OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 2 May 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 2 May 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
15th Meeting 2023, Session 6

CONVENER

Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeff Ace (NHS Dumfries and Galloway)
Dr Wael Agur (NHS Ayrshire and Arran)
Professor Grant Archibald (NHS Tayside)
Professor Jann Gardner (NHS Lanarkshire)
Dr Anna Lamont (NHS National Services Scotland)
Dr Alan Mathers (NHS Greater Glasgow and Clyde)
Terry O'Kelly (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 2 May 2023

[The Convener opened the meeting at 09:00]

Deputy Convener

David Torrance (Kirkcaldy) (SNP): Good morning and welcome to the Health, Social Care and Sport Committee's 15th meeting in 2023. I am the MSP for Kirkcaldy. As the oldest member of the committee, I have the pleasure of convening the meeting for our first item of business.

I have received apologies from Clare Haughey, and Tess White will join us remotely. Paul O'Kane has left the committee and has been replaced by Carol Mochan, whom I welcome.

Agenda item 1 is to choose a new deputy convener. The Parliament has agreed that only members of the Scottish Labour Party are eligible for nomination as deputy convener, so I invite members of that party to nominate one of their number for the post.

Carol Mochan (South Scotland) (Lab): I nominate Paul Sweeney.

Paul Sweeney was chosen as deputy convener.

David Torrance: I congratulate Paul Sweeney and welcome him as deputy convener.

09:01

Meeting suspended.

09:01

On resuming—

Decision on Taking Business in Private

The Deputy Convener (Paul Sweeney): Ms Haughey, who is the convener, has sent her apologies—she is not available because of illness, unfortunately—so I will chair today's meeting.

Item 2 is a decision on taking items 5 and 6 in private. Do we agree to take those items in private?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Dumfries and Galloway, NHS Tayside and NHS Lanarkshire)

09:02

The Deputy Convener: Item 3 is engagement with national health service boards. The committee will take evidence from Jeff Ace, the chief executive of NHS Dumfries and Galloway; Professor Grant Archibald, the chief executive of NHS Tayside; and Professor Jann Gardner, the chief executive of NHS Lanarkshire. I welcome you all and thank you for joining us.

The first area that we will look at is financial sustainability. There are significant budgetary pressures across the public sector, and we want to establish the position on key aspects. I will kick off. Audit Scotland's report "NHS in Scotland 2022" noted that only three of 14 health boards are predicting that they will break even in the 2022-23 financial year and that extensive waiting lists and increases in emergency care are among the pressures. Will the witnesses provide detail on the efforts that their boards are making on early intervention to prevent the need for emergency care and acute care down the line? I start with Professor Gardner of NHS Lanarkshire.

Professor Jann Gardner (NHS Lanarkshire): Good morning. Although NHS Lanarkshire is forecasting to break even at the end of the 2022-23 financial year, that is with significant efforts across the patch, and we are in a much more challenging position as we go into 2023-24.

Our approach is fourfold. First, we are looking to minimise any waste or non-value-added areas in the organisation, and secondly, we are looking to optimise performance by looking at the upper quartile and benchmarking in other areas to optimise productivity wherever possible. However, unfortunately, those two elements alone will not bring us to a more sustainable financial position so, in addition, we are looking at service change and radical redesign and reform of our service. Because of the challenges that NHS Lanarkshire has been facing, one area that we have been focusing on is our unscheduled care performance.

As colleagues will note, it has been a very difficult winter; NHS Lanarkshire and the people of Lanarkshire were hit most significantly by the direct and indirect impacts of Covid, and the health inequality gap has—unfortunately—widened. We are feeling that acutely at our front doors. Our system was designed to be effective for healthcare needs in 2019, but we need to acknowledge that healthcare needs have changed and are significantly different in 2023. That relates to complex care needs and our population coming forward with frailty issues and broader chronic condition issues.

We have been doing a piece of work that we term operation FLOW. It began at the end of January because of the really difficult winter and the challenges that our patients and staff faced. As we go into the redesign phase, we are mindful that we do not wish to repeat the winter that has just passed and we want to take all the clear learning from it.

The redesign programme of operation FLOW looked at the different elements, including how to keep people well at home, how to redirect people appropriately at the front door, how to restructure our front door, ward optimising and how people flow through. We undertook a firebreak of nine days at the beginning of March and we saw significant change in our occupancy levels and improvement in our four-hour access. We did that for two reasons. We wanted to be comfortable that we were taking the right actions to make the change and we wanted to lift the spirits of staff who have gone through such a challenging period.

The approach had a fantastic impact. Some occupancy rates at our sites dropped from 106 or 107 per cent down to the 90 per cents; our four-hour access performance improved; and our eight-hour and 12-hour wait levels reduced significantly. However, the challenge is that the redesign requires resources and further change.

As we came out of the firebreak, we moved back into challenging performance, but operation FLOW 2 has now kicked off. It is looking at the new phase, taking all the learning from the trial period and making a robust plan for winter 2023-24. That is where we are at.

That is a whole-system effort, and I have to say that Lanarkshire works well as a whole system across health and social care and with other partners. The work that we did during the firebreak and the work that we are doing in operation FLOW 2 is being carried out closely with the Scottish Ambulance Service.

The Deputy Convener: That is really encouraging. Has the ability to do three-year financial planning made a difference? Has it made an impact on your ability to sustain your approach?

Professor Gardner: Yes—three-year planning will certainly allow us to do that. We need to shape change and reform, which means that we will need to change where we put some of our investment to bolster the front end of the hospital and get people back into their homes as quickly and effectively as we can.

Doing that across one year is incredibly challenging, but doing it across three years gives us further flexibility. We are working with Scottish Government colleagues on our plan, and the challenge is whether we will be able to undertake a full redesign and reform and look at how we can have sustainable services across our three acute sites within the three-year period. Our aspiration is to use the flexibility most effectively.

The Deputy Convener: What impact has the recent inflationary pressure had on your cost base and capital investments? In the several evidence sessions that we have had so far with NHS boards, we have noted particular issues with repair backlogs. There are issues with operational flow, maintaining efficiencies and the three-year financial envelope, but what impact has the increase in inflation had on your ability to plan for a break-even point?

Professor Gardner: In 2022-23, inflation had a significant impact on our energy costs. We estimated that, up to the end of the calendar year, some of our energy costs were up by as much as 59 per cent, and that was challenging. For the coming financial year, we hope that increases will be significantly lower, and we estimate an increase of 14.5 to 15 per cent, but we are still concerned about the impact.

We have done a huge amount of work to make our buildings more sustainable. In Lanarkshire, we have three private finance initiative buildings and, as colleagues might be aware, we continue to work through significant repair issues at the University hospital Monklands site, which have been in the media recently.

Those are our most significant areas of pressure as far as maintenance is concerned because, under the PFI contracts, we have to manage some of our capital for maintenance slightly differently. Unfortunately, we still face on-going challenges with repairs on the Monklands site; indeed, another on-going issue is the Monklands replacement project, which we are looking at.

The Deputy Convener: Is that replacement project still on track? Are you facing any challenges with procurement as a result of the increase in construction inflation?

Professor Gardner: There have been increases, as you would expect, but our business case includes all those costs. We are awaiting the decision on that, which is with the executive at the Scottish Government.

The Deputy Convener: Professor Archibald, will you comment on the points that your colleague from NHS Lanarkshire just made about the need for flow, financial stability and, in particular, the introduction of measures that address people's issues further down the chain of the patient journey, which avoids the costs that arise when people present later to acute services?

Professor Grant Archibald (NHS Tayside): Good morning, colleagues. I will reflect on what Jann Gardner said. The deputy convener referred to the Audit Scotland report, which identified the issue not as an NHS or Scotland matter but as part of the global challenges that are emerging from the post-Covid environment. A lot of that relates to very high inflation rates—at levels that we have not seen since perhaps the 1970s—and increasing energy costs. Anyone who has been in any hospital facility will know the high demand that we place on energy.

You asked about performance. If I may, I will point out that, according to data that will be reported on today, our unscheduled care performance in Tayside is at 94.9 per cent, and we have had no 12-hour or eight-hour breaches in the past week. Our unscheduled care system is recognised as the best performing in mainland United Kingdom, and our percentages are regularly in the high 80s or low 90s.

As Jann Gardner said, we take a whole-system approach. The deputy convener asked about the management of demand and presentations; that is a key element, and it is a product of general practitioners, good primary care services, good relationships and good working inside hospitals. We have invested considerably in that approach over the past decade, and it continues to give results.

With regard to the diversion of activity—it might be better to call it managing activity in the best place—we have established a flow navigation centre as required by the Government, but we put senior clinicians such as consultants in the front line. I will give you some figures. In a week, we routinely see 1,600 emergency department attenders across NHS Tayside, and our flow navigation centre deals with 700 contacts. A third of those contacts come to hospital immediately; a third are asked to come at a convenient time for the patient and us—that is, outwith busy times; and a third are diverted to other services. That includes direct contact between our consultants and ambulances on the road to ensure that patients are taken to the right place.

What we need to remember in all this is that this is about people and how they work together. It is about relationships and understanding, which has been key to all our designs. I am hugely impressed with my clinical team and how it comes up with ideas for driving services forward, and that has been the case not only in unscheduled care. Since the former cabinet secretary's announcement last July, we have also continued to outperform the Scottish metric with regard to improvements for long waiters on our waiting lists,

both for out-patients and for in-patients and day cases. We outperform the Scottish average in our cancer services, too.

The whole point is that we see this as a whole system. That approach has already involved some redesign—for instance, we have gone from doing about 12 to 14 cataracts in a day session to doing about 50, as a result of our consultants coming forward with ideas about how things might be improved. Not only has that led to a great improvement in our ophthalmology waiting times, but it has made us the third most productive unit in the UK.

We have such examples of clear actions that have led straight away to benefits and results for patients, and we have identified improvements in productivity. Given the financial challenges that we face, the least that we should be aiming for is upper quartile or upper quintile performance, to be as efficient as we can be.

Finally, I am interested in population health and prevention. I have worked in the NHS in Scotland for 40 years; we are still seeing a 10-year gap in life expectancy between those who are most in need financially and those who are wealthiest.

A recent report said that, in the number of healthy life years, there can be a 26-year difference between those in the lowest economic group and those in the highest economic group. I am working with fantastically supportive colleagues in NHS Tayside and from Dundee City Council, Angus Council and Perth and Kinross Council. We are all working together, as the key stakeholders and biggest employers in Tayside, to find out what we can do to prevent people from falling into ill health and to promote a health service, not an ill-health service. We may pick up on examples of that throughout the meeting.

09:15

The Deputy Convener: Dr Gulhane has a supplementary question.

Sandesh Gulhane (Glasgow) (Con): Before I ask my question, I draw people's attention to my entry in the register of members' interests. I am a GP and have recently worked in the NHS Dumfries and Galloway and NHS Lanarkshire health board areas.

Professor Archibald talked about figures. You implement a continuous flow model, which means that patients move out of accident and emergency whether or not a bed is available for them. They might sit in a corridor, side room or waiting room or might sit as an extra patient in a ward environment. Where are those patients captured in the data?

Professor Archibald: Patients are captured in the data. Anyone who has to be moved out of the ED is still on the clock. Our services have been audited, and we have had visits from Government. We would be pleased to invite you to attend and see that system. There is a commentary that is often offered about us.

My office looks out over A and E and I do not see queues of ambulances, which would be the first indicator of a system that was under pressure. We do not have that. It might be useful for us to share more detail with you, but I assure you that our processes in Tayside are in good working order. I am content for people to come and see that.

The Deputy Convener: I turn to Mr Ace from NHS Dumfries and Galloway. We have talked about patient flow and the need to avoid costs where possible, to address the financial stability of health boards. Bearing in mind what your colleagues have said, will you talk about some of the things that you are doing in NHS Dumfries and Galloway?

Jeff Ace (NHS Dumfries and Galloway): I will avoid repetition. We are all engaged in the sorts of redesigns and best-value work that you would expect us to be engaged in to reduce waste and to improve efficiency and performance.

It is important to note that this is not the usual financial position for the NHS in Scotland. Times are difficult and there are financial pressures. In 2022-23, NHS Dumfries and Galloway will have been running at a deficit for the first time this century. We can project the scale of the gap by using inflationary pressures and the requirement to achieve activity goals. The gap is probably beyond our usual level of efficiency savings. We set ourselves a target of achieving a 3 per cent saving per year, which would be right up there with the highest level that the system has achieved historically, but that is not enough. It will not bridge the gap; the gap continues to grow.

Although we are probably at the top end of Scotland's financial problems proportionately, all boards are reporting difficulties in breaking even as they look at forecasts for the next two to three years. That is not how things have been in Scotland over the past decade, when things have been difficult but have not been as they are now or as it seems they will be.

We will require a level of service redesign and really difficult decisions that we have not seen so far. Individual boards—particularly relatively small ones such as mine—will have to collaborate regionally and nationally in a way that we have not managed before, so that we have a once-for-Scotland programme to bring plans together.

To turn to the workforce, technically, I cannot afford one in 10 of my workforce, but I clearly need all those people and more to meet the service demands that we are facing.

I want committee members to be aware that the financial challenge is quite extraordinary at the moment. Like Grant Archibald, I have worked in the NHS since the 1980s. I am a finance director by background and I have never seen a position as challenging as this. It will require all of us, from national and regional perspectives and local boards, to be focused on redesign to give us a chance of getting through this.

Emma Harper (South Scotland) (SNP): I have a question for Jeff Ace, but before I ask it I remind everybody that I am a former NHS Dumfries and Galloway employee and was part of the Covid vaccination team as a nurse during the pandemic.

What particular changes have been made for service delivery? We met last Friday, as part of our normal updates. Parts of Dumfries and Galloway are really remote and rural, so one of the things that you talked about was the development of home teams. Will that help to manage the service in a better way—not necessarily to make savings, but to improve efficiency?

Jeff Ace: Yes—I hope that it will do both. I hope that there will be a much better service for the local population and a more efficient one in terms of use of resources.

A number of boards will be able to talk to you about hospital at home models. Because we have a very dispersed rural population, we have looked at having eight local teams across Dumfries and Galloway. We have tried to base those around general practice clusters so that we have our primary care teams right at the core, linked with community and district nursing.

We are trying to avoid hospital admissions wherever appropriate, and are working closely with local care homes on that to allow flexibility in our bed-base use. When an individual is admitted to either the Galloway community hospital, the Dumfries and Galloway royal infirmary or Midpark hospital, we allow repatriation of that individual as fast possible to a facility close to their home or we support them back to their home.

We are in the really early days of the project, as you are aware but, initially, it seems to be popular with patients and a good environment for our staff to work in. We are getting very positive reports back. We are getting good engagement from primary care and it is delivering the efficiency that we need.

I do not wish to be gloomy in front of the committee, but I will say that the efficiencies that we can talk about here are absolutely what the systems need constantly to be aiming at. However, they are not currently of a scale to address the financial deficit. What is probably causing sleepless nights at the moment is the scale of cost reduction that faces us.

Home teams are something that we are throwing an awful lot of management resource and time at in order to get them right, because we think that that is the right thing to do and the right model for our dispersed community. It will improve efficiency and it will save a little bit of money, but not at a scale that would address the financial problem.

The Deputy Convener: You made a major point about one in 10 people on your payroll not being affordable. You also said that the financial efficiencies that you are hoping to achieve will come nowhere near addressing the backlog, even with a three-year planning window. What is needed to make you not have sleepless nights?

Jeff Ace: As I said, we need co-ordination across Scotland. We need service plans, workforce plans and financial plans that work at national, regional and local levels to deliver a service that is fit for the future. We all have good examples locally of change that can be made to improve services and reduce costs. We now have to implement those sorts of changes at scale.

During the pandemic years, we did not have the capacity to look at our models and ask what will work for our demographic challenges of the next 20 years. A fantastic piece of work by Professor Roy came out a week or so ago. It looks at Scotland's demographics over the next generation and beyond, right up into the 2070s. It shows that there will be a significant increase in the number of older adults and a significant reduction in the working-age population in Scotland. That creates a sort of existential challenge to our current service models. We have to be similarly radical in reshaping models locally, regionally and nationally in order to meet the challenges. I fear that if we do otherwise the scale of the financial challenge will force us into the sorts of service cuts and reductions that none of us wants to see.

It is up to us, at the moment, to be very bold in terms of our models of what we see as being the right health and care service for Scotland at regional, national and local levels, and we need to start engaging with our population about the big changes that are needed.

Emma Harper: Jeff Ace talked about a Scotland-wide approach, with combined or joint services. Do you mean combined human resources as part of joint work and integration, or combined financial services? Is that something that could work for NHS Dumfries and Galloway,

which is a small board, or does there need to be a Scotland-wide approach, as well?

Jeff Ace: I think that both are needed; we need consideration of joint services—clinical and non-clinical—and integrated patient pathways.

We also have huge opportunities with changes in technology. Take imaging, for example. I chair the diagnostic steering group, and we can now set up systems in which a radiologist in one board can report on scans from another board. We can save huge amounts of resources by pooling demand and addressing it to the available capacity, rather than individual boards either not being able to report on scans or having to go to the private sector for reports on scans. Things are happening technologically that allow us to collaborate much more effectively than we have in the past.

Imaging is an obvious example. Laboratory services is another area where we can be quite bold and look at what will be required over the next generation for a population of 5.2 million or 5.3 million. We need to ask what is the best laboratory service that we can provide for that population and how we can configure it in the most effective way. Those are the big questions that we now have to ask and answer in the context of the financial problem.

None of that is to say that there will be a worse service at the end of that. We have huge opportunities to catch up on changes that we did not make during the pandemic years, and to create a much more modern and effective future service, but that requires us to think at national and regional scales.

The Deputy Convener: That leads us neatly to Evelyn Tweed's questions on performance.

Evelyn Tweed (Stirling) (SNP): Good morning, panel. My first question is to Professor Archibald. I am really interested in your A and E figure—91 per cent is fantastic. Can you share with us how that works? Sandesh Gulhane asked a related question earlier. Are you sharing your learning with other boards?

Professor Archibald: As I tried to explain, that is a product of keeping a system in harmony and being able to ensure that flows continue to work. Part of the question about flows is about delayed discharges, on which we have achieved significant improvements recently. I have worked in other boards in Scotland; the level of delayed discharges in Tayside is significantly lower than it is in them. Again, that is down to good co-operation between ourselves and our integration joint board colleagues. I believe that the Angus IJB is probably the best performing one in Scotland. Last week, we had one patient in from Angus, which has a reasonable population.

The whole design has been formulated by clinicians. That is key. I have run emergency departments in Glasgow, Edinburgh, Lanarkshire and Fife, so I have seen other parts of the system. The thing that impresses me most about Tayside is that the clinicians have engaged for a long time with a very clear view about what they are trying to do, and we—I and previous people—have tried to support them in their endeavours.

09:30

The flow navigation centre is a great example, because it is about creative thinking. If all 700 of its patients were to turn up at the door of my hospitals this week, my attendances would go from 1,600 to 2,300, which would be unsustainable in hospital terms. It is necessary to think clearly about that. We also have an expert frailty model that tries to deal with frail elderly patients. There are several examples.

We also have a command centre. Jann Gardner and her colleagues from Lanarkshire have been to see it. We have also had people from NHS Ayrshire and Arran and NHS Grampian has been in contact with us, and two of our colleagues went to work with colleagues in Glasgow. Although we are not saying that everything that we do would be an immediate fit elsewhere, I am—as I said to your colleague—more than happy for people to come and see what we are doing, because I am immensely proud of the efforts that are being put in. Given the challenges that have been seen across not only Scotland, but in England, Northern Ireland and Wales, our having regularly achieved the performance levels that we have achieved is quite remarkable. In the period from January to April this year, we had—I think—12 12-hour breaches. Scotland as a whole had 19,000. We are, therefore, different, and we are working to continue that.

As I said, that is a product of collaborative working, but there are also systems of ours that colleagues from elsewhere have come to see. We are very pleased to share that learning. I have said that we in Tayside do not need to be the first to do things, but that we need to try to be the best, including through learning from others. I have reached out to other boards that are good at things in order to be supported by them.

Evelyn Tweed: Thanks, Professor Archibald. That is a great offer. It is certainly one that I would like to take up. Perhaps the committee will chat about that after the meeting.

My second question is for Professor Gardner. Will you tell us more about the firebreak? How did that work, and were there any negative impacts of it?

Professor Gardner: That leads on nicely from Grant Archibald's comment. In the run-up to the firebreak, we took time to design what we were going to do and to bring our staff on board and take them with us. Similarly, it is our clinicians who have done the fantastic work; they are the people who drive the service and who have the ideas. As I touched on before, we also wanted to help them to have hope and to look at how we could do things differently in the future. We did various site visits. We are all very open to learning, and Grant and his team are fantastic and supportive in helping us to evolve our plans. The first part, prior to the firebreak, was to design what we were going to do.

The second part, in the firebreak, was a period during which we took resource from various parts of our system to create, in effect, the model of care that we wanted and would like going forward. We have just—literally yesterday—launched operation FLOW 2. As we enter that, we will embed some change.

What we are doing is full-system and is about using all the learning. The elements that have been talked about take a decade for laying down a structure. The resource piece is really important for us: we recognise that we need to resource things in a different way and to redesign some of the distribution of our resources in order to run a service effectively, in the way that Tayside and others have done. We have also been to Glasgow and seen the flow model that your colleague spoke about, and we have seen the Tayside model.

It is about the whole flow. At the back end of the hospital, we have to make sure of what we do in relation to our delayed discharges. We worked cohesively with our health and social care partnerships to take an active view. It starts at the beginning. It is about each different part of the pathway. It starts before somebody comes into hospital.

We looked at different ways of supporting: I will give a few examples. In relation to care homes, when patients might have been brought to hospital we augmented our flow navigation in order to give advice to people who had elderly patients in care homes, rather than have them bring the patients into the hospital. Through the firebreak, we doubled the number of hospital at home beds—virtual beds—that we had, and we augmented care of the elderly and the advance nurse practitioner roles, in that space. We were looking first for opportunities to keep people well.

In our flow navigation—taking some of the learning from Tayside and other areas—we then worked with our Scottish Ambulance Service colleagues to do professional-to-professional calls. We try to give advice to a range of professionals in our community and in the Ambulance Service, in the right place and at the right time, to avoid conveyance in ambulances.

We then tried to achieve a flow for patients who arrived in the A and E department. We know that, unfortunately, as bed waits become a problem, the departments become clogged. The worst challenge—which has a terrible impact on staff morale and the patient experience—is when A and E is full, in effect, and our staff try to manage that flow almost at the same time, in parallel.

We were therefore working hard in our ward area to make sure that, every day, every person understood their role. That was the big communication piece that we were doing in the run-up to the firebreak, and people are really keen to get back to that. Every ward had a ward beat and a discharge rate that it was trying to work to. Staff did board rounds—again, to constantly focus on what every patient needed and the most efficient pathway for them.

On working in partnership, I cannot overstress the fact that everyone who has skin in the game has to be involved. Every part of the system must work cohesively. We saw that happen, because everybody was able to free up enough resource.

The changes are not enormous, but we look at it as a jigsaw puzzle. We have a lot of fantastic pieces: we have brilliant people and great clinicians who work really hard. However, some of our jigsaw pieces are missing. During the firebreak, we tried to put the right pieces in place to augment and to give a more cohesive picture. That made our wards work more effectively, so we had a better flow, and, although this is not statistically significant, because the period was not long enough, we started to see a reduction in the length of stay. There also started to be a reduction in onward care needs, so discharge care needs caused less impact. We also saw a difference in our patients' experience and our clinicians' ability to deal with patients.

You asked about adverse impact. The hardest part was that we knew that we could not sustain the model: people went into this knowing that the purpose was to test a new model and then to confidently build. We will need to make a significant resource shift, so we had to make sure that we were clear on the return on investment in every jigsaw piece. That is what has come out.

It has been hard for staff. Their heads were lifted: people started to work in the way that they want to work and our clinicians felt assured. Of all our work on health and wellbeing for our staff, the best thing is to enable them to work in the right environment in the right way to provide care. For everybody, the distress of working in the wrong way has been significant. The hard thing is that we

have dipped, but spirits are high and people have the ambition to get back up there right now. However, the commitment has to be that we do it now and build in time for winter.

Evelyn Tweed: Thank you. Deputy convener, can I ask one more question?

The Deputy Convener: Certainly.

Evelyn Tweed: My last question is for Jeff Ace. I am a former resident of Dumfries and Galloway, where I stayed for 16 years. One statistic jumps out of your written submission; it is that the turnover in senior managers was 33.3 per cent in 2022-23. Will you talk us through that?

Jeff Ace: We have such a tiny cohort of senior managers that only a few retirements generated that figure. In some years, the figure could be nought per cent. It was driven purely by a small number of retirals.

Evelyn Tweed: Okay, so are there no issues in culture or leadership?

Jeff Ace: I would hesitate to say of any organisation that there are no issues of culture. We should always challenge ourselves. However, in that particular case, I know the reasons for the retirals of the individuals, and culture was not a driver. All organisations—especially as we come out of the past three years—need to be very aware of pressure on staff, including managerial staff, and of how we can regenerate the optimism that Jann Gardner was talking about a minute ago—trying to get the belief that teams can make things better.

That is a challenge for all of us at the moment. You will have heard previously about the sense that staff are tired after the pandemic and that it has felt like a long slog without much light at the end of the tunnel. As leaders, it is our job to try to re-inject optimism and give staff the sort of plan that Jann talked about—how we can make things better, how we can make it feel better to work in the environment and how we can improve patient outcomes and experience. That return of optimism after the past three years is a critical thing on which we, as leaders, need to focus.

The Deputy Convener: Before we move on, I want to ask a quick question of Professor Gardner. From the chart that I saw, A and E performance in NHS Lanarkshire is at 60 per cent, which is relatively low in comparison with other areas' performance. Can you account for that?

Professor Gardner: As colleagues will be aware, we have three acute hospitals in NHS Lanarkshire, which, in itself, is both an opportunity and a challenge with regard to workforce sustainability and the provision of the three services. The three hospitals face very different challenges and, indeed, opportunities, and we have seen quite the variation in performance across them. Without going back into all the detail, I note that the work that I have spoken about is targeted at what each of the three sites need. University hospital Wishaw has had particular challenges through the winter; there is a slightly different configuration on that site in that it operates as the Lanarkshire trauma centre and has a paediatric, neonatal and obstetrics area, and its location—very close to the centre of Wishaw—means that the flow in from the population that is served is different.

Through the work that we are doing, we are looking to understand how to rebalance across our three hospitals and how to rise to the challenge. I am sorry to keep coming back to the same point: our issues are not about our A and E service but about the whole system——our wards and the fact that our length of stay has drifted back up. Our delayed discharges are going very well and are in a positive place, although we are working to reduce them further. This is about every single part of the system—it is about finding the jigsaw puzzle pieces and getting that perfect picture.

On why NHS Lanarkshire is in a more challenging position than the rest of Scotland, much of that is linked to our demographics and the system that we have at the moment, which is not effectively designed to deliver for that demographic. For us, the direct and indirect post-pandemic issues—frailty, chronic conditions and the throughput of patients with the most complex conditions—have had a significant impact.

The Deputy Convener: Thank you very much. Emma Harper will ask about Covid recovery.

Emma Harper: The Scottish Government published a Covid recovery document—the "NHS recovery plan 2021-2026"—in August 2021. How is that plan working out for the different boards and would you change anything in it after implementing some of its recommendations?

Professor Archibald: Thank you very much for the question. First, I have some reflections from NHS Tayside and then a broader comment. In Tayside, we have Stracathro hospital, Perth royal infirmary and Ninewells hospital, which is our major hospital. Throughout the pandemic, unlike other places we did not ever suspend all elective surgery but tried to keep some sites running and to continue to deliver services—that is evidenced by the Scottish data about the management of waiting lists, which shows the relative growth of our waiting list when compared to the all-Scotland position.

Regarding the recovery plan, which has been key for us all, we are looking to recover not to 2019 but to what is required in 2023 and beyond. We did have targets, and I am pleased to advise

that in the recently issued Scottish data—not my own—Tayside is at 99 per cent of its pre-Covid position in relation to in-patients and day cases and at 96 per cent in relation to out-patients.

09:45

At each stage in the recovery plan, we have overperformed against the trajectory that we agreed with the Government. The key challenge is that, although that is the picture now, as Jeff Ace and others have reflected, the next period looks quite different to the pre-Covid period. It is important that we remain versatile and adaptive and that we understand where our pressures are. I would much prefer that we could put more time into prevention, rather than ill-health services, but there is already a backlog of people who need care, so Scotland will have to manage that over the next few years.

It will be important for us all to give hope not only to the patients who might be waiting for services such as elective surgery, but to our staff—hope that things will be better and different and that they will not continue as they are now. That is part of the redesign element with our clinical teams in relation to how we build, not back to 2019 but to something different, better and more appropriate for the demands that we are seeing.

Professor Gardner: Planned and unplanned care go hand in glove, so the challenge for Lanarkshire has been to ensure that we have sufficient beds to bring in elective patients when there are unscheduled care pressures. However, we are working diligently to redesign and find new ways of working to address the plans that were set out.

Across a variety of specialties, we are sitting at between 70 and 90 per cent of pre-pandemic levels. We have an additional challenge, in that Lanarkshire uses the Golden Jubilee university national hospital as part of its elective plan. Obviously, and rightly, given the needs of Scotland, some of those allocations have changed to be given to the patients who most need care. That means that we have lost some of our pre-pandemic capacity and that has also been a challenge. We are looking at ways of redesigning service delivery.

We are embracing the use of technology, with things such as colon capsule endoscopy and cytosponge tests offering people different ways of accessing diagnostics. We continue to work differently. However, the NHS is a system, and we keep coming back to the balance within the whole system. We are all focused on improving our unscheduled care performance and returning our planned care, but a number of us have made the point about the recalibration to what is right in 2023.

We are also working with the new national elective co-ordination unit—again, that is a national piece of work—to try to look at the waiting list that we have and to ensure that those who are waiting are still in need of the same thing and that, while they wait, they are well supported. We are trying different ways of supporting people as we bring our performance back.

Emma Harper: The recovery plan is a five-year plan; coming out of Covid is not an overnight fix. It will take time, and I know that as a nurse myself.

I am interested in the cancer diagnostics centres. One was created in Ayrshire and Arran, one in Fife and one in Dumfries and Galloway. Prevention and early diagnostics are happening in NHS Dumfries and Galloway, where there is a trial of self-sampling for cervical cancer diagnosis. Would Mr Ace like to comment on that?

Jeff Ace: Yes, thanks. On the early diagnostics work in Scotland, as you say, we set up three initial pilot schemes and we now have five boards using the early diagnostics route. That is really promising in what it is delivering. As you know, like much of the UK, Scotland's record on early diagnosis and treatment of cancer is relatively poor compared to international best practice. However, what the pilot schemes are showing is that, if we work in partnership with GP colleagues, giving rapid access to diagnostic expertise and multidisciplinary review, we can identify earlier some previously difficult cancers that do not present with standard markers that make diagnosis easy. All three of the original pilot sites report positively on what can be done with a fairly small resource. The issue is more one of reorganisation. I am very pleased with that, both locally and given that I am part of the national working group on early diagnostics.

When it comes to the broader catch-up with our pre-pandemic performance, it is important to stress that, as Grant Archibald said, all our systems are working to get back to their pre-pandemic activity levels, and that is a challenge. We have found it particularly difficult in major elective surgery that requires several days of post-operative stay. We have found it difficult to guarantee those beds, because of the pressure on unscheduled care. There is no elective centre locally, so DGRI has to operate as both a hot site and a cold site, and it has been hard to ring fence cold capacity for major surgical work. That is a challenge.

However, I also point out that just getting back to our pre-pandemic levels will not fix the backlog but will simply stop things from getting worse. We need to overachieve on activity for several years—

as you have pointed out—in order to catch up with the huge amount of work that was lost during the pandemic. A five-year period is ambitious. It will certainly take us time to create that catch-up.

In the early 2000s, we radically reduced waiting times. We made enormous strides in cutting waits from years to weeks. That came with huge amounts of resource and extra staffing—none of which is likely to be on the table, given the context that we have talked about. This is a massive redesign challenge for Scotland, which we will throw ourselves into. We will absolutely continue to make the gains that we are making, but the challenge is very significant over the next few years.

Emma Harper: Professor Archibald, you talked about prevention and keeping folk out of hospital. I am the convener of the cross-party group in the Scottish Parliament on lung health. We talk about keeping fit, healthy and out of hospital people who have chronic obstructive pulmonary disease. It is the same for asthma. Are you undertaking such work as well?

Professor Archibald: Yes, absolutely. In my mind, there are two elements. The first is immediate prevention, as in your good example of managing people who have COPD.

Some of us are old enough to remember that people used to come in for four days to get their tonsils out. Now, people walk out of Stracathro hospital on the day that they have a hip or knee replacement. The world has moved on, yet the demand is still there.

My two points are, therefore, first, who can be managed at home, through frailty units and support, exactly as has been said. Secondly, there is a bigger question about how we manage demand and get out into communities. We can identify the communities that will have issues in their health over the next few years. My wish and ambition in Tayside is to engage more and to put more of our effort into that, to make sure that we are able to deal with the levels of demand that might present in the next three to five years.

People think of public health and population health as paying back over decades. Sometimes, it can pay back quickly, if it is focused. For example, in Dundee, we eradicated hepatitis C among the drug-using population within three years—13 years ahead of the World Health Organization's international standard.

I have studied public health and therefore know that there are issues about taking aeons—a long time—to deal with things. However, the origin of public health was the identification and fixing of a dirty standpipe that was poisoning the population in Victorian London.

My last point is about an analogy that I have used when speaking to my colleagues, which I hope will be helpful to the committee. I am young enough to remember that firemen used to run around—their lights were always blazing and they were going up and down ladders. Now, 80 per cent of the firemen's time is spent on prevention. They put in smoke detectors. What are the smoke detectors in health? I ask that because we cannot keep developing acute and emergency services, given the staffing challenges that we will have over the next few years and the financial challenges that we face. I hope that that was a helpful analogy, deputy convener.

Gillian Mackay (Central Scotland) (Green): Would witnesses highlight any areas where good progress has been made on the recovery plan, and why do you think that that is?

Professor Gardner: I will first talk about what "good" is. That is a challenge for us, because we are often drawn to the numbers, but actually, some of those innovative examples of care are also good. It is about trying to keep that balance, although we always keep an eye on performance.

To link back to the previous point, Lanarkshire is about to have one of the early diagnostic centres for cancer. We have done a lot of good, innovative work in and around cancer as a challenge. One element that is coming out of Covid is the fact that a higher number of patients are presenting with early symptoms, although the conversion rate to confirmed diagnosis is not the same as it would have been pre-Covid. Although the numbers are higher, fortunately the numbers of people with a positive cancer diagnosis are not in direct correlation.

We are using video technology and telehealth to do active referral triage early doors, which means that people are being seen and their case considered early by senior clinicians. Again, that gives people peace of mind. It is the right focused approach, which is important so that we do not waste resource.

We also use discharged-patient-initiated reviews. Rather than giving people lots of return appointments, there are ways of coming back into our service when patients themselves are concerned. I touched on things such as the colon capsule and cytosponge. We also use things such as double quantitative faecal immunochemical testing to look at the patients who are most likely to need our help.

A significant part of the next phase is pathway redesign: keeping people well, using advanced practice where we can and giving patients access when they know that they need the help. That is what we are trying to do. In things such as the low-risk lung pathway that we are looking at as an

example in Lanarkshire, advanced practice nurses are able to help patients to see somebody when they need it most. It is also important that we continue to work with national services such as the national elective co-ordination unit, where we can pull in resources from across Scotland to help triage our patients.

Those are examples of where we are beginning to reform. That is not how we used to do things. We are looking at our workforce and technology and trying to harness those changes into our services.

Professor Archibald: Our approach has been twofold. First, it has been about demand management in its real sense. We put in a review of patient-initiated returns. Rather than having new-to-return ratios dictated by us, we considered how we could get patients to indicate by a call whether they felt that they needed to come back. That freed up more than 5,000 appointments, which was a huge achievement.

We went through our active clinical referral programme and were able to identify another more than 12,000 appointments that could be used. It is very important that we engage in our communities in all that we do. Professor Gardner identified the cancer example, which is important, because if we get a lot of the "worried well" being referred in, it will block up diagnostics and slow down the level of capacity that is available for people who are diagnosed with cancer. That is why demand management, our engagement with our population and our GPs, clear referral guidelines and constant dialogue are important.

It is clear that there is a delivery and productivity issue. I referred to the huge jump in clinician-led productivity that we have achieved in our ophthalmology service. We have the best performing single robot site in Scotland.

Professor Gardner mentioned Monklands; one of my challenges in Tayside is that 53 per cent of my real estate is more than 50 years old. Ninewells is 50 years old this year, and it is my major hospital. I have been lucky enough to work at the Royal infirmary of Edinburgh, and I opened University hospital Wishaw and Queen Elizabeth university hospital in Glasgow. New hospitals do not guarantee better care, but they give you a better chance of delivering it. We need to look at infrastructure as well.

Finally, with regard to our key productivity metrics, we are looking at how we become more adaptable to our population needs and how we provide services at times that are most convenient and when they will be used. That will be about embracing issues such as the DNAs—or the "did not attends"—and looking at the productivity of theatres. We have to set ourselves the most challenging of standards; as I have said, we need to be in the upper quintile to be able to identify ourselves as a high-performing organisation. We can then have a debate on the challenges of resourcing, as referenced in the Auditor General's report.

10:00

Gillian Mackay: I wonder whether Jeff Ace can comment on this question, too.

Jeff Ace: We can certainly list our own surgical productivity examples. For example, we very recently undertook our first four-joint list; I know that that will be pretty old hat to some of the elective centres, but for us, as a small district general hospital, it was quite a milestone. We have also just redesigned our ophthalmic theatres to allow for a significant increase in our productivity.

As Grant Archibald said, boards will need to be challenged on their productivity improvement as we move forward. I do not think that we in Scotland have the luxury of being able to allow for significant variation in productivity; if my board cannot be as productive as a board elsewhere, my whole service model needs to be questioned and I need to be put under pressure to increase my productivity. We in Scotland need, as individual boards, to give that absolute guarantee that we are exploring the real leading edge of efficiency, productivity, flow, redesign and so on.

The bigger issue is population health. How do we work with our population to give them the health that allows our services to cope? It feels like a huge challenge, but the fact is that sections of our population are already at that level of health. At the moment, the most affluent parts of our population are not using our services to the extent that the least affluent are. That is not some historical accident; they are able to benefit from being able to make certain choices, from their own experiences, from their access to leisure and so on, which puts them in a health position that is markedly different from that of those who do not have such choices.

As Grant Archibald said, we can focus our public health and health improvement activity on those where it will make the most massive and rapid difference. Not only will that take pressure off services, but it is, ethically, the right thing to do. It is completely unacceptable that in the 21st century we have the sort of gap in healthy expected life years that we have between our least and most affluent. There is therefore a moral imperative for us to do the right thing here, which at the same time will take enormous pressure off our services.

We have seen from work such as the Newcastle LifeCurve how we can enable healthy ageing. You

can make dramatic changes to people's frailty and reduce their dependence on services. That must be a huge part of how Scotland recovers from Covid and delivers a health and care service that is sustainable and high performing and which meets the needs of those who need it most. It is one of those beautiful occurrences where the right thing comes together with what we need to do and sets our agenda over the next decade.

Gillian Mackay: That very neatly leads me on to my second question. I agree with the panel that we need to look at how we improve population health as a whole, not just to make the NHS more sustainable but to give people a better quality of life. Does the panel believe that the NHS recovery plan that we have now can act as a catalyst to change some of the way in which we are doing things and to move more attention towards the preventative health agenda, or are we at risk of focusing just on the acute pathways and repeating the old mistakes of not moving quickly enough?

Professor Gardner: Your points are well made. We need a balance. As an anchor organisation, we have an incredibly important role as we look to the future. As many other boards are, NHS Lanarkshire is looking to our youth. We do direct public health work on vaccination and better health—in fact, we have just launched our new healthcare strategy, "Our health together", which is about providing better care and better value for our population—but I will use the example of our youth.

We have started to work more closely with schools, particularly those in deprived areas, in order to inspire children and help them to understand the opportunities in being employed in healthcare. We are also starting to develop different pathways for people for whom on-going university or college opportunities might not be appropriate.

How can children come to us after leaving school? We are looking at modern apprenticeships and at qualifications given by the Scottish Qualifications Authority that might help children to come to us. We are looking to inspire people from a young age and help them to understand the opportunities. There is a double edge. It is wonderful if people want to become part of our workforce one day, but, even if they do not, they can learn about healthy living and some key messages.

We also want to help our young people to come to us through academies. We have a local care academy, and we work with a number of academic institutions in central Scotland and with the NHS Scotland Academy to provide further employment opportunities for children, particularly those from deprived backgrounds.

It is about health, education, employment and the onward benefits that come with all that. As part of our broader plan, those elements are important. The health sector sees itself as both a direct deliverer and a critical influencer as an employer.

I have touched on the issues relating to NHS Lanarkshire and our challenge in that 52 per cent of our population live in deprived areas. Our staff belong to those communities—those people are their families—so what we see in our population is what we see in our staff group and vice versa.

Through providing a number of opportunities—I have spoken about just one—we hope that we can start to have an influence in our community.

The Deputy Convener: I invite Tess White to lead on the escalation framework and mental health theme. If it is okay, I would appreciate brevity, as we are up against time.

Tess White (North East Scotland) (Con): I have two questions for Professor Gardner and two questions for Professor Archibald.

Professor Gardner, 74 per cent of children and young people are waiting more than a year to start treatment in NHS Lanarkshire. Why are the waits so long?

Professor Gardner: We have had some significant challenges with our services in relation to our approach to design. However, we have done a radical review of our child and adolescent mental health services and our psychological services for young people. Recently, I was delighted to take part in the opening of a new facility that has resulted from investment in our CAMHS and to meet some service users, who talked about the difference that the facility is making. It has had a significant impact; we will have already reduced CAHMS waits by almost 50 per cent between August of the year before and this August, and we are looking to continue to bring down waits significantly throughout this financial year. We are developing new ways of working, such as providing group opportunities for children to access, and we are trying to address needs earlier in the pathway by providing education to children in schools.

In relation to our CAMHS and psychological services, we are doing a range of improvement work, which is having a direct impact on our performance as it begins to change. Obviously, we focused on our longest waits, but we will now see a significant improvement in performance across CAMHS and psychological services during the rest of this year. That has been done through innovation, a refresh of our teams and the ambitious and visionary approach of the clinical teams who drive the services.

Tess White: A lot of work is going on, but have the Scottish Government cuts to mental health funding affected NHS Lanarkshire's mental health services?

Professor Gardner: There is a challenge with resources in all parts of our system, but we have used our available resources and worked with the Government. As I have said, a recent example of that was the £1.5 million investment in refurbishing a building to provide an area where children and young adolescents can share their stories and talk about their issues. Although it remains a challenge, we have been able to focus on the issue and, as a result, have been able to bring about a significant change in performance. Every number in the figure for performance is linked to a child and the difference that is being made for them.

Tess White: Thank you.

Professor Archibald, you used the powerful analogy of smoke detectors. The report of the independent inquiry into mental health services in Tayside expressed concern about workforce planning. What steps is NHS Tayside taking to improve strategic planning, staff appraisal and exit interviews?

Professor Archibald: Thank you for the question. Mental health services in Tayside are a key challenge area for us, as is well known, and an independent oversight group worked with us on the issue and concluded its report.

We are approaching the issue on a whole-system basis, which I will take a minute to explain. It involves the Tayside executive partners—the three council chief executives, me and the chief inspector of police—because we see the challenges of mental health as needing a whole-system approach instead of involving just the acute phases. However, you are entirely right; we have staffing challenges, particularly with regard to consulting. It is a challenge for the whole of Scotland but is most acute in Tayside.

We are also looking to ensure that we can fully staff all of our nursing services. We are appointing nursing graduates proleptically, which means that, during their last allocation to a ward or department, we offer them a job as well as the opportunity to spend their last session working in that department. That approach has involved 70 mental health nurses of a total of 308 nurses for the whole of Tayside, and it is part of our engagement with the University of Dundee and the colleges on how we can retain a workforce in Tayside while ensuring that we attract people in the future.

As for our consultant body, we have a high number of locums; they are long term, but it is not how, ideally, the service would be designed. That is important, because this is about designing for the future. If we know that we are going to face such staffing challenges, we need different models.

Ninety-four per cent of mental health services are delivered in community care environs and only 6 per cent in acute care. According to a UK report that came out last September, Tayside had more beds than 95 per cent of the rest of the country, and 95 per cent more admissions. We need to get underneath that and understand why that should be the case, because we want to design a preventative and community-based mental health system.

Our Perth and Kinross IJB is taking the lead in the strategic redesign of services. Part of the narrative around that is whether we have single sites for our mental health services, much as Jann Gardner referenced with regard to acute care, and therefore maximise the benefit of the staff who need to be in hospital environments.

It is important, too, that we understand that 94 per cent of the service is delivered in the community. If we have more beds than most of the rest of the country, we have to ask: why is that the case? How do we redesign our services differently while, at the same time, seeking to recruit and making the service an attractive place to work?

Tess White: How are you continuing to drive change in mental health services, particularly when it comes to the six areas of strategic focus highlighted by the independent oversight assurance group?

Professor Archibald: That is quite a big question, given the time that we have, so if you do not mind, I will give you the high-level version. Given that you are a local MSP, we can engage in a more detailed discussion outside this room.

On progress towards a single site, I have tried to describe what is happening. A strategic commissioning engagement is being led by the IJBs, as it is a delegated function, although we contribute to it.

We have accepted the need to streamline the priorities and the change programme in our strategic document "Living Life Well" and to have far quicker and clearer delivery times for certain parts of that ambitious programme. Again, that is being worked on through our IJBs and the health board.

10:15

As for making integration work and engaging with the workforce, both of those elements are about how we redesign the service and make it different. You have asked about engagement with our workforce, and a lot of that work is being done

through exit interviews so that we can understand why people leave and can try to make the place more attractive for the 70 new recruits.

Engaging with patients and their families has been a huge challenge for us. We have tried, but the important question is whether people feel that we have tried to do the right things. We have had feedback that that is not the case, so the IJBs are leading a complete restructure of our engagement programmes with a multiplicity of groups to ensure that we hear people's voices. Our original document was called "Listen Learn Change". We want to get the listening bit right and hear what the population wants.

There is continuous focus on patient safety. We are concerned that, even though the number of beds that we have is at the high end of UK provision, there are still times when, because of the level of demand, I have to use unfunded beds and try to get staff at short notice. That brings me back to my earlier analogy. We should not try to build more beds; instead, we should work out why people need to be admitted and whether we can intercept that earlier.

As a final example, we had a young man who was suffering from depression; he became part of a walking group in Camperdown park and he is now a park ranger with friends and so on. He is the poster boy, I guess, for what can be done with a non-medicalised intervention, because it gave this guy a job, hope, friends, and social networks. Those are the things that I need help with, because NHS Tayside does not provide them alone. That is why we are trying to do this with all our colleagues in Tayside.

The Deputy Convener: Thank you. We now move to Dr Gulhane, who will lead questions on staffing issues.

Sandesh Gulhane: I want to start by asking Professor Archibald about his high staff turnover rate of around 13 per cent. What are the main challenges for retaining staff in your area?

Professor Archibald: Analysis of that 13 per cent shows that a lot of it has to do with people going on to other jobs and retiral. The recent changes to pensions and the ability to bring people who have retired back to work will improve that position considerably.

I am doing some work with the business unit at the University of Dundee to try to cut through all the narrative and find out what the situation is by asking people what happens in their jobs, what makes them feel rewarded, what would make them stay and what would make them consider doing something else. Having spent 30 years working in the central belt, I am struck by the fact that recruitment beyond the central belt is just more difficult. I returned to Tayside, because I am a Dundonian; whether I would have gone there had I not been is a different question. As a result, what we are trying to do with the universities, particularly the medical and nursing schools, is ask how we retain the people who train in Dundee. They are our best capture. How do we retain our existing workforce by making them feel valued?

Something that we in Tayside are proud of is our commitment to partnership working with our staff and their trade unions. They have been so supportive and helpful in the four years that I have worked there, and they have been a key part of what we are trying to do. I have 13,000 people working for me; we all need to work together and we all need to feel valued, and that, essentially, is all about coming to work and believing that you are successful, rewarded and recognised in your job. That has been difficult in the past few years, particularly with Covid, but I remain committed to the statement that we value and want to retain our staff. Having spoken to some of my consultant colleagues and others, I believe that the new pension rules will help us do that.

We talk a lot about nurses and doctors—which is understandable, as they are the big part of the workforce—but at times we are challenged by other areas such as allied health professionals and radiodiagnostics. Beyond that, one of the challenges that I face at the moment is recruiting trained staff to my estates department. After all, they are the people who need to be there to make sure that everything works as it should. We have engaged with the University of Dundee on this, because we wanted to cut through the narrative, determine the causation and find out what we can do about the situation. We will develop a plan for that.

Sandesh Gulhane: So you have a plan for looking into what is happening.

Professor Archibald: Yes.

Sandesh Gulhane: I often hear staff say that it is, as they always describe it, the little things that make a huge difference. On my visit to University hospital Ayr, I noted that it had a fantastic canteen that provides hot food at night time. Does your hospital do that?

Professor Archibald: We have a fantastic canteen with hot food in the evening, but not overnight. I might be wrong, but I think that that is typical everywhere.

We created 15 rest, recover and recharge—or RRR—rooms where staff can sit down and get a break from the work environment and where we provide basic teas and coffees and so on. During Covid, we provided food, too, but we have just given that approach a bit of a flex.

As you have said, it is all about the small things. We have talked about EDs; the biggest queue that I could show you is for the fish and chips at the Dundee canteen on a Friday. Consultants tell me that the service is great. In fact, they asked me whether we could get the catering guy to talk to us about change, given how he has turned the catering department around.

You are right, though—it is the small things that make people feel valued. When we make those kinds of changes, people understand that we are listening to them and are trying to provide for them. Our RRR rooms have been a good statement of that. As you have said, too, a good canteen has value and makes a difference. Unfortunately, I am a product of the fish and chips that I talked about, but it is those sorts of things that we need to think about.

Sandesh Gulhane: It really does make a difference.

My last question is for Jeff Ace. In NHS Dumfries and Galloway, 12 per cent of medical, dental and consultant roles and 11 per cent of allied healthcare professional roles are vacant. Given that you are in an even more rural area, what challenges do you face, and what are you doing to improve the situation?

Jeff Ace: It is a staggering challenge that is on a par with the financial issues that we discussed earlier.

We are working very closely with the University of the West of Scotland, the University of Glasgow and Dumfries and Galloway College—all of which are next door to me on the Crichton park, here in Dumfries—to look at our future vacancy projections. That work will examine in what professions we will experience particular problems and how we can optimise training offers in them.

The best example of where that approach is working well is the Scottish graduate entry medicine programme—or ScotGEM—through which we and other boards have got together with education providers and local general practitioners to provide a different route in for professions. Locally, we have been astonished at ScotGEM's success; it has been almost transformational, particularly with regard to GP capacity.

Secondly, we in Dumfries and Galloway face a problem that goes beyond health—and, indeed, probably applies to rural Scotland as a whole. If we look at future population projections, we see that our working-age population is going to fall and our older adult population is going to increase. If nothing is done about that, we will become a less vibrant economy and potentially a less attractive place for people and their families to relocate to. In such a future, we will be constantly pushing the rock uphill with regard to professional recruitment and trying to bring into the area people whom we want to locate here. We want them to see the fantastic opportunities and facilities that we can provide and the fantastic teams that they can work with.

A real challenge is turning that demographic future around, so that the future of rural Scotland is not one of working-age population decline or of an increasingly elderly, perhaps economically inactive, population, but one that is vibrant and attractive to professions and families to move into. We are working with our community planning partners, particularly the council, on trying to change that much larger issue. If it is not fixed, the challenge with regard to health will always be about how we bring professionals into this community and get them to relocate here with their families and see how brilliant working in rural Scotland can be.

Carol Mochan: I have two questions. In the interests of time, I will ask both of them now.

First, in general, we understand and recognise that staffing is a longer-term solution. However, what one or two things could we—the boards, the Scottish Government and the Scottish Parliament—do, by working together, that might ease the pressure in the next year or two?

My second question is on midwifery. We see a lot of figures for nursing and midwifery together. However, I have met some midwives—there were midwives in the Parliament last week—who say that there are particular pressures around the recruitment and retention of midwives. Midwifery is an essential part of the healthcare system. How do you find the situation in your own areas? I would be interested to know that.

Professor Gardner: I will start with the first question, on the general elements and how Parliament can provide support.

I go back to my point about ensuring that our policies can enable us to bring our systems back into balance. When I speak to staff, the biggest thing that they ask for is retention. We often go straight to recruitment, but retention is almost more important. We need to look after the fantastic people we have, and then look to how we bring in more people and make the health service a good place to work in.

There is positive work to be done to help to tell our public about that. We have gone through a challenging space. Everybody clapped for the NHS, and it was really positive. We then went into a space where colleagues are concerned about pay and conditions.

There is sometimes a skewed view among the public that the health service is not a good place in which to work, as they hear about the challenges

that we are working with. There is an opportunity to help to tell the people of Scotland about all the good work that is being done and the good experience that can still come from working in a healthcare environment, which we all love. We need to encourage the public to see some of those positive opportunities.

A second element is linked to the working conditions for staff, which, in turn, are linked to some of the reform that we have talked about. We will need to make some brave decisions to change the shape of services radically and do what is right for our population, and to create good places for our people to work in as we move forward.

That also brings in education. As I touched on earlier, we need to make it easier for people to come in, and make recruitment processes easier. We know that how people are recruited and how they respond are quite different now. There are drop-in days in which people come in and are interviewed; they see the workplace and talk to staff. We need to do those types of things. We also need to build relationships with communities and with families as early as possible in a child's life in order to bring families in. That is the general piece of work.

With regard to midwifery in particular, a lot of those elements play out in that area, and they probably play out more strongly because of the emotional aspect and the importance of those services. We know how much we value our maternity services and, indeed, our neonatal and paediatric services; the community holds those very dear.

We need to create the right conditions and offer ways of allowing our staff in post to develop. We want to have a more sensitive ladder of development for people so that it is easier for them to develop. They do not necessarily need to go out and do a postgraduate course, but they can develop through easier access. They do not need to come in fully qualified. It is about those types of things. We want different pathways. That will take time to lay down, but working in different ways to support people and give them those opportunities will be the most significant aspect.

We also know that, in the environments in which people work—maternity is an example—there is often loss, which is really hard. We have seen the same issues throughout the pandemic. Our population has complex health needs, and the women who come into our services have more and more such needs.

Locally, in the recent period, we have had a number of people coming in, and some acute phases in which a number of women—a much higher number than we would previously have seen—were unwell themselves or had complex health needs and were pregnant. We need to make the career supportive and provide development opportunities to learn midwifery. We need to support and develop multidisciplinary teams. We need to create areas—as we are currently doing in Wishaw—for people who may be experiencing a stillbirth, for example, and make the whole experience better for families and also for our staff.

10:30

Emma Harper: I have a quick question for Jeff Ace about international recruitment. You have been quite successful in recruiting nurses. Not only a warm welcome, orientation and training are required; a wider holistic approach is required. Is housing a challenge in recruiting folk to remote or rural areas such as Dumfries and Galloway? If so, what can be done about that?

Jeff Ace: Help with housing was going to be my one ask from the Parliament. You are right: we have enjoyed our experience of international and non-European Union recruitment. We have been relatively successful, and we have brought a couple of dozen nurses and other staff into the system. We can provide wraparound support with initial accommodation and orientate those individuals in the community, but we cannot provide affordable housing, which is a real problem in Dumfries and Galloway and, I am sure, in the rest of rural Scotland. Staff who try to move into the area experience significant difficulties in accessing convenient and affordable housing.

If healthcare in rural Scotland is to thrive in the next generation, a lot of non-healthcare things need to be done to the economy and to our ability to house key workers in the right sort of affordable accommodation. If I could ask the Parliament for one thing, it would be to look at housing pressures in rural Scotland and what could be done to make it more attractive for companies to build, share or provide affordable housing, particularly for key workers.

Tess White: I have a question for Professor Archibald. The smoke alarm is definitely going off in the area of staff turnover. There is a 13 per cent staff turnover rate in NHS Tayside. You get information from exit interviews. What are the main challenges in retaining staff within your health board?

Professor Archibald: As I have said, initial analysis of people's reasons for leaving shows that they do so because they have been promoted, they are going into other jobs or they are retiring. I think that I am right in saying that 25 per cent of my mental health nursing workforce could retire in the next three years. We need to find different ways of working with that. It is clearly

for staff to make the life choice to retire. We need to understand the profile of who is leaving as well as their reasons for doing so, because the age of the workforce will be a telling determinant of where we go next.

As I have tried to articulate, our emphasis has been on seeking to recruit. To go back to a previous question, we have made a number of proleptic appointments from the nursing cohort in Tayside this year. Forty of those people will go into midwifery, which is an area that we have a challenge in. We have taken focused actions to try to achieve real results.

The engagement with staff needs to go on. We are trying to brand NHS Tayside as an employer of choice. We cannot put ourselves any closer to the central belt, where there is a better concentration of available staff, so we need to make ourselves remarkable through three things. One is our performance and having a reputation as a high-performing board. The second is being a caring board for our staff—a board that looks after its staff, makes them feel valued, and gives them opportunities. The third, and most important, thing is having a place to which people come and do their job and see the benefit of that reflected in high appraisal from those who use the service, their relatives and the communities that those people serve.

The Deputy Convener: Mr Torrance has some questions about culture.

David Torrance: Good morning, everyone. In the absence of a national dignity at work survey, how do boards monitor bullying and harassment in the workplace? Are boards confident that national whistleblowing standards are being followed and that people who have concerns are being suitably supported?

Professor Archibald: In recognition of the time, I will be brief.

We have arrangements through our human resources function, we have the whistleblowing function, and we also have our staff governance committee. That committee analyses any reported cases of bullying and harassment and assures itself that the cases were managed appropriately and the issues were resolved. In that context, it is important that there is a high emphasis on early resolution and trying to get people to work together but, if that does not work, there are further actions that can be taken.

Can I be assured? Yes, I am assured through my staff governance process, and through the area partnership forum, which is where we meet with all our staff-side colleagues. We have a narrative there about confidence in the conduct and culture of the organisation. The situation is not always the same in all areas, and we need to embrace that, understand why, and address issues where they are identified. However, I am assured through those arrangements not only that we are aware of cases of bullying and harassment and seek to resolve them, but that we seek to learn in order to prevent such cases in future.

Professor Gardner: Similarly, we have a range of approaches. We very much value the relationship with our staff-side colleagues. We get direct feedback from staff but, through those staff-side colleagues, we also get the assurance that we have good interactions. We carried out an internal audit of whistleblowing to ensure that our framework was in place. That came back in November 2022, and it noted substantial assurance and commended the process and the various routes.

Of course, we always remain alive to the issue. Any organisation that takes it for granted that the culture is right does so at its peril. We live and breathe the issue each day, but we feel that we have done significant work, and we continue to do so, through staff wellbeing work and through listening to the feedback from iMatter surveys and interactions with our staff side, as well as feedback from our area partnership forum, our staff governance committees and audit.

Jeff Ace: I agree entirely with what colleagues have said. The only thing that I would add is that we also find it useful locally to talk to specific networks, such as the LGBT network and black and minority ethnic staff networks. Visiting those and getting first-hand opinions of what it is like to work in NHS Dumfries and Galloway provides rich information that might not be captured by some of the bigger survey work. We find that to be a useful addition to the sort of work that my colleagues have talked about.

The Deputy Convener: Ms Harper has a quick supplementary question.

Emma Harper: It is just a quick question. What has been learned from the Sturrock review, which has been taken forward in other NHS boards?

Jeff Ace: It feels as if the Sturrock review was quite a long time ago now. We had a joint session of our board and our staff-side colleagues on all the Sturrock recommendations, and we prioritised our local action plan and tried to implement that as best we could. As I said, given what has happened during the pandemic, we almost need to start again with some of that work. It has been an unusual three years, and we almost operated under an emergency command and control environment for two of those three years. The board will probably now look at a good reset of where we are with Sturrock. As I said, at the time, we had a full joint review with our staff side to

ensure that we were on top of all the recommendations.

The Deputy Convener: As there are no further urgent points to make, I thank Professor Gardner, Professor Archibald and Mr Ace for coming to the meeting—you have given very helpful and detailed responses to the questions. If we want to correspond with you on any further points, we will follow up. We appreciate your time this morning.

We will have a short break to allow the witnesses to change over. It will be very short, as we have less than a minute until the scheduled time for the next panel.

10:39

Meeting suspended.

10:44

On resuming—

Complex Mesh Surgical Service

The Deputy Convener: I welcome the panel of witnesses who have joined us for our next item. Dr Alan Mathers, who is chief of medicine for women and children's services at NHS Greater Glasgow and Clyde, is joining us online. Dr Wael Agur is lead urogynaecologist at NHS Ayrshire and Arran and a member of the Scottish Government's mesh complications working group. Dr Anna Lamont is medical director for procurement, commissioning and facilities at NHS National Services Scotland. Terry O'Kelly, who is senior medical adviser to the Scottish Government, is also joining us online.

I welcome all four of you. We will begin with some questions about experiences of referral and access to the complex mesh surgical service. What are the appropriate pathways into the service? How are they communicated to health boards, general practice and relevant specialties? Can more be done to increase awareness of the service?

10:45

Dr Wael Agur (NHS Ayrshire and Arran): The pathway for treatment of mesh complications in women has improved significantly, but there are still areas in which it can be improved. That starts from the GP side, with the GP practices, and goes through to secondary care and the national centre. There are also pathways from GPs directly into the national centre. Ideally, they should first go through the local specialist centre in the local health board that is responsible for the patients, and then to the national centre. However, it is my understanding that there are direct referrals from GPs straight to the national centre. I am not sure how many of those referrals there have been, but I think that I read that somewhere in one of the documents that have been circulated.

An important area in which there is scope for improvement of the pathway is GP awareness of mesh complications. It is my understanding that the Scottish Government has taken significant steps on that, but we need to be clear that GPs deal with a wide and diverse range of conditions, and there needs to be persistent communication to raise awareness of mesh complications, because this is an emerging field. We need to raise awareness that the symptoms that women present with can mimic those of a wide variety of conditions.

There also needs to be a lower threshold for attribution of the presenting symptoms to the presence of a mesh device. Rather than attributing

the presenting symptoms to a common condition such as menopause or endometriosis, it is important to look back at the medical history and find out whether there has been a urogynaecological procedure for incontinence and prolapse and whether a mesh device has been implanted. It is important to actually listen to the women if they say, "I think that something has not been quite right since the operation I had."

Our awareness as clinicians in secondary care and the awareness of GPs have increased, but more improvement is certainly needed, and GPs need to be supported in that regard. It came across in the committee's survey that more GP awareness is required. That is one aspect of the pathway that could be improved.

Dr Anna Lamont (NHS National Services Scotland): In response to the critical feedback that we received from women looking for surgery and support for mesh complications, it is important first of all that I express sincere regret, both on a personal level and on behalf of NSS, for the difficulties that they have experienced. We appreciate the courage that it takes to share such lived experience and the challenge that is involved in sharing such personal information.

It is critical that we acknowledge the difficulties that they have experienced and that we look at the pathway variations between individual boards, the lack of cohesion in referrals and the lack of information around GPs and local specialists that we have heard about. I understand the stress that the women experience in trying to access treatment and the challenge that they describe in their feedback.

Back in June 2022, we established a clear collaborative pathway for referral to independent providers in the US and down in Bristol. As a result of that pathway, which was shared with the boards and with specialists, there have been 37 women referred so far to an independent provider. That does not mean that we are content with that; we want to continue to improve.

If we reflect on the survey responses, we can see that there is, as has been mentioned, a clear need to improve the communication that we have with the women all the way through that pathway, particularly within primary care and in the journey between primary care and the local specialists. Reflecting on that, we should now be looking to communicate more directly with GPs about the need to raise awareness of mesh complications.

It is important that the survey work continues. I am sure that Dr Mathers will describe some of the more recent survey work, but we need to learn from the feedback and to continue to improve. Where we can improve, we will, and we will continue to ensure that the services that we provide are both effective and efficient. I think that we can all agree that that is the least that we can do for those women.

The Deputy Convener: Dr Mathers, would you agree with that assessment? What can be done, in practical terms, to increase awareness of the service?

Dr Alan Mathers (NHS Greater Glasgow and Clyde): I echo the two previous speakers' comments about the difficulties encountered by patients who have been harmed in this way. Just to correct something—or to make it clear—the mesh centre does not now take direct referrals from GPs. There is a historical element to that. It may be that GPs in the health board area refer to one of the urogynaecologists but, in circumstances where the patient requires the mesh centre multidisciplinary team, they are referred by local secondary care using the electronic form that we have insisted on since October 2022.

Obviously, the mesh centre gets referrals in. How those patients are initially seen and triaged and the awareness that there is out there will be very different in different parts of the country. It is a testament to the fortitude of a lot of the patients, who will not take some of the responses that are in the survey for granted, and who push for referral. More national awareness and better local awareness and referral patterns will all help, because the mesh centre is at the top of the pyramid.

The Deputy Convener: Thank you. Mr O'Kelly, would you like to offer an assessment of the current pathways for referral and increasing awareness of them?

Terry O'Kelly (Scottish Government): Can I make a comment, from where I am sitting in Aberdeen? I think that we are aware of issues—[*Inaudible*.]—expected that there will be difficulties—[*Inaudible*.]—patients and clinicians—[*Inaudible*.]—symptoms to a particular cause.

The Deputy Convener: We are struggling with your sound a bit.

Terry O'Kelly: The chief medical officer has already written to primary care regarding that, stressing the importance of patients being listened to when they are reporting symptoms. We have also worked with colleagues in the rest of the United Kingdom. Health Education England has prepared an education programme for primary care concerning mesh and mesh-related complications and that is up and running. The various rights and so on have been addressed.

That programme will be available in Scotland in the very near future. We had hoped that it would be available by now, but unfortunately we have a different electronic platform for learning and

education in healthcare in Scotland—the Turas system—so the programme is being modified for that. In the very near future, we will have an education programme available for all in primary care; the chief medical officer will write out to primary care again at that time to advertise and promote the programme.

With regard to the pathway, visibility for patients needs to be improved, and we would like to work with the service in general on that. Whether it is available on the complex mesh centre website or through NHS Inform is perhaps to be decided. There is an upcoming meeting of our accountable officers at which that can be discussed in greater detail. It is very important that the initial interface between patients and clinicians is favourable and that patients feel as though their issues are being taken seriously and that their care is being taken forward in a reasonable fashion.

The Deputy Convener: There is a supplementary question from Dr Gulhane.

Sandesh Gulhane: It is important to say that I am a practising GP. Dr Agur, you spoke about the pressures on GPs and the number of conditions that we need to be aware of, and I can give examples of those. People have come to the Parliament to press GPs to be more aware of chronic kidney disease and brain tumours, for example.

I am sure that you are aware that we do not always know that patients have had mesh. When we get our letters, we do not know what surgical procedure has taken place; all we know is that someone went into urology and has come out. Is it not better to also have a central access point for women to be able to call directly if they know that they have had surgery and they have had problems since then? That is an easy one—if someone tells me, "I have had problems since surgery," my first thought is, "Surgery." However, common things are common, and surgery is not always our first thought.

Dr Agur: Yes—I totally agree. It is the case not only that some GPs will not be able to know whether a mesh device has been inserted but that some women themselves do not know that. Some women present with a common complaint such as bleeding after the menopause; they are investigated for post-menopausal bleeding and we find, incidentally, that it is mesh exposure that is causing the bleeding instead of the most common cause for post-menopausal bleeding.

There used to be a central helpline. The Scottish Government put in a national helpline for women to contact; I think that that was at the height of the crisis a few years ago—perhaps Terry O'Kelly can correct me on that. When there was more awareness UK-wide of the crisis, the national helpline became a UK national helpline. I am not sure whether the helpline is still going on. My understanding is that the national helpline was more of a supportive and signposting service for the women. It is also my understanding that the women who engaged with the helpline found it incredibly helpful. What I am not sure about just now is whether it is on-going and active and whether there is still someone at the end of the line answering patient questions. The person answering used to be a specialist nurse who was mesh aware. The service was first provided by the nurses here in Glasgow and then it moved to England.

Sandesh Gulhane: What is important is that, if no one is sure whether mesh has been implanted, if a woman calls the helpline, they need to be able to find out.

Dr Agur: For a national helpline to find out, the staff need to be able to go into the patient's record. Those who have access to the hospital records are clinicians such as me, so I need to know whether the patient who is presenting with problems in relation to mesh has had a mesh device or not. Clinicians in the local hospital or health board are best set to find out that piece of information to support a woman and her GP and to receive the referral when it happens. Therefore, I am not sure how a central helpline or the existing helpline would support that.

11:00

Dr Lamont: A central helpline is useful when there is public awareness. I emphasise that I am also a practising GP. It is challenging for all clinicians to be aware of all complexities and details, which is one reason why the pathway is for a referral from a specialist. However, we can do more to improve awareness.

We also have to consider the fact that, if a specialist helpline is made available, women need to know that they have to access it. The first step is the critical one.

A central helpline would also not have access to people's records. So, although it could be reassuring, supportive and helpful and could guide people, it would not be able to provide the critical information that is required. As has already been said, accessible resources, such as NHS Inform, should be where people would expect to find them and that is where such information should be put.

There is a challenge with information and guidance for GPs in Scotland. The introductory statements mentioned an educational platform for doctors and the ways in which they access information.

A helpline is only useful if people have already realised that they need to phone it. The information must be provided in an accessible form.

We also need to learn from the women themselves. We have looked at the evidence and we have feedback about people's journeys and their experiences of those journeys. Before we put any kind of educational support in place for women, we need to hear from them about how they look for information and how they come to understand that they need it.

We must also recognise that GPs cannot be specialists in every area. They need awareness, so that someone who presents with a concern can be referred to a specialist who can take a more critical view.

The Deputy Convener: Mr O'Kelly, do you want to raise any points?

Terry O'Kelly: The NHS established and staffed a helpline at the height of the concerns about mesh, during the period of maximum activity and publicity from 2015 to 2018, but the number of calls dropped off quite dramatically and remained at a low level that made it unreasonable to continue, so the helpline was withdrawn. There are now information pages on NHS Inform.

We may be bigging up our practice, but, speaking as a practising surgeon in secondary care, I think that patient care in the NHS works best when it is integrated across primary and secondary care. I am a great believer in a patient's best advocate being their GP. Their first contact, whether medical or non-medical, should be with primary care so that they can explain problems and find ways to move forward. That is when the interaction with secondary care is important.

If we dismantle that—which, sadly, we are now seeing in the NHS because of post-Covid issues—the integration breaks down and we end up with communication problems and problems for patients who might have many intercurrent issues. If those are overlooked or not taken into account, we will end up practising poor medicine, which we must avoid if at all possible.

To go back to what Dr Agur said about a patient who might present with post-menopausal bleeding, that is a reason why a patient should be assessed and referred and it might become apparent that mesh is the underlying cause.

One would like to think that standard practice would assist, but it is important that general practitioners and primary care are tied into on-going patient management. Otherwise, we will end up with poor medicine and patients will suffer as a consequence.

The Deputy Convener: Evelyn Tweed has some questions about waiting times and referrals.

Evelyn Tweed: I have some questions for Mr O'Kelly regarding his comments about educating GPs. Those comments were really difficult to hear, but I think that the sound has been amended and it is now much better, so I will go back to what he was saying.

There is obviously an issue with referrals. GPs do not always know how to deal with them, which is having a knock-on effect on when people are seen. Did you say that the Scottish Government has an education programme to help GPs? What are you doing immediately to help them?

Terry O'Kelly: The chief medical officer has already written to primary care providers drawing their attention to issues with regard to mesh and alerting them that patients may present, that they need to be listened to and that issues need to be acted upon.

We have also worked with colleagues across the United Kingdom. Health Education England has developed an education and training package for primary care. Unfortunately, the electronic platform for medical education here in Scotland is different from that in England, and at the moment the programme is being modified. As I said, I had hoped that it would already be in the domain of primary care for education and training. We expect it to be available very soon. I apologise that there has been a delay in its coming.

Once the programme is available, the chief medical officer will write to general practitioners again, advertising it and drawing their attention to it. We hope that that, in addition to what has gone before, will help to address the issues that have been described. All that we can do is to promote that education and then canvas opinion from primary care providers and patients as to whether they still have the same issues with colleagues in primary care. If they do, we will need to make some modifications.

Evelyn Tweed: Why are there such long waits between appointments? I put that question to anyone who would like to comment.

Dr Lamont: I ask for a bit of clarity on the question. We need to recognise the differences between different stages of the appointment. There is a referral from a specialist to the complex mesh service. There have been delays in that process, but the capacity of the complex mesh service has recently increased, the number of people that it is seeing per clinic has improved and the waiting time is coming down. I will let Dr Mathers speak more about that.

There is then the waiting time from a decision to have surgery to that surgery being undertaken.

That has been reducing and, after this month, the service is offering surgery within 12 weeks of a decision being taken.

However, I point out that a large part of the complex mesh surgical service is not about surgery. We talk about it being the complex mesh surgical service, but more women, after speaking to the service and understanding the complexities and challenges of surgery, what they might and might not gain and what issues they might have with it, opt not to have surgery or to have some other form of treatment. It is really important to understand that the complex mesh surgical service is about more than surgery; it is also about deciding positively not to have surgery, or perhaps to delay having it. Surgery is not a procedure without cost to the women. We talk about the financial cost, but it is also important to understand the time and the recovery period that are involved, as well as the complications that might happen after surgery.

Returning to your question about waiting times, I note that time is also involved if a decision is made to refer someone to an independent provider—I refer to Dr Veronikis or Professor Hashim. At the moment, an MDT will make that decision. The decision will then be referred back to the local consultant specialist, who will come to the national services division—the NSD—with a request to refer out of the area to the US or Bristol. Typically, that decision will be taken within 48 hours and we will then make a referral. Dr Veronikis has been very good about booking appointments and working with the women to find a date that works for them, and we will organise travel. That time is typically a lot less than six weeks.

The waiting time, which I think people tend to focus on, and quite rightly so, is the time from referral to the complex mesh service to being seen. We acknowledge the challenges in that, and some of that is reflected in the survey responses. The situation is improving. The time from a decision on surgery to having that surgery is certainly a lot better than it was.

The Deputy Convener: Would you like to comment, Dr Mathers?

Dr Mathers: As the papers demonstrate, we are reducing waiting times for first assessment. Something that came out of our feedback was that women were finding the way in which the initial referrals were being made quite overwhelming, with patients being seen by a large number of clinicians at one time. As I said, the feedback was that that was overwhelming for some individuals, so we have adjusted the process.

As with every other specialty, we are trying to manage quite considerable waiting pressures. However, although I am still very uncomfortable at the length of time that people are having to wait, I think that we have a good news story in that, as you will see from the data that we have presented, the waiting time has been going down steadily, and we expect it to have reduced by a further eight weeks by the summer.

Evelyn Tweed: What treatment is being offered to patients on these long waiting lists? What happens to these women while they are waiting?

Dr Mathers: The women will have been referred by the GP to secondary care and, through that, to the mesh centre, and the problems that they will face in that time will be pain management, psychological issues and issues requiring physiotherapy. They do not have to wait until they are seen at the mesh centre to have those aspects managed locally, but the fact is that every part of the health system has differential waiting times with regard to the more holistic side of things as opposed to the functional aspect of simply identifying with an individual patient whether she would prefer surgical treatment of some form.

Carol Mochan: Thank you very much for the information that you have given, which is much appreciated. I wonder whether Dr Lamont or Dr Mathers can clarify something for the record. You have provided some information, but it would be useful to know the average waiting time and the longest waiting time. How long have the women who have been waiting the longest had to wait to be seen by the service?

Dr Mathers: As you will see from the survey, there are patients who have been waiting ostensibly for years. One of the problems is with knowing exactly which route an individual should take into the service. We have quoted an average waiting time in our submission, but there is a huge range, simply because there will be some people with problems that have been identified as requiring more urgent treatment and other patients for whom other needs will have arisen and who will, as a result, defer their appointments.

As far as the longest wait is concerned, we have to take the evidence from the women's survey that some have waited for years. However, with the reset of the establishment of the mesh centre, we are trying to consistently bring that waiting time down and identify why there are long waiters. Indeed, we do the same for all the other gynaecological services—and, I am sure, all the board's services.

11:15

Carol Mochan: Women are referred to the service, but we cannot be clear why they have not been seen yet—it is sometimes just a long process. Is that what you are saying?

Dr Mathers: If a woman is electronically referred to the service through the process that was introduced in October 2022, they will be put into that process. In 2021-22, the average wait for the service was 72 weeks. We have moved it down to 55 weeks and we expect it to be 47 weeks by June 2023. That partly reflects increased capacity. It is also an acknowledgment that we were overwhelming women because they were seeing an awful lot of individuals when they attended. No one is suggesting in any way that coming to be seen in the service, with the long history of problems that these women have had, can be dealt with in a short appointment.

Carol Mochan: Dr Lamont, do you have anything to add?

Dr Lamont: As the commissioner of the complex mesh service, we have exact details of median waiting times, longest waiting times and shortest waiting times on a quarterly basis. That detailed data can be provided on request if that is what is being looked for. When we look at this, though, we also need to acknowledge that the Covid and winter pressures have impacted on the Glasgow service. That is not to excuse what has happened; it is to explain why there has been, perhaps, a bit of a pause and a delay in terms of catch-up.

I also want to acknowledge the efforts that the Greater Glasgow and Clyde health board and the complex mesh service have made this year in catching up and improving the access time. The outpatient clinic has doubled its capacity and it is now seeing double the number of women weekly that it was seeing last year. That is the number that is critical. The surgery waiting time has also improved and it is now going to be under 12 weeks. However, the fact that the outpatient clinic is seeing that number of women means that the waiting list will be coming down.

The longest waiting time is not always the best measure. I can understand why it is a measure that is of interest, but sometimes people will choose to delay appointments. Sometimes the timing does not work for women and it needs to be changed. We therefore tend to work by the median waiting time each quarter. I can provide you with that detailed information.

Carol Mochan: I would really appreciate getting that data. People come to us as individuals as well, and it is important for us to be able to feed back. These long, long waits for women have been going on for years and it is our job to scrutinise things and make sure that everything is being done.

Where women have chosen the other option—to go down south or across to Dr Veronikis—is anybody currently waiting for a referral on in the system or has everyone who has requested that option to date had a referral on?

Dr Lamont: The pathway that I spoke about is a referral. The MDT will work with the women to understand what their preference is. We have a preference service, which is unique, whereby women can say whether they wish to be referred to an independent provider, and they have a choice of which independent provider they wish to go to. So far, 37 women have made a choice and they have been referred. Of those 37 women, 29 have been referred on.

The reason for the difference between the numbers is that a number of women are with local health boards awaiting referral to NSD for financial approval and for arranging the transport and surgery. That typically takes 48 hours. Before the meeting, I asked the team whether they were aware of any cases that had taken more than 48 hours, and they were not. Within 48 hours, we will approve the referral and we will then get in touch with Dr Veronikis. A clear pathway has been worked out with the boards. We have a mechanism by which the information is shared with Dr Veronikis and he will then contact the women.

So far, only one surgery has taken place with Professor Hashim, but that relates to the patient preference for the date of surgery. I am confident that no significant delay is taking place between the decision being taken for referral to an independent provider and that being arranged.

Carol Mochan: Do the figures that you quoted mean that eight women, who have chosen a different pathway, are waiting to get their final referral?

Dr Lamont: The MDT, which is the multidisciplinary team—I apologise for using acronyms; we are used to them in the NHS—and the complex mesh service work with the women to decide whether that is the route that they wish to go down. The referral is then passed back to the local specialist service, because the complex mesh surgical team is not able to make that referral itself. It has to come from the women's own health boards. Once the referral is made, it comes to NSS and we will then authorise it and make arrangements. There is a short delay—usually a matter of days or a week or so—between the referral coming back from the MDT and it being returned to us at NSD.

The Deputy Convener: Emma Harper might have a supplementary and some questions on communication.

Emma Harper: I will go directly to the communication theme. I am looking at the NSS website and the NHS Greater Glasgow and Clyde website. The NSS website is quite clear on the

pathway and what the process would be, but the NHS Greater Glasgow and Clyde website is a bit clunky for finding the information that people need—that is obviously not something that you can control, Dr Lamont.

I am interested in how women are communicated with, from the start of the process through to referral and as the process goes on. Is there open dialogue and does it happen by contact with the direct clinical nurse specialist, for instance? What is the process for communicating to keep people feeling that they are well informed?

Dr Lamont: The responsibility for communication and care rests with the women's own health boards. The initial decision around referral is with the MDT from Greater Glasgow and Clyde. Women will therefore be aware that that referral decision has been made, and their own specialist will then communicate with them about it.

As soon as we receive that referral at NSS, we establish a direct line of communication with the women—Dr Veronikis and Dr Hashim directly contact the women, too, and arrange a surgical date based on the women's preference. We continue that contact around arranging transport, travel, expenses and contact the women again when they return to ensure that surgery has taken place. Information is also passed back from Dr Veronikis and Dr Hashim to the local health board and the women's specialists about their patient stay.

However, given the feedback from both the critical survey and the continuing feedback that we receive, we are not resting on our laurels. We need to look at where we can improve communication. We can continue to improve websites. In particular, after the return from the US or Bristol, it is about improving the handover of care to the women's GPs and specialists. Although that is not an area that we can directly influence, we can share the feedback and look at how to make that pathway better. As I said in my opening statement, where we can improve, we will improve and we have a responsibility to do so.

Emma Harper: How are women advised about waiting times, for instance, or what they should expect? Do you have feedback around the processes? Is the communication done electronically or by letter or telephone call? How do we ensure that each individual feels that their preferred way of communicating is what is used?

Dr Lamont: Regarding communication around waiting times and the pathway before the referral reaches NSS, I refer you to Dr O'Kelly and Dr Mathers, whose responsibility is primarily around that part of the pathway.

NSS contacts women directly by telephone. Sometimes, we have communication by email, but we generally try to avoid it because of the sharing of personal information; we are very sensitive to the challenge that those women have with regard to sharing information, and we want to make sure that we are consistent.

Dr Veronikis arranges Teams video calls for consultations, and checks in with the women by video consultation once they have come back. Primarily, our part in that communication is by telephone, but I defer to my colleagues about communication on waiting times.

The Deputy Convener: Mr O'Kelly, do you want to come in?

Terry O'Kelly: [*Inaudible*.]

The Deputy Convener: Sorry, will you start again? You were muted for a few seconds.

Terry O'Kelly: I apologise, and I am sorry that I am joining you remotely, but there are reasons for that.

Anna Lamont has concentrated on the pathway in communication between the patient services, NSS, Dr Veronikis and Professor Hashim. Of course, the majority of patients come from secondary care under their local clinicians to the complex mesh centre in Glasgow. They follow an NHS route.

I draw the committee's attention to the work of the patient engagement and public involvement team in Glasgow, who have looked at communications specifically as one of the domains in their surveys. I hope that you have seen that. Clearly, they have shown that they have asked questions and have listened to what patients have said, and they have made changes in Glasgow.

From the results of that survey—another iteration is due soon—it appears that the performance of the outcomes is now at a very high level, with very significant results when it comes to patient satisfaction. Alan Mathers may want to say more about that.

The Deputy Convener: Dr Mathers, will you come in on that point?

Dr Mathers: I confirm that, when the patients are seen at the mesh centre and elect to have their treatment, we either send a standard letter to the referring consultant to ask for a referral to the relevant party, or we will list them for care at GGC if they wish to have their surgery in the mesh centre. Because we insist on an electronic referral pattern, we can get those outcomes faster.

Gillian Mackay: I will follow on from that, Dr Mathers. You, I think, referred earlier to the amount of information that women receive as a result of going down that pathway. How is that

information followed up? Is there a standard way of communicating in writing, or is there another way to ensure that, after an initial appointment, women can digest that information in a way that is accessible for them?

Dr Mathers: The short answer is that we are always trying to improve communication, but I do not have specific data to tell you the degree of that. Feedback suggests that we are doing well—we have had two cycles of feedback and will have another two by June 2023. I would be grateful if I could take that question away and find out more.

The Deputy Convener: No problem.

Gillian Mackay: That would be useful.

I wonder whether my next question might need the same treatment. How do you communicate how women can keep themselves well and receive alternative support while they are on waiting lists? After all, many will be experiencing pain and a variety of other symptoms, and long waits will exacerbate those things and those presentations will continue. Is there a standard way in which women receive information about where to seek additional support or how to keep themselves well while waiting for appointments or surgery?

11:30

Dr Mathers: Obviously, individual women will see a range of specialists, including psychologists and doctors, depending on their needs. We will deal with some people more urgently than others, because they might have a septic issue or have been triaged into a more urgent phase.

The other aspect of this is that one has to be careful when women have comorbidities. They have not just a mesh issue; they will come with rheumatic problems, diabetes and so on, and they will potentially have a whole stack of different medicines. As a result, one must be very careful, and general practitioners, who have a much better handle on drug interactions, ensure that there is no risk of our causing medical problems by intervening in areas that we should not be primarily responsible for. The centre attempts to deliver a holistic approach to a wide-ranging problem, and surgery is not always the offered or preferred solution to it.

Does that answer your question satisfactorily?

Gillian Mackay: Yes, it does. Thank you.

The Deputy Convener: I invite Mr Torrance to lead on the next theme.

David Torrance: Good morning to the witnesses.

I think that my question is for Dr Mathers. For how many women seen by the service was surgery not advised and other forms of management or treatment advised instead? The committee did ask for that information before today's meeting.

Dr Mathers: I have data on the patients who elected to have—and had—surgery, but I do not have at my fingertips the answer to the precise question that you have posed. I am sure that we can look into that.

It is probably also worth emphasising that some women are given an offer and then go and think about it, sometimes for as long as a year. If someone is waiting but has not yet determined whether to have surgery, we have a system of follow-up contact and, after a year, seek their re-referral, simply to ensure that they are not lost.

Dr Lamont: I do have the data. In financial year 2021-22—and so far in 2022-23, too—59 patients out of the 165 first assessments seen by the complex mesh service have opted either for conservative treatment or to defer the decision on surgery. As of 31 March, 56 surgeries have been carried out; 13 were on the waiting list for surgery in Greater Glasgow and Clyde and we have had 37 independent provider referrals.

David Torrance: Thank you for that.

The complex mesh surgical service submission states that its service is primarily a surgical service. To what extent are the witnesses confident that women who engage with it are given a clear understanding of what treatment it can and cannot provide?

Dr Lamont: I will pass the question to my colleague Dr Mathers in a moment to speak specifically for Greater Glasgow and Clyde, but you are right to highlight that the service has been commissioned as a surgical service. Indeed, we talk about the complex mesh surgical service, so we tend to think of it as a surgical service.

However, a significant part of that is about assessment. It is about the experience and about assessing how much mesh might remain after partial removals as well as the contribution of mesh to other complexities—we have heard people talk about comorbidities, by which we mean other concerns and problems. It is also about recognising that mesh would have been inserted to address a concern in the first place. A significant part of the service is about the expertise in assessing women who have complicated and complex concerns and understanding what can be done to help them.

The mesh service provides the assessment, the scanning, the psychological support and the pharmacological support with regard to which medicines can help with pain and other

complications. Obviously, it provides that centre of expertise for surgery.

I made the point earlier and I will reiterate it: although we talk about it being the complex mesh surgical service, it is really the complex mesh service. I want to acknowledge that, for the women who have been harmed by mesh, it is about the whole system—it is a complex form of complaint; it is not just about doing the surgery. If we could do surgery for all these women to solve all their problems, that would be quite a simple service, but it is far more complex than that, and the complexity of the service reflects that.

Terry O'Kelly: I support what Anna Lamont said. When we undertook the work back in 2019-20 on the need for a centre for management of mesh complications, it was thought that surgery would be the answer for most women. However, over time, it has become clear that, for a number of women, mesh removal is not necessarily the best way forward. Clearly those decisions are made by sharing information and through conversations between clinicians and patients, so that patients are empowered to make decisions about themselves and their health.

The service was developed with a holistic foundation, which will be important as we go forward. I suspect that more women who come to the service might not go down the path of having surgery. Certainly, that is the experience of the other centres across the United Kingdom. The mesh centres had a summit in London in December, and it was very interesting that one of the key messages that came forward was that surgery might be an answer for some but not for all. However, even in the case of surgery for full mesh removal, patients will need non-surgical care and other interventions in the future, so it is important that we have that expertise.

Dr Mathers: I would like to emphasise that the patients who elect not to have surgery are not left bereft of care. A GG and C patient might see a urogynaecologist in the mesh centre but, if they elect not to have surgery, they can still be referred to a urogynaecologist sub-specialist in the service. The same would be the case for someone coming from Lothian—they would go back to a specialist in that area, because as Dr Lamont said, it is not just about pain; some women will have continence issues, recurrent urinary tract infections and things that will require on-going specialist care.

Dr Agur: One of the respondents to the committee's survey mentioned the identity of the service, and I think that everyone agrees that it is not just a surgical service. It is a holistic service, as we have been saying. Whether that holistic service is delivered in the mesh service or in the local health board, that needs to be communicated very clearly to the women, so that they do not feed back in a subsequent survey that there are still concerns about the identity of the service. That could come in the mesh centre information leaflet or perhaps in the information leaflet that we provide locally in the hospital. It is about a holistic service, and surgery is just part of that. Perhaps we should also consider whether we need to keep "surgical" in the title.

Emma Harper: You have said that it is about a holistic approach. As I read the papers, I saw information about continuing feelings of being let down, of prolonged and continued anxiety and of disappointment, because the expectations were already low and they were not being met. It seems that there is also conveyance of lack of empathy for their experiences. It is almost like there needs to be a Maggie's centre equivalent for people who have had mesh injuries. It is quite difficult to read some of what has been presented. How would you describe the holistic approach? I know that psychologists and clinical nurse specialists are involved. How would you see progress being taken forward based on feedback from surveys about people's experiences?

Dr Lamont: In response to the survey, I said earlier—personally and on behalf of NSS—that we sincerely regret that that has been the experience. You asked about how we progress; I believe that we have progressed, but that is not to be complacent. I believe that the surveys that have been published in the past week, and those that will be published by Greater Glasgow and Clyde, show that we have progressed. I can certainly point to the information that we have in the feedback about providing an independent provider pathway.

I express my thanks to the Scottish Government and to my colleagues here for highlighting and progressing the issue and for making it possible to have the independent provider pathway, which is one option, and also the specialist service, which continues to be responsive.

I believe that the continued survey responses will show how we are responding. Dr Mathers can speak about how specific pieces of feedback have been acted on in order to change the way that care is being delivered in the service. As I have said, where we can improve, we will improve—and we are improving.

Sandesh Gulhane: I am not sure whether Dr Lamont or Dr Agur would be the best person to answer this. Dr Mathers referenced the urogynaecological specialist, but there has been a vacancy since July 2022. There is no consultant in post. How does that impact the service?

Dr Lamont: I would probably refer that back to Dr Mathers, but I note that there is active recruitment for that position. We are also looking

at how the service can be supported by other areas in Scotland to fill that position. The number of women who are being seen surgically through the clinic at the moment is below the capacity that could be seen if we were functioning under a system that had recovered entirely from Covid pressures. At the moment, I do not believe that that vacancy is significantly affecting the waiting list. That is reflected in improvement in waiting times. However, as I said, that is not to be complacent. We are actively recruiting, and we are also looking at how that support can be provided from elsewhere.

Dr Agur: I agree with that. There are already urogynaecologists in the service. There are also two colorectal surgeons, which is absolutely wonderful. However, the absence of a urologist is a concern. I am not part of the service, but I refer to the service. The vast majority of the mesh devices are implanted close to the bladder, which is where the urology specialist comes in. Clearly, there has been engagement with urology before. There was a urology member in the service before, and it is important that the service ensures that someone from urology joins the team, because that will improve confidence in the care for both clinicians and patients.

11:45

Dr Mathers: I want to be very clear that we have urogynaecologists, who come from gynaecology, and urologists. At present in the UK, both those services are having a great deal of difficulty with recruitment and appointments. As Dr Agur mentioned, we had an arrangement with NHS Lothian, through which we have developed a specialist in Lothian, who we hope will be able to work in Glasgow as part of their contract with NHS Lothian. We continue to sculpt in trying to attract a urologist to the current post. We are in no way complacent about the need to have urologists in the service.

Sandesh Gulhane: Dr Lamont, I do not want to get into a comparison, but I am looking for reasoning. NHS England has established a number of specialist services for women with mesh complications. How many of those services have been rolled out? What differences do they have? If there are no differences, why is that?

Dr Lamont: My understanding is that nine specialist services have been developed in NHS England, and that number reflects the difference in population sizes between England and Scotland. There is the option for a referral between the specialist mesh service in Glasgow and the specialist mesh services in England. Certainly, for NHS England, there is an option—which is similar to the independent provider pathway—whereby, if a woman does not wish to have surgery, she can be referred up to NHS Greater Glasgow and Clyde, although I am not aware of any women who have taken that option yet. I think that that reflects the evolution of the services. The service in Greater Glasgow and Clyde is a very advanced service and its expertise is recognised nationally across the UK, not just in Scotland. Therefore, I am confident that our service in Scotland is UK leading.

Certainly, as Terry O'Kelly mentioned, there have been recent conferences and there are shared experiences. There is a move to credentialling, which has not been spoken about so far today, but I want to acknowledge that that work continues to be developed. There is an expectation that, once that is up and running, all the surgeons in GG and C will meet the requirements and will be, in effect, credentialled as well.

Sandesh Gulhane: I have one final and, I hope, quick question for Dr Agur. We are talking about mesh specifically in this environment, in relation to all the concerns that we have and the specialist mesh service, but people are also concerned about the implantation of other devices and types of mesh in other types of surgery. Do you feel that those patients having mesh in different scenarios is safe and something that they should not be overly worried about?

Dr Agur: I am sorry—could you repeat the question?

Sandesh Gulhane: We have a specialist service here for women who have suffered complications with mesh, and I am looking at the difference between that and the use of other types of mesh in other types of surgery. When people hear the word "mesh", they think that it applies to absolutely all mesh and all types of surgery. I am looking for your opinion as to whether we can reassure women that the use of mesh in other circumstances is very different and safe.

Dr Agur: As a gynaecologist, I can comment only on mesh that is used for gynaecological procedures; I am unable to comment on the use of mesh for hernia surgery, for example. I am aware that there is a petition in front of the Citizen Participation and Public Petitions Committee with regard to the use of mesh devices in other areas, but I am unable to reassure women about those issues.

Since September 2018, when the then Cabinet Secretary for Health and Sport confidently suspended the mesh procedures, no mesh devices have been implanted vaginally. However, abdominal mesh procedures are being performed for gynaecological surgery. The risks with that are different—they are perceived to be lower. However, we have gone far in providing

information and offering alternatives to abdominal surgery for prolapse.

While I have my own views on that, the standard in Scotland now is that mesh for gynaecology can be implanted only abdominally, after full informed consent has been given and the patient has fully understood the alternative. That is a significant improvement since the height of the crisis around nine years ago.

The Deputy Convener: I think that Mr O'Kelly wanted to come in.

Terry O'Kelly: To go back to the mesh centres in England, we have worked closely with development of those. It should be recognised that the centre in Scotland was established almost a year prior to the publication of the Cumberlege report. We recognised the need for that, so we were forerunners.

Colleagues in Glasgow are to be congratulated on the work that they have done, and now on the evidence that they have gained from patient engagement and public involvement in the improvement team and on the performance that they are registering.

On Dr Lamont's comments about the Glasgow centre being a leader, I think that that is right in a number of fields, such as taking forward credentials and so on for full mesh removal surgery. Colleagues are to be congratulated on that. It should also be pointed out that they have achieved all that at a time of intense scrutiny both from the media and in Parliament. That has been very difficult for them, and we should recognise that.

With regard to the use of mesh in other sites, your colleague on the committee—he can correct me if I am wrong—spoke in a debate in Parliament on mesh being used in other sites, in particular in hernia repair. That issue has been considered at length. The Scottish Health Technologies Group undertook two reviews: one into inguinal hernia repair, predominantly in men, because men are affected, and subsequently into hernia sites elsewhere, involving more women. The conclusion was that, in hernia repair, mesh should be used, although alternatives should be available, and the use of mesh in other sites should be supported.

We know from the longevity of mesh that has been inserted for hernia repair that there are not the same issues, in the same volume, that we are seeing with women. To go back to Dr Agur's comments about transvaginal mesh, there is a halt to the use of that, and there is no prospect that that will be removed; the cabinet secretary has reiterated that point.

With regard to the use in gynaecology of mesh through the pelvic or abdominal routes, that is subject to a high vigilance protocol. The accountable officers—Alan Mathers is one of them—are responsible for ensuring that there is attention to detail, with dotting of i's and crossing of t's, to ensure that patients understand. In those cases, mesh can be used only where there really are no reasonable alternatives, and where there is a high degree of scrutiny in order to ensure that patients completely understand what is going to happen and why it is happening, and that they have had the information and are empowered to make decisions for themselves.

The Deputy Convener: I call Tess White.

Tess White: My question is for Terry O'Neill.

Mr O'Neill, there should be scrutiny, and it is about more than just dotting the i's and crossing the t's. What I read in the papers for this meeting was harrowing. What has happened to many of these women is harrowing. Has the service for women in Scotland been set up in line with the NHS England service specification? If not, why not?

Terry O'Kelly: My name is Terry O'Kelly, rather than Terry O'Neill.

The commissioning of services in England is different, as you know. In England, certainly, there have been a number of commissioned specialist services for women who suffer from stress urinary incontinence and pelvic organ prolapse. I think that there are 40 of those, and within that, nine centres have applied for and been designated as able to manage mesh removal surgery, should that be required.

Therefore, the commissioning is different and the payment is different in England. As you know, commissioning is done through health boards here in Scotland. Each health board in Scotland has an accountable officer, and we have been meeting accountable officers since 2018-19. They are either medical directors or very senior medical managers, such as Alan Mathers, who are responsible for ensuring that the care for women goes forward in the way that they need and in a way that is commensurate with their problems. I am absolutely not complacent about the management of these women's care. In fact, I am probably at the Raab-esque end of the spectrum of engagement and demand.

The stories that women tell are absolutely harrowing, and I have great sympathy for them because of what has happened to them. However, we need to move forward, and we need to ensure that the services that we provide for women and the way in which we communicate with them are at a level where women feel not only supported and empowered to make decisions about their treatment but that, when that treatment goes forward, it is provided at the highest possible level.

We have worked very hard with the boards and clinicians to ensure that that is the case. However, I am sorry and I was very concerned to read the Scottish Parliament information centre report. I was very troubled by it. It is not clear whether all the comments are contemporary, and it would be helpful to spend some time looking at that. I draw your attention to the work that has been done—it is on-going in Glasgow—with the patient experience and public involvement team. It is addressing those issues, and it appears, given the satisfaction that patients are reporting, that a lot of what has gone on before has been addressed and corrected. I hope that that answers your question.

Tess White: It does not really answer it, Mr O'Kelly. Can you say what has been set up in line with the provision in NHS England and, if that has not happened, can you say why? I would be grateful if you would answer that question.

Terry O'Kelly: Are you talking about people with mesh complications or the treatment of patients—the care for patients who are presenting with stress urinary incontinence and pelvic organ prolapse?

Tess White: I am talking about the latter.

Terry O'Kelly: We have worked with the health boards—with accountable officers—and we have looked at the provision of services for those patients. The work is on-going, but I have no reason to suspect that what we are asking of health boards and what they are delivering is any less than what is being delivered in NHS England. I have been part of a pelvic floor oversight group that has been looking at that.

Tess White: Thank you.

The Deputy Convener: Carol Mochan will lead questions on options for non-surgical treatment.

Carol Mochan: For me, today's meeting has raised the issue of the importance of the non-surgical side of treatment. I am sure that the same is true for other members, so I really appreciate the fact that the witnesses have spoken about that. A lot of the issues have been covered as we have gone through the evidence session.

Do we need to do anything on communication with health boards around that? Should there be an expansion of the multidisciplinary team in relation to pain management? A lot of work is being done on pain management in the community and with other services that provide that. Would that be helpful for women who cannot, or choose not to, go down the surgical route?

12:00

Dr Lamont: I hope that you would recognise from what I have been saying—I think that you have—that we really value that non-surgical approach and all the elements of it: not only the pain management and the psychological support, but providing people with an explanation and an understanding of what has happened to them. Sometimes, as the survey reflects, there is difficulty with communication and with understanding what has actually happened.

We see women who have had multiple surgeries—multiple partial removals. The question is asked about what has happened to them—what is left? A significant part of this process is about re-establishing trust. That is reflected by the fact that we have these committees and these meetings. A lot of it is about establishing that trust relationship with women again and about them understanding what the mesh was in there for in the first place. Why was it put in? What were we trying to do by putting it in? No one put the mesh in with the intent to harm. No doctor would have done that. Everything that was done was done in the true belief that that was going to help the women. It is a sad reflection to think about the harm that has happened, as was covered in the Cumberlege report.

We cannot undo the harms, but we can try to do the best that we can for these women. The GG and C centre has some state-of-the-art scanners that work in a different way from the scanners that other specialist services have, which allow us to see exactly what is there and what can be done.

There is also the point about the need for skills around interpreting that information and being able to convey it. A lot of the feedback that the GG and C service has had is in relation to the number of MDT members. In fact, in response to the survey, the service is ensuring that not everybody in that multidisciplinary team is there in the room every time, because that can be a bit overwhelming. Another big change that has been made is about delivering the information in a steady way; people may need to come back and have that information repeated.

We have spoken about pain control and psychological support, and there is dedicated pharmacy support around that within the GG and C team.

Dr Agur: Obviously, there are historical issues that affect the women's level of confidence in the service and we fully understand why many of these women describe communication issues, empathy issues, lack of trust and so on.

One way of improving that level of confidence is by reassuring them that we are communicating well within the multidisciplinary team, that we know everything about them and we are communicating well from the local hospital to the national centre. That is easy when we talk about surgical issues—

it is easy to communicate that a particular surgery has been done locally and that the patient then wants to have surgery done nationally or outside Scotland. What is difficult is the communication around the non-surgical treatment.

When the patient is referred from the local health board to the national centre, the national centre will not know exactly what sort of non-surgical treatment happened locally. One of the reasons for that is that we do not communicate that to the national centre. We could say, "Yes, the patient has been referred to the psychologist," but that does not explain what has actually happened. What was the response of the patient to that referral? We could say, "The patient has been referred to the physiotherapist," but that does not explain whether that improved things for the patient. It will probably not have improved things, because she requires a referral to the national centre.

I propose that we have a multidisciplinary team discussion and the local clinician and the national team talk about those patients and explain exactly what we have done. There are things that I can communicate to a clinician colleague that the electronic form will not communicate. We used to have that level of communication, as I covered in the paper that I circulated to the committee a few days ago. It is a historical paper—it describes practice that is probably from a decade ago—but it shows what happens when we talk to each other, either virtually or when we are present in the same room. Most of these meetings were done virtually, by the way, a few years before Covid. We were able to communicate well and we had the trust of the women because a woman could ask, "Oh, have you spoken to this person that I am going to see in Glasgow?" and we could say, "Yes, I have."

That is a good approach and would also reduce the waiting times. In the patient leaflet provided by NSS I can see that there are two steps in the pathway that could be replaced by an in-person meeting, a virtual meeting or an invitation to the local clinician who referred from the local hospital to the national centre to attend that part of the national mesh MDT meeting that discusses their patient. At that meeting, I would be able to present my patient to the team and tell them what sort of treatment the woman had locally and what her wishes are. That interface between secondary care and the national centre would boost patient confidence, and hopefully that will be reflected in the next survey.

Carol Mochan: That was very helpful. Thank you.

Emma Harper: I am interested in going right back to the beginning, knowing what we now know about complications caused by mesh implanted for stress urinary incontinence. As a nurse who worked in the operating theatre, I participated in anterior and posterior pelvic floor repair operations. However, before we even go there, is there work being done to encourage continence nurses, physios, midwives, and so on, to talk about things such as pelvic floor exercises? That advice would be free. Are we measuring whether that work, which might mitigate the need for any surgical intervention in the first place, is happening?

Dr Agur: Yes, there is engagement with non-surgical treatment for conditions that are induced by childbirth injuries—such as incontinence and prolapse. The first non-surgical options are physiotherapy and continence advice. Physiotherapists and continence nurses are an integral part of MDTs in almost every health board. Their intervention has prevented many women from having surgery. The MDT, which includes myself and other surgeons and gynaecologists, would discuss surgical options for the women for whom those interventions do not work.

However, yes—that system is there. I am not sure whether there is anything at the Government level. Perhaps Terry O'Kelly will be able to answer that part of the question. Pelvic floor education could be done on a larger scale—for example, in schools, even before the reproductive period—because planting this seed at the beginning is important.

Emma Harper: One of my former colleagues teaches Pilates, and she also does pelvic floor exercises as part of that, to destigmatise the issue. She sees young women in schools and is breaking down the barriers of conversation. Do you support taking education out to schools before young women start having experiences that might lead to urinary incontinence?

Dr Agur: Yes, there is no doubt about it. Many women come to us after childbirth with damage that has caused incontinence and prolapse, and the reason that the mesh was introduced in the first place is that when they came in many of them did not even know what the pelvic floor was or how to contract it and engage it. That is why physiotherapists spend a lot of time with them, educating them. If that happened at school, it would mean that if they were unlucky and developed these conditions during their reproductive career, they could at least know what was going on and could perhaps engage better with physiotherapy services.

The other improvement that could be made is in postpartum physiotherapy immediately after delivery. My understanding is that, at the moment, the programme for that is relatively short. It would be possible to improve that programme to enable prevention by extending it or having more regular sessions that are supervised by the

physiotherapist in the first few weeks after delivery.

The Deputy Convener: Mr Torrance wants to cover some points on local and national services.

David Torrance: What are the benefits of a national service over a local one in supporting women who are affected by transvaginal mesh?

Dr Lamont: Nationally commissioned services are highly specialist services that it would not be possible to provide in 14 different territorial health boards. There are nine specialist centres across the entirety of England and one in Scotland. The NSD, as part of NSS, commissions approximately 150 highly specialist services for Scotland, which are funded through the individual boards but all contribute to that national service, and which reflect where there needs to be highly specialised services that can provide competence and confidence in a national service.

We would not be able to have these conversations about confidence and trust if we tried to provide those services from multiple places that would only see a small number of cases. Primarily, we need to concentrate that expertise to be able to provide it as a national service, both to attract people into those services but also to convey confidence and competence to the people who are using them.

David Torrance: In the current financial circumstances, is it feasible for bespoke services to be established in every health board or region?

Dr Lamont: I refer to my previous answer. It is neither possible nor desirable to try to establish a bespoke service in every single centre, because you would not have the number of cases to be able to provide that level of experience, expertise and confidence. We have to recognise, too, the value to the NHS and to the women who are accessing those services. As part of the responsibilities of the NHS, we need to provide highly effective and efficient services, and providing those highly specialised and competent services in individual centres is a mechanism to achieve that.

We would love to be able to provide highly specialised services that are accessible and at short distances from home for everybody. However, the demographics and geography of Scotland do not allow us to be able to provide those services in every centre of the country—that is the reality that we all face when we look to arrange services.

The Deputy Convener: In the petitions committee, of which I am a former member, we heard evidence from Dr Netto from the Shouldice hospital in Ontario in Canada, who made a similar point about the need for centralised services to provide that sufficient scale of experience and critical mass of expertise. Did you undertake any international benchmarking on service design when considering how to develop the service in Scotland?

Dr Lamont: Under our service agreement, the national services are under continual review and we have a regular cycle of review.

As Dr O'Kelly has already mentioned, the service in Glasgow was the first service in the UK to be set up. We have talked about whether we are following England, but in many respects, what is being done in England is following what has happened in Scotland.

We are at a very early stage in relation to that benchmarking idea. It has already been mentioned that national committees are in place. Primarily, the mechanism towards that benchmarking is credentialing, which is the route that we are going down. It will take time because it has not been done specifically in Scotland. However, there is a commitment to that credentialing from the team within NHS Greater Glasgow and Clyde, which has already progressed and applied for it, with the expectation that all those in NHS Greater Glasgow and Clyde will then qualify for it.

The Deputy Convener: I think that Mr O'Kelly wants to make a point.

Terry O'Kelly: It is just to say that I recognise the point about Shouldice hospital.

The recommendation for establishing the centre was the outcome of the short-life working group, which engaged with all necessary stakeholders, health boards, patients and other clinical groups. The decision was taken to support continued development of the specialist service in Glasgow. As has been noted, that came a year before the conclusions in the independent medicines and medical devices safety review report were produced.

Anna Lamont mentioned credentialing, which will be really important in order to benchmark clinicians in Scotland against a curriculum and framework that has been published by the Royal College of Obstetricians and Gynaecologists and will involve working with the Royal College of Surgeons in England, with specialist associations and with the patient reference group. The documents have been out for wide consultation, including public review, and I encourage people to look at that.

12:15

We will soon introduce a registry to look at not only patients who are having mesh removal surgery but those who are having primary surgery for stress urinary incontinence and pelvic organ

prolapse. All procedures will be captured on that UK-wide registry. It will allow us to look at our activity and our outcomes, including patient-reported outcomes, for all the procedures, and that will allow benchmarking comparison. The hope is that that will build further confidence in the centre in Glasgow and in care for patients across Scotland.

The Deputy Convener: Does Dr Agur want to make a point?

Dr Agur: No, thank you—Terry O'Kelly has just made the point that I would have made.

The Deputy Convener: That is fine. Does Ms Harper want to make a supplementary point?

Emma Harper: Yes—I have a quick point. The deputy convener mentioned the Shouldice approach. A Shouldice repair has strict criteria such as losing weight, having no alcohol and being able to exercise. It might be difficult to apply that in Scotland, where people who present as needing an inguinal hernia repair that uses mesh, for instance, might have additional comorbidities. We cannae compare apples wi oranges.

Dr Agur: Again, the question is outside my expertise, because I am not a general surgeon. I have done only two hernia repairs in my whole life, and that was before I specialised as a gynaecologist. I am not qualified enough to give you a full answer, but I will answer in general.

The Shouldice repair is a non-mesh repair that has had a wonderful outcome in Shouldice hospital. People there have managed to save the vast majority of their patients from having to have a mesh device implanted for ever, which can cause problems in the future.

Hernia mesh appears to induce fewer mesh-related complications than mesh that is used for gynaecological reasons does. There are many reasons for that. However, if we compare the populations in Scotland and Canada, I do not believe that the presence of, or any perception of, a difference in comorbidities should prevent a Shouldice-like approach here in Scotland. We should at least start building the native tissue approach and allow the surgical technique to evolve, which will allow our surgeons to improve their skills and be more confident in offering native tissue non-mesh surgery. The selection criteria for patients who would benefit best from the Shouldice repair will need to be clinically based.

Such evolution needs to start as soon as possible. It involves clinical decisions about individual clinical patients, which will definitely consider comorbidity. That needs to be supported by local and national Government.

I am not an expert in this area, but that is how I see things. I had a Shouldice hernia repair, and the two hernia repairs that I have done were Shouldice repairs.

The Deputy Convener: Before we conclude the session, do any panellists wish to make any final burning points?

Terry O'Kelly: I am not sure whether this is the environment for discussions about the Shouldice approach, which have been well rehearsed. One thing that we have not mentioned is the major issue of patients waiting in Scotland and in the United Kingdom. We have not touched on programmes such as waiting well and fit for surgery. I am part of the waiting list team in the Scottish Government and I advertise and promote those initiatives.

There are opportunities for patients to make lifestyle changes and get fit in the time that they are coming to surgery. Evidence from around the country suggests that the long-term health benefits of that can be substantial. Colleagues in Glasgow know about those programmes, but we should probably consider and promote them.

The Deputy Convener: I thank all our panellists for their attention, expertise and contributions, which we as parliamentarians value hugely. We show our appreciation for that. I wish you a good afternoon.

12:20

Meeting continued in private until 12:44.

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

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