OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 26 September 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 26 September 2019

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PUBLIC PETITIONS COMMITTEE
17th Meeting 2019, Session 5

CONVENER

Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Gail Ross (Caithness, Sutherland and Ross) (SNP)

COMMITTEE MEMBERS

*Maurice Corry (West Scotland) (Con)
*David Torrance (Kirkcaldy) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Paul Cauchi (Scottish Ocular Oncology Service)
Jim Downie (Loch Lomond and the Trossachs National Park Authority)
Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Martin Gray (Historic Environment Scotland)
Alpana Mair (Scottish Government)
Dr Padmini Mishra (Scottish Government)
George Potts (Scottish Countryside Rangers Association)
Robert Reid (Scottish Countryside Rangers Association)
Elaine Smith (Central Scotland) (Lab)
Eileen Stuart (Scottish Natural Heritage)
Chris White (Scottish Government)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Public Petitions Committee

Thursday 26 September 2019

[The Deputy Convener opened the meeting at 09:00]

Continued Petitions

Thyroid and Adrenal Testing and Treatment (PE1463)

The Deputy Convener (Gail Ross): Good morning, everyone, and welcome to the 17th meeting in 2019 of the Public Petitions Committee. I ask everyone to switch their mobile phones to silent.

Our only agenda item this morning is consideration of continued petitions. The first petition for consideration is PE1463, on effective thyroid and adrenal testing, diagnosis and treatment, which was lodged by Sandra Whyte, Marian Dyer and Lorraine Cleaver. I welcome Elaine Smith MSP for our consideration of this petition.

When we last considered the petition in June this year, we discussed commitments that had been made by the Minister for Public Health, Sport and Wellbeing with regard to triiodothyronine prescribing, alongside recent evidence that the committee had received from people who continue to have negative experiences.

We invited the minister to give evidence at a future meeting and I welcome him here today. From the Scottish Government, the minister is joined by Anita Stewart, team leader, neurological conditions, chronic pain and long-term conditions, and Alpana Mair, head of effective prescribing and therapeutic branch. I welcome you all and invite the minister to make a brief opening statement of no more than five minutes.

The Minister for Public Health, Sport and Wellbeing (Joe FitzPatrick): Thank you, convener, and thanks to the committee for inviting me. I value the important contribution that the committee has made towards awareness raising and understanding of this complex issue.

I reassure the committee that I remain fully committed to seeing a consistent prescribing policy towards T3 across Scotland. Our overall aim is for people to be able to access the best possible care and support, and to benefit from healthcare services that are safe and effective and put people at the centre of their care. We continue to strive to ensure that that is the case.

I wrote to all Scottish health boards to clarify the Scottish Government's position on T3 prescribing. All boards have confirmed that they are committed to a holistic and safe review of patient prescribing and that patients can initiate and continue to be prescribed T3 where it is safe and clinically appropriate. I am pleased to advise that, in March of this year, the Scottish clinical biochemistry network published guidance on thyroid testing. That guidance was peer reviewed and is now available on the network website. The draft National Institute for Health and Care Excellence guideline was published in June 2019; the Scottish clinical biochemistry network has reviewed that guideline and identified areas in its own guidance that it may revisit once the final NICE guideline is published in November.

I hope that those actions have gone some way towards persuading the committee that we are acting to improve treatment for thyroid conditions and I look forward to hearing the discussion and answering questions.

The Deputy Convener: Thank you, minister. During the debate on the petition last year and in correspondence with the Health and Sport Committee this year, you made a clear commitment to engage directly with the people who cannot access the treatment that they should get. Will you outline the extent of that engagement and say what the outcomes have been?

Joe FitzPatrick: I made the commitment that I would engage directly with national health service boards, and I asked members across the chamber to make me aware of any cases in which the process continued not to be the smoothest. A number have continued to come forward and my officials have engaged with the boards in which there continue to be problems. In spite of the boards having said to us initially that they had processes in place, that was not the initial experience on the ground, so we have engaged directly with those remaining boards.

The Deputy Convener: Do you think that there is still an issue with clinicians not believing people who present with the symptoms that they are experiencing and that those people, in turn, are not getting the treatment that they need?

Joe FitzPatrick: I think that we have seen a huge improvement in the experience that most people are having across Scotland. There were two remaining boards that I thought were challenging, but considerable progress has been made there as well.

Brian Whittle (South Scotland) (Con): Good morning, minister. The Scottish Government has said that it is looking for a consistent prescribing policy for T3 across Scotland. As you outlined, we understand that the health boards have confirmed that they want to go in that direction of travel.

Health boards were asked to confirm their commitment to

> “a holistic and safe review of patients prescribed T3 which is undertaken by a healthcare professional based on the needs of the individual patient”

and to

> “clinicians initiating and continuing T3 where it is safe and clinically appropriate to do so, as agreed with a consultant who specialises in endocrinology.”

To what extent do you think that consistency of prescribing is happening and how can you assure the petitioners that what the Government is looking for is happening on the ground?

Joe FitzPatrick: I think that people’s experience has improved. In some cases, it is clear that the issue related not so much to clinicians, but more to the processes that were then in place. The remaining more challenging board is looking at putting T3 on the formulary, which will make that process more straightforward.

Brian Whittle: During our consideration of the petition, we have found that almost 50 per cent of the experts said that the prescribing of T3 was a good thing and 50 per cent did not believe it. Has there been a shift in understanding about where T3 sits within the prescribing pattern?

Joe FitzPatrick: I think that the evidence is that, for most people, thyroxine would be their preferred treatment. However, there is a significant group of people for whom, for a number of reasons, T4 would not be the best treatment. Even getting a test has been challenging. Padmini Mishra might want to add to that.

Dr Padmini Mishra (Scottish Government): To clarify, I am from the chief medical officer’s directorate. I am not Anita Stewart, whose name is on the nameplate; Anita is sitting behind me.

Even now, most clinicians will follow the guidelines that exist—the British Thyroid Association guidelines—which take account of guidelines produced in America, Europe and elsewhere. It is not that they do not believe, but that they still say that there is not enough evidence to support the regular use of T3 and that it should be used within a trial-type scenario. They still do not recommend that T3 should be given as a monotherapy, but think that it could be considered as a joint therapy, regulated and monitored, with T4. They have called for more randomised control trials to be done.

What worries the clinicians is a lack of evidence, rather than there being evidence that T3 does not work—there is a slight difference between those two views. They are asking for more evidence, and they are saying that they will use it in a very controlled way and monitor it. Everyone understands that too much replacement is harmful, and too little is harmful. How do they get it right for an individual person with all the complications that individuals may have? That is where the clinicians are at the moment.

Brian Whittle: During our evidence sessions, it seemed that a certain element among clinicians—it was about 50:50—were resistant to even allowing T3 to be used in cases in which perhaps the other 50 per cent would have said that it was appropriate. Is there a shift away from that resistance?

Joe FitzPatrick: The peer-reviewed guidance that was published in March gives a bit of consistency, so we hope that that pulls it together. The group needs to continue to look at the evidence, and the new NICE work needs to be taken into account so that there is consistency. Ultimately, it has to be about the individual patient.

The Deputy Convener: I must apologise, Dr Mishra. We were not informed that another witness was going to be here. Will you repeat your name for the record, please?

Dr Mishra: I am Dr Padmini Mishra.

The Deputy Convener: Thank you. Elaine Smith has some questions.

Elaine Smith (Central Scotland) (Lab): Thank you very much, convener, and thank you to the minister and officials for coming along. I am struck by how far we have moved since the previous minister and officials were in front of the committee and I am heartened that the issue is being taken rather more seriously.

There is a specific problem that I would like to ask about. At the meeting in February, we heard evidence that NHS Tayside had removed T3 from its formulary. Can you confirm that it is now back on its formulary?

Joe FitzPatrick: It is not back on the formulary, but I understand that the board is going through the process to put it back on the formulary. That has proved to be one of the particular barriers, in that because it was not on the formulary, the processes that someone had to go through—including the endocrinologist—involved more hoops than you would imagine would have to be gone through.

Alpana Mair (Scottish Government): The board feels that, in the processes that it has gone through so far, it has considered each patient case, so even though T3 was not on the formulary, it was still available to individuals who needed it. We have to be clear that the fact that something is not on the formulary does not mean that a clinician cannot prescribe it. However, the processes that the board went through were much lengthier for some patients.

There has been an application by the endocrinologist to have T3 added back to the formulary and that will be in place later this year.

Elaine Smith: The problem is that we had evidence that that was not the case. We heard that endocrinologists had prescribed it, but that there were patients—mainly women—who had been taken off it and that was part of the issue. I do not want to contradict the evidence that you have or what you have been told, but what we were told contradicted that.

Joe FitzPatrick: The important thing is that there has been an application to put it back on NHS Tayside's formulary. We would all welcome that.

Elaine Smith: Absolutely—that is hugely important.

The minister referred to guidelines. Again, the problem is that people such as Dr Midgley and some of the constituents who have written to us have said that the references in those guidelines are 28 years old and that they use the archive 2006 guidelines from the British Thyroid Association, which were then overtaken. That is the slight problem with those clinical guidelines on testing.

Joe FitzPatrick: The new guidelines have been peer reviewed, which is important, and we are waiting for the final NICE work.

Dr Mishra: There might be references that are old, because some of the trials are very old and no new trials have been done. The guidelines would look at all references; they will be peer reviewed and critiqued as well. The NICE guidelines might change because they are going through a drafting and consultation process, but the good thing about those guidelines is that NICE has looked at more recent literature in the processes that it goes through. There is very little difference, in very few areas, between those guidelines and what the Scottish biochemistry group has produced. There is a commitment that, if there are any discrepancies, the guidelines will be reviewed and updated.

Elaine Smith: Dr Midgley, who was one of the architects of the testing, also had some issues with the guidelines. I wonder whether the Government and the group might look at Dr Midgley's comments to this committee.

Joe FitzPatrick: We can pass on your comments to the group. Obviously, everyone wants the guidelines to be as up to date as possible. That is why it is important that the new NICE guidelines have been taken into account.

The Deputy Convener: I will take questions from members of the committee now, starting with Maurice Corry.

Maurice Corry (West Scotland) (Con): Thank you, convener. We have heard concerns that there is a gap between what you think is happening with the T3 prescribing and what the committee is being told is happening. What is your response to that? Also, you highlighted the Tayside situation. Can you open up on that a bit?

09:15

Joe FitzPatrick: Yes. After the debate, I wrote to all the boards. They all confirmed that they understood and that they had processes in place. However, at that time some patients—mainly women—said that that was not their experience on the ground. That is why officials engaged with those boards directly.

Maurice Corry: Are you happy that that is beginning to be addressed?

Joe FitzPatrick: In the main, that is certainly what my inbox would suggest. There is still the issue with the formulary in Tayside, but I think that the processes—

Maurice Corry: What are you doing to rectify that?

Joe FitzPatrick: A process is under way in Tayside—

Maurice Corry: Is that being monitored?

Joe FitzPatrick: NHS Tayside is adding T3 to its formulary. When it was not on the formulary, I think that the problem was that the processes, rather than anything else, were the blockage. There is no monitoring. There is a process at NHS Tayside to take that forward.

Maurice Corry: I have read extensively about Dr Toft's holistic approach to the whole matter. How much of that has been taken on board and been applied to patients? Are you aware of that?

Joe FitzPatrick: In all cases, with all patients, we should be taking a person-centred approach. That is why the decision—

Maurice Corry: But is that happening?

Joe FitzPatrick: It is, in all cases. That is why the decisions that are made will vary between patients, because all patients are different.

Maurice Corry: Is that in the guidelines?

Joe FitzPatrick: It is about realistic medicine, which I have mentioned just at the right point, because it is about making sure that treatment is holistic and person centred.

Maurice Corry: Are you happy that that is being applied? There is an opportunity to look at what Dr Toft has said about the holistic side and the whole body picture.

Joe FitzPatrick: Ultimately, that is a discussion between the clinician and the patient. It is important that people recognise that, in all cases across our health boards.

Maurice Corry: Thank you, minister.

David Torrance (Kirkcaldy) (SNP): Good morning, minister. You said earlier that the Scottish clinical biochemistry network published guidelines for thyroid testing in March 2019. The petitioner is of the view that those guidelines merely copy the same old ideas and take into account none of the new evidence. How do respond to that?

Joe FitzPatrick: The guidelines have been pulled together by the clinicians. They are peer reviewed, but as we said, the group is alert to the new NICE guidelines, which are more current, and it will adapt its guidelines, taking that into account. That will take into account more up-to-date evidence going forward, which is correct for anything.

Brian Whittle: You alluded previously to there being new NICE guidelines in the offing. In a letter to the Health and Sport Committee, you committed to following the development of those NICE guidelines. Is it correct that they are due out later this year?

Joe FitzPatrick: Yes. Are they due in November, Dr Mishra?

Dr Mishra: Yes.

Brian Whittle: What work has the Scottish Government done to fulfil that commitment? Have you had any engagement in the development of those guidelines?

Dr Mishra: A lot of senior clinicians are part of the NICE guidelines group from Scotland. The input into the guidelines is United Kingdom-wide, and when they are produced, they will be promoted in Scotland as the guidelines to follow.

Brian Whittle: Elaine Smith alluded to the fact that the petition has moved on quite significantly from when it was first lodged with the committee. We need to understand whether the Government's commitment is happening in practice. Has there been any re-engagement with those patients who gave evidence to you before, as a final check to ensure that what you think is happening is actually happening on the ground?

Alpana Mair: If patients have issues, particularly in relation to prescribing or access, quite often they contact us directly as a branch. We speak to them and then, if there are any outstanding queries, we follow that up with the health board. On the back of the minister's letter to the boards and the commitment for people to contact him, people have been in touch with us. We follow up with them and the boards if there are issues.

Brian Whittle: Is it your sense that the progress that we think is being made reflects what is happening on the ground?

Joe FitzPatrick: That is certainly the experience from my mailbox, yes.

Elaine Smith: The minister said that most people did well on T4, but part of the problem is that they might not know that they are not doing well in other ways. They might be on T4 but have lots of other symptoms—I have been there. Prior to T4, desiccated thyroid hormone was the normal treatment in this country, and it worked very well for patients. I know patients who were on it who were put on T4, and although they might be functioning, they have never been particularly well since then.

We also know that 10 per cent of patients do not do well on T4—that is admitted by the establishment. The figure is 15 per cent in America. We must consider those people. Although the use of T3 is a trial, it is extremely important for those 10 per cent of people who do not do well on T4—when I say "do not do well", I mean that they might die if they are not treated on T3; they certainly would not be functioning and would be extremely disabled. That needs to be considered. With the dual T4/T3 approach, we should also bear in mind that there are people who, like me, are allergic to T4. That is another issue.

The petition started out by talking about testing, diagnosis and treatment in the round. We focused on T3, which was not an issue at the beginning. We focused on it because of the 6,000 per cent price hike. If that had not happened, the people on T3 would still have been on it. The motivation to start taking folk off T3 was money based.

Are there any further plans to do a research exercise that involves talking to the people involved, rather than just peer reviews or looking at other countries? Can research be done that involves looking at the testing, diagnosis and treatment of the people affected to see whether it is appropriate?

Joe FitzPatrick: As Mini said at the start, research is challenging. The chief scientist office is the place that can fund research, but the chief scientist does not commission research, as such, because that is not the way science works. People will take a research proposal to the chief scientist.

It feels as though there is scope for some research here. An application would have to be made to the chief scientist office if that was to be carried out in Scotland. There is no reason why such research should not be carried out in Scotland. It might be the case that such research would have to be carried out among a wider pool of people to get good data, but it does seem as though it would be useful research. We have some anecdotal evidence, but if we want to make sure that we have the best treatment for individuals, proper scientific research is the only way to go.

Elaine Smith: It would be good to send out the message to universities and so on that such a research proposal would be looked on favourably, because it would be worth pursuing the goal of Scotland leading the way in this area.

Could I ask Ms Mair a specific question? Is that appropriate? It is a small question about her brief.

The Deputy Convener: You can ask one small question.

Elaine Smith: Thank you. NHS Lanarkshire is using Avastin as a drug for eye condition treatment. It has said that although it is an unlicensed drug, it is perfectly normal to use unlicensed drugs. The petition started as a result of women like Lorraine Cleaver having to buy desiccated thyroid hormone over the internet. They want to be as well as Hillary Clinton, who is on DTH and gets it easily in America, so they buy it from America. They come back to life; they would not be without it. Why is it that DTH is not available on prescription in this country, or is it available and it is just that clinicians are not prescribing it?

Alpana Mair: The difference between the two scenarios is that desiccated thyroxine is not a licensed product, so the Medicines and Healthcare products Regulatory Agency has not given it a licence. Avastin is a licensed product, but it is being used for an unlicensed indication. There is a bit of a difference there in that the product is safe. When the company did the trial for its use, it did not test it for a particular therapeutic use but, over time, it found that the two products could be used interchangeably. However, the company has not gone back and done the trials for use for that particular indication. Avastin is a licensed product that is being used for an unlicensed indication. There is a difference in that it has gone through the safety processes, whereas natural desiccated thyroxine has not.

I know that that is a subtle difference and that, for a layperson, it will seem that the two things are the same. They will wonder why one product that is unlicensed can be used in a certain situation when another cannot, but the difference is that Avastin is a licensed product that is being used for an unlicensed indication.

Elaine Smith: Can DTH be prescribed in this country?

Alpana Mair: No. The General Medical Council does not recommend the prescribing of unlicensed products where a licensed product is available, because of safety. T3 and T4 are available. The GMC would not recommend that clinicians prescribe unlicensed products where a licensed product is available.

Elaine Smith: I am sorry—I asked whether DTH can be prescribed. I know that there is some prescribing of it going on. Can it be prescribed if the clinician is willing to be insured against any risk, for instance?

Dr Mishra: Yes, clinicians can prescribe unlicensed products. The liability will be taken by them entirely, but they have an ethical duty not to cause any harm to the patient. If they are convinced that no harm will be caused, that is one thing, but they have an ethical duty. The GMC does not only say, “You are responsible—you have to take liability”; it also says, “It is your ethical duty not to harm the patient.”

Elaine Smith: I suppose that patients feel that the harm is caused by them not being able to get it and not being able to live a full life. When they buy it over the internet from America, they come back to life. That is a huge issue. I do not know whether DTH can be licensed, because it is a natural product. I think that the problem is the fact that it cannot be patented. I do not know whether it would be worth exploring whether it can be licensed.

Joe FitzPatrick: The fact that the licensing of medicine is reserved is another challenge that we would have, so it might be a theoretical consideration for us.

The Deputy Convener: I thank everyone for that very useful session and the minister for that helpful clarification.

Before we move on to comments and suggestions for action, I remind the committee of what the convener said the last time we considered the petition. She said:

> “If we were to make one, and only one, commitment on the matter, it would be to bring Joe FitzPatrick before the committee and ask him questions ... However, we would not want things to go beyond that.”—[*Official Report, Public Petitions Committee,* 6 June 2019; c 23.]

I would like members to bear that in mind during our consideration of how to proceed.

Brian Whittle: I think that it is one of those petitions that, from the petitioner’s perspective, has gone a long way to achieving what they called for in the first place. We took a great deal of evidence and produced a very thorough committee paper. We had a committee debate in the chamber. The Health and Sport Committee was involved, too. As the minister said, the Scottish Government has taken significant action on the back of the evidence that the committee supplied.

In my view, we need to gather evidence over a period of time to ensure that what the Scottish Government has requested is happening on the ground. That will take time. Given that the petitioners can come back to us in a year's time if that is required, I would be comfortable if we were to close the petition at this stage, because we have gone as far as we can with it.

09:30

David Torrance: I echo what Brian Whittle said. I feel that the petition has come a long way since it was first brought before us, and I am quite happy for us to close it.

Maurice Corry: I tend to agree. As someone who has rejoined the committee, I have seen a significant advance since way back, so I feel that things are being taken forward, and I thank the minister and his team for that.

It is a difficult issue. I referred to Dr Toft's comments about the holistic approach, which I think is vital. If that approach is being taken, I would feel comfortable that we were moving in the right direction, but if it is not and progress is not being made, I think that the petitioner should come back to us in a year's time. We need to keep a watching brief on the situation. We must make sure that progress continues to be made, because it is not fair that people's lives are being disturbed and their quality of life is being affected when there is medical help available.

I am concerned about the issue that Elaine Smith asked about—people bringing in medicine from overseas, including the United States. I have often heard about that happening. I have a niece whose medicine is brought in from Germany, so I know something about that. The issue is one that ought to be considered.

If progress is not made, we might need to review the situation at a later stage but, at this stage, I suggest that we close it. We have put down a marker, but we rely on the minister and his team to keep monitoring progress and to keep pushing forward.

Elaine Smith: A lot of work has been done on the petition. I do not know what the protocol is for such a long petition—it is the longest one ever. I do not know whether it would be possible to have the petitioner back, to see how they feel about the situation at the end of the process. I asked for that to happen previously. I also think that we have become very tied up in T3. That is fine for me, because I am on it, but the petition was also about diagnosis, and there are still many women who are not being properly diagnosed because of the scale of the issue and the situation as regards testing and so on. I do not think that the matter is finished at all.

It would have been good to have held an evidence session with the people who have been directly affected by the issue. Many people have written to the Health and Sport Committee and the minister, and it would have been good to have heard directly from them and to have given them a voice and enabled them to put their stories on the record. I had hoped that it might have been possible to hold a final round-table session to hear from some of those people—they are mainly women, because it is a huge women's issue, but there are men who are affected, too. I would regret it if the committee decides to close the petition without having held such a session. Perhaps the committee could have gone slightly further or could have referred the petition to the Health and Sport Committee—I thought that that would happen. The people who wrote to the Health and Sport Committee could have been referred directly to this committee, as happened with the mesh issue. Hearing directly from those who are affected is extremely powerful. That would be my regret if the committee closes the petition today.

The Deputy Convener: Thank you for your comments, which we take on board. We have had a huge amount of written evidence from people who have been affected, and that is all on the record. If we close the petition today, those people are still welcome to provide feedback, and they are welcome to continue to put pressure on the Government through their local MSPs. Elaine Smith is absolutely right: it is the longest-running petition. The Health and Sport Committee has been involved, as have many other MSPs and other people.

We have the option of writing to NHS Tayside to express our concerns about the on-going importance of people getting the treatment that they need.

Maurice Corry: Elaine Smith has a valid point, which bothers me. I have to be honest: we should probably hear face to face from the petitioners who have submitted the evidence. If we are going to close the petition, it would give me peace of mind if we round things up by hearing it from the horse's mouth. I know that there has been progress—I have absolutely no doubt about that—but Elaine Smith is deeply involved with the issue and I think it would not be a bad idea to hear from the petitioners. We might close the petition in the future, but I feel that we need to do something with the people who originally came up with it.

Brian Whittle: With all petitions, the petitioner is able to reply to any evidence that is taken, and the petitioners have done that very thoroughly.

Elaine Smith has experience in this area and knows people who have been affected. I have experience as well—I know one of the few male people who are on T3. I spoke to the endocrinologist who prescribed that to him.

I am with Maurice Corry on seeking a bit more understanding. We have to consider what the committee can do and what the outcome of that might be, and—I have to say this—we have to think about the petitions that are not getting the time that they require. We have to consider all of that in the round.

There is still some work to do, which will take time, but it is my opinion that we have gone as far as we can. As the minister indicated, once the evidence on what is happening on the ground comes back, the petitioners have the ability to bring this back after one year. I am inclined to say that the committee has gone as far as it can go.

Maurice Corry: Minister, I might be sort of off wicket here, but do you have any plans to have a forum with the petitioners and the other people who have given evidence?

Joe FitzPatrick: If people with particular problems continue to write to us, we will engage with them. We have probably been more hands on with this issue than we would ordinarily be. It is not really for politicians to get involved in this area, but I felt that the issue was more about processes, so we have been doing that and that will continue.

We will also continue to work with the Scottish clinical biochemistry network and the Scottish endocrine interest group, which is led by the CMO's specialty adviser for endocrinology. We will engage in that way to make sure that we continue to look at the best evidence. Elaine Smith made a call there for researchers to submit research projects, which obviously will be looked at by the chief scientist office with regard to how to the improve the patient experience. Research is always—

Maurice Corry: So, you could have a focus group of patients.

Joe FitzPatrick: That is not something that is in my proposals just now.

Maurice Corry: Is it something that could be possible?

Joe FitzPatrick: I think that I would put that to the network to discuss. We could feed that in, if you feel that that would be helpful.

I guess that some of the people who wrote to us will just be wanting to get on with their lives now, if they are having a better experience. Others will want to continue to engage in the process—that will be for them to decide. There are good campaign groups—Thyroid UK and so on—and I know that they will continue to put pressure on Governments across these islands to seek improved treatments.

The Deputy Convener: We are in no doubt as to the issues that have been raised. As I said, the petition has been going on for a number of years—over two parliamentary sessions—and we have a wealth of evidence from the people involved. I am struggling to see what more could be added from a round table.

I am minded to write to NHS Tayside with our concerns and to close the petition, bearing in mind everything that we have heard today about what the Government and others are doing. Do we agree to do that?

Members *indicated agreement.*

The Deputy Convener: Thank you. I thank the petitioners and give special thanks to Elaine Smith and everyone else who has been involved. Closing the petition does not mean that we do not recognise the issues. We have said time and again that we do, but we see the actions being taken to address them. After a year, if the petitioners feel that the issues have not been addressed, they can bring forward another petition.

I thank everybody here today for your evidence, which was very good. I suspend the meeting to allow a change of witnesses.

09:39

Meeting suspended.

09:41

On resuming—

Ocular Melanoma (MRI Scans) (PE1629)

The Deputy Convener: Our next petition for consideration is PE1629, on magnetic resonance imaging scans for ocular melanoma sufferers in Scotland. The petition was lodged by Jennifer Lewis.

Last time we considered the petition, in January 2019, we took evidence from the Cabinet Secretary for Health and Sport. During the evidence session, the cabinet secretary stated that there was no clinical consensus across the UK on the use of MRI scans following an ocular melanoma diagnosis. In order to build greater clinical consensus in the area, a Scottish group for consensus on metastatic surveillance for uveal melanoma was established, and the group published its findings in a report in August. The work has been led by Dr Paul Cauchi, consultant ophthalmologist and lead for the Scottish ocular oncology service at Gartnavel general hospital, and he joins us today.

Thank you for attending, Dr Cauchi. I invite you to make a brief opening statement of no more than five minutes, after which we will move on to questions.

Dr Paul Cauchi (Scottish Ocular Oncology Service): Thank you for inviting me to give evidence to the committee. Eye melanoma is a rare cancer, but it is absolutely a very important condition. Our service in Scotland takes the condition very seriously and the support of our patients is something that we care a lot about.

First, I would like to clear up something that has, I think, been unclear from the beginning. The premise of the petition is that there is a difference between Scotland and the rest of the UK. I have to disagree with that. There is a problem in the UK with a consensus as to how surveillance should be undertaken, but that is not a Scottish issue; it is a UK one. I would like to make that very clear.

I tried for many months to engage the other three ocular oncology centres in the UK—in Sheffield, London and Liverpool—to try to get a UK-wide consensus, because that is the best way forward to provide clarity for our patients. Unfortunately, I was not able to get engagement from the other three centres. I do not know why, but that is the situation that I faced. I therefore felt that we needed to press ahead in Scotland and come up with our own consensus statement, which I suspect will have quite an influence on the rest of the UK and perhaps further afield.

The statement group had representation from patients. We had a patient representative—Ronnie Blair from Scotland. We also had an English oncologist, who is a general cancer specialist—not just an eye cancer specialist—with an interest in eye cancer, three Scottish oncologists, an English ocular oncologist, two Scottish pathologists, two Scottish radiologists, me, and my colleague Vikas Chadha.

09:45

This was not an attempt to draw up guidelines, but an attempt to bring together a consensus statement. That is an important point, because we already have guidelines from 2015 that we cannot override. Our work has to complement those guidelines, if you like. The problem with the guidelines from 2015 is that they were left quite vague because the group could not agree on a protocol that all the centres could follow. The main reason for the disagreement was the lack of evidence and consensus.

The recommendation from those guidelines was that a non-ionising form of radiation be used to image the liver every six months. That is a vague statement. The two forms of non-ionising radiation are ultrasound and MRI scanning. We needed to try to clarify that statement for our patients in Scotland. Unfortunately, despite an updated review of the literature from 2015 that takes account of the four years since then, there is still a lack of evidence that MRI surveillance alters life expectancy for our patients with eye melanoma. Furthermore, there is no curative treatment for patients who develop spread of this type of cancer. Although there are lots of new and exciting treatments, the evidence is still—unfortunately—lacking that any of them make a difference.

There are, however, many exciting clinical trials. We are very excited about them and we want to be at the forefront of allowing our patients to access them. The Beatson unit, which is in the building next to where I work, is very much part of that.

The group decided to adopt a risk-stratified approach. I have read most of the Public Petitions Committee's previous discussions about the petition, and in one of the discussions it was suggested that we are unable to stratify risk in Scotland. I absolutely refute that. Every single one of our patients has a risk attached to their tumour, and it is not correct to say that we have to have a biopsy to have that risk stratification. There is a very accurate way of stratifying risk based on size and location of tumour, so we know the risk of all our patients who come through in Scotland.

One of the main drivers is that we want to allow our patients to access the clinical trials. We decided that we would adopt a high-risk/low-risk strategy where the high-risk patients would be offered MRI scanning every six months and the low-risk patients would continue as at present, getting liver ultrasound and then going on to MRI scanning if required. There is no risk-free aspect to this. MRI scanning has many risks, which I might discuss later.

We feel that we have reached as far as we can with a group of clinicians and a patient representative to try to come up with a pragmatic approach for our patients in Scotland and to allow our high-risk patients to access the exciting clinical trials that are coming online, and also the liver-directed and systemic treatments that are available for them. I feel that the consensus statement is a real step forward in clarifying the situation for our patients. At least we in Scotland will be able to say that this is the line in the sand for our patients.

The report has been approved by the national services division in Scotland. It has been circulated to all the health board chief executives around the country, and it is now up to the boards to decide how they are going to implement the protocol—the statement. Thank you.

The Deputy Convener: Thank you for your very useful opening statement. You mentioned—and we have previously heard from the chief medical officer about—the lack of clinical consensus across the UK on the use of MRI scans. What do you think is the reason for that?

Dr Cauchi: It is interesting. Dr Ottensmeier, who was quoted a lot in the group, is a passionate advocate of MRI scanning. However—this is why medicine is such fun—we also have Paul Nathan, who is an eminent oncologist at Mount Vernon hospital. He was part of our group—he was also part of the original guidelines group in 2015—and he has completely the opposite view.

The fact that we can do something does not mean that we should do it. No one is disputing that an MRI scan of the liver is able to image the liver in a more accurate way than a liver ultrasound can but, in a way, that is not what is important for patients. What is important for patients is whether it will make a difference to their quality of life and their life expectancy, and there is absolutely no evidence for that.

An MRI scan is not a trivial thing. It takes 45 minutes to an hour to do a scan, and it is a pretty unpleasant experience, as you will hear if you speak to patients about it. Some of you might have had an MRI scan. My wife certainly has. It is pretty unpleasant for someone who is claustrophobic. There is some debate as to whether the contrast that is given can accumulate in the brain. That is another aspect, but the jury is out on that. There is also the anxiety that an MRI scan creates in the build-up and while the person is waiting for the report to come out afterwards. It is much harder to get an MRI scan, so it is likely that there will be some delay involved in trying to get one, and there will almost certainly be some delay in getting the report. It is very hard to get MRI scan reports in Scotland at present. Patients are waiting for their reports: they are phoning in every day to my unit and others. People speak about MRI scans as if they are easy and simple things to do, but they are not. They are a big undertaking and they can create a huge amount of anxiety.

The other thing is that MRI scanners are not available everywhere in the country. If someone lives in Lewis or on one of the islands, they might have access to an ultrasound but not to an MRI scan. The other day, I had a patient who would have to travel to Aberdeen to get an MRI scan, whereas they could get an ultrasound scan locally on their island. That is an example.

Doctors like evidence. We like to be directed by evidence. The reason why we get polar opposites is that there is a gap in the evidence. The problem with a rare disease is that it is very hard to get evidence on it, although that does not mean that we do not try to push to get as much as we can for our patients. I think that the bottom line is that with a lack of evidence comes almost a personal opinion of what should be done. We should try to get away from personal opinions and emotion and try to help our patients in a factual, evidence-based way. Many of my patients say to me, “Is this going to make a difference?” That is really what counts. I return to what I said: the fact that we can do something does not mean that we should do it. It is important that we use investigations in an appropriate manner.

In other countries such as America, people get a lot of investigations, and there are many reasons why they may or may not get investigations. That creates two things. First, it creates a financial and economic conveyor belt, and secondly, for the patient, it can open up a can of worms. False positive results in scanning are very common. If we scan a liver, we will find a lot of things in it. We will find cysts and haemangiomas—we will find all sorts of things—and that often leads to further investigations. It may lead to biopsies, and we are then going down a road that can almost cause more harm than the investigation itself.

I try to give the other side of the coin. Sometimes, it seems very easy and people say, “Why don’t you do MRI scans for everyone?” There are reasons why we do not do that. I will leave it there.

Brian Whittle: Good morning, Dr Cauchi, and thank you for coming. The consensus group contained just one patient representative. How, if at all, did their involvement influence the group’s proceedings and thoughts?

Dr Cauchi: It was very valuable to have Ronnie Blair there. He is one of our patients and he is also a member of OcuMel UK, which is one of the patient pressure groups. He is a very balanced individual. He has his own personal journey. I do not think that I need to go into that, but he had a profound influence on the group. Like any group, we had a lot of debate, especially among the oncologists—not the eye cancer specialists, but the general cancer specialists who have an interest in eyes, as opposed to me, because I have an eye cancer interest. We had a lot of disagreement among the people in our group. I always think that that is a great thing, because if we are going to have a consensus group, we do not want everyone to be thinking in the same way; we want a balanced approach.

It was great having Ronnie there, because he could say, “Hang on—this is what’s important from my point of view." He was excellent. We chose him for that reason, because we knew that he was going to bring a lot of quality to the group, and he had a big impact on it. I think that, at the end of the process, he realised that we had reached quite a pragmatic decision. We probably did not reach the decision that he wanted, but I think that we reached a decision that we could all be happy with.

Believe me—there was so much heated debate, and not all of the names would be here if we had not agreed. There was a time when we thought that we were going to lose a few people who would not give their agreement to the consensus group. The group was well run, there was robust debate, and we gave our patient representative a lot of time and a lot of influence over the proceedings.

Brian Whittle: If his impact was as helpful as you say, was there any discussion about engaging with other patients in the same situation?

Dr Cauchi: Are you asking whether we should have involved other patients in the group?

Brian Whittle: Yes.

Dr Cauchi: We decided to have one patient representative. There was no conspiracy about that—

Brian Whittle: I was not suggesting that there was.

Dr Cauchi: It was just the way that we set it up. I do not know what a minimum requirement would be for the number of patients on a group, but he was a good fit because he is one of our patients, he is Scottish and he is involved in OcuMel UK. He ticked a lot of boxes from that point of view, and he was prepared to come. Many patients would find this kind of thing quite daunting. I do not think that we deliberately had just one representative to dilute the impact.

Brian Whittle: I was not suggesting for one second that that was the case. Thank you.

The Deputy Convener: Dr Cauchi, since our papers were circulated, we have received two written submissions from Iain Galloway and OcuMel UK. The joint position paper on MRI surveillance that has been compiled with melanoma patient network Europe and OcuMel UK indicates how they would like the issues that the petition raises to be resolved. I will bring one part to your attention and I ask you to respond to it. The paper says:

> "The Scottish Guidelines Group did not seek patient representation from either OcuMel UK or Melanoma Patient Network Europe."

Is that a true statement?

Dr Cauchi: That is incorrect. Ronnie Blair is a member of OcuMel UK. We did not get a representative from the Europe group, though.

The Deputy Convener: Okay. Thank you for that clarification.

Maurice Corry: You touched on consensus and the Sheffield, London, Liverpool and Glasgow centres not coming together in relation an unwillingness to develop a consistent approach to the issue. Why do you think that they did not stitch together?

Dr Cauchi: I am not sure, to be honest, because those people are my friends and colleagues and I know them well. I think that the statement will have a very big impact, and if it is taken up in England, it will have a big impact on them, too. Of course, they have a different health service and different ways of commissioning, imaging and all the rest of it, and it could become quite an issue for them. Maybe that is part of the reason. It is difficult to second-guess them.

10:00

Sometimes people do not want to open the can of worms, because they are not sure where it is all going to lead. I like clarity. If patients have a problem or an issue, I think that it is terrible for them to have different experiences depending on where they go. What happens in England is a lot less regulated than what happens in Scotland, mainly because the population is much bigger. In England, you will get your eye cancer diagnosed and treated by an eye specialist. Then, if you are unfortunate enough to develop a metastatic issue in the liver, you will be referred to an oncologist. The eye cancer specialist will have washed their hands of that patient from the liver point of view—they will have gone on to another specialist.

Some centres will have a very good integrated multidisciplinary team set-up, but others may not. In fact, you can imagine all the geographic areas in London and all the clinical oncologists who cover all those areas, and we have spoken about Dr Ottensmeier in Southampton and Dr Nathan in Mount Vernon—and there are many, many others, too. They cannot all come to the MDT; that is not practical. If you go to Dr Nathan, you will get a liver ultrasound; if you go to Dr Ottensmeier, you will get an MRI scan; and if you go to someone else, you might get one treatment if you are high risk and another if you are low risk. In other words, there is a whole variety in what goes on.

In Scotland, we have a much tighter picture, mainly because of the size of the population, I suppose. Therefore, we had a fighting chance of trying to get a consensus for this country and for our patients. Maybe in England, it is a much harder task because of the population issue. If I was one of the English oncologists, I would welcome the consensus and I would want to be on the group, but I tried multiple times and at every turn, it was a negative. Unfortunately, I cannot do very much about that.

Maurice Corry: In Scotland, you can plough ahead, on the basis of what you talked about, because you feel that we are more together up here—which is good news; that is great. Do you feel that we are missing out on anything by not having the UK group consensus?

Dr Cauchi: Absolutely.

Maurice Corry: What are we missing out on?

Dr Cauchi: We are missing out because Scotland is not an isolated community and we speak to other patients in the UK. In fact, I think that we will have a reversal: English patients will be pretty unhappy that Scottish patients are going to get MRI scans for high risk while they are not. That is unsatisfactory because there are only 450 patients a year who get melanoma in the UK. It is a very small group of patients, and we feel very united as a UK group. In Scotland, we have, on average, about 40 patients a year—it is between 30 and 50 patients a year. We meet regularly, we meet our English counterparts and we compare our results. We are very much united.

This will be a situation where Scotland is going off on its own—in, I think, a good, positive way. However, not having the UK on board and not having the English centres on board is unfortunate, because it will pit us against them, which is not something that I want. I want all patients in the UK to feel that they are getting a standard of care and I do not think that that will happen because of the non-engagement of the English centres.

Maurice Corry: So, if we look just at Scotland, we will not lose out and the quality of our medical support will not be depleted because we cannot get an agreement with the rest of the UK.

Dr Cauchi: No—I think the opposite.

Maurice Corry: I am playing devil's advocate here.

Dr Cauchi: I think that more patients are going to get MRI scans in Scotland because of the consensus than will be the case in England.

David Torrance: Do you agree with the petitioner's concerns that, because ocular melanoma is so rare, there is a lack of understanding among the medical professions about the condition and the risks associated with it?

Dr Cauchi: I have to respectfully disagree with that. The condition is our passion—it is what I dedicate my life to. The idea that I do not take it seriously because it is a rare cancer is not correct. There is an interesting point, however, as there are similarities with conditions such as colorectal cancer, because the organ of spread of disease from the colon and the rectum is often the liver—although it is not just the liver; it can be other organs as well. When considering colorectal cancer, how do you image the liver, how often and so on? There are a lot of treatments for colorectal cancer that are a lot better and more effective than those for our cancer. However, most centres only image the liver for five years and then they stop. They do not use MRI; they use computed tomography and ultrasound. There are also varying opinions on what to do in colorectal, but it is a very common cancer.

I disagree with your statement. We adopt surveillance for a much longer period in a rare cancer than happens for a similar but common cancer, so I am not sure that your statement holds up.

Brian Whittle: Your consensus statement paper states that

> "In high-risk uveal melanomas, this surveillance should be performed by offering serial MRI imaging of the liver ... Serial ultrasound imaging may be considered as an alternative modality if the operator has experience of its use in uveal melanoma metastatic disease."

In that instance, ultrasound operators are required to have specific experience relating to the disease. Given the rarity of the disease, which you have talked about, there cannot be that many experienced operators out there.

Dr Cauchi: I would agree with that. You might have picked up that that comment is in the statement because one of the members of the group felt strongly about it. From a Scottish perspective—and of course it is a Scottish statement—I think that all high-risk patients will get MRI scans because there are very few specialists who will have the expertise to be able to image the liver in a consistently accurate way that we would be happy with. However, there are excellent radiologists who are incredibly good at ultrasound. We have one in Glasgow. Can she image every one of our high-risk patients every six months? I do not think that she can. Therefore, the practicalities mean that we will almost certainly be doing MRI scans for most of our patients. There are a couple of very special individuals who have the skills to do the surveillance, but I do not think they have the time to be able to perform it on a wide scale.

Brian Whittle: Have you had responses to the consensus statement from chief executives?

Dr Cauchi: They are digesting it at the moment—it is very recent. I have another hat—I am clinical director of ophthalmology in Greater

Glasgow and Clyde. It has reached my desk because my director is asking, “What are we going to do about this statement?”, not realising that I wrote it.

Every health board is having to look at its numbers. In Scotland, it is okay, in a way, because we have been taking this approach in the west of Scotland for some time now, although obviously we were waiting for the official statement to come out. Out of 40 patients in Scotland, maybe 14 come from the Glasgow area and about half of those might be high risk, so we are talking about six or seven patients a year who are going to need six-monthly MRI scans. The number in the Highlands is lower, so the number who need the scans will be even lower. The two biggest centres—Lothian and NHS Greater Glasgow and Clyde—will obviously have the lion’s share. Even in those centres, the number of high-risk patients will be about 50 per cent of the number of new patients per year—and it is a rare disease.

However, we will now have quite an exercise, because all our current patient cohort will have to be offered that approach. We will have quite a headache over the coming months, but we will do it. That exercise will involve not just those six or seven a year for us in Glasgow or the 20 a year across Scotland, but our cohort of existing high-risk patients. We will have to have conversations that will be quite upsetting for some of our patients, to be honest. We will need to say, “You have a high-risk tumour. We have been doing liver ultrasounds, but the new recommendation is to do MRI scans”. We always base our decisions on the conversations that we have with our patients, and some patients will not want an MRI scan.

There will be an impact on the radiology departments across Scotland, but I do not think it will be a huge impact, in comparison with what would happen with more common cancers, for example. I suppose that the rarity is an advantage, in that we have lower numbers.

Maurice Corry: On scanning and so on, can you explain why those who have low-risk uveal melanomas do not require ultrasound operators with experience in UMM disease, whereas those in the high-risk category do?

Dr Cauchi: It comes down to the risk benefit ratio again. Most of the people in Scotland who do ultrasound of livers have been trained to a level where they can pick up abnormalities in the liver. What that abnormality is can be open to interpretation. When an abnormality is picked up, we move on to MRI scanning if there is a concern.

You could say that we should offer everyone MRI scans. However, on the risk of getting metastatic disease—there is an appendix about this attached to my paper—if you have a stage 1 cancer, your risk is very low, and you have a 10-year survival rate of 94 per cent; and, if you have a 3A cancer, you have a 10-year survival rate of 60 per cent. I go back to my comments about MRI scanning, about the length of the test, the anxiety it induces in patients and so on. We felt that we drew the line at the correct place, where if someone has a low-risk melanoma, the easier, less anxiety-inducing test can be done. It is shorter; it is tolerated a lot better by patients; it is a quick and easy test; and it can be done closer to home.

It is about saying to the patient, “Yes, you can get the Rolls-Royce test, but if you are low risk the chances of picking something up are very low, and if we pick something up with the ultrasound we will move on to MRI scanning anyway.” It is about using the most appropriate test for the level of risk involved.

Maurice Corry: Do you feel that there would be a greater risk of missing something even in a low-risk patient because the person doing the MRI would have less experience in operating the equipment?

Dr Cauchi: My colleague, Vikas Chadha, went to the Scottish clinical imaging network and spoke quite carefully with the people there about how their operators are trained in imaging livers and in ultrasound. We have been given very strong assurances that all their operators are trained to a level where they can detect abnormalities within a liver and that there should not be an problem.

There may always be issues, of course. For example, the operator may not be able to image the liver of a very obese patient completely, so there may be a substandard scan. Our group looked at that category. If a report came back saying, “We imaged the liver and it was clear, but we could not see the whole liver”, we would move on to an MRI scan. There are always caveats.

On the specific point about whether the radiographers or radiologists who do the scans are able to pick up abnormalities within the liver, we have been given assurances by SCIN that they can, and we have to have confidence in that.

The Deputy Convener: I hate talking about money when it comes to people’s health but, unfortunately, it is inevitable. Do you anticipate any additional costs or funding implications?

10:15

Dr Cauchi: There will be a cost implication, clearly, because we will be doing more MRI scans than we did previously. Being a clinical director, I know that there is a lot of pressure on radiology, and people forget about the reporting. It can take several months to get a report back after you get your scan, and that can be the most anxious time for patients, believe me. Given the numbers involved, I would hope that the extra cost could be absorbed in the current setup. I do not envisage needing more infrastructure or staff or any great changes from that point of view, but it will cost more money, undoubtedly.

Of course we always have to think of resource, because an MRI scan takes about an hour. That is an hour of scanning that you are taking away from the system, which has an impact on someone who is desperate for a scan. For example, someone who has a headache may wait several months to get an MRI scan. It is issues with the slots that are available within the system that prevent that patient from getting their scan. Like everything in health, you cannot just think about your own little bit; you have to think about the whole system.

Brian Whittle: I understand that new NICE-accredited uveal melanoma guidelines are due to be published next year. Is there scope for the consensus statement to feed into the development of those?

Dr Cauchi: That is our hope, absolutely. The 2015 melanoma focus guidelines are due to be updated in 2020. Maybe that was another reason why there was a reluctance for the other groups to be involved. Perhaps they thought, “Why should we go through all the bother now when we are going to have to do it anyway in 2020?” Clearly, we were not prepared to wait for that time to come. I think that the consensus statement will have a big impact on those guidelines. Paul Nathan, who was a member of our group, was the chair of the previous guidelines group, and I suspect that he will be on the next group. I cannot imagine that that will not have an impact.

Recently, all the eye cancer groups in the UK met in Sheffield to compare our results. We presented our work at that meeting and I was pleasantly surprised to see that it was very well received. I expected that there would be negative feedback from my colleagues in England, because I think that it will have an impact on them in the long run and a lot of people would disagree with the use of MRI scans in high-risk patients. However, we have stolen a march on them and have said, “We need to get this problem resolved. If you do not want to engage, we will do it.” However, they are going to have to consider the issue in 2020.

The problem that we have here is that, if you just go on evidence, you would not scan anyone. I have spoken to clinical oncologists who have that opinion and have asked, “Why are you doing any of these scans? We do not agree with that.” The problem with a rare disease is that, if you are waiting for the evidence, the evidence may never come. We need to be pushing the boundaries, but at the same time we need to have a balance. If someone has a very high-risk cancer, it is very different to someone who has a very low-risk cancer. You cannot lump everything together; it would not be fair.

The Deputy Convener: You have touched on the position in the rest of the UK a few times now. If we wanted to understand this from an English or rest-of-UK position, who would you suggest that we could write to about that?

Dr Cauchi: Probably the most appropriate person would be Ayesha Ali, who is at the moment the commissioner for specialised services in England, just as our commissioners in Scotland are NSD. She is not a clinician, but she has overarching governance over the English centres. She is new in post, but I think that she would be the person to write to. I can give you her email address later.

The Deputy Convener: That would be helpful.

Maurice Corry: I noticed that centres across the UK are well represented on your consensus statement group. However, two centres are missing: Liverpool and Southampton. Why is that?

Dr Cauchi: Southampton is not an ocular oncology centre, and we had plenty of representation from clinical oncologists.

Maurice Corry: Is Liverpool not a centre of excellence?

Dr Cauchi: All the centres are centres of excellence. I have to say that I found some of the comments previously about one centre being better than another to be quite unsavoury—they are all centres of excellence.

We needed to get a group together. There was no representation from London and there was no representation from Liverpool.

Maurice Corry: Northwood is represented. Is that not London?

Dr Cauchi: That is not necessarily London. That is clinical oncology. There is eye cancer and there is general cancer. The quick answer is that we did not want the group to become too cumbersome and we did not feel that we needed representation from all the centres.

Maurice Corry: Thank you.

The Deputy Convener: The submission from OcuMel UK—I apologise for you not having seen it in advance, but it came in quite late—is at odds with the evidence that you have given today. One paragraph says:

> “We have not been consulted on this consensus statement and so we have not seen this document in depth. The patient involved in the consensus group made it clear

they could give their personal view but not one representing patients."

How do you respond to that, given the evidence that you have already given us?

Dr Cauchi: I do not agree with that. The patient was chosen because he was a member of OcuMel UK, because he was a patient with a condition and because he was a Scottish patient. Our purpose was to make recommendations in this current situation, and he was represented in that regard. We did not write to specific groups. We did not write to OcuMel UK, just as we did not write to a whole load of other groups. We did not write to all the centres. OcuMel UK is not the only patient focus group. That was not the remit of this consensus statement, it was to come to a conclusion on what we should offer our patients for surveillance.

I do not think we needed to consult OcuMel UK; I do not think we needed to consult, for example, Southampton. You need to draw a line as to where you are going to stop consulting people. We needed to get this statement out. The Public Petitions Committee has a robust process and I do not think that we needed to involve other people. This committee has been pretty thorough in addressing all the issues. OcuMel UK might have been unhappy that we did not consult it, but we did not feel that we had to consult it.

Regarding the patient representative, I am sure that he did not get exactly what he wanted from the group, nor did a lot of other people on the group. There were people on the group who did not want to recommend MRI scanning, but they were prepared to reach a compromise and to move forward on the issue. I am not surprised that there are unhappy parties, but this is better than the previous situation.

The Deputy Convener: Thank you very much. Do members have any comments or suggestions for action, reflecting on the evidence that we have heard?

Brian Whittle: I was just having a quick read over what the petitioner was looking for. Based on what Dr Cauchi has said, it seems that, from the start of this process, significant, comprehensive and leading work has been done.

We have to be careful in our deliberation. It is not our responsibility to direct clinicians; our responsibility is to gather evidence. For me, the petitioner has been responsible for quite a significant shift in the way in which treatment is being given. I think that the only thing that is left for us to do is to get a response from the petitioner to the evidence that has been given today so that we can see whether they are satisfied with the work that has been done. I think that comprehensive work has been done here and that the petitioner has performed a great service. I am almost of a mind to suggest that we close the petition, but I would like to get a response from the petitioner first.

The Deputy Convener: Are there any other comments or suggestions?

David Torrance: I agree with that.

Maurice Corry: I agree with that, too. Brian Whittle is right, and I would like to hear what the petitioner has to say.

The Deputy Convener: The suggestion is that we agree to seek the views of the petitioner in response to the consensus statement and also the evidence today, and ask Dr Cauchi to respond in writing to the two late submissions that we have had, because there are some things in them that we want to hear his views on, and to write to us with guidance on the English position. Do we agree with that suggested action?

Members *indicated agreement.*

The Deputy Convener: Thank you for your evidence, Dr Cauchi. I suspend the meeting for a change of witnesses.

10:26

Meeting suspended.

10:33

On resuming—

Countryside Ranger Services (National Strategic Framework) (PE1678)

The Deputy Convener: Our next continued petition is PE1678, on a national strategic framework for countryside ranger services, which was lodged by Robert Reid on behalf of the Scottish Countryside Rangers Association.

At our previous consideration of the petition in April 2019, the committee agreed to take oral evidence in a round-table meeting to explore the role of countryside rangers, why the role is important, what the challenges are to sustainability of the ranger service and the possibility of there being a working group to examine issues in detail.

I welcome you all to the committee. We will go around the table with introductions, starting with me. I am the MSP for Caithness, Sutherland and Ross and I am the committee's convener today.

Martin Gray (Historic Environment Scotland): I am a ranger and visitor services manager for Historic Environment Scotland.

Jim Downie (Loch Lomond and the Trossachs National Park Authority): I am a ranger manager for Loch Lomond and the Trossachs national park.

Brian Whittle: I am an MSP for South Scotland.

Robert Reid (Scottish Countryside Rangers Association): I am the Scottish Countryside Rangers Association's archive specialist. *[Laughter.]*

Maurice Corry: I am the regional MSP for West Scotland.

Eileen Stuart (Scottish Natural Heritage): I am deputy director of Scottish Natural Heritage.

George Potts (Scottish Countryside Rangers Association): I am chair of the Scottish Countryside Rangers Association.

David Torrance: I am the MSP for Kirkcaldy.

The Deputy Convener: Also at the table are the official reporters and the valuable clerks, who provide the committee with background support. This is a round-table evidence session, so I will very much welcome flowing discussion and exchanges of views. Feel free to engage directly with each other, but do so through the chair, please. If you catch either my eye, or the eye of one of the clerks, we will bring you in when we can. As you have seen, you do not need to press the buttons on your consoles if you wish to speak—our very capable sound engineer will do that for us.

In its submission, Loch Lomond and the Trossachs National Park Authority said:

> "Without a clear understanding and appreciation across the public sector of the value of ranger services, the profession faces a challenging and uncertain future."

In that light, could we hear an outline of the benefits of the ranger service?

Jim Downie: Loch Lomond and the Trossachs National Park Authority has a large ranger service. We currently have about 22 permanent rangers who are joined by 40 or so seasonal rangers, depending on budgets, across the year. The authority certainly sees the ranger service as being integral to the work that we do. Rangers are passionate about the outdoors and about the environment: we provide environmental protection, and we provide visitors with a warm welcome and information on, assistance with and interpretation of the special qualities of the national park.

We provide outdoor learning opportunities for schools and other visiting groups. That can make a real difference to curriculum work. Many visiting geography students get real first-hand experience of the work that we do to balance the needs of all the different people in the national park, from landowners to recreational visitors. We use things such as the John Muir awards in order to reach harder-to-reach groups and people who might not otherwise visit a national park. Such frameworks help us to bring people in.

We have expertise in access, path maintenance and enforcement. The role of a ranger is wide, which is one of the real benefits of the ranger service. We have officers who are specialists, but the ranger service is able to turn its hand to many different things. Rangers are also out in communities and so provide a point of contact.

Brian Whittle: I declare an interest, in that a friend of mine is a ranger down near Middlesbrough, in Guisborough.

Jim Downie mentioned the environment: outdoor learning is a big passion of mine. Many of the submissions highlight the important work that rangers do, especially in respect of health and wellbeing, yet ranger numbers are declining. Can you shed a wee bit of light on why that might be?

Jim Downie: I was describing rangers' position within the Loch Lomond and the Trossachs National Park Authority. We are probably slightly different from local authority, charitable organisation or private ranger services. The authority values the ranger service very highly within the organisation, and we resource it accordingly. We point a fair bit of resource at the ranger service to maintain it and ensure that it exists. I am not sure that that is the case across all bodies.

Eileen Stuart: There is a range of reasons why ranger numbers are declining. There is inevitable pressure on public bodies' budgets, which we see across the piece in national agencies such as SNH and local authorities, which obviously have a key role in supporting ranger services.

Another dimension that is probably worth recognising is that ranger services are offered in a multitude of ways. Some local authorities focus on health and wellbeing, for example, so rather than have a traditional dedicated ranger service, they offer health walks, and focus more on specialisms so that they have biodiversity officers or access officers. They do many things that rangers do, but the focus is slightly different.

A range of people offer services that are similar to what rangers do, but there has definitely been evolution towards there being less of what we think of as core ranger services—which we recognise as being really valuable and, in fact, critical in national parks and country parks to which we welcome people—to offer a more bespoke ranger service. It is quite a complex picture.

Brian Whittle: You have hit the nail on the head of where we are likely to go with the discussion in terms of stresses and strains on public funding. I do not want to put words in your mouth, but it looks like ranger services are an easy target when it comes to public funding. Public bodies are having to come up with creative ways in which they can deliver services. Where do you sit on that? Are there ways in which you can deliver the service more creatively?

Eileen Stuart: There are things that we can do. SNH supports a small number of ranger services—we have been supporting services that we know find it difficult to access other funding. We have been trying to make clear the direction of travel in respect of our funding, so that we give people warning and an indication of where things will be in the coming years.

We have also been trying to ensure that the pain is shared, if you like, so that ranger services can work together to look for alternative sources of funding. That is not easy, as we absolutely acknowledge, but we have been surprised by how creative the ranger services have been.

An interesting current example is the Mull and Iona ranger service, where we currently support two posts but had indicated that the number was likely to go down to one. We have had some follow-up discussions because the service was finding that challenging. It now has a range of funding offers and bids and discussions under way, but the service knows that they will not come through until next year. We have been able to extend our funding for another year to help the service with that transition and to encourage and support its funding efforts.

It is interesting that ranger services are looking to other visitor activities from which streams of donation money come in. Ranger services are also starting to charge for what they provide: that is becoming quite common and is fairly well accepted by the public.

Ranger services are also having discussions with deer management groups, and are asking deer management groups to have discussions with estates. They are considering using bronze, silver or gold levies, or at association. Different models are appropriate in different ways. Our approach has been to try to support that transition.

George Potts: I will highlight a funding anomaly that exists within the services. Agencies like Historic Environment Scotland, Loch Lomond and the Trossachs National Park Authority, and Forestry and Land Scotland get their funding directly from the Government. Local authorities, through block grants and because of their fiscal autonomy, work in a very different landscape.

The SCRA's survey looked at ranger numbers and job losses over the past 10 years: 50 per cent of job losses were in local authority areas. Local authority funding for rangers was, previously, ring fenced and service delivery was monitored by SNH. All that has gone, and along with it SNH's ability to maintain a national overview.

There has been, from my point of view, a very disproportionate effect on local authorities and the communities that they serve. That has been an unintended consequence, and it has had serious implications for substantial urban populations, for social inclusion and, as we have mentioned, for the health and wellbeing of vulnerable communities. Therefore, I feel that the current funding model is not fit for purpose and would like it to be reviewed.

10:45

The Deputy Convener: I know from having been a councillor that local authorities sometimes do not appreciate the Government telling them that money must be ring-fenced for a particular sector. Have you had any conversations with chief executives of local authorities to see whether ring fencing is something that they would welcome?

George Potts: We went down the road of speaking to the Convention of Scottish Local Authorities because there is such variety among councils, as has been described. Chief executives are also not always aware of some of the treasures that they have.

The Deputy Convener: That is the subject of my next question. Do local authorities understand fully and appreciate the benefits that come from a ranger service?

George Potts: No, although they enjoy the publicity from the good news stories that rangers generate. They are having to make some very tough financial decisions, however.

Ranger numbers are small: we heard about Mull and Iona, where a 50 per cent cut in ranger numbers takes them from two to one. That is reflected across Scotland. Rangers are small in number, so a cut of only one post might be 20 per cent of a team, or a cut of a couple of posts might be half the team, but the workload does not change.

Over the past few years—let us say decades—we have raised customers' expectations. We have developed sites that rely on staffing presence, so now, when more and more people are visiting the countryside and when the health agenda is rising to the top, we really need to invest in ranger services.

Eileen Stuart: I absolutely agree with George Potts that local authorities do not always recognise the value of rangers. Sometimes we do not appreciate something until it is gone, which is unfortunate. Recently, we have had—this has been welcomed and was very much stimulated by the petition and the discussions by the Public Petitions Committee—much more effective engagement with COSLA. It invited us to put a paper to its environment and economy committee, which it welcomed. I think that we have managed to raise the profile of ranger services.

We have also been working with the Scottish Government. A contribution to the block grant was previously SNH's money to distribute for rangers. We explored that and realised that the money was not categorised in the settlement. I am not sure that I fully understand transfer of money to local authorities, but funding is now labelled as being for biodiversity and rangers, so that it is absolutely clear to local authorities that the money should be directed towards support for access to the countryside. We are hopeful that that will be beneficial.

The other new move that we have made is also on work with the Scottish Government. We had found it difficult to monitor and get good information on ranger services across Scotland. The Scottish Government is required to get information on access provision as part of the Land Reform (Scotland) Act 2003. It does that routinely, so we have agreed that it will include questions about ranger services and provision across the local authority network. We hope that that will allow us to monitor provision then question, or follow up on, where we think changes have been unhelpful.

The Deputy Convener: Eileen, you mentioned that Mull and Iona had considered charging for services. Do you think that charging might become the norm across the sector?

Eileen Stuart: I am sure that other people can answer as well. The position is variable, but a number of services charge. We were talking about this just prior to coming in here. There seems to be an increasing recognition among the public that it is appropriate that they should pay. We do not see that charging is leading to any decline in the number of people taking up the services. It would not necessarily be applicable everywhere, particularly when we are trying to encourage people who otherwise would not access the countryside, but it is certainly being looked at increasingly in high-profile locations, and it seems to be working.

Martin Gray: It is obvious that a number of services that were previously either grant funded or funded by their councils or organisations are now being asked to supplement their income. To be blunt, they are being asked to find other ways to sustain their budgets. Having worked in rangering all my life, I am aware that services immediately around us—for example, in East Lothian and, in Edinburgh, the Pentland Hills ranger service, which is just over the back from where we are now—have been looking to car parking charges and charges for events.

Our organisation charges for certain but not all of our events. As Eileen Stuart says, that is to demonstrate parity and allow access to events but also to recognise that some events cost us money and we need to supplement their funding. Some events are more expensive than others to run. This goes back to the funding model that was being talked about as to how ranger services are being augmented, but it also clearly demonstrates the pressures that services are being put under.

Jim Downie: That is absolutely right. There are examples of where services are charging and it is working well. Forestry and Land Scotland and the RSPB are charging for guided walks. However, we have to remember that, when it comes to inclusion and the many people who cannot afford to come out and enjoy these places, we have to provide opportunities that are free at the point of sale. It is a balance between those things. There are organisations that are charging for events and services such as guided walks and the public are taking that on board.

Martin Gray: It is important to say that it is about placing value. I will give you a very small example. I manage Holyrood park, where a number of our guided walks are put out to the public. We can have 20 or 30 people phone up to say that they want to come on a guided walk and then only five of them turn up on the day. Putting a levy on the service places a value on what we are delivering to some degree. At the same time, we do not want to discourage people who are less able to afford to do that or less able to get outside. We have to strike a balance.

The Deputy Convener: I will bring the petitioner in now.

Robert Reid: The 32 registered country parks are where the park system for Scotland was born. From those, we moved on to regional parks and then special parks, which are now national parks. The whole point is that a lot of those country parks had to be located in urban areas to make access easy and give people the opportunity to enjoy the countryside. For rangers, people's enjoyment of the countryside is the ultimate, as well as the other functions that they do. At the end of the day, there are many people I have dealt with in my career who just could not afford to pay because of social problems. Although raising money is important, if they had to pay, a lot of people would be excluded from being involved in rangering and the fundamentals that the cradle of rangering set out in 1972.

Maurice Corry: In my area is Loch Lomond and the Trossachs national park, which I know very well; I live in Helensburgh. I agree entirely with the convener. Having been a councillor in Argyll and Bute Council, I do not believe that councillors knew enough about how the national park and the ranger service operated. I would welcome more being done to promote that to the 32 councils, particularly in areas where there are parks. There has always been a little bit of a discussion, shall we say, between the councils and the national park authorities.

One of the issues is planning. In my old area of Argyll and Bute, the national park stretches from the Trossachs practically down to Dunoon and Holy Loch, which is a massive area. There are three councils involved: West Dunbartonshire, Stirling and Argyll and Bute. I think that more needs to be done from that point of view, so I agree with the convener on that point.

SNH has produced an outline of a refreshed "Rangers in Scotland" national statement, which has been circulated to the ranger development partnership members for initial comments. How does the new statement differ from the current one?

Eileen Stuart: That is a very good question. What we have tried to do in the new statement that is in development—we are waiting for feedback and we will be exploring it further at the next meeting of the ranger development partnership—is recognise the slightly different context. Ranger services are provided in a range of ways and perhaps not exclusively in the dedicated ranger services that many of us who are rangers have known. We have to recognise that the picture of provision and people's experience of the outdoors and nature is changing and that their desires and needs are changing. We have tried to reflect that.

We think that ranger services have a core role and value and we need to protect them and secure their future, but we also think that the future approach should be to support skill sharing, development and the professional nature of ranger skills. That has to be at the core, so that we get the same level of provision and the same skills and knowledge across all the different providers. That is very much what we see as the direction of travel and we support the use of branding and logos to recognise that identity and raise the profile. I would not have said that it is radical, but it is about recognising the changing nature of the world and making the most of that new model.

Maurice Corry: I am happy with that. As I say, it is about getting the message out. It is good to see that you have applied some of the lessons learned in your new statement.

I can give an example of where I find the ranger service very valuable. In my patch is the village of Luss, where we have an enormous problem with tourism—the tourism is great, but the problem is the number of people: 750,000 a year. More than 9 million people go from Balloch up to the top of Loch Lomond on the A82 and so on, so there are some issues coming out on that. We are trying to engage with the rangers. I am looking at the idea of using special constables to help with community policing in the area because, unfortunately, we have an issue that we are needing to address in byelaws and regulations. We have wild camping and guys who are under age getting a box of beer from Morrisons or Asda in Dumbarton or wherever and then drinking it. That is a bit of an issue. Rangers are very important in working with us on that, so it is great to hear what you are going to do.

David Torrance: Good morning, everybody. The petitioner, Bob Reid, has constantly called for the Scottish Government to convene a limited-life independent expert group to review the key issues and propose ways forward for a sustainable delivery of a national ranger service. What are your views on that?

Robert Reid: A national ranger service has been a dream of a lot of people, going back to the conception of the ranger services in Scotland. It happens elsewhere in the world and I think that it would bring advantages. It goes back to the point that local authorities now have to hopefully provide the ranger service by an agreement. My concern is who polices it. Another aspect is that some local authorities do not fulfil their requirements in legislation, not necessarily in countryside but in other areas. That would be my concern. A national ranger service is a model worth looking at. I think that it would be welcome to a lot of rangers, but how do you put that national service into place when a high proportion of ranger employers are local authorities? Do you take them out of it? There is a need to take a good look at that in a review.

George Potts: Can I draw your attention to the contents of the Glover report, which looks at designated landscapes in England? It was issued just last week. You may have read in the press that all children are to have a night under the stars or that there is to be a 1,000-ranger workforce in England—that type of thing. Those were elements of that report, which is very comprehensive and makes some bold recommendations on the future of designated landscapes such as national parks.

11:00

One proposal that is of relevance in this meeting is proposal 13:

> "A ranger service in all our national landscapes, part of a national family."

Glover recommends a ranger service with both a national identity and a single unifying vision. He asks for a workforce of 1,000 professional rangers to serve England's designated landscapes and he cites a social return on investment of £7 for each £1 spent. It will not be lost on you that we in Scotland are in danger of losing the very thing that England aspires to. Eileen Stuart has explored other models of ranger delivery, but the key element and the key area that we would like to protect is the professionalism. We have a strong brand with the badge. We have a national network, although it is fragile at the moment. We have a national identity, which we are struggling to maintain. SCRA is pushing to maintain that. There has been very significant investment of public money over four or five decades now. We have built a model that is looked at across the world as one that is worth copying. Glover has made a huge number of recommendations in relation to designated landscapes, but at the very heart of what he is asking for is a professional ranger service.

Brian Whittle: It seems to me that Scotland is in and of itself probably our greatest asset. If we are going to achieve the potential of that asset and ensure that it is fully enjoyed and realised, a professional ranger service will be integral and key to that delivery. It is to the benefit of us all. It sounds to me as if it may need an education and marketing campaign on the benefits of a ranger service to the people who pay the wages. The anomaly is that, from the evidence that we are hearing, the people whose responsibility it is to pay for and deliver the ranger service do not recognise what they have.

If we are going to have outcomes and if we are going to focus on solutions around the issues that we have discussed today, what can we do practically? What is achievable to make sure that the potential of that big asset—Scotland—is realised?

Jim Downie: I was just thinking about George Potts's point. One of the great strengths of a ranger is the range of duties that sits inside the job—working with landowners, promoting access, protecting the environment, patrolling, being involved in education and interpretation. All those things are very important. The knowledge is not at an expert technical level as such, but rangers have a good knowledge of lots of different parts of the job. That is one of the great strengths. If we go down specific roads such as access officer or biodiversity officer, that is good. It can feed into a professional ranger service that has a broad portfolio of skills, and that is where rangers are at their best. They see opportunities in communities and empower communities to work for themselves and deliver the outcomes that the Scottish Government is looking for.

That is one of the keys. If local authorities or people who are employing rangers do not know what they are doing, it is easy to forget the important part that they play. If there is an agreed set of outputs across the board that we are looking to deliver, the ranger service in Scotland is in a much stronger place to say, "We are going to deliver." SNH's agreement in the past was about ensuring a welcome to the countryside and mediation between public use and other rural land use. Those are common across all ranger services. If we report on that together and we present that, it makes a much stronger case for us, and that is one of the things that are missing.

Brian Whittle: When Jim Downie was talking about the range of services that rangers can supply, it occurred to me that many of the petitions that we have had in my time on the committee, which is not that long, have pertained to the countryside, such as those on the culling of mountain hares, raptors and the management of grouse moors, and those things relate to the role that a ranger plays as an interface between the public and landowners. It seems to me that we are not selling the ranger service in the way we should. It goes back to what I said earlier about education and marketing. Collectively, the ranger service has to set that out. I do not know who does that and whose responsibility it would be to raise all these issues. It seems to me that rangers have a big part to play in a lot of the work that we are doing in the committee.

Eileen Stuart: This has been a useful and interesting discussion. It is right to say that because people do not necessarily understand and recognise what rangers do it is harder for us to make the case for the funding. It is a chicken-and-egg situation. I think that we are all very much agreed that it is important that we raise the profile and recognition of what rangers do and what they can offer.

It struck me in the discussion that there are three things that we are working on that should help. The idea of a national service with everybody having the same employer does not seem to be a model that sits comfortably in Scotland. Even within Cairngorms national park, a single service has not been created; instead the range of services that are provided by both public bodies and landowners and so on have been branded. What rangers do and should have in common is the single, unified vision and clarity of purpose. The professionalism and the identity of rangers absolutely have to be at the heart, so that people are recognise that common identity and help to reinforce the value. That then makes the case for further funding.

There are some interesting ideas on funding that are definitely worth exploring. What SNH sees is that the refined, refreshed statement provides a platform for all of us. It is a shared role to promote and highlight the value of rangers. We have had some productive discussions with the Minister for Rural Affairs and the Natural Environment, and we hope that she will provide the foreword to the statement and help us to raise the profile. We will probably be contacting MSPs and others to see whether they will support that.

We have an opportunity now if we can get that up and running and set it in train. As things evolve, particularly on the funding side, one of the potential opportunities is around the tourist tax—we do not call it that; it is the visitor levy. Highland Council is consulting on that and other local authorities are looking at it. It seems an obvious place to seek funds. Tourists are bringing very useful economic benefits, but they are also having an impact, so the levy would be a logical source of funding to support the rangers and the welcome that we want to see in the countryside. Those are just some thoughts.

Martin Gray: I will reiterate some of what Jim Downie said but add a little example from my organisation, and I will touch on some of Brian Whittle's points. My organisation went through a period of losing ranger teams. However, after a considerable amount of work with our line management and our current director and chief executive, all now understand what we are trying to achieve with our ranger teams and are very supportive. As a result, we have brought in more permanent and seasonal staff to support our sites at Holyrood and up in Orkney. The increase in visitors to the countryside and tourists to sites has led us to put rangers on site, because they are seen as a key way of delivering to the public.

The diversity of role is there. As an organisation, we now support the idea of rangers when we give advice to others. The Kilmartin glen museum is looking at its funding models and what it is going to do, and we have suggested that a ranger might be part of the way for it to deliver for the community and engage with land managers. The trust at Callanish standing stones is another organisation that is considering how it might fund what it does on its site. Again, we have suggested that a community ranger or somebody of that ilk could be beneficial. As Brian Whittle said, it is about getting the message to the higher decision makers that rangers are great and setting out what they can deliver. Basically, it is about saying, "You need to fund it."

David Torrance: There is a lot of expertise and experience round the table. How often do you get together to promote the vision of the ranger service and to push for funding? It seems like a lot of great work is going on in different areas such as the Cairngorms and Trossachs, but how often do you all come together to promote that vision of what the ranger service does?

Robert Reid: SCRA plays a role in that and it has meetings with employers. I believe that there has not been one for some time, but there is that opportunity. There used to be a good system by which the employers got together regularly to spend a day discussing the issues. For whatever reason, that has fallen by the wayside.

The Deputy Convener: Does that lead back to the suggestion of an expert group? Is that maybe a way forward, Mr Potts?

George Potts: It would certainly help, and it would provide a focus. The variety of work that you have heard about covers many of the national priorities, including health and wellbeing and social inclusion. An expert group needs to reflect that range of work. Just round this table, we have people working all the way from Orkney right down to deepest darkest Balloch. We work right across Scotland in a variety of settings.

Can I come back to Eileen Stuart's point about SNH's role?

The Deputy Convener: Of course.

George Potts: All my working life, I have worked in partnership, first with the Countryside Commission for Scotland and then with SNH. I have reported to them and agreed work programmes with them, and we have had funding. In the latter years, the funding has been a tiny percentage of my budget, but I have still been able to report 100 per cent of my outcomes to SNH.

In recent years, we have seen SNH actively disengaging from ranger services. The SNH written submission shows that there is perhaps a couple of years of funding for some of the few services that are still involved. The word "ranger" does not now appear in SNH's corporate plan and, if we have a wee trawl on the website, we do not find the word "ranger" there, either. That has been a very worrying trend.

We need SNH and that partnership. SNH sits at the table with the Government and it can help to influence priorities and represent us at that big table. That is the partnership that I was used to. SNH can provide that focus, but it has been moving away from that. The services that SNH funds now are community-based ones. It has been funding those for several years, but that sector is still only 2 per cent of the total in Scotland. Does that reflect the influence of SNH on that sector, or is it that SNH is putting money into an area where there is no growth and no need for investment? That is a challenge for SNH. I realise that it has had rigorous budget constraints placed on it, but it is not offering value for money if it does not include in its approach the outcomes that rangers can deliver.

The Deputy Convener: Maurice Corry has a supplementary.

Maurice Corry: It is probably addressed to Bob Reid and it relates to the new statement, which I referred to when I was talking to Eileen Stuart. Could the ambition of the new statement be seriously affected by the cuts to ranger posts or do you have a plan B that could deliver the ambition with reduced personnel?

11:15

Robert Reid: SCRA members are suffering because of the loss of jobs. In the beginning, that was basically about early retirement and people being let away and the jobs going unfilled. That was the start of the move down. We are now finding that rangers in Scotland are having mental health issues because of the increased pressure. Another issue is that a lot of services are being moved to single services with only one person, and there are health and safety issues related to that. On Sunday, I spoke to a young ranger who works in nature reserves in an urban area in Lanarkshire, and she has to take a volunteer with her so that she can feel safe in carrying out her job.

When rangers started up, we were all taken for national ranger training. That gave us the skills to work from the top of the mountain to the marine environment and whether it be in a village, a rural area, forests, town or cities. That is where the rangers are. Certain ranger services in cities have been told that, as a cut, transportation was to be taken away. That did not happen, but were the rangers in a city supposed to go on the bus to do their job? There are issues that need to be drilled into to understand what is really going on with rangers and to find out what local authorities are thinking and how they perceive the service. Everyone who has signed up to the petition cannot speak highly enough about ranger services, but we are continuing down the road to oblivion. Funding is going to other jobs that are basically ranger jobs, so what is wrong with using the title?

The Danish Government adopted the Scottish process, working with local authorities, but the local authorities in Denmark get substantial funding from the Government to provide a professional service. At the end of the day, it is budgeting that will have to resolve the issue, if it is ever going to be resolved.

Maurice Corry: George Potts talked about more cohesive working with SNH. Could that help to fill the gap?

Robert Reid: Yes. We have a working relationship, but it needs to go a bit further, possibly through a memorandum of understanding so that the two organisations work in tandem to resolve some of the issues.

The Deputy Convener: I ask Eileen Stuart to outline some of the challenges that SNH is finding with delivering the ranger service.

Eileen Stuart: There are a number of things. I will come back to the expert group, but I will first say a little about our role and our relationship with rangers. Our role continues to be very supportive. We recognise the role of SCRA and the other employers and we actively work with all the individuals here.

Our external profile is not as high as it has been in the past. Part of the reason for that is that there is nothing in particular to tell. We hope that, when the new statement is finalised, along with it will come a communications plan about how we use the statement as a platform to engage and to promote the value of a ranger service. We would develop the two things in tandem.

With regard to engagement with rangers, the ranger development partnership is an active and valuable group. It involves the individuals who are round the table today and representation from COSLA. COSLA has not engaged so much in the past, but it is now signalling that it will be round the table and will be active. That is encouraging, but we need to ensure that it happens in practice. We also have a number of other bodies. That group has all the expertise that we need, so we may be able to do something with it. Having an independent chair of the group might fulfil the same purposes as having a new group. Inevitably, a new group would have almost the same people round the table, so we could do something with the existing group that would achieve the same thing.

We all recognise that we are living with a funding challenge and that we have to work together to try to find ways to address it. Bob Reid alluded to the fact that some people who were rangers are still in employment but are called something different, such as an access officer. We need to maximise and use the collective resource of professionals who engage with people and the outside world and we need to ensure that they are recognised as rangers, so that there is commonality and recognition. That would be beneficial. We might be able to encourage funders, such as the national health service or local authorities, that employ people who provide ranger services to put “ranger” in the job title. We know that there are sometimes rangers with other responsibilities, who we might call rangers plus, but we need to ensure that the term “ranger” is used so that they become part of the collective.

That will mean that we can develop the pathway so that they have the same training and skills and work to the same vision.

A lot of work is under way, and the petition has been a useful catalyst for starting the ball rolling. There is obviously the will and the expertise round the table to take forward the matter.

George Potts: In recent years, organisations have become more dynamic in the way that they change their management structures, and managers across Scotland have inherited ranger services that they do not know what to do with. Previously, there was a reasonable career path for rangers. They would have been in a parks or recreation department—I worked for many years for the planning department—and there was manager representation of rangers in the headquarters. Now, for example, my service in Dundee is managed by somebody with a waste management background. Such managers do not have the background or understanding to take on board the big picture of the national network and the value of the national identity. For us as an association, that has made it difficult to get people to come on board. Bob Reid and I represent SCRA, but we are not representative. We are a pair of old duffers who should be retired.

Brian Whittle: Are you all right with that, Bob?

Robert Reid: I am, yes. *[Laughter.]*

George Potts: It is a young person's profession. It is an active career choice for young people and I would like them to have the opportunity to get into the profession. There is a job of work to be done to bring those new managers up to date with what rangers are, what they have to offer and how they individually contribute to the national network and national identity. In that way, we can maintain professional standards in Scotland.

The Deputy Convener: I will follow up on the suggestion that there should be an expert group. The Loch Lomond and the Trossachs National Park Authority submission outlines the benefits of a strategic framework for the park. Jim Downie, is there a network that can work strategically across the whole of Scotland? Do you agree that there should be an expert group?

Jim Downie: As I said earlier, if ranger services across Scotland worked to a common goal that was set out for us—there is a commonality to our work, but a more concrete goal could be stated—ranger services would benefit.

A lot of what we have been talking about highlights the benefits of having a ranger service. Everybody who has been involved and who comments on the ranger service speaks highly of it. We understand that there are benefits to people being outdoors and we understand the benefits of the ranger service to that. However, as a service—for the national park, but also for Scotland—we need to be aligned with the priorities of Scotland. We can do a lot in delivering those priorities, from improving health and wellbeing to inclusion. Getting people out into nature is important for us all. A national framework, an agreement that we are all working to, is a really good idea and we would be happy to be involved in it.

The Deputy Convener: Does anyone else have any additional comments or suggestions? Would Bob Reid like to reflect on the evidence?

Robert Reid: When the Countryside Commission for Scotland set up the ranger service, what is known as the final report of the Speyside project outlined what the ranger service would be. It has not changed much. Perhaps if we go back and look at that document, it might help to give some focus.

Over the years I have quoted our first president, Frank Fraser Darling, who was renowned worldwide. At the very first conference that we held, he said that, "You, as rangers, have the opportunity to develop what the Scottish ranger service will be." We worked at that and that is what we did, from that point of view.

Rangers all have hope and look to the future. I think that by looking to the future and working cross party, in the sense of across all the organisations, matters can be resolved. Our members see the benefit of that and see that there is value and worth in working together.

Eileen Stuart: We very much welcome the vision. The ranger statement must be a collective, cohesive document and we are working with partners so that the statement reflects everybody's view and has an ambitious, high-profile role for rangers. The statement is out there for comment and I encourage everybody to look at it. We will look very closely at comments and work together. Most of us here are probably in the latter stage of our careers, so we need to make sure that young peoples' voices and the future are reflected.

A memorandum of understanding is a very useful idea. It is something that we would encourage.

My final comment is about the independent group. One way of getting the ranger development partnership to have a slightly different identity, and perhaps more independence, would be also to have an independent chair. Perhaps SCRA or others have thoughts about that. We chair the group at the moment, but that is almost by default because nobody else has been keen to step into that role. We absolutely would welcome it if there was somebody else who had a higher profile or could bring a new perspective to the role. That would be worth thinking about.

The Deputy Convener: The heart of the petition is about a strategic approach to rangering and the ranger service. The statement that is being worked up by SNH has a timescale for completion of early 2020. Is there any way for the discussions that we are having about the petition to feed into that statement?

Eileen Stuart: Yes, absolutely. The statement is evolving. We have been taking on board things that have emerged in this discussion and will continue to do so. We are very open and want the statement to be something that we feel reflects the views of rangers across Scotland.

George Potts: There is a meeting of the ranger development partnership on 11 November and the statement will be first and last on the agenda. We will take it forward from there.

Brian Whittle: I am reflecting on the mood of the Parliament. Yesterday, we passed the Climate Change (Scotland) Bill. For goodness' sake, if the rangers cannot be part of that whole ethos and strategy, there is something completely wrong here. To me, we are pushing at an open door: I cannot imagine that anybody would speak against it.

Yes, the Parliament has a role in trying to raise the rangers' profile and to make sure that the rangers have a framework to work within, but I will throw it back to you that it is the people in this room who have a serious responsibility to bring to us the strategy and vision that we can sell to the public and public services.

11:30

Everything that we have talked about fits very well with Government strategy that has been agreed across the chamber. So, I will throw it back to you. We can discuss this with Government and ask its views on the independent group, but I am pretty sure that there will be no problem or pushback. In my view, it will inevitably come back to the people in this room.

The Deputy Convener: Does anyone else have any other comments or suggestions?

Eileen Stuart: My final suggestion is a bit cheeky, but you are all here and offering your support. There is a sharing good practice event that we are jointly holding in December, in our Battleby office in Perth. It is particularly about rangers and their role in promoting health and mental health by encouraging people to access and gain the benefits of the outdoors. I assume that we would be very happy to extend an invitation to members; they might find the event a useful insight into the work of rangers.

Brian Whittle: I am always up for that.

The Deputy Convener: Thank you for that. Do committee members have any other comments or suggestions?

David Torrance: I would be interested in the Government's view, especially on a short-life working group, to see how we could push and promote the ranger service.

Maurice Corry: I agree. David Torrance is absolutely right on both those points. I am happy with that.

George Potts: I thank the Public Petitions Committee for giving us such a fair hearing. The petition was lodged in December 2017 and here we are in September 2019. I have appreciated the opportunity to engage with the Parliament. Thank you for your support.

Robert Reid: I second that.

The Deputy Convener: Thank you. We will agree to write to the Scottish Government on various points that we have heard in our evidence today.

I would also like to pick something up with COSLA. Even though COSLA provided a written submission in July and is happy to work with stakeholders to find solutions, I think that we need to probe a little bit more about the understanding within local authorities of the benefits of a ranger service, how they think the service should be funded and whether they think that ring-fencing funding is the right way to go about it.

If there are no other suggestions, I also ask SNH to reflect on the evidence that we have heard and to keep us updated as to progress on its side, if that would be okay.

Eileen Stuart: Absolutely.

The Deputy Convener: It remains for me to thank you all for coming along, with special thanks to Bob Reid, the petitioner. Thank you.

Meeting closed at 11:33.

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