announced an independent review in June 2014. At the time, the health secretary also announced a suspension of the use of mesh implants, but we know that half of Scotland's health boards continued to use the devices, with more than 400 procedures having been carried out despite the ban.

My colleagues Brian Whittle and Michelle Ballantyne raised real concerns about the role and impact of ministerial directives on NHS health boards in Scotland. Monica Lennon asked why those directives were blatantly ignored. Why have the health secretary and the Scottish Government been totally disregarded by some Scottish health boards when they have issued such directives? All of us in this chamber will want answers to those questions.

Since the ban, and despite the Scottish Government's position, continuing concerns about the safety of mesh tape implants and the fact that the NHS in Scotland faces several hundred damages claims from women who have been affected, hundreds of women have received mesh tape implants. We heard three great speeches today from Jackson Carlaw, Neil Findlay and Alex Neil, who have been involved from the outset. All three demonstrated that the contents of the report have been compromised and diminished. I very much endorse Alex Neil's call for any future guidelines to involve patients and take account of their experiences. The fact that the cabinet secretary has had to appoint Professor Alison Britton of Glasgow Caledonian University to conduct a report into how the inquiry was undertaken only highlights the extent of the concerns about the inquiry.

In recent weeks, we have had a major new development with the news that NICE is set to recommend that mesh operations to treat organ prolapse should be banned. It is understood that the draft guidelines from NICE say that the implants should be used only for research and not routine operations, and that

> "evidence of long-term efficacy [for implants treating organ prolapse] is inadequate in quality and quantity".

NICE's move will mirror a similar decision by equivalent bodies in Australia and New Zealand and comes at a time when more very worrying academic evidence has been produced about mesh erosion rates. NICE's guidance should act as a further wake-up call to the Scottish Government and should prompt it to take decisive action to ensure that there is no interruption to the current suspension of the use of mesh, in order to prevent any more women or men being harmed.

Patients in Scotland deserve better than the response to this major issue that has been provided to date. I agree with Jackson Carlaw and Alex Neil that the Scottish Government should act now to convene an international summit here at Holyrood to allow Scotland to seek answers for families and, once again, gain the political initiative.

I hope that this debate will help to push ministers to address in full the genuine and legitimate concerns of mesh campaigners, and to ensure that the safety of patients is always the overriding priority when the use of such invasive surgery and new technology is being considered.

On 7 November, the First Minister apologised on behalf of the Scottish Government to gay men convicted of now-abolished sexual offences. That was a welcome moment in this Parliament's history, in which we saw parties from across the chamber come together as an injustice was addressed and acknowledged and saw the Scottish Government take action.

I believe that the Scottish Government and this Parliament need to make amends to those women and their families across Scotland who have so clearly been failed. There is a lot of work to do to regain the confidence of those affected by the mesh scandal, including the survivors. It is time for Scottish Government ministers to act and make Scotland the leading beacon once again, for all of them.

16:55

Shona Robison: I thank members for their speeches in this afternoon's important debate. I will try to respond to as many as possible of the points that have been made. Like other members, I hope that we can work together on this important issue.

First, I will touch on the role of the Medicines and Healthcare Products Regulatory Agency. Many members raised concerns about it and referred to its key role as the only organisation that can ban a procedure or product. To highlight what I said in my opening remarks, it is important that the MHRA takes account of international evidence that is emerging and the action that is being taken in other places, such as the Australian Therapeutic Goods Administration. That is why the chief medical officer has written to the MHRA asking what its response is to the action taken by the Australian TGA to remove mesh for pelvic organ prolapse and single incision mini-slings. That does not apply to stress urinary incontinence, I have to add, so the MHRA must be very clear what the TGA has done—its focus is on removing mesh for pelvic organ prolapse and single incision mini-slings. We await the response of the MHRA on that issue.

John Scott: Will the member take an intervention?

Shona Robison: Yes—I promised that I would let John Scott in.

John Scott: Thank you. Given the alleged conflict of interest of the MHRA and the source of some of its funding, does the cabinet secretary think that it is time for a review of its corporate governance arrangements and is that something that she might consider pursuing?

Shona Robison: I am happy to pursue that. We have raised a number of concerns about the role of the MHRA, not least from points made by members in this chamber. We have regularly put those to the MHRA and the Department of Health, which has oversight of the MHRA.

Many issues have been raised about the independent review process and I will come on to one specific issue in a moment. However, I think that we should allow Professor Britton to carry out her review, which will look at all of the issues raised during this debate, not least the issue that was raised by Alex Neil—and by Neil Findlay, I think—about how interests are disclosed and registered. It is important, not just for the present independent review, but for future reviews on any issue, that there is full disclosure of interests and that they are registered. Professor Britton will be looking at that issue along with the many other issues that have been raised about the independent review process.

Neil Findlay: Given what the cabinet secretary has just said, which is very important, is it now her view that the review was compromised by that issue?

Shona Robison: I certainly understand the concerns about the review process; I would not have asked Professor Britton to look at the independent review if I did not have concerns. However, that fact does not detract from the important recommendations that the review has made. With regard to POP, it has effectively restricted the procedure to exceptional cases only, and I will come on to NICE in a minute, in relation to taking that even further. We need to recognise, as other members have, that some of the recommendations are very important.

Members have asked how procedures could still have gone ahead in the light of the moratorium on mesh procedures. As I have said before in this chamber, in a small number of cases where a woman who had been fully informed of the risks still wanted to go ahead with the procedure, as they were experiencing very distressing symptoms, and a clinical judgment to proceed was reached in a fully informed discussion between the clinician and the patient, nothing could be done to stop it from going ahead, because the procedure is not banned. I understand members' frustration about that, but those were clinical decisions and the procedure is not banned. However, it is very important that the restrictions that are placed on the use of mesh are fully and consistently implemented. I will say a bit more about that in a second.

Johann Lamont: Will the cabinet secretary clarify what she understands a moratorium to be? What advice was she given in that regard? What did her predecessor expect a moratorium to be?

Shona Robison: I cannot speak for what Alex Neil wanted to happen, although I assume that it was the same as what I wanted: that the boards would suspend the procedures.

We were fully aware that the procedure is not banned. Therefore, if there was a clinician with a fully informed patient who wanted that procedure to go ahead, nothing could be done to prevent that. I have explained that a number of times in this chamber. It might be frustrating for members to hear that, but those are the facts.

The MHRA is the only organisation that can ban the procedure, and I have already said what we are doing to make sure that it is more fully informed.

Brian Whittle: Will the cabinet secretary take an intervention?

Shona Robison: Very briefly, because I have got other points to cover.

Brian Whittle: I recognise that the MHRA is the only organisation that can withdraw mesh devices. However, given that the NHS funds the operation and the cabinet secretary has the ability to take away that funding, she could stop the procedures from going ahead.

Shona Robison: I am not a clinician. I cannot make a judgment about withdrawing the funding for a procedure that is not banned. That would get us into very difficult territory. We have to be guided by the clinical advice. If the MHRA is going to look again at the issue, and I understand that it continues to look at the international evidence—

Neil Findlay: Will the cabinet secretary give way on that point?

Shona Robison: Not at the moment—I want to make progress.

The MRHA will look at the Australian and other evidence. I hope that it keeps the evidence under review. I would like the MRHA to reach a different conclusion but, so far, it has not done so.

Alison Johnstone asked a very important question about the NICE guidance. First of all, it is very important to understand that the NICE guidance on pelvic organ prolapse says that mesh procedures can be delivered for research purposes only.

NICE has been clear that it cannot ban mesh procedures; it has provided guidance. I must be very clear about that: NICE has been very clear in saying that it cannot ban the procedure. It provides guidance, and we will follow that guidance. The NHS in Scotland always follows NICE interventional guidance in the same way as would be the case in the rest of these islands—I hope that that reassures Alison Johnstone.

It is important to have further restriction beyond those that are in place for POP. The oversight group will incorporate that additional guidance into the guidance that it is developing.

Alex Neil made a number of important points, the most important of which was probably to ask how patients will be involved in the oversight group. I confirm that patients will absolutely be involved. I understand the trust issue that many of the women, not least Elaine Holmes and Olive McIlroy, have. It would be very hard, and perhaps unreasonable, to ask them to be involved in any other processes. Personally, I hope that they would consider being involved, because women who have had personal experience are exactly who we want to be involved in the oversight group, to take forward the issues and to develop leaflets for women so that they have the full information and can make fully informed decisions. I certainly hope that patients will be involved in the process, because it will make the procedures and the work of the oversight group very important and, perhaps, will help to build confidence in the material that will be put out in order to help ensure that patients are fully informed about any procedure that they undertake in this area.

I am sorry if I have not been able to respond to all members. If I have not been able to answer specific questions, I will write to members to make sure that they get the full information that I have not covered in my closing remarks.

The Deputy Presiding Officer: I call Angus MacDonald to close the debate for the Public Petitions Committee.

17:05

Angus MacDonald (Falkirk East) (SNP): Thank you, Presiding Officer. How long do I have for my speech?

The Deputy Presiding Officer: How long do you wish?

Angus MacDonald: Nine minutes?

The Deputy Presiding Officer: Nine minutes is absolutely fine by me. I might even give you 10 minutes.

Angus MacDonald: Perfect.

Alex Neil: You can take an hour.

Angus MacDonald: I am pleased to close the debate on behalf of the Public Petitions Committee. I thank members from across the chamber for their excellent individual contributions, which I will turn to in a short while.

As the convener said when she opened the debate, the petition was lodged during session 4. I have been a Public Petitions Committee member throughout consideration of the petition to date and, in that time, a wide range of evidence has been presented by the petitioners, the Scottish Government and other relevant parties. The strength of feeling and the emotions at meetings when the petitioners and fellow sufferers have given evidence have been tangible. We have taken substantial amounts of evidence, including from a lawyer who represented mesh-damaged women who were involved in litigation in America, and from the Medicines and Healthcare products Regulatory Agency, which is responsible for licensing medical devices in the UK.

It has been made clear throughout the debate that there is no doubt about the seriousness of the issues that were raised by the petition, or about the physical and emotional impacts of the adverse events that have arisen from mesh procedures. It is clear that it was partly, if not wholly, thanks to the petition that the Scottish Government asked health boards to suspend use of mesh in 2014 due to clinical concerns. That clearly reflected the seriousness that the Scottish Government attached to the issue. Alex Neil is to be commended for the action that he took as health secretary to introduce the suspension and the review until all the necessary procedures, approvals and restrictions were in place.

The petition asked for several things, including suspension of all mesh procedures, the establishment of an independent review, mandatory reporting of adverse events and the introduction of fully informed consent. Much of that has been, or will be, achieved as a result of the petition, so I join the convener and other members in paying tribute to the work of the petitioners on putting the issue in the spotlight.

Valid and salient points were made by Jackson Carlaw in a strong speech. He is a former member of the Public Petitions Committee: he asked searching questions during our evidence sessions and raised a number of those points this afternoon—not least of which was the woeful performance of the MHRA's representatives in giving evidence.

Neil Findlay has doggedly pursued the issue in committee meetings, and has worked on the issue outwith the committee system. He has made a significant impact in the campaign and continues to raise concerns regarding how the issue has been handled

Alex Neil made a heartfelt and candid contribution to the debate, including his call to review the contents of the initial review. He has called—in September in the committee and today in the chamber—for an international mesh summit to address the growing global crisis. There is much merit in that suggestion; it may be beyond the capacity of the Public Petitions Committee to hold such a summit, but I am sure that we can consider including the suggestion in the forthcoming committee report, which I hope will be completed in the not-too-distant future.

Rona Mackay detailed the review recommendations and, as other members did, rightly questioned the role of the MHRA. Monica Lennon spoke of the rage that is felt by mesh survivors; she referred to the issue as "a national scandal" and "an outrage" and called for a judge-led review. Alison Johnstone highlighted the lack of informed consent, and concentrated on the evidence that was given to the committee by Dr Agur.

David Torrance highlighted the successful visit to Brussels by the Public Petitions Committee, under the convenership of David Stewart, on which we made sure that the issue was well and truly on the radar of the European Commission.

Michelle Ballantyne is a new member of the committee who has made a strong contribution to the committee's work. She highlighted Dr Agur's evidence, during which he detailed the adverse impacts of mesh implants.

Willie Coffey spoke about the harrowing evidence that was given when he was present, and Brian Whittle, among many salient points, questioned the failure to have the moratorium fully implemented. Alex Cole-Hamilton went into some detail about the situation that his constituent has endured. We have heard excellent speeches in the chamber today, so I am sorry that I cannot dwell on many of the other points that were raised.

In his closing speech, Anas Sarwar spoke of the medical establishment closing ranks and about conflicts of interests, which we hope to get to the bottom of through Professor Britton's review of the review, and Miles Briggs highlighted in his closing speech the disregarding of directives by some Scottish health boards and the current situation regarding NICE guidance.

Although there has been a focus throughout on the issue in the Scottish context, there is little doubt that the issues that we have been considering extend far beyond our own borders; indeed, it has been referred to as "a global scandal". There was a sense, back in 2014, when the then cabinet secretary, Alex Neil, announced the independent review and moratorium, that Scotland was taking the lead on what was considered to be a matter of significance around the world. As work in Scotland has continued, there have been developments in other countries, and it may now be the case that some other countries are seen as leading the way, which is unfortunate, given where we were. I will leave to others the judgment about who is leading the way.

I would like to comment on some recent developments in other jurisdictions that have been mentioned this afternoon. Last week it was reported that, later this month, the National Institute for Health and Care Excellence will issue updated guidance on use of mesh. On that point, it is worth noting that the office of the chief medical officer has previously advised NHS boards and directors that the investigation and treatment of all patients should follow NICE guidelines which, although they are not mandatory in Scotland, are recommended as good practice. I hope that the cabinet secretary will provide an update to the committee on best practice across Scotland in the event that NICE updates its guidelines.

As recently as 28 November, Australia's Therapeutic Goods Administration, which is the equivalent of the UK's MHRA, announced that, with effect from 4 January 2018,

> "transvaginal mesh products whose sole use is the treatment of pelvic organ prolapse via transvaginal implantation"

will be removed

> “from the Australian Register of Therapeutic Goods”.

That decision was based on the TGA’s belief

> “that the benefits of using transvaginal mesh products in the treatment of pelvic organ prolapse do not outweigh the risks these products pose to patients.”

It added:

> “The TGA also considers that there is a lack of adequate scientific evidence before the TGA for it to be satisfied that the risks to patients associated with the use of mesh products as single incision mini-slings for the treatment of stress urinary incontinence are outweighed by their benefits.”

I believe, thanks to information that has been received from the petitioners, that that is also the situation in New Zealand. For the Public Petitions Committee, the recent developments here and abroad will be something to reflect on as we consider our draft report.

I think that it is more than likely that we will also, in time, consider the findings of Professor Britton’s review of the review. I hope that it will be a robust review: it should report on the process and flaws of the first review, so that lessons can be learned for the future, including ensuring that patient representatives feel that they can fully participate—which was, sadly, not the case in the first review. Professor Britton’s review will consider the process of the independent review and will make recommendations for the conduct of similar reviews in the future. However, the professor will not re-examine the evidence that was considered by the initial independent review, and her conclusions will therefore have no bearing on the moratorium that was ordered in 2014 and which continues to this day. I understand that Professor Britton will soon begin consulting for her work. I hope that individuals who have been impacted by mesh feel able to respond to that consultation; in fact, I encourage them to do so.

In the meantime, the Public Petitions Committee will continue to welcome any contributions from members of the public who want to ensure that Parliament hears their voice. I am sure that I speak for all the committee’s members, if not for the whole Parliament, when I say that I look forward to working on the draft report and to ensuring that the petitioners and campaigners who have ensured that this dreadful set of circumstances is on the radar are given their voice and listened to. To paraphrase the convener’s remarks in her opening speech, this petition is far from closed.

The Deputy Presiding Officer: That concludes the debate on petition PE1517 on polypropylene mesh medical devices. It is time to move on to the next item of business. I suspend the meeting briefly to allow a change of seats for the next item, which will be an urgent question.

17:15

Meeting suspended.

17:16

On resuming—

Urgent Question

NHS Lothian (Waiting Times)

Miles Briggs (Lothian) (Con): To ask the Scottish Government what its response is to reports that underreporting of accident and emergency waiting times has taken place across NHS Lothian, and how it will ensure that people responsible are held to account.

The Cabinet Secretary for Health and Sport (Shona Robison): The findings from NHS Lothian's final internal audit report, which I received over the weekend, are concerning. As the member will know, I have instructed an independent investigation to be carried out by the Academy of Medical Royal Colleges, led by Professor Derek Bell.

It is important to wait for the outcome of that independent review and its recommendations. In the meantime, I welcome the interim actions that are being taken to ensure that practices in NHS Lothian are brought into line with ISD Scotland's guidelines to ensure accuracy going forward. My officials will continue to work closely with the board to ensure that the recommendations are fully implemented as soon as possible.

Miles Briggs: When was the cabinet secretary first made aware that NHS Lothian accident and emergency waiting times had been underreported across other accident and emergency facilities within the health board area and not just at St John's?

It is only a few years since NHS Lothian was involved in another waiting times scandal, when it was found to be marking patients as unavailable to artificially reduce the number of breaches of the waiting time guarantee. Can the cabinet secretary therefore say whether she has confidence that NHS Lothian has the leadership to make sure that such things never happen again?

Shona Robison: I will give Miles Briggs and members a little bit of background. On Wednesday 11 October, a member of staff from St John's hospital wrote to the chief executive of NHS Lothian and to me, outlining allegations of bullying and intimidation, and the alteration of waiting times in St John's accident and emergency department. I was concerned about that and asked NHS Lothian to start an investigation immediately to check the veracity of those concerns and to look into the matter in detail.

From the internal investigation, it became apparent that the concerns were not restricted to St John's but went across the acute sites in NHS Lothian. Essentially, national guidance was not being adhered to. National guidance is very clear about how the four-hour target should be recorded, and the guidelines were not being followed within NHS Lothian; local operating procedures were being followed instead. That has now changed, as I said in my initial answer. We are now making sure that NHS Lothian is following the national guidance.

I felt that it was important to go beyond the internal investigation and make sure that there was an external look at the issues in more detail. The review will look at some of the issues that Miles Briggs hinted at, such as where the instructions emanated from and the governance around that. The external review will look into all those issues. I expect to have the report early in the new year and will publish its findings in due course thereafter. We should wait for that report and then see what further action is required at that stage.

Miles Briggs: In this case, it is quite clear that local guidelines have been put in place that go against what should have been taking place. It is important to note that although NHS Lothian's problem has been exposed, it may not be happening only in Edinburgh and the Lothians. What assessment has the Scottish Government made of how waiting times are being recorded in every health board across Scotland? To reassure patients across our country, can the cabinet secretary guarantee today that no other health board is producing local guidelines to underreport A and E waiting times?

Shona Robison: We have of course contacted the chief executives of other health boards to make sure that they can assure themselves and us that the national guidelines are being applied in their boards. We have no evidence that national guidance is not being followed in those other boards.

It is important to recognise, among the issues being raised in NHS Lothian, the very strong performance by our A and E departments across Scotland. Certainly, the work of the unscheduled care team has led to a sustained improvement of our A and E departments. We should make sure that we send out a clear message of support for all our hard-working staff in A and E departments across Scotland, who will face winter pressures that are beginning to emerge in our health system, as they are elsewhere.

I reassure Miles Briggs that we will not just look at the internal review; the external review will answer some of the wider questions about NHS Lothian in this regard and I am happy to ensure that the report is published once I have received it.

Anas Sarwar (Glasgow) (Lab): The findings will be of huge concern to patients and staff. While performance continues to decline, impacting on patients and staff, the one positive has been the ability to rely on detailed statistical analysis, which was perceived to be accurate. The fear will now be that this is not an isolated case but a deliberate attempt to game the statistics, meaning even poorer performance than was previously feared.

Given the situation, will the cabinet secretary give an undertaking that she will instigate an urgent, nationwide independent review of reporting procedures, come back to Parliament with the outcomes of the review and outline what additional resources will be provided so that we meet the expected patient treatment standards? Our overworked, undervalued and underresourced NHS staff and Scotland’s patients deserve nothing less.

Shona Robison: I think that what our staff and patients deserve is due recognition of the huge efforts that our A and E departments have put in over the weeks, months and years to dramatically improve the performance within those departments in Scotland. It would be quite wrong to assert that what has happened in NHS Lothian is an issue anywhere else in Scotland. There is no evidence that any other A and E department is not following the national guidance; chief executives have been clear about that and have been clear with us.

The interests of patients are of course at the heart of this and the external review, which is being led by Professor Derek Bell, will look at whether any patients have been impacted by the issues that have been brought to light within NHS Lothian. That will be part of the work of Derek Bell and his team.

We have made Audit Scotland aware of the issue and will now discuss with it the findings of the full internal report in the light of the external review by the academy. Derek Bell has also been very involved in the work of the unscheduled care team in making improvements across our A and E departments in Scotland.

At this time more than any other, as we approach winter, I hope that members will get behind our A and E departments, because they are facing winter pressures—as A and E departments will face such pressures across the whole of these islands. I put on record my thanks for the hard work and effort that each and every one of them puts in to keep us safe during winter.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): I welcome the fact that Professor Derek Bell, whom I note is also president of the Royal College of Physicians of Edinburgh, will carry out the review of the allegations. Will the cabinet secretary outline the remit of the review and can she confirm that it will report as quickly as possible? [*Interruption*.]

The Deputy Presiding Officer (Linda Fabiani): I ask members to be aware that we are still in session and to keep their conversations down.

Shona Robison: The external team’s remit is to leave no stone unturned in looking into what happened in NHS Lothian. Importantly, the team will look into the governance on the issue and at whether there was any impact on patients. We have, of course, made sure that all of NHS Lothian’s acute sites are now adhering to the national guidance.

As I said, I expect the independent review to report early in the new year, and the findings will be published in due course thereafter. If there are any wider lessons to be learned from the report for the rest of the system, those will of course be applied.

Alex Cole-Hamilton (Edinburgh Western) (LD): Reports in the press suggest that revelations about NHS Lothian and its reporting of A and E waiting times came from a whistleblower. Given that confidence in the mechanisms around whistleblowing in the NHS is not high, will the cabinet secretary instruct the independent review to expand its focus to other health boards and perhaps to issue a confidential staff survey to other A and E departments so that we can ascertain whether the problem is more widespread?

Shona Robison: I can confirm that the whistleblower contacted me directly as well as the chief executive. The whistleblower has been kept informed of the process as it has gone forward. The issue shows that, when people raise concerns, they are listened to and, importantly, acted on. That sends out an important message to staff in the NHS that, should they raise concerns, whether that is through the whistleblowing helpline or directly with me as the cabinet secretary, those issues and concerns are acted on promptly and swiftly and with determination to get to the bottom of what has gone on.

It should be noted that we are strengthening the whistleblowing processes. Just this week, we announced the creation of the role of independent national whistleblowing officer, with whom concerns can be raised. We must ensure that the message goes out to staff that, if they have any concerns in whatever setting in our health service, they should report those and that, importantly, they will be acted on.

The Deputy Presiding Officer: If we speed up a wee bit, I will get the last three questions in.

Colin Smyth (South Scotland) (Lab): Would the underreporting of accident and emergency waiting times by NHS Lothian have been picked up by the Scottish Government had it not been for a whistleblower? If not, will the Scottish Government review its procedures for gathering, monitoring and scrutinising waiting time data to ensure that the Government does not have to rely on a whistleblower to make sure that its own figures are correct?

Shona Robison: As I said in my earlier answer, if there are any lessons to be learned about how we monitor any changes and fluctuations that need further investigation, those will be picked up by Derek Bell and the external review. Colin Smyth makes an important point. We have to wait for the external review to give us an indication of what the impact has been on NHS Lothian's reporting figures so that we can see the scale of that.

I want to give further reassurance that the issue will not have had a huge impact on the overall national performance of our A and E departments, which continue to perform very well. As we go into winter, it is important that we support our A and E staff and understand the pressures that they will be under over the next few weeks.

The Deputy Presiding Officer: This will have to be the final question, I am afraid.

Alison Johnstone (Lothian) (Green): Will the cabinet secretary provide assurance that the review will investigate any suggestion of bullying and harassment, and that staff have adequate time for continuing professional development to ensure that they are familiar with best practice? While we await the arrival of the national whistleblowing officer, what additional support will be put in place for whistleblowers?

Shona Robison: As part of the internal and external review, it is important that staff are interviewed in such a way that they feel confident to raise issues. There is an on-going process to make sure that staff have the opportunity to raise any issues or concerns in a confidential environment. My officials are fully supporting the process to make sure that the work that Derek Bell and his team are getting on with is taken forward as quickly as possible. I reassure Alison Johnstone that, as I have said to other members, any recommendations that emerge from the external report will be implemented not just in NHS Lothian but, where appropriate, elsewhere.

Decision Time

17:30

The Deputy Presiding Officer (Linda Fabiani): There is one question to be put as a result of today's business. The question is, that motion S5M-09241, in the name of Johann Lamont, on petition PE1517, on polypropylene mesh medical devices, be agreed to.

Motion agreed to,

That the Parliament notes public petition PE1517 on polypropylene mesh medical devices.

Neurological Conditions (Sue Ryder Report)

The Deputy Presiding Officer (Linda Fabiani): The final item of business is a members' business debate on motion S5M-07698, in the name of Bruce Crawford, on a Sue Ryder report. The debate will be concluded without any question being put.

Motion debated,

That the Parliament recognises the devastating impact that neurological conditions can have on the lives of many people affected by these and their families; considers that specialist care and support for people in the Mid Scotland and Fife parliamentary region, and across the country, with a neurological condition can help them to live as independently as possible, minimising the impact of the condition on their day-to-day living and provide quality of life; recognises the Sue Ryder report, *Rewrite the Future*, on the benefits of consistent specialist care and support; welcomes the current review of clinical standards for neurological health services which, if rigorously monitored and measured, should, it considers, lead to better care and support, and notes the call for work to be undertaken between people with neurological conditions, the third sector and public bodies to develop a neurological health and social care strategy to ensure that people with such conditions are supported to live their lives as fully as possible.

17:32

Bruce Crawford (Stirling) (SNP): I thank those who signed the motion and, in particular, those who have stayed behind for the debate. I thank Sue Ryder for its support in the lead-up to the debate and, in particular, Elinor Jayne.

Over recent years, I have learned a great deal about the fantastic work that the Sue Ryder charity does, and I have a huge admiration for that work. Sue Ryder delivers high-quality, much-needed home care in my constituency of Stirling and around the country, and it also has a passion for improving care for people with neurological conditions in Scotland.

As we know, neurological conditions can affect anyone at any age and can turn people's lives upside down by affecting their ability to move, to live the lives that they used to live, to look after themselves and their families, to work or to leave the house, or they can affect their mental health. The list of effects can go on and on. Such conditions include progressive conditions such as multiple sclerosis, motor neurone disease, Huntington's disease and Parkinson's disease, and sudden ailments such as head injuries and stroke. All those conditions can have a devastating impact on the individual and their family, so I am delighted to support Sue Ryder in its campaign for better neurological care.

Indeed, that is incredibly important, as we are talking about a group of people who have a devastating condition that can affect every aspect of their lives. As if that was not enough, their condition can be coupled with care that may not always meet their individual requirements. Let us be clear that there is no question but that if you have a neurological condition, you should receive good quality, specialist care to try to manage what can be a complex condition.

One surprise for me in Sue Ryder's research is that it revealed that we do not even know how many people in Scotland have a neurological condition, or where they live, which raises the question of how health boards and integration authorities can plan to provide services that meet those people's needs. Sue Ryder's first report revealed that health boards and local authorities did not know what neurological services they or their counterparts provided in many cases. Gathering such information means that people with neurological conditions and their families can be better advised on where to turn, for instance, for respite care or specialist speech and language therapy. In addition, people of all ages with neurological conditions have been placed in older people's care homes when those are not the appropriate settings for them. That is simply not a sustainable solution, nor one that can adequately meet the needs of those who require specialist care.

The report also showed that the national clinical standards for neurological health services were not being met in a number of cases. I am delighted, therefore, that since Sue Ryder shone a light on where neurological care in Scotland can be greatly improved, the Scottish Government has listened and is acting. It is vital that everyone works together to design services that meet the needs of people with these complex, life-changing conditions. Coupled with the work that the Government's national advisory committee for neurological conditions is doing to map neurological services in Scotland, there is now an opportunity to make a real difference. The recent welcome Government announcement, following dedicated and informed campaigning by Sue Ryder and others, that it will produce Scotland's first ever action plan on neurological conditions, is a huge step forward. Not only that, having carried out a review of the existing neurological standards, Healthcare Improvement Scotland is rewriting them to encompass all health and care services for people with neurological conditions. All that is being done with a view to making those standards as person-centred as possible. That is good work and the agency should be applauded for it.

As the motion notes, it is important that the Scottish Government works with people with neurological conditions, the third sector and our health and care services to ensure that the new action plan and all the other work is a success. I know that that is the Government's intention, so what now? It is important that all the Government's goodwill is capitalised on. I would like a commitment that, once the action plan is published, it will be followed through to ensure that the new standards for neurological care are acted on and measured in a meaningful way. To help achieve that, I ask the Government to look at whether the necessary funding is available for appropriate organisations to enable successful delivery.

Integration authorities also need to be given support to provide care for this group of people, so I would like the Government to give consideration to another of the Sue Ryder recommendations, which is to provide commissioning guidance for neurological services. The process of reforming neurological care in Scotland will require dedication to, and support of, our integrated local health and social care services. I am confident that we can build a system of care that is fit for the future. Indeed, to its credit, the Scottish Government is trying hard to do that. All that we need to see now is action on the ground.

There is really only one way to ensure that some people with neurological conditions in Scotland no longer feel written off and are supported to live their lives as fully as possible.

In conclusion, I am determined that this is one area of care that should not be used as a political football for cheap political point scoring. It will take all of us working together, while recognising the very real challenges that exist, to achieve solutions. Let us just do that.

17:40

Jeremy Balfour (Lothian) (Con): I thank Bruce Crawford for securing the debate.

I suspect that being informed that you have been diagnosed with a neurological condition is shocking. You must feel that you will never be able to cope with what life has dealt you. Overwhelming feelings of sorrow, anger and unfairness would suddenly appear.

Eventually most people adjust to their new lives, but often only with the support of organisations such as Sue Ryder, which provides hospice and care at home for people who are facing a life-changing diagnosis. As well as providing expert medical care, Sue Ryder also provides emotional and practical support, from personalised care through to advice, education and support services, to help improve the lives of individuals, including carers and their families. Its knowledge and insight is vital if we are to improve services for people with neurological diseases, and I welcome the findings of its report.

The first report published by Sue Ryder, in 2016, identified a lack of consistent data on the number of people with neurological conditions. Clinical standards for neurological services were not being followed, and the vast majority of health boards did not have a service delivery plan despite that being required by clinical standards.

If we fast-forward to 2017, its report published in September aimed to establish how much progress has been made and what difference the integration of health and social care was making to the lives of people with neurological conditions.

Disappointingly, it found that health boards still do not have a neurological service plan in line with national clinical standards. Six health boards stated that they had no plans to develop joint plans with local authorities, despite the national and local policy direction to integrate health and social care services.

When I was elected last year to the Scottish Parliament, I was made aware of NHS Lothian's Lanfine service by a constituent with multiple sclerosis who had used the service. He lived on his own and appreciated the respite care that was provided by the Lanfine service. He particularly enjoyed the environment where he could talk with people and discuss their condition. However, in 2010, NHS Lothian commenced the process of redesigning the service. Key elements of the redesign included a reduction in bed numbers from 33 to 10; an outreach team that, when fully established, would have more than seven staff; a new carer support officer; and a fund to support carers with breaks from caring.

NHS Lothian has assured me that cost has not been the driver during the redesign; instead it wanted a service that was fit for the 21st century. That is all well and good, but I discovered that six years on from the start of the redesign, there are still outstanding vacancies in the outreach element and on-going discussions about the remaining posts.

I accept that many people want to be treated in their homes and I welcome care in the community, but in my view the redesign has not ensured better local health care and faster access to it, but has made a vulnerable group even more vulnerable, and we simply have not learned the lessons.

I welcome the minister's intent to produce an action plan, and I am pleased that acknowledgment is being given to the need to improve services for people living with neurological conditions. However, when I read the Sue Ryder report, I was struck by the lack of data on people with neurological conditions and their use of health and care services. Bruce Crawford picked up on that. Therefore, I ask the minister to ensure that any changes that are recommended in an action plan are evidence based and effective. There is no point in producing an action plan before we have a good, clear view of the services that we have at the moment and what is and is not working. We need to look at what local authorities are doing and ensure that everyone in Scotland gets the service that they require.

17:45

Lewis Macdonald (North East Scotland) (Lab): I congratulate Bruce Crawford on securing today's debate.

Like other members, I have seen Sue Ryder's work at first hand—in my case, because of its excellent work at Dee View Court, in Aberdeen, which is in the minister's constituency. It has been inspiring to see the facility develop over the years and to hear from its users and their families about the quality of their experiences there—I am sure that Maureen Watt will vouch for that.

Sue Ryder's "Rewrite the Future" reports on the state of neurological care in Scotland have made an important contribution, identifying gaps in the provision of care and what must to be done to fill them.

For 13 years, Dee View Court has provided care for people with multiple sclerosis, motor neurone disease, cerebral palsy and acquired brain injury, enabling residents to live as independently as possible in shared houses and to feel that they are still part of the local community. There are spaces for only 24 residents, which means that many people in the north-east who need expert care and supported living are not able to take advantage of Dee View Court's excellent facilities. In that context, a waiting list is partly a problem of success; nonetheless, it is a problem for those concerned. Too many people under 65 are in older people's care homes in Aberdeen, as is the case elsewhere.

That is why, earlier this year, Sue Ryder launched a campaign to raise £3.9 million to build a new wing at Dee View Court, to accommodate an additional 20 residents. I am pleased that, last week, Sue Ryder was able to announce that the campaign had raised its first £1 million, just five months after being launched. That is a great achievement by Sue Ryder and good news for people in the north-east who are affected by neurological conditions.

The support that is provided at specialist facilities such as Dee View Court is important to residents and their families. Our wider health and social services must also be equipped to provide the care that people need if they are to treat or manage their symptoms and live independently in their own homes. Sue Ryder's first "Rewrite the Future" report, which was published last year, found that six of Scotland's 14 regional health boards either had no current plan for providing neurological health services to their population or were unable to say whether such a plan was in place. It is worrying that when Sue Ryder updated its report this year, the number of boards that were unable to report positively had increased from six to nine.

The Scottish Government's commitment to developing a national action plan on neurological conditions is welcome, but, as with all such plans and strategies, actions matter more than words. As Alan Milburn said in another context at the weekend, ultimately what counts is not what the Government says but what it does. The Scottish Government has promised that the first national action plan on neurological conditions will be published in summer. I hope that the minister can confirm that today.

I also hope that the minister will confirm that additional resources will be provided to health boards to allow them to take the actions that are required under the action plan, and that resources will be related to levels of need. The incidence of multiple sclerosis in the Aberdeen area is one of the highest in the world, and general year-on-year funding of NHS Grampian is lower than it should be under the NHS Scotland resource allocation committee formula. It would do no favours to anyone in the north-east to impose additional spending requirements on NHS Grampian without also increasing the resources available to meet those needs.

Sue Ryder will continue to campaign for improved care for people with neurological conditions. It will have the support of members of this Parliament in doing so, and I am confident that we will soon be congratulating the charity on reaching its next million-pound milestone as it raises funds for the very welcome expansion of Dee View Court.

I look forward to continued co-operation between all parties in the Parliament, the Government and Sue Ryder itself in delivering the quality of care that people with neurological conditions require.

17:49

Graeme Dey (Angus South) (SNP): I begin, as is customary, by congratulating my friend Bruce Crawford on securing the debate, which allows members to highlight the report and the work of Sue Ryder home care staff across Scotland.

In my constituency of Angus South, we are lucky to have a Sue Ryder team that offers expert care for people living with neurological conditions.

Most areas in Scotland do not yet have access to such a specialist service. I want to highlight the tailored care that Sue Ryder offers service users in Angus, not simply to blow the trumpet of my constituency but in the hope that that care points the way for the wider care provider community in supporting people with neurological conditions and allowing them to live as independently as possible.

Since the provision of home care started its move from Angus Council to external organisations, Sue Ryder has become one of the largest home care providers in the area. The team, which is based in Arbroath, currently operates with a staff of 47, who deliver 1,300 hours of care a week for more than 200 service users. As well as providing day-to-day home care, Sue Ryder staff in Angus offer help with end-of-life care, provide respite to carers and offer short-term rehabilitation programmes so that people can leave hospital sooner and continue their recovery at home.

To be honest, I usually cringe when I hear the phrase “person centred”. First, it represents the jargon that pervades the service element of the public sector. Secondly, on the ground, it is all too often deployed simply to mask the delivery to individuals of the care that they can be given rather than the care that their circumstances require or that they want. However, it seems to me that the Angus Sue Ryder team reaches beyond the standard care process and provides users with a tailored service that truly focuses on their overall quality of life.

The report urges healthcare professionals to focus on the experience of living with a condition and how that informs the person’s whole life, rather than on the neurological disease. That means listening to them and considering them as a person rather than simply treating them as a patient with a condition. The Angus team’s desire to put that approach into practice is demonstrated by how it has organised its Christmas party this Thursday. As we are all aware, life with a debilitating neurological condition can be lonely and isolating, especially at this time of year. The party—in which local school kids take part—is an opportunity to bring service users together in a social setting, in the company of the familiar faces of the Sue Ryder home care team.

That approach to building relationships outside working hours is not confined to annual gatherings. For example, the Angus team recently took an elderly service user out of her home to see the town’s Christmas lights, and on another occasion a member of staff accompanied a lady to a family member’s wedding, thereby allowing her to take part in that special day with the support of a specialist carer by her side. To me, that sounds like care that is genuinely “person centred”—in other words, care that is tailored to the needs and wishes of the individual.

The care that is provided by the Sue Ryder team in Angus is greatly valued by those who receive it, and it is frequently rated by the Care Inspectorate as “excellent”. In the inspectorate’s most report on the team, one service user described the staff as “superb” and acknowledged that some staff “go above and beyond”.

Only last year, alongside Sue Ryder colleagues in Stirling, with whom they made up the Scottish home care team, representatives from Angus scooped the accolades of team of the year and overall winner at the Sue Ryder UK awards, in recognition of the Scottish team’s commitment, resilience and excellent care.

Those of my constituents who live with a neurological condition have access to top-class personal home care from the Sue Ryder team. As we seek to make the Scottish Government’s healthcare quality strategy a reality by 2020, I hope that it is seen as a role model for services elsewhere in Scotland.

17:53

Alexander Stewart (Mid Scotland and Fife) (Con): I am very grateful for the opportunity to participate in the debate. I pay tribute to Bruce Crawford and congratulate him on securing it.

Mr Crawford’s motion asks that the Parliament

> “recognises the devastating impact that neurological conditions can have on the lives of many people affected by these and their families”.

It must be very harrowing for people to find themselves in that position, supported by their family. That statement in the motion is extremely poignant, and a huge push for recognition is needed. I have been looking at diseases of a similar nature, and I look forward to putting forward my report on and proposal for a member’s bill on brain tumour and the disability that that can cause people to suffer.

During my research into neurological care, it has become clear that Sue Ryder is unquestionably a beacon and a force to be reckoned with. I had great pleasure in attending a recent parliamentary event that gave us the opportunity to find out more about what is taking place.

However, I have been disappointed at health boards’ continually slow reactions to individuals who have neurological conditions. The situation is quite tragic, and the plans that are put in place are vital. We have already heard in the debate that health and social care integration is still causing some concerns.

Sue Ryder wants everyone with a neurological condition in Scotland to receive incredible care—we would all want to see that happen. Yet, in reality, we have found that the care provided across Scotland can be patchy—it can be poor or not well co-ordinated, which the individuals affected and their families find difficult to understand. Patients feel as though they are stuck in yet another postcode lottery. It really is a scandal that nine of our 14 health boards have no neurological services plan and that six of them do not intend to introduce such a plan.

I know that the Government is looking at and addressing such issues. However, it is vital that we look forward to what can be achieved—actions are required, not words or documents. Sue Ryder's new "Rewrite the Future" report for 2017 shows that there is still a lot of work to be done on the ground to improve care for people with neurological conditions.

We talk about councils having a role to play and about how they need to do much more if they are to be effective in supporting people who have neurological conditions. Mr Crawford's motion makes it clear that third sector and public bodies want to do all that they can and that they want to co-operate with people who have such a condition. They have a part to play in ensuring that everything comes together, which must happen if we are to ensure that people can go forward with confidence.

However, I would go further. The Scottish Government has had 10 years in which to gather momentum on the issue. Vital work urgently needs to be commenced on overhauling health boards' plans in order to ensure that the quality of care for those who live with neurological conditions is at the forefront. Ultimately, that is what we are trying to achieve. Individuals and families are suffering every day. They must be able to have confidence in the health service and in the services that look after them. They should not have to rely on charitable organisations to provide them with support and care.

17:57

Gillian Martin (Aberdeenshire East) (SNP): I thank Bruce Crawford for securing the debate and for hosting Sue Ryder in Parliament a few weeks ago, when I was able to learn more about the work that it does across the country. That gave me the opportunity to talk to Valerie Maxwell, who is centre director of Dee View Court in Aberdeen.

For more than 13 years, Dee View Court has played a key role in the delivery of expert and compassionate long-term care for people with neurological conditions who live with complex care and support needs. It is Scotland's only purpose-built specialist residential facility for people who live with such conditions. Although Dee View Court is not in my constituency, it is very near to it, being in Kincorth, in Aberdeen city, in the Aberdeen South and North Kincardine constituency of my friend and colleague Maureen Watt, and some of its residents are from my constituency of Aberdeenshire East. We are tremendously fortunate to have a facility such as Dee View Court in our area, but I am conscious that most of Scotland does not have access to such specialist residential care.

The staff at Dee View Court work closely with a range of health and social care professionals to deliver incredible 24-hour care and support to people who live with very complex needs and neurological conditions. They provide a safe environment in which people can live as full a life as possible, and where staff provide quality care and support. As Lewis Macdonald has mentioned, they are very much integrated in the local community and live a full life there. Each resident has their own specially adapted room, is free to participate in recreational activities and is able to get a good deal of independence back in their own space, whereas many had previously been reliant on family members for their care.

Sue Ryder's "Rewrite the Future" report highlights that many people without access to a specialist resource such as Dee View Court suffer needlessly and are unable to live their lives as fully as possible. Many neurological conditions are no respecters of age, so the fact is that, without specialist facilities, hundreds of people end up in old people's homes because they have nowhere else to go for their care, as Bruce Crawford mentioned in his compelling opening speech.

A place like Dee View Court could have made a tremendous difference to the life of my brother-in-law Keith and his mother Audrey when his dad, Eric Allardyce, lost a great deal of his mobility due to the multiple sclerosis that developed in his late 20s and eventually took his life when he was in his mid-30s. Eric was cared for at home until his death by Audrey, who only just managed to raise Keith and arrange part-time work around Eric's care.

Dee View Court's very existence depends on fundraising by Sue Ryder. We need more facilities like Dee View Court, which has a waiting list and wants to expand to offer its expert care to more residents. A couple of months ago, Sue Ryder launched a campaign to raise £3.9 million to build a much-needed new wing and cater for an additional 20 residents. The planned extension will consist of 14 new en suite bedrooms and six supported-living apartments.

I end with good news. Just this week, Dee View Court announced that the generous and public-spirited people of the north-east have helped the appeal to reach the £1 million mark. I close by letting everyone know how they can help Dee View Court to reach its target. Simply go to www.sueryder.org/care-centres/neurological-centres and find Dee View Court to donate there. We can provide specialist care for more than 20 more people in the north-east, but we need commitment from every health board to make services available that are appropriate for those with neurological conditions, whatever their age.

18:01

Anas Sarwar (Glasgow) (Lab): I join others in congratulating Bruce Crawford on bringing forward the debate and for his important work with Sue Ryder.

The good work of Sue Ryder is widely recognised by parliamentarians across the chamber. It has almost 70 years' experience in the field of neurological care; when Sue Ryder speaks, it speaks with authority. I welcome its significant contribution to the care and improvement of the lives of people in Scotland with a neurological condition. Part of that contribution has been in the form of various reports that Sue Ryder has published on the standard of neurological care in Scotland. Those reports highlight the many benefits of consistent care and support. Sue Ryder is clear that a properly delivered health and social care strategy can help people with neurological conditions to live life as fully as possible.

However, in its 2016 report, Sue Ryder highlighted a number of areas of concern. It said that there was a lack of consistent data, that national clinical standards were not being followed, that there was patchy provision of services, that long-term service delivery plans were not in place and that some people with neurological conditions were being treated in non-specialist locations. It was a poor report card on neurological care in Scotland, which led to the Scottish Government rightly initiating a review of clinical standards and making a commitment to gather better data.

Although there is some progress at a national level on data collection, with the first set of data due to be published next spring, sadly not much appears to be changing for people on the ground. Of particular concern is the fact that, for many, the situation appears to be getting worse. Nine of Scotland's health boards had no neurological services plan, despite that being a requirement of national clinical standards. One said that it had a draft plan, whereas four had plans that were due to expire. It gets worse. Despite there being, rightly, a national policy direction for the development of joint neurological care plans by health boards and local authorities or integration boards, only one had started to do that. Frankly, that is not good enough.

The evidence is clear that, so far, the integration of health and social care has done little to improve services on the ground. I am sure that that is something that everyone across this chamber, regardless of political party, will want to see made right. There is a real risk of people being left behind as the reforms continue. That is why I ask the Scottish Government to do more than produce a national action plan—although that is important—and simply hand it over to integration joint boards and hope for the best. The Scottish Government has to show real and on-going leadership on this issue to make sure that we see genuine improvement in all health boards across the country.

In particular, if the national action plan identifies the need for new resources, I hope, like Bruce Crawford, that the Scottish Government will commit to those new resources. Will Healthcare Improvement Scotland be given the resources to monitor the new standards and drive forward improvements to make sure that we have a consistent approach across the country? That is crucial, because the last set of clinical standards was not being delivered. It was hard to deliver those standards across the country, because nobody was monitoring their implementation.

The Scottish Government has rightly led people to expect that services will continue, and it has worked to deliver an action plan. I hope that we can all get behind that and see those improvements in resources across the country, and see HIS actually monitoring progress and making sure that we have deliverable and delivered clinical standards. I hope that the minister will address that in her closing comments.

18:05

The Minister for Mental Health (Maureen Watt): I am pleased to respond on behalf of the Government. I commend Bruce Crawford for bringing the debate to the chamber. I am encouraged by the commitment across the Parliament to improving the quality of life of people who are affected by neurological conditions, which have a profound effect not only on the individuals but on their families and carers, as Bruce Crawford said.

I assure members that the Government is fully committed to improving the lives of people who live with neurological conditions, and welcomes the Sue Ryder report, which is a valuable contribution to the debate on how we can make things better for people with neurological conditions. As a Government, we have an excellent relationship with Sue Ryder, and we have been working closely with the organisation over the past few years. The Cabinet Secretary for Health and Sport will visit the Sue Ryder centre in Aberdeen in January to continue discussions on our shared goals. Perhaps Bruce Crawford can go at the same time.

As Lewis Macdonald said, I am also familiar with the excellent care that Sue Ryder provides at Dee View Court. I am a frequent visitor there and have held constituency surgeries in the premises. I was very pleased to note that the fundraising campaign to expand the centre's facilities recently reached the £1 million mark. That is testament to the high quality life-changing care that Sue Ryder workers provide. In the interests of transparency, I declare an interest, in that I provided a supporting statement for its bid to the Wolfson Foundation for funding for the extension. I am not sure whether that has been revealed yet.

I am pleased to say that the Government is making good progress on a number of the fronts that Sue Ryder highlights in its report. We listened to Sue Ryder and others who called for changes to charges for personal care, and we announced in the programme for government that we will take steps to extend free personal care to all those under the age of 65, thereby fully delivering on the commitment to introduce Frank's law. That means that up to 9,000 people who are currently in receipt of personal care will no longer be liable to pay charges for the care that they need. That will assist many people with neurological conditions including motor neurone disease, multiple sclerosis and Parkinson's disease.

We are also making good progress on improving the data that is collected on neurological conditions. The data will assist NHS boards and integration authorities, thereby informing better service planning that supports people who are living with neurological conditions. Our aim is to have that data set in place by spring 2018.

We are also committed to reviewing the neurological standards: Healthcare Improvement Scotland is in the process of developing new standards of care.

We know from statistics that people who are living with neurological conditions mainly access primary and community care services. We therefore expect the new standards to apply in a range of care settings across health and social care. Graeme Dey admirably described the excellent level of care that Sue Ryder provides in Angus. I hope that those high standards of care will be replicated elsewhere because, as Jeremy Balfour said, most people really want to live at home or in a homely setting.

The standards will be developed by a project group that will—crucially—include people who live with neurological conditions. It is vital that policy makers and healthcare professionals consult and listen to the people who have lived experience, because they are the experts.

We also note Sue Ryder's call for the new standards to be accompanied by a programme of measurement and improvement. I assure members that the Government is considering that call closely, and we will be working with partners over the next year to explore what such a programme would look like and how it could be delivered.

Sue Ryder has also been calling on the Government to develop a national approach to neurological conditions. Again, we have listened to that call. The Minister for Public Health and Sport recently announced that work has started on Scotland's first national action plan on neurological conditions. The new plan will support the development of integrated, expert neurological and rehabilitation services, and will focus on the needs of individuals living with neurological conditions, across health and community services. Gillian Martin mentioned the work of Dee View Court. In addition to providing in-patient services, it provides excellent outreach services. It has recently introduced outreach services for people living with MS, which has had a fantastic and positive effect on those who have taken part.

As part of our work, we will undertake a programme of engagement with health and social care partnerships to ensure that they are sufficiently sighted of and supported on the aims of our national action plan. The plan will incorporate the new national neurological standards that are being developed by Healthcare Improvement Scotland, and will be designed to drive improvements for people in a range of healthcare settings.

To ensure that our approach to the new plan is as open and collaborative as possible, we are seeking to co-produce it with clinicians, the third sector and people who live with neurological conditions. We have also commissioned the Health and Social Care Alliance and the Neurological Alliance. They will, working in partnership, engage with people living with neurological conditions so that we learn and understand their experiences of accessing services, as well as their priorities for the future. I know that Sue Ryder and other third sector bodies will continue to feed into that important work. The draft plan will be produced by next summer and consulted on before being published later next year.

The perspective of lived experience is central to any work that we take forward in this area. I hope that we will be able, as the work progresses over the next year, to rely on support from across the chamber, and that all members get involved and promote their ideas.

I offer my continued support for the work that Sue Ryder does to represent and to support people with neurological conditions. I again confirm that the Government is fully committed to improving the lives of such people throughout the country.

Meeting closed at 18:14.

This is the final edition of the *Official Report* for this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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