OFFICIAL REPORT
AITHISG OIFIGEIL

Citizen Participation and Public Petitions Committee

Wednesday 10 December 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 10 December 2025

CONTENTS

CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

19th 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)
Kirstie Campbell (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)
Carol Mochan (South Scotland) (Lab)
Edward Mountain (Highlands and Islands) (Con)
Tess White (North East Scotland) (Con)

CLERK TO THE COMMITTEE

Jyoti Chandola

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 10 December 2025

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Jackson Carlaw): Good morning, and welcome to the 19th meeting in 2025 of the Citizen Participation and Public Petitions Committee. Our first item of business is to decide whether to take item 4 in private, to consider the evidence that we will hear this morning. Are colleagues content to do so?

Members *indicated agreement.*

The Convener: We have received apologies from Fergus Ewing and, as he is an independent member now, there is no substitute for him. Maurice Golden has been called to speak on amendments to a bill that he is progressing, which is being considered by our colleagues in the Rural Affairs and Islands Committee. He was here and then was summoned away, but we hope that he will join us again at some point during this morning's proceedings.

Continued Petitions

Specialist Neonatal Units (Centralisation) (PE2099)

09:32

The Convener: The first continued petition is the very important petition that we have been considering for some time, following our visit to University hospital Wishaw in September and our evidence session at our previous committee meeting. PE2099, which was lodged by Lynne McRitchie, calls on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading—it is important to say that that is what it is—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 the decision in the light of contradictory expert opinions on centralising services.

We last considered the petition at our previous meeting, when we heard evidence from the British Association of Perinatal Medicine and then from the best start perinatal sub-group. I am delighted that today we are taking evidence from Jenni Minto, the Minister for Public Health and Women's Health, and her supporting officials Kirstie Campbell, unit head of maternity, neonatal and IVF policy, and Danielle Le Poidevin, neonatal policy manager. Minister, please invite your colleagues to join in when you think it appropriate, or they can signal to me if they would like to offer an additional contribution.

We are also joined by our colleague Clare Adamson MSP. I will invite Clare to join the questioning after the committee members have spoken, or, if she lets me know, we may bring her in on a key point. Minister, I know that you would like to make some opening remarks before we move to questions, so over to you.

The Minister for Public Health and Women's Health (Jenni Minto): Thank you for inviting me to provide evidence today. Addressing concerns about the new model of neonatal care is very important to me, so I am pleased to be here to talk about the petition. First, I will address a point made at the previous committee meeting and make it absolutely clear that no units are closing as part of the new model of neonatal care.

In 2023-24, around 4,500 babies were cared for in neonatal units. Just over 800 were admitted to intensive care. The majority of those babies need intensive care for only a short period—less than 48 hours. A small number need longer, highly specialised intensive care. For those babies, the complexity of that neonatal intensive care has

increased, particularly for babies born at extremes of prematurity or with extremely low birth weights.

As the committee heard from Stephen Wardle of the British Association of Perinatal Medicine and Andrew Murray and Jim Crombie, the chairs of the best start perinatal sub-group, the clinical evidence shows that outcomes for the smallest and sickest babies are improved when they are born and cared for in a unit with a high throughput of cases, defined as at least 100 new, very low birth weight admissions per year and where support services are co-located.

That evidence underpinned the best start recommendation and also the professional guidance published by the British Association of Perinatal Medicine. As defined in the guidance and as highlighted by Stephen Wardle to the committee, local neonatal units will continue to provide a level of intensive care and be able to care for singleton births over 27 weeks' gestation, with babies receiving care in one of the three intensive care units being transferred back to their local neonatal unit for on-going care as soon as possible. The best start report—"The Best Start: A Five-year Forward Plan"—was based on evidence and a range of expert clinical opinion. The options appraisal that followed, as you heard from Jim Crombie and Andrew Murray, was objective, followed evidence-based criteria and was undertaken by an expert group comprising clinicians with service users represented by Bliss Scotland.

I was disappointed to hear at the last committee meeting that colleagues raised again that NHS Lanarkshire was not present within the process. I have corrected that point many times previously, and I am grateful to Jim Crombie for further clarifying to the committee NHS Lanarkshire's involvement in both the best start perinatal sub-group and the best start programme board. The members were appointed based on national roles that they represented, to provide an objective view to an evidence-based clinical approach. As the committee previously heard, having the right infrastructure in place is essential to support implementation of the new model and to optimise the parents' experience.

When I announced those changes in 2023, I asked the regional chief executives to lead on detailed implementation plans that described how they would build capacity in the three units before commencing any changes. The Scottish Government also commissioned detailed capacity modelling to inform those plans. In addition, work is under way with the regional chief executives' task and finish group to look at maternity capacity, financial modelling and cot capacity management. The best start report had family-centred care as one of its core principles. Among the earliest best start recommendations were the establishment of the neonatal expenses fund in 2018, now the young patients family fund, and the provision of accommodation on or near all neonatal units for the parents of the sickest babies. Other improvements include accessible psychological support services for parents, offered throughout their neonatal journey.

Since my appointment, I have been committed to listening to both families and clinicians from across Scotland, and I have seen at first hand the passion and commitment of the neonatal staff by visiting University hospital Wishaw, the Queen Elizabeth university hospital in Glasgow, and the new Royal infirmary of Edinburgh. I have also met with Wishaw neonatal campaigners and elected representatives on several occasions. I had the pleasure of presenting both Ninewells and Forth Valley neonatal units with their Bliss baby charter gold awards, recognising the care that those units provide and will continue to provide.

I also want to thank staff at Ninewells for their efforts in reassuring the local people that the new model is the right model. I want to put on record my thanks to all the neonatal nurses and consultants who do such a fantastic job in caring for babies and supporting families, and to thank Bliss for all its work for families at a time when they need that support the most, and their work to advocate for those families in national policy. I recognise that families will be concerned about the change, but I want to provide reassurance that this decision has been made in the best interests of the very smallest and sickest babies.

I thank the committee for listening carefully to the evidence of those involved in the process, and for taking time to visit Wishaw university hospital.

The Convener: Thank you, minister. Let us start where we are all agreed. Any concerns that there were financial motivations have been dispelled to the committee's satisfaction. We are convinced from the evidence that we have heard that the best interests of babies have been at the forefront of the decision-making process. We are agreed on that point.

I also agree that there has been a certain amount of confusion and misinformation. I was careful to say at the start again that some units are being downgraded, and are not being closed. I will come to the detail of that.

However, where we are still wrestling is that there was the prospect of a reduction in the number of units at the full level of services, down to somewhere between three and five, and we landed at three. Concerns have been expressed about the geographical inconsistency of Glasgow, Edinburgh, Aberdeen and the south of Scotland,

and all the way up to Wishaw, and therefore, the central belt being underprovided.

Another thing that impressed the committee was that we heard from the specialist services last week—those who had been involved in the decision—and there was a caveat to their support for their own recommendations. That caveat is that the capacity, resourcing and everything that is required to ensure that this model can work has to be in place. The committee, given that we are politicians of long standing, have all, from personal experience—not only in the field of health but elsewhere—been aware of similar initiatives for all manner of services, where, in the event, that did not prove to be the case. For the lives of very fragile newborn babies, not having everything in place right from the start would be a concern. So, there is the geographical issue and the question whether the resource will be in place.

The committee understands—although I have not seen the letter; Davy Russell will speak to it in a little more detail—that the clinicians at Glasgow have written asking for the proposal to be paused, because they do not believe that Glasgow has the capacity, that it is currently overstretched and therefore unable to take up the commitment that is being suggested that it would embrace. That rings alarm bells for us as a committee because it plays directly to our concern that the capacity will not be in place when this goes live.

I am sorry; that was a long preamble to my question. You said a moment ago that the changes would evolve when the capacity is in place. My initial questions are about the geography, the capacity, the resilience of the preparation for that capacity and when you think that it would be safe, given the concerns that are being expressed? If Glasgow is at full capacity, we would have that geographical issue that has been represented to us time and again of parents finding their baby separated from them by being as far away as Aberdeen. When do you think that it would be safe to deploy the new model?

Jenni Minto: I will start by quoting from the best start report from 2017. It said:

> "It is proposed that three to five neonatal intensive care units should be the immediate model for Scotland, progressing to three units within five years."

That is the full quote. I am absolutely clear that we need to do this in the safest way possible, given that the intended outcome is to ensure the safety of and the best outcomes for the smallest and sickest babies.

The intention, from 2017, was always to phase the change, and that started in 2019 with two units, Crosshouse hospital in Ayrshire and Arran, and Victoria hospital in Fife. Ayrshire and Arran linked with QEUH, and Victoria in Fife linked with Lothian.

We made that first step and took learnings from that. I do not need to remind anyone in this committee that we then hit Covid, so there was a pause in the services. After Covid, as you have heard in evidence, there was a review to ensure that the circumstances were still the same. Again, that still supported the best start work.

09:45

In July 2023, I announced three new neonatal intensive care units. Last week, you heard evidence from Stephen Wardle about the model in England and the fact that, for the population size of Scotland and the number of babies, two units would be the appropriate number. However, because of the geography of Scotland—I think that Andrew Murray and Jim Crombie noted this—it was felt that a unit was needed in the north and Aberdeen was selected. That goes some way to responding to your question about geography.

I live on Islay, which is an island, as everyone knows. If these circumstances arose on Islay, the family would have to be helicoptered off the island. We have the Scottish specialist transport and retrieval service, ScotSTAR, which is both a helicopter and ambulance service, which is currently moving babies around between Wishaw, for example, and QEUH. That service has been set up for about 20 years. It is seen as a world-class service. We have hugely experienced neonatal staff working in that service giving the best support, treatment and care to families that require it. We have looked at the geography. We have looked at the central belt and also further north in Scotland. ScotSTAR and the Scottish Ambulance Service have been very involved in the work as it has progressed. Therefore, we have that support.

On capacity, you are absolutely right. My officials and I have been working hard on this question. We commissioned work to look at the capacity within each unit and the best model to support the move to three units. From my perspective, that is very important. That work spoke to the staff in each unit and took wider information, which was shared with the regional chief executives, who set up a task and finish group to move the work forward. It was never the intention to make an announcement on day 1 and have the change happen on day 2. There has always been an intention of incremental steps as we move towards the more concentrated neonatal intensive care units, which will have a throughput of around 100 babies each year, with the co-located additional services. It is important to recognise that.

I will hand over to Kirstie Campbell to talk about the clinicians' comments.

Kirstie Campbell (Scottish Government): The minister has highlighted the process that we have in place for implementation planning. Three regional chief executives have established plans in their regions for how they are going to implement the new model. As the minister highlighted, the expectation was not that we would be implementing everything on day 1 after the announcement was made; we always knew that there would be a period of implementation.

We commissioned the work from RSM UK that modelled the capacity required in each unit, and then we shared that with the regional chief executives. We set the expectation that their regional plans would identify how they will move from where they are now to the position in which they have the capacity to implement the model.

The task and finish group identified several pieces of work that needed to happen before we were able to move. That included doing some work on maternity modelling, looking at the maternity capacity in the units and recognising that, for the majority of the women, the expectation would be that the transfer happens while in utero. They would then give birth to their babies who need neonatal intensive care in the units they are moved to. We have therefore done some work on modelling the maternity capacity required.

We have also done some work on looking at the financial model that needs to be in place, so that the funding follows the babies. The Government has pump-primed the implementation in practice, and to date we have provided over £7.5 million-worth of funding to both Glasgow and Edinburgh and a small amount to Aberdeen, to support building the capacity that is required to start the move.

The process will always be incremental, as the minister outlined. We will start potentially with moving the smallest babies—the ones who are most at risk. When those babies are moved and the system is in place and is seen to be working, we will move forward with incremental change. The expectation is that we will be able to build capacity as we move forward with that change.

The Convener: Two questions follow from that. Can you illustrate for us, relative to the size of the current unit in Glasgow, the size of the new unit that you expect, and what you envisage the timetable of the transition being?

Kirstie Campbell: I can. That was outlined by the report that we commissioned from RSM UK. RSM UK set the expectation for an additional 10 cots in QEUH in Glasgow, an additional four cots in Edinburgh royal infirmary and an additional one and a half cots in Aberdeen maternity unit.

The Convener: Just for the completeness of the record, what is the existing capacity that those additional units are on top of?

Kirstie Campbell: The capacity flexes. I have to research in my folder for the precise numbers, but the capacity flexes across the units, because a number of intensive care beds can also be used as high-dependency beds. They will flex between the two in different cases. I can get the numbers for you later.

The Convener: That would be helpful. This is the guts of any reassurance about the capacity of the model to cope. What timeline do you imagine the model evolving over?

Kirstie Campbell: The timeline has moved since we started the implementation. We asked the regional chief executives to look at the timeline, the development that would be needed and how long that capacity building would take.

We had some experience from running the early implementer boards in Fife and Ayrshire, as the minister outlined. In those two boards, it took us a full year from start to finish to get the work from initial discussions through to actually starting to move the babies. Those units were at a significantly smaller level than the units we are now talking about, so the current task is much bigger.

It is fair to say that we are behind schedule. Much more work has been required, and I mentioned some of the work around maternity modelling and financial modelling, which has taken a bit longer than we expected. The expectation is that, once the work begins, we should be able to conclude it within a year to 18 months.

The Convener: If I am looking at this in political chunks, is it right that sometime in the first half of the next parliamentary session, which begins in May 2026, you would expect the transition to have been completed?

Kirstie Campbell: I would expect that, yes.

The Convener: That is helpful, and members may come back on that issue as we progress.

Before I bring in Davy Russell, I have one final question that I think it would be helpful to understand. Minister, can you set out what types of cases will be handled by each level of the national service?

Jenni Minto: There are three levels under the BAPM structure. The national intensive care units are the ones that we are talking about for the three areas: Glasgow, Edinburgh and Aberdeen. They will care for the smallest and sickest babies—those who are those born under 27 weeks and with a body weight of less than 800g. Those are the babies we are talking about—babies who need

additional care, sitting beside co-located surgery and other neonatal support.

I should say that decisions to move babies are very much taken from a clinical perspective. Clinicians would decide whether a baby should move.

There are then local neonatal units, which support babies of up to 1,500g. Those units provide all levels of care for singletons greater than 27 weeks and multiple births greater than 28 weeks, and for babies requiring perhaps a short period of intubated ventilator support—a level of intensive care that was highlighted last week by both Andrew Murray and Jim Crombie.

The special care units provide care for babies of 32 weeks' gestation and upwards, and some may care for babies of greater than 30 weeks of gestation. Again, that depends on local geography—as we know from Mr Ewing's questions last week, that is a key thing within Scotland. Those units will also provide care for babies with additional care needs who do not meet either the intensive care or the high-dependency care criteria.

Those are well-known categories in neonatal practice, and Scotland is following the BAPM guidelines in moving in this direction.

Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab): You mentioned ScotSTAR transfers. Obviously, the role of ScotSTAR will significantly increase when we move down to three units. Does ScotSTAR have the capacity? In your financial modelling, have you built in any costs for ScotSTAR to increase its capacity to manage the increase in demand?

Jenni Minto: You are absolutely right that ScotSTAR is key to ensuring the right support. As I highlighted earlier, ScotSTAR has been operating for 20 years. It is a well-recognised model of providing transfer between hospitals for the smallest and sickest babies. As I said earlier, ScotSTAR and the Scottish Ambulance Service, which operates ScotSTAR, have been involved in the best start work right from the start, and that is very important.

Any modelling that is required will be done. As Kirstie Campbell noted, the work is happening on a financial basis. One of the directors of finance, who is part of the task and finish group, is looking at the work from a once-for-Scotland approach. If the capacity of ScotSTAR needs to increase, that will certainly be built into our approach to ensure that babies are transported in the safest, most careful way, to ensure the best outcomes for them.

Davy Russell: Based on your answer, I think that you are telling me that it has not been done yet.

Jenni Minto: I am sorry if I have given you that impression; that was not the intention.

All the capacity work is being done now, and it is important that it is done. We have been very clear that it needs to be done carefully. I am aware that some of the evidence that you heard last week was that the modelling had not been done. That is exactly the work that we have asked the task and finish group to do, to ensure that we have the right services to provide the right care for the babies.

10:00

Davy Russell: You mentioned that the original report was done in 2017 and that, after the Covid period, you reviewed it again to make sure that it was the right way forward. Did the same people review it, or was it done independently?

Jenni Minto: It was reviewed by the initial group—the experts who were basing their decisions on expert evidence, which you heard last week. However, once I had made the decision and I was, rightly, being questioned by families and other clinicians, I asked the deputy chief medical officer to review it again to ensure that we had followed the right evidence and that the right results were coming from the report.

Davy Russell: As part of the review, Bliss has said—I read this last night—that it did not consult parents because it was not in their terms of reference.

Jenni Minto: Yes, I have read that as well.

Bliss is an advocacy group to represent generally people who have experienced this type of care. To help progress the move to three neonatal intensive care units, I asked for—and in June last year we ran through Citizen Space—a survey of patients and parents who had experienced neonatal intensive care to ensure that their voices were heard. We also ran a number of focus groups. As I indicated in my introductory remarks, I have also met with parents and with patients and their parents in neonatal units in Scotland to hear about the care that they are getting.

I am confident that that voice is listened to. I have also been very clear in the task and finish group that the importance of listening to the patient's voice is recognised to ensure that it is heard clearly.

Davy Russell: Yet the parents' groups that I have heard from—and we had a chat with them—say that you are listening but are still just carrying on regardless.

Jenni Minto: I would be remiss if I were not following the expert clinical advice that you heard last week, which is clear that the smallest and

sickest babies get the best outcomes if they are treated in neonatal intensive care units that have a greater throughput. I find that a really awkward phrase to use when we are talking about babies, but it means a greater number of babies going through the system to ensure that the clinicians, the nurses and everybody else in the units looking after the babies are of the right standard to get the best outcomes for the babies.

I have visited Wishaw, Ninewells and other neonatal units in Scotland. As I indicated in my opening remarks, the staff are fantastic, and I respect and have great confidence in the work they are doing. However, it would be remiss of me as the Minister for Public Health and Women's Health not to listen very clearly and read very closely the evidence from other experts, clinicians and also BAPM.

Davy Russell: Obviously, there will be more transportation and logistics involved when transporting mothers and babies. When a transfer has to take place, will it be the general ambulance service or will they need to make their own way to the units?

Jenni Minto: I have been very clear that ScotSTAR will transfer the babies. The decision about whether the mother can travel with the baby depends on the health of the mother. My understanding of the layout of a ScotSTAR ambulance is that the mother would have to sit for the duration of the journey, which might not be appropriate for her own health, so separate transportation decisions as to the safest and the right way for a mother to be transferred would be needed. It may be by ambulance, but it may also be by private car.

Davy Russell: I hear every week in my casework that the Scottish Ambulance Service is stretched—that is me putting it mildly—and this change is going to put more pressure on the Ambulance Service. Do you have any plans to increase its capacity?

Jenni Minto: ScotSTAR provides a separate ambulance; it is not a general ambulance. ScotSTAR ambulances are key ambulances designed specifically for neonatal baby transfer.

The Convener: Sorry to interrupt, but I think that Mr Russell's point is different.

As we were talking about a moment ago, I would be interested to know if there is an expectation that the ScotSTAR service will need to be augmented in some way, irrespective of the initial planning that is going on. Is there such an expectation? However, I think that Mr Russell's point is that if the general ambulance service is called on to ferry the mother and that journey was from, say, south of Wishaw to Aberdeen, the ambulance is going to be out of the system for quite some time, in an environment when we already know that there can be very long waiting times for ambulances.

There is a concern. You also said the transfer could be by private car, so I accept that there could be other options, but the current environment is not one that a mother or somebody contemplating being in this position might feel reassured by.

Jenni Minto: You are absolutely right, convener. I cannot imagine what it would be like for any family to be in this situation, which is why I am trying to be completely candid with you. The baby would be transferred by ScotSTAR, and the mother would be too, if she were able. If that was not possible, we have to recognise the pressures that are on the Scottish Ambulance Service just now and the transport would be organised to mitigate any issues on availability of ambulances to support the mother's transfer.

The Convener: Sorry, Mr Russell. I interrupted.

Kirstie Campbell: May I add something? When women require to be transferred by ambulance, it will largely be from an obstetric unit to another obstetric unit. We have clear protocols in place, which have been developed by our Scottish perinatal network and published in the last few years, to outline exactly how to transfer women by ambulance from an obstetric unit to another obstetric unit, and the priority that those calls have to take within the system. That guidance has been developed, recognising that we are going to need it for the new model, and it has been published.

Davy Russell: Yes, but my original point was that, if that is the case and that transfer is the number 1 priority, there must be strain on the system somewhere else. If this is going to be used a lot more, some people will be waiting a lot longer for other things.

Kirstie Campbell: The numbers will be low. We reckon that about 50 to 60 women a year will need to be transferred under the new model. The expectation is that the vast majority of women will be transferred from the hospital that they are in to the nearest intensive care unit. The long transfers should be rare, if not negligible in terms of distance travelled. There will be very rare occasions, for example, when there is a high number of multiple births and babies need to travel a little further, but that has happened so rarely over the past 10 years that it would not factor into planning.

Davy Russell: The convener mentioned the letter from the neonatal consultants in Glasgow. Do you have that letter?

Kirstie Campbell: I have seen that letter, yes. The letter came in, I think, about 18 months ago.

At the time, we discussed it with the regional chief executive who was leading the implementation. The regional chief executive at that time was also the chief executive of the Greater Glasgow and Clyde NHS Board, Jane Grant. She assured us that the issues raised in that letter were being accounted for in the regional plan that they were putting together.

Davy Russell: Why was it not brought to the attention of this committee until now? It was not you who told me; it was somebody else. I think that the letter is relevant, because they are expert people as well.

Kirstie Campbell: They had concerns about the process of building capacity within the QEUH and how that would be managed. They also had concerns about capacity within their own unit at that time—they were clinicians at the Princess Royal maternity hospital, which will be changed to a local neonatal unit under the new model. Some of the concerns were local concerns that were addressed by NHS Greater Glasgow and Clyde, and some were taken into the regional planning process. It was some time ago and, as we understand it, the issues have been considered within the regional plans.

David Torrance (Kirkcaldy) (SNP): Good morning. What work has been carried out on how to identify women who could be in this situation and should be transferred before they give birth?

Jenni Minto: Thank you for that question. I think that you heard some evidence from Stephen Wardle about that last week.

From the work that we did with Crosshouse in Ayrshire and Arran sending patients to Glasgow and the Victoria in Fife sending patients to Lothian, it was clear that the best outcomes are if the mother can travel while the baby is in utero. That should be picked up in the visits that mothers-to-be have with their maternity staff. They will be put on one of the different pathways for expectant mothers and that would be taken into account. There will be certain areas that will require the maternity staff to ensure that they recognise whether a mother is likely to give birth early.

Kirstie Campbell: The Scottish perinatal network has put together a piece of guidance in anticipation of requiring really strong, clear guidance on the identification of expected pre-term labour. That guidance has also been published and shared widely around the Scottish clinical community. A number of elements have been put in place ahead of us making this move to help support clinicians across the country, to make sure that this is done safely and done well.

David Torrance: On family-centred care, how would you respond to the point that families at the moment do not receive enough financial or care support? Considering the distances that will now be involved, what financial help will the Scottish Government put in place for families who will have to travel those huge distances?

Jenni Minto: I refer to Bliss's involvement in the best start programme. Right at the start, they made the point very clearly that if you have a baby who is in intensive care for some time, it can be financially draining on the family. Accordingly, one of the requirements of best start was to set up the neonatal family fund, which provided money for families in this situation, whether for food, accommodation or travel. That was covered. We have since extended that to the young patients family fund, which ensures that support is available for families in those circumstances.

I visited the people who organise the YPFF in QEUH, and for people who deal with expenses and finance, they were some of the most caring people that I have met, because they recognise the impact—the pressures and the stresses—that such circumstances can have on families. They ensure that all the staff in neonatal wards are aware of the YPFF, but also make visits themselves, and will support families in completing the application forms for the funds. That can be done on a weekly basis or at the end of a stay. The regularity with which the funds arrive is entirely up to the family. The fund is most important and I commend Bliss for its work to ensure that it was included in our recommendations.

Bliss was very positive on not only the finance side but around psychological support for families in this situation. Psychological support can be provided either on the wards or by the third sector, including by Bliss.

10:15

David Torrance: How would you respond to claims that the new model relies heavily on the third sector to provide that care?

Jenni Minto: Generally, I think that our health service can only benefit from support from the third sector. The operational improvement plan, the population health plan, and the strategic review framework all point to a need for much more holistic healthcare. That includes both the primary care that we get in our general practitioner surgeries and from opticians and pharmacists and so on, and the acute care in our hospitals, as well as a wraparound, if I can describe it like that, from the third sector, providing a different type of support that it is very good at.

Kirstie Campbell: To add to what the minister has said, people will be aware that the recommendation came from the best start report, which we published in 2017. Improving neonatal

intensive care was among the fundamental premises of the best start report, but there was a whole package of improvement recommendations around neonatal care that we have been putting in place ever since.

Improvements to neonatal units across Scotland include the development of transitional care, which sees mothers and babies kept together in a maternity ward, rather than babies being taken off to a special care baby unit as would have previously been the case; the addition of seven-day neonatal community care, allowing parents to get their babies home earlier with support in the community so that they can they can receive the care that they need at home; and a range of other things, including the young patients family fund, which was previously the neonatal expenses fund that the minister highlighted.

Another thing to highlight is that in Scotland we have been moving forward with the implementation of the Bliss baby charter. Bliss has developed a set of standards for all neonatal units and we have been supporting neonatal units in Scotland to implement the criteria within the charter to provide the best care for families. It covers a range of things that make it easier for families to be with their babies in neonatal care, including providing food and accommodation. Parents are recognised not as visitors to neonatal units but as partners in the care of their baby. That fundamental ethos and that change to a family-centred care approach has been a core part of implementation and Bliss, one of our leading charities as the minister outlined, has been instrumental in helping our units to move forward with that package of measures.

The Convener: Can I pursue that a little further in the context of my meetings with parents in Wishaw? The parents spoke about the situation that might develop for other parents post the implementation of these changes. We are talking here about families in extremis because we are talking about the sickest child. One parent said that his wife was left in a life-threatening state after the birth of the baby and that, had the new model been in place, he would have been left with an invidious choice, with his wife and child being not at the same hospital but potentially one being in Aberdeen and one being in the local hospital. There are also siblings in the family. In listening to those people talk about the family-centred care package, I noticed that those other responsibilities do not seem to necessarily be accommodated within the thinking of those who are offering support.

Does yet more work need to be done on what is provided within family-centred care? Clearly, it might be that accommodation and travel costs are covered but parents may have other children and there could be a need to provide emergency childcare to support that family in those circumstances. That does not seem to be part of the package at the moment. I think that when parents said that they did not feel supported enough, they felt that although there are provisions to meet some of the emergency financial pressures that they were faced with, there is not the comprehensive level of support that they felt would be helpful. In the conversations with parent groups, has that all been teased out? Could the provision be made as easy as possible to access in such circumstances for families in extremis—and in an unplanned way, obviously, rather than a planned situation where people can anticipate that they might be going to be in a hospital further away from where they might have expected?

Jenni Minto: That is a fair point. I understand that the majority of boards allow siblings to stay on site with their parents. I recognise what you are describing. I cannot imagine what it would be like to be in that situation. I reflect on the nursing staff, the clinicians and the people that work for the YPFF who I have met and recognise how caring they are. Where possible, they will want to support families in these difficult, traumatic circumstances.

The Convener: I make the point.

Jenni Minto: You make the point.

The Convener: You referred to the phasing that has already taken place. What have been the outcomes of that? What has been the success rate in terms of mortality?

Jenni Minto: I cannot comment on mortality, but perhaps Kirstie Campbell can give more information.

Kirstie Campbell: When we introduced the phasing, our expectation was that we were testing the implementation of the model but we always knew, and we discussed this around the table in the perinatal sub-group, that we would not really be able, within that phasing process, to test the impact on outcomes because the number of these babies is very small, as you can imagine. They are very, very sick babies, the sickest babies in Scotland. Our expectation and what we have been building towards is that the evaluation process will need to take place over a much longer time period. To have a realistic assessment of the impact of the changes on these babies in terms of mortality, morbidity and other outcomes, such as their long-term developmental outcomes, we need a much longer process. We are looking at putting in place a full study that will analyse over a period of about 10 years how the changes impact the children.

The Convener: In essence, we have confidence in the model that we are pursuing and

it is underwritten by the clinicians and others who have been involved in the design, the development and the recommendations that are being implemented, but it will be some time before we can absolutely determine that the decisions that were made were in fact the correct ones.

Kirstie Campbell: Absolutely. From the evidence that the best start decision was based on, it is clear that the expectation is that these babies will have improved outcomes, but because the numbers are so small it will take us a long time to be able to properly evidence the change.

Jenni Minto: I think that the committee heard evidence from Stephen Wardle last week about the change in the model in England and the improvements in outcomes there.

The Convener: I accept that that was the case.

I think that we are getting to the end of this element but I want to allow you to reflect on one thing. I think that you touched on all the people in the group that made the decisions being there for their professional experience and judgment, rather than as representatives of their hospitals. When that final decision was made, however, there was a residual feeling in one or two of the other units that they potentially were not represented. In your own mind, have you discounted any sense of bias?

Jenni Minto: Yes.

The Convener: Fine. That is all that you need to say.

Clare Adamson (Motherwell and Wishaw) (SNP): I have just a couple of questions. As the convener said at the start, there has been a level of misinformation and I see the impact of that almost every day in speaking to constituents. We talked about service levels going from level 3 to level 2. Is Glasgow level 3 at the moment?

Kirstie Campbell: There are three units in greater Glasgow: the Queen Elizabeth university hospital, the Princess Royal maternity and the Royal Alexandra hospital in Paisley. The Queen Elizabeth university hospital and the Princess Royal maternity are both what we used to call level 3 units and will be neonatal intensive care units under the new language. The Royal Alexandra hospital in Paisley is already a local neonatal unit.

Clare Adamson: I was getting to the question. We talked about downgrading, but is this not a realignment? As a local representative in Wishaw, I know that babies have to travel to Glasgow at the moment for co-located services, such as neonatal surgery. The experts told us last week that that was valid not just for neonatal surgery but also for paediatric pharmacy and anaesthesia and all those other expert areas that just do not exist at Wishaw at the moment. Is it appropriate to still be using level 2 and level 3 terminology? Should we be moving to a different terminology in the new model?

Kirstie Campbell: We want to align neonatal care in Scotland with the terminologies used across the UK, which is around neonatal intensive care units. The expectation is that there will be three of those. Currently, we have six neonatal units. There will be three neonatal intensive care units in Scotland.

I recognise that the terminology of “local neonatal units” is not entirely descriptive of what those units will do because they will provide intensive care for babies for up to 48 hours. Then we have the special care baby units, which are the level 1 units, and they provide care for babies at a higher gestational age.

Clare Adamson: I have a final comment for the committee. We have talked about the impact of neonatal care on families. Some of the employment law on where maternity leave legally kicks in should be looked at. I know that there is a fund for neonatal care but these disadvantaged children face immense challenges right from the start, as do their families, and I think that there should be some provision for more support from employers between the date of birth and what would have been the normal birth week. It is not only about the initial costs for families.

The Convener: Thank you for that. Consideration of areas of deprivation was part of the discussion that we had last week as well.

Minister, is there anything that you or your colleagues would like to add? I think that we have covered all of the ground that was of central concern to the committee.

Jenni Minto: I would like to reiterate my thanks for the work that the committee has done in this area. Clearly, it is a very emotional area of healthcare and one that we really want to get right, so the questions that you have prompted in your evidence gathering have ensured that we have that covered in the work that we have been doing with the task and finish group and we are very appreciative of that.

The Convener: My final comment and reflection is that the petition is here because there are still people out there who are unconvinced and they can only be so because, for whatever reason, they have not understood the issues or they have raised concerns which may yet hopefully be accommodated or addressed. Communication is always very important in these matters and maybe work still needs to be done to offer the reassurance that people would want in advance of finding themselves in this situation.

Jenni Minto: Convener, I could not agree more with that final comment. I think that communication is incredibly important. The task and finish group is being clear about communicating within their sphere of influence, but I absolutely take that on board and think that it is a very fair point well made.

The Convener: Minister, thank you once again to you and your officials for engaging with us so constructively. We very much appreciate that.

10:30

Meeting suspended.

10:32

On resuming—

Patients with Autonomic Dysfunction (Specialist Services) (PE1952)

Insulin Pumps (PE2031)

People with Hypermobile Ehlers-Danlos Syndrome and Hypermobility Spectrum Disorders (PE2038)

Li-Fraumeni Syndrome (Screening) (PE2080)

Covid-19 Vaccinations (PE2086)

The Convener: Welcome back. We move to the consideration of other open petitions. Given that there are only a handful of meetings of the committee left, it is terribly important to say that, irrespective of the merits of many petitions, the committee will have no option but to close them before this session of the Scottish Parliament comes to an end with the final sitting of Parliament in March. Therefore, although there are a number of very important petitions on which the committee believes that there is still work to be done, the petitioners' interests may well be best served by the lodging of a fresh petition to the Parliament when it meets in its new session in May next year.

We may hold over a very small number of petitions in the legacy document that we pass on to our successor committee in the next session. In the committee's last meetings before the dissolution of the Parliament, we may feel that there is little that we can do to advance the aims of a petition, given the very limited time still open to us, but that is no reflection on its merits.

Our consideration of the sequence of petitions under this item follows on from our evidence session with the Cabinet Secretary for Health and Social Care on 24 September, at which we explored a number of themes: patient experience, diagnostic and treatment pathways, capacity skills and training, sustainability of funding and health service infrastructure, and post-Covid-19 impacts and responses. After the evidence session, the Cabinet Secretary for Health and Social Care followed up in writing on a number of the outstanding issues.

This morning, we will consider the petitions that sit under the theme of diagnostic and treatment pathways, and then we will consider a petition on the theme of sustainability of funding and health service infrastructure. The committee has explored the specific issues raised in the petitions by seeking written evidence from stakeholders and ministers. The thematic issues have also been explored in our recent oral evidence session with the Cabinet Secretary for Health and Social Care.

During the thematic evidence session, we raised that a number of the petitions have highlighted issues with diagnostic and treatment pathways, particularly in relation to conditions that may not be easily understood or easily diagnosed. The cabinet secretary stated that a balance needs to be struck, as decisions about pathways might need to take place at a national level while at other times it will be for local boards to determine how best to deliver services. I will provide an overview of the evidence received on each petition since it was last considered, and we will then move to consider what action should be taken on the petitions.

We have been joined by our colleague Edward Mountain, who has an interest in the petitions in this group. I will be able to invite only very brief comments, given the volume of business that we have before us this morning.

PE1952, which was lodged by Jane Clarke, calls on the Parliament to urge the Scottish Government to instruct Scotland's NHS to form specialist services, training resources and a clinical pathway for the diagnosis and treatment of patients exhibiting symptoms of autonomic nervous system dysfunction—dysautonomia. We last considered the petition on 11 December, when we agreed to write to the Minister for Public Health and Women's Health, from whom we have just heard.

The minister's response reiterates that autonomic disorders are part of the neurology speciality training curriculum, and it is within the remit of neurologists to diagnose and manage symptoms as part of their routine practice in the majority of cases. The submission also highlights the training resources on autonomic nervous system dysfunction that are available for our practitioners on the NHS learning platform. The petitioner and Dr Lesley Kavi have provided a joint submission, which states that PoTS UK is not

aware of any neurology specialists in Scotland who manage postural tachycardia syndrome and related conditions.

The submission highlights a 2025 survey of people with suspected and diagnosed autonomic dysfunction, which revealed that 90 per cent of patients experienced difficulty accessing NHS healthcare, and 59 per cent reported that their GP had not heard of PoTS or did not believe that it existed.

PE2031, lodged by Maria Aitken on behalf of the Caithness Health Action Team, calls on the Scottish Parliament to urge the Scottish Government to ensure that children and young people in Scotland who have type 1 diabetes and would benefit from a life-saving insulin pump are provided with one, no matter where they live.

We last considered the petition on 29 May 2024, when we agreed to write to the Scottish Government and NHS Highland. In his correspondence following the evidence session, the Cabinet Secretary for Health and Social Care highlighted significant progress made since the petition was lodged. In 2024, the Government committed £8.8 million to expand access to closed-loop systems—CLS—partly to ensure that all children and young people living with type 1 diabetes in Scotland could access CLS. By early this year, approximately 75 per cent of the under-18s affected had CLS access. The Cabinet Secretary for Health and Social Care reiterated that NHS boards are expected to offer hybrid closed-loop systems to all eligible under-18s within a year of referral. He also points to specific targeted funding for NHS Highland to support access to diabetes technology, including for insulin pumps.

Mr Mountain has an interest in the petition. Is there anything that you would like to contribute, Mr Mountain?

Edward Mountain (Highlands and Islands) (Con): Very briefly, convener, if I may. First, I thank the committee for all the work that it has done on the petition. It is without doubt due to the fact that the committee got involved in the petition that we are in the situation that we are in now. I appreciate the extra money that the Government has put forward and that the committee's scrutiny has driven NHS Highland to make sure that all affected children, bar a small few—most of whom do not want insulin pumps—have got insulin pumps. I think that this is a victory for the committee, and I thank you and your team for doing that. I fully understand why you would now close the petition, convener.

The Convener: Thank you very much, Mr Mountain. It is encouraging to hear about the progress that has been made during the period in which we have been considering the petition.

PE2038, lodged by Ehlers-Danlos Support UK, calls on the Parliament to urge the Scottish Government to commission suitable NHS services for those with hypermobile Ehlers-Danlos Syndrome and hypermobility spectrum disorders, and to consult patients on their design and delivery. We last considered the petition on 9 October 2024, when we agreed to write to the Scottish Government and NHS Wales.

The Scottish Government's response to the committee highlights NHS Education for Scotland's awareness-raising videos, which encourage healthcare professionals to "think rare" when people present to them. Work has been under way to consider other resources to improve diagnosis, including a suite of digital tools that enable convenient and quick decision making. The response also points to assessment and referral guidance for hypermobile Ehlers-Danlos syndrome that was developed by NHS Dumfries and Galloway last year.

The response from NHS Wales outlines its work to create an international pathway, which will offer a number of supports, including advice on diagnosis and treatment for primary care clinicians, direct access to therapy services for primary and community care rehab and supported self-management interventions, and clear referral guidance for those with the rarer forms of EDS that require genetic testing and speciality involvement. The Scottish Government has confirmed that it will speak to its Welsh counterparts about the project plan for Ehlers-Danlos syndrome and consider whether it would be feasible for a similar exercise to be taken forward in Scotland. The petitioner has provided a written submission that reiterates her view that EDS is not actually a rare condition, with studies suggesting a prevalence of about 1 in 227 and 1 in 500.

The submission also sets out a number of questions for the Scottish Government.

PE2080, which was lodged by Louise McKendrick, calls on the Scottish Parliament to urge the Scottish Government to implement screening for people with Li-Fraumeni syndrome in line with the guidelines recommended by the UK Cancer Genetics Group.

We last considered the petition on 15 May 2024, when we agreed to write to Cancer Research UK, the Scottish Government and NHS Scotland genetic laboratories in Aberdeen, Dundee, Edinburgh and Glasgow. The Scottish hereditary cancer genetics group states that NHS Grampian, NHS Tayside, NHS Lothian and NHS Fife are all offering surveillance for patients with Li-Fraumeni

syndrome, in line with the guidelines published by the UK Cancer Genetics Group in 2020. However, the SHCGG considers that there is a gap in the Scotland-wide process for managing patients.

In its submission, Cancer Research UK encourages the Scottish Government to strengthen its links with the research community in this area, as well as to engage in further dialogue from the UK National Screening Committee. The NSC has not made any recommendations about targeted surveillance or screening programmes for those with Li-Fraumeni syndrome.

PE2086, which was lodged by William Queen, calls on the Scottish Parliament to urge the Scottish Government to acknowledge those who are injured by Covid-19 vaccines and to have the NHS offer appropriate treatment to them. We last considered the petition on 5 March this year, when we agreed to write to the Cabinet Secretary for Health and Social Care and NHS Scotland.

The Scottish Government's response to the petition reiterates that, in many cases, it may be difficult for a clinician to explicitly determine whether an illness or condition is linked to vaccination, and that it understands how that lack of acknowledgement may be deeply frustrating for citizens. The submission reiterates that, if a patient has been vaccine injured and is experiencing a particular condition or symptom as a result, the NHS should treat them for that condition, as it would any other patient who displayed those symptoms, regardless of the cause. The petitioner's most recent submission highlights differences in the national response to long Covid and vaccine injury. He states that resources have been given to address long Covid, whereas people with vaccine injury feel ignored.

As I set out in my opening remarks, we are now limited in the time remaining in this parliamentary session. I feel that we have made as much progress as we can with the petitions. For one or two of them, the petitioners may want to see the realisation of promises that have been made, and fresh petitions may well emerge in the Parliament's new session.

Mr Torrance, do you have any recommendation for the committee?

David Torrance: I wonder whether the committee would consider closing petitions PE1952, PE2031, PE2038, PE2080 and PE2086 under rule 15.7 of the standing orders, on the basis that the committee has progressed the issues raised in the individual petitions as far as possible in this parliamentary session and that the committee has raised relevant issues as part of a thematic evidence session for the Cabinet Secretary for Health and Social Care.

The Convener: Thank you. Does the committee agree to that suggestion?

Members *indicated agreement.*

General Practice Building Projects (PE2125)

The Convener: We now move to a healthcare petition that sits under the theme of sustainability of funding and health service infrastructure. PE2125, on ending the pause on new NHS building projects and prioritising capital funding for primary care buildings, has been lodged by Victoria Shotton, and it calls on the Scottish Parliament to urge the Scottish Government to restart overdue work on NHS Scotland buildings and prioritise funding for primary care building projects, to ensure that community health teams have the physical spaces and renovations required to treat their patients sufficiently and safely.

We last considered the petition on 19 February, when we agreed to write to the Cabinet Secretary for Health and Social Care. His response was that work to develop a whole-system NHS infrastructure plan was being progressed in two key stages, the first of which was focusing on short-term priorities that were already in progress and the other on longer-term investment priorities across the health estate.

In our evidence session with him, the cabinet secretary stated that, although the short-term plans were set out and voted on by Parliament as part of the budget process, the long-term capital position was under review as part of the infrastructure investment plan, which the Government expects to bring forward as part of the budget and spending review process.

Patrick Harvie initially indicated his wish to come and speak to this petition today, but I am grateful for his understanding in view of the responses that we have received. Do colleagues have any suggestions as to how we might proceed?

David Torrance: I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders, on the basis that the committee has progressed the issue raised in the individual petition as far as possible in this parliamentary session and that the committee has raised relevant issues in its thematic evidence-taking session with the Cabinet Secretary for Health and Social Care.

The Convener: Do we agree with Mr Torrance's recommendation?

Members *indicated agreement.*

The Convener: We will therefore close the petition, but again, progress will become apparent in the next parliamentary session.

Rape Charges and Convictions (Record of Sex) (PE1876)

The Convener: PE1876, which was lodged by Lucy Hunter Blackburn, Lisa Mackenzie and Kath Murray, calls on the Scottish Parliament to urge the Scottish Government to require Police Scotland, the Crown Office and the Scottish Courts and Tribunals Service to accurately record the sex of people charged and convicted of rape or attempted rape.

We are joined this morning by our MSP colleagues Tess White and Carol Mochan—good morning, both. I remind colleagues that the Scottish Government's previously stated position is that the ask of the petition is an operational matter for the relevant bodies and that the Crown Office and Procurator Fiscal Service and the SCTS have indicated that they are operating with data received from reporting agencies, including Police Scotland.

Chief Constable Jo Farrell answered the committee's questions on this matter in an evidence session on 12 November, when she unequivocally stated that Police Scotland supports the petition and that a man who commits rape or attempted rape should be—and will be—recorded by Police Scotland as a male. Although the chief constable agreed that, at times, Police Scotland messages have been mixed, she clarified that Police Scotland has been recording the biological sex in relation to rape and sexual offences, and that that can be demonstrated in all 16,000-plus relevant offences recorded since 2018.

We also heard that Police Scotland is actively undertaking a broader review of the terminology and recording practices that it uses to collect and record sex and gender data in order to recommend improvements, and that review is informed by developments in law and statutory guidance, human rights advice and on-going engagement with stakeholders. The chief constable expects a substantial update on this work to be provided through the Scottish Police Authority next year.

Additionally, in mid-October, Police Scotland decided to extend the recording of a person's biological sex and, where relevant, their transgender status to suspects and victims of all crimes and offences. The chief constable indicated that Police Scotland will implement that at pace across all relevant data systems, starting with nine priority systems, which include custody, criminal justice cases, intelligence and crime recording.

In an additional submission, the petitioners expressed their satisfaction with Police Scotland's position toward the petition. They also ask that the committee now writes to Crown Office and Procurator Fiscal Service and the Scottish Courts and Tribunals Service to seek confirmation that they will follow Police Scotland's lead and not retrospectively alter any record of a person's sex, and also to seek similar reassurance from the Scottish Prison Service, although it should be noted that that would go beyond the scope of the petition itself.

Before I invite suggestions from colleagues, I ask Tess White and Carol Mochan whether they would like to make a contribution. I must ask that they do so briefly, given the time pressures that I am afraid that we now have.

Tess White (North East Scotland) (Con): Thank you, convener, and thanks to the committee for its work on this petition. We welcome the commitment from Jo Farrell and Police Scotland, and it is also good to hear that a key loose end will now be closed and that the committee will be writing to the courts.

I want to say two things, if I may. First, will the letter to the courts be sent before the end of the year, convener? Secondly, I note that, for completeness, Murray Blackburn Mackenzie has formally asked the committee to obtain the same assurance from the Scottish Prison Service.

The Convener: Actually, we have not taken a decision to send a letter yet—it is the petitioners who have recommended that we might consider doing so. You have rather jumped the gun, but who knows? We might be minded to do it.

I call Carol Mochan.

Carol Mochan (South Scotland) (Lab): I thank the committee for allowing me to say a few words.

I fully support the petition, convener, and I want to reiterate what you and Tess White have said about the police decision. It is very welcome.

However, I believe that the committee could look at some relatively simple and straightforward issues in order to complete all this work, and I therefore urge it to write to the Crown Office, the Scottish Courts and Tribunals Service and the Scottish Prison Service to seek similar assurances to those from Police Scotland that we have heard about today. That would complete what we are trying to do in accurately collecting this data, which is essential to maintaining public trust, to monitoring and to research and public policy in this area.

The Convener: I was going to suggest that, under rule 15.7 of standing orders, we close the petition on the basis that Police Scotland has stated that it has been recording the biological sex

of suspects in rape and sexual offences, that it will continue to do so and that it has decided to expand this approach to all crimes. The COPFS and SCTS operate with data received from reporting agencies, including Police Scotland, and the Scottish Government's position is that the issue raised in the petition is an operational matter for the relevant bodies.

However, in closing the petition, I am quite happy to propose that the committee write to the COPFS, the SCTS and the Scottish Prison Service to seek their assurance that they will be implementing the recommendations outlined by the chief constable. We will follow that suggestion from the petitioners, but do so as part of the process of closing the petition.

Tess White: I was brief before, convener, and I would just like to say thank you now.

The Convener: That is fine. Are colleagues content to proceed on that basis?

Members *indicated agreement.*

The Convener: We will do so.

Drink Spiking (Support for Victims) (PE1995)

The Convener: Moving on to PE1995, I must first of all offer an apology. I regret to say that there are two petitions that have rather slipped under the radar.

The first is this important petition, which was lodged by Catherine Anne McKay, on improving support for victims of spiking. The petition, which we heard about at a previous meeting, calls on the Scottish Parliament to urge the Scottish Government to develop a multi-agency approach to the investigation of spiking incidents to ensure that victims are given access to appropriate testing and incidents are investigated robustly.

Rather unusually, the committee has not considered this petition since 6 December 2023, when we agreed to write to the Scottish Government and Police Scotland. Police Scotland has since confirmed that it monitors all occurrences of spiking and the progress of relevant investigations, including forensic ones. Current data allows Police Scotland to identify whether forensic samples have been obtained, refused or not obtained for other reasons, and it also allows for comparative analysis of reported incidents, recorded crimes and the number of forensic samples submitted.

The response also points to Police Scotland's investigative strategy, which provides guidance and direction to all staff who respond to or investigate spiking. Additionally, senior investigating officers are appointed within each territorial police division to act as divisional single points of contact for all spiking-related matters.

From the Scottish Government's very recent update, we understand that the Minister for Victims and Community Safety has continued to chair regular multi-agency round tables on spiking, most recently just last month, not just with partners in policing, health, victims organisations and prosecution, but with representatives of colleges and universities, community safety organisations and the night-time economy sector. The Government highlights that there is now a consistent national approach that has been designed to ensure that individuals who present to accident and emergency departments receive clear advice regarding the roles of health professionals and the police when they report incidents of spiking.

Additionally, since October, the NHS digital system has been allowing for the recording of those who present to A and E as potential victims of spiking, with the aim of improving understanding of the extent to which such incidents also lead to formal police reporting. The Scottish Government highlights that although proposals relevant to spiking are included in the United Kingdom Government's Crime and Policing Bill, existing legislation in Scotland already enables the police and prosecutors to tackle perpetrators of the crime effectively.

I think that an awful lot of work has taken place since 2023 to directly address the issues raised in the petition, but do colleagues have any suggestions for action?

Davy Russell: I suggest that we close the petition under rule 15.7 of standing orders on the basis that the Scottish Government has been actively undertaking work to address the issues at the core of the petition, including having regular multi-agency engagement and making improvements in reporting and data gathering.

The Convener: Are colleagues content with that suggestion?

Members *indicated agreement.*

The Convener: Progress has been made. Indeed, it seems like quite a successful outcome for the petition, notwithstanding the fact that it has been some time since we were last able to consider it.

Chronic Kidney Disease (PE2081)

The Convener: PE2081, which was lodged by Professor Jeremy Hughes on behalf of Kidney Research UK in Scotland, calls on the Scottish Government to make chronic kidney disease a key clinical priority. We last considered the petition on 7 May 2025, when we agreed to write to the

Cabinet Secretary for Health and Social Care. We then heard from the Minister for Public Health and Women's Health, who reiterated that the Scottish Government does not designate certain conditions as key clinical priorities. The minister explained that, although there is a long-term conditions policy unit in the directorate general for health and social care, it works on the implementation of specific policies and does not cover all major conditions. A separate unit, the long-term conditions strategy unit, is leading on the Scottish Government consultation for the new long-term conditions framework.

During a chamber debate in September, the minister suggested that work on developing the framework was very much in progress, with the governance arrangements due to be finalised. The consultation analysis has also been published. The minister encouraged continuing engagement from relevant organisations, highlighting its importance to the way in which the Government would develop the framework in order to improve services for people with long-term conditions, including chronic kidney disease prevention, diagnosis and care.

In an additional submission, the petitioner reiterates his concern that there is still no named national clinical lead for chronic kidney disease and no dedicated civil service team member responsible for driving forward improvements.

Do members have any comments or suggestions for action?

David Torrance: In light of the evidence that has been given to the committee, would the committee consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government has reiterated that it does not designate certain conditions as key clinical priorities, is in the process of developing a long-term conditions framework and has an associated action plan that is designed to improve services for people with long-term conditions, including CKD?

The Convener: Are colleagues content with the recommendation?

Members *indicated agreement.*

The Convener: We are. We thank the petitioner again for raising the issues, but the Scottish Government position is quite clear.

Rape and Sexual Assault (Minimum Sentences) (PE2102)

The Convener: PE2102, which was lodged by Anna-Cristina Seaver, calls on the Scottish Government to require anyone who is found guilty of rape or sexual assault to be registered as a sex offender. The petition calls on the Scottish Parliament to urge the Scottish Government to abolish the option of an absolute discharge in cases where the accused is found guilty of rape or sexual assault and to introduce a statutory minimum sentence for those offences, which includes the convicted person being registered as a sex offender.

We last considered the petition on 7 May 2025, when we agreed to write to the Scottish Sentencing Council, the Cabinet Secretary for Justice and Home Affairs and the Lord Advocate. The cabinet secretary's response notes that sentencing judges will be aware that a consequence of an absolute discharge is that the offender will not be subject to notification requirements and that that is a factor that they will consider. The submission notes that courts have the option to admonish rather than absolutely discharge where they consider that no punishment is warranted, but the crime should be recorded and the offender should be made subject to notification requirements. The secretary also notes that the COPFS has the power to appeal against an absolute discharge if it considers that it is unduly lenient.

The Scottish Sentencing Council's response highlights an instance where the Crown did appeal an absolute discharge. The Scottish Sentencing Council's response highlights the development of sentencing guidelines for the courts on certain sexual offences, including rape and sexual assault. The draft guidelines make no provision for an absolute discharge as a disposal within the proposed sentencing ranges for either offence. Accordingly, any court that wished to impose one would be taking a decision not to follow a guideline and, under the relevant legislation, would be required to state its reasons for that decision.

The Lord Advocate's response reiterates points that were made by the cabinet secretary and Scottish Sentencing Council. The submission also sets out details of relevant cases. I should note that people may find some details in the submission distressing.

Do members have any comments or suggestions for action?

11:00

Davy Russell: I suggest closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government does not have any current plans to adjust the powers of the courts to impose absolute discharges in criminal cases. Also, if it is considered that the offence should not be punished but that the crime should be recorded and the offender should be made subject to notification requirements, courts have the option to admonish rather than absolutely discharge. The draft guidelines on the sentencing of rape include

a minimum custodial sentence of four years and make no provision for absolute discharge as a disposal within the proposed sentencing ranges for rape or sexual assault. This means that a court imposing an absolute discharge would be taking a decision not to follow a guideline and would have to state its reasons for that decision. The Crown can appeal sentences of absolute discharge if it is considered to be potentially unduly lenient.

The Convener: Thank you for that reflection on the various responses that were received in respect of this petition. Are colleagues content with the recommendation, as put to the committee?

Members *indicated agreement.*

Compulsory Microchipping for Cats (PE2145)

The Convener: Our next petition is PE2145, lodged by Jillian Brown, which calls on the Scottish Government to bring in compulsory microchipping for cats and kittens in Scotland. We last considered the petition on 21 May 2025, when we agreed to write to the Scottish Government. The Scottish Government's response to the committee states that, although it recognises the level of feeling that is associated with this subject, there are no plans at this time to introduce legislation to make the microchipping and registration of cats compulsory in Scotland. The Scottish Government notes that it is considering the recommendations that have been made by the Scottish Animal Welfare Commission in its report concerning the responsible ownership and care of cats.

Do members have any comments or suggestions for action?

Maurice Golden (North East Scotland) (Con): Microchipping needs to be a wider holistic approach. It is not just about initially microchipping a cat; it is about ensuring that details are kept up to date and indeed that there is a single database that vets or other individuals can check, which we currently do not have. Given that the Scottish Government is considering recommendations, as the convener highlighted, I would hope that those are dealt with in the round and, ultimately, therefore, I believe that the committee should close the petition under rule 15.7 of standing orders.

The Convener: In a more rounded way, it might be that, if we accept the recommendation, a fresh petition could come in the next parliamentary session addressing those broader concerns that both the Government and you have identified. Are we content to close the petition on the basis of the recommendation made to us by Mr Golden?

Members *indicated agreement.*

Women-only Homeless Accommodation (PE2147)

The Convener: Our next petition is PE2147, lodged by Laura Jones on behalf of the Scottish Tenants Organisation, which calls on the Scottish Government to create more women-only homeless accommodation that protects and meets the specific needs of women. The petition calls on the Scottish Parliament to urge the Scottish Government to reform homeless services in Scotland and to ensure that services protect women from sexual assault and exploitation by increasing funding and supporting the creation of more women-only homeless accommodation.

We last considered the petition on 7 May 2025, when we agreed to write to the Scottish Government. The Scottish Government explained that its delivering equally safe fund supports a signposting service for appropriate women-only services, as well as advocacy to women's aid and other organisations tackling domestic abuse. That includes providing advice and support to prevent women from becoming homeless in the first place. The response also indicates that the 2025-26 budget provides local government with a real-terms funding increase of 5.5 per cent. The Government reiterates its position of allowing local authorities to manage their own budgets and allocate funds based on local needs and priorities, including on women-only homelessness services.

Additionally, the Government states that it targeted 80 per cent of its capital funding for voids and acquisitions over 2024-25 and 2025-26 to areas with the most sustained temporary accommodation pressures. The aim is to increase the supply of social and affordable homes through acquisitions and, if appropriate, to bring long-term empty social homes back into use. The Government's view is that that policy should reduce long periods in temporary accommodation, especially for families with children.

Do colleagues have suggestions for action?

David Torrance: I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government has stated that it has increased funding to local authorities, including for 2025-26; that it is the responsibility of individual local authorities to allocate financial resources on the basis of local needs and priorities, including for women-only homelessness services; and that the Scottish Government has provided some targeted funding to areas with sustained pressures in order to reduce long periods in temporary accommodation.

The Convener: Thank you, Mr Torrance. Are colleagues content with that action?

Members *indicated agreement.*

New Petitions

11:06

The Convener: Agenda item 3 is the consideration of new petitions. Before we consider new petitions, I always say to those who might be following our proceedings that, before we consider a petition, we ask the Scottish Parliament's independent research body, the Scottish Parliament information centre, to do some detailed work advising us on the issues underpinning the petition and also seek a preliminary view from the Scottish Government. However, as I said at the start of today's meeting, I am afraid that we are now considering the very last of the new petitions submitted to us with very little time left in this session, if any, to do justice to any of these petitions. We have barely a handful of meetings left, and it may well be that the interests of the petitioners will be best served by the petitions being freshly submitted to the new Parliament in May.

I will upset the order because I recognise that Mr Mountain, who joined us for an earlier petition, is still with us. I will move first to the one that I know he has an interest in, so that he can pursue the very many busy aspects of his day yet ahead, and to acknowledge, of course, that he will not be with us in the next session to advocate on behalf of the issues that are raised in the petition. This is his moment so to do.

Personal Footcare Guidance (Rural and Remote Areas) (PE2186)

The Convener: The first new petition is PE2186, which has been lodged by Maria Aitken on behalf of the Caithness Health Action Team, from whom we heard on another petition that we considered earlier this morning. This petition calls on the Scottish Parliament to urge the Scottish Government to review the personal footcare guidance to ensure equity of access to toenail cutting services in rural and remote areas of Scotland. It says that everyone should have access to healthcare, including footcare services, no matter where they live, and that to deny people access leaves them vulnerable to infection, less mobile and more at risk of falling, particularly elderly people, which is very often overlooked and underappreciated. It suggests that the personal footcare guidance fails to consider mitigations to ensure equity of access to toenail cutting services.

The Scottish Government makes clear in its response that it has no intention of reviewing the guidance, which was refreshed in March this year. In its submission, the Scottish Government highlights relevant legislation and a host of national policy frameworks and strategies that it

considers underpin the current guidance, and notes that it is for individual health boards to take decisions on service delivery, tailored to local populations' needs and priorities.

Edward Mountain, would you like to say a few words in relation to the petition?

Edward Mountain: Thank you, convener. I will start off by paying tribute to Caithness Health Action Team for all the work that it does, in particular Maria Aitken. She has been a petitioner of this Parliament over the entire period of this session. The petition came about as a result of the removal of services in Caithness, which meant that anyone wanting footcare treatment would have to travel to Raigmore, which is beyond the capabilities of most. I fully understand the pressures that the committee is under. I am working hard with the local health board to try to get the service reinstated. On that basis, I doubt that we will get much further action on this petition before the end of this session.

Reluctantly, I would probably agree that it is appropriate for the committee to close the petition, on the understanding that the Caithness Health Action team can bring this back in the next parliamentary sessions if it finds that the health board is not prepared to look after the many people who need help, mainly because they are diabetic and cannot do this themselves or there is a risk if they do it themselves. Reluctantly, convener, I will fall on my sword in what is my last meeting and say that I am happy for you to close the petition.

The Convener: It is very generous of you to anticipate our actions, Mr Mountain.

Can I therefore propose two actions? First, I propose that we close the petition under rule 15.7 of standing orders on the basis that the Scottish Government does not intend to review the guidance, as it was refreshed in March 2025 and is underpinned by a wide range of national policy frameworks that promote equitable access to personal care, including footcare, and notes that decisions about service delivery are made at a local level by individual NHS boards. However, in closing the petition and noting that point, I propose that we write to the relevant health board expressing the concern that the committee has heard about the distances that are now required for people in Caithness to travel, as they now have to go to Raigmore for this service, which is beyond the capability of many involved. We will say that, although the committee was unable to do more in this session of Parliament, it anticipates that the petition might re-emerge and it would therefore be helpful if NHS Highland considered these matters in advance of and in anticipation of that fact. Are colleagues content with us to proceed on that basis?

Members *indicated agreement.*

Council Tax (Debt Collection) (PE2174)

The Convener: PE2174, which has been lodged by Marianne Duncan, calls on the Scottish Parliament to urge the Scottish Government to abolish enforcement of council tax debts.

The Scottish Government's response to the petition states that councils have powers to write off arrears where appropriate, and that that is a decision for councils to take locally. It also states that the Scottish Government is aware of concerns around the use of enforcement measures and, through on-going engagement with the Convention of Scottish Local Authorities, continues to encourage local authorities to adopt proportionate and empathetic approaches, particularly where individuals are experiencing hardship. I would have thought that appropriate where individuals are experiencing hardship, but in other circumstances I would hope that they would pursue the debt, frankly.

The Scottish Government provided an extra £2.2 million in funding for a Citizens Advice Scotland project that supports people with council tax debt. The response also notes that the Government is aware of concerns regarding local authority practices in issuing final demand notices and that it is working with COSLA to promote consistency and best practice in debt recovery procedures. The Scottish Government states that it is open to considering related issues, including the prescription period for council tax debt, and has committed to consulting on this matter in due course, should it be in a position to do so.

The petitioner has provided a written submission that asserts that the cost of living crisis has left many people choosing between food or fuel before paying council tax. The petitioner believes that the harsh enforcement regime of debt collection can take much-needed money away from people through wage arrestment, bank arrestment or benefit deductions. She claims that that is forcing people into a perpetual cycle of debt and poverty. The submission states that a lack of impartial scrutiny and monitoring of the administration of council tax leads to inconsistencies, inequalities, undetected errors, abuse of authority, abuse of process, fraud and a lack of accountability.

Do members have any comments or suggestions for action?

David Torrance: In light of the evidence before us, would the committee consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government is currently undertaking work with COSLA and the Institute for Fiscal Studies that will inform potential council tax reform proposals in the next parliamentary

session? In doing so, we can highlight to the petitioner that the consultation is open until 30 January 2026 and suggest that she can submit a new petition in the next parliamentary session.

The Convener: Yes, I think that makes sense. There is a consultation. We would very much encourage the petitioner to participate in that, but were it to fall short of her expectations, a fresh petition could be submitted in the next parliamentary session. Are we content with that?

Members *indicated agreement.*

Business Improvement Districts (Veto Powers) (PE2179)

11:15

The Convener: PE2179, which has been lodged by Gavin Templeton, calls on the Scottish Government to strengthen veto powers when assessing business improvement district proposals. This is the first of two BID-related petitions that we will consider today. It calls on the Scottish Parliament to urge the Scottish Government to require local authorities to veto proposals for business improvement districts if the levy due to be paid by businesses is not proportional to the rateable value of properties and to introduce a duty on Scottish ministers to take such levy proportionality into account in any decisions regarding BID proposals.

A business improvement district is a formal partnership of businesses and other organisations that works together to improve a defined area, often a town centre or a shopping area within a city. The Scottish Parliament information centre briefing explains that a proposal for a BID has to set out the levy to be paid by individual businesses before a vote takes place to establish the BID formally. All businesses located in the area are balloted and a majority of businesses, by both number and rateable value, are required to vote in favour of a BID before it can progress. A local authority can veto a BID under certain circumstances, including if it considers that the levy will lead to a significantly disproportionate financial burden being imposed on any person or business entitled to vote in the ballot.

The petitioner asks that the ability for local authorities to veto a BID proposal should become a requirement in the above circumstances. In additional submissions, both the petitioner and the campaign group Unfair Nae Mair express a number of concerns, supported by examples, regarding the impact of existing legislation on small businesses and the lack of a mechanism for local authorities to assess BID proposals fairly and consistently.

Our SPICe researchers asked Scotland's Towns Partnership whether any local authority had ever vetoed a BID proposal. The response was that STP was not aware of any such instances.

The Scottish Government submission reiterates that existing legislation enables veto powers for local authorities, but it does not address the petition's ask for that power to be made a requirement. The Government states that there are no plans to review or amend existing BID legislation during this parliamentary session, given the potential cost and resource implications of such work. The Scottish Government does not see a benefit to introducing a duty on Scottish ministers to take levy proportionality into account in decisions regarding BID proposals. The Government's view is that the management and governance of a BID are matters for the BID itself. It also states that local authorities have better knowledge and intelligence of the local context and that involving Scottish ministers would add a further level of bureaucracy and complication—that point inevitably being true. Are there any comments or suggestions for action?

Maurice Golden: I think that the committee should close the petition under rule 15.7 of standing orders on the basis that current BID legislation contains a dual-key mechanism to help protect against large firms forcing through a BID proposal against the wishes of small firms or vice versa. The Scottish Government's position is that the regulatory role in relation to BIDs should be for local authorities and not Scottish ministers. The Scottish Government has no plans to review or amend existing BID legislation during this parliamentary session, due to cost, resource and time constraints.

The Convener: That latter point being the operational one. However, that is in the course of this parliamentary session. It seems to me that the petition might have the opportunity to gain further traction in the next parliamentary session because I can see that there would be a route to exploring the issue in more depth at that time.

David Torrance: I agree. If the petitioner wants to resubmit the petition in the next parliamentary session, that would give the committee time to look at it and take evidence.

The Convener: I can see how we could pursue it were time available to us, but, in the time left in this session, we would not get a response from the various authorities to which we would have to write. There seems to me to be merit in the petition, and I say that as someone who has come up against BID proposals.

The proportionality issue is quite an important one, which has been expressed to me as well. With some regret, I think that we should close the

petition at this stage, but very much recommend to the petitioner that this is a petition that it would be well worth resubmitting at the start of the new parliamentary session for the new committee to explore in more detail. I know that that might be a bit frustrating to the petitioner—who I think might be with us—but with only three meetings left in this session, it is inevitably the case that we just will not make any progress on the aims that have been identified. However, I think that the objectives identified are certainly worth exploring.

Unfortunately, I am not able to take comment from the floor, but I would very much hope that that would be the case. I am overhearing that it might be that there are metrics missing. Reluctantly we close this petition, but with the recommendation that it is one to have standing on the stocks to resubmit to the new committee in the Parliament that meets after May in the hope that we can take the issue forward at that time. It is with some regret that I say that. Are we agreed?

Members *indicated agreement.*

Business Improvement Districts (Levy Relief) (PE2184)

The Convener: We come to the second of the BID petitions this morning. PE1284, which has been lodged by Tommy Reid, calls on the Scottish Government to provide BID levy relief to charities and non-profit organisations. It calls on the Scottish Parliament to urge the Scottish Government to amend the relevant legislation so that charities and non-profits that qualify for mandatory or discretionary rates relief under section 4(2)(a) of the Local Government (Financial Provisions etc) (Scotland) Act 1962 are also exempt from paying the BID levy, or receive equivalent relief; conduct a survey of businesses affected by BIDs in order to assess the impact of the levy more widely, particularly on small businesses and third-sector organisations; and to implement any further legislative changes that may arise from such a review.

According to the SPICe briefing, it is possible for a charity to be required to pay a BID levy, even if it is in receipt of 100 per cent relief from the local authority in respect of business rates payments. However, as shown in the Scottish Government response, current legislation allows BID proposals to include a levy exemption or relief for certain organisations. That can apply to charities and non-profit organisations if the individual BID chooses to set that out in the proposal and if the proposal is approved in the follow-up ballot. As we have seen during consideration of the previous petition, the Scottish Government indicates that it has no plans to review or amend existing BID legislation before the end of this parliamentary session.

The Government considers that the second ask of the petition is both practical and achievable. It suggests that the annual BID survey undertaken by Scotland's Improvement Districts could incorporate questions regarding the impact of BIDs, including the BID levy, on businesses, including charities and non-profit organisations.

I cannot recall us receiving representations on this area of policy during the whole of this parliamentary session. It seems to me that work could be done exploring some of these issues.

Mr Torrance, would you make a similar proposal, with regret, to the one that we made for the previous petition? Again, I think that there are issues here that the Parliament should explore.

David Torrance: I wonder if the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the BID proposals can already include exemptions and reliefs for charities and non-profit organisations. The Scottish Government believes that mandating exemptions by law would create additional layers of bureaucracy and complications.

The Scottish Government believes that the second ask of the petition is practical and achievable and it suggests that it could be incorporated by Scotland's Improvement Districts in its annual BID survey. In closing the petition, the committee could write to Scotland's Improvement Districts and encourage it to consider implementing the second ask of the petition as part of its annual survey, as suggested by the Scottish Government.

The Convener: In doing that, we will write to the petitioner saying that we are minded to accept that the issues being raised in relation to BIDs are something that the Parliament might like to take an interest in, but that that would be for the next Parliament. Again, I think it would be useful to have the petition standing ready to be resubmitted for the new committee to consider when it meets in May. Is that agreed?

Members *indicated agreement.*

Gulls (Removal of Protected Status) (PE2189)

The Convener: That brings us to our two final new petitions. PE2189, which has been lodged by Ian Boyles, calls on the Scottish Government to remove legal protected status for gulls to help reduce their numbers in residential areas, which was the subject of a recent debate in Parliament. The petition calls on the Scottish Parliament to urge the Scottish Government to no longer grant protected status to gulls, in order to facilitate the reduction of seagull numbers in populated areas and ensure the safety of residents from attacks.

The SPICe briefing shows that the common gull, great black-backed gull and herring gull are now all red-listed species of conservation concern in the UK, while the lesser black-backed gull and black-headed gull are amber listed. Certain species now appear to have a higher proportion of their UK breeding population nesting in urban and inland nest sites, rather than on coastal sites. Those members who live in urban constituencies are very aware of that because gulls have become the subject of quite a few representations—certainly, I have received them.

Gulls are protected by the Wildlife and Countryside Act 1981, as amended by the Nature Conservation (Scotland) Act 2004. It is illegal to intentionally or recklessly kill, injure or take any gull, and an offence to take, damage or destroy an active nest or its contents. In Scotland it is also illegal to obstruct or prevent gulls from using their nests. NatureScot has powers under the act to license activities—for defined legal purposes—that may otherwise be an offence. Those purposes include, for example,

"preserving public health or public or air safety".

Hopefully our friends in NatureScot might do something in that regard.

The Scottish Government's position is that legal protected status for gulls should not be removed, as it does not consider this to be the solution to help reduce their numbers in residential areas—perhaps we should send them a little letter asking them to fly elsewhere. In its submission, the Government highlights that the maximum level of licensed control authorised between 2020 and 2023 could have led to gull population declines, according to research carried out by the British Trust for Ornithology.

In September, the Minister for Agriculture and Connectivity chaired a gull summit in Inverness, which was the subject of some controversy. As a result of the summit, the focus over the coming months will be on five key areas in relation to gull management. These actions include the joint development and delivery of a gull management pilot for the city of Inverness by NatureScot and Highland Council, which will inform the development of national best practice. Additionally, the Government makes it clear that NatureScot will work to support licence applications earlier in the year and that its focus will be on licensing in areas where health and safety needs are highest.

Do members have any comments or suggestions for actions? Mr Torrance, are you supplanting Mr Golden's prevailing interest in wildlife?

David Torrance: I am. I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government does not support the removal of legal protected status for gulls given declining gull populations; the Scottish Government has indicated that NatureScot's work to support licence applications for gull control will focus on areas where health and safety needs are highest; and that projects such as the gull management pilot led by Highland Council and NatureScot will inform future national best practice in this area.

The Convener: I thank Mr Torrance for that proposal. I would be most interested to know how NatureScot defines the areas where health and safety needs are highest.

Maurice Golden: I agree with Mr Torrance, but I think that it is worth putting on the record first that the aim of the petition is to reduce gull numbers in residential areas and that to conflate that with a wider piece around declining gull populations would perhaps be wrong. People out there see what many of us see, which is a massive increase in aggressive gull populations, particularly over the summer, when you might be dining outside, and they are all set to attack. I am astonished that a pilot is required to assist with the issue. Nonetheless, I encourage the petitioner, if they are so minded, to reintroduce the petition, with a specific focus, in the new session, because I feel that the response from the Scottish Government is utterly inadequate.

The Convener: Yes. We have no option but to close the petition, given the Scottish Government response. I hope that it can be resubmitted. The issue seemed to attract some ridicule when it was raised in the chamber, but I think that that was from those who do not represent urban populations and residential areas where, as you say, there is outside dining. I have evidence in my own constituency of young children being attacked by the urban gull population and there being absolutely no remedy open to the council to do anything about it, given the protected status of gulls. That is why I wonder what

"areas where health and safety focus needs are highest",

means to our friends at NatureScot—I say that, although I have not been all that friendly to them.

Are we minded to close the petition? This is the kind of subject matter that our committee was designed to consider. It is a matter that no party would pursue in a public manifesto, but it is an actual concern to living communities.

11:30

I would very much encourage the petitioner to resubmit this petition in the new session because I think that the matter could be pursued more

actively. I would very much welcome watching NatureScot—if I am not in a position to question NatureScot myself—being tackled on the issue.

Do members agree to the suggested action?

Members *indicated agreement.*

Education (Kindergarten Stage) (PE2195)

The Convener: The last of our new petitions today is PE2195, lodged by Willie French and Tam Baillie on behalf of Upstart Scotland, which calls on the Scottish Parliament to urge the Scottish Government to establish in Scottish education a relationship-centred, play-based kindergarten stage for children between the ages of three and seven.

The Scottish Government's response to the petition states that the early level of the curriculum for excellence is designed to support the implementation of a responsive, continuous, play-based curriculum for children from age three until the end of primary 1 for the majority of children. The submission goes on to state that raising the school starting age and introducing a kindergarten stage would represent a fundamental change in the scope of education in Scotland and a significant structural change to the provision of education. The response states that there would be a number of significant delivery implications in raising the school starting age.

The petitioners' submission notes that children in Scotland start formal schooling at an earlier age than most of their international peers. The petitioners recognise the value of the Scottish Government's policies in the "Realising the Ambition: Being Me" document, but point to a lack of published evidence regarding the extent to which the guidance has been implemented. The submission highlights that evidence from its group, Upstart, suggests that the adoption of "realising the ambition"—that is the name of the programme—is inconsistent and that other policy drivers may hinder its implementation. The petitioners believe that establishing a kindergarten stage would align better with the priority of reducing the poverty-related attainment gap and would meet the developmental needs of children more effectively than current arrangements.

Do members have any comments or suggestions for action?

Davy Russell: I wonder whether the committee would consider closing the petition under rule 15.7 of standing orders on the basis that the Scottish Government has not indicated that it will take forward the aims of the petition, and has stated that raising the school starting age and introducing a kindergarten stage would represent a fundamental change in the scope of education in Scotland and a significant structural change in the provision of education. There would be a number of significant delivery implications in raising the school starting age, including for the early learning and childcare school workforce, infrastructure, legislation and the curriculum framework, which would need to be fully analysed and costed.

It is therefore unlikely that the petition's ask could be achieved at this point in the parliamentary session and the committee is limited in the actions that it can take to progress the petition in the time remaining in this session.

The Convener: Thank you. It is an interesting concept, but again it is one that would need far more time—even then, I suspect that such a petition would probably be referred to the education committee in due course. Nonetheless, it could be the subject of some preliminary work by a subsequent committee of this Parliament in the next session. Again, it is worth advocating that the petition be resubmitted when Parliament resumes.

Members *indicated agreement.*

The Convener: That brings us to the end of the public part of our meeting. Our next meeting is scheduled to take place on Wednesday, 14 January 2026.

11:34

Meeting continued in private until 11:43.

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