The Scottish Parliament
Pàrlamaid na h-Alba

PUBLIC PETITIONS COMMITTEE

AGENDA

11th Meeting, 2014 (Session 4)

Tuesday 3 June 2014

The Committee will meet at 10.00 am in the Robert Burns Room (CR1).

1. **Consideration of a current petition:** The Committee will consider—

   PE1501 by Stuart Graham on public inquiries into self-inflicted and accidental deaths following suspicious death investigations

   and take evidence from—

   Stephen McGowan, Deputy Director of Serious Casework, Crown Office and Procurator Fiscal Service;

   Alan McCreadie, Deputy Director of Law Reform, Law Society of Scotland;

   Detective Chief Superintendent Gary Flannigan, Police Scotland;

   Alan McCloskey, Director of Operations, Victim Support Scotland.

2. **Consideration of new petitions:** The Committee will consider—

   PE1517 by Elaine Holmes and Olive McIlroy, on behalf of the Scottish Mesh Survivors - "Hear Our Voice" campaign, on polypropylene mesh medical devices

   and take evidence from—

   Elaine Holmes, and Olive McIlroy;

   Marion Scott, Sunday Mail.

3. **Consideration of current petitions:** The Committee will consider—

   PE1319 by William Smith and Scott Robertson on improving youth football in Scotland;

PE1460 by Susan Archibald, on behalf of the Scottish Parliament Cross-Party Group on Chronic Pain, on improvement of services and resources to tackle chronic pain;
PE1482 by John Womersley on isolation in single room hospitals;
PE1488 by Pete Gregson, on behalf of Kids not Suits, on whistleblowing in local government;
PE1497 by Ellie Harrison, on behalf of Say No to Tesco, on supermarket expansion on local high streets;
PE1500 by Stuart Housden OBE, on behalf of RSPB Scotland, on the golden eagle as the national bird of Scotland;
PE1510 by Jody Curtis, on behalf of Emergency Service and Non-Emergency Service Call Centres, on emergency service and non-emergency service call centres and PE1511 by Laura Ross on Inverness fire service control room.

4. **Inquiry into tackling child sexual exploitation in Scotland:** The Committee will consider a response from the Scottish Government.

Anne Peat
Clerk to the Public Petitions Committee
Room T3.40
The Scottish Parliament
Edinburgh
Tel: 0131 348 5186
Email: Anne.peat@scottish.parliament.uk

The following papers are attached for this meeting—

Agenda item 1

PE1501	Note by the Clerk	PPC/S4/14/11/1
PRIVATE PAPER		PPC/S4/14/11/2

Agenda item 2

PE1517	Note by the Clerk	PPC/S4/14/11/3
Professor Tom Joyce Email of 23 March 2014		PE1517/A
Dr Michael Margolis Letter to the Cabinet Secretary for Health and Wellbeing of 8 September 2013		PE1517/B

Agenda item 3

PE1319	Note by the Clerk	PPC/S4/14/11/4
Scottish Youth Football Association Letter of 28 May 2014		PE1319/TT
Scotland's Commissioner for Children and Young People Letter of 29 May 2014		PE1319/UU
PE1460	Note by the Clerk	PPC/S4/14/11/5
PE1482	Note by the Clerk	PPC/S4/14/11/6
Scottish Government Letter of 15 May 2014		PE1482/G
Petitioner Email of 26 May 2014		PE1482/H
PE1488	Note by the Clerk	PPC/S4/14/11/7
Perth and Kinross Council Letter of 24 March 2014		PE1488/G
COSLA Letter of 1 April 2014		PE1488/H
Angus Council of 31 March 2014		PE1488/I
East Lothian Council Letter of 4 April 2014		PE1488/J
Aberdeen City Council Letter of 9 April 2014		PE1488/K
Dundee City Council Letter of 11 April 2014		PE1488/L
North Ayrshire Council Letter of 11 April 2014		PE1488/M
Glasgow City Council Letter of 14 April 2014		PE1488/N
South Lanarkshire Council Letter of 8 April 2014		PE1488/O
West Dunbartonshire Council Letter of 15 April 2014		PE1488/P
Accounts Commission / Audit Scotland Letter of 15 April 2014		PE1488/Q
Renfrewshire Council Letter of 15 April 2014		PE1488/R
Midlothian Council Email of 15 April 2014		PE1488/S
East Renfrewshire Council Email of 16 April 2014		PE1488/T
City of Edinburgh Council Email of 16 April 2014		PE1488/U
Fife Council Email of 18 April 2014		PE1488/V
Comhairle nan Eilean Siar Email of 1 May 2014		PE1488/W

Moray Council Letter of 26 May 2014		PE1488/X
PE1497	Note by the Clerk	PPC/S4/14/11/8
Scottish Government Letter of 14 April 2014		PE1497/J
Sandra White MSP Letter of 28 May 2014		PE1497/K
PE1500	Note by the Clerk	PPC/S4/14/11/9
Economy, Energy and Tourism Committee Letter of 30 April 2014		PE1500/E
Rural Affairs, Climate Change and the Environment Committee Letter of 30 April 2014		PE1500/F
Education and Culture Committee Letter of 1 May 2014		PE1500/G
European and External Relations Committee Letter of 6 May 2014		PE1500/H
Petitioner Letter of 28 May 2014		PE1500/I
PE1510 and PE1511	Note by the Clerk	PPC/S4/14/11/10
Justice Committee and Justice Sub-Committee on Policing Letter of 8 May 2014		PE1510/A

Agenda item 4

Scottish Government response of 30 April 2014

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1501 on public inquiries into self-inflicted and accidental deaths following suspicious death investigations

Note by the Clerk

PE1501 – Lodged 13 December 2013
Petition by Stuart Graham calling on the Scottish Parliament to urge the Scottish Government to introduce the right to a mandatory public inquiry with full evidence release in deaths determined to be self-inflicted or accidental, following suspicious death investigations.
Link to petition webpage

Purpose

1. This petition was last considered on 18 March 2014. The Committee decided to convene an evidence session to consider how the police and procurators fiscal interact with bereaved families.

Background

2. The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 provides for a form of public inquiry – the fatal accident inquiry (FAI).

3. An FAI is generally mandatory in the case of a death: apparently resulting from an accident sustained at work; or occurring whilst the deceased was in legal custody. The Lord Advocate may waive the requirement for a mandatory FAI where satisfied that the circumstances of the death have been sufficiently established in the course of relevant criminal proceedings. An FAI may also be held, on a discretionary basis, where a death is "sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern" and the Lord Advocate believes that the holding of an FAI is "expedient in the public interest" (section 1(1)(b) of the 1976 Act).

4. The petitioners do not seek an extension of the FAIs to cover more instances and types of fatality. The petitioners seek a simplified procedure whereby families are able to challenge an investigation into a death and the outcome of that investigation without having to hold an FAI or seek a judicial review should the Lord Advocate decide that an FAI is not required.

Scottish Government Action

5. In 2008, the Scottish Government appointed Lord Cullen to review the operation of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. His report 'Review of Fatal Accident Inquiry Legislation' was published in 2009 and it did not recommend the type of reform sought by the petitioner. In 2011, the Scottish Government published a response to the recommendations set out in

Lord Cullen's report. The Scottish Government intends to introduce legislation in this area in the lifetime of this Parliament,

Scottish Parliament Action

6. Public petition PE1280 (lodged September 2009) called for FAIs to be held when a person from Scotland dies abroad. It was last considered by the Justice Committee on 18 February 2014 when the committee decided to keep the petition open pending introduction of legislation on FAIs and also to write to the Cabinet Secretary for Justice for an update on the Government's position.

7. Possible Members' Bills include a proposal from Patricia Ferguson MSP for an Inquiries into Deaths (Scotland) Bill:

> "to re-enact with amendments the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:
>
> (a) to extend the scope of inquiries to cover work-related deaths not resulting from accidents, such as deaths from industrial diseases and deaths resulting from exposure at work to certain substances
>
> (b) to make the process of investigating deaths quicker and more transparent, to refer appropriate cases to specialist sheriff courts, and to give the families of the deceased person a more central role in the process".

8. A consultation on her proposal ran until 31 January 2014.

Committee Action

9. The Public Petitions Committee first considered this petition on 14 January 2014 hearing evidence from the petitioners and agreeing to write to a number of stakeholders. The Committee considered the petition and the evidence received on 18 March 2014 following which it agreed to convene a further oral evidence session.

Action

10. Following today's evidence session, the Committee is invited to agree what action it wishes to take in respect of the petition. Options include—

> (1) To invite comments from the petitioners and the Scottish Government on the evidence heard and to consider the petition again once responses are received.
>
> (2) To refer the petition to the Justice Committee on the basis that it expects to consider draft legislation on FAIs during this Parliamentary session.
>
> (3) To take any other action that the Committee considers appropriate.

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1517 on polypropylene mesh medical devices

Note by the Clerk

PE1517 – Lodged 1 May 2014
Petition by Elaine Holmes and Olive McIlroy, on behalf of the Scottish Mesh Survivors – "Hear Our Voice" campaign, Calling on the Scottish Parliament to urge the Scottish Government to:
1. Suspend use of polypropylene Transvaginal Mesh (TVM) procedures;
2. Initiate a Public Inquiry and/or comprehensive independent research to evaluate the safety of mesh devices using all evidence available, including that from across the world;
3. Introduce mandatory reporting of all adverse incidents by health professionals;
4. Set up a Scottish Transvaginal Mesh implant register with view to linking this up with national and international registers;
5. Introduce fully Informed Consent with uniformity throughout Scotland's Health Boards; and
6. Write to the MHRA and ask that they reclassify TVM devices to heightened alert status to reflect ongoing concerns worldwide.
Link to petition webpage

Purpose

1. This is a new petition that the Committee is invited to consider and agree what action it wishes to take. The Committee has invited the petitioners to speak to the petition.

Background – the following information is taken from the SPICe briefing

The use of Transvaginal Mesh

2. Transvaginal mesh (TVM) can be used in pelvic organ prolapse (POP), and transvaginal tapes (TVT) can be used in the treatment of stress urinary incontinence (SUI).

3. For both conditions there are non-surgical interventions, though it may be necessary to consider surgery in certain cases. However, traditional surgery techniques are associated with a range of short and long term complications[1]. Indeed, in terms of surgery for POP, there is a 20%-30% failure rate from primary prolapse surgery and women may need second and subsequent procedures to address prolapse recurrence. As a result, synthetic (non-absorbable) and biological (absorbable) meshes were introduced into surgery as

[1] Scottish Government (July 2013) 'Letter from the Chief Medical Officer to NHS Boards: Transvaginal mesh' (p 3)

supporting materials in surgical treatments.[2] It is estimated that about 1,500 TVT for SUI and 350 TVM for POP are implanted annually in Scotland[3].

Regulating the safety of Transvaginal Mesh Products

4. TVM and TVT products are medical devices. The regulation of medical devices (including a determination of safety before a CE mark is applied and ongoing vigilance monitoring thereafter) is a matter reserved to the UK Parliament. Regulation of Medical Devices is governed through a number of EU Directives transposed into UK law by regulations. The Medicines and Healthcare Products Regulatory Agency (MHRA) is the competent authority in this area for the UK. A short description of the regulatory system is provided in Appendix 1.

5. The petition calls for the Scottish Government to initiate a Public Inquiry and/or comprehensive independent research to evaluate the safety of mesh devices. Whilst the Scottish Government could initiate the latter, under section 28 of the Inquiries Act 2005, Scottish Ministers do have the powers to set up a public inquiry, but only where the matter concerned is devolved.

6. After a medical device has had a CE mark applied, there should be on-going vigilance monitoring including any adverse incidents that are reported on the use of a device. Whilst the MHRA has an overarching role in this, in Scotland adverse incidents are handled by Health Facilities Scotland. Its role is outlined in Appendix 2. HFS has received 14 adverse incident reports concerning TVM and TVT between 24 December 2012 and 27 March 2014[4].

Current UK guidance and evidence on the safety of TVM and TVT

7. The petitioner makes note of the recent decision by the United States Food and Drug Administration (FDA) to issue two proposed orders, which if approved, "will require manufacturers to provide premarket clinical data to demonstrate a reasonable assurance of safety and effectiveness for surgical mesh used to treat transvaginal POP repair". This followed a number of reviews by the FDA which "identified clear risks associated with surgical mesh for the transvaginal repair of pelvic organ prolapse".[5] It is important to note that the proposed order does not cover surgical mesh for SUIs and a number of other conditions.

8. The FDA's decision has led to calls for regulators at European and UK levels to review their guidance. The current MHRA view[6] is that whilst it has received a number of reports of complications arising from the use of TVM for POP, it has "no evidence the devices themselves have inherent problems that would necessitate consideration of any steps up to and including consideration of

---

[2] Medicines and Healthcare Products Regulatory Agency (Online) 'Vaginal mesh for pelvic organ prolapse'

[3] Scottish Government (July 2013) 'Letter from the Chief Medical Officer to NHS Boards: Transvaginal mesh' (p 3)

[4] Scottish Government. Personal communication 28 May 2014

[5] US Food and Drug Administration (April 2014) 'FDA issues proposals to address risks associated with surgical mesh for transvaginal repair of pelvic organ prolapse'

[6] As outlined in MHRA (Online) Vaginal mesh for pelvic organ prolapse

product removal from the market". However, due to concerns being raised, the MHRA commissioned The University of York's Health Economics Consortium to undertake an independent review of the safety and of any adverse effects associated with TVM for POP and TVT for SUI. The report was published in November 2012. This research confirmed that for TVT for SUI the rates of adverse events were low, but that for TVM for POP the rates of adverse events were higher and this is a factor which patients considering surgery will wish to take into account in discussion with their surgeons. [7]

9. The Scottish Government's advice concerning safety is discussed in the Chief Medical Officer's letter to NHS Boards from July 2013.

Determining whether a medical device is used in the NHS

10. Whilst the regulation of medical devices is reserved, whether or not a product is used in the NHS in Scotland is a devolved matter. However, unlike in the case of newly licensed medicines, newly CE marked applied medical devices are not routinely appraised for use in the NHS, though it is possible to request an assessment or apply evidence from elsewhere. For example, NHSScotland is a partner in the National Institute for Health and Clinical Excellence's interventional procedures programme which has provided guidance on the use of mesh in certain POP operations[8].

11. Whether a particular technology is used is a matter for individual clinicians and NHS Boards taking account of evidence and guidance. There are structures within the NHS in Scotland that can provide advice, including the Scottish Health Technologies Group[9], though it has not undertaken any work on TVM or TVT.

12. The petitioner calls on the Scottish Government to suspend the use of TVM procedures. The Scottish Government could issue guidance in this regard. However, in recent Parliamentary Questions, its position is for the regulatory bodies at UK and EU level to consider the evidence concerning the use of these products. Recently, the Minister for Public Health, Michael Matheson MSP stated: "…if there is any change to the guidance or a recommendation is made by the MHRA or the European Community, the Government will act swiftly on that"[10].

Informed consent

13. Another key part of the petition concerns ensuring that patients give informed consent when they are offered surgery involving TVM. In 2009, the Scottish Public Services Ombudsman upheld a complaint by a patient who had TVM

---

[7] Scottish Government (July 2013) 'Letter from the Chief Medical Officer to NHS Boards: Transvaginal mesh' (p 5-6)

[8] IPG267: Surgical repair of vaginal wall prolapse using mesh (June 2008) and IPG282: Insertion of mesh uterine suspension sling (including sacrohysteropexy) for uterine prolapse repair (January 2009)

[9] This is an advisory group that sits within Healthcare Improvement Scotland that provides advice on the evidence about the clinical and cost effectiveness of existing and new technologies that are likely to have significant implications for patient care in Scotland.

[10] S4T-00695

surgery without giving proper consent. The Scottish Government has outlined what it expects as regards obtaining proper consent from patients[11]. Included is a reference to two of the health care principles (Schedule) of the Patient's Rights (Scotland) Act 2011, namely: patients participate as fully as possible in decisions relating to the patient's health and wellbeing; and, patients are provided with such information and support as is necessary to enable them to participate in accordance with paragraph 12 and in relation to any related processes (general or specific). Further information is provided in the Health Rights Information Scotland leaflet 'Consent – it's your decision'.

14. Specific for patients who are being considered for mesh or tape surgery, the MHRA has outlined the questions patients should ask of their doctor, as well as links to professional body guidance for TVM and TVT.

Scottish Government Action

15. In addition to the actions discussed above, the Scottish Government[12] has set up an expert working group, chaired by the Deputy Chief Medical Officer, to address the issues affecting women who have undergone transvaginal mesh surgery. The group is developing:

    - A revised patient information and consent booklet for NHSScotland, to be given to women considering undergoing a synthetic vaginal mid-urethral tape procedure for stress urinary incontinence.
    - New care pathways for those women who decide to go ahead with a mesh procedure and for those who have suffered complications.
    - A strengthened process for adverse incident reporting.

16. The Cabinet Secretary for Health and Wellbeing has also written to the MHRA and the European Commission asking that they urgently consider the United States FDA's proposed reclassification of surgical mesh for the treatment of pelvic organ prolapse.[13] Other actions have included:

    - Undertaking work on the feasibility of recording the type of medical device used in treatment, and how it was used, on a patient's electronic record, to assist in identifying clearer picture of the number of patients who may be affected should problems occur with a particular implant in the future.[14]
    - Undertaking discussions with stakeholders on the establishment of an implant registry.[15]

Scottish Parliament Action

17. No committee of the Scottish Parliament has considered the specific issues contained within the petition. However, the Health and Sport Committee did take

---

[11] S4W-18278
[12] S4W-20948
[13] S4T-00695
[14] S4T-00695
[15] S4W-18271

evidence on the response of the Scottish Government and the private health sector to the PIP Breast Implants case during 2011-12.

Evidence received

18. The Committee has already a written submission from Tom Joyce, Professor of Orthopaedic Engineering at Newcastle University who argues that when there are major concerns over the use of medical implants, their use should stop. The petitioner has also provided a copy of a letter from a Dr Michael Margolis to the Cabinet Secretary for Health and Wellbeing, in which he highlights his experience of treating women with TVM implants and argues that their use should stop.

Action

19. The Committee is invited to agree what action it wishes to take in respect of the petition. Options include—

    (1) The Committee may wish to seek views on the petition from:

    - The Scottish Government
    - The Medicines Healthcare Products Regulatory Agency
    - NHS National Services Scotland

    (2) To take any other action that the Committee considers appropriate.

Appendix 1: The regulation of medical devices

Transvaginal Mesh (TVM) products are regulated as medical devices. The term "medical devices" covers a range of products, from non-invasive support products such as bandages, to implanted devices such as pacemakers breast implants and TVM. It is estimated that there are over 90,000 types of medical devices on the market in the UK[16]. Regulation includes establishing the safety of the product both prior to market authorisation (i.e. CE marking) and thereafter, and is a reserved matter to the UK Parliament. Regulation is governed through a number of EU Directives, transposed into UK law through regulations.

Medical devices are classified by the Directives according to the level of risk they pose to the patient. There are four classes of risk (I, IIa, IIb, and III), with the lowest risk devices (e.g. stethoscopes) falling into Class I, and products such as dental fillings being defined as Class IIa. Medical implants, such as TVM) are always classified as Class IIb or III, because they are placed within the body, require invasive surgery, and are designed to be in continuous use. As a result these products must be regulated in a particular way (see Figure 1).

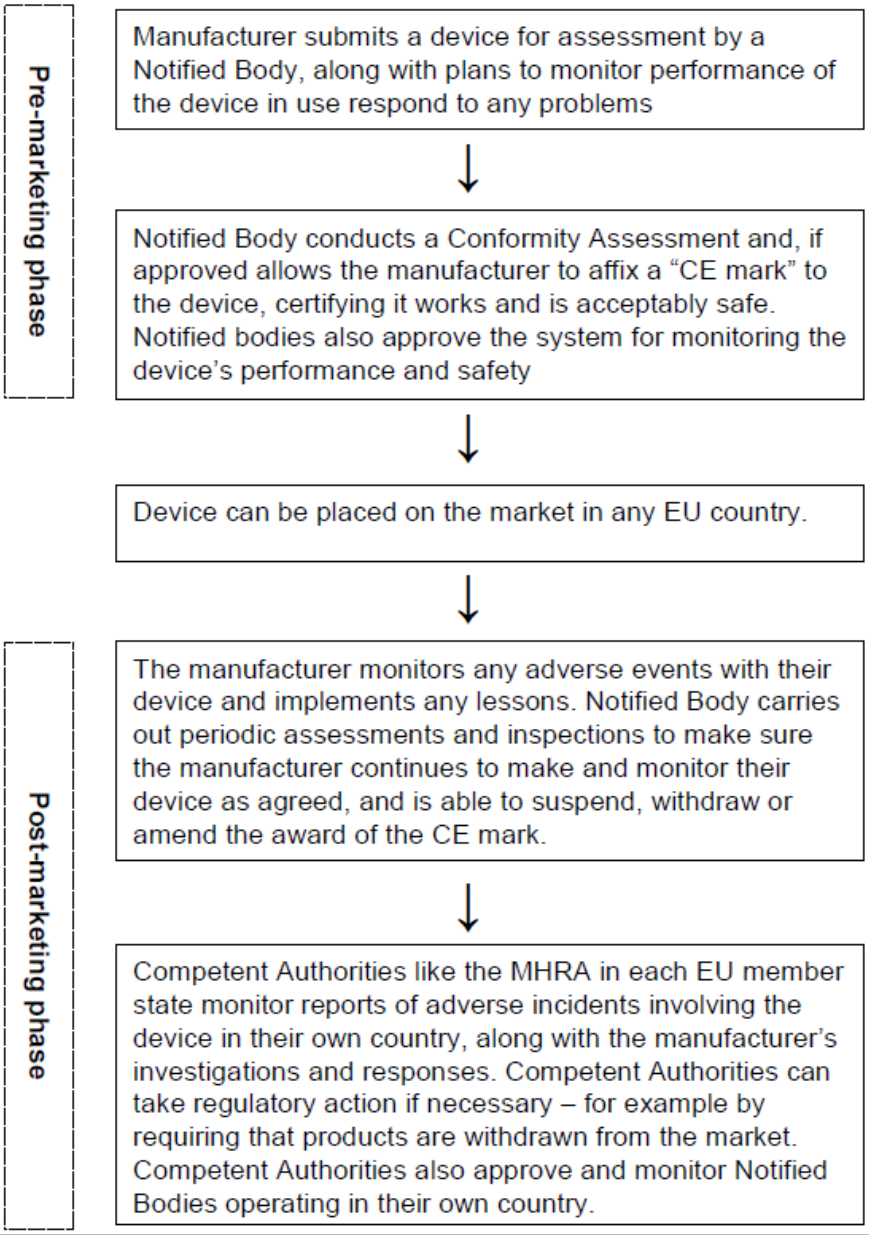
The safety of TVM and other invasive medical devices is assessed by an independent third party organisation (or "notified body") of which there are around 80 across Europe. These bodies are appointed and audited by the competent regulatory authority in each member state, which is the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK. The role of the notified body is to determine whether a particular medical device meets the relevant regulatory requirements and, whether, when used as intended, it works properly and is acceptably safe. A manufacturer can select any notified body across Europe irrespective of location, provided that their field of expertise covers the device being considered. Once a CE mark is applied the medical device can be sold in all EU countries without further controls.

Following market authorisation, the notified body should ensure that the manufacturer adheres to quality systems and provides it with agreed information. The notified body may also pay unannounced visits to the manufacturer and carry out or ask for tests in order to check the quality system is working properly. A notified body may suspend or withdraw a CE certificate, place restrictions on it or trigger an intervention from the competent authority. In such circumstances the notified body must inform the competent authority in its own country, and the competent authority must inform other competent authorities and the European Commission of such action.

However, the device manufacturer is central to the vigilance and incident reporting system. Manufacturers must report certain adverse incidents to the relevant national competent authority (the competent authority where the incident has occurred, unless otherwise specified) for recording and evaluation.

[16] Keogh, Sir Bruce (6 January 2012) 'Poly implant prostheses (PIP) breast implants: Interim report of the Expert group'

Figure 1: European medical device regulation – key stages in the process



Source: Earl Howe (2012) 'Poly Implant Prothèse (PIP) silicone breast implants: Review of the action of the MHRA and the Department of Health'

One of the roles of the competent authority is to establish a 'vigilance' programme in relation to post-market surveillance of the performance and safety of medical devices. In the UK this involves investigating both mandatory serious adverse event reports from manufacturers and adverse events reported voluntarily by healthcare professionals and members of the public. Adverse incidents in Scotland are handled by Health Facilities Scotland (a division of NHS National Services Scotland). Its role is outlined in Appendix 2. If adverse events are proved, the MHRA can take a series of actions including the removal of the CE mark, the recalling of faulty products and providing advice to the health service through Medical Device Alerts. Where

regulations are breached, the MHRA has the power to prosecute. It can also withdraw unauthorised / illegal products form the market.

The rationale for employing the notified body system for medical device regulation is because of the sheer size and breadth of the market for the products and the large number of new products that come onto the market. It is also seen as an efficient and flexible system.

However, over recent years there have been a number of concerns raised into the system, most notably following the PIP breast implants case. The European Commission published a proposed revision of the medical devices directives in September 2012. This has now been considered by the European Parliament, and now awaits consideration by the European Council. This was not a reaction to the PIP and other cases themselves, as the public consultation on it began in 2008, but it has since taken account of the issues in those cases.

Meanwhile in the UK, there have been a number of reviews into PIP and the regulatory system of medical devices, including:

- House of Commons Health Committee (March 2012) Sixteenth Report: PIP Breast Implants and regulation of cosmetic interventions [webpage includes link to the UK Government response]
- Earl Howe (May 2012) 'Poly Implant Prothèse (PIP) silicone breast implants: Review of the action of the MHRA and the Department of Health'
- House of Commons Science and Technology Committee (November 2012) Regulation of medical implants in the EU and UK [webpage includes link to the UK Government response]
- Review of the Regulation of Cosmetic Interventions Committee (April 2013) Review report

Appendix 2: The reporting of adverse incidents concerning medical devices in NHS Scotland

Adverse incidents reported through the NHS in Scotland are handled by the Incident Reporting and Investigation Centre (IRIC) at Health Facilities Scotland (HFS) is part of NHS National Services Scotland. HFS is responsible for receiving adverse incident reports from NHS Boards and Local Authorities in regards to equipment and facilities. Medical devices are included in the definition of health and social care equipment used by HFS.

In October 2009, the Scottish Government published new guidance, which outlines the role of HFS and its responsibilities (as well as the responsibilities of public bodies).

The role of HFS

IRIC is responsible for receiving adverse incident reports and co-ordinating investigations so that, as far as possible, root causes can be established and remedial action taken to prevent or reduce any identified risks.

The MHRA is responsible for the regulation of medical devices throughout the UK and for issuing Medical Devices Alerts (MDAs). HFS works closely with MHRA, and will notify MHRA of each adverse incident reported in Scotland and the results of any investigation. For example, HFS may identify a need for an MDA and will liaise with MHRA in their assessment of the need for and drafting of the alert. If a health professional or other person in Scotland was to report an incident directly to MHRA, then MHRA would send that to HFS to consider.

HFS also liaises with other UK Health Departments, NHS bodies and agencies on the safety of estates and facilities equipment. In particular, information is exchanged on adverse incidents reports and investigations. In relation to adverse incidents involving medical devices, HFS provides each NHS Board Equipment Co-ordinator (or risk manager) a list of reports sent to HFS by their organisation during the previous quarter, as well as a list of all investigations still in progress.

HFS also has a role in maintaining a list of Equipment Co-ordinators for all NHS Boards (as well as local authorities) and should be notified immediately of any change. HFS also runs a network to support the work of Equipment Co-ordinators and their organisations. This includes various events to promote the management of risk and equipment safety in each organisation and generally throughout Scotland.

NHS Board responsibilities

Under the 2009 guidance NHS Boards are responsible for ensuring all staff are aware of all relevant policies and procedures. The guidance outlines the role of the Equipment Coordinator, the duties for which include:

- ensuring managers and staff are aware of the procedures for reporting adverse incidents and for implementing safety advice
- monitoring all adverse incidents reports from within own organisation

- receiving emails from HFS notifying of alerts and bulletins, and cascading within own organisation
- monitoring internal cascade systems to ensure alerts are received, assessed and acted upon

Boards must also ensure there are clear written and policy procedures for the prompt recording of all adverse incidents, including:

- preserving evidence and keeping records
- informing the organisational Equipment Co-ordinator
- maintaining a central register for equipment incidents in each organisation

There must also be clear policies for receiving, assessing and implementing all alerts and bulletins sent by HFS and MHRA (see paragraph 6.2).

Reporting incidents to HFS

The policy for reporting adverse incidents by a clinician or NHS Board is set out in Chief Executive Letter CEL 43 (2009). However, there can be a number of reasons why an adverse incident has not be reported. This could be because it is not clear that an adverse incident has been caused by a fault with the device. Other factors include the condition of the patient at the time of the procedure and clinician error.
As regards the timing of reporting, some Boards may report incidents immediately while others may wait until they have collected evidence of a trend or undertaken their own investigation as to whether it is an issue with the device. There may also be differences within Boards by hospital and clinician.

Nevertheless, when it is believed that there may be an issue with a device, this should be reported to HFS. How an incident should be report to HFS is outlined in Annex B of the 2009 guidance.

Adverse events framework

Healthcare Improvement Scotland has provided a framework for the management of adverse events and is linking into the work on adverse incidents. The reports are available here

Reporting by clinicians

Clinicians cannot be compelled to report an incident. Why this is appears to be related to the fact that there may be reasons for the adverse incident that may not be related to the device itself.

However, non-reporting of an adverse incident concerning a medical device would contravene the standards laid down by the General Medical Council which regulates all doctors. The regulation of doctors is a reserved matter.

The principal document which lays out what is expected from a doctor is 'Good Medical Practice', which was updated this year. Contained in domain 2 concerning safety and quality, it states that to help keep patients safe a doctor must:

> "…report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another at risk" (23c).

This is backed up by 'Good practice in prescribing and managing medicines and devices' guidance which came into effect in February 2013. Paragraphs 46 to 50 outline what doctors must do in reporting adverse incidents. The separate arrangements for Scotland are included.

The MHRA has undertaken work with professional medical bodies, Royal Colleges and others to encourage greater reporting of incidents by clinicians. The work that has been undertaken is outlined on pages 4 to 7 of a progress report MHRA published in June 2013.

The responsibility of manufacturers

The 2009 guidance notes that the alerts system is not a replacement for direct action by manufacturers, who have responsibilities under EU regulations to address safety issues concerning their devices. This is discussed further in Annex D of the guidance.

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1319 on improving youth football in Scotland

Note by the Clerk

PE1319 – lodged March 2010
Petition by William Smith and Scott Robertson calling on the Scottish Parliament to urge the Scottish Government to investigate the (1) legal status and appropriateness of professional SFA clubs entering into contracts with children under 16 years; (2) audit process and accountability of all public funds distributed by the Scottish Football Association to its member clubs; (3) social, educational and psychological affects and legality of SFA member clubs prohibiting such children from participating in extracurricular activity; and (4) appropriateness of 'compensation' payments between SFA member clubs for the transfer of young players under the age of 16 years; and to (5) increase the educational target from 2 hours curricular physical activity to four hours per week; and (6) develop a long-term plan to provide quality artificial surfaces for training and playing football at all ages across all regions.
Link to petition webpage for written submissions, written questions asked, SPICe briefing and previous consideration.

Purpose

1. The Committee took evidence on training compensation at its last meeting and is invited to consider the evidence heard and agree what action it wishes to take on the petition.

Background

2. The 2010 SPICe petition briefing provides some background information on this petition that was carried over from Session 3.

3. At the Public Petitions Committee meeting on 5 October 2010 Henry McLeish, Chairman of the Scottish Football Review Committee, gave evidence. He drew attention to his report and advised that work was already underway in the SFA to consider the concerns raised.

4. In January 2011 Shona Robison MSP, Minister for Public Health and Sport; Stewart Regan, Chief Executive, Scottish Football Association, Neil Doncaster, Chief Executive, Scottish Premier League; Tam Baillie, Scotland's Commissioner for Children and Young People; Jim Sinclair, Director of Youth Development, Rangers Football Club; and Chris McCart, Head of Academy and Youth, Celtic Football Club all attended and gave evidence to the Committee.

Session 4 consideration

5. By way of re-cap, the petition originally called for the Scottish Government to investigate 6 areas in relation to youth football. 4 areas have been dealt with.

Two are still under consideration by the Committee; contracts and compensation payments, primarily matters for the SFA.

"contracts" with children under 16 and compensation payments

6. The issues of contracts and compensation payments were discussed with the SFA at an evidence session on 11 January 2011.

7. In 2012, the SFA formed a working party, chaired by Scottish FA President Campbell Ogilvie "to review the existing system of training compensation for youth players that is currently applied with senior Scottish football." The evidence received by this Committee and its predecessors was passed to the chair of the working party to be taken account of as part of its review.

8. In October 2013 the SFA advised that new proposals had been approved by the SPFL Board and would be put to the general meeting of all 42 clubs in January. The SPFL membership approved the new arrangements which will come into effect in June 2014 as set out here:PE1319/00 Paper by the SFA 18 October 2013

9. The Committee held a further round-table discussion at its meeting on 20 May 2014 to consider the new arrangements. Andrew McKinlay (SFA) outlined the changes made with regard to reimbursement of training costs and advised that FIFA requires associations to have a system in place to reward clubs for investing in young players.

10. Registration of a player to a club must be signed by the player and his or her parent(s) or guardian(s). From the ages of 10-14 registration lapses at the end of the season; a 15 year-old's registration may be extended by the club to cover the following two seasons, without a further registration form being required. The system now in place requires a club to register interest in acquiring a young player with the SPFL. The SPFL then passes that information to the player/parents. Compensation payable is laid down and is dependent on the size of the club. The Committee was advised that any offer of monies over and above the set amount due would be a breach of rules and a disciplinary case would be brought if evidence of breach was provided.

11. The view of the petitioners is that registration is a form of "contract" that is not appropriate for players of 15 years of age and younger and should not be required until a player signs a professional contract.

12. Since the Committee's last meeting the Scottish Youth Football Association has written to the Committee responding to points made in the last evidence session. Scotland's Commissioner for Children and Young People has also written in. The Commissioner suggests that it would be of benefit to review the current registration process from a rights perspective.

Action

13. The Committee is invited to agree what action to take. Options include—

(1) To invite Scotland's Commissioner for Young and Young People to review the current registration process from a rights perspective and to report back to the Committee with his findings;

(2) To take any other action that the Committee considers appropriate.

Public Petitions Committee

11th Meeting, 2013 (Session 4), Tuesday 3 June 2014

PE1460 on the improvement of services and resources to tackle chronic pain

Note by the Clerk

PE1460 – Lodged 11 December 2012
Petition by Susan Archibald, on behalf of the Scottish Parliament Cross Party Group on Chronic Pain, calling on the Scottish Parliament to urge the Scottish Government to (a) hold a debate on the matter with a vote or voting rights (b) transfer more of the management for chronic pain into primary care (c) provide more social model care instead of medical model (d) change its policy to provide direct funding to ensure radical improvements to the service can be made including establishing a residential unit in Scotland to prevent Scottish pain patients being sent to Bath in Somerset for treatment.
Link to petition webpage

Purpose

1. The Committee last considered this petition on 10 December 2013 and agreed to keep the petition open for one more meeting to await the outcome of the Scottish Government's consultation and announcement of the way forward. The Scottish Government's response to the consultation has been published and the Committee is invited to agree what action it wishes to take in respect of the petition.

Scottish Government Action

2. There was a Government debate on chronic pain on 29 May 2013 during which the Scottish Government made a number of announcements, including—

    - That there would be a consultation this summer of the best model for a specialist residential pain management service in Scotland;
    - That a decision would be made around September this year on the delivery of such a service;
    - That there would be a continued drive to reduce waiting times for services that are crucial to sufferers of chronic pain;
    - To ensure there is no 'postcode lottery' in the delivery of services;
    - To accelerate the implementation of the Scottish service model for chronic pain;
    - To ensure clear reporting mechanisms are in place from next year to monitor progress;
    - That the Scottish Government is committed to providing integrated services for the treatment of chronic pain.

3. The Scottish Government held its consultation on the future provision of specialist chronic pain services during September/October 2014. To support the consultation, events were held in Glasgow, Inverness, Dumfries and Glenrothes. A SIGN

guideline on chronic pain was published in December 2013. In April 2014, the Scottish Government published its response to the consultation and advised that work was underway to take forward the establishment of the new specialised residential chronic pain management service.

Action

4. The Committee is invited to consider what action it wishes to take in relation to the petition. Options include—

   (1) To close the petition under Rule 15.7 on the basis that a Chamber debate on chronic pain took place on 29 May 2013; that a consultation on the future provision of specialist chronic pain services was held following which the establishment of a new specialised residential chronic pain management service is being taken forward.

   (2) To take any other action that the Committee considers appropriate.

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1482 on isolation in single room hospitals

Note by the Clerk

PE1482 – Lodged 15 June 2013
Petition by John Womersley calling on the Scottish Parliament to urge the Scottish Government to ensure that patients in new-build hospitals are given a choice to share a multi-bedded room with other patients or offered a single room; and to subject all the evidence on the single room policy to independent scrutiny.
Link to petition webpage

Purpose

1. The Committee last considered this petition on 1 April 2014. At that meeting, the Committee agreed to write to the Scottish Government. The Scottish Government has responded and the Committee is invited to agree what action it wishes to take on the petition.

Background

2. The petitioner is concerned about the apparent lack of evidence and public support for the policy of ensuring that new-build hospital accommodation and hospital refurbishment provides single-room accommodation for all in-patients. The petition asserts that the evidence base for such a policy is not robust and that a balance between single and shared accommodation in four-bedded bays would be the optimum option for necessary infection control and patient choice, as well as allowing better scope for future internal structural modifications.

3. Research and evidence pertaining to single-room provision is available in the Appendix to the SPICe briefing.

Scottish Government Action

Single Room Provision Steering Group

4. It was decided, given the significant capital investment programme underway in Scotland, that the Hospital Wards Configuration report (2004) should be peer reviewed. The peer review was sponsored and facilitated by the Scottish Executive and NHS Education for Scotland. One of the review recommendations was to establish a steering group whose remit was to consider single room provision.

5. Members of the steering group were drawn from those who participated at a Peer Review event, with the Health Department providing the Chair. Members were selected from a range of professional interests. The Group considered the matter of single room provision under the headings of Control of Infection, the Patient Environment, Operational Issues and Financial Issues.

6. On 21 February 2007, an interim statement was issued to health boards, based on the principles and recommendations of the EuPHN report above. The Steering group report contains a collation of documents, including a report on single room provision published on behalf of the Executive Nurse Directors' Group.

Further consultation and recommendations

7. In November 2008, the Chief Nursing Officer issued a Chief Executive's Letter (CEL 48) to all health boards setting out the conclusions drawn from the Report. It states that for all new-build facilities 'there should be a presumption that all patients will be accommodated in single rooms, unless there are clinical reasons for multi-bedded rooms to be available.'

8. It also states that 'in developing proposals for substantially refurbishing healthcare facilities NHS Boards should seek to provide the maximum number of single rooms consistent with the approach for new-build.

9. A further CEL was issued in July 2010, CEL 27 2010. This followed an expert Delphi[1] consultation exercise drawing on experts from the Chief Medical Officer's clinical specialities advisers, and this letter states that:

> 'the current provision of single room accommodation is not sufficient across NHS Scotland and 100% single room provision is clinically appropriate in most clinical settings.' It goes on to instruct that if there are clinical reasons for not adhering to this, then a Business Case is to be made in each circumstance.

Scottish Parliament Action

10. There have been a number of Parliamentary Questions on the provision of single rooms, and about hospital acquired infections in relation to single rooms which can be found here.

Committee consideration

11. The Committee first considered this petition at its meeting on 17 September 2013 and heard evidence from the petitioner. The Committee then wrote to the Scottish Government about the extent of patient choice and additional costs.

12. The Scottish Government advised that the existing policy has a "presumption" for 100% single rooms in new builds, but decisions on the use of single or multi-bedded rooms are made on a clinical basis, and "the policy is being applied as intended". The Scottish Government stated that it will be review research over the next year to test the assumptions within the current policy.

13. The Scottish Health Council advised that a proposal for a single room policy would have benefited from public engagement and consultation, and encouraged the Scottish Government to seek public views for its proposed review.

[1] See here for explanation of Delphi method.

14. Following the meeting on 28 January 2014, the Committee wrote to the Scottish Government requesting that the review of the policy on single room provision include consultation with the public and patients. The Committee also asked for information on the comparable costs of a new-build hospital with 100% single rooms and one with a mix of single and multi-bedded wards.

15. The Cabinet Secretary for Health and Wellbeing replied to the Committee on 19 March 2014 but did not acknowledge or address the Committee's request that the views of users and patients be taken into account as part of the review. His letter states that the financial impact of the policy is estimated at "between 2-2.75% on capital expenditure" and references page 24 of the Single Room Steering Group report of October 2008[2]. The relevant section is included in the Annexe to this paper.

16. The quoted figures appear to refer to the estimated revenue costs. In terms of additional capital costs, the paper refers, among other things, to a Northern Irish study which found that an increase in single rooms from 50% to 100% would increase costs by between 2% and 4%, depending on the size of hospitals, with higher additional costs occurring on projects for larger hospitals.

17. The Committee considered the petition on 1 April 2014 and agreed to write again to the Scottish Government asking it to confirm that patient and public views were being sought to inform the proposed review and to ask whether the Government had undertaken a cost benefit analysis of 100% single rooms as opposed to 50% over the course of a hospital's lifetime and, if so, to share that information with the Committee.

18. The Scottish Government replied on 15 May 2014. The Cabinet Secretary stated that should the review of evidence on the provision of single rooms, being undertaken this year, lead to a reassessment of policy, any revised guidance will be "subject to an appropriate consultation". The letter sought to bring to the attention of the Committee the report of the Single Room Provision Steering Group. As noted above, the relevant section of that report is included in the Annexe to this paper.

19. The petitioner has advised that he is content with the Cabinet Secretary's undertaking to conduct a consultation following the review however he does not consider the analysis in the report of the Single Room Provision Steering Group to be thorough. He requests "a more robust analysis of the cost implications of providing all-single rooms in hospitals".

Action

20. The Committee is invited to agree what action it wishes to take. Options include:

[2] http://www.scotland.gov.uk/resource/doc/253500/0075129.pdf

(1) to write to the Scottish Government to ask that a cost benefit analysis of 100% single rooms as opposed to 50% over the course of a hospital's lifetime be undertaken.

(2) to defer consideration of the petition until the Scottish Government's review of the research on single bedded accommodation in hospitals is complete and the results of that review published.

(3) to take any other action that the Committee considers appropriate.

ANNEXE

Extract From Single Room Provision Steering Group Report (October 2008)

Financial Impact

The financial impact of increasing the provision of single room accommodation can be split into two broad categories, namely capital and revenue costs.

Capital Costs

A study was undertaken for NHSScotland prior to the Peer Review Event to explore the additional capital and revenue costs which would be incurred by increasing the space around hospital beds. This study did not consider the impact of a higher provision of single rooms but the impact of increased bed spacing was deemed to be a reasonable proxy as far as the impact of capital costs is concerned, as these are directly attributable to the footprint of the building. It was recognised that the design of ward accommodation would have a significant effect on this and much activity is now taking place across the UK and Europe on different models of ward design incorporating single rooms with en-suite facilities. This paper does not consider these in detail but it is important to acknowledge that an increased focus on appropriate design can have a significant impact on the subsequent capital (and revenue) costs. The study based on increased bed spacing identified capital cost, increases which at a hospital level range from approximately 0.5% to 3% for large hospitals and approximately 1% to 5.5% for small hospitals.

The Group also benefited from a Northern Ireland study which supported the general conclusions of the Atkins Report. The Northern Ireland study found that the additional capital cost of increasing the ratio of single rooms from 50% provision (the then current policy position in Northern Ireland) to 100% would be between 2% and 4% dependent on the size of the hospital in terms of bed numbers. The higher percentage increase being for the larger hospital.

Although there is inevitably an increase in the capital cost of a hospital associated with an increased level of single room provision, it is important to bear in mind that the investment must be measured against the added health benefits which result. As noted by the European Health Property Network:

> *"lifecycle costing should involve an assessment of a building's contribution to healthcare over its lifetime by balancing questions of short-term affordability with future needs for adaptability and longer-term functional effectiveness".*

Revenue Costs

The evidence from the Atkins Report which looked at the revenue cost of bed spacing recognised this relationship to be less directly relevant when considering the revenue cost impact from a higher level of single room provision. What was considered crucial was the additional floor area needed and the supply of the services contained in the additional en-suite facilities, which will need to be maintained and cleaned. It is likely, therefore that this report has understated the increase in revenue costs which can be anticipated from a higher level of single room provision. However it is recognised in all studies into additional revenue costs

that as a minimum there will be an increase proportionate to the increased floor area in the ongoing cost of heat, light, power, cleaning, maintenance etc.
The Atkins Report, based on increased bed spacing, identified the increased revenue costs to be around 0.5% to 1.5%, but the Steering Group recognises that this assessment is likely to have understated the full impact from additional single room accommodation, in particular, on facilities management/capital charge costs.

As with capital costs the Group were able to draw on the outcomes of studies undertaken in Northern Ireland which suggested that the increased revenue costs associated with moving from a position of 50% provision of single rooms to 100% provision would be around 2% to 2.75%, dependent on the number of beds with the greater bed number increases reflecting larger hospitals.

Health Facilities Scotland considered the issues raised by increasing the provision of single rooms. This exercise involving HFS's major stakeholders raised a significant number of issues, including:

- Individual room controls would add marginally to the cost but may mean better environmental conditions for the patient.
- Sanitary facilities will be more numerous increasing both installation and maintenance costs.
- With proper design the patient environment is likely to be enhanced with better natural light, views, lower ambient noise levels and some degree of individual control of room conditions.
- Potential increase of general utility costs as a result of increased maintenance lighting, ventilation and facilities.

The paper noted that any additional costs arising from areas of concern such as those detailed above can be viewed as marginal. This paper also looked at examples published by the Department of Health which identify the cost of additional space, cleaning and nursing could range from 0.5% to 1.5% of a typical revenue budget.

The overall view of Health Facilities Scotland was that in developing a new healthcare facility, the percentage of single rooms chosen could have less impact on construction and maintenance costs than other decisions routinely made in the design and planning process. The HFS Group also believed there were grounds for optimism in that individual control of environmental conditions would bring a significant improvement in patient satisfaction.

Having considered all relevant information (including the Atkins Report; the Northern Ireland Study; the examples produced by the Department Of Health; the assessment carried out by Health Facilities Scotland and the Nurse Staffing Report) the Group has concluded that the potential revenue impact from increased single room provision/bed spacing could be up to 2.5% of overall running costs. This assessment assumes that any clinical staffing implications will be off-set by savings from reductions in patient transfers, reduced ward closures and better use of patient accommodation.

For refurbishment options where accommodation has to be extended due to physical space constraints/maintain bed capacity, the Group recognised that the revenue implications are likely to be considerably higher than the overall average of 2.5% of hospital running costs. The NHS Body concerned will need to determine the extent of the revenue implications as part of the business case justification on how best to address local needs. In reaching a decision in each particular project the dimensions of existing multi-bed areas will be significant as it may not be possible to conveniently alter the space to take additional en-suite facilities and provide the necessary space recommended around the bed. Where the number of beds for a given patient group cannot be accommodated within the physical space available and it is appropriate for that patient group to be accommodated in single rooms it may mean the use of additional space and this could have a significant financial impact.

The Group also recognised that other benefits may be realised. Experience from elsewhere in Europe, America and Canada tends to support the case that increased provision of single room accommodation will enable increased patient turnover as a result of improved bed utilisation, reduced length of stay and improved infection control. An enhanced level of single room could enable patient throughput to increase by a level greater than the increase in running costs thereby offering the possibility of improved overall hospital performance.

The full text of the Health Facilities Scotland paper is contained at Annex 8 [of the report, reproduced below].

Annex 8 of Single Room Provision Steering Group Report (October 2008)

Financial Impact Paper (Health Facilities Scotland)

Individual room controls on Heating, lighting and ventilation, which will add slightly to the cost of the installation and maintenance. This might, however, mean better environmental conditions and a greater feeling of control for the patient.

Sanitary facilities will be more numerous, increasing installation costs and maintenance costs, particularly to manage the Legionella risk.

Services such as medical gasses and electricity supplies will likely be marginally more expensive to install and although the maintenance workload may increase slightly, this might be offset by better access.

With proper design, the patient environment is likely to be enhanced, with better natural light, views, lower ambient noise levels and some degree of individual control of room conditions.

More definite separation of patient and work areas, combined with appropriate controls might allow for different heating strategies in each area with consequent energy savings.

The key determinants of the relative costs of installation and maintenance in single room installations will be design strategy and design quality, e.g. four bed bays will require ventilation but single rooms may not, also individual room controls for heating and ventilation can be avoided but probably shouldn't. This will depend on the roles of the various services, i.e., ventilation for temperature control or fresh air supply.

In terms of designed capacity, heating and lighting costs will be proportional to floor area; however, in practice the impact of increased individual control might be as significant. This cannot be predicted generically as it will depend on the quality of the design and unknown constraints such as building location and orientation.

Designing into existing facilities might be difficult.

Labour intensive for Soft FM services, e.g. cleaning, might have reductions in cost in relation to issues such as rails.

Potential lack of general observation of patient's well being, particularly in relation to eating.

Potential increase in utility costs as a result of increased lighting, ventilation and facilities such as showers.

Higher level of furniture and fitting costs; these are considered to be marginal.

Cost Indications
The above costs could be viewed as marginal. However, looking at examples published by DOH Estates and Facilities, the cost of additional space, cleaning and nursing could range from ~% to 1.1/2% of a typical revenue budget. When considered in relation to cost ofFCEs, the figures range from 07% to 2.1%.

Work carried out by The Property and Environment Forum (through W S Atkins) would indicate an increase in revenue costs between 1.4% - 2.7%, depending on size of the hospital.

Typical capital cost increases are 1.6% to 3.1%, depending on the size of the hospital.

Overall, the Scottish Engineering Technical Advisory Group (SETA G) *took the view that, in developing a new facility, the implications of the percentage of single rooms chosen would have less impact on construction and maintenance costs than other decisions routinely made in the design and planning process, such as the decision to design out heat gains, rather than install air conditioning. There was also optimism that individual control of environmental conditions would bring a significant improvement in patient satisfaction.*

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1488 on whistleblowing in local government

Note by the Clerk

PE1488 – Lodged 17 August 2013
Petition by Pete Gregson, on behalf of Kids not Suits, calling on the Scottish Parliament to urge the Scottish Government to support the introduction of staff whistle-blower hotlines to report mismanagement in Scottish local authorities, with reports overseen by councillors from each party.
Link to petition webpage

Purpose

1. The Committee is invited to consider the evidence it has received on this petition since it considered the petition last on 18 March 2014. The Committee has received a number of responses from local authorities as well as a further response from Audit Scotland; the Committee is invited to agree what action it wishes to take on the petition.

Background

2. The petition states that around 40% of UK local authorities have a hotline; up to 10% have a "helpline". However, the petitioner is aware of only one Scottish public organisation with whistleblowing measures in place, the NHS, who have a helpline. The key difference between a hotline and a helpline, according to the petition, is that a hotline "passes reports back to a designated person; a helpline offers advice on whether and how employees can raise a whistleblowing concern."

3. The petition calls for every Scottish local authority to provide staff with a hotline, as defined in the British Standards Whistleblowing Arrangements Code of Practice. The petition explains why the petitioners see this action as being necessary.

Scottish Government

4. The Scottish Government's "Local Government in Scotland Act: Best Value Guidance" states that a local authority which "secures best value" will be able to demonstrate, among other things—

> "10. That effective procedures are in place to help ensure that members and employees comply with relevant codes of conduct and policies. This includes ensuring that appropriate policies on fraud prevention, investigation and 'whistleblowing' are established."

5. Although the Government has guidance for its own staff with regard to whistleblowing, this does not apply to local authorities, and it is for each individual council to come to its own arrangements and to ensure that their staff are aware of the policies in place to encourage and protect whistle-blowers. The Government has, however, issued a Code of Conduct for Councillors.

6. In terms of guidance for local authority staff, Audit Scotland has published Whistleblowing: An employee's guide to what to do if you suspect fraud or corruption, which covers local government employees.

Scottish Parliament Action

7. The Parliament does not appear to have dealt with whistleblowing in local government specifically, although parliamentary committees (and questions to the Scottish Government) have considered whistleblowing in the NHS regularly.

Committee consideration

8. The Committee gave initial consideration to this petition on 29 October 2013 and heard evidence from the petitioner. The Committee agreed to write to a number of stakeholders.

9. At its meeting on 14 January 2013, the Committee agreed to seek submissions from those organisations that had not responded to the Committee's original request for views. On 18 March 2014 the Committee decide to seek further views from the Accounts Commission and Audit Scotland on its scrutiny of local authorities' whistleblowing policies, as well as asking COSLA and every local authority about the involvement of elected representatives in their local authority's whistleblowing policy.

10. The Committee has received responses from 15 local authorities, COSLA and Audit Scotland (who wrote on behalf of the Accounts Commission also). Audit Scotland confirmed that it examines whistle-blowing policies of local authorities as well as how those policies are disseminated to staff. The Accounts Commission has not found it necessary to flag up any concerns with regard to whistle-blowing in any of its reports on local authorities.

11. COSLA does not hold information on how each local authority's whistle-blowing policies involve elected representatives. In its submission, COSLA repeated its that all councils have, as a minimum, statutory provision for whistle-blowers and many have helplines or hotlines. COSLA also reiterated its view that whistle-blowing policies are "a matter for local determination by locally elected politicians".[1]

12. The responses from local authorities outlined a variety of approaches to whistle-blowing policies and councils differed somewhat in the involvement of elected members in determining the policy and involvement in procedures. Every local

[1] COSLA, Submission to the Public Petitions Committee, Available at: http://www.scottish.parliament.uk/S4_PublicPetitionsCommittee/General%20Documents/PE1488_H_COSLA_01.01.14.pdf

authority that responded confirmed that elected members had agreed the policy, either in committee or during a full session of council.

13. Most whistle-blowing processes at local authorities do not involve elected members directly. Reasons given include: the need to ensure confidentiality and the anonymity of the whistle-blower; the process is an administrative one; and that whistle-blowing is sometimes related to grievance or disciplinary proceedings in which elected representatives can be involved at a final appeal. However, most local authorities had a mechanism to report concerns raised or investigations resulting from whistle-blowing to elected members, normally a committee with an audit remit.

14. Different local authorities appear to have different scopes for their whistle-blowing policies. North Ayrshire Council's policy is specifically focused on whistle-blowing of wrongdoing as defined under the Public Interest Disclosure Act 1998. In its submission, North Ayrshire Council argued that the same protections afforded under the 1998 Act should not apply to whistle-blowing of mismanagement, as it mismanagement is a subjective judgement. Other councils, such as Fife, appear to have a wider scope for its policy; however, it is not necessarily possible to directly compare two local authorities in this way as there may be overlap with other policies.

15. North Ayrshire echoed the view of COSLA and others that whistle-blowing policies are matters for individual councils and that it "would not expect the Scottish Parliament to seek to prescribe the internal operations of Local Authorities".[2]

Action

16. The Committee is invited to agree what action it wishes to take on the petition. Options include—

    (1) To close the petition on the basis that the petition is about policies that are matters for locally elected representatives. Audit Scotland / the Accounts Commission is responsible for auditing these policies. To date, it has not identified any weaknesses related to whistleblowing which have required to be flagged-up in the annual report for a local authority.

    (2) To take any other action that the Committee considers appropriate.

[2] North Ayrshire Council, Submission to the Public Petitions Committee, Available at: http://www.scottish.parliament.uk/S4_PublicPetitionsCommittee/General%20Documents/PE1488_M_North_Ayrshire_Council_11.04.14.pdf

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1497 on supermarket expansion on local high streets

Note by the Clerk

PE1497 – Lodged 7 December 2013
Petition by Ellie Harrison, on behalf of *Say No to Tesco*, calling on the Scottish Parliament to urge the Scottish Government to give local councils and communities the power to stop unwanted supermarket expansion on their local high streets.
Link to petition webpage

Purpose

1. The Committee last considered this petition at its meeting on 1 April 2014 and agreed to write to the Scottish Government. A response has been received and the Committee is invited to consider what action it wishes to take on the petition.

Background

2. Currently, anyone wishing to build a new shop or substantially change the use of a premise to that of a shop (e.g. from a bank to a shop) has to obtain planning permission prior to doing so. However, anyone wishing to change the nature of the goods and/or services provided from an existing shop does not need planning permission for that change of use under the provisions of the Town and Country Planning (Use Classes) (Scotland) Order 1997 (the Order), as amended. The Order sets out a number of Use Classes (e.g. Shops, Food and Drink, Hotels and Hostels, Houses, etc.), and under what circumstances planning permission is required for the use of premises to change from one class to another. Planning permission, however, may still be required for changes within a class if there is, for example, changes to the frontage of a shop.

3. Another part of the planning process is the Retail Impact Assessment (RIA). An RIA is generally undertaken when a proposed development is of a sufficient scale to have a significant impact on other retail centres. Normally an RIA is required for a proposed retail development of 2,500 m^2 gross retail floor space, although RIAs may be required for smaller developments. The Committee may wish to note that RIAs can only be required for proposals that require planning permission.

Scottish Parliament Action

4. The Scottish Parliament has not considered the Use Classes Order.

Committee consideration

5. The Committee first considered this petition on 28 January 2014 hearing evidence from the petitioners. The Committee agreed to write to a number of

stakeholders seeking views on the petition. The Committee considered the petition again on 1 April 2014 when it considered the written evidence it had received. Those submissions largely focused on two distinct areas, the planning system and the impact of small-scale supermarkets, and the issues that arose from the written evidence are very briefly outlined below.

Planning system

6. The petitioners suggested that the cumulative floor space of shops owned by a single company should be taken into account when considering whether a new shop required planning permission. The petitioners also suggested that large chain stores should fall into a Use Class of their own, which would mean that if a large chain store wished to open a store it would be subject to planning permission regardless of size.

7. Many respondents noted that the planning system, as currently drawn does not allow for the owner of a potential store to be a relevant factor when deciding whether planning permission is required. The Scottish Government stated that the Order is a "de-regulatory mechanism that is intended to permit and not restrict compatible land uses" and that the planning system "does not exist to protect the interests of one person or business against the activities of another". The Scottish Government has no specific plans to review the Order at present.

Impact of small-scale supermarkets

8. The petitioner provided qualitative evidence of a number of shops in west Glasgow that claim to have suffered from the competition created by small supermarkets, including some that had either closed or were considering closure. The petitioners provided examples of where it was felt supermarkets were given preferential treatment when applying for alcohol licenses. Other submissions recognised the importance of a variety of shops on high streets and the difficult and changing market conditions for independent retailers.

9. Glasgow City Council provided information on occupancy rates in the areas the petitioners were specifically concerned about. That data did not conclusively show that small supermarkets impacted on occupancy rates in the Byres Road, Hyndland, St George's Cross and Kelvinbridge areas of Glasgow. Several respondents argued that small supermarkets on high streets have a beneficial effect on the local shopping area by, for example, attracting more shoppers to an area.

10. The Federation of Small Businesses (FSB) argued that the benefits of a small supermarket entering a particular market will depend on the location. "They may be a positive move for depressed town centres but less so for vibrant areas that the petitioner cites."

11. Glasgow City Council suggested rate relief or improvement grants as possible ways to assist independent traders. It also suggested that concerns about small supermarkets could be referred to the Competition Commission. Members will be aware that rate relief is available under the Small Business Bonus Scheme, for example, and that competition law is reserved.

Recent evidence

12. At its meeting on 1 April 2014, the Committee decided to write to the Scottish Government to ask how it ensures consistent application of planning law and about the assistance available to small and medium sized retailers under the business rate relief or other similar schemes. The Scottish Government responded on 14 April 2014 drawing the attention of the Committee to the Scottish Planning Policy (SPP). A revised SPP is due to be published in June 2014 and the letter notes that the Scottish Government will monitor planning authorities' compliance with the SPP. The Scottish Government notes, however, that each planning case is unique, it is for the planning authority to consider applications and that a planning system should have scope for some variation to reflect local circumstance.

13. With regard to assistance available to small and medium sized retailers, the Government outlined the Small Business Bonus Scheme and the Fresh Start initiative. The Scottish Government indicated that it proposes to create a new power next year to allow local authorities to create local rate relief schemes.

14. The petitioner has asked that the Committee reconsider her submission of 23 March 2014.

15. Sandra White MSP has written to the Committee expressing her support for the petition. Ms White suggests that the Committee consider writing to the Scottish Government and Glasgow City Council asking for clarification of the use of Retail Impact Assessments (RIA) for units of less than 2,500 square metres which may have a "significant impact on vitality and viability".

16. Ms White also asks the Committee to seek the Scottish Government's view on the FSB's request that the group which has been tasked with producing a "town centre master-planning toolkit" be asked to look into the issues raised by the petitioner.

Action

17. The Committee is invited to consider what action it wishes to take in relation to the petition. Options include—

    (1) to write to the Scottish Government in the terms suggested by Sandra White MSP, asking for more information on the use of RIAs for shops of under 2,500 square metres and for its views on the suggestion by the FSB that the town centre master-planning tool-kit takes into consideration the issues raised by the petition.

    (2) to take any other action the Committee considers appropriate.

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1500 on the Golden Eagle as the national bird of Scotland

Note by the Clerk

PE1500 – Lodged 7 December 2013
Petition by Stuart Housden OBE, on behalf of RSPB Scotland, calling on the Scottish Parliament to urge the Scottish Government to formally declare the Golden Eagle, Aquila chrysaetos, as the national bird of Scotland. This could be done either through legislation, or through a parliamentary motion.
Link to petition webpage

Purpose

1. The Committee last considered this petition for the first time on 1 April 2014. The Committee decided to seek views from a number of other committees and responses have been received. The Committee is invited to consider what action it wishes to take on the petition.

Background

2. The Golden Eagle is an iconic species for the environment, conservation and culture in many countries. The UK population is approximately 5% of the total European population and ecologically is considered to be very significant as it comprises about a quarter of the population in the mountainous, Atlantic-influenced North West of Europe; hence it contributes significantly to the maintenance of the Golden Eagle's range.

Scottish Government Action

3. As part of the Year of Natural Scotland, a campaign called Scotland's Big 5 ran from spring until the end of October 2013. This asked people to vote for their favourite from the following species – Golden Eagle, Harbour Seal, Otter, Red Deer and Red Squirrel. The Golden Eagle received 38% of the 12,000 votes cast, and was 18 points ahead of the next nearest, the Red Squirrel.

Scottish Parliament Action

4. A previous petition (PE783) was submitted on the same subject in 2004 by Mr James Reynolds after a poll in the Scotsman newspaper voted the Golden Eagle the country's most loved bird. The petition was referred to the Enterprise and Culture Committee, which was unable to identify a formal process to create national symbols for Scotland.

Committee Consideration

5. The Committee considered this petition for the first time on 28 January 2014 and sought the views of the Scottish Government, Scottish Natural Heritage (SNH) and the Scottish Raptor Study Group (SRSG). Letters were received from these three organisations, as well as a response from the petitioner.

6. The SRSG supported the call to designate the Golden Eagle as Scotland's national bird. SNH acknowledged there are other species which are also worthy of consideration should the concept of a national bird be pursued.

7. In his response, the Minister for Environment and Climate Change stated that he was "not yet convinced that there are compelling arguments in support of having a national bird", and that "the Scottish Parliament might wish to reflect on the value, purpose and means of choosing further national symbols."

8. The petitioner supported the suggestion by the Minister to consult with other committees on this issue, and offers the assistance of RSPB Scotland in supporting the Public Petitions Committee's consideration of the petition.

9. The Committee considered the petition again on 1 April 2014. At that meeting the Committee decided to seek the views of a number of Committees on the value, purpose and means of choosing any new national symbols.

10. The Economy, Energy and Tourism Committee and the European and External Relations Committee had no comments on the matter. In its letter, the Education and Culture Committee supported the process used for assigning the Scots Pine as the national tree.

11. The Rural Affairs, Climate Change and Environment Committee's (RACCE) view was that the purpose of national symbols is to unite people by "creating a visual, verbal or iconic representation of the national people, their values, goals and history". The letter from RACCE also noted that Scotland has a number of national symbols and expressed its view that there is merit in exploring the benefits of assigning further national symbols. RACCE supported a considered approach to the issue and suggested that such an approach should include "engaging directly with the people of Scotland in an open debate".

12. The petitioner wrote to the Committee on 28 May 2014. He welcomed the input from other committees and suggested that support for a national bird could be demonstrated through a debate in the Chamber and if a debate was not felt to provide a sufficient mandate, a public consultation could follow. However, the petitioner argues that the popularity of the Golden Eagle has already been demonstrated and therefore the choice of the Golden Eagle as a national symbol would also be supported by the public.

Action

13. The Committee is invited to consider what action it wishes to take in relation to the petition. Options include—

    1) To request that RSPB Scotland undertakes a public consultation to enable it to demonstrate that there is widespread support for the concept of a national bird, and for the choice of the Golden Eagle over other bird species that may be worthy of consideration.

    (2) To request that the Scottish Government undertakes research on the benefits of assigning further national symbols.

    (3) To take any other action that the Committee considers appropriate.

Public Petitions Committee

11th Meeting, 2014 (Session 4), Tuesday 3 June 2014

PE1510 on emergency service and non-emergency service call centres and PE1511 on Inverness fire service control room

Note by the Clerk

PE1510 – Lodged 23 March 2014
Petition by Jody Curtis, on behalf of emergency service and non-emergency service call centres, calling on the Scottish Parliament to undertake a committee inquiry into the closure of Police, Fire, and Non-Emergency Service Centres north of Dundee. In particular, the major concerns raised have been the loss of public knowledge; public safety; officers being off the street and overwhelmed in managing the increased workload this would create.
Link to petition webpage

PE1511 – Lodged 27 March 2014
Petition by Laura Ross calling on the Scottish Parliament to urge the Scottish Government to review the decision made by the Scottish Fire and Rescue Service to close the Inverness Control Room.
Link to petition webpage

Purpose

1. The Committee first considered these two petitions on 22 April 2014 and is invited to consider a letter it has received from Christine Grahame MSP, in her capacity as Convener to the Justice Committee and the Justice Sub-Committee on Policing. The Committee is also invited to agree what action it wishes to take on the petitions.

Background

2. The Scottish Government reformed police and fire and rescue services by way of the Police and Fire Reform (Scotland) Act, 2012. The 2012 Act abolished the pre-existing eight police forces and eight fire and rescue services and in their place created a single police force[1] and a single fire and rescue service[2]. Both of the new services commenced operations on 1 April 2013. The Scottish Government's intention was to remove duplication, improve police and fire and rescue services and enhance accountability to local communities.

3. The Scottish Fire and Rescue Service (SFRS) Board has strategic oversight of the SFRS. Police Scotland is held to account by a separate body, the Scottish Police Authority (SPA). Police Scotland is directly responsible for operational matters and the SPA has a strategic and oversight role. Both the SPA and the

[1] The Police Service of Scotland, but commonly known as Police Scotland
[2] Scottish Fire and Rescue Service

SFRS Board have a duty to take forward the strategic priorities of the Scottish Government.

4. The SFRS inherited eight control rooms from the legacy fire services. As part of its Contact, Command and Control arrangements, Police Scotland inherited eleven legacy area control rooms and service centre sites; the eleven sites are Aberdeen, Dundee, Dumfries, Bilston Glen, Glenrothes, Inverness, Motherwell, Glasgow Govan, Glasgow Pitt Street and Stirling. In addition Police Scotland also took on a further seven sites which had been used for these purposes but had been mothballed and are currently unused.

5. In September 2013, the SFRS Board agreed to reduce the number of control rooms to three. The locations of these control rooms were decided by the Board in January 2014 and will be Johnstone, Dundee and Edinburgh. The sites earmarked for closure are Aberdeen, Inverness, Dumfries, Thornton (Fife) and Maddiston (Falkirk). The SFRS estimate that closing five Control Rooms and establishing a three Control Room model will take around 3-5 years.

6. At its meeting on 30 January 2014, the SPA agreed Police Scotland's strategic direction for Contact, Command and Control arrangements. The strategic remodelling of Contact, Command and Control includes the closure of operational sites in Aberdeen, Dumfries, Glenrothes, Motherwell, Stirling, and Glasgow (Pitt Street); it also details investment in ICT and the development of a wholly integrated service. Closure of Area Control Rooms and Service Centres are scheduled to take place between 30 April 2014 and 31 December 2015, while ICT[3] investment is scheduled to conclude on 1 July 2016.

Scottish Parliament Action

7. The decisions of both the SFRS Board and the SPA to close control rooms have been scrutinised in the Parliament. A number of questions and motions have been lodged on the issue since these decisions were made. The Scottish Government's view is that the number and locations of control rooms are matters for the SFRS and the SPA and Police Scotland.

8. The Justice Committee and its Sub-Committee on Policing are reviewing the operation of the 2012 Act as part of statutory post-legislative scrutiny; the Justice Committee's focus is on the provisions of the Act which relate to the fire service and the Sub-Committee on those provisions which relate to policing.

Public Petitions Committee Action

9. At the meeting on 22 April 2014, members expressed a desire not to duplicate work that may be undertaken by another committee and agreed to write to the Justice Committee and the Justice Sub-Committee on Policing to ask whether those committees have or were planning to undertake work in this area.

[3] C3i ICT systems

10. Christine Grahame MSP, in her capacity as Convener of both the Justice Committee and the Justice Sub-Committee on Policing, wrote to the Public Petitions Committee on 8 May 2014. In that letter, Ms Grahame said—

    "Neither the Committee nor the Sub-Committee has any current plans to examine the specific issue of control room closures. However, the petitioners may be interested to note that, in August, the Justice Committee plans to conduct a one-off evidence session with the chief inspectors of fire and constabulary on their inspection and thematic work in relation to the first year of the single services. There is a strong likelihood that the issue of control rooms will arise during that session."

Action

11. The Committee is invited to agree what action it wishes to take in respect of the petition. Options include—

    (1) To refer the petitions to the Justice Committee to consider as part of its remit with the request that the issues in the petition are raised at the planned evidence session with the chief inspectors of fire and constabulary;

    (2) Take any other action the Committee considers appropriate.