OFFICIAL REPORT
AITHISG OIFIGEIL

Meeting of the Parliament (Hybrid)

Tuesday 8 September 2020

The Scottish Parliament
Pàrlamaid na h-Alba

Session 5

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Scottish Parliament

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

Time for Reflection

The Presiding Officer (Ken Macintosh): Good afternoon, colleagues, and welcome. Before we begin, I remind members that social distancing measures are in place throughout the campus, and I remind you to observe those measures when you enter and leave the chamber.

Our first item of business today is time for reflection. Our time for reflection leader is the Very Reverend Dr Isaac Poobalan, provost of St Andrew's cathedral and chaplain at Robert Gordon University, Aberdeen.

The Very Rev Dr Isaac Poobalan (Provost, St Andrew's Cathedral, Aberdeen): Today, we celebrate the birth of Mary, the mother of Jesus. Mary said yes to life when life was full of uncertainty and the fear of the unknown. Mary's audacity for life made Luke, the physician and historian, record her vision for her times and her people, which I believe is apt for us now.

The manifesto of Mary, known as the Magnificat, inspired generations of composers and artists. Her voice of defiance against the dehumanising powers of her time can be heard echoing down the centuries. A version of that song was recorded specifically for the pleasure of this chamber, at the cathedral church of St Andrew in Aberdeen. It is available on the church's website for you to hear at your leisure. Hear now a paraphrased version.

My soul proclaims the greatness of life
My spirit rejoices in the power of saying yes to that life.
In the face of disease and death, life bursts out with beauty and splendour.
It brings new life in pandemic and lockdown.
This life is the light of humanity.
It shines in the darkness and the darkness of death cannot overcome it.
For saying yes to life, generations to come will call us "The blessed".
The life that we now live will do great things for us.
Our audacity for life is most gracious and most merciful.
This our choice for life humbles the conceited proud.
It casts down the mighty from their thrones and lifts up the humble.
Our "yes to life" will feed the hungry and send the rich away empty.
The promise of life is for all life.

We say yes to life as we emerge from a season of uncertainty and the unknown. We see signs of new life and new opportunities, and we have learned how precious life is and that all life matters.

When Aberdeen entered a period of local lockdown, I received nothing but words of solidarity and compassion from friends of Aberdeen and the cathedral church of St Andrew from around the world. St Andrew's cathedral in Aberdeen, the birthplace of the worldwide Anglican communion and the Episcopal Church USA, had the audacity to say yes to life when life seemed impossible, more than three centuries ago.

In solidarity with Mary, we say yes to life today. May God bless you in this chamber as you say yes to life in Scotland. [*Applause*.]

The Presiding Officer: Thank you very much.

Topical Question Time

14:04

Covid-19 (Increase in Cases)

1. **Alison Johnstone (Lothian) (Green):** To ask the Scottish Government what its response is to the recent rise in Covid-19 cases to a level not seen since May 2020. (S5T-02368)

The Deputy First Minister and Cabinet Secretary for Education and Skills (John Swinney): The recent rise in Covid cases, although not unexpected as lockdown restrictions ease, is still unwelcome. This is the experience of most countries that are impacted by Covid-19. The Scottish Government has had to take action, in consultation with some local authorities, to address that increase, and further measures may require to be taken.

Test and protect is working well and doing exactly what we need it to do, which is to identify positive cases early and trace contacts so that they can get appropriate public health advice. Fluctuations in demand have been anticipated, and we have acted immediately to bring additional testing capacity online to manage the recent surge in demand across the country. That has included deploying three mobile testing units, improving the accessibility of testing and further work to increase laboratory capacity in Scotland. Later this month, we will launch the protect Scotland proximity tracing app to complement the proven person-to-person approach of test and protect.

Alison Johnstone: The Scottish Greens have strongly supported a precautionary approach to managing the Covid-19 outbreak, and so, like many, we are increasingly concerned about the public health implications of the end of the furlough scheme. Can the cabinet secretary say to what extent the end of furlough is removing the option of local restrictions to deal with outbreaks?

John Swinney: The Scottish Government is arguing for a continuation of the furlough scheme for a longer period. The experience in Scotland is not dissimilar to that of other countries where local lockdowns or restrictions are having to be applied that raise issues of financial sustainability for the individuals for whom furlough arrangements are relevant.

We would always take the approach that we must base decisions on the public health interest. We will continue to argue for financial support to be in place for individuals who are affected by any form of restriction that is driven by the public health advice, but I reassure Alison Johnstone and Parliament that public health considerations are uppermost in the decision making of the Scottish ministers.

Alison Johnstone: There have now been a number of incidents of transmission in schools. A recent Educational Institute of Scotland survey shows that social distancing is often absent in high schools. Is the cabinet secretary concerned about the contribution that that could be making to the resurgence of Covid across Scotland? What measures are being taken to ensure that we are doing absolutely all that we can to better protect pupils and teachers?

John Swinney: I would challenge the premise of the question, to an extent. Although cases have emerged among the school-age population and the teaching population, there is very little evidence that those cases have arisen because of in-school transmission of the virus; they are much more to do with transmission within the community. Nonetheless, I accept that there are certain circumstances in which in-school transmission has happened to a limited extent.

Through the education recovery group, we have put out clear guidance to schools on the mitigation measures that must be in place. Alison Johnstone will be familiar with the fact that the Government strengthened those mitigations by applying the requirement that face coverings should be worn in communal areas and corridors in secondary schools and when movement is being undertaken, to minimise the risk of transmission.

I would encourage all interested parties to follow the guidance, which requires there to be physical distancing in schools among adults and between adults and young people. I hope that the measures are followed in all circumstances. I think that there has been extensive compliance on the wearing of face coverings in schools.

David Torrance (Kirkcaldy) (SNP): How is the Scottish Government expanding testing capacity, particularly as we approach the winter months, when we know that there is likely to be an increased demand due to the prevalence of symptoms of common colds and flu?

John Swinney: As I indicated in my original answer, we are taking various steps to expand the testing capacity around the country and to ensure that Scotland is prepared for anticipated winter pressures. Our planned maximum sampling capacity will be around 41,000 tests per day by the end of October. That will consist of mobile testing units, regional testing centres, the social care portal, home test kits, community testing and national health service testing. We also intend to have 11 walk-through centres—one of which, at St Andrews, is already operational—which will increase sampling capacity by a further 3,300 tests per day.

Mike Rumbles (North East Scotland) (LD): Can the Deputy First Minister confirm that the restrictions on liberty imposed by the First Minister in greater Glasgow are lawful?

John Swinney: Yes.

School Leaders (Workloads)

2. **Iain Gray (East Lothian) (Lab):** To ask the Scottish Government how it will respond to reports from school leaders that they are facing “excessive” and “unsustainable” workloads. (S5T-02364)

The Deputy First Minister and Cabinet Secretary for Education and Skills (John Swinney): I do not underestimate the extraordinary efforts that are being made by all school staff. Their work to welcome our children and young people back into schools in challenging circumstances is vital. Our guidance on school reopening, which has been developed in partnership with the Covid-19 education recovery group, makes it clear that the health and wellbeing of staff is a key principle of education recovery. Education Scotland, the General Teaching Council of Scotland and other national organisations, along with local authorities, currently provide a range of support to the workforce, including employee assistance programmes and online professional learning. We will also shortly launch a new and focused package of support for school staff that has been developed with the education recovery group. Furthermore, we have provided £80 million to local authorities, which is enough to recruit around 1,400 additional teachers and 200 support staff to bring much-needed resilience to the education system.

Iain Gray: Does the Deputy First Minister understand the pressure that was put on heads and deputy headteachers by the sudden shift from preparation for blended learning to preparation for a full-time return? That pressure has continued as they now try to keep pupils and staff safe, keep parents informed, ensure that health measures are complied with and deal with staff who are ill or self-isolating. Does he accept that headteachers cannot do all that and lead learning in their schools as they would wish to? What real practical help can he offer them?

John Swinney: I accept in all circumstances the demands that are placed on school leaders as they navigate their way through the extraordinary circumstances that we have to deal with in the current context. I am confident, from my dialogue with senior education leaders and individual schools, that although the demands are significant, school leaders are committed to ensuring that schools are safe and strong places of learning and teaching. As I indicated in my previous answer, Education Scotland is providing support to schools to enhance the work that is undertaken by local authorities. We are putting in place a package of support that has been designed by the education recovery group to provide further assistance, and we are trying to ensure that there are more teaching resources on the ground to assist in the delivery of learning and teaching for young people across the country.

Iain Gray: Headteachers’ commitment is not in question, but they are hardly helped by the failure of Education Scotland and the Scottish Qualifications Authority to come up with guidance for the teaching of practical subjects and changes to curriculums and courses for exams for teachers who are already trying to teach those courses and headteachers who are trying to manage those teachers. When will the cabinet secretary get the SQA and Education Scotland to step up and play their part?

John Swinney: Both organisations are making their contribution to addressing those issues. For example, the SQA is wrestling with a number of very different views in relation to the consultation on the approach that is to be taken for examination in 2021, and Education Scotland is providing practical assistance to individual schools around the country and the strong digital learning platform that will be essential for young people should their education be interrupted at an individual, class or school level as a consequence of Covid. I am confident that those national organisations are making their contribution and that they will continue to contribute to the work of the education recovery group, which brings together the interests and the perspective of all stakeholders in education, including the professional associations.

Clare Adamson (Motherwell and Wishaw) (SNP): How will the £45 million for schools to recruit additional teachers and the £5 million for teaching assistants and other support staff help to alleviate the pressures on senior management in our schools? What discussions has the Cabinet Secretary for Education and Skills had with the Convention of Scottish Local Authorities on the recruitment of the additional teaching and support staff?

John Swinney: We recognise the challenges that individual schools face, which is why we have taken steps to expand the workforce.

The most recent information that I have is that local authorities have recruited an additional 740 teachers and that plans are in place for the recruitment of another 250. We expect that number to increase over the coming weeks as schools continue to assess the needs of children and young people.

We remain in continuous dialogue with local authorities about the progress in utilising those resources to expand the teaching workforce.

Jamie Greene (West Scotland) (Con): It was worrying enough that, during the lockdown, many pupils struggled to access online learning because of a lack of information technology and infrastructure. We have now learned, from a survey by the Educational Institute of Scotland, that many teachers, headteachers and school staff are also struggling with IT infrastructure and connectivity. If blended learning, as a contingency, is going to work, they must be given everything that they need. It is not good enough to say that it is a matter for local councils. What leadership is Education Scotland taking?

John Swinney: It is a matter for local authorities, because local authorities have a statutory duty to deliver education. That might not suit Mr Greene's political narrative, but it is what the law says.

Schools must be supported by their local authorities, which must deliver the leadership and the practical support to ensure that school staff—who are their employees—have all the equipment that they require. It is for local authorities to take that work forward.

The Government supports and enhances it. We have delivered additional devices to local authorities, to which we have added new resources to make it easier for those commitments to be deployed. It is important that every member of staff and every pupil has access to the digital technology that will enable them to fully participate in learning and teaching.

Beatrice Wishart (Shetland Islands) (LD): Those reports on excessive and unsustainable workloads should serve as a reminder that real people are at the other end of decisions on such matters.

On top of working throughout the pandemic, schools and their staff have had to work around U-turns from the Scottish Government. The Cabinet Secretary for Education and Skills waited until the last days of term to score out the first unworkable plan, after teachers had spent weeks wrestling with it. That made working through the summer inevitable.

Does the cabinet secretary know how much overtime was accrued over the summer?

John Swinney: The kind of terminology that Beatrice Wishart chooses to use does not help in the debate.

I do not think that it is a matter of regret that there was a significant reduction in the prevalence of Covid in May and June, which resulted in our being able to contemplate the full-time reopening of schools. I would have thought that that would have been something to welcome, as opposed to something to complain about. Members need to think carefully about the implications of some of the things that they say.

We have a perfectly robust approach to blended learning, which we may need to use if education becomes interrupted because of Covid. I do not want that to be the case.

I have just answered a question from Alison Johnstone about the increased prevalence of Covid. I do not want its prevalence to increase, but, if it does, that will increase the risk to our ability to deliver full-time education. We can deliver it; we were the first part of the United Kingdom to be able to return our schools full-time, as a consequence of commitments by members of the public to reduce the prevalence of Covid. We should welcome that rather than complain about it.

Drug Consumption (Safe Facilities Report)

3. **Rona Mackay (Strathkelvin and Bearsden) (SNP):** To ask the Scottish Government what discussions it has had with the United Kingdom Government regarding the Scottish Affairs Committee report on safe drug consumption facilities. (S5T-02371)

The Minister for Public Health, Sport and Wellbeing (Joe FitzPatrick): The Scottish Affairs Committee inquiry into problem drug use in Scotland took place in 2019 and I gave evidence on 9 July 2019. The United Kingdom Government's response was published yesterday, and I have already put on record my disappointment that it has rejected the majority of the committee's recommendations—of the 19 recommendations that the committee made, the UK Government rejected 16.

Rona Mackay: I am sure that the minister was as disappointed as I was to hear that the UK Government does not accept that problem drug use is singularly a health issue and that it has rejected the recommendations in the Scottish Affairs Committee report.

Given that, in Scotland, we recognise the severity of the public health emergency, will the Scottish Government continue to press the UK Government to either change the law or devolve the powers so that we can take the action that is necessary to reduce the harms and deaths associated with drug use?

Joe FitzPatrick: The UK Government's determination to have a justice-based focus rather than a public health focus on the matter is hugely depressing. I fully intend to continue to press the UK Government to take action on a variety of matters where it is needed in order to tackle the public health emergency that we are facing in relation to drug deaths.

For example, I want to see action taken to regulate pill-pressing machines and to amend the legislation to expand the ways in which naloxone can be distributed. We are clear that we want to tackle the issue using an evidence-based, health-focused approach. However, our ability to implement several aspects of that is being frustrated by areas in which legislation is reserved and the refusal of the UK Government to take action that will help us to save lives.

Rona Mackay: Has the drug deaths task force continued its work during the Covid-19 pandemic? What further steps will it take in the future?

Joe FitzPatrick: The task force has continued to meet—virtually—throughout the pandemic. It has worked to implement a range of actions to mitigate the increased risks during the pandemic for those who are already at risk as a result of drug use. Action has been taken and lessons have been learned in several areas. We can make use of that learning after the pandemic to improve the support that we give to people across Scotland.

Annie Wells (Glasgow) (Con): In 2007, there were approximately 352 rehab beds in Scotland. In the 10 years since then, the number has dropped to fewer than 70—282 rehab beds have been cut under the Scottish Government. Surely, the first priority should be to increase the number of people accessing treatment and to reverse the cuts to the drug and alcohol partnerships that have been made by the Government?

Joe FitzPatrick: It is really important that we do not have the illusion that there is one silver bullet. All the support that we provide to people is important. That is why I have said previously to Parliament, and to the spokespeople when we have been discussing drugs, that we are looking at whether the pathways into rehabilitation are appropriate and properly accessible. One thing that we have been looking at during the pandemic is a national route from prison through to rehabilitation. That appears to have been successful, and we might look to expand that model.

To improve the range of options and pathways that are available, we have established a working group to consider the provision of residential rehabilitation services and make recommendations to strengthen referral pathways. That work is being chaired by David McCartney, who is the clinical lead for the Lothians and Edinburgh abstinence programme. I look forward to bringing further news on that work to the Parliament in due course.

Neil Findlay (Lothian) (Lab): The Tory approach to Scotland's drugs crisis is ridiculous and a disgrace. However, there is a huge amount that we, in Scotland, can do in relation to the mental and physical health of drug users, residential rehab, policy co-ordination, care, policing and much more. Will the minister stop looking at this desperate situation through a constitutional lens and instead take the decisions that he has the power to take to save lives—not in another year's time or in five years' time, but now?

Joe FitzPatrick: I have tried very hard not to look at the issue through a constitutional lens, but we have to realise and accept that there is an uncomfortable interface between the public health and justice approaches, both of which are devolved, and drugs legislation, which is reserved. There is no question but that that interface is making it difficult for us, here in Scotland, to take all the actions that we could take. No one is suggesting that the actions on which we can work with the UK Government in relation to pill presses and safe consumption places are a silver bullet; a lot of other work is going on.

Prior to the pandemic, I spent a great deal of time going around and speaking directly to service users and service providers all across Scotland. It is very difficult to do that just now, under the restrictions because of the pandemic, but it is important that we listen directly to the voices of people who use and provide such services. I am continuing to try to do that as best I can, and the task force is working hard alongside us to do that. There is a huge amount of work to do, and we are undertaking that work at pace.

Willie Rennie (North East Fife) (LD): The minister is correct in saying that there is no silver bullet, and I commend him for his work in pursuing the safe consumption room policy. Will he be equally strong in advocating for the Portuguese-style commissions that have helped to deal with the drug problem in that country?

Joe FitzPatrick: There is no question but that the public health approach that was taken in Portugal some 20 years ago has led to the country going from having one of the highest levels of drug deaths in Europe to now having one of the lowest. It has been a remarkable transformation. It is clear that we cannot take a legal or health system from one country and implant it directly in another, but there are huge lessons for Scotland from Portugal, Canada and lots of places in Europe. Safe consumption facilities are just one example of a public health approach that is saving lives right across the world. I really hope that, when I meet the UK minister on two occasions later this month, he will have found a way to square that circle and to move from a justice-based approach to a public health approach, which, as international evidence shows, will save lives.

The Presiding Officer: I do not have time to take all the questions today. I apologise to colleagues who have missed out.

Mike Rumbles (North East Scotland) (LD): On a point of order, Presiding Officer. Earlier in the session, the Deputy First Minister confirmed to me that the restrictions of liberty that have been imposed on more than 1 million people are lawful. When I raised a point of order last week, you pointed out that no regulations to change the law had been laid and that the imposed restrictions were simply guidance or advice. As I recall, you said to the First Minister that, if the law were to be changed, regulations would need to be laid. I am concerned about whether our proper parliamentary procedures are being followed; that is what I am trying to find out.

Presiding Officer, I ask you again: have regulations to change the law to restrict people's liberty in Glasgow now been laid before Parliament, or do the restrictions continue to be guidance or advice, as was the case last week? The reason that I ask is that, as an MSP, I for one have been approached by people who are affected by the restrictions. As a result of the intervention last week, I have been saying that the restrictions are good advice and guidance, but they are not the law. I think that there is confusion, and I want to know whether the regulations to change the law have been laid, because, according to the Deputy First Minister, the actions of the First Minister are, indeed, lawful.

The Presiding Officer: I thank Mr Rumbles for the point of order. I cannot do much more than repeat the advice that I gave last week, which is that the term "restrictions" is used to cover both voluntary guidance and matters for regulations. All regulations are laid before Parliament. If a change in the law is being made, regulations are laid before Parliament, which has the chance to express its view on them. It is for the Scottish Government to clarify whether, in this case, the restrictions are guidance, statutory guidance or regulations.

That is not a point of order for the chair; it is a matter for the member to put to the minister or ministers in the form of either a written or an oral question, or to raise at other opportunities in Parliament. I hope that that addresses the point of order.

Mike Rumbles: No. Forgive me, but can I follow up on that point? I am genuinely trying to seek the reality here. Regulations needs to be laid before parliamentary authorities, and they must know whether those regulations have, indeed, been laid. It would be immensely helpful if we knew. If they have not been laid, there is no change to the law. What I am trying to find out is simple, and I have not found out since I raised a point of order last week. It is important because more than 1 million people are affected. I need to know—and I think that MSPs need to know to fulfil their duties—whether this is a change in the law or simply advice, because if it is a change in the law, the police will enforce it, but if it is not, they will not.

The Presiding Officer: There is nothing wrong with Mr Rumbles's line of questioning on the information that he wishes to elucidate. However, I suggest that it is not a matter for me, as the Presiding Officer, because it does not affect the order of this Parliament or relate to the standing orders.

I am trying to clarify that the member is quite at liberty to put a question to the minister on various occasions—in fact, he had an opportunity earlier, and I am sure that there will be others this week. He can do so in writing or he may be able to approach parliamentary staff in the Scottish Parliament information centre; they would certainly be able to clarify whether any regulations have been laid. However, it might be that the regulations are delayed. The member will know that, sometimes, orders are made and the regulations come in after those orders take effect. They have to be passed by the Parliament, and there might be a delay.

It is a matter for the Government, not the Parliament, to clarify. However, the Parliament can certainly assist in providing that information. I hope that that is helpful.

Baroness Cumberlege Report

The Presiding Officer (Ken Macintosh): The next item of business is a debate on motion S5M-22635, in the name of Jeane Freeman, on the Baroness Cumberlege report. I invite all members who wish to ask a question to press their request-to-speak button—[*Interruption*.] Sorry—I meant that those who wish to contribute to the debate should press their request-to-speak button now. It has been so long since we had a debate that I have forgotten the procedure.

14:32

The Cabinet Secretary for Health and Sport (Jeane Freeman): I start by welcoming the independent medicines and medical devices safety review—the Cumberlege report—and the opportunity in this Government debate to discuss its findings and their implementation in Scotland.

At the outset, I want to pay tribute to the many women in Scotland and across the United Kingdom who gave evidence to the review. That will have been very difficult for them to do, and I put on record my admiration of their courage and determination and their efforts in persistently raising issues over a number of years.

To all those directly harmed by mesh, sodium valproate and Primodos, I offer the Scottish Government's sincere apology. I offer that apology to them and to those who have seen their children, family members, friends and colleagues suffer.

The review and its recommendations are of significant importance to us as we work to improve how the healthcare system responds to harm, and I am grateful to the review team for not only its work but how it has done that work.

I was pleased to be able to speak with Baroness Cumberlege and her team yesterday and to hear from her about the experience of the review's work, the thinking behind the recommendations and her determination to see them acted on. I was able to confirm to her this Government's commitment to implement all her recommendations where we have the power to do so, and to support her in convincing the UK Government to act on the recommendations that lie solely at its hand. I was grateful for her recognition that much of the work that we have under way is aligned to her recommendations.

Let me now set out our response to the recommendations. The independent medicines and medical devices safety review was commissioned by a former UK secretary of state for health and social care. Therefore, there are recommendations that only the UK Government, with its reserved responsibilities, can implement.

The regulation of medicines and medical devices is reserved to the UK Government, so the recommendation that says that the Medicines and Healthcare products Regulatory Agency should be subject to substantial reform is for the UK Government to implement.

However, I strongly support that recommendation. We have long argued for reform of the assessment of medicine and medical device safety. We have communicated directly with the MHRA on that and have been disappointed that the MHRA believes that its assessment systems are fit for purpose. I gave Baroness Cumberlege my assurance that we will use the avenues that are available to us to press the UK Government to act positively and swiftly to review that body, with patient safety at the heart of that.

The recommendations in relation to the General Medical Council will require consideration by that organisation, particularly around transparency of payments to clinicians and expansion of the GMC's register. In Scotland, we have established a declarations of interest steering group that aims to formulate a common set of principles for the identification and management of declarations of interest across NHS Scotland and related sectors. The group is due to complete its work early next year, and I hope that that will help to inform the GMC's response.

I turn to recommendations 3, 4 and 5. I understand that those who have suffered harm as a result of these treatments want redress, not only financially—although that is important—but in the form of access to appropriate, on-going care that addresses the consequences of the harm that they have experienced. That is both right and fair.

I welcome the approach taken in seeing the redress agency as independent, funded in part by the pharmaceutical and medical device manufacturers and adopting a non-adversarial approach that looks to base determinations on avoidable harm through systemic failures. That is critically important, and it is a recommendation that we support. It is important not only for the individuals involved, but for the healthcare system as a whole. That approach will allow us to learn from the determinations of that body and to apply that learning to improve patient safety.

The review recommends the establishment of specialist centres. As members know, we have invested £5.1 million over three years in a new complex pelvic mesh removal service in Glasgow, which was designated as a national service in July this year. The service will assess all a woman's relevant health needs and, subject to fully-informed agreement, will offer vaginal mesh removal surgery for women over 16 who have mesh complications from mesh insertion, vaginally or abdominally, for urinary incontinence and prolapse.

Neil Findlay (Lothian) (Lab): How many mesh women have been involved in the co-production and co-design of that service?

Jeane Freeman: I was about to move on to that. Through the involvement of the Health and Social Care Alliance, which was actively involved in canvassing women's views and which continues to do that work, women were involved in the initial design and will continue to be involved throughout.

The specialist service follows directly on from a recommendation by the short-life working group on mesh complications, which has representation from the Health and Social Care Alliance, which, as I have just said, has been actively involved in canvassing women's views. The short-life working group has ensured, and will continue to ensure, that women's views are central to the creation of the service in Glasgow.

There will be a phased introduction this year, offering assessment and treating patients with complex needs on a clear patient pathway. The service is at an advanced stage of development and it is important that all those affected have access to high-quality services now. It is a service that women themselves have asked for. They have been involved, through the alliance, and will continue to be involved, in its design, which is now at an advanced stage. Knowing that, I therefore cannot accept Neil Findlay's amendment to the motion, which asks us to stop that work.

A close working relationship is being developed with equivalent specialist centres in England.

Neil Findlay: Will the cabinet secretary give way?

Jeane Freeman: I will in a moment.

That will be in place as soon as those centres are established and will provide the opportunity to support advances in knowledge, techniques and practice. We also intend that it will allow referral pathways outside Scotland where that is the right thing to do for the patient and is what the patient wants.

Neil Findlay: There is a multitude of questions about that service. The women themselves are asking those questions. They do not have faith in the way that the service has been set up. I am not asking for the service to be cancelled; I am asking for it to be paused until all those questions are answered and people can have faith in what is being built.

Jeane Freeman: I accept the core of what Mr Findlay says about the importance of women having faith in the specialist service. Undoubtedly, one of the harms that has been done is the harm to trust—I accept that. However, the alliance has canvassed and reached large numbers of women, many of whom have written to me. Women want the service, notwithstanding the fact that there are questions that need to be answered. However, I do not think that it would serve them well to pause the service; rather, we should try to address all those questions while we continue to develop that work. I think that it is entirely possible to do both, hand in hand.

The close working partnership between the specialist service and the specialist centres in England will allow for benchmarking and peer review, and I hope that it will help to restore trust and confidence in our services. As such, we are happy to accept Jackson Carlaw's amendment to the motion.

In respect of other specialist centres, my senior officials recently met patient groups and we are considering whether additional centres or services would be helpful for those affected by sodium valproate and Primodus, in line with the other review recommendations.

As members know, we have established a £1 million fund for women with mesh complications. The fund opened to applications on 1 July and runs through to next year. To date, 276 applications have been received.

The Cumberlege review makes an important recommendation on data. Members will be aware that patients expressed concerns about that area to the Public Petitions Committee. The MHRA has been working on a sodium valproate-specific registry, the aims of which include monitoring the use of valproate in women and girls across the UK, compliance with the current regulatory position and identifying and monitoring any children born to women taking that drug.

We have set up a device identifier programme unique to Scotland to develop a system for collecting data on implanted devices. Our aim is that the information that we collect, particularly when combined with similar information collected elsewhere in the UK, will allow for better quality assurance, comparison and peer review. We have agreed to work with NHS Digital on a UK-wide database of procedures that it is establishing. We will join the pilot, which has an initial focus on pelvic floor procedures, including those using mesh and related procedures. In the longer term, NHS Digital ultimately intends to capture information on procedures concerning all surgical devices and implants from NHS and private providers. Those are all important drivers of change and continuous improvement, and a key aim of the programme is to support NHS Scotland's commitment to continuously improve patient safety.

I now turn to what I think is a key recommendation of Baroness Cumberlege's report: the appointment of an independent patient safety commissioner. It is clear to me from not just her findings but my discussions with mesh-injured women, families and professionals that there is still work to be done to ensure that people are listened to and heard, and that their experiences are acknowledged and valued. They should not be experiencing additional distress when what they need is further care and support.

NHS Scotland carries the mantra "safe, effective and person-centred"; I believe in that absolutely, but I also know that there is more for us to do to deliver on it. People must be at the centre of the decisions that are made about their care. We fully expect clinicians to facilitate shared decision making, listen to their patients' concerns and explain the risks and benefits of treatment options to allow them to make informed decisions. That is central to the principles of realistic medicine and should be fully embedded in the new specialist service for mesh complications. Indeed, when I met Baroness Cumberlege yesterday, she spoke at length about that. It is vital, and it is why we agree with Alison Johnstone's amendment to the motion.

It is vital that patients have confidence that, every time that they access any part of the healthcare system, they will receive not only the information that they need to make an informed decision but the best available treatment without fear of harm. By creating a culture of openness and learning, everyone should feel able to share what has gone well but also what has gone wrong and what could have gone better. That will help us all to learn and to continually improve our services, our experiences and the outcomes that we seek. The challenge is to make that a reality and ensure that learning and improvement happen even when things go wrong.

Whether through boards or through the Scottish Public Services Ombudsman, there are established routes for patient feedback and complaints, but those routes are largely reactive, and it is clear that not everyone gets the outcome that they are looking for and not everyone feels that they have been properly listened to or that change will come from their feedback. As a result, relationships between patients and health and care providers break down, with patients losing faith in the service. That needs to be addressed, and establishing the patient safety commissioner role for Scotland is now a programme for government commitment.

The role will initially focus on improvements to patient safety around the use of medicines and medical devices, as set out in the review. The role must be proactive and enhance what we already have in place, with the emphasis on listening to and learning from people's experiences and driving implementation to continually improve patient safety.

To get that right and make it work for patients, we must listen to them, so we will shortly begin a consultation to understand what patients want from the new role and then act to implement that as soon as possible. I am anxious that we do not delay in that area.

I hope that what I have set out makes it out abundantly clear that we take the findings of Baroness Cumberlege's report seriously. Although there is a great deal of alignment between our thinking and our actions to date, her report gives us the opportunity, and arguably the impetus, to go further.

As we draw together our implementation steps, I am pleased that Baroness Cumberlege has accepted both my invitation to offer me advice on our delivery plan and my offer to support her as she seeks to ensure that the Governments of all four nations implement her recommendations.

As we move forward with that and put in place the detail and, in particular, the consultation on the patient safety commissioner, I will be happy to keep all members advised of our progress.

I move,

That the Parliament welcomes the recommendations made by Baroness Cumberlege in her report on the independent medicines and medical devices safety review; acknowledges the Scottish Government's apology to women and families affected by Primodos, sodium valproate and transvaginal mesh; welcomes the Scottish Government's commitment to establish a Patient Safety Commissioner, and notes the actions taken by the Scottish Government to offer improved services for women who have suffered complications as a result of transvaginal mesh.

14:46

Donald Cameron (Highlands and Islands) (Con): I highlight my entry in the register of members' interests on an interest in health technologies.

I am grateful for the opportunity to open for the Scottish Conservatives. I recognise that the thorough and rigorous report by Baroness Cumberlege covers a wide variety of cases and issues, and I intend to cover some of them.

However, I begin by focusing on polypropylene mesh implants. The report was thorough on that matter, and it is clear from the often harrowing accounts about mesh implants by victims that swifter action should have been taken when concerns were first raised.

It is with that in mind that I pay tribute to several people who have been at the forefront of campaigning on the issue. First and foremost, I pay tribute to the many women who have campaigned and lobbied the Parliament and Scottish Government on mesh implants. Ever since I was elected as an MSP in 2016, the passion and persistence of the campaigners have been obvious to me and, indeed, to anyone else who is involved in politics in Scotland.

In particular, I note the efforts of Elaine Holmes and Olive McIlroy, who first raised the matter with Parliament through the Public Petitions Committee, back in 2014. Armed with more than 1,700 petition signatures, their efforts and determination from that point onwards, alongside the words of countless others, have not only helped to develop substantial change but have played a critical role in events that led to the development of the report. As Baroness Cumberlege noted,

> “the Scottish women and their evidence played a substantial role and my hope is that Scotland will adopt my recommendations and ensure patients are listened to.”

I want to take this opportunity to pay tribute to three MSPs in the chamber whose contributions should be recognised and who will, no doubt, speak in later in the debate. The first is Jackson Carlaw. As Conservative health spokesperson in 2014, he met the campaigners, took up the issue on numerous occasions in Parliament and took evidence while on the Public Petitions Committee. He has been a champion for the many women who have been affected by mesh implants, and he continued campaigning on the subject even when it was out of the public glare.

I also pay tribute to two other members who have played critical roles in securing change. Neil Findlay and Alex Neil have been powerful advocates for women who have been affected by mesh in different ways. Both inside and outside the chamber, Neil Findlay has been a potent voice for those women, and he has not shied away from robustly holding the Scottish Government to account when it has dragged its heels. Alex Neil, who was the Cabinet Secretary for Health and Wellbeing when Elaine Holmes’s and Olive McIlroy’s petition first came to Parliament, was the one who listened to campaigners and requested suspension of the national health service’s use of mesh implants in Scotland, pending safety investigations.

Neil Findlay: Is it not an indication of the extent of the scandal that, when Alex Neil did implement a suspension, health boards continued to implant mesh in another 1,000 women? That shows how much the medical establishment took heed of a cabinet secretary telling them not to implant.

Donald Cameron: I accept that there were issues around that. However, my point is that three MSPs from different political parties getting together to play a role in getting things to where we are now is a fine example of political differences being put to one side for the greater good in pursuance of such an important cause.

I also note that, although the report is overarching and clearly exposes significant system-wide failures, it is true to say that many clinicians do an excellent job, are respectful of their patients and want the best outcomes for them.

I turn now to the substance of the report, which was commissioned by the former UK Secretary of State for Health, Jeremy Hunt. Its recommendations are primarily focused on England. Baroness Cumberlege has called on Scotland to lead the way in implementing her report’s recommendations, where appropriate. That is why Scottish Conservatives welcome the commitment that was made in the programme for government, and which has been repeated today, to establish a patient safety commissioner as is recommended in the report. We will closely monitor implementation in order to ensure that whomever is appointed to the role has the clear support of patients and campaigners.

As has already been mentioned in the debate, one of the recurring themes of the mesh scandal is the lack of confidence in the system among women who have been affected. Neil Findlay spoke of that. I am afraid to say that there has been a history of kicking the can down the road and hoping that the problem would go away. When it comes to the mesh issue, trust in the Scottish Government and those who are responsible in the health service needs to be revitalised. That is an urgent imperative. This should not be the moment when the issue is yet again kicked into the long grass. If I know anything about the women who have campaigned so hard, it is that they will not let that happen—and we will not let it happen.

Although we note and welcome the recent announcement by the Scottish Government that it will provide additional support for patients, including the £1 million fund to support women with transvaginal mesh complications, and its announcement of the establishment of the national mesh removal service, we will carefully scrutinise the efficacy of both of those measures, taking into account the experiences and views of the women who have suffered from mesh implants.

However, that should not be the end of the road. For instance, we remain concerned by the inability of the Scottish Government to secure the vital services of the mesh removal specialist surgeon, Dr Veronikis. It is the clear wish and desire of patients' groups, including Scottish Mesh Survivors, that the expertise of Dr Veronikis be secured.

Indeed, the inability to secure his services was described bluntly in Scottish Mesh Survivors' most recent submission to the Public Petitions Committee, in which it said:

> "Losing out on this opportunity was not only shameful, it left Scotland's mesh injured women devastated, terrified, and unwilling to use the service of the very surgeons who had not only implanted them with the mesh which destroyed their lives, but had also campaigned to continue using the implants long after evidence showed devastating lifelong injuries were being inflicted on upwards of 30 per cent of patients".

Jeane Freeman: Does Mr Cameron acknowledge that, as far as the Scottish Government and I, as the cabinet secretary, are concerned, the offer to Dr Veronikis remains open? The preconditions that he has set and has put down in black and white cannot be met, and would not be met for any visiting clinician or surgeon of any standing.

The conditions that we require, for reasons of patient safety, are that, as he previously agreed to do, he would come and be part of our multidisciplinary team process, advise us of what he needed, and meet the people with whom he would operate. Then, a contract of employment and subsequent General Medical Council approval would be granted in short order. I remain regretful that Dr Veronikis has withdrawn his offer, but our offer to him remains open.

Neil Findlay: On a point of order, Presiding Officer.

I have a copy of a letter that was sent to the cabinet secretary six days ago. She has made no reference to it in her comments so far, so I wonder whether you would allow me to read an excerpt from it that would clarify the position with Dr Veronikis, because that is important to the debate—

The Deputy Presiding Officer (Linda Fabiani): Mr Findlay, I see from my list that you have been put forward to open for Labour in the debate, so that will be your opportunity to contribute to the debate however you wish.

Donald Cameron: Scottish Mesh Survivors has been clear; it took a firm view about the services of Dr Veronikis and the need for him to take action.

Our amendment makes it clear that, for the women who have had mesh implants and require removal surgery, such surgery must be

> "undertaken by surgeons who enjoy the full confidence of the women affected".

That is the issue—it is about confidence. That surgery must be fully funded by the NHS. It is no less than the women deserve. We hope that the Scottish Government recognises that and will support our amendment.

It is also worth remembering the people with conditions other than pelvic organ prolapse and stress urinary incontinence who have suffered from mesh implants. At the end of 2018, the *Sunday Post* reported the stories of patients—male and female—who had received mesh implants during hernia operations. One patient described the pain following the treatment as "agonising", and like

> "being strangled from the inside",

so it is clear that that particular material has had wide-ranging effects and has caused untold damage to many lives.

The Cumberlege report is clear about use of mesh to treat POP and SUI. Although it stops short of calling for an overall ban on its use, it says that

> "women must be able to make a fully-informed decision based on clear and unbiased information—the benefits, the risks, the alternatives, and doing nothing"

and that mesh treatment should be

> "considered as a last-line option after conservative non-surgical options, and after consideration of non-mesh surgery".

The report also covers two other significant areas of public health failings, namely the use of Primodos and other hormone pregnancy tests, and the use of sodium valproate for treatment of epilepsy and bipolar disorder, with emphasis on its effects during pregnancy. Although the report provides significant detail, in both cases it is the personal experiences of those who have suffered from the treatments that are most sobering. Their stories are heartbreaking, and are just some of the many accounts that were noted in the report.

Two of the key themes throughout many of the stories are the lack of information being given to patients about potential side effects of the treatments, and the manner in which patients were ignored by clinicians when they raised their concerns. Those were not one-off failings, or failings that could be attributed to a particular hospital or general practice. Rather, they were indicative of a clear system-wide failure.

The report argues that

> "The influence of patients within the NHS and the overall delivery of healthcare needs to be increased to balance the authority both directly and indirectly of those we call stakeholders in the healthcare system".

The report also notes that the consequence of failing to listen to patients often leads to patients feeling

> “vulnerable and ... unable to challenge and question. The patient is ignored and feels belittled.”

The report terms this theme “The patient voice dismissed”. That is a damning indictment. It is clearly vital that that be improved, so I hope that the appointment of a patient safety commissioner can go some way towards achieving that outcome.

I have merely scratched the surface of the detailed report. I proffer the thanks of Conservative members to Baroness Cumberlege and her team for their tireless work in putting the report together.

It is clear that, here in Scotland, some immediate steps have already been taken, and we welcome and support those steps. However, in the case of the many women who continue to seek mesh removal treatment, their fight continues. In Scotland, we can make a difference, if we have the resolve to do so.

I move amendment S5M-22635.1, to insert at end,

> “, and believes that this must include the early prospect of full transvaginal mesh removal surgery being undertaken by surgeons who enjoy the full confidence of the women affected, fully funded by the NHS.”

14:59

Neil Findlay (Lothian) (Lab): I thank Baroness Cumberlege for her excellent report. It stands in stark contrast to the discredited sham of a review that was conducted in Scotland a few years back.

It has taken eight years for a debate on mesh to happen in Government parliamentary time, despite this being one of the biggest medical scandals in the history of Scotland’s NHS. Every step of the way, ministers and the medical establishment have had to be dragged, kicking and screaming, to take action to support mesh-injured women. The situation is exactly the same for women who were victims of sodium valproate and Primodos.

Mesh-injured women have faced systematic cover-up, denial, manipulation of medical records and vested interests protecting themselves and forgetting that the priority should always be patient care. Warm words and sympathy cut no ice with those who have lost their jobs, homes or life savings, or those who have lost their organs, relationships or ability to walk. Those words cut no ice with women who now use wheelchairs and walking aids, who have double incontinence and live lives of chronic debilitating pain, or whose children’s health, growth or development have been terribly affected.

They do not need another clinician or minister empathising with their plight; the mesh women already feel used by a First Minister who, having ignored them for eight years, suddenly became desperate to meet them. I wonder whether the fact that that was in the middle of a general election might have had something to do with it. [*Interruption*.] Those were their words, not mine.

Those women demand from the medical establishment action that puts them first rather than action that puts first the vested interests of the surgeons who implanted them or the manufacturers whose products maimed them. They need a care pathway that includes the right for them to have this poison removed from their bodies safely, if that is what they want. However, that removal must be undertaken only by clinicians who know what they are doing. Would any member here trust a doctor whose recommendations and actions had wrecked their life to be the person to remove a product that is designed not to be removed from the body?

Like the cabinet secretary, I have seen medical notes that were signed by senior clinicians stating that a full or complete mesh removal had taken place only for the same patient to have up to another 20cm of mesh removed after they had to fund themselves to go to the US to get treatment from Dr Veronikis. What is the cabinet secretary’s and the GMC’s view of those shocking cases? Are they medical errors or are patients being misled?

Jeane Freeman: Does the member accept that, in response to those situations, we have established an independent case review that will, using senior clinicians from outwith Scotland, go through each of those cases with the women involved and decide with them what further steps will be taken? Is the member saying that a surgeon who implants mesh cannot be a surgeon who removes mesh?

Neil Findlay: No. I am asking whether members would trust a surgeon who had caused such devastation to their lives to be the person to remove the mesh. I certainly would not, and I know that half of the women who responded to a survey said that they would not, either.

The Cumberlege report cites multiple systematic failings resulting in life-changing harm and makes nine recommendations. I am pleased that the cabinet secretary has confirmed that the Government will implement all the recommendations where it has the power to do so. That is a major step forward, and I welcome it. However, I have to say that mesh-injured women have huge questions about the new mesh service that is being established.

As far as I know, none of the members of the Scottish Mesh Survivors group has been involved in the Health and Social Care Alliance Scotland project—and I have been receiving texts from members of that group as we have been speaking today. They have questions. Who is going to staff the service? Will it be the same clinicians in whom women have lost all confidence? I am advised that it will be. What removal techniques will be used? Will they be the same ones that have caused even more damage to some women who have already had partial mesh removals? What accredited training have those who will staff the service had?

The service evaluation that was handed to the First Minister in November 2019 confirms that all of the women who have had partial mesh removal surgery in Scotland continue to suffer chronic pain and that half of those surveyed did not undergo removal surgery because they do not trust the service. The service's only published research confirms that surgeons did not do total mesh removal but thought that they had—they thought that they had taken it all out, but they had not.

How can the service be allowed to carry out surgery when surgeons cannot do safe total removal? Why did the lead clinicians fail to engage with Dr Veronikis when he offered help, advice and learning? What happened to the patient information leaflet? That decision-making aid was developed by Dr Agur and Scottish mesh-injured women and was sent to the First Minister in November 2019, but it still has not been introduced across the board a year later.

Why are mesh-injured patients being denied access to the multidisciplinary team meetings that are held to discuss their health and their cases? They are being denied access to those meetings. It is not for surgeons to tell women what they can and cannot have. Even if the clinician's preference is to leave an implant in, women must have autonomy of choice over what happens to their health and their body.

Why have only a hand-picked few been involved in the design of the service? None of the Scottish mesh-injured women from the group that has campaigned so vigorously here has been involved in the design process. If the service continues in the same way it is setting itself up to fail from the outset, and it would be a crying shame if that were allowed to happen.

The development of the service must be suspended at this point until all those questions are answered; if that happens, we might be able to move forward. I make a plea to the cabinet secretary: do not waste public money on the service when there are so many question marks hanging over it. There are people out there who are desperate for help, but they will not go to the service under the current circumstances.

The NHS guidance says:

> "In very rare circumstances, consideration will be given to funding referral to a highly specialised care provider in an internationally recognised unit overseas."

This is a unique set of circumstances: patients have been abandoned by the system for 20 years, there is an unprecedented scandal around implants and there has been a failure to commission full safe removal. The First Minister and the health secretary have recognised the very rare circumstances of the scandal. They recognised that international help was needed—hence the contact with Dr Veronikis. It is unprecedented that Alex Neil's suspension of the use of mesh, which followed the work of the Parliament's petitions system, remains in place. There is also an unprecedented level of mistrust in the surgical community and what skills the members of that community might or might not have. They are entrenched in a legacy of a failure to adhere to the principle that is central to their oath: first, do no harm.

We are talking about a massive global female health scandal, and there is now only one credible option that respects the autonomy of the women concerned, that recognises the unique set of circumstances that they are in and that will instil confidence in them—to allow, without further delay, the NHS to finance travel abroad or within the UK, if the right service can be found, to receive treatment from a surgeon of their choice. They must have autonomy. These women are heroes and they deserve nothing less.

Let us remember all those who have died too young of mesh-related illnesses. Today, especially, let us remember Mrs Eileen Baxter, who was the first woman to have mesh identified on her death certificate as a contributory factor. God bless her and her family, who continue to fight in her memory.

I move amendment S5M-22635.3, to insert after "Commissioner":

> "; calls on the Scottish Government to commit to the implementation of all of the recommendations of the report over which it has power; urges it to halt the development of the new specialist mesh service until it confirms who will be carrying out procedures at these centres, what training they have had and whether this is credible, whether any of the surgeons are proficient in carrying out full mesh removal procedures, that patient decision aids have been introduced and that representatives of mesh-injured women have been involved in the design of the service".

15:07

Alison Johnstone (Lothian) (Green): I know that all members will wish to pay tribute to all the people who have been affected by the failings in our health system as listed in the review. They did what their health service failed to do—they supported one another and fought for years, sometimes decades—to have their stories heard. I hope that the Cumberlege report has been the cause of some relief to them, but it should never have come to this.

I would like to focus on the issues that I highlighted in my amendment. I should say that my amendment has been selected alongside the amendments of two of the three “meshketeers”—that is the name that has been given to Neil Findlay, Jackson Carlaw and Alex Neil by the Scottish mesh survivors. The fact that those incredible campaigning women are still able to employ humour tells us so much about their spirit; it also shows how grateful they are to each of those members for their consistent, on-going determined and vocal support. I think that it is fair to say that few women would ever imagine that they would share their most intimate health problems with men who were neither physicians nor partners.

I want to focus on the issues that I highlighted in my amendment. We cannot ignore the fact that the scandals that were examined in the review specifically affect women. Its findings speak to a larger culture of silence around women’s pain and discomfort. It should not be news to anyone here that that pain is still being normalised and dismissed as “women’s problems”. How many times in the chamber have we discussed the stigma around periods and the menopause? Despite that, the review highlights instances in which women were told that their symptoms were just “part of that time of life”. Aside from the fact that that was obviously not the case, why are women continually expected to simply put up with distressing symptoms because it is part of being a woman? When will women be listened to and, more important, believed?

It is clear to me, having read the review report, that the ways in which women are disadvantaged when accessing the health service played a significant part in the scandals. The report states:

> “the whole pharmaceutical and devices regulatory systems have been criticised as being sub-optimal for women.”

We need to recognise how issues such as race intersect with this. The 2019 report by MBRRACE-UK found that

> “black women are five times more likely to die as a result of complications in their pregnancy than white women.”

The risk for Asian and mixed-race women was twofold and threefold respectively. We need to acknowledge the barriers that all women face when accessing healthcare in Scotland. That is the key to ensuring that women such as the mesh survivors are never again forced to battle for years just to be heard.

Like many other members, I met the mesh survivors when they came to the Parliament in 2017. I will never forget meeting them, in that small room on the ground floor, off the garden lobby. The room was too small for those who had made the huge effort to come here to their Parliament to share their shocking personal details with their representatives. That group of women had undergone surgery to address incontinence and found themselves requiring crutches and wheelchairs. One woman and her husband described her 24-hour-a-day incontinence. I cannot imagine the impact that that will have had on their lives—not just the physical limitations, but the impact on their independence, mental health, self-esteem and self-confidence.

Like other colleagues, I met women who had been forced to leave their jobs—really important jobs—who could no longer look after a loved one, or who were heartbroken because they could no longer lift up their grandchildren. They were women of different ages and backgrounds, who banded together and supported one another at a time of great physical and mental distress. Their persistence and bravery are truly awe-inspiring, but they should never have had to fight that battle, and it certainly should not have taken this long.

The mesh survivors have had to deal with unimaginable pain, loss of career and income and impacts on family relationships—and imagine having to campaign relentlessly at a time when your focus should be solely on your health. I am sure that we all agree that no one should ever again have to go to such lengths to be listened to, and that every women affected should have access to the support and treatment that are required to bring about the most optimal health outcome possible.

We need a complex mesh removal surgical service for women experiencing complications following vaginal mesh implants, given the trauma that the women have experienced as a result of their pain and their struggle to be listened to. Psychological support has to be an important part of that service, too.

There must be a rebuilding of trust between the women affected and the health service. Many women will, understandably, be very wary of being treated by the same clinicians who implanted the mesh in the first instance.

Neil Findlay: Will the member accept that, given that the pressure for a suspension has come from the women themselves, it would be wise to pause for the questions to be answered before the service moves on any further?

Alison Johnstone: Yes—many questions regarding the service remain, and I have some sympathy with the suggestion that there should be a temporary suspension to ensure that there is trust and confidence in any service.

The review notes that some mesh survivors have so lost faith in the NHS provision for mesh removal that they have been prepared to pay for expensive private surgery. In some cases, they have travelled overseas at great cost, both personal and financial. No one should have to do that and, of course, that is not an option for everyone. People must not feel so let down by a healthcare system that they have no option but to pay for their care. The rebuilding of trust must be prioritised.

The review makes it clear that its findings were not the result of a handful of bad apples. It states:

> “The issue here is not one of a single or a few rogue medical practitioners, or differences in regional practice. It is system-wide.”

This is a chronic problem whereby women are not listened to and fear of retribution can prevent clinicians from coming forward when mistakes are made.

I move amendment S5M-22635.2, to insert after “review”:

> “notes the review’s assertion that there is a ‘widespread and wholly unacceptable labelling of so many symptoms as ‘normal’ and attributable to ‘women’s problems’’; acknowledges that the review’s findings highlight the repeated dismissal of women’s pain and discomfort; is concerned by the failure to obtain informed consent from many of the women affected by Primodos, sodium valproate and transvaginal mesh; agrees that, without the campaigning of these women and their families, many of the issues cited in the review would not have come to light;”.

15:14

Alex Cole-Hamilton (Edinburgh Western) (LD): I, too, recognise the work of Jackson Carlaw, Neil Findlay and Alex Neil on this issue. It has spanned my entire career in Parliament and has been awe inspiring.

I welcome the opportunity to debate the findings of the Cumberlege review. The stories told by patients are of debilitating pain that has life-changing consequences. What links all the cases is the level of acute suffering that could have been avoided, and that truly is a public health disaster.

Common to all three of the medical interventions that are examined in the review is that the patients were nearly always women, and in many cases the interventions were linked to their pregnancies. The fact that their chronic symptoms were dismissed for so long as so-called women’s problems is scandalous and a horrific example of gender inequality. When we look back at how many lives have been wrecked by those interventions in the past few decades, it is a matter of national shame. Nothing can undo the damage other than an apology, compensation, corrective surgery and psychological support.

Thousands of women who took the drug Primodos had children who were born with sometimes painful disabilities, and those children are now adults. There is no doubt in my mind that the redress needs to be significant for all the cases in the review. That compensation should come from the UK Government, as well as the regulatory bodies that failed those women and the German drug company Bayer, which needs to accept some responsibility. It knew in the 1960s that the drug was harmful but carried on marketing and making a profit from it. It is outrageous that Bayer continues to deny the link between the drug and the disabilities.

My former colleague at Westminster Norman Lamb called the use of sodium valproate during pregnancy in the 1970s an “extraordinary scandal”. An estimated 20,000 children, also now adults, have been left with disabilities as a result. Even more painful to mothers is that they would certainly never have taken the drug, which was used to treat mild seizures, had they been fully informed of the potential side effects for their babies.

However, it is the issue of mesh that has united Parliament this afternoon, and I will focus the remainder of my remarks on that. I welcome the national vaginal mesh removal service that was launched last month, in particular the much-needed psychological support alongside the £1.3 million fund. I ask the cabinet secretary to say in her closing remarks whether patients will be able to choose their own surgeon for corrective surgery. It is an important point, also made by Neil Findlay, that many women do not have confidence that the surgeon who originally caused their injury should be part of the solution. I think that we need to recognise that fear and anxiety.

I also want to be sure that, if they need to travel outside this country, the women will have the costs of so doing reimbursed to them by NHS Scotland. I raise the issue of international intervention, because, as we have heard, the US-based obstetrician Dr Veronikis is a world leader in mesh removal surgery. It is hugely regrettable that he has withdrawn his offer to come to Scotland, following difficulties and delays in arranging the visit. I recognise, from what the cabinet secretary has said, that that offer to him is still open, and I hope very much that he will come here and train surgeons to carry out corrective surgery, as that is fundamental in doing right by these patients.

Alison Johnstone mentioned in very eloquent terms the visit, which she and I attended and which was organised by Neil Findlay, of the mesh survivors group in a ground-floor room of the Scottish Parliament. That visit will stay with me for the remainder of my parliamentary career and probably the rest of my life. Many of those women were in wheelchairs and in abject pain, and they found it difficult to move in any way. I find their dignity and their strength inspiring.

That visit prompted me to hold a members' business debate later in 2017 on the need for a national continence strategy, because all too often mesh was used as a quick fix for incontinence issues. As a country, we should be far more proactive in encouraging women and men to talk about when they leak and the fact that humans naturally do leak—the majority of us will do at some point, but that is okay. There are easy ways of fixing that with proper pelvic floor physiotherapy, rather than the insertion of potentially devastating implants, which are used all too often, or the use of pharmaceutical products that should never have made it out of trial phase, given the impact and physical injury that we know they can cause.

Although the report rightly focuses on transvaginal mesh, because that is the type of implant that the majority of mesh survivors have received, I would like to remind Parliament of the forgotten survivors. I believe that Donald Cameron pointed out that the pause on surgery did not apply to the operations on those who have suffered mesh surgery to fix hernias. They have received very little recognition, no corrective surgery and certainly no financial payout. I cannot see why they are discounted from this.

The cabinet secretary will remember that I previously raised with her the case of Lesley Hughes, who is a constituent of mine. Lesley underwent mesh surgery to help to relieve pain around her groin hernia in 2017. After the mesh was implanted, she found herself in even worse pain; indeed, the pain was so bad that she could not move at all. She had to rely on a walking stick or even a wheelchair, as the pain was so unmanageable, and she found it tricky to return to work.

Lesley travelled to London in October 2018 to have the mesh removed privately rather than on our NHS. Although that helped the pain and mobility, she still has chronic fatigue, pain, migraines and reduced mobility. She is now saving money to buy a scooter. She has been financially hit, because she has had to reduce her hours of work, and she has been physically unable to work full time. She was offered removal surgery from the NHS, but she paid for the surgery privately because, as she told me, she had no trust in, or evidence of good practice from, the surgeon who was assigned to her. She was not willing to risk matters getting worse.

I can see that my time is coming to an end.

I once again thank all the mesh survivors, and I assure the movers of all the amendments that we will support all of them. I am grateful for the opportunity to contribute to the debate.

The Deputy Presiding Officer: We will now move to the open debate. We are already way over time and later contributions may have to be curtailed. Meanwhile, speeches should be up to six minutes, please.

15:21

Alex Neil (Airdrie and Shotts) (SNP): There are very few issues that unite all five parties in the Parliament, but all three issues that the Cumberlege report addresses significantly add to that total. I, too, pay tribute to Lady Cumberlege and her team for a first-class report on all three areas that they looked into. However, I will, obviously, concentrate on the mesh issue.

I would like to make a number of points to take us forward.

I very much welcome the Scottish Government's commitment to create a Scottish patient safety commissioner. That is long overdue, and the commissioner could be a huge advantage for people who find themselves in the position that the mesh women found themselves in many years ago. I will make three or four suggestions for consideration by the cabinet secretary and the Government in taking forward the consultation on the creation of that post.

First, to maximise the impact of and the confidence in such an commissioner, we should follow the example of the ombudsmen and make the position a parliamentary appointment, not a Scottish Government or NHS appointment. To maximise confidence, the person must not be seen to be part of the internal system, where the problems arise in the first place.

Secondly, the commissioner must have a wide remit. Their remit must not be so narrow that it becomes ineffectual.

Thirdly, the commissioner must have powers. One of the shortcomings of the ombudsmen is that, at the end of the day, their powers to implement their recommendations are extremely limited. The commissioner must have teeth and the power to prevent mistakes before they are made, let alone to rectify them once they have been made.

Finally, let us not make the same mistake that we made with the Scottish Human Rights Commission, whose commissioner is not allowed to investigate individual cases. I see the patient safety commissioner being able to look at generic issues to do with patient safety, as well as able to investigate individual cases.

If those powers, that remit and that status as a parliamentary commissioner are awarded, we will have a very strong patient safety commissioner, which is what we are looking for.

I very much agree with the cabinet secretary's motion and Jackson Carlaw's amendment, which proposes that the Parliament believes that the Scottish Government's actions should

> "include the early prospect of full transvaginal mesh removal surgery being undertaken by surgeons who enjoy the full confidence of the women affected, fully funded by the NHS."

I think that the cabinet secretary has said that she agrees with that. That is fundamental to the basic principle that the patient comes first.

I welcome, as part of the mesh removal service, the individual case review whereby the patient, along with the relevant consultant or medics, takes a joint decision about the best course of action for them as an individual. No one is qualified to tell a patient what is best for them other than that patient in consultation with their doctor. [*Interruption*.] I will just finish my point.

Fundamentally, a significant number of women will have reached, or will reach, the conclusion that the only person on the planet who can safely remove their mesh is Dr Veronikis in America. However, we do not know how many women there are in that category, nor the individual complexities of their cases, and nor should we. I am not going to get into who said what when, why Dr Veronikis is not here in Scotland or why we are not there—primarily, I am not interested in that. I just want us to get to a position where, one way or another, the women who need their mesh removed by Dr Veronikis and see that as their only solution get access to his services. I believe that we owe it to those women to make sure that that happens.

The National Health Service in Scotland, and indeed the rest of the UK, has a tradition of sending people abroad for any procedure that cannot be carried out safely in our country. That is not new. What is probably new in this case is the potential scale at which we need to do that. As a Parliament, a Government and a society, we need to take it on the chin that we owe it to those women to foot the bill for those whose only solution is to go to the States and have their mesh removed by Dr Veronikis.

In the short term, that is the most important aspect of the debate, because we cannot allow the lives of those women to be destroyed by the failure to remove the mesh that probably should never have been inserted, and certainly not in the way it was, into their bodies in the first place.

The Deputy Presiding Officer: Could you come to a close, please.

Alex Neil: Finally, the patient decision aid should be used much more widely. Although MHRA reform is a reserved matter, all devolved governments should be heavily involved in the decision-making and process of reform so that we can rectify that organisation. Never again should any manufacturer be able to destroy people's lives in the way that mesh manufacturers have over the past 10 or 20 years.

15:28

Brian Whittle (South Scotland) (Con): I begin by pointing members to my register of interests, specifically my interest in healthcare technologies.

I am pleased to have the opportunity to speak in the debate on Baroness Cumberlege's report. This is not the first time that the Parliament has debated polypropylene mesh implants and the devastating impact that their use has had on so many patients. My remarks will be focused on that.

I was a member of the Public Petitions Committee and it will be hard for me to forget the harrowing evidence that that committee took, along with the Cabinet Secretary for Health and Sport and the chief medical officer. That session will not leave me, not even long after I have left the Parliament. I can still vividly picture the discomfort of those who were giving evidence. So many of the sufferers—many in wheelchairs—were sitting behind the witnesses and reacting to every question and answer. The discomfort of those giving evidence was because there was little that could have been said to justify why more had not been done to alleviate the suffering, or to prevent future suffering, of so many. Actions that could and should have been taken swiftly had just not been implemented. The reality was that there were no excuses.

I pay tribute to those who have campaigned and lobbied so passionately. Others have mentioned Elaine Holmes and Olive McIlroy for bringing the petition to Parliament in 2014.

As members said, MSPs of all parties have been instrumental in keeping this travesty on the agenda. Jackson Carlaw, Neil Findlay and Alex Neil joined members of the Public Petitions Committee for every evidence session on the mesh petition and were vociferous in cross-examining the witnesses.

There has been undoubted progress, but the journey is far from over, which is why I ask the Parliament to support the Scottish Conservative amendment in the name of Jackson Carlaw, which calls for mesh removal surgery to be undertaken

> "by surgeons who enjoy the full confidence of the women affected, fully funded by the NHS."

Alex Neil spoke well to that point, which, surely is the least that the women can expect. The Scottish Government must try to secure the services of the mesh removal specialist Dr Veronikis. It is baffling to the campaigners that that has not already been done.

Let us remember that the petition was brought to the Parliament in 2014, six years ago. We have heard how the then Cabinet Secretary for Health and Wellbeing, Alex Neil, called for a moratorium on the use of mesh in Scotland's health boards, in the belief that that would halt the use of the procedure while further evidence was taken. I know that he was as shocked as we were to find out that the moratorium was not binding and several health boards had continued with the procedure regardless. There is a lesson for the Parliament there. A cabinet secretary can make what is undeniably the right decision to protect public health, unaware that his decision can be overruled without his knowledge.

It is poignant that the report that we are debating is entitled "First Do No Harm", considering how mesh surgery and other treatments that are mentioned in it have been deployed. As my colleague Donald Cameron said, the report falls short of recommending an outright ban on the use of mesh implants but suggests that such implants should be used as a last resort and only after other treatments have been fully explored.

Just as important is how patients are engaged in adverse event reviews, which has to change. I have raised the issue in this Parliament many times in the context of other events, such as childbirth mortality. The appointment of a patient safety commissioner seems to be a logical way to promote the importance of listening to and learning from patients' experiences, and it is good to hear the Scottish Government's commitment to the approach.

The report highlights the need for a substantial review of the Medicines and Healthcare products Regulatory Agency. I have to say that the MHRA's engagement with the Public Petitions Committee was far from satisfactory. I look forward to the review.

Another recommendation of the report is:

> "A central patient-identifiable database should be created by collecting key details of the implantation of all devices at the time of the operation."

Members have called for accessible data in healthcare on many occasions. The development of an IT platform that enables the use of accessible data in healthcare is necessary if we are to make significant progress. We are behind the curve, which makes mistakes such as we are considering harder to identify and they then take longer to investigate. Accessible data is a prerequisite in so many issues that face our healthcare system.

In many ways, Scotland has been at the forefront of the drive to change how mesh is presented as a solution for patients—and the petitioners have been at the forefront, too. However, it is fair to say that the Scottish Government has been a little lethargic at best. It is worth pointing out that we have had three health secretaries in those six years. Since Alex Neil took what looked like decisive action and called for a moratorium on the procedure, the Scottish Government seems to have been reluctant to respond with urgency.

Jeane Freeman: Will the member take an intervention?

The Deputy Presiding Officer: Mr Whittle cannot take an intervention; he is just closing.

Brian Whittle: Six years is too long. If the Covid crisis has taught us anything, it is that if there is a will, moves can be made swiftly. It is time that the women who suffered and who campaigned got to the end of their journey. I urge members to support the amendment in the name of Jackson Carlaw.

15:34

Kenneth Gibson (Cunninghame North) (SNP): I put on record my appreciation of the hard work and tenacity of Jackson Carlaw, Neil Findlay and Alex Neil on transvaginal mesh implants and that of the people who campaigned outside this place for many years.

The Scottish Government has been quick to respond to the Cumberlege report, demonstrating its continued commitment to women's health during the Covid-19 pandemic. The cabinet secretary has taken measures to support women with mesh complications, including provision of a £1 million support fund, and she has set up the complex mesh removal service, which is supported by more than £1.3 million of Scottish Government funding, although that service must involve patient choice. Following the establishment of the west of Scotland endometriosis unit last year, that will be another step to help women in the west of Scotland and beyond. Furthermore, I look forward to a patient safety commissioner becoming a national advocate for patients. I concur with my colleague Alex Neil that such a commissioner should be appointed by this Parliament, and I share his views on the remit and powers of the commissioner.

One does not have to be female to know that women and girls can suffer from a multitude of conditions that are truly life changing and harrowing every single day. Many women have been encouraged by society to feel that they just have to get on with it, not because they want to be hard on themselves or trivialise their own situation but because some males have trivialised often very distressing conditions and because concentrating on other things is the only way for some women to get through the day.

When it comes to the impact of medically induced conditions on women or their loved ones, physical pain is often exacerbated by an unwarranted feeling of guilt. I am sure that many members across the chamber have listened to and spoken to women who feel guilty about taking medication that led to birth defects, for example. Although the love for a child does not change, the notion that a child's life would have been different if a woman had not taken Primodos or sodium valproate—the negative impact of which they did not know—must be unimaginably difficult. None of those women are to blame. They trusted medicine and their doctors, and they only took what, to their knowledge at the time, was the best course of action.

In the review, Baroness Cumberlege and her panel met more than 700 people across the UK, mostly women, often accompanied by partners, other family members and sometimes their children. It cannot have been easy for participants to open up about something so painful and personal, but they did it to help others and I admire them greatly for it.

The baroness states in her report that she is particularly impressed with the developments of the pelvic mesh patient decision aid developed by NHS Ayrshire and Arran together with patients. The PDA assists patients with the decision about whether to have surgery, with a focus on understanding the potential short, medium and long-term outcomes that matter to the patient. Every decision to have anything implanted in one's body should be made with all information available, as should any decision to remove it.

On the back of that innovative Ayrshire project, the National Institute for Health and Care Excellence developed its own PDA. Side effects of medical treatment are accepted to a degree, but when something has a major impact it is not acceptable to gloss over that. That is why it is so important to have proper systems in place.

I am a member and former convener of the cross-party group on epilepsy, and sodium valproate has been a regular topic of discussion over the years. While I am aware that it is much less prevalent than pelvic mesh complications are, how that has been dealt with provides an interesting insight into how we gather data and empower patients further in their own decision making about what treatment they are and are not willing to undertake.

The onus on making sure that patients are provided with all relevant information lies with healthcare professionals. If a woman on sodium valproate falls pregnant, there is a 10 per cent chance that the child will have a physical defect and a 30 to 40 per cent chance that the child will have developmental issues. For a woman of childbearing age to be prescribed sodium valproate, they have to be seen by an epilepsy specialist, get effective contraception and be seen on an annual basis.

Like other health boards, in 2017, NHS Ayrshire and Arran immediately implemented NHS Scotland's advice that sodium valproate should not be used by women of childbearing age or pregnant women unless other treatments are ineffective or not tolerated, and it should be prescribed only by a specialist. If sodium valproate is the only effective option for a woman of childbearing age, she must always be given effective contraception, or at least the choice thereof.

In 2014, the European Medicines Agency advised that clinicians must be more aware of the impact of sodium valproate, which led to the Medicines and Healthcare products Regulatory Agency advice in 2018 that it could not be prescribed to women of childbearing age unless they were compliant with the prevent programme. Some general practitioners now no longer prescribe sodium valproate to any patients, meaning that some who might benefit from that epilepsy drug do not get it.

Last September, at the cross-party group on epilepsy, Dr Ian Morrison, a consultant neurologist at NHS Tayside, described how helpful gathering data for a national epilepsy register can be for such purposes. It allows clinicians to see how many female patients have been prescribed sodium valproate and their age, and they can then contact them directly. Without the database, that would have taken weeks, if not months. Many patients did not want to switch from sodium valproate, having achieved seizure freedom, and they had no desire to extend their family or live in a same-sex relationship. Only two came to the clinic because they considered starting a family.

That seems like an effective way to create awareness among patients, as their personal circumstances might change while they are on medication but others could still benefit from the drug as an epilepsy treatment. A similar register is currently being piloted by NHS Greater Glasgow and Clyde. Epilepsy Scotland's chief executive, Lesslie Young, has called for personalised support and to make it a national register rather than health board based. I look forward to seeing further progress as soon as possible and urge the Scottish Government and the health boards to do what is necessary to keep patients and their families safe from inappropriate use of sodium valproate or mesh implants.

15:40

David Stewart (Highlands and Islands) (Lab): One of the great strengths of the Parliament is when members across the political divide unite in common cause to achieve a shared goal. In the past, that has been illustrated by campaigns to support free personal care, international development and animal welfare. The campaign to support women who face the physical and psychological harm from mesh implants is a prime example of that theme. I echo Donald Cameron and other colleagues who praised the work of Neil Findlay, Jackson Carlaw and Alex Neil—they deserve praise and congratulations for their unswerving support and dedication to the campaign.

I remember the first time that I met the mesh campaigners. I was the fresh-faced and newly minted convener of the Public Petitions Committee and, in advance of the meeting, I thoroughly read and absorbed the brief and the petition, but nothing prepared me for the evidence from the mesh campaigners. Many of the petitioners were in tears as they entered the committee room; some were in wheelchairs and others were in obvious pain. The lead campaigner said to me that the mesh devices had gone from gold standard to no standard. They spoke of serious complications, chronic pain, infections, reduced mobility, sexual difficulties, auto-immune diseases, psychological strain and incontinence. In my four years as convener, it was the most powerful and, frankly, upsetting meeting that I have ever witnessed. That has been echoed in the Cumberlege review, which quotes a patient as follows:

> “my journey to find a surgeon who believed that my current health situation is down to mesh complications has been like traipsing through treacle.”

The GMC made a pertinent point in its response to the report when it argued that the harrowing experiences of patients that are drawn out in the Cumberlege review are a stark reminder of the life-changing harm that mesh implants can cause. It is clear to me that patients on both sides of the border have felt ignored, and that is not acceptable in a modern, fit-for-purpose national health service.

It is easy for health bureaucrats to wax lyrical about shared decision making and informed consent, but it is clear that that broke down in the mesh scandal. I welcome the fact that the GMC commissioned independent research on the subject, which should improve practice in the future. I thought it was interesting that the Cumberlege review is subtitled, as others have mentioned, “First Do No Harm”, which, as members will know, is contemporary parlance expressing the underlying ethical rules of modern medicine. For those who were off that day, that was taken from the ancient Greek Hippocratic oath, which is fundamental to the work that doctors and others do.

The thrust of the report is perhaps summarised in the following brief quote:

> “We have found that the healthcare system – in which I include the NHS, private providers, the regulators and professional bodies, pharmaceutical and device manufacturers, and policymakers – is disjointed, siloed, unresponsive and defensive.”

The general findings, which other members have mentioned already, make for depressing reading: the general systematic failings resulting in life-changing harm; patients ignored; a culture of denial; and manufacturers motivated by profit, speed to market and returns to shareholders rather than patient safety—a case of checking the purse before the pulse. The report has a strong and well-argued set of recommendations: the apology to patients; the patient safety commissioner; an independent redress agency; ex gratia payments; a network of specialist centres to provide treatment, care and advice for those affected; and a mesh registry. I accept that the Government has implemented a number of those recommendations, but what about the others?

I will conclude, as I am conscious of the time.

As other members have said, I will not forget the day that I spent with the mesh campaigners: their pain, their sorrow, their psychological strain, their reduced mobility and their serious complications—all of which were avoidable.

The word “scandal” is often misused but, to my mind, it is not misused in connection with that valiant and steadfast group. I commend the work of the mesh campaigners. Let us implement all the relevant recommendations of the Cumberlege report, and let us right a wrong that has, for far too long, been a stain on our NHS.

The Deputy Presiding Officer: Thank you for your brevity, Mr Stewart.

15:45

Clare Adamson (Motherwell and Wishaw) (SNP): I, too, thank Baroness Cumberlege and all those who contributed to that really important report.

Having met the women in 2017, at the event which was organised by Neil Findlay, I, too, pay tribute to their courage, determination and tenacity in making sure that the issue was given the full exposure that it so rightly deserved.

The report covers three important areas: hormone pregnancy tests, sodium valproate and—the area which I want to look at in particular, as have many members during the debate—pelvic mesh implants and their consequences for many patients in this country.

I stand back and ask how it is possible for that to have gone on for so long and for the concerns that were raised and the voices of the women to have been ignored for such a long time? It smacks of a bias in the medical professions, whether intentional or unintentional. A fundamental attitude has to be challenged.

I pay tribute to the women. If they had not been so tenacious, brought their voices forward and ensured that the report came to publication and that we would debate it, some of those issues in our health services would have gone unaddressed.

In 2018, Serena Williams was very vocal about her experience in giving birth and about what she saw as the complete lack of medical attention to her concerns during childbirth. She was very seriously ill—she suffered a thrombosis and virtually had to beg for the assistance that she needed to save her life and that of her child. That brought to the fore something that Alison Johnstone mentioned: the amount of health inequality and the biases in our health service.

In 2020, the Royal College of Obstetricians and Gynaecologists held a special international women's day event at which it looked specifically at inequalities for black and minority ethnic women. It pointed out:

> "in multiple areas of healthcare ... how essential it is that action is taken to highlight, address and tackle these disparities that are literally costing lives."

The main focus of the work of the Royal College of Obstetricians and Gynaecologists women's network was to ensure

> "that women's voices are heard and their views and experiences used to shape education, guidance and policies around their care. In order to reduce these disparities, we must open the debate and ensure women's voices are at the centre of it."

Without the voices of the women mesh survivors, today's debate would not be taking place.

I will talk about something that has been raised by Alex Cole-Hamilton and Donald Cameron. Someone—one of my constituents—has been forgotten. I will not mention her name, but I have her permission to talk about her case; in the past, I have written about it to the Cabinet Secretary for Health and Sport.

In 2008, my constituent suffered complications after a caesarean section. She contracted a nosocomial infection, which led to her requiring mesh implants to rebuild her abdominal wall. At the time, she was a very young woman. Since then, she has exhibited the same pain and discomfort and all the complications that we have heard about today. She believes that the mesh has caused her issues with terrible chronic pain.

She repeatedly asked for joint gynaecological and plastics consultations and to be seen by a plastic surgeon. She has been asking for that since 2008 and only now is she getting to see the medical professionals who can explain to her what has happened. She does not know how much mesh is in her body or where it is in her body; she just knows that, since the mesh was put in, she has experienced unbelievable chronic pain.

She has made many requests for her full medical records and she has only now been given them. I hope that they provide some of the answers that she has been looking for. We will continue to represent her, to try to alleviate her situation, but, unfortunately, she falls outwith the current rules on the support that has been put in place by the Government for those who have suffered following transvaginal mesh implants. That support is very welcome—[*Interruption.*]

The Deputy Presiding Officer: Ms Adamson is in her closing minute and cannot take an intervention.

Clare Adamson: I hope that the appointment of a patient safety commissioner will mean that no one who is affected by such issues will be left behind. I commend all those women who have fought so strongly to be listened to and to have their concerns recognised. We should never, ever, not listen to the voice of patients and women who have been affected.

15:51

Annie Wells (Glasgow) (Con): I welcome the publication of "First Do No Harm" and the recommendations that it makes. I thank Baroness Cumberlege and her team for their diligent work over the past two and a half years.

Although the report is primarily focused on the NHS in England, there are clear implications for practices and procedures in Scotland, so I am pleased that ministers are engaging with the substantive issues that it identifies.

However, the report makes for incredibly painful reading. It tells the story of women who went through treatments and were provided with medication that did not just harm them, but degraded the conditions in which they live their lives. As the report puts it:

> "We met so many women with limited mobility having to rely on a wheelchair or crutches to move around, unable to sit for periods at a time, unable to play with their children or carry their grandchildren. Living daily with the consequences of the operations and procedures they thought would cure them."

To go through an experience like that and still be able to express it speaks to an inner resilience that most of us would be lucky to have. I commend the bravery of the women who volunteered to speak up and share their truths, for without them, the real extent of the problem would have been obscured for some time to come.

It is clear that there was systematic belligerence on the part of those dealing with patient complaints. A theme that runs throughout the investigation is that patients were either not fully informed of the extent or possible side effects of their treatments, or had their concerns written off and ignored. That means that we cannot look at it as an issue about a few practices that have, for the most part, been stopped. The scale of the human cost demands more than an apology. The extent to which complaints and requests for information were mishandled means that the response has to be considered across both the Government and the NHS.

The report sets out nine conclusions, and I am grateful that the Scottish Government has agreed to consider each, with some action already being taken. I acknowledge that the Cabinet Secretary for Health and Sport has apologised to the women affected, and in line with the second recommendation, that the programme for government commits to establishing a patient safety commissioner. I hope that that will be implemented as quickly as possible.

There are some recommendations that can be enacted by the Scottish Government without needing to look for action elsewhere in the UK. The fourth recommendation, on separate schemes for additional treatment, would be particularly helpful. Our amendment falls within that scope, although I will discuss that in detail later. Similarly, the fifth recommendation around a network of specialist centres for treatment, and the seventh, which would improve the data available to audit treatment outcomes, could be actioned now. I am sure that all parties would work constructively on those proposals if the Government were to introduce them.

The Minister for Mental Health (Clare Haughey): I want to correct Annie Wells. She said that the Scottish Government will consider the recommendations, but we have said that we will implement them, and we will accept Jackson Carlaw's amendment to the Government's motion. I am sure that she will welcome that. In the spirit of cross-party working, will she work with her colleagues in Westminster and ask the UK Government to also accept Baroness Cumberlege's recommendations?

Annie Wells: I welcomed the fact that the cabinet secretary and the Scottish Government were accepting the recommendations and that some had already been actioned. I will speak to my colleagues in Westminster to see where they are with the report and its recommendations.

There is cross-party support across the chamber. As we have heard, Jackson Carlaw, Neil Findlay and Alex Neil have worked tirelessly on the campaign for years. I have met the women themselves, and we just want the right thing to be done for those women.

Other recommendations, such as a proposed redress agency, revisions to the MHRA and improvements to the transparency of the GMC, need to be considered on a UK-wide basis, and the Scottish Government's participation would be welcome.

Our amendment intends to ensure that women who require corrective surgery have it performed by a surgeon whom they trust, and that they do not suffer financial penalty for that. That would not only represent a sensible step forward in terms of treatment but would send a message to those affected that we are committed to doing right by them. It would allow them to have confidence in the surgical team to take forward the procedure—confidence that has been shaken by their harrowing experiences over the years.

There has been some debate about the role of surgeons from overseas, particularly Dr Veronikis, as has been mentioned by other members. I, too, urge the health secretary to redouble her efforts to get him here—and, if that is not possible, to allow the women to go to him—for the sake of the women who feel let down in their interactions with the NHS so far. Our amendment seeks to address a fundamental issue as we try to move forward, and I have heard that parties across the chamber will support it.

The Cumberlege report and its conclusions are not easy to read—they should not be. They should, however, focus our minds on the action that must be taken now to ensure that the circumstances that led to the disastrous side effects of medications and treatments cannot occur again, and to ensure that the women who had the courage to speak out after suffering life-changing harms receive the best possible care in the months ahead.

15:57

Joan McAlpine (South Scotland) (SNP): I welcome the opportunity to speak in the debate, and I particularly welcome the news that the cabinet secretary has established such a positive dialogue with Baroness Cumberlege, whose report is so welcome.

My remarks are about sodium valproate, which is a drug that has had devastating effects on some of my constituents. It was given to pregnant mothers, despite extensive evidence that it damaged unborn children. One little girl whom I met outside the Parliament today is only seven years old, yet the drug's dangers have been known since the 1970s.

I have followed the campaign on mesh implants, which has been ably led by colleagues across the Parliament and by the brave women who have been quite rightly praised today. The sodium valproate issue has received less attention, but I hope that, after the Cumberlege report and today's debate, that will change. My constituents Charlie and Lesley Bethune, who recently formed the Scottish first do no harm valproate group, are determined to change that. The families deserve nothing less. As someone who remembers the scandal of thalidomide in the 1970s, I find it shameful that a similar scandal can occur, as if no lessons had been learned at all.

As others have explained, sodium valproate is an anti-epilepsy drug that is also prescribed for bipolar disorder and, occasionally, for migraines. It can cause spina bifida and malformations of the face, skull, limbs, heart, kidney, urinary tract and sexual organs. A lady whom I spoke to outside the Parliament today lost her baby daughter at the age of six months due to a heart defect, and she had other children with developmental disorders. It is estimated that 30 to 40 per cent of affected children have delayed development, learning disability and autism spectrum disorders.

The lady whom I spoke to discovered the connection to sodium valproate only when she met other Scottish campaigners two years ago.

The statistics that I quoted on birth defects appear on a 2018 NHS leaflet that informs mothers who are of child-bearing age who are receiving epilepsy treatment, and I was shocked that that advice was given only in 2018.

Baroness Cumberlege stated that sodium valproate has been licensed in the UK since 1972. She also stated that it was known from the very beginning to be harmful to unborn children, and that no-one disputes that. Even today, hundreds of women who are taking sodium valproate become pregnant without being aware of the risks.

Lesslie Young, the chief executive of Epilepsy Scotland, has also said that clinical trials in the 1970s

> "clearly documented foetal abnormalities in animals as a concern. Yet, it continued to be prescribed to women for over forty years often with little, if any, discussion about the associated risks."

Of course, families that are affected often have the double difficulty of coping with children with significant care needs while their mother has her own medical issues.

Epilepsy Scotland says that despite the pregnancy-prevention programme, mothers are still not getting the information that they need, and, like Kenny Gibson, I back the charity's call for a national epilepsy database along the lines that he described, although I welcome the progress that has been made. That is also the view of the Scottish valproate group, which was formed by my constituents. However, they were very pleased by the announcement of the patient safety commissioner made by the First Minister in the programme for government.

They will also take comfort from the cabinet secretary's apology on behalf of the Government today, and for her acceptance of Baroness Cumberlege's recommendations. The cabinet secretary mentioned the recommendation on specialist treatment centres, which is very important to my constituents, who estimate that 1,500 people in Scotland are damaged in the womb by this drug.

However, many go undiagnosed because of a lack of specialist expertise here; some travel to Manchester to see a neuropsychologist. Without proper diagnosis they cannot have appropriate care packages, and some of those who are damaged before birth will never live independently. Therefore, care is of vital importance, and the group are keen that their needs are considered by the review into adult social care. They also point out that it is important that younger children have a diagnosis to access appropriate educational support.

Recommendation 3 of the report asks for a redress agency. It is absolutely shocking that a legal case involving sodium valproate victims in England collapsed when the complainants lost legal aid. Those people had absolutely no hope against such a giant pharmaceutical company. The Scottish group recognises that regulation is reserved, but if a redress agency is not established at UK level, they ask whether there is anything that can be done in Scotland to hold those responsible to account, because clearly someone is responsible and it is not the mothers who took those drugs.

I will finish by quoting a British Medical Journal editorial that was published after the "First Do No Harm" report. It said:

> "What the Cumberlege team has flagged is the stubborn flaw that lies at the heart of the practice of medicine. It is often called "culture." But this type of embedded attitude seems to go beyond culture, beyond fear of liability, and beyond the profit motive when that exists. It is a patronising and insufficiently curious way of doing business that is often at odds with the realities of helping patients heal and is increasingly out of place in a connected modern world."

Our NHS is wonderful in so many ways, but once we put an institution or certain professionals beyond criticism we enter dangerous territory, and it is for us politicians to ensure that all agencies of the state are open to challenge and that people who are affected by their mistakes are adequately compensated and supported.

The Deputy Presiding Officer (Christine Grahame): All members who remain to speak—whether back benchers or those giving closing speeches—will be given their full allocated time to do so, because the Presiding Officer agreed to a motion to extend the debate until 10 minutes past 5, so not to worry. Although we are running slightly over in this debate, you will be given your full summing up and open debate time.

16:04

Alexander Stewart (Mid Scotland and Fife) (Con): I am grateful for the opportunity to speak on the recommendations in the report by the independent medicines and medical devices safety review. We all acknowledge that medical professionals face difficult situations every day. The Covid-19 pandemic has again brought that sharply into focus. However, we all have the right to expect that the benefits of any treatment recommended to us will outweigh any associated costs. That was not the case with the devastation caused by mesh implants, which have done immeasurable harm to some women. It is important that we acknowledge that today. I welcome the fact that Baroness Cumberlege's report reminds us to "First Do No Harm".

It is shocking that that practice was allowed to continue for so long. We know that over 1,000 women had that treatment after the then cabinet secretary for health, Alex Neil, requested in 2014 that it be suspended. Those women were poorly advised and were not given the appropriate information to make a genuine and informed choice about whether to have the procedure. In some cases, women were not even aware that they were having mesh implanted in their bodies. There must have been a comprehensive and systematic failing in that part of the health system.

Like many members, I have met many of the survivors of mesh implants. I pay tribute to them all for their courage. They experienced wide-ranging complications, including chronic pain and mobility issues. Many women have also suffered difficulties at work and in their personal lives because of those procedures. Their stories are difficult to listen to, but each survivor is brave and resilient.

As we have heard today, we must first acknowledge the pain and hurt those women have endured. It cannot be taken away, but we can and must learn lessons to ensure that we support survivors so that this does not happen again. One of the report's key recommendations is the appointment of a patient safety commissioner. The announcement last week in the programme for government that that position will be established in Scotland is welcome indeed.

It is important that, although accountable to patients, the new commissioner should be completely independent and should not be afraid to speak out and seek the truth. Although many members and others have spoken out on particular issues, patients deserve a champion who is specifically tasked with ensuring that their voices are heard.

The Government has made a commitment to put funding aside for the national mesh programme. I welcome that, but I hope that that will become much more. It cannot be right that the surgeons removing mesh implants from survivors could be the same ones who implanted them in the first place. Women who have had mesh implants understandably have no trust or confidence in those surgeons. Those women should have the right to have the implants removed by a surgeon of their choice, whom they can trust.

That is one of the main reasons why we should support the report's findings. The state failed those women; it is reasonable and responsible for the state to do all that it can to support them. I am delighted that members across the chamber wish to support the Conservative amendment.

As we have heard many times, mesh implants harmed women not only physically, but also emotionally. The report talks about the need for consultation on those emotional effects. I hope that we will support those efforts on mental health: women have not suffered only from physical problems.

Many people, within and outside Parliament, have championed the cause of justice for the women who were affected by that treatment. I pay tribute to my colleague Jackson Carlaw, who has been a champion for those women. He has ensured that the right questions have been asked and that voices were heard in Parliament. I pay tribute too, to Neil Findlay and Alex Neil, whose endeavours have also ensured that outcome.

We must right the wrongs that have occurred, support mesh survivors and ensure that they get the treatment that they deserve and that we never let anything like this happen again. I support the amendment in Jackson Carlaw's name and encourage other members to do likewise.

16:10

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): We have all had constituents affected by these issues, and I want to share—with their permission, of course—a little of the experience of one local family. First, I am delighted that the Scottish Government welcomes the recommendations of the Cumberlege report and is committed to the establishment of the patient safety commissioner in Scotland, as mentioned by so many members.

That will be welcome news to the McKerrow family, who are my constituents, and whose daughter Claire's life has been adversely affected by sodium valproate, one of the key areas covered in the review. The McKerrow family has long been actively involved in attempts to get full recognition of the damaging effects that that prescribed drug has had and continues to have on families. Charlie and Caroline McKerrow gave evidence to the Cumberlege review group when it met in Jurys Inn Glasgow on 13 November 2018. I believe that they were one of only two families who did so. They followed that up by writing to the review team and provided a very personal account of their daughter Claire's story.

I thank Mr and Mrs McKerrow, and especially Claire, for sharing their experiences and informing the Cumberlege review so thoroughly and poignantly of the consequences that sodium valproate has had for their lives and those of similar families across Scotland and the UK. The review is the culmination of years of battling by the McKerrows to be heard. Their motivation throughout those long years has been to prevent other families from being harmed and to obtain financial and care support for their daughter Claire and people like her. The amount of time and effort that that family has dedicated to trying to address the lack of knowledge surrounding the effects of sodium valproate and to highlight the need for care and support for those who bear its consequences is quite remarkable.

Prior to the Cumberlege review, the McKerrows made significant progress, having dealt directly with the BBC, professors of medicine, general practitioners and hospital consultants at each and every stage of Claire's life to demonstrate the link between sodium valproate, the drug that Caroline took while pregnant, and the disabilities that Claire, who is now an adult, has suffered to her growth and development, which have affected her ability to lead a normal family life and to meet any needs that she might have in the future.

Sodium valproate has done that family significant harm, and it is my sincere hope that, as recommended by Baroness Cumberlege, the state and the manufacturers acknowledge that they have a moral responsibility to provide ex gratia payments to those who experienced avoidable damage from the interventions that we have reviewed. I extend my thanks to the McKerrow family, who have never given up their fight to obtain recognition of the damage that sodium valproate did during Caroline's pregnancy.

Over the past few years, I have been approached by several constituents who have experienced transvaginal mesh complications and I also met some of them, as did so many other members in Parliament, in 2017. Those women described their experiences as life altering, telling harrowing stories of excruciating pain and having to give up their jobs, which led to difficulties claiming benefits and relationships with partners breaking down. However, many women have had successful mesh procedures that have been truly transformational for them, so we need to better understand why it works well for some women but has been a disaster for many others.

I am pleased that the Scottish Government has introduced and opened up applications for the £1 million fund created to help support women who have experienced complications, and my constituents welcomed that announcement warmly. I am also grateful to the First Minister and the cabinet secretary for their programme for government commitment to establish the patient safety commissioner role and for their apology to those affected and the families who have had to watch their loved ones suffer.

There has been great disappointment, of course, that Dr Veronikis has not been able to accept the Scottish Government's offer to come to Scotland. I very much hope that the recent Scottish Government letter to him may result in a change in that position.

Neil Findlay: Will the member take an intervention?

Willie Coffey: Hold on a wee minute, please.

I welcome the cabinet secretary's request to NHS National Services Scotland to establish a national designated service for complex mesh removal for those who require specialist surgery to mitigate complications of their surgery.

I am happy to take an intervention, if there is time, Presiding Officer.

The Deputy Presiding Officer: Very briefly, please.

Neil Findlay: I have got a copy of the letter that Dr Veronikis sent to the cabinet secretary. It says:

> "For clarity's sake, I have never received a written offer from the First Minister, yourself, the Scottish CMO or any other government or NHS official. I had taken the project partners that you appointed at their word and have been disappointed."

The Deputy Presiding Officer: Mr Coffey, you must conclude at six minutes, please.

Willie Coffey: I cannot respond to that, Mr Findlay. I can only highlight what the cabinet secretary said in her opening remarks. Perhaps she can address the point when she winds up.

Great thanks are due to Baroness Cumberlege and the review team for listening to families such as the McKerrows, and for making the nine recommendations that form the basis of more work to come. Great thanks are also due to the sodium valproate advisory group members, who listened to the concerns of patient groups. Those families, along with those affected by transvaginal mesh implants and Primodos, have waited too long to obtain the redress that they so rightly deserve.

16:16

Pauline McNeill (Glasgow) (Lab): This harrowing and alarming story has not yet ended, but it has at last been recognised. It is clear to me that the women involved must have a say in the way forward, and I support Alex Neil's suggestion that the independence of a patient safety commissioner is paramount. I would be interested to hear from the minister in her summing up what Dr Veronikis's conditions are, because we did not hear them.

This is a story of pain ignored; complaints not believed; harm that was avoidable if women had been listened to; a culture of an NHS with system failures that do not seem easy to correct; closed doors; a lack of transparency; women's health destroyed; lives destroyed; and a lack of confidence in the system to fix—[*Inaudible*.] If it were not for the powerful efforts of Neil Findlay, Jackson Carlaw and Alex Neil, I would not know about these women, yet it is one of the most disturbing health cases that I have heard in my career.

As Neil Findlay said, women must have control over their own bodies. That is the fundamental basis of women's equality, which is why this situation presents such a serious setback for women in so many damning ways.

The report author, Baroness Julia Cumberlege, and her team travelled throughout the UK, including Scotland, where they met and listened to 700 people, most of whom were women.

The report highlights the shocking experience of so many women who have suffered as a result of mesh being placed in their bodies, sometimes without their full knowledge. It also examines the experiences of women who were given the home pregnancy test Primodos, which is associated with the birth defects and miscarriages that Joan McAlpine talked about, and the anti-epileptic drug sodium valproate, which causes physical malformations, autism and developmental delays in many children when it is taken by mothers during the pregnancy. Unbelievable.

Kath Samson, who founded the Sling the Mesh campaign, has welcomed the recommendations, but she said:

> "The report is hard hitting and recognises the total failure in patient safety, regulation and oversight in the UK.
>
> It also makes it very clear that our medical establishment is deeply entrenched in institutional denial and misogyny."

That statement is hugely telling about the nature of the system failure to the women, which is at the very heart of the problem.

June Lees's story is also typical. In 2009, she had general mesh repair to treat prolapse and incontinence. She said:

> "I had some concerns ahead of surgery ... But was repeatedly told there was nothing to worry about.
>
> The complications started four years later.
>
> I could feel my body deteriorating.
>
> Sometimes the pain is so severe, I feel like I will pass out.
>
> But when I told GPs and surgeons, they didn't believe me.
>
> They just looked at me like I was mad."

The fact that these women were not believed is fundamental to understanding the failures in what happened to them. Sadly, research suggests that women's pain is taken much less seriously by doctors than men's pain. The gender pain gap has a number of serious, far-reaching implications, including that women in acute pain are left to suffer for longer in hospital and are more likely to be misdiagnosed with mental health problems due to misogynist stereotyping that portrays women as being emotional when it comes to pain.

One of the most concerning aspects of the report is that the culture in the medical profession often leads to women's concerns being dismissed. Women found themselves up against a defensive, sexist system—a culture of denial that prevented them from being heard. Rather than being taken seriously, women's problems were routinely attributed to psychological issues.

Baroness Cumberlege notes that, in her travels around the country and the volume of emails and correspondence that she received from patients, it was almost universally the case that women

> "spoke in disbelief, sadness and anger about the manner in which they were treated by the clinicians".

She also said that

> "The words 'defensive', 'dismissive' and 'arrogant', cropped up with alarming frequency"

and that

> "Some clinicians' reactions ranged from 'it's all in your head' to 'these are women's issues' or 'it's that time of life' wherein anything and everything women suffer is perceived as a ... precursor to ... or a post-symptomatic phase of, the menopause."

Lastly, the conflicts of interests in some aspects of the medical profession and the financial links between it and the pharmaceutical industry are highlighted in the report, which states:

> "All that we have heard leads us to conclude the system is not safe enough for those taking medications in pregnancy or being treated using new devices and techniques"

and

> "The issue here is not one of a single or a few rogue medical practitioners, or differences in regional practice. It is system-wide."

Therefore we must immediately set it as a priority that we give these women the healthcare that they demand and trust, whatever that might be. The Minister for Older People and Equalities should consider how these women were treated—it was with an attitude that is unacceptable in any public service. I hope that members can work together with ministers, the women and others who have been affected by the issue to ensure that it never happens again.

16:22

Rona Mackay (Strathkelvin and Bearsden) (SNP): "First Do No Harm" is the title of Baroness Cumberlege's review and recently published report on three life-changing medical interventions that have harmed women beyond measure.

As we have heard in the debate, the hormone pregnancy test Primodos, the anti-epileptic drug sodium valproate and surgical mesh implants have been long-standing sources of huge concern and controversy for many sufferers in Scotland and throughout the UK—since before I was elected in 2016. We now know that terrible harm was done by those drugs and that invasive, damaging treatment, which should never have been given to women. Collectively, thousands of lives have been ruined and an entire generation is paying the price for clinical mismanagement.

Baroness Julia Cumberlege's review considered a range of matters, including whether any further action is needed relating to the complaints around Primodos, sodium valproate and surgical mesh; the processes that are followed by the NHS and its regulators when patients report problems; and how to ensure that communication between the different groups involved, which until now has been entirely non-existent, could be improved. The review has also made recommendations regarding the three specific interventions but also on how the healthcare system could improve its response to concerns that are raised about other medicines and medical devices in the future.

Sadly, the fact that such medical outrages affect women is not surprising. I entirely agree with Alison Johnstone, Clare Adamson, Pauline McNeill and others on that. Historically, women's health has been at the back of the queue for priority. We know from the work of the Parliament's cross-party group on women's health, which is convened by Monica Lennon, and the work that has been done by my ministerial colleague Christina McKelvie that many long-standing issues affecting women's health need to be addressed now. For far too long, a range of conditions such as endometriosis, perinatal care, thyroid problems, the effects of the menopause, painful periods and much more have been seen as women's issues. Thankfully, societal and clinical attitudes are finally changing, but it should not have taken so much work and the suffering of victims to get to where we are now.

For two and a half years, Baroness Cumberlege and her team travelled across the UK and met more than 700 women and their families to find out the impact that these medical devices had. What they heard was harrowing: relationships destroyed, lost homes, broken careers and financial ruin. Some women had even faced their children being taken into care. Baroness Cumberlege said:

> "They spoke of the most intimate details not only about their lives, but about their bodies. They spoke with such dignity and courage. Above all I want to thank them."

Mesh sufferers in Scotland have been through too much. Their fight for justice and recognition should never have had to happen. On top of their disabling health issues, the mental exhaustion of battling against a system which was, for far too long, in denial, must have been completely overwhelming.

During my time as an elected politician, Olive McIlroy and Elaine Holmes have been at the forefront of that battle and I wish to express my admiration for their strength, which is a constant source of amazement to me. I must also mention the great work that has been done by the "meshketeers"—Neil Findlay, Alex Neil and Jackson Carlaw—in highlighting the plight of these women in this chamber and beyond. Thanks, too, should go to campaigning journalist Marion Scott, who has been with the women every step of the way, unflinching in her determination to help them to achieve justice.

There is not enough time to go over all the watershed moments in the mesh sufferers' plight, but we have heard many of them today. Where are we now and are we finally getting there when it comes to some sort of reparation?

I was pleased to hear the cabinet secretary outline the progress that has been made. The Scottish Government has implemented one of the Cumberlege review recommendations by appointing a patient safety commissioner for Scotland, as announced in the programme for government last week. I support Alex Neil's proposal that the post should be independent. That is a welcome initiative but, sadly, it is one that the UK Government has yet to ratify. A £1 million mesh fund for sufferers has also been established, which is open now, to help with problems relating to their conditions.

Scotland's new national mesh service is a huge step forward for campaigners and one that has been long fought for. However, I was unaware of the claims that were made by Neil Findlay today and I would like to find out more about that. It sounds very concerning. Patients should come first and the women must be listened to.

Nevertheless, I hope that the Cumberlege report will act as a watershed moment and that women will be listened to and heard, because this is a human rights issue for women and it is a humanitarian issue. All of us must believe that it is finally being addressed and that the courage of all the women affected by drugs that they should not have been given or treatment that they should never have been subjected to will be recognised and their fight will help generations of women to come.

16:27

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I will start, as others have done, by thanking Jackson Carlaw, Neil Findlay and Alex Neil for their efforts in championing women who have been afflicted by mesh implants. Most of all, I thank the women campaigners and mesh survivors.

I have written to the cabinet secretary regarding the matter that I am raising this afternoon. In my constituency surgery in 2014, I heard from a constituent whom I will not name. She raised the same issues that we have heard right across the chamber this afternoon. Her consultant at the time insisted that my constituent was receiving not mesh but tape. Indeed, her consultant, just last year, remained adamant that, at that time, the Scottish Government had not sought to suspend mesh implants. Both those assertions were simply not true.

At a follow-up meeting with another clinician ahead of my constituent's surgery, that clinician raised concerns over the procedure and suggested that my constituent thought carefully before agreeing to the procedure. However, the final meeting was with the consultant surgeon once more, who again told my constituent that the procedure was perfectly safe and involved the use of tape as opposed to mesh and that concerns were being exaggerated. My constituent clearly feels misled and misinformed by her consultant.

It is hardly surprising that women feel so badly let down and will struggle to have confidence in any national pelvic mesh removal service. I therefore support Jackson Carlaw's amendment, which states that this

> "must include the early prospect of full transvaginal mesh removal surgery being undertaken by surgeons who enjoy the full confidence of the women affected, fully funded by the NHS."

That brings me on to some of the points that were raised by Neil Findlay. Like other mesh campaigning women, my constituent has asked a number of questions; Neil Findlay mentioned some of those this afternoon as well.

I was asked to find out who will be running the new mesh centre and the names of the surgeons doing full TVTO—tension-free vaginal tape obturator—removals. My constituent is concerned that her consultant from 2014 is part of that team. I was asked what additional training, if any, the surgeons have received in mesh removal and who trained them in the full removal process; how many TVTO removals have been done in the past five years and, of those, how many were full removals; and how many patients found it successful and how many consider it to have failed.

Mr Findlay calls for the halt of the development of the specialist service until those questions have been answered. That might be a moot point, because I suggest that many of the women might not engage with the new specialist service anyway unless those questions are answered. What level of detail can my constituents and others expect as the Scottish Government addresses the questions that have been raised?

Following surgery, my constituent had substantial and almost immediate health issues. She struggled to be taken seriously and to be listened to and not simply dismissed—that is a common theme across the chamber today. Indeed, my constituent felt that lies and misinformation continued throughout. She continues to be in severe pain and has mobility issues. She believes that she continues to get conflicting information. On the one hand, she has been told that she has had tape and not mesh, and on the other hand she has been told that tape can be removed, only to discover that that would be a clip and a partial removal. Those themes are fairly consistent in all the stories that are in the public domain.

I would welcome more information on the case record review that will be carried out for mesh-injured women, which we have heard about this afternoon. That will be important to building up trust. I commend Jeane Freeman's speedy action in responding to the powerful Cumberlege report. She has accepted the recommendation for a patient safety commissioner, provided £1 million for mesh survivors and taken steps to develop a national mesh removal service, as well as given an on-going commitment to continue to engage with Baroness Cumberlege. Those are all vital actions, although I suggest that they are probably a starting point.

I urge the NHS and the Scottish Government to allow mesh survivors to make an informed choice over treatment where possible. I do not know how we do that. It might mean Dr Veronikis performing mesh removal and supporting aftercare, which is the important thing, in Scotland or somewhere else; alternatively, it might be done through building confidence in the national complex mesh removal service. We need what works for the women who are victims. That is the underlying and most powerful aspect that we are debating today. On that issue, we have complete cross-party agreement, from Government and Opposition, and we are mapping out together how best to get there.

16:32

Alison Johnstone: Baroness Cumberlege concluded that

“the system is not safe enough”.

She pointed to “systemic failings” and noted that patients have

“suffered at the hands of clinicians”.

Her recommendation 1 was:

> “The Government should immediately issue a fulsome apology on behalf of the healthcare system to the families affected”.

I very much welcome the fact that the cabinet secretary did so this afternoon in her opening remarks.

We have been debating the issue in the Parliament over a long period, and we are not finished yet. It is absolutely essential that we prioritise time in the chamber until we are satisfied that everything that can be done has been done for the mesh survivors and all who have been impacted. I share others' frustrations—frankly, it seems tragic that we still have no agreement in relation to Dr Veronikis coming to Scotland so that those who need his help most can benefit from it.

Alex Cole-Hamilton was right to highlight the dignity of the mesh survivors in the face of so much pain, suffering and frustration. There have been many excellent contributions, so I will struggle to refer to them all. I agree wholeheartedly with Alex Neil that the patient safety commissioner should be a wholly independent appointment, with the power that will make a difference. As Alexander Stewart said, the commissioner should be a champion for patients.

Brian Whittle pointed out that this is not the first time that we have debated mesh, and it absolutely will not be the last time that we do so. When we debated the issue in 2017, in response to a statement, I noted:

> “Ninety-eight per cent of the women in the report said that their consent to mesh surgery was not informed, and 70 per cent said that their surgeon was not open to the idea that mesh was the cause of their symptoms.”—[*Official Report*, 30 March 2017; c 66.]

There is much to debate in that idea of informed consent. What does it mean? It means that permission is granted by the patient in full knowledge of the possible consequences, and I think that many of us across the chamber are aware that the women did not understand what the potential consequences were. I would be extremely grateful if the cabinet secretary could elaborate on what information women might expect to receive in the future in relation to any procedure that they might be going to have. It is not always enough to be offered a booklet; it is important that people have the chance to speak to others who have suffered in a similar way.

Bob Doris was right to highlight the questions that remain outstanding. He noted that women are still receiving conflicting information about the device that they have implanted in their bodies. Alexander Stewart made that point, too. The review highlights instances in which women did not know that they had had mesh implanted, or in which the mesh was referred to by another name, such as “tape”. There were even cases in which women had been told that they had undergone full mesh removal only to find out later that that was not the case.

Likewise, we have heard today of women who were never told of the effect that valproate could have on their unborn children. I am sure that we would all agree that that is simply unacceptable. Despite the fact that it was not their fault, heartbreakingly, many of the women told the review about their guilt and the terrible toll that their treatment had taken on their relationships and family life.

More must be done to improve health literacy and to ensure that the benefits and risks of medical interventions are explained clearly and in a way that patients can understand. The review states:

> "every patient should be able to stand back, look at their patient journey and say 'I recognise my handwriting all over those choices.'"

I wonder how many patients in Scotland who were involved in the cases that we have discussed this afternoon can do that.

The review notes that, in parts of our NHS, there remains an overriding culture of "Doctor knows best", and many people who access health services will not feel confident enough to challenge their clinician's recommendations—some might not even know whether they can. I would be interested to hear what action the Scottish Government will take to get out the message, and to emphasise, that patient care should be the result of a conversation in which the patient participates fully.

I will vote for Jackson Carlaw's amendment—in fact, I will vote for all the amendments. Jackson Carlaw's amendment is absolutely correct: it is imperative that the mesh survivors have access to full mesh removal surgery, and that that is provided at no cost to them. That is the very least that they deserve.

I will also support Neil Findlay's amendment, which calls for a temporary suspension of the development of the removal service, because it is absolutely essential that those who access that service have complete trust and faith in the people who will undertake their surgery. I appreciate the cabinet secretary's comments about two processes continuing at the same time, but there can be no more errors. These women have put up with enough, and they must have whole-hearted confidence in the service.

Joan McAlpine rightly highlighted the challenges for those who seek redress, particularly when they come up against large bureaucratic organisations and companies. We must make sure that there is sufficient strength in the system for individuals to challenge decisions that, frankly—given the impacts that they have had on lives—have been devastating.

In drawing to a close, I want to mention Rona Mackay and Pauline McNeill, who rightly highlighted that system-wide failures have had a huge impact on women. We have some way to go, and I look forward to continuing to debate this important issue with colleagues across the chamber.

The Deputy Presiding Officer: I call Neil Findlay to close for Labour.

16:38

Neil Findlay: We might have had to wait eight years for this debate, but it has been an excellent one. I commend Clare Adamson, Dave Stewart, Alison Johnstone, Alex Cole-Hamilton, Pauline McNeill and, of course, Jackson Carlaw and Alex Neil on their speeches, but I have to say that I thought that the best speech of the day was Bob Doris's speech—it was an absolutely outstanding contribution to today's debate.

Primodos and sodium valproate caused horrific damage to children. As happened with mesh, the medical establishment, led by the big pharmaceutical companies, closed ranks and denied that there was a problem. We had denial, cover-up, regulatory failure, governance failure, institutional greed and professional arrogance, and all the time profit was placed before people.

I have been thinking back to 2012, when I first got involved in this campaign. I will tell you something that you might balk at, Presiding Officer, but it is a quote. We called a press conference to try and get the Scottish media interested in the issue, and just one journalist turned up. I asked this very senior journalist from the parliamentary press pack why other journalists did not turn up. He said:

> "We don't write about women's fannies."

That is what he said: that we could not discuss medical problems about a woman's anatomy or reproductive system in 2012 in Scotland in this Parliament. Forget the fact that, only a few years back, the same newspaper had been printing photographs of semi-naked women. That is how far we have travelled since 2012.

I have to say thank you to the campaigning journalist, Marion Scott, who is an outstanding tour de force. Without her help, we would be nowhere near where we are today. I also thank every one of those women who have campaigned and pushed this issue at every opportunity.

Baroness Cumberlege's review is a watershed. She reported:

> "The issue here is not one of a single or a few rogue medical practitioners ... It is system-wide."

She said that the system

> "has failed to listen to ... concerns and when, belatedly, it has decided to act it has too often moved glacially."

The fact that it has taken eight years to bring a debate to the chamber simply confirms the point that Baroness Cumberlege makes about that glacial progress. The review is a damning indictment of the failings in the system across all three areas. There have been similar experiences for victims, with a lack of information to make informed choices; a lack of awareness about who to complain to and how to report adverse incidents; a struggle to be heard; women not being believed, dismissive and unhelpful attitudes from clinicians; a sense of abandonment; and life-changing consequences for the patient, their friends and family. Various members have mentioned family breakdown; the loss of jobs, financial support and sometimes housing; a loss of identity and self-worth; persistent feelings of guilt; and children becoming their mothers' and siblings' carers. Clinicians have been untutored in the skills required to carry out proper diagnosis and treatment, and they have not known how to learn from patients. There have been inaccurate and even altered patient records. There has also been a lack of interest in monitoring adverse outcomes.

I am a great champion of the NHS, which is the greatest social policy ever implemented. However, when things go badly wrong, it must be better than it is. It must accept that and respond to mistakes.

The nine recommendations in the report come with a number of changes attached, and the Government has already issued a fulsome apology, on behalf of the healthcare system, to the families affected by Primodos, sodium valproate and pelvic mesh. We have heard nothing, however, from NHS boards. We have heard no apology from clinicians, the regulator or the manufacturers. Where is their apology for their role?

The Government has agreed to a patient safety commissioner, and that is very welcome, but that person must carry the confidence of survivors of mesh, Primodos and sodium valproate, and I suggest that survivors should be heavily involved in the recruitment of that person. Alex Neil's suggestion is a good one: they cannot be a hand-picked placewoman or placeman. Alex Neil's suggestions provide a sensible way forward.

I hope that patients will be at the centre of the review group that is to be established, so that they can oversee the implementation of everything that needs to be done. That work should be done properly—unlike what took place at the time of the independent review in Scotland, when all sorts of shenanigans went on to exclude patients from the body's decision making.

My greatest concern is over the new mesh service. I desperately want it to work, and I hope that it is a roaring success, but I do not want it to work as much as the Scottish mesh survivors do. They could have the opportunity to be free of pain and suffering and the constant psychological trauma of having that poison in their body. They are desperate for the service to work.

However, I fear that we are about to repeat the very mistakes that Baroness Cumberlege has just identified. None of the Scottish mesh survivors has been involved in the design of the service, which has been done by a hand-picked few, through the alliance. The Scottish mesh survivors group do not even know who they are—I have just had a text from them telling me that.

The review identified

> "the struggle to be heard ... clinicians untutored in the skills they need ... dismissive and unhelpful attitudes",

failures of governance, professional "arrogance", failed regulation and "defensiveness". We have the opportunity to help women, but if we ignore the concerns that they have raised about the new service we will repeat the mistakes of the past. Let us stop non-urgent procedures now, pause the development of the service—not scrap it; no one is saying to do that—take on board survivors' concerns and answer all the questions that Bob Doris laid out. They are the very legitimate questions that the Government has been written to and asked about.

We must take on board those concerns and take input from the women. They are knowledgeable, talented and intelligent, and they will help design a service that we and they can be proud of. I plead with members: do not allow us to collectively repeat the mistakes that Baroness Cumberlege has identified. Let us do no harm.

The Deputy Presiding Officer: Before I call Jackson Carlaw, I am minded to accept a motion without notice, under rule 11.2.4 of the standing orders, to move decision time to 5.10 pm.

Motion moved,

That, under Rule 11.2.4, Decision Time be moved to 5.10 pm.—[*Graeme Dey*]

Motion agreed to.

16:46

Jackson Carlaw (Eastwood) (Con): This is the first closing speech in Parliament that I have given for several years; I have been detained in other ways. I am absolutely delighted to be able to contribute to a debate as outstanding and informed as the one that we have had this afternoon.

Most of the content that I want to address relates to the mesh scandal and the way that it has unfolded, but first I want to thank Kenny Gibson, to whom I must apologise—his lectern was up earlier, and I was not sure whose it was; I asked Brian Whittle whether Christine Grahame was sitting there, which might be the first time that that mistake has been made. I want to thank Kenny Gibson, as well as Joan McAlpine and Willie Coffey, for bringing in the issues relating to sodium valproate and Primodos, which is an issue that Theresa May has also focused on at Westminster. All the health scandals that are summed up in the work of Baroness Cumberlege deserve attention. I am so pleased that the Government is taking forward the recommendations that have been made.

On 25 November last year, the First Minister met with many of the mesh women. It is true that that was during a general election, although it is a little uncharitable to suggest that there was a connection. That meeting was in response to a request that I made at First Minister's questions—as I recall, the original date was postponed due to a bereavement in the First Minister's family. She also met a second group of women in Edinburgh. The First Minister heard first hand the powerful testimonies that members of this chamber have heard when meeting those women over a great many years.

Five years before that, as we have heard, Elaine Holmes and Olive McIlroy launched their petition in the Parliament. Several years earlier, in 2007, mesh procedures first began in the NHS. One could point out that Nicola Sturgeon was health secretary then, but that is coincidence rather than a consequence. Therefore, over three sessions of Parliament, we have gone from the implementation of mesh implants to hearing what the consequences of mesh implants have been and going through a series of investigations and reports on what we would do about the issue. Now—months away from a fourth parliamentary session—we must ensure that we finally resolve and draw a line under the suffering of the women who have been subject to mesh implants.

Recommendation 6 is on the MHRA. Angus MacDonald might be the only surviving member of the Public Petitions Committee from that time—I apologise if there are others—who heard the appalling testimony of the MHRA's representative. In front of a room full of mesh-suffering women, he told the committee that the approvals process had been a two-week desktop study by three students at a cost of £20,000 and that, as far as he was concerned, maybe a handful of women had been adversely affected—never mind the rows of women who were sitting behind him as he spoke.

If any service is unfit for purpose, it is the MHRA. Medicines regulation is a reserved function at Westminster, but that is not an issue of contention. If a motion on the issue ever came before the Scottish Parliament, all parties would be united in saying that the position must be addressed and completely changed.

It was after that meeting that we found out that some of the people in the MHRA had direct links to the industries that were producing the mesh product—links that had gone undeclared and from which they were profiting. That is completely unacceptable and it is why the MHRA requires to be the subject of major change and review. We will support the cabinet secretary in arguing for that to take place.

Many people have talked about the way in which the women's voices have been dismissed and about the way that they were treated. Those of us who sit on the cross-party group on chronic pain know that that goes on today. Men are asked, "Did you play football when you were younger, son? Did you have an accident at work? Were you in the armed forces, or were you a fighter in your youth?" Women are asked, "Are you feeling a bit under the weather with all that you're having to do? Can we give you some antidepressants and see if that helps?" There is a ridiculous inequality in the way that women are treated in the health service. If people stand up and say that they are suffering unbelievable chronic pain and are unable to carry on with their normal lives, it is because they probably are. The symptom should be taken seriously and addressed.

In a Public Petitions Committee meeting, I and others sat in a room in which we saw men in grey suits argue to the women who were sitting at the back of the room that it was all in their heads, that they really were not suffering at all and that, if they could speak to somebody about it, they would probably get over it all and all would be well. They were not people whom we might meet in the street; they were the clinicians who had been implementing the mesh and who were in complete denial that there was any adverse consequence.

I remember when Elaine Holmes walked through the door of my constituency office, trembling at the thought of having to discuss with a man something that was unbelievably intimate. It is because of her courage that I have been happy to work on the issue across parties for the past three sessions. It has become an issue that I have become more passionate about than anything else, and I am determined to see justice achieved.

We should remember that much of the progress that has been made is about preventing this from happening again. That was the objective of the women concerned. They did not really think that mesh removal was an option—just think about the way in which tissue grows around mesh and the extraordinary difficulty, if not excruciating pain, of trying to remove it. However, we have moved from that to a point at which mesh removal is now an option.

That is what underpins my amendment. Like Alex Neil, I do not necessarily want to get into the whys and wherefores of what Dr Veronikis may or may not do or what he might have said about coming here. A finite number of women are involved. We may still have to quantify how many there are but, if no further mesh is being implemented, the number is quantifiable. I want those women to know that, if it comes to the bit, they can go to the United States and to Dr Veronikis, and they can have the mesh removed, fully funded by the NHS.

Two of my constituents—Elaine Holmes, at a cost of some £20,000, and Lorna Farrell—have done that. Members can watch Lorna Farrell on YouTube. Having had the mesh removed, she went to the bottom of the steps in Philadelphia that Rocky Balboa ran up. With her crutches and out of her wheelchair for the first time in years—to be honest, I think that she took on more than she realised—she struggled up to the top of those steps and turned in triumph, having got some control back over her life. Whether it is there or through the other processes that the First Minister and the health secretary are seeking to achieve, I want that to be an option that is open to all the women who have given so much of their own lives to fight for the cause, so that they have hope for the future.

Some members have been quite kind about Neil Findlay, Alex Neil and me this afternoon. We met earlier today and we solved all the problems of the world so, if the Government falls, we stand ready to serve, and we are flattered by members' confidence.

However, many other people have been involved. Marion Scott, who is an investigative journalist, has been mentioned. She has been an absolutely tireless emotional support to the women. Mandy Rhodes and the *Holyrood* magazine team have been hard working on the issue as well. Wael Agur has enjoyed the confidence of the women throughout, and of course I acknowledge the work of Elaine Holmes, Olive McIlroy and other women who have tirelessly campaigned on the issue over three sessions of Parliament.

Two of the meshketeers have indicated that they will not be returning to the Parliament for a fourth session's work on the issue. I can only say that if the electorate is kind enough to return me, I will work with Rona Mackay and others who have become real champions of the issue over the past few years to ensure that the resolutions that we make today and the recommendations that we implement finally draw a line under the mesh scandal, and that we give all those women the justice that they deserve.

The Deputy Presiding Officer: Thank you, Mr Carlaw. I call Jeanne Freeman to close for the Government.

I beg your pardon. It is not my fault—my notes are wrong. Someone has erred. I am looking around. I call Clare Haughey to close for the Government.

16:55

The Minister for Mental Health (Clare Haughey): I thank all members who have contributed to the debate. I extend my thanks to Baroness Cumberlege and her review team, and to those who contributed to the report's findings. The Cabinet Secretary for Health and Sport and I were grateful to meet the baroness and her team yesterday. She spoke of the courage, determination and strength that was shown by those who came forward to tell their stories. We echo her thoughts.

I take this opportunity to reiterate the cabinet secretary's apology to all those who have been affected by Primodos, sodium valproate and mesh. Their tireless campaigning to bring their feelings to public attention, while also coping with pain and such upset, has been, and remains, courageous beyond description.

We know that, for too long, women's concerns have not been heard or, when they have been heard, have not always been taken seriously. That is not acceptable. Voices must be heard, so we are determined to do all that we can to ensure that we continue our actions to put that right, and to ensure that women receive the care and the treatment that they need. Similarly, that applies to the women, children and families of people who have been impacted on by Primodos and sodium valproate.

The patient must be at the centre of every decision that is taken about their care. Baroness Cumberlege made it clear when we spoke to her that she is determined to see her recommendations being taken forward, and for her report to inspire, and to be a force for, change across the UK's healthcare systems. Both the cabinet secretary and I are fully behind Baroness Cumberlege, and are similarly determined that Scotland should lead the way.

With that in mind, it is important to remember that the baroness's report is the latest in a series of reports, including one in 2017 on the Scottish Government's independent review of mesh. I hope that it is clear to Parliament and—first and foremost—to those who have been affected, that we are listening and will continue to do so.

Baroness Cumberlege's report gives clear justification for many of the decisive actions that the Scottish Government has taken in recent months and years. We brought a halt to use of transvaginal mesh in Scotland and have no plans to change that. We have established a £1 million fund to help women with the cost of the emotional and practical support that they need as a result of mesh complications, and we have progressed plans for a mesh specialist service. Informed consent and shared decision making will be central to that service, which will fully align it with the principles of realistic medicine.

We have established a review of case records for women who raised concern about the extent of their mesh removal. That review will begin soon, and further information will be provided by the Government as soon as possible.

Neil Findlay: The minister mentioned shared decision making. We know from women who have been in contact with the specialist service that some of them have been excluded from multidisciplinary team meetings to discuss their healthcare. That is among the concerns that are being raised. It should not be happening.

Clare Haughey: The independent case review will look at that, among other issues.

We note members' concerns about women who want, because they lack trust in services, to seek treatment elsewhere. It is vital that every time a patient accesses any part of the healthcare system, that person can have confidence that they will receive the best available treatment, without fear of harm.

For that reason, we are establishing a patient safety commissioner role—something for which Baroness Cumberlege advocated passionately yesterday. That is now a programme for government commitment. As members heard today, what the role looks like, where it sits and how it functions must take into account the Scottish landscape and will, of course, require input from patients and the wider public. Alex Neil and other members raised that important issue.

The Scottish Government is beginning consultation on the patient safety commissioner role. Patients, who are at the heart of the issue, are the first people whom we are consulting. Our commitment to patient safety has been, and remains, key to the delivery of healthcare in Scotland. The role will operate alongside our world-leading patient safety programme.

As the cabinet secretary said in her opening speech, it must be remembered that it is outwith the Scottish Government's gift to act on some of Baroness Cumberlege's recommendations. I welcome the Scottish Conservatives' commitment to work with us and to encourage the UK Government to act on some of the issues.

The Scottish Government will meet the General Medical Council and the MHRA over the next few months, and we will seek further reassurance on areas that are not within our devolved powers. We will also do all that we can to ensure that the views of Scotland, as an equal partner, are taken forward, and we will offer support to the UK organisations whenever we can. Scotland has long called for reform of the MHRA, so that it becomes more patient focused and outward facing. That is no secret. We are encouraged by the steps that the agency has taken towards reform, thus far. The cabinet secretary wrote to the MHRA in support of its efforts, and we will continue to press for change to remain a priority.

A key recommendation is about the need for better data, as Brian Whittle said. We can work closely on that with the MHRA and others across the UK. The matter is important for patient safety, and has been highlighted by clinicians in the context of sodium valproate. The MHRA and NHS Digital are working on a sodium valproate registry. Kenneth Gibson supported the approach and Joan McAlpine talked about a national registry, in that regard. I confirm to Parliament that we will give early and active consideration to establishing a national sodium valproate registry. In addition, we will consider what else might be needed in Scotland for people who are affected by sodium valproate and by Primodos.

It is important that Parliament comes together to support the themes and recommendations of Baroness Cumberlege's review and to ensure that they are embedded in our health service. As the First Minister has said in Parliament, and as we have said in the debate, we urge people who have genuine concern about the issues to work with us. We must work to rebuild women's trust in services; our working together would be a helpful step. We have seen in today's debate what cross-party support can achieve.

I was struck yesterday by Baroness Cumberlege's passion and her determination to ensure that her recommendations are implemented. We will, in the spirit of working together, continue to seek her views, as the cabinet secretary said, as we progress the work in Scotland.

There have been passionate and interesting speeches from members in today's debate—I have acknowledged a few of them. As Donald Cameron said, and as the baroness said yesterday in her meeting with the cabinet secretary and me, it is important that Scotland leads the way and is at the forefront of implementing the recommendations of the review.

Alex Cole-Hamilton talked about surgery being undertaken by surgeons who enjoy the full confidence of the women who have been affected by mesh. We will support Jackson Carlaw's amendment on that. I hope that that reassures Mr Cole-Hamilton.

We heard considered speeches from David Stewart, Clare Adamson, Willie Coffey and Alison Johnstone. Members ably recounted some very difficult constituency cases in which they had been involved.

I cannot stress enough the importance of rebuilding women's trust in our services; Baroness Cumberlege made that point yesterday. We know that there is more work to do to ensure that that happens, and we are acting. I urge members of all parties who have raised concerns to work with us.

Period Products (Free Provision) (Scotland) Bill: Financial Resolution

17:06

The Presiding Officer (Ken Macintosh): The next item of business is consideration of motion S5M-22484, on a financial resolution for the Period Products (Free Provision) (Scotland) Bill.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Period Products (Free Provision) (Scotland) Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3(b) of the Parliament’s Standing Orders arising in consequence of the Act.—[*Ben Macpherson*]

Business Motion

17:06

The Presiding Officer (Ken Macintosh): The next item of business is consideration of business motion S5M-22649, in the name of Graeme Dey, on behalf of the Parliamentary Bureau, setting out revisions to Thursday's business.

Motion moved,

That the Parliament agrees to the following revision to the programme of business for Thursday 10 September 2020—

delete

2.30 pm	Parliamentary Bureau Motions
2.30 pm	Portfolio Questions: Transport, Infrastructure and Connectivity
followed by	Stage 1 Debate (Committee Bill): Scottish Parliament (Assistance for Political Parties) Bill
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.05 pm	Decision Time

and insert

2.45 pm	Parliamentary Bureau Motions
2.45 pm	Portfolio Questions: Transport, Infrastructure and Connectivity
followed by	Stage 1 Debate (Committee Bill): Scottish Parliament (Assistance for Political Parties) Bill
followed by	Ministerial Statement: Internal Market Update
followed by	Business Motions
followed by	Parliamentary Bureau Motions
4.15 pm	Decision Time—[*Graeme Dey*]

Motion agreed to.

The Presiding Officer: I am minded to accept a motion without notice to bring forward decision time to now. Minister, would you move such a motion?

Motion moved,

That, under Rule 11.2.4, Decision Time be brought forward to 5.07 pm.—[*Graeme Dey*]

The Presiding Officer: Does any member object if I move decision time forward to now?

Neil Findlay (Lothian) (Lab): On a point of order, Presiding Officer. Does that mean that the bell will go now, or has the bell already gone?

The Presiding Officer: Both bells have already rung, and I am conscious that, if we have a division, we will suspend, so there will be a break.

Neil Findlay: The reason I ask is that members were advised that decision time would be 10 past 5.

The Presiding Officer: That is right. Decision time was delayed until 10 past 5. Either the motions and amendments will be agreed to unanimously, in which case there will not be a division and no one will miss out, or there will be a division, in which case there will be a technical break and plenty of time for members who have not yet made it to the chamber or who are online to join us. I am moving decision time forward by only five minutes.

Mr Findlay has made a point of order. I think that I will just wait till 10 past 5, if members do not mind.

Decision Time

17:10

The Presiding Officer (Ken Macintosh): There are several questions to be put as a result of today's business.

The first question is, that amendment S5M-22635.1, in the name of Jackson Carlaw, which seeks to amend motion S5M-22635, in the name of Jeane Freeman, on Baroness Cumberlege's report, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that amendment 22635.3, in the name of Neil Findlay, which seeks to amend motion S5M-22635, in the name of Jeane Freeman, on Baroness Cumberlege's report, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: We are not agreed. We will move to a division on the amendment, but we will first have a technical break to make sure that colleagues online are logged in to the remote voting system. I will suspend Parliament for a few moments while we make sure that everybody is logged in online and in the chamber. To colleagues who are online: do not worry if you cannot hear anything for a minute while broadcasting is suspended—we will be back. Do not panic if you hear nothing for the first minute.

17:11

Meeting suspended.

17:28

On resuming—

The Presiding Officer: We move to the vote on amendment S5M-22635.3, in the name of Neil Findlay, which seeks to amend the motion in the name of Jeane Freeman, on the Baroness Cumberlege report. Members may vote now. This will be a one-minute division. If any member has difficulty voting, they should raise their hand and someone will come over to address the problem. Members who are not able to vote online should raise their issue online.

Colleagues, the vote has closed. However, because we had some technical difficulties with this vote, I ask any member who thinks that they were not able to vote to raise a point of order so that I can formally recognise that for the record.

Stuart McMillan (Greenock and Inverclyde) (SNP): I had some difficulties. I would have voted no.

The Presiding Officer: That is noted. Margaret Mitchell, can you confirm whether you think you were able to vote, for the record?

Margaret Mitchell (Central Scotland) (Con): I was not able to vote. I would have voted yes.

The Presiding Officer: I note both of those comments. I will now direct the clerks to change the vote to ensure that both of those votes are added before we announce the result.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Balfour, Jeremy (Lothian) (Con)
Ballantyne, Michelle (South Scotland) (Con)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Bowman, Bill (North East Scotland) (Con)
Boyack, Sarah (Lothian) (Lab)
Briggs, Miles (Lothian) (Con)
Burnett, Alexander (Aberdeenshire West) (Con)
Cameron, Donald (Highlands and Islands) (Con)
Carlaw, Jackson (Eastwood) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Peter (North East Scotland) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Davidson, Ruth (Edinburgh Central) (Con)
Fee, Mary (West Scotland) (Lab)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Green)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Golden, Maurice (West Scotland) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Greene, Jamie (West Scotland) (Con)
Greer, Ross (West Scotland) (Green)
Hamilton, Rachael (Ettrick, Roxburgh and Berwickshire) (Con)
Harvie, Patrick (Glasgow) (Green)
Johnson, Daniel (Edinburgh Southern) (Lab)
Halcro Johnston, Jamie (Highlands and Islands) (Con)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Glasgow) (Lab)
Kerr, Liam (North East Scotland) (Con)
Lamont, Johann (Glasgow) (Lab)
Lennon, Monica (Central Scotland) (Lab)
Leonard, Richard (Central Scotland) (Lab)
Lockhart, Dean (Mid Scotland and Fife) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Mason, Tom (North East Scotland) (Con)
McNeill, Pauline (Glasgow) (Lab)
Mitchell, Margaret (Central Scotland) (Con)
Mountain, Edward (Highlands and Islands) (Con)
Mundell, Oliver (Dumfriesshire) (Con)
Rennie, Willie (North East Fife) (LD)
Rowley, Alex (Mid Scotland and Fife) (Lab)
Rumbles, Mike (North East Scotland) (LD)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Sarwar, Anas (Glasgow) (Lab)
Scott, John (Ayr) (Con)
Simpson, Graham (Central Scotland) (Con)
Smith, Elaine (Central Scotland) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Smyth, Colin (South Scotland) (Lab)
Stewart, Alexander (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wells, Annie (Glasgow) (Con)
Whittle, Brian (South Scotland) (Con)
Wightman, Andy (Lothian) (Green)
Wishart, Beatrice (Shetland Islands) (LD)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Denham, Ash (Edinburgh Eastern) (SNP)
Dey, Graeme (Angus South) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Ewing, Annabelle (Cowdenbeath) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Freeman, Jeane (Carrick, Cumnock and Doon Valley) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Harper, Emma (South Scotland) (SNP)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Uddingston and Bellshill) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Macpherson, Ben (Edinburgh Northern and Leith) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McKee, Ivan (Glasgow Provan) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robison, Shona (Dundee City East) (SNP)
Ross, Gail (Caithness, Sutherland and Ross) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Todd, Maree (Highlands and Islands) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow Pollok) (SNP)

The Presiding Officer: The result of the vote on amendment S5M-22635.3, in the name of Neil Findlay, is: For 57, Against 58, Abstentions 0.

Amendment disagreed to.

John Scott (Ayr) (Con): Presiding Officer, according to my WhatsApp messages, Alison Harris was apparently unable to vote.

The Presiding Officer: We have just recognised that this second, and we are addressing the issue.

Neil Findlay: Irrespective of the vote, the confidence in this voting system is ebbing away every single day we come here. When members have raised very legitimate points of order on this issue before, there has been an insistence that the system is working, but the system is self-evidently not working to the satisfaction of all members. I think that that is a general feeling. We have a major problem with the system, and we cannot continue in the farcical way that we are now.

The Presiding Officer: Thanks for the point of order, Mr Findlay. Michael Russell also has a point of order, but I have not even addressed Mr Findlay's.

The Cabinet Secretary for the Constitution, Europe and External Affairs (Michael Russell): It pains me to say this, but I agree entirely with Neil Findlay.

I have to make the point that I voted two weeks ago in divisions on a bill, and during each division I was terrified that the vote was either not being counted or not being counted properly. Today, we have seen a vote that, at the very least, must be one in which those in the chamber will have no confidence. The amendment was disagreed to by a single vote, and we do not know whether individuals have voted.

Presiding Officer, I suggest—perhaps controversially—that you suspend the session and that we return to voting tomorrow when we have personal assurances from you that the voting system is working and can be reliable. If we cannot have those assurances, we should not be using that system.

The Presiding Officer: We are debating that option at the moment. Contrary to Neil Findlay's point of order, the system is working. However, I recognise that there are issues that I agree are undermining confidence. I will suspend business until we work out what happened in that vote.

People missed votes for many reasons all the time under the old system. People in the chamber pressed the wrong button or did not put their cards in. They missed votes for lots of reasons and it happened often. Members might not be aware of that, but I assure you, from the chair, that I am aware of it. We are having difficulties with the new system, but many of the difficulties are not with the system—they are with us and our level of familiarity with it.

I am not going to defend the system now. I am going to make sure that our system is working and that you, Mr Russell, can have confidence in it.

I will suspend while we establish what happened in that vote, and I will get back to you in a few minutes.

17:36

Meeting suspended.

17:38

On resuming—

The Presiding Officer: We need a thorough debrief of what happened in that vote to make sure that everybody, including me, has confidence that the vote was carried out effectively and robustly. We will do that tomorrow.

There is another question today, which is on the Period Products (Free Provision) (Scotland) Bill. I suggest that we take that vote. If there is a division, we will also hold that division tomorrow. If it is agreed now, that will be able to go through this evening.

Neil Findlay: On a point of order, Presiding Officer. Can you say from the chair that the vote is now annulled and invalid and that we will retake the full vote? I would like you to say that so that we know that.

The Presiding Officer: I am not deciding at the moment to run that vote again. That decision will be taken tomorrow.

Neil Findlay: You announced a decision. You declared numbers.

The Presiding Officer: That is right. I will inform the chamber tomorrow, once we have had a thorough debrief, whether that result was valid.

I am sorry, Mr Findlay. This kind of thing happens and there are procedures in the standing orders to deal with it. I am suspending the vote now, and we will come back to it tomorrow to allow me and others to look at what happened. I will be able to give you a firm decision tomorrow; I am not going to give you a decision now.

Neil Findlay: On a point of order, Presiding Officer. Is it in order for me to move formally that that vote be annulled and that any further vote that is to be taken be taken tomorrow?

The Presiding Officer: No, Mr Findlay, that is not in order. I have already given my decision that we will come back to the matter tomorrow. I will discuss it with the business managers and I will make sure that the chamber is fully informed of how we will resume our approach to the vote. However, we should do that in the light of knowing exactly what happened in the vote. I am sorry, but we need to know exactly what happened in the vote before we do that, and that is the reason why we are moving everything to tomorrow.

However, with the—

Neil Findlay: On a point of order, Presiding Officer.

The Presiding Officer: One more point, Mr Findlay.

Neil Findlay: I just want to be absolutely clear: do the standing orders of the Parliament say that a member is not allowed to move such a motion at this point?

The Presiding Officer: I am not accepting such a motion at this point, which is more to the point, Mr Findlay. [*Interruption*.] I am sorry, Mr Findlay, but I am in the chair and I have already given my decision. We can decide what you may or may not do tomorrow. At the moment, I am not saying that the amendment is defeated or that the vote is annulled or cancelled. I am going to suspend business on that vote and we will come back to it tomorrow.

I will be able to inform Mr Findlay—[*Interruption*.] The fact that Mr Findlay does not like the outcome of the vote is not the same as not having confidence in the outcome. I am sorry, but I need to know what happened in the vote, at which point we will be able to make a proper decision.

Now, we have a final question—

Michael Russell: On a point of order, Presiding Officer. I do not want to prolong this, but, while I accept that you clearly do not have to take a motion from Mr Findlay, I hope that you will reassure the chamber of two things. The first is that you will consult fully with the business managers when looking at the vote and will make sure that they have full access to all the information on it. The second is that you will look at the wider question of how to restore the confidence of the chamber in the new voting system, given the experience that we have had not just today but over the past few weeks.

The Presiding Officer: I think that I addressed both of those points, Mr Russell, which is why we are going to return to the subject tomorrow. Not only will I share the information with all the business managers, but I will make sure that all members are fully aware of what happened in that particular vote and any decision to rerun it or do otherwise.

Jackson Carlaw (Eastwood) (Con): On a point of order, Presiding Officer. I just point out that this confusion has come at the end of a very important debate that thousands of women will have been watching online, and they will be dismayed at the turn of events. I think that Parliament owes an apology to the many women who have been looking to see what Parliament's view on the Cumberlege report is going to be.

The Presiding Officer: I am very conscious of that point, Mr Carlaw. I heard all of the debate. It was an extremely emotional debate as well as a powerful one, and the very fact that the vote itself is close is an important matter. You are absolutely right: the business managers, members and the public need to have confidence in this Parliament and its procedures, which is why we will return to the matter tomorrow. However, I fully accept your point.

Daniel Johnson (Edinburgh Southern) (Lab): On a point of order, Presiding Officer. Standing orders rule 11.7.3 states:

> "If it appears to the Presiding Officer that the electronic voting system has produced an unreliable result, he shall ask members to cast their votes again in accordance with any manner of voting the Presiding Officer considers appropriate."

My reading of that, Presiding Officer, is that, because there is doubt, we need to rerun the vote as you have described—possibly tomorrow—but in so doing, we have to declare the previous result null and void. I think that that is the clarification that Mr Findlay was asking for. Can you confirm the position?

The Presiding Officer: Mr Johnson is absolutely right, which is why we are going to return to the matter tomorrow to make that decision. I will make that decision tomorrow, in the light of knowing exactly what happened in that vote.

Can members accept that we will return to the matter? The vote has not yet been approved or agreed.

We will now end, if we can, by my putting a further question. If it comes to a division, we will have it tomorrow.

The question is, that motion S5M-22484, in the name of Kate Forbes, on the financial resolution to the Period Products (Free Provision) (Scotland) Bill, be agreed to.

Motion agreed to,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Period Products (Free Provision) (Scotland) Bill, agrees to any expenditure of a kind referred to in Rule 9.12.3(b) of the Parliament's Standing Orders arising in consequence of the Act.

Alcohol Foetal Spectrum Disorders

The Deputy Presiding Officer (Lewis Macdonald): The final item today is a members' business debate. I am delighted to welcome back members to these debates after a hiatus of some months. I know that their return has been eagerly awaited by many members across the chamber.

The debate is on motion S5M-21194, in the name of Kenneth Gibson, on recognising the impact of alcohol foetal spectrum disorders. The debate will be concluded without any question being put.

Motion debated,

That the Parliament recognises the prevalence and significant impact of Foetal Alcohol Spectrum Disorders (FASD) in Scotland, as discussed at the meeting of the parliamentary Cross Party Group on Improving Scotland's Health: 2021 and Beyond on 26 February 2020; notes the presentation by Dr Sarah Brown of the Foetal Alcohol Advisory and Support Team at NHS Ayrshire and Arran, which highlighted that FASD results from alcohol exposure in the womb and is preventable, yet is the most common neurodevelopmental condition in Scotland; further notes data from Glasgow Royal Infirmary research, which showed that one-in-seven babies born there were at high risk of FASD, which suggests a much higher prevalence in Scotland than previously thought; understands that FASD affects neurodevelopment, attainment, physical and mental health and that, without adequate support, it reduces life expectancy to around 34 years of age; believes that 94% of people living with FASD experience mental health problems, 79% experience unemployment, and over a third struggle with addictions; acknowledges the vital work that is being carried out by FASD Hub Scotland in providing a national telephone helpline and range of support for parents/carers and those supporting families affected by FASD, as highlighted by the presentation to the group by Aliy Brown, FASD Project Lead at FASD Hub Scotland, which is run by Adoption UK Scotland; supports the "No Alcohol, No Risk" message, which makes clear that any alcohol consumed during pregnancy can be damaging to the unborn child, and acknowledges its calls for implementation of the new SIGN 156 clinical guideline for Prenatal Alcohol Exposure, and welcomes the development of the National Preconception Framework as a key opportunity to reduce risks to parents and children from alcohol and other health-harming products in Cunninghame North and across Scotland.

17:46

Kenneth Gibson (Cunninghame North) (SNP): First, I thank colleagues from across the chamber who signed my motion, which has allowed this debate on foetal alcohol spectrum disorders—FASD—to take place this evening. I also thank everyone who has managed to stay behind tonight after what went before.

The timing of the debate is welcome, because tomorrow is international FASD awareness day. For their invaluable briefings, I thank Alison Douglas and Simon Jones of Alcohol Focus

Scotland; Dr Jonathan Sher of the Queen's Nursing Institute Scotland; Fiona Aitken and Aliy Brown of Adoption UK; and Dr Sarah Brown, consultant paediatrician, and Dr Jennifer Shields, principal clinical psychologist, of the foetal alcohol advisory support team, NHS Ayrshire and Arran, which is funded by the Scottish Government. I know that it sounds like an Oscar speech so far, but I will soon move on.

On 26 February, Aliy Brown and Dr Sarah Brown together delivered an excellent and informative presentation on FASD to the cross-party group on improving Scotland's health: 2021 and beyond, of which I am the co-convener, along with Brian Whittle and David Stewart.

FASD is a range of conditions caused by exposure to alcohol at any stage of pregnancy. It affects physical and mental health, and capacity to learn. It is the most common but unrecognised neurodevelopmental condition in Scotland.

The United Kingdom has the world's fourth-highest rate of alcohol consumption in pregnancy, and Glasgow's Queen Mother's hospital found that 40 per cent of newborns had alcohol biomarkers in their systems. It is of particular concern that 15 per cent of babies had levels indicating frequent binge exposure, with one in seven inferring a significant risk of FASD.

There is currently no research on FASD prevalence in Scotland. International research estimates the rate to be 3.25 to 5.25 per cent, which is three to five times that of autism, equating to 165,000 to 275,000 affected individuals. The majority will never have been assessed or diagnosed with FASD, or understood as having a lifelong brain injury that requires support through adulthood, as such individuals rarely have a global learning disability. Their patchy cognitive profile masks difficulties until milestones are not reached. Paradoxically, those who are cognitively impaired to the degree of a formal learning disability have better outcomes, as their needs are identified earlier. The journey into adulthood of those who are unidentified as having FASD and are without support is often characterised by poor educational attainment, unemployment, chronic mental health, trauma and addiction.

FASD affects people throughout their lives. Early diagnosis and support are crucial to avoid a range of issues that are commonly encountered. Some 90 per cent of those affected were estimated to suffer mental health problems; 79 per cent had experienced unemployment; 60 per cent had disrupted school experiences; 43 per cent had educational problems; 35 per cent were imprisoned as adolescents; and 23 per cent needed in-patient psychiatric care. Misdiagnosis and inadequate support shorten the life expectancy of people with FASD to just 34 years, with many preventable deaths attributable to addiction, misadventure or suicide.

Of course, drinking during pregnancy does not happen in isolation; it is a symptom of Scotland's continued unhealthy relationship with alcohol. One in four people regularly drink above the chief medical officer's low-risk drinking guidelines. Alcohol consumption in women of childbearing age is common, and 45 per cent of pregnancies in Scotland are estimated to be unplanned. It is vital that we recognise the profound impact that FASD can have on someone's health and wellbeing throughout their life.

That the prevalence of FASD in Scotland is much higher than was previously thought is cause for concern, and we must do more to ensure that the message "No alcohol, no risk" during pregnancy is well known and understood not just by prospective mothers but by partners, family and friends who can offer support.

I highlight the case of John, a 10-year-old who was referred by his GP for assessment of his neurocognitive function due to his parent reporting behavioural problems, emotional concerns and poor school performance. His mother, Mrs Smith, worries about John being held back at school and her inability to control him at home and around other children. Since he was a toddler, John has displayed aggressive behaviour and difficulty with emotional control. He often provokes fights with other children and can have tantrums that last over an hour—crying, screaming, destroying property and hurting others. Behavioural concerns also include impulsivity and difficulty in maintaining attention and following directions. John frequently steals his siblings' toys, hides broken toys and lies about how they were broken. Mrs Smith reports that he is never invited to friends' homes, and teachers report repeated difficulty with peer interactions. Generally, John gets along with children two or three years younger than he is.

John has been seen by several mental health professionals and continues to be engaged in both psychopharmacological interventions and behavioural therapy. Mrs Smith drank several times a day and binged at weekends before and during pregnancy. John was diagnosed as having a neurodevelopmental disorder associated with prenatal alcohol exposure, and given a personalised education programme that included particular focus on providing additional time and repeating new lessons until competence was achieved. He was also given behavioural reinforcement, for example, by getting a gold star sticker immediately after turning in his homework. Due to difficulties with concentration, John sits at the front of the class and is given extra time to complete tasks. It will be a long, hard road ahead for John and his family.

Dedicated resources and practical assistance for parents of children with FASD and early assistance from professionals who are expert in the condition and on how it can be supported can transform the prospects of younger people who are affected. Adoption UK's FASD hub Scotland, which is funded by the Scottish Government, sets an example of best practice by offering telephone and online support for families living with the condition. However, people with FASD might struggle to access diagnosis due to a misdiagnosis or lack of identification. NHS Ayshire and Arran's foetal alcohol advisory and support team aims to address those challenges by offering support to FASD practitioners.

The Scottish women's alcohol framework includes a commitment to

> "support the current system to be much more responsive to the needs of individuals, families and communities affected by FASD".

The Scottish Government's rights, respect and recovery strategy commits to implementing a "whole family approach" to reducing drug and alcohol harms, providing a platform for increased focus on that issue.

Work is also under way to develop Scotland's first national preconception framework, to support women of childbearing age and their families to access reproductive health services and avoid unplanned pregnancy.

A dedicated national strategy for FASD treatment and prevention is vital to bring focus and to co-ordinate efforts and resources in order to reduce and ameliorate the condition's impact. Such a strategy would enable experience and learning from services such as the FASD hub Scotland and NHS Ayshire and Arran's foetal alcohol advisory and support team, as well as the use of international evidence to improve the life prospects of people with FASD and their families.

Inconsistent messaging on alcohol products remains a concern, with 28 per cent of women in the UK unaware of the current health advice. The chief medical officer's guideline for pregnant women and women who might become pregnant is to avoid alcohol completely, as no safe amount of alcohol can be consumed during pregnancy. Providing pregnancy-related warnings on alcoholic drinks is an important way of informing consumers of risks that are associated with drinking during pregnancy, but, sadly, such labelling is usually only pictorial and of minimal detail, and 30 per cent of it is illegibly small.

Alcohol Focus Scotland and the Alcohol Health Alliance UK are urging the Scottish Government to mandate, monitor and enforce alcohol labelling standards in line with World Health Organization recommendations. I ask the minister to commit to doing so today, while the power to do so is still devolved.

For those who are affected by FASD, understanding the condition and getting assistance is fundamental for enabling the children to go on to lead healthy, happy lives. The work of FASD hub Scotland is a lifeline for the parents and carers who need that vital support.

17:55

Brian Whittle (South Scotland) (Con): I thank Kenneth Gibson for bringing the debate to the chamber, and I congratulate him on having got time to discuss the subject in Parliament.

As he said, foetal alcohol spectrum disorders is a lifelong condition that affects the neurodevelopmental system, and is a result of prebirth exposure to alcohol. Estimates indicate that between 165,000 and 275,000 individuals in Scotland are living with FASD. That wide range in the estimate should tell us that the diagnostic rate for FASD is not great, in comparison with rates for other neurodevelopmental conditions. Nevertheless, the condition has wide-reaching implications not only for the individuals and their families, but for health and social care, education, criminal justice and the third sector.

The evidence shows that when FASD is not identified, people who have the condition are more likely to experience poor educational attainment and health difficulties, are more likely to be unemployed, and are more likely to have an addiction, to experience homelessness or to be involved with the criminal justice system. We also know that affected individuals are highly likely to experience trauma and poor physical health.

The condition is linked directly to alcohol consumption during pregnancy, so that is where we have to start. We have to accept that Scotland, within the United Kingdom as a whole, has the fourth-highest rate of drinking in pregnancy: 40 per cent of pregnancies in Scotland are exposed to alcohol, and one in seven babies are exposed to high-risk levels. Prevention is the key to tackling Scotland's relationship with alcohol, and must be our starting point. Education on FASD across healthcare is being called for, because outcomes are drastically improved through early intervention, understanding and support.

I have to admit that my knowledge of the condition started only when I was asked to coach an athlete who has FASD. His foster parents were really keen that he would progress as an athlete. I have often wondered whether their idea was to give him to me in order to deplete his ever-growing energy reserves, because I would describe him as being enthusiastic in life. You would not be able to tell from looking at him that he has a condition; he is very enthusiastic and energetic. That young man is now a European medallist—he qualified for the world championships and has an eye on the Paralympics. He is even at college now.

When FASD is recognised, and access to organised activities is available, much can be achieved. Those are the pathways that we should be pursuing. Track and field athletics has given that young man purpose, structure and an opportunity to achieve through providing him with an outlet for his boundless energy.

Presiding Officer, you knew that somehow or other I would find that sport is the answer. However, I am in fact calling for investment in education on identifying FASD and investment in tackling Scotland's relationship with alcohol. I have been given the following figure: when a person has FASD and the condition is not tackled early, the resulting cost could be upwards of £1 million during that person's lifetime.

We talk about the preventative health agenda, which would be an ideal way of tackling the issue. That type of investment has been called for by FASD hub Scotland, and I whole-heartedly support that call.

I once again thank Kenneth Gibson for bringing the debate to the chamber, and for allowing me the opportunity to speak to the issue.

17:59

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I thank my colleague Kenneth Gibson for the opportunity to discuss this important subject.

Reading the motion, I was moved and saddened—in particular, by some of the statistics. For example, the average life expectancy of a child who is born with foetal alcohol syndrome disorders is a mere 34 years. In recent days, we have seen an outpouring of grief for a young actor who died at the age of 43, which is nearly 10 years older than the average life expectancy of a youngster who is affected by FASD.

Foetal alcohol spectrum disorders lead to quite variable outcomes, with some sufferers being affected more significantly than others. The presenting symptoms are not necessarily consistent among the cohort of people who are subject to the disorder—hence the difficulties that there often are in diagnosing the condition and in getting appropriate support in place.

What is shared, however, is that the syndrome is preventable. No parent—or very few parents—deliberately set out to harm their children. The syndrome is a side effect of an addiction to, or abuse of, one of our most widely available drugs of choice: alcohol. The danger with alcohol is that although it is an addictive drug it is not addictive for everybody, so people think that it is safe. For children in the womb, it is not safe. There is enough knowledge out there; people should know that they should not drink when they are pregnant.

However, not everyone is able to respond to the rational case for their stopping drinking. That is especially the case for an addict. It is our responsibility to support mothers during pregnancy and to support the children who suffer from foetal alcohol spectrum disorders. The championing of campaigns such as #NoAlcoholNoRisk is welcome.

I encountered issues to do with alcohol addiction when I was a nurse, 56 years ago, and one of our patients was an alcoholic who suffered extremely as a result of his addiction. My father was a general practitioner, and I used to provide some social support to addicts who were on his list. The issue is not far from a great many of us.

Children cannot look after themselves; they do not have the knowledge or the power to do anything about their situation. It is important that we identify the help that is required, and that people who suffer from FASD get everything that they require to lead as normal a life as possible.

I listened to Mr Whittle. I think that members can see the range of options that are available to support people, and to ensure that intervention comes early enough in a child's life to ensure that they can get the maximum out of however long they have in this world. Early diagnosis, a loving and stable home and the absence of violence are rights that we all want for children in our society, and which we all have a duty to uphold. It is necessary to create a world in which people are supported. We will do all that we can to support future generations.

I very much welcome tonight's debate. I hope that it brings the condition to the attention of a wider audience, and I hope that mothers and potential mothers are aware of the damage that alcohol can do to the precious child in the womb.

18:03

Monica Lennon (Central Scotland) (Lab): I commend Kenny Gibson for shining a light on foetal alcohol spectrum disorders, and I thank Alcohol Focus Scotland, the foetal alcohol advisory and support team at NHS Ayrshire and Arran, and the FASD hub Scotland that is hosted by Adoption UK for their helpful briefings.

Alcohol harm in Scotland continues to be a serious public health challenge. More than 1,000 people die from alcohol-related illness every year. We have had positive measures in recent years, including minimum unit pricing, but problem drinking remains a widespread and stigmatised issue. For women who are struggling with drinking who become pregnant, the stigma and public judgment are magnified. However, prenatal alcohol exposure can have lifelong damaging impacts, so it is in everyone's interests to reduce it as much as possible.

We think that FASD affects 3.2 per cent of Scotland's young people, but the rate could be much higher, which is troubling. We need bolder public health policy and we need adequate and sustainable funding of treatment and recovery services. It is worrying that the number of publicly funded residential rehab beds in Scotland has plummeted in recent years, at the same time as there has been a rapid increase in alcohol-related and drug-related deaths.

Improving women's access to rehab and other wraparound support is one measure that could help to prevent FASD. As the #NoAlcoholNoRisk message points out, FASD is preventable.

I want to focus on the needs of children who are affected by FASD. I was struck by an email that a mother sent me, ahead of the debate. With her permission, I will read out her words. She said:

> "My daughter has just turned 8. She has probable FASD. I say probable because, despite starting the diagnosis process when she was in P1,"—

four years ago—

> "we are still crawling our way through it ... There's no joined up approach and parents are left to do everything themselves. We have been waiting for 2 years for the Cognitive Assessment through CAMHS. An assessment which would help identify areas where she needs support and would make it much easier to get her the right help at school ... FASD affects my daughter in lots of ways. It affects her memory, her sleep ... and her cognitive abilities. Some days are better than others—she can go from bright and bubbly, to not being able to dress herself because she just can't remember what to do next.
>
> FASD often goes alongside early trauma and attachment issues, because so many children are care-experienced".

She continues:

> "My daughter is a masker. She tries incredibly hard at school and holds herself together all day, then crumbles as soon as she's out of the gates.
>
> Masking is another challenge to diagnosis, she can see a Speech and Language Therapist for half an hour and push all her effort into that, leaving them with the impression that she's 'fine', but emerge exhausted and unable to function for the rest of the day. In England, and in other countries like Norway, they take a different approach to assessment, where it's a whole day, or in Norway two days, all in one place, making it impossible for a child to mask, so a more accurate picture of their difficulties emerges. It also means the child misses less school and doesn't have to endure having their 'faults' listed to a never-ending series of professionals, who often have a very poor understanding of FASD.
>
> We have accessed workshops through the FASD Hub that Adoption UK runs, but otherwise, we've been on our own. I feel my daughter has really been let down by both the Health Service and by Social Work, who have not provided any support, despite her care-experienced status. They say that early diagnosis is one of the best ways to avoid poor outcomes for children with FASD, but what chance do Scottish children have of that?"

She goes on to say:

> "I'm an articulate, assertive parent with qualifications, and I know how hard I've found it to navigate the system. What chance is there for parents who haven't had my advantages?"

We must do better than that. I hope that today's debate leads to much-needed positive change, and I thank Kenny Gibson again for bringing it to the Parliament.

18:08

Rona Mackay (Strathkelvin and Bearsden) (SNP): I thank my colleague Kenny Gibson for bringing this important debate to the Parliament, just a day before international foetal alcohol spectrum disorder awareness day.

Monica Lennon's speech was incredibly interesting and powerful. There was so much in it that I did not know.

This Government and this Parliament believe in giving children the best start in life. The Scottish Government has evidenced that with its introduction of the baby box, its planned expansion of early years education and much, much more.

Some children are denied the best start in life even before they are born. FASD is a family of complex conditions that arise from exposure to alcohol at any stage of pregnancy and affect a child's physical and mental health and their capacity to learn. FASD is the most common unrecognised neurodevelopmental condition in Scotland. It is also entirely preventable.

During my time on the children's panel, I attended a tutorial by a clinician who was originally from Canada—his name escapes me, sadly. It was about a decade ago, and he was one of the very few specialist researchers in FASD at the time. Back then, the message to pregnant women was that they should limit their alcohol intake. Women were told, "The odd glass of wine won't do you any harm as long as you are sensible."

The professor pointed out that alcohol affects everyone in different ways and that what might have an impact on one person might be devastating to another. His message was, "The only way to avoid giving your baby FASD is to drink no alcohol at all." He also highlighted the fact that many children at children's hearings may well have been affected by FASD and that they and we were unaware of that. We now know, of course, that many were also impacted by adverse childhood experiences. Thankfully, we know much more about that now.

As the helpful FASD briefing points out, early diagnosis and support for people with FASD is crucial to avoid a range of issues that they commonly encounter. It is estimated that 90 per cent experience mental health problems, 79 per cent experience unemployment, 60 per cent have disrupted school experiences, 35 per cent have been imprisoned as adolescents and 23 per cent have needed in-patient psychiatric care.

We heard Kenny Gibson say that it has been estimated that around 3.2 per cent of Scotland's young people are living with FASD. However, a 2017 study in the west of Scotland found that as many as 40 per cent of babies showed signs of exposure to alcohol in the second trimester. That suggests that the figures are higher. I find that absolutely shocking.

Support for families that are affected by FASD and early diagnosis can transform the prospects of the young people who are affected. Adoption UK's FASD hub Scotland provides telephone and online support for families that are living with FASD. It is funded by the Scottish Government, and it has reported that 55 per cent of children waited for two years or longer for their diagnosis and 78 per cent of parents whose children were diagnosed did not think that healthcare professionals were knowledgeable about the condition or its various presentations.

The Scottish Government's alcohol framework includes a commitment

> "to support the current system to be much more responsive to the needs of individuals, families and communities affected by FASD"

and a whole-family approach to reducing drug and alcohol harms. It provides a platform for increased national attention to the issue.

Drinking during pregnancy is a symptom of Scotland's unhealthy relationship with alcohol. We are trying to address that by way of minimum unit pricing and improved public awareness of the dangers of drinking too much.

In conclusion, FASD is entirely preventable. It requires women not to drink for the entirety of their pregnancy, including avoiding alcohol while trying to conceive. In what we are facing today, with the scourge of the global pandemic still prevalent, surely that is not too much to ask to ensure that our children get the best start in life.

18:12

Alison Johnstone (Lothian) (Green): It is fair to say that there has been a lot of agreement across the chamber on the issues for debate this afternoon. Undoubtedly, we all share a desire to see children who are born in Scotland healthy and happy.

Foetal alcohol spectrum disorders have a devastating effect on children who are born with them, as my colleague Kenneth Gibson illustrated in his motion, which I thank him for lodging. I, too, thank all those who have provided briefings and all those who have worked for a long time to raise awareness of these unacknowledged and misunderstood disorders. It is clear that we still have a way to go.

One of my colleagues described FASD as

> "a side effect of an addiction".

It is also a side effect of the health inequality that continues, in too many cases, to blight Scotland.

Like many issues, the problem cannot be tackled in isolation. If we pare it down, we could suggest that FASD is preventable by abstaining from alcohol during pregnancy, but a broader perspective would, of course, acknowledge that the relationship between alcohol and pregnancy is far more complex. It involves location, economics, education and much more. We need to look at the bigger picture of how society views alcohol, not least during lockdown. Some people have managed to cut down their consumption of alcohol, whereas others have perhaps found themselves drinking more than they did previously. There will be various reasons for that. It might be several years before we understand not just the impact of Covid-19, but the impact on our individual coping mechanisms.

The range of alcohol foetal spectrum disorders is serious and lifelong, so it is imperative that we do all that we can to provide the best healthcare, support and information to women and parents well before conception, particularly where dependencies are an issue. We need to look at any underlying causes, such as financial instability, domestic abuse, past trauma—Rona Mackay mentioned that—and unaddressed mental health issues.

Alongside that, it is imperative that we, as a nation, get better at dealing with alcohol. Minimum unit pricing appears, at this stage, to have had some success, but that alone does not mean that we have tackled problem drinking. Across Scotland, we have 16 times more licensed premises than we have GP surgeries, and we know how difficult it can be to access our GP surgery. There is an imbalance there.

From the moment a child starts to read, they see alcohol adverts. They see them when they watch sport with the rest of their family or when they are at the bus stop, on their way to school. We are yet to understand fully the impact that social media and influencers have on children and young people's perceptions of alcohol.

We probably all agree that disease that results from a preventable cause can sometimes be the saddest and most heartbreaking to see. It can be frustrating, as we know that it is preventable. However, we know that choices are made in different contexts and that behaviour change is complex, as is pregnancy. It is not always a happy time, full of excitement, as adverts would have us believe; it can be very stressful, and women can feel under pressure and intense scrutiny from friends, family and even strangers, who feel that they know better than the women themselves and are often unafraid to offer unsolicited advice. That is just one of the challenges that women face during pregnancy.

Maternity discrimination in the workplace continues to be an issue, and taking a pregnancy to term while studying is a challenge. Kenny Gibson described John's journey and spoke about all the challenges that that young person faces, although opportunities exist where support is available.

Monica Lennon described the situation of a constituent's daughter. Masking can happen in specific situations if we break up the day into small chunks, and the young person can be somewhere where the situation does not bring on stress. If there are people in institutions or organisations who see the young person over a longer period, there is a far better chance of understanding what the condition is. There have been many interesting contributions to the debate.

I would love to see a Scotland in which no child is born with FASD, and I believe that that can be achieved with hard work. We can help to bring that about by creating a society in whic pregnant women and families are supported before, during and after conception and birth.

18:27

The Minister for Children and Young People (Maree Todd): I thank Kenny Gibson for securing the debate, and I welcome the opportunity to make these closing remarks. By happy coincidence, I note that I closed the last members' business debate before Parliament paused this particular institution. It is a real privilege to come back to the chamber and continue our members' business debates with another topic that is close to my heart.

The debate's being had today is really great timing, because tomorrow is international FASD day, which marks an opportunity to raise awareness of the condition in countries around the world. The FASD hub Scotland plans to mark the day with the #IcanFASD campaign, which highlights what children and young people with the condition can do, rather than focusing on what they cannot do. We should all reflect on that message as we seek to improve the lives of children, young people and adults with FASD. What are we missing out on as a country and a nation by not providing the correct help and support to enable them to thrive?

As Mr Gibson correctly pointed out, 3.2 per cent of babies who are born in the UK are affected by foetal alcohol spectrum disorders. Knowing what support is needed is vital. In order to help health and social care professionals to support patients, Healthcare Improvement Scotland last year produced a Scottish intercollegiate guidelines network—SIGN—guideline, "Children and young people exposed prenatally to alcohol". We expect that guideline to lead to more uniformity in practice, which will, in turn, enable patients to receive the best possible care. We hope that situations such as the one that Monica Lennon described her constituent's daughter going through will be improved in the future.

I know that guidance is useful only when it is backed by support and training for those whom we expect to follow it, so we arranged for experts from Manitoba to lead, in June last year, a three-day training session with healthcare professionals. Representatives from all Scottish health boards had an opportunity to learn and to connect with each other, and to share their understanding and knowledge. In addition, an e-learning module is in production, which will reinforce the guidelines and raise awareness. It will be available in the coming months.

We know that FASD is caused by alcohol exposure in the womb and that the advice to women in Scotland is to avoid alcohol completely when they are pregnant or trying to conceive. In fact, for a number of years, Scotland was the only country in the UK that advised women not to drink at all during pregnancy or when they were trying to conceive. However, since 2016, the other UK chief medical officers have agreed to use the same message: no alcohol, no risk.

Improving health in the pre-conception period is vital; we are committed to helping families to understand the impact of poor health behaviours prior to pregnancy. Pre-conception and pregnancy are, arguably, the earliest stages at which services can work together effectively to offer guidance and support to families.

Women do not need to be alcohol dependent to have a child with FASD. It is much more common when that is the case, but a baby's brain begins developing at the earliest stages after conception, and can be damaged at any point during pregnancy. That is the reason for the strong message of the #NoAlcoholNoRisk campaign. The physiological impacts occur at different stages, so the visible effects of FASD are present in only about 1 per cent of those who are affected—hence some of the complexity with diagnosis.

A pre-conception framework is in development. The plan will focus on mental and physical health, healthy weight and diet, vitamin supplementation and tobacco and alcohol use before becoming pregnant, and it will be out for consultation later this year. The Scottish Government's plan for FASD is set out in "Alcohol Framework 2018: Preventing Harm". Action 18 states:

> "We will continue to prevent and reduce the harm caused by alcohol consumption in pregnancy through increased awareness of the risks, increased awareness of, and improved diagnosis and support for, Fetal Alcohol Spectrum Disorder."

I am sure that Mr Gibson will be pleased to hear that we have continued our funding to the foetal alcohol advisory and support team to explore a different model for its work, and we will work with it to consider what next steps are needed. Our actions are set within the alcohol framework so that we can work right across policy areas. That places FASD firmly within all the other structures of policy development.

I am clear that all areas of Government have a part to play in supporting our understanding of the impact of FASD in policy initiatives. Work on FASD does not, and should not, sit in a silo; it is part of a much wider picture of decision making, in which we all need to play our part. Alison Johnstone brought that point to life very powerfully in her speech. The Minister for Public Health, Sport and Wellbeing and I met recently to agree that we will work together to provide leadership in that area.

The 2018 programme for government included a commitment to increase support for children and families who are affected by FASD. As part of that commitment, the FASD hub Scotland was launched. Before Covid, the Minister for Public Health, Sport and Wellbeing met families who have been supported by the hub, to hear their stories and to hear about the impact that the hub is having in supporting them in difficult times. We have invested £333,401—there is a funny figure—in the service to date, with highly positive results.

Mr Gibson noted the presentation by Dr Sarah Brown of the foetal alcohol advisory and support team. I am pleased to confirm that the Scottish Government has continued funding to that team to help it to explore new ways of working. Dr Brown and her colleague Jennifer Shields have played a pivotal role in improving our knowledge and supporting health colleagues. We have invested a bit more than £601,000 in that work to date, and we continue to support the sharing of learning much more widely across the clinical community.

Once again, I offer my thanks to members for their contributions. I reiterate our commitment to improving outcomes for people with FASD. I pay tribute to the children and young people with FASD—many of whom I have met in my role as Minister for Children and Young People—and wish them all the very best in their future journey.

Meeting closed at 18:24.

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