OFFICIAL REPORT
AITHISG OIFIGEIL

Citizen Participation and Public Petitions Committee

Wednesday 26 November 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 26 November 2025

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CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

18th Meeting 2025, Session 6

CONVENER

*Jackson Carlaw (Eastwood) (Con)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Fergus Ewing (Inverness and Nairn) (Ind)
*Maurice Golden (North East Scotland) (Con)
*Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Clare Adamson (Motherwell and Wishaw) (SNP)
Jim Crombie (Best Start Perinatal Sub-group)
Monica Lennon (Central Scotland) (Lab)
Douglas Lumsden (North East Scotland) (Con)
Liam McArthur (Orkney Islands) (LD)
Dr Andrew Murray (Best Start Perinatal Sub-group)
Dr Stephen Wardle (British Association of Perinatal Medicine)

CLERK TO THE COMMITTEE

Jyoti Chandola

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 26 November 2025

[The Convener opened the meeting at 09:35]

Decision on Taking Business in Private

The Convener (Jackson Carlaw): Good morning, and welcome to the 18th meeting of the Citizen Participation and Public Petitions Committee in 2025. I apologise for our starting slightly late. We will be joined by a galaxy of parliamentary talent from different parties during the course of the meeting. As always, I hope that time will permit those who wish to contribute to our proceedings to have the opportunity to do so.

Our first item of business is the always rather technical one of agreeing that we will consider the evidence that we have heard this morning in private under agenda items 4 and 5. Are colleagues content with that proposal?

Members *indicated agreement.*

Continued Petitions

Specialist Neonatal Units (Centralisation) (PE2099)

09:36

The Convener: The second item on our agenda is consideration of continued petitions. The first petition is PE2099, an extraordinarily important petition on which the committee has previously engaged and has undertaken a site visit to the neonatal intensive care unit in Wishaw, where we were pleased to meet the petitioner, Lynn McRitchie.

The petition calls on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading of established and high-performing specialist neonatal intensive care services across NHS Scotland from level 3 to level 2 and to commission an independent review of that decision in the light of contradictory expert opinions on centralised services.

At our previous consideration of the petition, the committee agreed to take evidence from the British Association of Perinatal Medicine's best start perinatal sub-group, and the Minister for Public Health and Women's Health. We will hear from the minister at a subsequent meeting, but at today's meeting we will take evidence first from Dr Stephen Wardle, the president of the British Association of Perinatal Medicine, who joins us online, and then from members of the best start perinatal sub-group.

Good morning, Dr Wardle. I see that all the graphics on your background image have been reversed, so we are seeing all the text behind you the wrong way round. It is difficult to work out what it all says—those who are following the proceedings can puzzle over what it means.

We are also joined by our colleagues Clare Adamson and Monica Lennon. If there is time after committee members have asked their questions, I will invite both of them to put their questions to the witness.

Dr Wardle, is there anything that you would like to say by way of introduction?

Dr Stephen Wardle (British Association of Perinatal Medicine): Good morning. I am a consultant neonatologist and, as you have said, the president of the British Association of Perinatal Medicine, which is a professional organisation that represents perinatal professionals: doctors, nurses, allied health professionals, psychologists and pharmacists who work in neonatal services.

The Convener: This is an emotive subject—we can all understand that. Our job is not to ignore

that, but to approach the issue in as professional and dispassionate a manner as possible in order to ensure that there is a proper opportunity to discuss the aims of the petition and that Parliament and the Scottish Government ultimately come to the right decisions.

What are the types of local and national factors and constraints that the British Association of Perinatal Medicine would expect to be taken into account when implementing its framework's recommendations? Are you confident that those have been adequately taken into account in the proposals that have emerged in Scotland?

Dr Wardle: In terms of the organisation of neonatal networks, there is some evidence that the centralisation of services improves outcomes. We know that the smallest and sickest babies who are cared for in larger, more centralised neonatal services have better outcomes than those who are not. In my written submission, I have documented some of the evidence behind that and the references involved. All that information, and the framework that was produced on behalf of the British Association of Perinatal Medicine, was taken into consideration in the best start review.

The centralisation of neonatal services in larger neonatal units that have all the right resources in terms of people, expertise, equipment and the wherewithal to be able to deal with the smallest and sickest babies helps to improve outcomes. That means that babies of 27 weeks and lower should all be cared for in neonatal intensive care units rather than local neonatal units or special care units.

Do I need to describe the difference between neonatal intensive care units and local neonatal units?

The Convener: It might be helpful if you could explain that on the record. The committee has gone through that previously, but it would not be unhelpful to hear it again.

Dr Wardle: The care that individual babies receive is divided into various levels, and individual neonatal units provide certain levels of care. The highest level of care is provided by neonatal intensive care units, which are the most complex, largest units. Those are the tertiary units that care for babies across a wider region and look after the smallest and sickest babies.

Local neonatal units tend to be smaller units at local hospitals. They care for babies who are born early—in general, babies from 28 weeks and above—but not the smallest and sickest babies. Special care baby units tend to be slightly smaller facilities that provide care for babies at higher gestations who do not receive any intensive care. In local neonatal units, short-term intensive care can be provided, but babies who need long-term intensive care are cared for solely at neonatal intensive care units.

As you will be aware, the British Association of Perinatal Medicine and associated services have defined levels of dependency and activity that a unit must be engaged in—that is, the number of babies who are looked after and the number of intensive care days that are provided—if it is to be designated as a neonatal intensive care unit or a local neonatal unit. Those levels ensure that the throughput for the larger neonatal intensive care units is sufficient in order to meet the criteria that we know help to improve outcomes.

The Convener: That is helpful.

Although there is a pattern to them, a lot of our questions cut across one another and are relevant to various points. Obviously, we are going to discuss why we went from having eight units to having just three, following a recommended reduction to between three and five. However, following our visit to Wishaw, my question is: how does the framework aim to maximise the experience of babies and parents—that is, the human aspect—alongside maximising clinical outcomes and cost-effectiveness?

The unit in Wishaw is an award-winning facility with highly experienced staff and is at a geographical point that is accessible for everybody in the south of Scotland. We know that some of the larger units that exist are turning people away because they do not have capacity, which raises the prospect that somebody from Lanarkshire could end up in Aberdeen.

In Wishaw, we spoke to a father who said that, following the birth of their child, his wife was left in a life-threatening situation and that, if the unit in Wishaw had not existed, he would have had to decide whether to stay with his wife, whose life was at risk, or stay with his baby, who might have been in Aberdeen. That would have been an awful choice to make. The human dynamic in such circumstances seems to be at risk.

As I said, there is an award-winning facility in Wishaw and, when we visited it, we saw that the quality of care that is provided is outstanding. To us, as laypeople, it seemed difficult to square the circle.

Dr Wardle: I understand all those issues. It is difficult to provide local services that are as specialised as they need to be in order to care for the smallest and sickest babies.

As I have said, the optimal way of providing the right level of care for those babies is by ensuring that care is centralised and that units are large enough to be able to care for enough babies to maintain expertise. That can be difficult, and the

movement of mothers and babies as a result of centralising care is inevitable.

It is important to avoid the movement of babies as much as possible. Ideally, sufficient capacity should be provided in all of the units that are providing the intensive care. In any review of the designation of services, it is important that the neonatal intensive care units that will be enabled to take all of the activity have sufficient capacity in terms of staff and space to be able to care for those babies.

If all those things are provided, it should be possible to transfer mothers antenatally—that is, before birth—when a pre-term delivery is expected. That should avoid mothers and babies being separated. It might mean that care is provided slightly further away from home for some families. That means that the capacity has to be in the right places, so that those journeys are minimised as much as possible.

In the first stages of neonatal intensive care, babies are very sick and need lots of expert intensive therapies and treatment. Later in their care, many babies can be transferred back to their local units. It is a system that seems to work well when networks are well organised. If the right capacity is in the right places, it should be possible, in most instances, to anticipate when women are going to deliver prematurely and ensure that the smallest and sickest babies are born in the right place, where intensive care can be provided on site, so that the baby does not need to be transferred. Following that, when those babies have progressed and done well, they can be transferred to their more local units.

You also mentioned local expertise and the excellence of some units. It is important that expertise is maintained, and I appreciate that the approach that we are discussing can be difficult in some units that are providing a higher level of care, particularly if the change is seen as downgrading the care that is provided by moving the facility to a lower level. However, the changes are not about individuals. The issue is not about which individuals can provide the best care; it is about making sure that the right people are in the right place to provide the right care for the babies, and that that care is provided in large enough centres.

The Convener: It is not always the case that the outcome is a happy one. In the scenario that I mentioned, the baby could have been transferred from Wishaw to Aberdeen and, in the worst-case scenario, it might not have been possible for the father, who was also concerned about his wife, to be present in the event that things did not work out well. We are talking about considerable distances. You say that adequate capacity will be available in the larger units, but I do not know whether my parliamentary colleagues are terribly sure that that has been the pattern when other services have been centralised.

Dr Wardle: It comes down to how the services are commissioned. If the resources are available, it should be possible to commission sufficient space and capacity in the right places.

I agree that transferring women and babies very long distances is not ideal, and that is why the right capacity has to be in the right places. Unfortunately, outcomes are not always good, and provisions need to be in place to deal with those situations.

Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab): You have said that travelling is not good for the baby, but you have also referred to appropriate capacity being available in the alternative unit. The nearest unit to Wishaw is Glasgow, which is at or near capacity. As a result, capital investment would be needed to increase capacity before there was any decision to close Wishaw. Is that right, or sensible?

Dr Wardle: I do not know the particular circumstances in Wishaw and Glasgow and what would be required to be opened to ensure sufficient capacity or, indeed, what the right capacity would need to be. Sometimes capacity just means having more nurses, or the right number of nurses, to look after a particular number of babies or to maintain a certain level of activity in a particular neonatal unit.

I am not aware of the exact circumstances in Glasgow that limit capacity at the moment. It could be that more nurses are required, or it might be that some capital investment needs to be made in order to have a larger space—I am not sure—but, ideally, all those things should be provided to ensure that capacity can be transferred.

David Torrance (Kirkcaldy) (SNP): Good morning, Dr Wardle. Does the proposed location of Scottish units raise any concerns about a disproportionate rate of transfers from areas of high deprivation?

Dr Wardle: High deprivation can lead to a higher incidence of prematurity and sometimes poorer outcomes. What do you mean by “deprivation”? Are you asking whether transferring might be more difficult in those circumstances?

David Torrance: In areas of deprivation, health is usually poor, so we will probably find more cases of premature babies being born and therefore more need for specialist units.

Dr Wardle: Yes, that is possible and, indeed, is often the case. Again, it goes back to capacity being in the right places and ensuring that there is sufficient capacity so that care can be transferred when required.

The distances that people travel need to be reasonable, too. The review has recommended the establishment, eventually, of three neonatal intensive care units and, as has been pointed out, Glasgow would be the closest to Wishaw. I do not know enough about the local circumstances but, as long as sufficient capacity is provided, it should be possible to manage the situation.

David Torrance: On that point about capacity, the central belt has the greatest population density in Scotland; indeed, the whole area of Lanarkshire and Wishaw has high population density. Would it not make sense to put the units where you have the highest population density, instead of people having to go to Aberdeen, Dundee or such areas?

Dr Wardle: I do not think that I can answer those questions. All those issues were reviewed in the options appraisal, but neither I nor my organisation took part in the review, so we do not have a specific view on that. However, the principles that were used were those recommended by BAPM on centralising care to improve outcomes.

The Convener: Davy, did you want to follow up on any questions?

Davy Russell: Just a couple, convener.

The review recommended the establishment of between three and five operational units. Obviously, Scotland's population is 5 million. What, based on your expertise, would be the right number of units? Would it be three or five—or four?

Dr Wardle: That is a good question. Geography would certainly need to come into it, but I would point out that the size of the population, and the number of deliveries that occur in Scotland, are similar to those in a neonatal network in England. There are 10 such networks in England, and typically, each of those neonatal networks will have two neonatal intensive care units. Some have just one, while others have three or four. In general, though, around two neonatal intensive care units will be required for that size of population. As I have said, geography will come into this, too.

Davy Russell: What do you think would be a reasonable distance for a mother and baby to travel?

Dr Wardle: What is "reasonable"? Sometimes, mothers and babies get moved considerable distances. Ideally, when care is provided within networks, the distance is minimised. Some of the networks in England are large and require the transfer of mums and babies over significant distances, but I do not think that there is any set distance, or time limit, for transfers.

The key thing is ensuring that capacity is in the right place and that transfers, particularly transfers of babies, are minimised. Mums need to be transferred rather than babies. We certainly do not make recommendations on distances, but organising care within networks helps minimise very long-distance transfers.

Davy Russell: How easy is it to identify mothers who might be prone to giving birth prematurely? Is there any methodology that you would use, or pre-work activity that you would do, to ensure that the mother is in the right place closer to the right time?

Dr Wardle: Yes, there is. Lots of work goes into that. This is really a question for an obstetrician, but there are tools to predict which mums are going to deliver early.

Sometimes, there are clinical factors, such as multiple births, that make early delivery more likely. Women who have had a previous pre-term birth are at higher risk of delivering early, as are some women who have problems with, say, their cervix. On most occasions, the obstetrician can predict when women are likely to deliver early. Some women just go into labour early, and that cannot be predicted, but as long as they can be transferred early enough in the process, it can happen in a safe and timely way.

Unfortunately, there are some women who go quickly, and unpredictably, into premature labour. In those circumstances, the baby needs to be transferred after birth, which, as I have said, is less than ideal and something we try to avoid. That is the purpose of organising care in networks and trying to ensure that mums are transferred rather than babies.

Davy Russell: Thank you.

The Convener: Maurice Golden, do you want to follow up on any of those points?

Maurice Golden (North East Scotland) (Con): I think that that would be helpful, convener.

Everyone will agree that there is already a degree of centralisation, given that we are starting with eight specialist units. However, the concern is the rationale behind all this and how we ensure not just the best clinical outcomes but the best patient outcomes.

I am interested in cases in which, as a result of closures, families might have to live apart and in the impact that that might have. Last month, *The Courier* reported on the case of Lois Cathro, whose triplets were born at 32 weeks, and all under 4 pounds in weight, at Ninewells hospital in Dundee. They received excellent care, but Lois said:

"Had the unit not been there, we could have faced an unimaginable situation."

Is it conceivable that parents and families might have to make round trips of hundreds of miles between hospitals just to see their babies? What impact might that have not just on their clinical care but on their overall wellbeing and, potentially, on future health and mental health outcomes?

10:00

Dr Wardle: Travel for parents is a big issue when care is centralised. It is important that, as well as providing the capacity to look after babies, we provide facilities for parents, too. That will mean help with accommodation for those parents who have travelled long distances, help with travel costs and help with things such as parking and food while their babies receive intensive care.

All those things need to be considered—and, I hope, provided where possible—to make the journey for those parents easier and more bearable. After all, having a premature baby is a considerably emotional and stressful experience. It is all about caring for babies as close to home as possible, so we need to avoid very long-distance transfers, and we should transfer babies back to their local unit, when that is possible, and based on their care. Hopefully, if all those principles are considered, we can optimise the experience for families and try to ensure that families, particularly those from deprived backgrounds, do not have to meet very high costs and avoid the stress and difficulties that can arise from having their babies being cared for at a long distance from their home.

Maurice Golden: Thanks for that answer, but you have highlighted, I suppose, the nub of the issue. It appears as though the arbitrary methodology behind closing units and reducing them down to three is almost setting mothers and very sick babies up to fail by building in that amount of travel from the outset. Huge swathes of Scotland, including the most deprived parts, will lose services if the closures go ahead. In your opinion, does this move need to be reconsidered?

Dr Wardle: I do not think that it needs to be reconsidered on that basis. Optimising outcomes is clearly the reason for centralising care in this way and for these recommendations being made. Providing appropriate care for parents and families will be key to all that.

The difficulty is that, if we continue to provide care in lots of smaller units in an effort to avoid transfers, fewer babies will survive and there will be poorer outcomes. A high level of resources is required to support the level of intensive care that is needed in a large number of smaller units and to provide the right staffing levels in all those places. It is not that centralising care is about saving costs—it is not. It is about improving outcomes. Trying to provide care in that many units would be difficult, because it is difficult to provide the right staff at the right level with the right expertise.

Maurice Golden: I am not a clinician, but clearly there is already a degree of centralisation. At the moment, we have eight units, and perhaps the number should be five or six. I know that the Princess Royal maternity hospital is already in Glasgow, so I would presume that, in that case, the effect on parents will not be so severe. However, it seems to me that the proposed move down to three units boils down to finances, which is deeply concerning. Can you assuage those concerns in any way?

Dr Wardle: I do not think that it is about that—our recommendations are not around finances; they are around improving outcomes. If we want the best outcomes for our babies and families, centralised care provides that. I do not think that it is around costs although, clearly, the costs need to be borne in mind. In a system in which resources are not endless, those things need to be taken into consideration. However, our recommendations are around improving clinical outcomes.

Fergus Ewing (Inverness and Nairn) (Ind): I understand the basic point that Dr Wardle is, quite fairly, making, which is that his views are driven by the desire to get the best outcomes. That is understandable. Where there are very low birth weight babies, that is extremely worrying for everybody. I was not in attendance during the visit that committee members made to Wishaw, but I understand that it was put to members that the process of centralisation in England was perhaps going to be revisited. Is that a false rumour, or is there substance to it?

Dr Wardle: No—there are no plans to revisit centralisation in England. In some networks, there is on-going review of the care that is provided and the designation of units, but there are no plans to revisit that type of centralisation. Providing care in operational delivery networks with centralisation of care for the smallest and sickest babies continues, and is planned to continue. I think that there are reviews in some networks to look at where the care should be provided, in the same way as care is being looked at in relation to the designation of individual units. However, there are no plans to revise that.

Fergus Ewing: Thanks for clarifying that.

In your written submission, you state that the recommendation is that

"Scotland should move to a model of three-to-five ... units ... in the short term, progressing to three units within five years".

I represent the seat of Inverness and Nairn, which is in the centre of the Highlands, but the Highlands is roughly the size of Belgium. For example, the journey time from Wick to Aberdeen is four hours

41 minutes by car—it is 204 miles. I have absolutely nothing against my colleagues and friends representing the Wishaw area, but the journey time from Wishaw to Glasgow is 30 minutes, and the distance is 20 miles. I want to put that in perspective, because the geography of Scotland, once one leaves the central belt is, by and large, one of very sparse populations spread over enormous areas.

It is your clinical judgment that there should be a move to five units and then to three. What would you say to those who say that, if there is nothing in the Highlands, the nearest place is Aberdeen, which means that people who live in the more rural parts of the Highlands—you could make the same case for the south of Scotland and other rural areas such as the north-east, Argyll and the islands in particular—are second-class citizens when it comes to neonatal care? Specifically, in your deliberations, did you consider geographical justice, if I can make it into a rather short, if somewhat crude, phrase?

You can see what I am driving at. There are very strong feelings in places such as Wick and Elgin that maternity services should be retained there. Indeed, campaigns have been going on there for many years.

Dr Wardle: I can see the difficulty. I have already said that geography needs to be taken into consideration in these decisions. Scotland is unique—it is different from many areas of the UK—but it is difficult to provide very specialised care in remote areas and in small units in multiple locations. The situation is similar in other countries. A good example is Australia, where transfers need to happen over very long distances and from very rural locations. From a neonatal point of view, the key thing is to ensure that transport services are good enough. In Scotland, there is a well-developed transport system—the Scottish specialist transport and retrieval services system. It is important that the resources and the wherewithal are available, when necessary, to transfer babies over large distances from very rural locations. Transport that is properly resourced, equipped and available is the key to providing care to those women and babies.

The Convener: Fergus Ewing has a final thought.

Fergus Ewing: A final thought, indeed. In Canada, they have flying doctors precisely because of this issue; they have the same thing in the Australian outback, and our outback is the Highlands. What you are advocating is that health services in remote areas must have on-call contracts for helicopters or planes in order to transport, when necessary, the mother and baby to a centre of excellence to receive the specialist care that it is your advice is essential. Is that right—that that must be part of the service?

Dr Wardle: Yes, that must be part of the service.

Fergus Ewing: No ifs, no buts.

Dr Wardle: Yes. In order to provide care for those women and babies, the appropriate transfer facilities must be available.

The Convener: I would like to invite our colleagues who have joined us this morning to put questions to you.

Clare Adamson (Motherwell and Wishaw) (SNP): Thank you for the opportunity, convener. Good morning. I would like to recap some of what you said, Dr Wardle. You said that ICU care in neonatal units will continue in Wishaw and the other hospitals that currently provide that service.

Dr Wardle: The proposal is that Wishaw would become a local neonatal unit. Local neonatal units will provide intensive care on a short-term basis, which means for up to 48 hours. They will still look after babies born at 28 weeks and above, which is still considerably premature, but they will not look after the very smallest and sickest babies born at 27 weeks and below.

Clare Adamson: Wishaw does not have the facility for neonatal surgery; Glasgow does. How important is that, and how often is it required for the smallest and sickest babies?

Dr Wardle: It is really important to co-locate paediatric surgical care and neonatal intensive care, where possible. That does not mean that every single neonatal intensive care unit needs to have surgical care available, but a proportion of the smallest and sickest babies will require surgical input. I cannot give you an exact figure, but, off the top of my head, I would guess that between 10 and 15 per cent of extremely pre-term babies might require some sort of surgery. Where possible it is really important to provide paediatric surgical care and other paediatric specialists on the same site. It is possible to provide neonatal intensive care without surgical care on site, but when problems that require surgical input arise, those babies might need to be transferred, and that might be at a time when those babies are sick and unstable, so it is always better to avoid that situation, when possible.

Clare Adamson: I pay tribute to all the parents who have given evidence and to everyone who speaks so highly of the care that they have had in these units. I want to turn to the example that Mr Golden gave of triplets that were born at 32 weeks. He said that they weighed 4 pounds; I am sorry that I do not have the capacity to translate that into kilograms. Would those babies have fitted

the criteria of the smallest and sickest, given that they were born at 32 weeks?

10:15

Dr Wardle: Babies at 32 weeks' gestation would be able to be cared for in a local neonatal unit. The type of care that those babies are likely to receive is short-term intensive care, and it is unlikely that babies born at 32 weeks would need more than 48 hours of intensive care.

Clare Adamson: Do you have any statistics that show what difference centralisation has made to outcomes and the survival rate in England?

Dr Wardle: I do not have data to answer that specific question on survival rates before and after centralisation. However, we know that outcomes and survival rates are improving over time, and we know from the data that I referenced in my written statement that, when people have looked back at the care provided in larger units and compared it to smaller units, they found clear differences in outcomes. It would be interesting to look at your specific question, but it is a little bit tricky to define a set time period when changes have occurred and when you might look at those sorts of changes. What we do know is that, in England, following centralisation, babies are now being delivered in the right place on more occasions. More of the smallest and sickest babies—the ones who we know are most at risk, who are most likely to have a poor outcome and whose outcome we know is improved by being cared for in a centralised unit—are now being cared for in centralised units.

The Convener: Monica Lennon, would you care to ask a couple of questions?

Monica Lennon (Central Scotland) (Lab): Yes, thank you, and thank you to the committee for all your work, and especially for the visit to University hospital Wishaw NICU.

Dr Wardle, thank you for your written evidence and your oral evidence today. To put that in context, are you able to explain for the committee's benefit whether you or your executive committee members have visited the site at Wishaw or Glasgow, or indeed the other units that we are discussing today?

Dr Wardle: No, we have not. We have not taken any part in the review in Scotland. I am giving evidence based on our framework and our evidence that we have produced as an organisation, but we have not taken any part in any of the decisions or the reviews that have happened in Scotland.

Monica Lennon: Thank you for clarifying that. I ask because you made a number of important points about what should be in place for babies and families across Scotland in terms of the right resources, transport and capacity, and you cited the evidence that has informed your position in relation to centralisation. However, the evidence that we have as MSPs, especially those of us who represent communities in Lanarkshire, is that we do not have enough resources, we do not have the right transport and we do not have the right capacity. Do you accept and acknowledge that, today, the unit in Wishaw is not simply a local unit, because it serves a huge region of Scotland—as the convener set out at the beginning of the evidence session; that it is already serving as an overflow capacity site for NHS Greater Glasgow and Clyde, because the reality is that Glasgow already cannot cope; and that, by the Scottish Government's own admission, the modelling that has been done so far and which may already be out of date shows that at least dozens of babies from Lanarkshire will have to go to Aberdeen, which is a considerable distance by ambulance, when, as you said yourself, travel is not ideal and would put babies at risk? It would be most helpful if you could address those points.

Dr Wardle: I go back to the point about the right resources being in place to provide the right capacity in the right places. I cannot comment on local circumstances; I can comment only on the underlying principles.

Monica Lennon: Thank you—that is helpful. It reinforces what has been my position all along, which is that the decisions need to be informed by people who work in the local services and those who have used local services—they need to have a seat at the table.

Dr Wardle, you are a member of the British Association of Perinatal Medicine, and you clearly have the best interests of patients and your members at heart. Is it regrettable that no one from NHS Lanarkshire had a seat at the table and was able to ask questions and inform the decision, when clinicians from Glasgow and elsewhere were involved? To have robust decision making, should there have been representation from NHS Lanarkshire?

Dr Wardle: I cannot comment on how the review was organised and who was invited. It is important to have stakeholder review from all parties, but it is not for us to comment on who was invited.

Monica Lennon: Okay—thank you.

The Convener: Thank you very much, Dr Wardle. I hope that none of that seemed unduly testy. I realise that we strayed into various areas and, obviously, it is an emotive subject. However, I am grateful for the range of evidence that you have supplied us with, all of which will help to inform the committee as we review the petition

and consider our recommendations, or otherwise, as we go forward. I am very grateful to you.

Would you like to add anything, or are you content with everything that you have contributed?

Dr Wardle: I am happy with everything that I have contributed. Thank you for the opportunity.

The Convener: The graphics on your screen came around the right way eventually, so we can now see them without needing a scribe. Thank you very much for joining us.

I suspend the meeting briefly while we change witnesses.

10:22

Meeting suspended.

10:23

On resuming—

The Convener: We will continue taking evidence on PE2099, which is on stopping the proposed centralisation of specialist neonatal units in NHS Scotland. For the second evidence session this morning, I am delighted to welcome Jim Crombie, co-chair of the perinatal sub-group of the best start implementation programme board; and Dr Andrew Murray, co-chair of the perinatal sub-group. Are there two co-chairs, or are there other co-chairs who are not with us?

Dr Andrew Murray (Best Start Perinatal Sub-group): There were more co-chairs, but we are representing the panel today.

The Convener: Right—so we have two of the posse of co-chairs with us this morning. I am grateful to both of you for joining us. Would you like to make any opening remarks, or are you happy for us to move to questions?

Dr Murray: I am happy to move to questions.

The Convener: Fine. Thank you very much.

Could you give us clarity on the intention of the best start report with regard to the final number of units? Obviously, we have eight, and there was a recommendation to move to between three and five, and the recommendation ended up at three. The committee is concerned to know whether there is scope to move beyond that figure of three towards the five that was within the range of parameters that were discussed.

Dr Murray: The intention was to acknowledge that the way in which Scotland's services are currently set up is not in line with the best evidence. You have just heard that clearly from your previous witness. The level of evidence meant that we needed to look to change and reconfigure the services.

It very much came down to the fact that there has to be a critical level of expertise and activity in the units to ensure that we achieve the best outcomes, including on mortality. More babies will survive and we will get better outcomes if a critical mass of activity and expertise in the units can be achieved. As you have heard, that is 100 births per year of particularly low-weight babies.

The best start programme was aware of that and set out in its recommendations that, because the units had been established in a more disparate way, we could not guarantee and assure ourselves that we were delivering the best services. Therefore, the recommendation was that we move to an evidence-based approach, which underpinned the reconfiguration. You have heard the evidence from the British Association of Perinatal Medicine. We should see our services through the lens of the figure of 100 very low-weight births and the number of respiratory ICU days to ensure that we can deliver the outcomes that the babies—the patients—deserve.

The Convener: What about the question whether there should be three, four or five units?

Dr Murray: Again, that was driven by the option appraisal and the data that we had. Your previous witness was clear that the number of births per year in Scotland would probably reach the threshold for only two such units in a network in England. We knew that we would need to use that data to drive the final decision making. As you know, the data is clear that, if we are committed to improved outcomes and reduced mortality, we cannot justify any more than three units.

On the move from five units, there has to be a transitional period. Your previous witness set out eloquently that there is a need to put in place resources, pathways and everything else that is needed to support successful implementation. The committee touched on inequalities. An equalities impact assessment needs to be put in place to underpin that and make sure that we get it right.

As one of the co-chairs of the sub-group, I envisaged a transitional period of having three to five units and then moving clearly towards the vision of ultimately having three units.

The Convener: I want to touch on something that Monica Lennon asked about and which came up quite a bit when we were on our visit. The review group included representatives from Glasgow, Edinburgh and Aberdeen, and, coincidentally, the three centres are to be in Glasgow, Edinburgh and Aberdeen. Lanarkshire was not represented. I understand that people from Lanarkshire were invited, but they took the view that, because there was a material interest, it might be prejudicial for them to take part, not realising that, in fact, it was potentially prejudicial

for them not to take part. Notwithstanding their view of how that might have been interpreted, could that not have been challenged to ensure that the review group was more representative of all of Scotland, rather than just of the centres of excellence that ultimately benefited from the outcome of the review?

Jim Crombie (Best Start Perinatal Sub-group): That is a really good point. It is important to note that the review kicked off in 2018. In the period from 2018 to 2024, the chief executive of NHS Lanarkshire was involved, as was the head of midwifery at NHS Lanarkshire, Lyn Clyde. There is a need to ensure that the approach to something as important as this allows individuals to contribute, focus and use the data. As we moved forward with the programme, we felt that clinical expertise and representatives from key clinical groups were informing the science of the issue, the decisions and the subsequent options appraisal, so that the outcome was predicated on evidence and on improving outcomes.

I heard a question about the exercise being finance driven. There were no finance representatives on the sub-group, and the criteria for the options appraisal did not include a financial criterion. The options appraisal was based on clinical outcomes, clinical co-locations and the availability of clinical expertise at the volumes that Dr Wardle has already briefed you on.

10:30

Davy Russell: Do you accept the potential for bias or conflict of interest in relation to the membership of the sub-group and the expert group?

Dr Murray: I do not. The members were a range of extremely experienced individuals. They were often in national roles because of their expertise, and there were also people from outwith Scotland. There was a clear attempt to get the right people with the right expertise to inform the decision making. From my perspective, there would not be any such potential.

The conversations that Jim Crombie laid out on the options appraisal were all about objective criteria. For example, you either have co-location of services or you do not. We went through a process of trying to build up that very objective picture. Subsequently, the decision making was reviewed by one of the deputy chief medical officers, I guess so that an integrity check was done.

I think that the integrity of the members of the group should not be impugned. Some of the members of that group were from health boards that are not part of the final three. There were individuals from Tayside—there were possibly individuals from elsewhere, if we were to review the whole list. As the co-chair, having been involved in a few national pieces of work, I got a sense of the clinicians' absolute commitment to achieving the best outcome for their patients. They were trying to do that as objectively and as transparently as possible.

Davy Russell: Dr Wardle mentioned that there is some evidence to back the reduction from eight down to three, but he did not say that there was a lot of evidence—he referred to the fact that he had never visited the sites and that it was more of a desktop exercise. Should the reduction be done in stages to see how it is working, rather than diving from eight to three?

Dr Murray: That is a good point. We tried to consider that, and there was the opportunity to do so with the pandemic. Just prior to the pandemic, we had set up early implementer sites so that we could test some of the thinking around the recommendation. That was about creating a wider network—Crosshouse hospital in Ayrshire linking to the Queen Elizabeth hospital, and NHS Fife linking to Lothian colleagues—so that we could try to problem solve what issues might arise.

On Dr Wardle's statement about the evidence, I think that the evidence is compelling. There are multinational studies from many highly thought-of centres that always come back to the point that unless you have enough experience to be managing 100 of the sickest babies, you will not get the same outcomes and the mortality rate will be higher.

If that point did not come across clearly in the previous evidence session, I can say, certainly from our perspective as co-chairs, that we have a pretty copious evidence list that comes to that repeated conclusion, which is why we needed to pursue it.

Davy Russell: What efforts were made to communicate to the stakeholders—families and so on—the membership of the sub-group and the reasons for their appointment?

Jim Crombie: We ensured that we had representatives of patients' voices, if you like, as part of the neonatal sub-group. The chief executive of Bliss Scotland is part of the programme, and she informed a lot of our communication processes.

The membership and the remit were published—they were widely available—and we reported to the best start programme board, which, again, had further representation outwith Glasgow and Lothian. There was a series of communications, and we were transparent about the content of our work and our process as we moved forward. Bliss was immensely helpful in

supporting that communication to wider users and so on.

The Convener: I have to say that, on our visit to Wishaw, everybody we spoke to was scathing of the contribution of Bliss.

Jim Crombie: I am not aware of that.

Dr Murray: I cannot comment on their view, I am afraid.

The Convener: People felt that Bliss was completely distant, and that what they got was simply a pro forma advancement of Bliss's view, without that having been subject to any direct engagement whatsoever.

Dr Murray: I am sorry, but I cannot comment on the individual relationship that Bliss had with that centre. We would need to see whether we have anything that would correspond to that view. We are happy to look at that, if it is an important point.

The Convener: Davy Russell, I apologise for interrupting your line of questioning. Please continue.

Davy Russell: No, I am fine, convener.

The Convener: Fergus Ewing would like to come in at this point.

Fergus Ewing: The witnesses have said that, as one would expect, careful consideration was given to the issues in arriving at the key recommendation that there should be three units, which would be in Glasgow, Edinburgh and Aberdeen. What consideration was given to Inverness?

Jim Crombie: The evaluation looked at all eight units, and the option appraisal criteria referenced key clinical elements of the provision, such as throughput, co-location on the site of expertise in, for example, paediatric surgery, which Dr Wardle referenced, and a number of other clear criteria that each of the units was matched against. As we came out of the options appraisal process, it was clear that there was a margin between the three units that scored best and the other units. From a clinical evidence and clinical data point of view, it was clear that those were the three units to go for.

Fergus Ewing: I can understand that, with the specialisms that are present in the units in Glasgow and Edinburgh—I should say that my partner is a very senior anaesthetist with nearly 40 years' experience in the national health service—it makes sense that they would be two of the choices. I think that most people would agree with that, whatever part of Scotland they represent. However, I understand that the unit in Aberdeen—I have nothing against Aberdeen; it is all one country—is not expected to meet the recommended threshold of 100 very low birth weight admissions per year, which means that it is some way behind Glasgow and Edinburgh. Would it not have been possible to provide more specialist resource in Inverness in order to provide a degree of geographical equity? Without downplaying Aberdeen, could there not be a case for four units, given that, as I said to Dr Wardle, the travel time to Aberdeen from most places in the Highlands is about three to five hours—it takes a day from the islands—whereas the travel time from Wick to Inverness is about two hours and 20 minutes? That latter time is not great, but, from most places in the Highlands, it is quicker to travel to Inverness than to Aberdeen.

I am just looking at things from a geographical point of view. I appreciate that clinical decisions must trump everything else when there is a case of a baby who requires specialist care. However, would it not be possible to have four centres, one of which would be in Inverness, although that would require more resource to be placed in Inverness, more consultants to be situated there and more provision to be made available for emergency situations, if I could put it crudely like that?

Jim Crombie: It is a really complex question. There is an ambition to have all services available to everyone as close to home as possible, but the clinical evidence is very clear that, if you have units that are not consistently delivering a volume of specialist care at the level that we are talking about, the outcomes from those units will be less favourable than outcomes from the units that are delivering that volume of care.

You are correct that the Grampian unit does not deliver 100 births per year of those particularly low-weight babies. Our estimations of the actual activity around Grampian and the flow from Tayside suggest that the figure is around 80.

There was a point at which there was a proposal that there would be two units in Scotland, because that is what the volumes suggested should be the case. However, for the very reason of geography that you raise, we considered that we should be able to support a third unit.

Fergus Ewing: Finally, did you consider demographic trends? The point that I am making is perhaps not immediately obvious, but Inverness is the fastest-growing city in Scotland, and possibly the fastest-growing city in Europe. The population is increasing. I do not know whether it is because of the fresh air or something in the water, but, over the next 10 or 20 years, the population is due to expand more rapidly than anywhere else in Scotland, not least because of renewables activity in the inner Moray Firth. Various figures have been put on it, but I think that the rise will amount to around 30,000 people over the next 15 years. That will substantially increase the pressure on Raigmore hospital, which is falling

apart at the seams and needs to be replaced—there is no doubt about that.

If we are thinking strategically about Scotland, these decisions need to be made on a long-term basis, and that means that, surely, we cannot just isolate the Highlands. Paragraph 56 of your report, which covers risks and conclusions—I was going to quote from it, but it would take too long—specifically says that Aberdeen is fine because it negates the problem of long journeys from the north. I am very sorry, but no, it does not. I was surprised to see that comment in your report, and I wonder whether you might want to rephrase or recast it.

More important, is there not a case for looking again very carefully at the changing circumstances, demographic and otherwise, in the Highlands, which I think would offer a strong case for providing four centres and not three?

Dr Murray: We did not look at those projected demographics, but, after the pandemic, we took the opportunity to re-evaluate some of our data from all the centres to see whether any new trends were emerging. At that point, there was not anything that changed the decision making.

The information from the option appraisal process and the scoring has been made available to the committee. If you look at it, you will see that there is a significant difference between the Grampian scores and the Inverness scores, so it was not as if there was a close decision between having three centres and having four.

Fergus Ewing: That could be redressed, because there has been a shrinkage of consultancies—

Dr Murray: It was cut and dried.

The Convener: I should say that I do not think that Inverness is one of the eight units currently.

Maurice Golden, you were going to raise issues around this area. Do you want to pursue anything on the back of what Fergus Ewing has just asked about?

Maurice Golden: I have a question about the cut-off point. Clearly, throughput was one of the criteria used, and I appreciate what you have said about Glasgow and Edinburgh. However, the difference in the scores between the units in Aberdeen and Glasgow is 17 and the difference between the units in Aberdeen and Dundee is 29—following that, there is a bit more of a drop-off.

I wonder about the case for Dundee and Wishaw in terms of the wider package beyond clinical outputs. Clearly, an ambulance can get from Wishaw to the Queen Elizabeth hospital quickly, but if you are a parent from Lanarkshire or the south of Scotland who is trying to visit your very sick child in Govan, you can be stuck for hours on the roads around Glasgow, whether you go via the M74 or M8. How was that taken into account in the overall findings?

Jim Crombie: As Dr Wardle said, the premise of the decision making is to create facilities that offer the sickest babies—the lowest-weight babies—the best opportunity to survive and thrive. That was central to our thinking.

In terms of the implementation of the recommendations, the issue that you describe needs to be part of the process. The Scottish Government set aside funds to support families as part of the programme, and that was augmented later in the process in order to try to address the issue that you have identified. There is no doubt that, as you centralise services, you increase the distance that people will have to travel. There was recognition that the strategy would certainly have an impact, but that was outweighed by the absolute benefit of the sickest babies surviving and thriving.

10:45

Dr Murray: Just to add to the point about whether we could have made any compromise on that approach, there was a lot of discussion about the veracity of the evidence that I just outlined. We needed that conversation to take place, and we needed to provide a lot of assurance to respond to the question, “How could it be such a round number. That seems convenient, doesn’t it?” We looked at that statistically and had a range of experts who were able to contribute and explain. The consistency of the evidence internationally meant that any deviation from our ambition—the wider package as you chose to describe it—would mean poorer outcomes for babies and an increased mortality rate. We would not be able to countenance that as the group that was charged with driving up those standards and outcomes.

Maurice Golden: The report is the first step towards developing a new way to deliver such care, but it is partly predicated on having a support network in place so that its rationale can ultimately be justified. My concern is that the support network might not be in place. After you have reported, who is ultimately accountable for delivering on the report’s recommendations in order to make your rationale successful?

Jim Crombie: That is a really important question. When we completed our option appraisal, we wanted to offer additional support for the areas that would be affected by the implementation. We wanted our analysis of the numbers of women who would be transferred to the units to be reflected. As Dr Wardle said, the ambition is to move the mum with the baby still in

situ, as that would be the safest transfer. That was our focus.

We procured external expertise to model the impact of our recommendations, so that it was explicitly clear what the flows would look like. I was clear that implementation was of such significance that it needed accountable officer-level leadership. Through the Scottish Government, we required each of the regions involved to designate a lead chief executive to oversee the implementation of our recommendations. I was clear that that offered the best opportunity for this clinically imperative model of care to be delivered. The accountability was clear in that structure.

Maurice Golden: Thank you.

Davy Russell: In the previous session, Dr Wardle said that transportation is key, whether it be air ambulances in the Highlands and Islands or just ambulances, as is the case here. We hear day in, day out about ambulance waiting times. Have you budgeted for enough ambulances? If a patient is going from Wigtownshire to Glasgow or wherever, it could take a vehicle and a couple of people out of the system for up to a day. Have you made arrangements to increase that capacity? Is that part of your business or is it somebody else's problem?

Jim Crombie: It is part of the implementation programme. The Scottish Ambulance Service is a member of the neonatal network and runs the specialist element of ScotSTAR, which is staffed by clinical experts.

Someone mentioned doctors getting on a plane and travelling. We are talking about highly expert clinicians and consultants who support the transport of very sick babies. They were fully involved in the discussions and were clear about the capabilities in play.

Davy Russell: It is the capacity issues that I am really talking about. My inbox is full of people who have waited X amount of hours for an ambulance. If you take somebody out of the system—for a day in some cases—that will be a bigger strain on capacity.

Jim Crombie: There is no doubt about that. We have to pay attention to the numbers, which require a level of specialist transportation. That was part of our modelling. As part of the implementation, each of the regions will work with the Scottish Ambulance Service—which is a national board, as you know—to look at the infrastructure requirements and what augmentations are needed to ensure that capacity is put in place.

Davy Russell: Okay.

David Torrance: Good morning. How do you respond to the criticism that the option appraisal exercise was weighed towards surgery, which does not adequately reflect the needs of most pre-term babies?

Dr Murray: As has rightly been said, co-location of surgery was in the criteria, as was co-location of other critical services. That was a question that I heard Dr Wardle pick up on. I am not a neonatologist, but he was able to give us an estimate of the numbers of very unfortunate babies who might come to require surgery. It is important that that was considered as a factor, but it was one of many clinical factors that were taken into account. You heard about the risks of transferring such surgeries to a specialist centre, which is why co-location was considered very desirable in the option appraisal.

Jim Crombie: As my colleague said, what we looked at in the option appraisal went much wider than surgery. We looked at the co-location of paediatric medical specialties, including respiratory, gastroenterology and ophthalmology, as well as cardiac, congenital, diaphragmatic hernia and abdominal wall conditions. We looked at a whole bunch of criteria, because, as Dr Wardle said, when the experts are co-located on the campus, the ability to support vulnerable babies to survive and thrive is optimised. The exercise was focused only on surgery.

The Convener: I have found all the evidence that we have considered fascinating. For the sake of the petitioners, I will be pejoratively political. There is an idealistic argument that is based on the technical availability of services and the best survival prospects for children, and there is the reality that politicians come across on behalf of our constituents every day. The great transport network in the health service, which ferries children from the south of Scotland up to Aberdeen at the click of a finger when the need arises, is effectively unavailable when constituents are left waiting up to 18 or 24 hours for an ambulance to turn up to take them anywhere. The additional consideration is that they, in fact, will simply go to Glasgow in such cases. In a previous evidence session, I talked about a parent who had a critically ill wife and was concerned about whether, in his circumstance, he should have stayed with the critically ill wife if the child was not in Glasgow but at the other end of the country.

In a sense, the clinical directive has generated what it believes to be the outcome that will lead to the highest level of survival among the sickest babies. However, that is dependent on the infrastructure support behind it, which politicians have found does not always follow. At some point down the line, constituents will come to us with an experience that goes against absolutely everything

that you have identified as the clinically designed outcome, because the practical reality will be that they will not have got the support that was necessary and they will feel that they lost a child in the worst circumstances because of it.

Jim Crombie: It is difficult to argue against that. There is no doubt that the impact on individuals and families should be a component part of our thinking—although I note the support processes that can be put in place.

You are anxious about the Scottish Ambulance Service, and I hope to reassure you by saying that it is part of the implementation process and comes under the overall review of the infrastructure. ScotSTAR is world class and is able to transport the sickest kids with rapid turnaround times. It is the envy of other countries. As has been said, the co-location of all the clinical services optimises the chance for the child.

I recognise the impact on the family, who may have to travel in a number of circumstances. The Scottish Government identified funds and processes to support families who find themselves having to travel by train or car, having to stay overnight and having to buy meals. All those things were identified when organising a fund to support families in those circumstances.

Dr Murray: The ambition has been described as idealistic, but we heard from Dr Wardle that other countries have been successful in this regard, including England. He caveated it, but he thinks that evidence about improved outcomes is starting to appear. We are going through a difficult implementation process, and I do not think that there is any doubt about the devil being in the detail as we try to ensure that everything is aligned to support the reconfiguration. We talk about the reality and about people experiencing difficulties as they go through the process, but our reality could involve delivering an improved network and an improved system with improved outcomes, which I think is what we all want.

The Convener: I invite my two parliamentary colleagues to contribute a question.

Clare Adamson: This is about the ScotSTAR specialist transportation unit. I understand that those ambulances are used only for transferring the sickest babies, so they would not be subject to the other pressures on the Ambulance Service generally. What about a woman who is being transferred? If the baby is still in situ, would she go with ScotSTAR?

Dr Murray: My understanding is that ScotSTAR is only for the transfer of the babies—but I am happy to be corrected. It is staffed by anaesthetists.

Clare Adamson: So, a parent would not necessarily be on that transport with the baby at the time.

Dr Murray: Again, I would need to double-check that. I should know more about it, because our ScotSTAR experts were very clear. It is primarily used for a transfer of the baby in an intubated and safe environment. I think that parents have to follow, but I am not sure of the operational detail.

The Convener: With the lower number of specialist centres, would the call on the service not be considerably greater than is the current experience?

Jim Crombie: Not necessarily, because the premise is that women are identified as being vulnerable in terms of premature birth, and the women are transferred to the unit at the prenatal point. ScotSTAR would not be involved in that process.

The Convener: I meant the ScotSTAR service itself. At the moment there are eight centres, but if there were only three, might the call on that resource, for transferring people to just three centres that are further away, be greater than is case at present, when there are eight?

Dr Murray: I do not think so. You have heard that the ambition is to have early identification of the mothers, so that they are in the right place for delivery. That is one of the key principles to underpin the arrangements. There will be less movement and fewer emergency transfers taking place. We might find that having fewer centres actually works more easily because of the established relationships—but I am speculating.

Monica Lennon: I know that time is tight and that there are still more questions and answers, but for now I just want to get some clarification.

Mr Crombie, you said that, when your group was making the decisions, there was a recognition that the strategy would have impacts, although they were outweighed by the clinical benefits. Dr Murray, I heard you say that the work would now begin on undertaking the equality impact assessment. These issues have been looked at since 2018, and I am hearing today that work is now beginning to look at the equality impact assessment. There have been some nods to what the social, economic and financial impacts might be, as well as the clinical impacts and outcomes.

11:00

For the benefit of the parents who are sitting behind you and people who will be listening or who will read the *Official Report* and want to be assured that everything is being given due consideration, can you tell us what the impacts are and what evidence has been gathered to ensure

that all the other issues—such as being more trauma informed and thinking about the health, wellbeing and life chances of the woman as well as the baby—are being given equal consideration?

Jim Crombie: You said that there were more questions than answers, so I am happy to clarify anything that I have not answered to your satisfaction. The prime responsibility of the sub-group was to offer a view on optimal provision of specialist care for the sickest and lowest-weight babies in Scotland. Using clinical evidence and clinical expertise from the membership of the sub-group, we formed a view that the research and the clinical expertise were pointing us to higher volume units, which means a smaller number of specialist units providing higher volume care, because there is evidence that the care in specialist centralised units will be optimised. We knew that that meant a reduction of access to specialist care from eight units to three, and we therefore recognised that there would be an impact on individuals and families.

The implementation process needs to look at finance. The Scottish Government identified finance; accommodation, because we need to look at how we are going to provide accommodation in these areas; and transport and access, because we need to consider these matters with the Scottish Ambulance Service and the ScotSTAR service. All those issues were identified and are part of the on-going implementation process. There is no getting away from the fact that implementation will have an impact, but I strongly believe that the evidence that we heard and saw—the clinical opinion that we sought—was explicitly clear: to offer our sickest babies the best opportunity to survive and thrive, this is the model of care that should be in place in Scotland.

Monica Lennon: I still do not understand the status of the equality impact assessment.

Dr Murray: That was a comment that I made. However, I stepped back as co-chair. The work has started to move into the implementation phase, and I would need to seek a statement for you from the current team that is supporting the work to try to encapsulate where we are against your requests.

Monica Lennon: I apologise—I thought that you were currently the co-chair. How many co-chairs have there been?

Dr Murray: There have been a few co-chairs. The pandemic got in the way and there was a protracted timescale, so I think that, ultimately, there were probably five or six of us. To give you some assurance, I think that all of us would regard ourselves as being at a very senior level, and we were asked specifically by the chair of the best start programme board, who had detailed conversations with us about what the roles would entail.

Monica Lennon: Your clinical expertise is valued and appreciated, but we have had five or six co-chairs, people with national experience and people from outside Scotland, but no one from Lanarkshire.

Jim Crombie: I think that I pointed out that Heather Knox, the then chief executive of NHS Lanarkshire, was involved in the early part of the programme, and that Lyn Clyde, who was head of midwifery in NHS Lanarkshire was involved in the programme.

Monica Lennon: But they have not made decisions. They said that they tried to do the right thing by trying not to prejudice decisions because they felt that they had an interest as one of the units, but it looks like there has not been consistency around other people's decisions.

Dr Murray: I am sorry to interject. I tried to give you some assurance that the option appraisal process is objective. It is a case of, "Are these services there or are they not?" As you can appreciate, when there is representation from all parts of the country, the difficulty is that there is lobbying that is not based on that evidence.

We were trying to create a high-quality process. Our colleagues in NHS National Services Scotland supported us through the whole process, so we have used an approved national methodology for all sorts of service redesign in order to make the process as objective as possible, and we would want to stand by that.

Monica Lennon: On the—

The Convener: You must draw your questions to a conclusion, Ms Lennon.

Monica Lennon: Thank you.

We have heard a lot today about the importance of high-volume provision in order to maintain the level of specialty. Everyone who I speak to is under the impression that the Wishaw NICU is high volume. It is already struggling to cope with the demand and it already services demand from Glasgow and elsewhere. What is it that the unit is doing wrong just now? We are hearing that we need to have the right people in the right place, but the unit is award winning and it is serving a huge population in Scotland and doing it to a very high standard, so what is broken about that? It seems to me that the unit works well. It needs more capacity, but why would we want to downgrade the unit, when it is already performing an excellent service to the people of Scotland?

Jim Crombie: I disagree with some of your descriptions. No one is suggesting much of what

you said there. The unit provides a level of activity—there is no doubt about that—but we are looking at activity that is linked to the smallest and lowest-weight babies and those who require the highest level of intervention with the co-location of the services that support the on-going provision post-birth.

Dr Murray: The unit does not have the co-location of the services that would make the service more comprehensive to really achieve those better outcomes. As a resident of Lanarkshire myself, I have no doubt that the clinicians in the unit are very skilled and committed.

Monica Lennon: I will just make an observation on that, as I know that I need to hand back to you, convener. If co-location was a factor, it sounds as though the process was weighted against Lanarkshire right from the beginning, because that was one of the criteria that you mentioned. It sounds as though our local service had no chance with all these different co-chairs, and that is regrettable.

Dr Murray: The reason why that criterion was in the option appraisal is that the evidence base shows that 100 of these very low birth weight deliveries per year achieve better outcomes because of the co-location of services, so that had to feature in our option appraisal—that had to be the rationale for it.

The Convener: I will draw the evidence session to a conclusion, but thank you both very much for your concise and informed evidence.

These are highly emotional and emotive issues. I hope that at no time would you get the impression that the committee is anything other than respectful of your clinical experience and the experience that you brought to any review. However, in pursuing the aims of the petitioner, I often say that we are at a magnificent advantage in this committee in that we are not following any party's political election manifesto; we are following the aims of a petition that has been lodged by people who are concerned. Our job is to take that argument as far as we possibly can. I am very grateful to you both for your time. I will suspend the meeting briefly before we move to the next agenda item.

11:07

Meeting suspended.

11:11

On resuming—

Essential Tremor (Treatment) (PE1723)

Mental Health Services (PE1871)

Perinatal Mental Health Support (PE2017)

General Practitioner Appointment Booking System (PE2070)

The Convener: Welcome back. Our colleague Maurice Golden is no longer with us, as he has to leave to move amendments at another committee.

As we move on to consider other petitions, I have to say, as convener—and this is very difficult to admit—that we have 119 or so petitions still open, and very few committee meetings left before Parliament dissolves in next April, with the last sitting day of the Parliament being 26 March. Therefore, the committee has to determine what more we can do in respect of open petitions, even if what we decide might disappoint petitioners. There are petitions that we still think have merit and which might even be progressed; with others, it might be best if a fresh petition were lodged at the commencement of the next parliamentary session in May 2026.

We will now look at four petitions that were part of a thematic healthcare evidence-taking session that we had with the Cabinet Secretary for Health and Social Care, Neil Gray: PE1723, on essential tremor treatment in Scotland; PE1871, on a full review of mental health services; PE2017, on extending the period that specialist perinatal mental health support is made available beyond one year; and PE2070, on stopping same-day-only general practitioner appointments.

Our health-themed evidence session looked at the themes of patient experience; diagnostic and treatment pathways; capacity, skills and training; sustainability of funding and health service infrastructure; and post Covid-19 impacts and response. We were, to a greater or lesser extent, able to explore those issues with the cabinet secretary and to follow up further matters in writing.

This morning, we are considering the petitions that sat under the first of those themes—that is, patient experience. The committee has explored the specific issues raised in the petitions through written evidence from stakeholders and ministers, and the thematic issues were also explored in our

recent oral evidence-taking session with the cabinet secretary.

During that thematic evidence-taking session, we raised the fact that a number of the petitions highlight a gap between policy, strategies and people's experience of services. The cabinet secretary accepted that there can be gaps between policy and delivery—indeed, that was the very subject of the evidence session that we have just held—and noted that there can be a variation in delivery between health boards for geographical or demographic reasons.

We are joined again by Monica Lennon, who will speak to the petition on the full review of mental health services, and I will invite her to say a few words after I have summarised the petition. We are also joined by our colleague Douglas Lumsden, who will speak to PE2017 on perinatal mental health support.

11:15

The first of the petitions in this section is PE1723, which has been lodged by Mary Ramsay and calls on the Scottish Parliament to urge the Scottish Government to raise awareness of essential tremor and to support the introduction and use of a focused ultrasound scanner for treating people in Scotland who have the condition.

The cabinet secretary confirmed to us that the ultrasound service is being provided in Tayside, and the written follow-up confirms that between April 2023 and April 2025 47 patients have been treated in Dundee, and that no patients have been referred to England for that treatment. During oral evidence, the cabinet secretary stated that, if it were found that a service had a level of demand that would merit expanded provision beyond one specialist service in Scotland, the Scottish Government would consider that. Therefore, considerable progress has been made on that petition.

PE1871, on a full review of mental health services, has been lodged by Karen McKeown, who we heard from earlier in the parliamentary session, on behalf of the shining lights for change group. It calls on the Scottish Parliament to urge the Scottish Government to carry out a full review of mental health services in Scotland, including the referral process; crisis support; risk assessment; safe plans; integrated services working together; first response support; and the support available to families affected by suicide.

We have pursued the issues that the petitioner has raised. In our oral evidence session, the cabinet secretary highlighted the Government's focus on preventing people from moving into a mental health crisis in the first place by looking at whole-family support and addressing poverty and social factors in order to reduce the acute level of mental health need.

The then Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, wrote to the committee in October 2024 to respond to a range of concerns raised by the petitioner, including data on effectiveness and consistency, admittance to mental health acute beds, workforce wellbeing, and training for the wider mental health and wellbeing workforce. The petitioner has provided a written submission highlighting outstanding issues in relation to data collection and reiterates her call for a review of mental health services.

Monica Lennon, do you wish to make any brief comments at this stage in the consideration of the petition?

Monica Lennon: I want to comment briefly on PE1871, which was lodged by my constituent Karen McKeown. I have been working with Karen for several years, including on this petition, and I again pay tribute to her.

I am grateful for the work that the committee has done. Its health-themed scrutiny with the cabinet secretary was really good, because we want to look at things in a joined-up way. In her letter of 18 November, Karen McKeown has highlighted to the committee that some progress has been made; after all, we cannot sit here as MSPs and say "Everything is terrible" all the time. I agree with what Karen has said, and I welcome the fact that

"80% of staff in Lanarkshire have completed Mental Health Carer Aware training".

That is really good, although we are still seeing a crisis across Scotland.

I must challenge the cabinet secretary's claim that there is a focus on prevention. That might be the intention, but the practice is somewhat different. Just at the weekend, I was listening to the Scottish Police Federation talk about the huge demand on front-line police officers to provide a mental health crisis response. That situation is nothing new, but it is getting worse.

Constituents are telling us that there is an overreliance on the police; that more and more people are having to find money to pay for private treatment, even when they cannot really afford it; and that although the NHS wants to deliver prevention and early intervention, it is still bogged down in having to deal with crisis. It just feels as though there is more still to be done. We now have another new minister; I welcome Tom Arthur to his post, and it would be good to hear directly from him, as Minister for Social Care and Mental Wellbeing, about the fresh ideas that he is bringing to the table.

Again, on behalf of Karen McKeown and for everyone bereaved by suicide, I want them to know that the Parliament is listening. We know that these deaths are preventable if the right action and resources are in place.

The Convener: Petition PE2017, lodged by Margaret Reid, calls on the Parliament to urge the Government to amend section 24 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to extend maternal mental health support beyond one year, to introduce a family liaison function at mental health units across all health boards, to introduce specialised perinatal community teams that meet perinatal quality network standard type 1 across all health boards, and to establish a mother and baby unit in the north-east of Scotland.

The then Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, wrote to the committee in February. The submission outlined that work is under way to produce a draft service specification for clinical perinatal services and stated that the draft specification should be published this year. She also set out the allocation of funding to support the most severely ill women in the perinatal period closer to home in the north of Scotland.

Douglas Lumsden, is there anything you wish to say to the committee at this stage of our consideration of the petition?

Douglas Lumsden (North East Scotland) (Con): I am becoming a bit of a regular at the committee. As you said, convener, the driving force behind the petition is Margaret Reid, who was forced to act after watching her sister struggle with postpartum psychosis six years ago. Because of a senseless and arbitrary time limit—her baby was older than one—she could not go to one of Scotland's two mother and baby units in Livingston and Glasgow. She was sent to a mixed-sex mental health ward, which was traumatic, as you would expect.

Kate Forbes has spoken about her experience with postpartum depression after she became a mum in 2022. She agreed to meet the Reid family in Dundee with the then mental health minister Maree Todd to see the hell that that woman had gone through for herself.

In a written submission to the committee in June 2024, the Minister for Social Care, Mental Wellbeing and Sport wrote:

> "I remain committed to ensuring equitable, coordinated access to mental health provision for women, infants and their families throughout pregnancy and during the postnatal period; and appreciate the Committee's interest",

but since then there has been nothing. Nothing has been done to address the fact that access to specialist perinatal mental health support is limited to the first year following the birth of a child. That is despite the Health, Social Care and Sport Committee inquiry recommending that access should not be restricted in that way. That was four years ago.

Maree Todd was also asked about the other part of the petition, which is about establishing a mother and baby unit in the north-east of Scotland following a 2022 consultation on the options to achieve parity outside the central belt. I would dearly love to see one in Aberdeen or Dundee. The minister said that the Scottish Government was considering its response. Three years have passed since then.

Postnatal depression affects one in 10 women within a year of giving birth, according to the NHS, and suicide is a leading cause of maternal death during the year after birth, but the issue is not limited to the first year after birth. The petition merely holds the Scottish National Party Government to account for what it has promised—to ensure the same equitable and co-ordinated access that the minister wrote about.

I would appreciate members continuing to consider the petition and asking the minister to appear and provide evidence on what the Scottish Government has done to address the valid concerns that have been raised in the petition, by experts and by MSPs.

The Convener: PE2070, lodged by Lorraine Russo, calls on the Scottish Parliament to urge the Scottish Government to stop general practice surgeries from allowing only same-day appointment bookings, enabling patients to also make appointments for future dates. In written evidence on same-day GP appointments, the Cabinet Secretary for Health and Social Care highlighted that how services are provided is left to the judgment of the responsible clinicians and that practices are not required by the Scottish Government to provide a particular type of service.

As I set out in my opening remarks, we are now limited in the time remaining in this parliamentary session—that is just the blunt reality. We must focus our efforts on issues on which we can make further progress. By that rather hard and unfortunate criteria, I wonder whether colleagues have any suggestions as to how we should proceed in respect of the petitions that I have just outlined and we have heard spoken to by our colleagues.

David Torrance: I thank all the petitioners. The four petitions in front of us have been heard by the cabinet secretary, and some have been more successful than others, but we should consider the time that the committee has available. Will the committee consider closing the petitions under rule 15.7 of standard orders on the basis that the committee has progressed issues raised on

individual petitions as far as possible in this parliamentary session and by raising relevant issues as part of a thematic evidence session with the Cabinet Secretary for Health and Social Care?

The Convener: I think that we should do that on the basis that we are not exercising any judgment. We think that the petitions are all hugely important and that we have done what we can to progress them. However, it would also be possible for a fresh petition to be lodged at the start of the next session of Parliament.

Fergus Ewing: I concur with what you have said, convener. There really is no choice, as we do not have any time left—that is the reality. We are all, I hope, pragmatists and realists, but there is also the next session of Parliament, so there is hope.

I want to say a couple of things. First, I am hugely grateful to the petitioners for raising these vitally important and sensitive issues that affect people's lives. Often, the petitioners have suffered loss of life in their family. It is right to record and reflect on that.

Secondly, in every case, the petitions have cast the light of open public debate in this committee on each of the issues, and we have not hesitated to exert maximum pressure on ministers at every opportunity.

Lastly, I do not mean to be political or negative, but I have to say that, on all the petitions, I have found the response from the Scottish Government to be less than satisfactory. We must do better in Scotland; otherwise, we are simply letting people down. If this committee serves any purpose, it is to speak up for people who come to it as best we can. I hope that the issues will reappear, as I am sure they will, in the next session of Parliament, when I hope that we will have a Government that is willing to listen more to the people who it is supposed to represent.

The Convener: I recognise that, on the essential tremor treatment in Scotland petition, the aims of the petition have been achieved, which is good to hear. I remember our consideration of that earlier in this session, when people were still being sent to England. It is good to know that we now have a centre in Scotland.

Are members minded to support Mr Torrance's proposal?

Members *indicated agreement.*

Human Tissue (Scotland) Act 2006 (Post Mortems) (PE1911)

The Convener: PE1911 is one of the long-standing petitions that we have given consideration to in this session of Parliament. It was lodged by Ann Stark, who, if my glasses are not fogged over and I can see into the distance, is with us in the public gallery. The petition calls on the Scottish Parliament to urge the Scottish Government to review the Human Tissue (Scotland) Act 2006 and relevant guidance to ensure that all post mortems can be carried out only with permission of the next of kin; that brains are not routinely removed; and that tissues and samples are offered to the next of kin as a matter of course.

Monica Lennon is with us again in relation to this petition, which we last considered on 23 April, when we agreed to write to the Lord Advocate. Throughout the lifetime of the petition, the committee has considered a number of issues concerning bereavement and pathology services. We have heard about specific improvements that could be made, such as the use of CT scanners for modern post mortems and giving loved ones more choice on the return of tissue samples. Indeed, we had a fascinating evidence session with clinicians who are using scanners for post mortems elsewhere in the United Kingdom.

We took evidence from the Lord Advocate and practitioners in England, and the committee raised several of Ann Stark's points in writing with the Scottish Government, the Lord Advocate and the Royal College of Pathologists. That work uncovered that there has been a lack of ministerial leadership to oversee and drive forward improvements in pathology services. I put that issue to the First Minister directly at the Conveners Group, and the First Minister followed that up subsequently in writing.

The Scottish Government has reiterated on a number of occasions its position that it is essential that the Crown Office and Procurator Fiscal Service is able to undertake independent investigations into the cause of death when a death is sudden or unexplained. The Scottish Government also maintains that it does not support legislative change to offer tissue samples to next of kin as a matter of course.

On the wider issues that we have explored, the Lord Advocate has provided information about the Crown Office and Procurator Fiscal Service's exploration of CT scanning. Senior representatives visited Dr Adeley, the senior coroner from whom we took evidence back in May 2023, along with pathologists and radiologists in Lanarkshire. The Lord Advocate stated that the information obtained was very helpful and will form part of the on-going discussions about any improvements that can be made to the process of death investigation. However, the Lord Advocate also stated that it is clear that the use of CT scanning is only one tool that can be available to assist in establishing the cause of death and that it cannot eliminate the

need for an invasive post-mortem examination in every case. I think that the committee accepted that that was obviously true. In certain circumstances, an invasive post mortem will always be necessary.

The submission highlights, however, that CT scanning is available in some circumstances in Scotland, although it has been restricted to particular cases such as homicides. From May this year, the University of Glasgow pathology department and NHS Greater Glasgow and Clyde were due to begin a service development pilot to investigate the potential benefits of incorporating CT scanning in procurator fiscal-instructed post-mortem examinations.

11:30

The petitioner, Ann Stark, has provided a written submission that reiterates her view that the Crown Office and Procurator Fiscal Service's investigations into deaths should look only at criminal circumstances rather than all unexplained or sudden deaths. She continues her call for permission from the next of kin to be required in cases of non-suspicious deaths. The petitioner also reiterates that changes to the system would create cost savings that could be used elsewhere in the public sector.

The committee has received a written submission ahead of this morning's consideration from Mark Griffin MSP, which calls for the petition to be carried over to the next parliamentary session. Monica Lennon is with us. Is there anything that Monica would like to add before we consider what to do next?

Monica Lennon: Thank you, convener. That was a helpful summary of all the work that has been done. The petition has already shone a light on practices that most families know nothing about until they are bereaved and find themselves in a difficult situation. I pay tribute to Ann Stark and her husband Gerry. Ann is here today with her friend. It has been a very difficult few years for the family. I know that Ann will feel that not a lot of progress has been made, but I think that, as a result of having the Lord Advocate here to give evidence, we were able to follow up on the issue.

The commitment on the scanner project is welcome, but it is clear that Scotland is still out of step with the rest of the UK and Ireland and other parts of the world where families have more choice and where reforms have been made following scandals coming to light. Colleagues will remember that Ann and Gerry had to hunt around Scotland to reclaim samples of their son Richard. After being told that there were no more tissue samples, we went to the Queen Elizabeth university hospital, and samples were found. No one has ever truly apologised for that. Ann advises that, just last week, the procurator fiscal told her that the names of the officials who attended on the day that Richard died have all been redacted from paperwork, for data protection reasons. There is no transparency for families when their loved one has an invasive post mortem, even when the death is clearly not suspicious, as was the case with Richard. For Ann, the issues remain very traumatic and heavy.

On what is next, I appreciate that you have taken the issue directly to the First Minister, convener, but we still do not have clarity on the scanner pilot. It would be good to hear directly from the Lord Advocate and her team on that. On the issue of informing and getting permission from next of kin, and the real issues around human tissue retention, this is not really an issue for the petition, but Ann has asked me to draw to the committee's attention the media coverage of some very difficult issues around human bones being sold widely on the internet. When organs are retained and families do not know about that, you can imagine where people's minds end up. I refer to the part of the petition that says that the brain should not be routinely removed when the death is not suspicious. The reasons for that have been set out in other meetings.

I sympathise with the committee, given the time that is left in this session of Parliament, but I agree with Mark Griffin that, by keeping the petition on the agenda, we can, I hope, continue to make progress and maintain momentum. Because it is such a taboo issue, it is difficult to talk about and it has been difficult to get MSPs and ministers involved.

At the moment, the committee is the only hope not just for Ann but for the 3,400 people who have signed the petition and who are looking to the committee for your help.

The Convener: Thank you. I absolutely pay tribute to the petitioner, whose work on the petition has been remarkable, particularly given the circumstances that led to the petition being raised in the first place.

Progress has been made in that we have been able to articulate issues in a way that they have not been articulated before and to take evidence in relation to all of that. It strikes me that, depending on the decision of the committee and taking account of the progress that has been made in this parliamentary session, the matter could potentially be admirably pursued in a refreshed petition for the next session's petitions committee to consider.

David Torrance, do you have any formal proposals to put to us on the petition?

David Torrance: I thank Ann Stark for the work that she has done on the issue. I have read the

emails that she has continually sent to keep me and the committee updated throughout the whole process that we have been through.

The Convener: I think it is fair to say that no petitioner has been more assiduous in keeping committee members abreast of developments, some of which have been outwith this committee: they have been the direct result of her own intervention.

David Torrance: Yes. In the whole time that I and the convener have been on the committee—13 or 14 years—I do not think that I have seen a petitioner pursue their cause as fiercely and in as dedicated a way as you have, Ann. Thank you. I suggest that you bring a new petition to the Parliament in the next session, which will allow time for it to be considered fully.

I suggest that we close the petition, under rule 15.7 of standing orders, on the basis that the Scottish Government does not intend to amend the Human Tissue (Scotland) Act 2006 to require consent from families for procurator fiscal post mortems. The Scottish Government does not support legislative change to require tissue samples to be offered to the next of kin as a matter of course. The committee has extensively explored issues raised in the petition, including through multiple oral evidence sessions, a substantial letter to the Scottish Government and a question put directly to the First Minister.

Fergus Ewing: I absolutely support the tributes that the convener and Mr Torrance have eloquently paid to the petitioner for her efforts. I will make a few other remarks.

The petition is now just over four years old. Had it not been pursued so determinedly and doggedly by the petitioner, I do not think that the pilot for the scanner would ever have been granted. Because that pilot began in May 2025 in Glasgow, it would make sense to see what the outcome is. I thoroughly endorse the idea of bringing back a petition, but if CT scanners had been used, some of the anguish that was caused to the petitioner in the loss of Richard would have been avoided. Therefore, I think that it makes sense for the petitioner to consider ascertaining more information, perhaps through local MSPs or MPs, as to how that pilot is doing, when it will conclude and when the outcome will be known, as well as whether there will be any delay—as, sadly, there so often is. That might inform a further petition.

I also support what Monica Lennon has said. For the life of me, I cannot understand why the Lord Advocate—a lady for whom I have the utmost respect—did not see fit to offer an apology. In her submission, she said that the reason why no change is being proposed is that the need to have independent investigations cannot be prejudiced. That is absolutely true. The whole point of having a prosecution system that is separate from Parliament is that it is entirely independent of politicians. That is at the core of a system of democracy. However, in no way does that prevent the return of tissue or, indeed, the avoidance of invasive post-mortem techniques. In other words, that does not prejudice independent investigations. That is a completely false argument and a non sequitur. It is very disappointing that the Lord Advocate should present an argument that appears to be flawed, I would argue. I am pretty sure that those of us who are here will return to the matter in the next session.

The Convener: Of course, one cannot predetermine whom the Government of Scotland will be after the next election or whether the complexion of that Government might lead to a different view being taken were a fresh petition to be lodged.

Are colleagues content—however reluctantly—to pursue Mr Torrance's recommendation?

Members *indicated agreement.*

The Convener: We are content to do so. We thank the petitioner very much and anticipate that she will ensure that the Parliament remains alert to the issues in the next session.

Motorhomes (Overnight Parking) (PE1962)

The Convener: Our next petition is PE1962, lodged by Lynn and Darren Redfern, which calls on the Scottish Parliament to urge the Scottish Government to improve licensing enforcement on motorhomes to ensure that they are parked only in designated and regulated locations.

We last considered the petition in April, when we agreed to write to the Scottish Government to ask whether, in the interests of safety and parity with formal campsites and aires, landowners who allow overnight motorhome habitation on their land should be required to obtain a licence for that activity.

The Scottish Government's response to the committee sets out that schedules 1 and 6 to the Caravan Sites and Control of Development Act 1960 make reference to allowing overnight motorhome and caravan habitation. Under the legislation, a landowner does not require a licence if they allow three or fewer caravans, at any given time, to stay for a maximum of 28 days within a 12-month period. A licence would be required if more than three caravans were sited on the land or if the land was in use for more than 28 days in a 12-month period. The exemption that is set out in paragraph 3 of schedule 1 applies only if the total period of occupation by caravans is less than 28 days in any 12-month period. The 28-day limit

does not reset after a period of occupation by one to three caravans ends.

The Scottish Government's submission notes that decisions as to whether any particular use would be material in planning terms are made by the relevant planning authority on a case-by-case basis. The submission states that, because of the existing licensing and planning rules, the Scottish Government's view is that there is no requirement to change the existing legislation.

The petitioner's response to the information that is provided in the Scottish Government's submission is that people are making up their own rules rather than following what is set out. The submission highlights instances in which sites are operating without a licence but authorities

"do not seem to care about it"

and cases in which people are operating in grey areas where overnight stays could technically be allowed.

Edward Mountain MSP has provided a written submission that states that there is no control of the use of parking sites over the 28-day period that is set out in the legislation. He states that, in fact, parking sites are available for 365 days of the year.

Do members have any comments or suggestions for action?

David Torrance: In the light of evidence from the Scottish Government, I wonder whether the committee would consider closing the petition under rule 15.7 of standard orders on the basis that the Scottish Government is of the view that there is no requirement to change the existing legislation and that the committee has no time remaining to progress the issues that are raised in the petition. I would add that the petitioners might consider bringing a fresh petition on the issue in the new parliamentary session.

The Convener: We have evidence from parliamentary colleagues that directly challenges the assertion regarding the implementation of the existing law and that contradicts the Government's statement that the existing law is sufficient in asserting that nothing is being done to enforce it. I think that the petition still has merit and that there is opportunity for further consideration, but are colleagues content with Mr Torrance's suggestion, given the reasons that he has outlined?

Members *indicated agreement.*

People with Dementia (Council Tax Discounts) (PE1976)

The Convener: Our next petition is PE1976, lodged by Derek James Brown, which calls on the Scottish Parliament to urge the Scottish Government to require council tax discounts to be backdated to the date on which a person was certified as being severely mentally impaired when they then go on to qualify for a relevant benefit.

We last considered the petition in March, when we agreed to write to the Cabinet Secretary for Finance and Local Government. We were struck by the merits of the petition. The cabinet secretary's response to the committee states that the Scottish Government appreciates the concerns that the committee has raised and that it agrees in principle with the argument that is presented by the petitioner. The submission confirms that the Government is

"exploring legislative options and intends to introduce proposals in the coming months"

to address the issue raised in the petition. The petitioner has warmly welcomed the cabinet secretary's response, and he hopes and trusts that the Scottish Government's work will lead to the adoption of the request that was made in the petition.

In this instance, we have had an encouraging response from the Government. Given that, I hope that the aims of the petition can be fulfilled. In the light of the circumstances that we have been returning to all morning, does Mr Torrance have a proposal for the committee's consideration?

David Torrance: In the light of the very positive response from the Scottish Government, I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders, on the basis that the Scottish Government

"is actively exploring legislative options and intends to bring forward proposals in the coming months"

to address the issue raised in the petition.

11:45

Fergus Ewing: The exact wording that the Cabinet Secretary for Finance and Local Government used in her written submission of 5 November was:

> "I can confirm that the Scottish Government is actively exploring legislative options and intends to bring forward proposals in the coming months to address this issue."

I do not mean to be pedantic, but that does not necessarily mean that the cabinet secretary is going to do what the petitioner has asked for. I am not suggesting that we keep the petition open, because I think that, with the petitioner's stimulus, we have achieved the outcome that he appears to have set out to achieve, but I wonder whether we might, in closing the petition, write to the cabinet secretary to urge her to make it clear to the Parliament as soon as possible precisely what will be done. At the same time, as a matter of courtesy, we could copy her letter to the petitioner.

The Convener: I am quite happy with that additional suggestion. I think that Mr Ewing is also suggesting that parliamentary colleagues might want to keep a wary eye on any such announcement of proposals in the remaining time in this parliamentary session, because all colleagues will have the opportunity to raise such matters in the Parliament.

Are we content to proceed in the way that was suggested by Mr Torrance, with Mr Ewing's addendum?

Members *indicated agreement.*

Horses' Tail Hair Removal (Ban) (PE2130)

The Convener: PE2130, which was lodged by James A Mackie, calls on the Parliament to urge the Scottish Government to introduce a ban on the removal of all hair from a horse's tail, leaving a bare stump, other than for medical reasons. We previously considered the petition in March, when we agreed to write to the Government to seek further information on the work to update the "Code of Practice for the Welfare of Equidae", including timescales for completing the update and how the petitioner and other stakeholders might contribute to the process.

In the Scottish Government's response, which was sent to the committee in April, it was stated that the new equine code was being drafted by stakeholders and that the Government was confident that a

"sufficiently wide-ranging and varied base of equine expertise"

was already contributing to the development of the new code. The Government anticipated that the code would be published by late summer, but there is no evidence that that happened.

In addition, in their submissions, the petitioner and the charity Animal Concern suggest that a number of organisations are supportive of a ban. They also point to the decision that was taken by the Great Yorkshire Show to ban all horses with shaved tails from any competition or exhibition.

Do members have any comments or suggestions for action? Given that we were promised that something would be published by the end of the summer, which did not happen, it might be appropriate for us to keep the petition open a little bit longer and to write to the Minister for Agriculture and Connectivity to ask for a progress report and a rather more clear timeline for the publication of the Scottish Government's equine code.

Fergus Ewing: I agree. In doing so, we could ask the Government to respond to the petitioner's submission of 30 October and Animal Concern's submission of 5 November. The petitioner pointed out that we should perhaps have written to the Scottish Society for the Prevention of Cruelty to Animals, and I think that he is probably right. So, mea culpa, or perhaps nostra culpa—that was our fault. I thought that I should put that on the record, because I am grateful to the petitioner for pointing that out.

There is quite a lot in the submissions from the petitioner and Animal Concern, so it would be helpful to put those points to the minister, although the main point is that, although the Government promised that the code would be published in the summer, it has not yet materialised.

The Convener: Thank you, Mr Ewing. Due to your erudition, Latin is used more frequently in this committee than it is in any other committee of the Parliament. In any event—mea culpa, nostra culpa or whatever—are we content to keep the petition open and to pursue the issues as described?

Members *indicated agreement.*

A96 Dualling (Inverness-Nairn Timeline) (PE2132)

The Convener: PE2132, lodged by *The Inverness Courier*, calls on the Parliament to urge the Scottish Government to publish a clear timeline for dualling the A96 between Inverness and Nairn and for the construction of a bypass for Nairn, and to ensure that that timeline is made public by Easter 2025.

In fact, we last considered the petition after Easter 2025, when we wrote to the Cabinet Secretary for Transport. The response informed us that the Scottish ministers took title of the land acquired through the general vesting declaration—or GVD—process on 21 April.

As for a timetable for progress, the cabinet secretary stated that that would be set in line with available budgets, following completion of the work to determine the most suitable procurement option for delivering the schemes. The cabinet secretary indicated that that work would align with the work on assessing the mutual investment model—the MIM—for the dualling of the A9. Therefore, the decision on the use of the MIM for the A96 would be considered alongside or following the A9 decision, which the cabinet secretary expected "later in 2025". Since then, there have been no further public updates regarding that work.

Do colleagues have any suggestions on how we might act?

David Torrance: In the light of the evidence and the delays in implementation, I wonder whether we can consider writing to the Cabinet Secretary for Transport to ask for updates on the Scottish Government's assessment of the most

suitable options for the procurement and construction of the A9 dualling project between Inverness and Nairn, including the Nairn bypass scheme. We could also ask for the Scottish Government's assessment of the mutual investment model for the A96, which was due to be considered this year alongside the MIM assessment of the dualling of the A9, and ask about the Scottish Government's progress on developing a detailed timeline for the project, as asked for in the petition.

Fergus Ewing: I am grateful to Mr Torrance for those suggestions, with which I heartily concur. Obviously, I have a strong constituency interest, and have had such an interest for 26 years now, and I know that the Nairn bypass scheme was promised to be delivered as part of the dualled A96 by 2030. That ain't gonna happen. In the summer, Nairn is probably about as congested as any town in Scotland, because there is really only one way in and one way out for most traffic. Increasingly, smaller roads are being used as rat runs to cut out delays arising from using the A96 to go through Nairn, which can take up to an hour. However, that is causing huge concern and, indeed, road traffic incidents.

This is a serious matter. *The Inverness Courier* held a public meeting that the transport secretary attended, to be fair to her, but she was not able to answer questions about the timeline or the financing, despite the fact that the Scottish Government's budget is now £7,000 million a year. There is more than enough money over the next few years to deliver on the promises that have, I am sad to say, been broken.

Lastly, on the A96 as a whole, a sum of no less than £92 million has been spent on the dualling programme, including the section from Smithton to Auldearn, but not an inch of tarmac has been laid. How that can possibly have been achieved is something that is completely beyond me and my constituents.

I hope that, in writing to the minister, we can ask when she will make the statement to Parliament that has been promised. Will it happen this year, or will it happen at the very fag end of this session of Parliament, in the same way that an announcement about a section of A9 dualling was made in February or March 2021—a section that, incidentally, has not yet been dualled?

This has been a tale of woe. I do not wish to take up the committee's time, but it is a highly important matter for the people of Nairn and the Highlands.

The Convener: I think that that is understood, but do you agree with Mr Torrance's proposal?

Fergus Ewing: Yes, I do.

The Convener: Are other colleagues content?

Members *indicated agreement.*

International Covenant on Civil and Political Rights (Implementation in Scots Law) (PE2135)

The Convener: PE2135, on implementing the International Covenant on Civil and Political Rights—the ICCPR—in Scottish legislation, was lodged by Henry Black Ferguson on behalf of wecollect.scot. As we consider the petition, it would be appropriate to acknowledge the recent passing of the petitioner. The committee will be aware that Mr Ferguson was dedicated to this particular cause and understands that his campaigning work will continue through his colleagues and friends at Respect Scottish Sovereignty. We are grateful to Mr Ferguson for the time that he took in pursuing with the Scottish Parliament this petition on a matter that was of great importance to him and on which, in fact, he wrote to the committee not that long ago.

The petition calls on the Scottish Parliament to urge the Scottish Government to ensure that, prior to the next Holyrood parliamentary election, the ICCPR is given full legal effect in the devolved lawmaking process.

We last considered the petition on 2 April, when we agreed to write to the Cabinet Secretary for Constitution, External Affairs and Culture. Members will recall that the national task force on human rights leadership considered whether existing treaties should be incorporated into Scots law through the Scottish Government's new human rights bill, and it did not recommend that the ICCPR be incorporated.

In his response to the committee, the cabinet secretary reiterates that the Scottish Parliament can give effect only to the provisions of international treaties that fall within its powers and responsibilities. That means that the incorporation of the ICCPR would not extend the Parliament's powers, nor would it allow the Parliament or the Scottish Government to do anything that would have previously been beyond devolved competence. The cabinet secretary also notes that the majority of the rights in the covenant have already been given domestic legal effect through the Human Rights Act 1998.

The petitioner provided two written submissions, the first of which sets out information that he felt should have been included in the introductory remarks when we last considered the petition. The second written submission states the petitioner's view that, because there was no notion of devolved competence prior to the Scotland Act 1998, any argument that implementation of the covenant might be beyond devolved competence

is meaningless. It states that, as the UK ratified the covenant in 1976 and devolved its implementation through the Scotland Act 1998, the next step is implementation by a majority of MSPs.

Notwithstanding the argument that is made in the petition, the evidence that we have received from the cabinet secretary and the Scottish Government, as well as the information that is set out in the Scottish Parliament information centre briefing, is clear on the issue. Although the Scottish Parliament has the power to legislate to implement international agreements such as the covenant, that does not extend the powers of the Parliament to allow it to take action that is beyond devolved competence.

The committee has also received a written submission from an individual, Ewan Kennedy, which expresses his view that the covenant is a long-established cornerstone of the principles that are necessary to support modern democracies.

In the light of the firm direction from the Scottish Government, which is supported by the Parliament's independent research body, do colleagues have any suggestions as to how we might proceed?

David Torrance: In the light of the direction that we have been given by SPICe and the Scottish Government, I ask the committee to consider closing the petition under rule 15.7 of standard orders, on the basis that the Scottish Government is committed to a new human rights bill that will incorporate further international human rights standards into Scots law; the national task force on human rights leadership did not recommend incorporation of the ICCPR into the new human rights bill; and, although the observation and implementation of international obligations are not specifically reserved under the Scotland Act 1998, provision in that respect applies only to devolved matters that are within the competence of the Scottish Parliament. This route cannot be used to, in effect, extend the Parliament's powers by claiming that the incorporated international treaty provisions now allow the Parliament or the Scottish Government to do anything that would previously have been beyond devolved competence.

Fergus Ewing: Convener, I was pleased that you made reference to the fact that, sadly, Henry Black Ferguson, the petitioner, has passed away. It is fitting that I say a few additional words.

Mr Ferguson was an accountant who went to work in the Bahamas and was the chief executive officer of an airline company, but he never lost his love for Scotland, and his commitment to the cause of independence for Scotland was absolute. He was the co-convener of Respect Scottish Sovereignty, and he pursued the petition doggedly—along with many others, some of whom, I should acknowledge, are in touch with me—attracting 7,500 signatures, which is a significant number.

At its heart, the petition is about the principle that is set out in article 1 of the covenant, which Ewan Kennedy quotes in his submission:

> "All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development."

12:00

I hope that we would all support and endorse that principle in its entirety. However, the implementation of it in Scots law has become ensnared—a matter of principle has become ensnared—in an entirely technical issue; namely, interpretation of the Scotland Act 1998. I am no expert, but I understand the argument that section 30 of the Scotland Act 1998 allows matters to be devolved. That, in turn, requires the permission of the UK Government, which is the superior Parliament in the devolution arrangement. In short, that is where we stand.

This is an argument that a cause that will never die will continue until it is successfully achieved. I pay tribute to Mr Ferguson and all the petitioners, but we are plainly not going to get any further with the petition in this parliamentary session. Although we might have a dream, we are also pragmatists, and that dream will not be achieved in the immediate future. However, thanks to Mr Ferguson's and others' dogged pursuit of the cause, we shall prevail one day, if I may be permitted to make that assertion.

The Convener: Thank you, Mr Ewing. Notwithstanding that, are colleagues content that we proceed with closing the petition?

Members *indicated agreement.*

The Convener: I have just had a note to say that the Westminster Government's budget has been completely leaked ahead of it being delivered this afternoon.

In-vitro Fertilisation (Privately Sourced Donor Eggs) (PE2146)

The Convener: PE2146, lodged by Jamie Connelly, calls on the Parliament to urge the Scottish Government to allow couples and individuals to purchase altruistically donated eggs from private clinics for use in NHS-funded IVF treatment, and to instruct NHS Scotland to create a clear clinical pathway to support those who use private donor eggs.

We last considered the petition on 23 April, when we agreed to write to the Scottish

Government. The Government's response states that NHS boards collect data on the waiting times for couples who require an altruistic egg donor. The fertility centre with the longest wait time is currently Glasgow Royal fertility clinic, which advises the Scottish Government that couples who require an altruistic egg donor might wait between three to four years for treatment. The wait times at the other three NHS fertility centres are below that time. The Scottish Government therefore believes that, as far as possible, NHS fertility centres are meeting the needs of couples who require donor gametes, which includes donor eggs, and NHS fertility treatment.

The petitioner has written a submission to the committee, which, in the light of the Government's assertion on the issue, questions why patients are being advised that their potential wait time for eggs is likely to exceed 30 years. He states that there are people and couples who are removing themselves from the assisted conception process due to the information that they are being given on potential wait times for eggs.

Do members have any comments or suggestions for action? I feel that Mr Torrance is bursting to speak.

David Torrance: In the light of the evidence from the Scottish Government, we should consider closing the petition under rule 15.7 of standard orders on the basis that the Scottish Government's position is that couples who are eligible for NHS fertility treatment should not pay for any aspect of their treatment, including the purchase and use of donor gametes. The Government has noted that NHS assisted conception units in NHS Greater Glasgow and Clyde run local donor gamete campaigns and that the board is planning several campaigns this year to recruit egg and sperm donors, to reduce waiting times.

The Convener: Are colleagues content to close the petition?

Members *indicated agreement.*

Parking Badge for Pregnant Women (PE2140)

The Convener: The final continued petition for consideration today is PE2140, lodged by James Bruce, which calls on the Scottish Parliament to urge the Scottish Government to introduce a new parking badge to assist women in being able to get in and out of their cars while they are pregnant and in the initial months after their pregnancy.

We last considered the petition in April, when we agreed to write to the Scottish Retail Consortium. Its response states that most stores located in high streets or retail parks do not have their own customer parking, which, instead, is often provided by local authorities, privately operated car parks or the retail park landlord.

I remind members that, in the initial response to the petition, Transport Scotland stated that there were no plans to create separate concessionary badges or to widen the automatic eligibility criteria for the blue badge scheme, which is designed for disabled people. The Government has also informed us that decisions to offer alternative parking concessions for off-street car parks sit either with the relevant authority or with landowners. We pursued the Scottish Retail Consortium as a last resort, but do colleagues have any suggestions for action?

David Torrance: In light of the evidence, the committee should consider closing the petition, under rule 15.7 of standing orders, on the basis that the Scottish Government considers the ask of the petition not to be practical and to be achievable in part only; makes it clear that the Scottish ministers are not responsible for reviewing guidelines or procedures; considers that amending the 2007 regulations is not a practical solution to addressing wait times; and considers that introducing case progress and hearing timelines in primary or secondary legislation would require consultation and come with cost and resource implications. The Scottish Government also points to the steps that have been taken, in conjunction with the Scottish Courts and Tribunals Service, to address the underlying practical reasons for wait times, including the appointment of additional members of the First-tier Tribunal—[*Interruption*.]

I apologise—I have got my papers mixed up. I would ignore exactly what I said, convener.

The Convener: I was slightly confused, I have to say. Interesting as those recommendations were, Mr Torrance, I think that they strayed a little from the asks of the petition.

In light of that, do you have a recommendation that directly speaks to the petition?

David Torrance: I think that it was because the convener jumped a petition there—that threw me out.

The Convener: I apologise. How dare I keep everybody alert?

David Torrance: Thank you, convener.

In light of the evidence, we should consider closing the petition, under rule 15.7 of standing orders, on the basis that the Scottish Government has no plans to create a separate concessionary badge or to widen the automatic eligibility criteria for a blue badge; that the blue badge scheme is designed to support disabled people who experience several barriers in their mobility and applies only to on-street parking; and that the

decision to offer parking concessions at other types of facilities is a matter for relevant authorities and landowners.

The Convener: Thank you, Mr Torrance. Do colleagues agree? I think that we were on a bit of a last-resort pass by writing to the Scottish Retail Consortium, given the previous advice that we received. It was worth a punt but, unfortunately, it has not really taken the aims of the petition any further forward. Are we content to support Mr Torrance's recommendation?

Members *indicated agreement.*

New Petitions

12:07

The Convener: Item 3 is consideration of new petitions. As always, I highlight that, before we consider a new petition, we initially seek the view of the Scottish Government. We also receive a briefing from SPICe, the impartial research service in the Parliament. That is because, historically, those were the first two things that we would ask for in order to pursue a petition, so we have shortcut that process.

At the risk of colleagues having to keep up, I will suggest that, given that Mr McArthur is with us and that the petition that he is interested in was going to be considered a little later, we bring it forward to now, in the expectation that he has productive hours to spend on other matters in the Parliament.

National Entitlement Card Scheme (Ferry Travel) (PE2188)

The Convener: Our first new petition is PE2188, lodged by Claire Sparrow, which calls on the Parliament to urge the Government to extend the national entitlement card scheme to include ferry travel for people aged 60 and over. The Scottish Government's response to the petition highlights the publication of "Islands Connectivity Plan—Strategic Approach" in May and the expanded concessionary ferry travel for under-22s only. The response states that the Scottish Government does not consider the ask of the petition to be achievable, as it is not affordable to expand ferry concessions any further to include over-60s at this time, beyond what is already provided.

The petitioner has provided two written submissions, which highlight that ferry travel is essential for older adults living on islands. They sometimes must travel to attend healthcare appointments that are not available locally—I can think of islands even in the west of Scotland where that is the case—to purchase groceries and other necessities, and to maintain social and family connections.

The petitioner states that older island residents are effectively excluded from the same freedom of movement that their mainland counterparts enjoy. She points out that, under the current arrangements, island residents must first pay for ferry travel before they can access a bus service to which free bus entitlement applies. The petitioner states that that is not simply a matter of inconvenience; it is a matter of geographical inequality and social isolation.

Before we consider whether the committee can do anything in the time that is available to us, I ask

Mr McArthur whether he would like to offer a few comments.

Liam McArthur (Orkney Islands) (LD): I am grateful to you, convener, not least for up-ending your agenda to accommodate me.

I echo the petitioner's sentiments. I do not think that I am betraying confidences by saying that she is the resident of an island that does not have a GP or a nurse—and there is no shop. Accessing services is often achievable only by taking the ferry to the mainland. I have long made the argument that, for islanders in Orkney—it is the same in Shetland, the Western Isles and on the west coast—ferries often perform the function that buses perform on the mainland and that, therefore, the extension of concessionary travel on buses for younger people as well as for older people, although very welcome, has led to islanders feeling that there is a growing inconsistency in the way that they are treated.

The Government is right, and is to be commended, for extending free interisland ferry travel to island residents under the age of 22. I made the case for that strongly, along with other colleagues for the Highlands and Islands, across parties. However, the Government now has a problem. As it has accepted the principle in relation to under-22s, it becomes more difficult for it to say that it cannot do the same for those over the age of 60.

I support a great deal of the principle and the argumentation behind the petition. I am pragmatic enough to understand that, in the time that is available between now and the end of the parliamentary session, it might be difficult to make progress. However, the argument will not go away. As I said, as a result of the more recent decision in relation to under-22s, the Government has helped to make the case that Claire Sparrow and other signatories to the petition are fairly making.

The Convener: Thank you very much, Mr McArthur. There is an issue here. Mr Torrance?

David Torrance: I am back on track, convener. I wonder whether the committee would consider writing to the Cabinet Secretary for Transport to ask her to respond to the petitioner's points that ferry travel is essential for older island residents to attend healthcare appointments and maintain social connections, and that older island residents are being excluded from the same freedom of movement that their mainland counterparts have.

The Convener: That is a powerful point and a perfectly reasonable one for us to inquire about. We will keep the petition open and hope that we can get a response that would allow us to at least consider the cabinet secretary's response to that point. Are we agreed?

Members *indicated agreement.*

The Convener: Thank you, Mr McArthur.

Liam McArthur: I will see you in the Conveners Group meeting shortly, Mr Carlaw.

The Convener: Yes, indeed.

Dental Check-ups (Pensioners) PE2187

The Convener: Our next petition is PE2187, lodged by David Corner, which calls on the Scottish Parliament to urge the Scottish Government to reinstate six-monthly dental check-ups for state pensioners.

The SPICe briefing explains that, in November 2023, substantial reforms were made to the treatments that dentists offering NHS care provide. Prior to the reforms, patients would be sent a reminder to visit their dentist annually, although a number of dentists did that every six months. The reform introduced the extensive clinical examination, which is intended to be more thorough, and for which most people will be recalled annually, rather than within a shorter time. However, dentists can still use their discretion to determine whether a patient should additionally attend a review exam between those thorough annual examinations.

In its response, the Scottish Government explains that the extensive clinical examination is based on clinical guidance on the appropriate recall for dental check-ups, which is produced by the National Institute for Health and Care Excellence. The response confirms that dentists can still see patients more frequently than every 12 months, based on their assessment of patients' individual oral health needs. The Government therefore concludes that the issues raised in the petition do not require remedial action. Are colleagues content with that?

David Torrance: In the light of the Government's evidence, I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders, on the basis that the Scottish Government's position is that the extensive clinical examination, which was introduced by the NHS dental payment reform in 2023, is based on the best clinical practice guidelines, and that dentists can use their clinical discretion to see patients more frequently than every 12 months, based on patient risk factors.

The Convener: That is Mr Torrance's recommendation. Are we content with his proposal?

Members *indicated agreement.*

First-tier Tribunal for Scotland (Review of Guidelines) (PE2180)

12:15

The Convener: The next petition is PE2180, lodged by David Sinclair Aiton, which calls on the Parliament to urge the Scottish Government to urgently review the correct guidelines for the First-tier Tribunal for Scotland housing and property chamber and to introduce case progress and hearing timelines, as the protracted and timeless nature of the current process is contrary to article 6 of the European convention on human rights.

The Scottish Government states that the Scottish ministers are not responsible for reviewing guidelines and that the administration of the First-Tier Tribunal is a matter for the Scottish Courts and Tribunals Service. The Scottish Government does not consider possible legislative changes to reduce wait times to be a practical solution and refers to engagement with SCTS on this issue, including the recent appointment of additional members to the tribunal and on-going work to identify further recruitment priorities.

The Scottish Parliament information centre briefing explains that tribunal procedures are set out in the First-tier Tribunal for Scotland Housing and Property Chamber (Procedure) Regulations 2017, as amended. The rules do not prescribe time periods for an eviction order application to be listed for either an initial case management discussion or hearing.

The briefing refers to an answer to one of my own parliamentary questions, which states that the average timescale for an application to be heard is slightly more than six months. The briefing also highlights information from the tribunal's annual report 2023-24, which states that the volume of applications received for 2023-24 is the highest ever and is 10 per cent higher than the figure for 2022-23.

In his submission, the petitioner considers that long wait times are not solely attributable to increasing case loads. He also argues that the proposed review of guidelines is fully achievable and suggests newer amended rules to enable expedited hearings and to introduce a provision for decisions on the granting of eviction orders without the need for a hearing when the facts of the case are not disputed by the parties involved.

Do members have any comments or suggestions for action?

Fergus Ewing: I think that we have little alternative but to close the petition, for the reasons that we have discussed before with regard to the limited time that is available in this session of Parliament, and on the basis that the Scottish Government has indicated that it considers the petition's ask to be not practical and achievable only in part.

The Government's response makes it clear that ministers are not responsible for reviewing the guidelines or procedures, and amending the 2017 regulations is not considered to be a practical solution to addressing wait times. Moreover, introducing case progress and hearing timelines in primary or secondary legislation would require consultation and comes with cost and resource implications. The Government also points to steps that have been taken in conjunction with the SCTS to address the underlying practical reasons for wait times, including the recent appointment of additional members to the First-tier Tribunal.

That is the Scottish Government's position, and it is not reasonable to expect that there will be any change in that position between now and the end of the parliamentary session. One might expect the additional members to the First-tier Tribunal to reduce wait times, simply by the fact that there will be more people to deal with cases. That is to be welcomed.

However, if members agree to close the petition, I recommend that the petitioner might wish to see whether the changes have impacted favourably or not, and then think about bringing the petition back in the next session of Parliament, depending on the answer to that.

The Convener: I think that that is a perfectly reasonable suggestion. Obviously, my constituency interest led to the parliamentary question that I lodged, and I think that the current situation is a matter of public concern.

Are we content with Mr Torrance's proposal, but that we recommend that this is a petition whose aims might—[*Interruption*.] Oh, have you not made your proposal yet, Mr Torrance?

David Torrance: No.

The Convener: I am sorry—I went straight to Mr Ewing, not to you, Mr Torrance. It was Mr Ewing's proposal, not yours. I thought that you had indicated that you wanted to add something.

David Torrance: No.

Are we content with Mr Ewing's suggestion as to how we might proceed?

Members *indicated agreement.*

Suicide Awareness and Prevention Training (PE2183)

The Convener: The next petition is PE2183, lodged by Craig Paton, which calls on the Scottish Parliament to urge the Scottish Government to make suicide awareness and prevention training

mandatory for high school students in order to help remove stigmas; to empower young people to speak openly; and to ensure that teachers can spot the vital signs and take appropriate measures to prevent a fatality. The petition notes that the training is, in fact, available in English schools.

The SPICe briefing explains that the curriculum in Scotland is largely non-statutory, with the content of what is taught being a matter for teachers, schools and local authorities. It notes that the Scottish Government has, since at least 2002, focused on reducing the number of suicides, including through working groups and a series of strategy, prevention and delivery plans that are published every few years.

The Scottish Government refers to the curriculum for excellence as a broad national framework rather than a statutory curriculum. Health and wellbeing is one of the eight curricular areas in the framework, and it is one of the three core areas that are identified as a responsibility for all, which means that all staff across the school community share responsibility for delivery.

The Scottish Government points to resources that are available through Education Scotland to support learning in relation to mental health, self-harm, suicide prevention and positive mental wellbeing. It also notes that Education Scotland is leading on the development and delivery of the curriculum improvement cycle, with work already under way on that.

Do members have any comments or suggestions for action?

David Torrance: In light of the evidence that is in front of us, I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders, on the basis that there is no mandatory curriculum in Scotland and that the curriculum for excellence is a broad non-statutory national framework, with the content of what is taught being largely a matter for teachers, schools and local authorities. Health and wellbeing is one of the eight curricular areas of the curriculum for excellence and, in addition, is one of the three core areas that are identified as a responsibility for all. The Scottish Government has pointed to resources that are available through Education Scotland to support learning in relation to mental health, self-harm and suicide prevention, and it notes that Education Scotland is currently leading on the development and delivery of the curriculum improvement cycle.

The Convener: Are we content with Mr Torrance's suggestion?

Members *indicated agreement.*

Use of Digital Material in Court Proceedings (PE2185)

The Convener: Our final petition today, PE2185, is on the introduction of stronger safeguards regarding the use of digital material in court proceedings. I have to assume that the three remaining guests in the gallery have suffered through our entire proceedings only to find that their petition is the last of those that we are considering today. Notwithstanding that, I hope that we can do something positive to assist.

The petition, which was lodged by Christopher Simpson, calls on the Scottish Parliament to urge the Scottish Government to amend the Criminal Procedure (Scotland) Act 1995 to ensure that any digital material that is presented in court, such as photos or screenshots, is verifiably sourced, timestamped and able to be independently authenticated before being considered admissible, unless both parties agree otherwise.

Regarding current court procedures, the Crown Office and Procurator Fiscal Service has explained to our SPICe researchers that

"before any item attains evidential status its provenance must be established; an item is meaningless unless its source is in some way proved".

If the defence and the prosecution do not agree on the provenance of an item, whether digital or not, there is a process in place that enables parties to challenge the evidence and lead their own rebuttal.

The Scottish Government indicates that the gathering and presentation of evidence are matters for Police Scotland and COPFS. The Government does not consider the action that is called for by the petition to be necessary on account of existing safeguards, which are meant to ensure that concerns about the authenticity of any digital evidence can be raised and investigated.

However, in an additional submission, the petitioner shares his distressing experience and reiterates that

"individuals can be subjected to lengthy investigations and restrictions based on unverified or fabricated digital material."

Discussions about the provenance of evidence take place after a person has been charged, and the petitioner sees that as a gap in the legislation. He insists that all digital evidence must be verifiably sourced, timestamped and authenticated before it reaches court.

Do colleagues have any suggestions for action?

David Torrance: In light of the evidence, I wonder whether the committee would consider writing to the Lord Advocate and the chief

constable of Police Scotland to ask for their views on the petition and the timing concern that the petitioner expressed in his additional submission.

The Convener: It strikes me that the timing concern is wholly legitimate. We know the opprobrium that can be attached to an individual being charged, and it would seem curious if evidence had not been corroborated before things got to that point in the process, so it is perfectly legitimate for us to seek further clarification on those matters.

Fergus Ewing: I support that, including for the reason that, although in theory the specific proposal should not be necessary, in practice, the petitioner has had an experience that is quite the contrary: one of a failure to carry out a proper process, according to the petitioner's narrative. Therefore, it would do no harm, particularly given the increasing importance of digital material and evidence in court, to understand what safeguards are in place to ensure that it is properly authenticated and verified as far as possible.

The main thrust of the petitioner's submission is that that should happen, but one doubts whether it in fact happens, for various practical reasons. Not least of those would be because, to be honest, some people of my vintage might not really understand how digital material works. I would be surprised if some of my learned friends were necessarily experts at digital technology. The petitioner has raised an interesting area of evidence in criminal proceedings that should be pursued and clarified.

The Convener: Yes. I should emphasise that, in pursuing these matters, we are not doing so on a purely theoretical basis; the evidence that is before the committee indicates that that was the actual experience of the petitioner.

Davy Russell: We can see how digital evidence can be manipulated from the recent BBC fiasco involving a US President.

The Convener: Indeed. The last time I checked, President Trump had not lodged a petition with the Scottish Parliament in relation to the digital evidence at the BBC but, actually, I would not put it past him, because he seems to be quite free in doing that sort of thing.

We will keep the petition open, notwithstanding the time that is left to us in this session of Parliament, and hope that we can advance further information in relation to the points that are raised as a consequence of the additional submission from the petitioner.

Fergus Ewing: For the sake of completeness, I point out that I recall—because I was present—when President Trump, who was then a businessman in north-east Scotland, appeared before a committee of this Parliament and stated that the wind turbines opposite his golf course should not go ahead. When he was asked what his evidence was, he replied, "I am the evidence."

The Convener: That is how the affairs of the United States are conducted, currently.

That brings us to the end of that item. I hope that the petitioner is content with our taking forward the petition on that basis.

12:27

Meeting continued in private until 12:34.

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