

PUBLIC PETITIONS COMMITTEE

Tuesday 2 October 2007

Session 3

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PUBLIC PETITIONS COMMITTEE

5th Meeting 2007, Session 3

CONVENER

*Mr Frank McAveety (Glasgow Shettleston) (Lab)

DEPUTY CONVENER

*John Farquhar Munro (Ross, Skye and Inverness West) (LD)

COMMITTEE MEMBERS

*Bashir Ahmad (Glasgow) (SNP)
*Claire Baker (Mid Scotland and Fife) (Lab)
Angela Constance (Livingston) (SNP)
*Rhoda Grant (Highlands and Islands) (Lab)
*Robin Harper (Lothians) (Green)
*Tricia Marwick (Central Fife) (SNP)
Nanette Milne (North East Scotland) (Con)

COMMITTEE SUBSTITUTES

Jim Hume (South of Scotland) (LD)
Marilyn Livingstone (Kirkcaldy) (Lab)
John Scott (Ayr) (Con)
*John Wilson (Central Scotland) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED :

Rob Gibson (Highlands and Islands) (SNP)
Christine Grahame (South of Scotland) (SNP)
Jayne Heron
Cassy McNamara
Gordon McPherson
Jane McPherson
Sandra White (Glasgow) (SNP)

CLERK TO THE COMMITTEE

Fergus Cochrane

ASSISTANT CLERK

Richard Hough

LOCATION

Committee Room 1

Scottish Parliament

Public Petitions Committee

Tuesday 2 October 2007

[THE CONVENER *opened the meeting at 14:00*]

Interests

The Convener (Mr Frank McAveety): Good afternoon and welcome to the Scottish Parliament Public Petitions Committee's fifth meeting in session 3. If anyone has a mobile phone, could they please switch it off. That includes people in the public gallery. We have apologies from Nanette Milne.

I welcome John Wilson to his first Public Petitions Committee meeting. He is substituting for Angela Constance, who is now on maternity leave. As this is his first meeting, I invite him to declare any interests that are relevant to the committee's remit, in accordance with section 3 of the code of conduct for members of the Scottish Parliament.

John Wilson (Central Scotland) (SNP): I am an elected local government councillor for North Lanarkshire Council, for which I receive no salary or pension. I am also a member of Historic Scotland, the National Trust for Scotland, the RSPB, the Scottish Wildlife Trust, the Friends of New Lanark, the Society of William Wallace, the Transport and General Workers Union and the Scottish National Party trade union group.

The Convener: Thanks very much, John. I am sure that you will make a positive contribution to the committee's work in the time that you are asked to serve on the committee.

New Petitions

14:01

The Convener: Before we take evidence on the first petition, I will make a brief statement. The volume of petitions that the Public Petitions Committee receives is always much greater than the number of people from whom we can hear oral evidence. It is of concern that people who have submitted petitions misunderstand the time constraints on the committee and its capacity to deal with petitions, even those for which individuals cannot provide oral evidence.

The decision on whether a petitioner is invited to make an oral submission to the committee is a matter for the convener, in consultation with committee members if necessary. No individual or organisation has an absolute right to give oral evidence. We always have to consider the petition's nature and context and the public interest involved to try to get a balance between petitions on which we hear oral evidence and those that we consider as written submissions. However, I stress to members of the public and petitioners in particular that we take seriously all petitions that are placed in front of the committee.

Although, because of the constraints of the committee structure, we do not have time to hear oral evidence on all the petitions that are submitted, we guarantee that we will try to process, where appropriate, petitions to the committee. We monitor such matters closely and, as part of the committee's on-going discussion, we will consider how we can make our engagement with members of the public more effective. It is regrettable that we do not have the capacity to take all evidence orally, but I assure members of the public that we treat each petition carefully and consider it before the next stage of development or discussion.

I hope that that is helpful to members of the public and committee members. Other committee members and I have had our constituency work intruded upon by folk expressing concern about petitions, and I would much prefer that process to be dealt with by the clerks to the committee. That is the appropriate way for the matter to be handled.

Rhoda Grant (Highlands and Islands) (Lab): It might be helpful to make the petition forms clearer. We should ask people whether they would be willing to give oral evidence if they were invited to do so. At the moment, there is a box for those who would be willing to give oral evidence and one for those who are not. It looks like people are being given a choice and, once they request it, they may go away with the impression that they are able to give evidence.

The Convener: There is an additional point about perceptions. I understand people's concern about not being given three minutes to speak—indeed, if I were a petitioner, I would feel the same as they do. However, giving three minutes to petitioners such as Gordon McPherson and Jane McPherson and others is only part of the process. Sometimes the process can be much lengthier. If every petitioner had the same time to give oral evidence, we would not have enough time to deal with every petition effectively. We will constantly review the process, but what Rhoda Grant said is helpful. I hope that we will come back to committee members on that.

Deep Vein Thrombosis (PE1056)

The Convener: I am sorry about the delay before consideration of our first new petition. Our petitioners have been very patient.

PE1056, from Gordon McPherson, Jane McPherson and Steven McPherson, calls on the Scottish Parliament to urge the Scottish Executive or Government to introduce mandatory assessment tools for all health boards for the diagnosis of deep vein thrombosis; to ensure commonality of patient guidance information on DVT; and to introduce a newborn screening programme for the factor V Leiden gene, which has been shown to increase susceptibility to DVT. Before it was formally lodged, the petition was hosted on the e-petition system where, between 2 March and 5 May 2007, it gathered 143 signatures.

I welcome Gordon McPherson and Jane McPherson to the meeting. Gordon McPherson has around three minutes to make an opening statement—Jane may also contribute—after which members may ask questions and enter into dialogue.

Gordon McPherson: Thank you very much.

In January 2008, it will be five years since our daughter Katie died of a pulmonary thromboembolism that was brought on as a result of a misdiagnosed DVT. Our petition breaks down into three distinct sections. It calls on the Scottish Parliament to urge the Scottish Executive to introduce mandatory assessment tools for all health boards to ensure commonality of assessment and treatment of DVT; to ensure commonality of patient information leaflets on DVT throughout all health boards in Scotland; and to introduce a newborn screening programme for the factor V Leiden gene, which has been shown to increase susceptibility to DVT.

First, I will deal with assessment tools for health boards. At the time of Katie's death, the Scottish Public Services Ombudsman agreed with our finding that no two health boards were working to

the same guidelines. In November last year, we found out that health boards were still not working to common guidelines—in fact, one health board had no guidelines that covered DVT. It is essential that all health boards work to the same guidelines.

Secondly, on the commonality of patient information leaflets, it is important that patients take responsibility for their own health. To do so, they must be better informed about the signs and symptoms of DVT. In the survey of health boards that we carried out last November, we again found that no two health boards were working to the same guidelines. Some were using pharmaceutical companies' own literature, while others were using an A4 sheet of paper. One information sheet stated that if the symptoms persist, the person should contact their general practitioner. Unfortunately, it did not state what symptoms a person should look for.

Thirdly, among many things that we have found out about DVT is the fact that one in 20 of the population has a medical condition called thrombophilia, which is an hereditary genetic predisposition that makes patients more susceptible to DVT. It is a bit like the genetic predisposition that leaves patients more susceptible to cancer. If a patient has the factor V Leiden gene, that does not mean that they will get fatal DVT, but if they have had a miscarriage or if they are overweight, on the pill, pregnant, on hormone replacement therapy or simply immobile for even four to six hours, they will be more susceptible. We are asking for the baby population to be screened, because if parents and doctors know about someone's susceptibility, accurate decisions about medications and lifestyles can perhaps be made. In the same way, someone with a penicillin allergy, for example, would decide not to take an antibiotic that contains penicillin. Testing is all the more important if there is a history of DVT-related illness in the family, which is not always known. Since Katie's death, our son Steven has been tested. It was found that he has the factor V Leiden gene. Instead of worrying, he is aware of the problem and can advise doctors about it.

We hope that, with commonality of protocols and procedures in testing for DVT, commonality of patient information leaflets and increased awareness of factors such as factor V Leiden, there will be a large reduction in unnecessary deaths like Katie's.

It is of added interest that Katie would have been 28 this coming Sunday.

The Convener: Do you want to add anything, Jane?

Jane McPherson: No, not at all.

The Convener: I appreciate your giving of your time today. The matter is a personal one and you have been brave in coming to committee. Your commitment to the issue is clear and I am pleased that you have pursued it with such vigour. We move on to questions from the committee on issues that you raise in the petition.

John Farquhar Munro (Ross, Skye and Inverness West) (LD): Good afternoon, folks. In PE1056, you make explicit your request for different procedures to be used in the diagnosis of DVT. You also talk about the national screening—or, at least, the local screening—of newborn children. Which of those suggestions is it more important for us to support?

Gordon McPherson: It is important that all aspects of the petition are supported. On the first item, there should be commonality among all health boards throughout Scotland. Katie was in the care of Lothian NHS Board first and then the former Argyll and Clyde NHS Board. The boards had two totally different ways of assessing DVT. If both boards had used the same method, Katie would have been here today. That has been shown to be the case.

On commonality of patient information leaflets, patients and members of the general public need to know what they are looking for. All too often, people think that they will get DVT only on long-haul flights. We must raise general public awareness. Again, the point of newborn screening is to raise awareness. The general public should be made aware that some people have a susceptibility to DVT, which does not mean that they will get DVT but means that they should change their lifestyle and take care of themselves.

Jane McPherson: It is important that screening is offered. We cannot possibly say that every child should be screened—we need also to consider the ethical aspects and so forth—but parents should be given the offer of DVT testing for their newborn child. If we were ever to have grandchildren, we know that our son would definitely say that they would be tested.

Such testing acts as a preparation for later life. If someone were to have major surgery, become pregnant, start to take the pill, be put on hormone replacement therapy, or be diagnosed with cancer or another illness that could raise their susceptibility, the fact that they have been tested will make them more aware of the greater risk of having DVT.

John Farquhar Munro: Is the procedure for DVT testing complicated?

Jane McPherson: It depends on the procedure that is used, which depends on the hospital to which someone goes. When I was tested for suspected DVT, I was given a simple blood test.

When it came back as positive, I was automatically given anti-coagulant injections. If I had gone to a hospital 4 or 5 miles in the opposite direction, I might have had a dye injected into my veins, or had my blood pressure checked—the test depends on the hospital to which someone goes. That is one of the big points that we are trying to put across.

John Farquhar Munro: You just had a simple blood test.

Jane McPherson: Yes.

Rhoda Grant: You said that, when your son was screened, the discovery was made that he had the factor V Leiden gene. Does that affect his insurance? Does he have to declare that for travel insurance purposes?

Jane McPherson: No. That request has never been made. Testing for the factor V Leiden gene is not like testing for HIV. Having the factor V Leiden gene will not necessarily kill someone; they simply have a defective gene. Testing lets someone know what to do if they develop symptoms of a DVT nature. If they are going on a long-haul flight, they will know to take aspirin before they go and to do their exercises, and if they are going on a long car journey, they will know to make stops. It does not affect the quality or quantity of someone's life.

Rhoda Grant: Are travel insurance companies more reluctant to insure your son? What if he plans to take a long-haul flight, which might increase his susceptibility to DVT?

Jane McPherson: He has never been on a long-haul flight, so I cannot answer the question. I think that the longest flight that he has made was probably four or five hours long, which is probably more of an average flight time.

Gordon McPherson: Insurance companies may jump on this and say, "Here's another way of excluding certain things." It is down to their ethics whether they do that, but it is not as if my son has cancer and is at risk when he flies. As long as he is aware that he has a factor V Leiden gene, and he drinks lots of fluid—I have told him before that that means water rather than cider—there is no problem.

14:15

The Convener: And did he listen?

Gordon McPherson: Of course not.

It is down to the insurance companies whether they wish to make an issue of it, and I do not see why they should.

Tricia Marwick (Central Fife) (SNP): Sons with that name are all the same. They never listen.

The Convener: Mine has the same name.

Tricia Marwick: It must be something about that name.

Thank you for coming along today. For me, one of the great things about being a member of this committee is that I find out information that I was unaware of. It is a measure of the difficulties with DVT that so many people are unaware of the problems and think that it is something that happens very occasionally to people on long-haul flights. I am extremely grateful to you for putting to one side your personal loss to campaign for other people. Since the Scottish Public Services Ombudsman produced the report, has there been any change in the way in which the Scottish Government, health boards and so on react to the problem?

Gordon McPherson: That is why we are here.

Tricia Marwick: Do you have any update on that? Have they done anything at all?

Gordon McPherson: We are in constant contact with NHS Quality Improvement Scotland and members of the Scottish Executive. We had a meeting in February with NHS 24, NHS Direct, NHS QIS and the Executive, and we were told that a report would be issued in March. We received it in August. We have also been told that in October a letter to all health board chiefs will be issued by Scotland's chief medical officer, countersigned by the chair of NHS QIS. I will believe it when I see it. We feel that we have to keep the pressure on because, if we do not, the issue will just keep slipping. It has to be dealt with now.

With regard to DVT, everyone has thromboses travelling through their body. Normally they are small enough that they dissolve in the bloodstream. It is only when they build up to being a big clot that there is a problem.

Tricia Marwick: Do you have any indication of the number of people in any given year who are affected by DVT, including those who have died and for whom it has been the cause of death, and those who have been treated? Is that information held centrally?

Gordon McPherson: I can refer only to the information from the chief medical officer of England, Wales and Northern Ireland, who issued a report in March or April stating that 30,000 deaths per annum can be attributed to venous thromboembolism. As Scotland represents 10 per cent of the UK population, I can only assume that there are 3,000 per annum in Scotland. However, the General Register Office for Scotland states that only five deaths in the past 10 years have been attributed to pulmonary embolisms. It is all down to how the death certificate is signed. We have been told by many consultants that they only knew that it was a pulmonary embolism that killed the person after the post mortem. Sometimes the

cause of death is put down as heart attack, sometimes as a stroke, and sometimes as cancer. Sometimes it is only when the post mortem is carried out that it can be stated categorically that it was a pulmonary embolism. The other thing that the chief medical officer of England, Wales and Northern Ireland stated is that 10 per cent of all deaths in hospital can be attributed to venous thromboembolism.

Jane McPherson: I think also that approximately one person in 20 is at risk of developing deep vein thrombosis. That is another figure that came from England.

Gordon McPherson: However, with regard to deaths, we can only give the figure that I mentioned.

Jane McPherson: The figures are difficult to come by. We have had great difficulty in getting accurate figures for the number of death certificates that mention deep vein thrombosis. Katie's death certificate stated that she died from a pulmonary embolism as a direct result of a deep vein thrombosis. Her post mortem showed that the clots had been present in her leg for approximately 10 days, which was about the length of time since she had first gone to the hospital with symptoms.

Tricia Marwick: The numbers that you have mentioned are truly horrific, so it is perhaps not surprising that the Government is reluctant to gather those figures centrally. You need to insist on that as part of your campaign because we need that kind of information.

Gordon McPherson: The health boards say that there might be 130 to 138 deaths per annum, but they cannot narrow that down to say that a definitive number of deaths are caused by DVT or pulmonary embolisms. It all comes down to how the death certificate is signed.

The Convener: If there are no further questions from committee members, we will move on to consider how to deal with the petition. Do members have any strong views on how we should progress the petition?

John Farquhar Munro: We should ask the charity that has a keen interest in the condition—Lifeblood: The Thrombosis Charity—for its views.

Jane McPherson: We are working closely with Lifeblood.

Gordon McPherson: We contacted Lifeblood just after Katie's death. For our work on the issue in Scotland, Lifeblood has been feeding us with the information that it has on the situation down south. However, as I said when I first started having meetings with politicians, the issue should be dealt with not by a charity but by the national health service. Why should a charity do the work of the national health service? Yes, Lifeblood is

knowledgeable—its medical director, Dr Beverley Hunt, is very knowledgeable—but why should a charity carry out work that should be done by the Government?

John Farquhar Munro: My suggestion was not that we should get the charity involved in doing something but that we should ask it for professional advice, which I am sure it would be willing to impart.

Gordon McPherson: I know that it would be very willing indeed because I meet Beverley Hunt each month down in London.

The Convener: From the petition and oral evidence that we have considered this afternoon, it strikes me that senior decisions could be made that could have a powerful impact both on the research on DVT and, more important, on the support structures for such conditions.

First, we need to consider the structure that exists within the health service for ensuring consistency across health boards. The issue that the petitioners have raised—which, to be fair, all politicians have been trying to tackle since the Parliament's inception—is about the anomalies that arise when things depend on a health board having a particular resource base or priorities or clinical expertise in a particular area. Some boards are more advanced than others, but the petitioners are looking for greater consistency so that people do not fall through the gaps. I suggest that we ask the Scottish Government's health department and the NHS quality improvement folk about the research base on those issues.

Another suggestion was the introduction of screening for the factor V Leiden gene. I meant to ask whether the UK National Screening Committee already issues guidance on that, but we can perhaps ask about the evidence base for that. The best way to address these concerns might well be a matter of clinical dispute—none of us is an expert on the issue—but it would be useful to get that information so that the committee can then come to a decision on how best to progress the petition. I think that those are the kind of folk with whom we might want to explore the issue, so the deputy convener's suggestion will be just one element of our consideration. I understand that the petitioners are in close contact with Lifeblood because of their experience.

Robin Harper (Lothians) (Green): I see no good reason why the health boards should not get together to identify best practice and to issue best-practice guidelines. We should ask the Scottish Government's health department to pursue the matter.

The Convener: I agree.

Rhoda Grant: When we write to the Government and NHS QIS, can we check what guidance will be issued to health boards in October? We need to know exactly what information they will put out, because if their guidance will tell each health board to react in the same way—

Gordon McPherson: They said that they would issue a report to all the health boards. I had sight of the first part of that report in August. They have tried to reinvent the wheel, but all that they have done is ask all the questions that we asked last November. They have gone round and asked all the health boards the same questions and have got the same answers that we got. I do not think that the report will be that much help to you.

Rhoda Grant: It would be interesting to know exactly what guidance will be provided, so that we have a full picture when we decide what action to take.

If we are to consider screening, I would be interested to find out about the stance that insurance companies take. It would be good to speak to a body that represents insurance companies collectively—I imagine that there is such a body—just to gather as much information as possible.

Jane McPherson: My only point on that is that there will be a strong need for the insurance companies to become aware of all the aspects of deep vein thrombosis before they can make a justifiable decision about how they will deal with the condition. It is an issue of education. They may just fly off the handle and say, "We're not going to insure anyone who tests positive for the factor V Leiden gene."

The Convener: I am not saying that we should not explore that route; it is just that I am always nervous about encouraging insurers to take views on such matters. The Association of British Insurers is probably the best United Kingdom body to write to.

Rhoda Grant: If we are to propose an action that would lead to people getting cover, we must find out what the insurers think and ensure that the education process takes place before we recommend a course of action.

Robin Harper: I want to clarify what you are saying about the report. Are you saying that the health boards cannot agree on what is best practice? You said that the same questions have been asked and the same answers have been received. What is the next sentence after that? Have the health boards still not come to an agreement?

Gordon McPherson: We had a meeting, at which we were assured that we would have a

report on our desks. It took a further three months of harrying to get part of the report sent to us. The report should have a beginning, a middle and a conclusion. All that we got was a copy of the beginning, which we provided. As far as the middle and the conclusion are concerned, there is nothing there—there was nothing there in August. September has gone by and we are now in October. It took from February or March until August for me to get the first 44 pages of a 67-page report. All of a sudden, 23 pages will be produced in a much shorter length of time.

I am extremely apprehensive about the contents of the report. I think that it will be inconclusive. I have a funny feeling that it will say that we should wait for two years to see how matters take shape and to build up more statistics. The chief medical officer in England says that there are 30,000 deaths per year from DVT. That means that there have been 150,000 deaths that can be attributed to DVT since Katie died. If we wait a further two years, there will be another 60,000 deaths, which will bring us up to a total of almost a quarter of a million deaths—and that is without including deaths in Scotland.

Jane McPherson: As a family, we feel that we have done as much as we can to get to this stage. It is time for action. People have been palming us off, giving us copies of this and bits of that. We feel that we cannot do any more. We need help to continue our campaign. Action is required. Something needs to be done because the present situation cannot be left to continue.

14:30

The Convener: That is a positive note on which to end today's consideration of the petition. Committee members must take on board that message. As Robin Harper suggested, we need to get clarification from the Scottish intercollegiate guidelines network about what the guidelines say. Once we get information back, the clerks will be in correspondence with you because there might be areas in which we want to do further probing. We must try to get clarity from a range of organisations.

I give you an assurance that after that work has been undertaken, a further report will come to members of the committee, so that we can consider what to do with the evidence that we have received. At that point, we might contact you again, to indicate our next course of action, so that you know what is happening.

Your family has embarked on a personal journey to try to deal with the tragedy that you suffered, because you do not want it to happen to anyone else. You will want to know that you did your best for your daughter by working to ensure that no

other family goes through what you went through. I hope that that can happen through the work of the committee. Thank you for your time.

Gordon McPherson: Thank you for listening to us.

Independent Midwifery Services (PE1052)

The Convener: PE1052, which was brought by Jayne Heron, calls on the Scottish Parliament to urge the Scottish Government to promote the services of independent midwives and to ensure that such services continue to be available to pregnant women in Scotland. Before it was lodged, the petition was hosted on the e-petition system, where it attracted 364 signatures between 1 March and 12 April.

I welcome Jayne Heron and Cassy McNamara. Ms Heron, you have about three minutes in which to make opening remarks, after which members will have an opportunity to ask questions. Do not be fearful of the committee—we are not that scary.

Jayne Heron: I have experienced two births: one courtesy of Greater Glasgow NHS Board and one under the care of an independent midwife. To be frank, the two experiences cannot be compared. In my national health service birth, it was clear that the hospital and its staff were at the centre of the system and that pregnant women must fit in around that. However, with the independent midwife, my needs were of the utmost importance and continuity of care meant that my midwife and I could build enormous trust. That trust makes all the difference, not only to the progress of the birth but to its aftermath.

My husband and I planned to have more children in a few years' time, but if I cannot access such continuity of care because independent midwifery is made illegal, I will think twice about becoming pregnant. I honestly think that I cannot cope with the prospect of being subjected to another NHS pregnancy and birth. The cold and robotic nature of the NHS factory production line—I saw a different midwife at every antenatal appointment and at the birth I faced another handful of strangers whom I could not fully trust—forces me to think again.

Why should I, or any woman in Scotland, have to put up with the current state of maternity care? I cannot fathom one good reason why I should not be able to contract an independent midwife via the NHS next time round, especially given that the cost to the NHS would be £1,300 less than a standard hospital birth. A new system of midwifery-led continuity of care for those who want it could save NHS Scotland millions of pounds and save many women from suffering awful experiences when they give birth.

Rhoda Grant: I am a bit confused about what you are asking the committee to do. I understand that independent midwives are private practitioners. Are you asking for them to come under the auspices of the NHS, so that they would be NHS employees rather than private practitioners? Are you talking about a shake-up of the midwifery service that the NHS delivers, or are you asking the NHS to fund private practitioners?

Cassy McNamara: At issue is the proposed Government legislation that would provide that independent midwives must have professional indemnity insurance. Independent midwives want it, but no companies in the UK or abroad provide it, partly because of the small numbers of independent midwives and the potential for high pay-outs. However, there has not been a substantial pay-out against an independent midwife since 1994, which is not bad going. Women should be able to choose whom they want to care for them. Independent midwives work privately. We are not asking for jobs in the NHS—I could get a job in the NHS if I chose to do so. We need to find a solution to our insurance problems, so that women have the right to choose their carers at any time. Perhaps the NHS could subcontract our services, so that women would not have to fund their own care.

It is true that we independent midwives work individually and privately, but we do so in a social enterprise-type way: we take less money from people who are less able to afford our services if we feel that we can meet their needs. I have colleagues who have had work done in their houses in exchange for care. We are more a kind of social enterprise and we work self-employed. We are not talking about BUPA midwifery.

Jayne Heron and I are here today to ask the Scottish Government to encourage health boards to provide subcontracts for women's care, so that it does not cost them anything. The Chief Nursing Officer for England and the Chief Nursing Officer for Scotland, Paul Martin, have recommended that we proceed in this way. We have written to the 14 health boards in Scotland, but 10 did not reply and four replied with letters that made no sense, but which basically said no. We have approached all the major insurance companies, as well as some that are less well known, to try to find insurance. If we do not have insurance, we will not be able to practise in 18 months and women will not be able to choose us to care for them. We would like the Government to step in and to ask health boards to fund the care that we provide.

Rhoda Grant: I am still having difficulty getting to the bottom of your reasoning. The public sector does not pay for insurance for the private sector. That is a strange request.

Cassy McNamara: I am not asking it to pay for our insurance, but to extend insurance. If I was contracted to care for Jayne Heron in her pregnancy, I would automatically be covered by CNORIS—the clinical negligence and other risks indemnity scheme—in Scotland. We have checked that with the administrators of CNORIS. We are acting on the recommendation of the Chief Nursing Officer for Scotland and are happy to follow his advice, but health boards have not replied to us and time is running out.

Tricia Marwick: I have the same concerns as Rhoda Grant. As I understand it, until 1994 all independent midwives were covered by the Royal College of Midwives indemnity scheme. The Royal College of Midwives, which I presume represents you, will no longer allow independent contractors such as you to be covered by its indemnity scheme. Is not your problem therefore more with the Royal College of Midwives? It seems to me that you are trying to get round the problem that your trade body, the RCM, is not prepared to offer an indemnity scheme.

Cassy McNamara: It is not a problem with the RCM. In 2002, a vote of the whole membership of the RCM was taken. It decided not to insure independent midwives because there were only 47 of them at that time. The RCM's 33,000 members felt that a £5 increase in their subscriptions to cover the increased insurance premiums was not fair on them. It was an open and democratic decision. Our problem is not with the Royal College of Midwives, which is our union. We want insurance and have made every effort to get insurance. However, it is not so much insurance that is the problem. The issue is not to do with the RCM.

Jayne Heron: The petition is about continuity of care. I cannot get continuity of care on the NHS: the only way I can is by contracting an independent midwife.

Tricia Marwick: Let me see whether I have got this right. You do not want to be treated by the NHS—you want to have an independent midwife because you can afford to pay for it—

Jayne Heron: No—I cannot afford to pay for it. I have had to remortgage.

Tricia Marwick: Okay. For you to get an independent midwife, midwives must have insurance indemnity, which they do not have at the moment, so you expect the NHS to pick up that insurance indemnity to allow you to have an independent midwife for whom you can pay but for whom others cannot pay. Is that fair?

Cassy McNamara: We are saying that we want the NHS to subcontract midwives in order to provide that kind of care. That already happens in the United Kingdom: the Albany midwifery practice

is a well established model that has been going for 10 years and the NHS contracts its midwives to provide a service for it. The issue is not about private care or pampering people who want unrealistic services: the women need not have chosen not to be cared for by the NHS, but might well have needs that mean that it is very important that they have continuity of care. I have had clients who have had histories of abuse and could not face seeing half a dozen different people in the NHS. The issue is not about BUPA by another name; rather, it is about women having access to the care that they want.

Tricia Marwick: If you were contracted to the NHS, as you wish to be, and the NHS said to you, "Cassy, we need you to look after a woman in Kirkcaldy and we are subcontracting you to do so," would you do that? What are you looking for? Do you want the woman to contact you, as an independent contractor, and for you then to be able to go to the NHS to get it to subcontract you to look after that woman? I am genuinely confused about what you are asking us to do.

Cassy McNamara: Maybe we are not explaining ourselves clearly. We are saying that we could subcontract to the NHS to care for any woman who specifically wants, for example, continuity of care or a home birth, or who has a history that means that she would benefit from having such continuity of care. It would be up to the NHS to send us to whatever women it chose. We are not looking for the NHS to pay for individual women in the way that you suggest. We would be contracted to care for, say, 60 women a year who want home births. They could be any women.

Tricia Marwick: But if the NHS is doing that—

Cassy McNamara: The NHS is not doing that.

Tricia Marwick: Bear with me for a minute. There are midwives in the NHS who are paid by the NHS to carry out home births and deliveries in the hospital. If you want the NHS to be able to use your services for any woman, why do you not just join the NHS?

Cassy McNamara: I could do that, but—

Jayne Heron: If a woman books a home birth or a hospital birth, she does not know who will be caring for her on the night she gives birth. It could be a complete stranger—someone she has never met. A woman in the most vulnerable position she will ever be in must suddenly form a huge relationship with a stranger who walks into the room.

Tricia Marwick: I fully understand what you are saying. However, given that Cassy McNamara wants the NHS to use the independent midwives as contractors, I am trying to establish whether, in

that situation, the NHS would ask the midwife to provide the care, or whether people such as Jane Heron could go to an independent midwife to ask for care, upon which the NHS would, because Jane wants it, contract Cassy to look after her. How would that help other women who need the same level of care but who simply cannot afford it?

Cassy McNamara: Because the NHS pays for the care now, any woman has access to it. The issue is not about who pays for care that is subcontracted.

14:45

Jayne Heron: When women have their 12-week booking-in appointment, they should be asked whether they would like to sign up for the present system or whether they would like continuity of care. Women who want continuity of care could be provided with a list of midwives in the area who might do that. That is the approach that I envisage.

Cassy McNamara: Any woman could do that.

Jayne Heron: Yes—any woman could do it.

Tricia Marwick: But there are only six independent midwives in Scotland.

Jayne Heron: Any midwife could work that way. If we start subcontracting midwives who want to work that way—

Tricia Marwick: So you want all midwives to be subcontracted.

Jayne Heron: No. Any midwife who wanted to work that way could do so and any woman who wanted continuity of care would have the choice of having the care subcontracted through the NHS.

Tricia Marwick: So you suggest that all midwives who are in the NHS at present could become independent contractors and the NHS could subcontract the care, to get over the problem that you cannot get indemnity insurance.

Jayne Heron: No. No specific studies have been done on the issue, but we are aware of a few midwives who wanted to work in that way and who left the NHS and midwifery because they could not. The Independent Midwives Association has statistics on that.

The Convener: I will abuse my role as convener a little. Members are raising critical points. It strikes me that two different issues are involved. One is the issue that Jayne Heron has raised about the nature of the care and the responsiveness and attractiveness of the current options that are available to expectant mothers. The other issue is the structure of the relationship and insurance indemnity. The two issues are linked, but in our discussion, we need to unravel

the responsibilities and roles in the NHS, and the problem in relation to insurance cover. Some of the crossover is not consistent, which makes it difficult for members to feel comfortable with the petition. That is what we are trying to explore. One or two other members have questions—we will get through those and explore the issues, but I do not know whether we will come to a satisfactory conclusion for anyone round the table. That is the concern that I have heard from members.

John Wilson: The witnesses have clarified some of the points that I was going to raise. If there is general agreement that the independent midwifery service is a good service, why not argue that it should be provided under the NHS, working with the RCM, rather than contract out services, which the witnesses say should happen? The concern of some members is that you say that we should contract out midwifery services to the independents. However, if the model of care for expectant mothers that you describe is a good one, perhaps we should have the RCM and the NHS work together to consider whether we could replicate it in the NHS.

Cassy McNamara: I absolutely agree. In fact, that is exactly what has happened in the past few years. The RCM supports continuity of care and that model of care working—there is no doubt about that. The NHS says that it would like to provide the service, but that it is unable to do so for several reasons. As the convener said, there is a mix of two issues. We want to provide continuity of care and some women want it. If legislation is introduced in 18 months that means that I will not be able to practise or maintain my registration as a midwife if I do not have insurance—which I cannot get anywhere—that will mean that, as a professional, I will be left with the option of an NHS job or no job. No other profession is put in that situation.

Mrs Marwick asked why the NHS should pay for private care—I understand exactly what she is saying. A bit of confusion may have arisen because of our explanation of the petition. We are not asking for people to have private care. We are saying that the model of care is cost effective, that lots of women want it, that some midwives would like to work that way and that although the Government has recommended that we do so, we cannot get health boards to reply to us. That is the major problem for us.

John Wilson: Cassy McNamara said that some health boards have responded and have said that they would be willing to offer this level of care if they could. What reasons have you been given for their not providing it?

Cassy McNamara: The health boards said that it is down to numbers because one-to-one care needs a lot of time commitment and involvement.

They also expressed concern about whether enough of their midwives would want to work in that way and whether enough women would have access to that model of care, but they had not asked the midwives. The Independent Midwives Association has asked midwives: 78 per cent of midwives, out of a poll of 1,200, said that they would like to work that way if they were given the opportunity. However, at present there is no opportunity in the NHS for them to do that, except at the Albany practice in London.

Rhoda Grant: If the NHS decided to offer this service and contracted independent midwives, how would that fit in with people's working conditions, holidays and the European working time directive? It is all very well for a woman to say that she wants the same midwife from the start of her pregnancy all the way through until several months after the birth, but people take holidays and get sick. Also, babies do not come to order and labours can go on for quite long periods. I can see why the NHS would be reluctant to say to one person that they had to be there all the time. It may not be safe for the same midwife to be in charge of the labour all the way through if it was a very long labour, because they could be absolutely exhausted.

Cassy McNamara: That is exactly how I work now, and it involves a huge amount of time. I spend nine months of the year on call for 24 hours a day for my clients. The Albany practice has been going for 10 years and has six independent midwives. They work three months on—on call for 24 hours a day—and one month off, and they cover for each other. Each midwife has a caseload of 30 women a year for whom they are the primary midwife and 30 women for whom they are the secondary midwife.

All the things that Rhoda Grant mentioned have been well considered and taken into account. I know that I would not be safe after so many hours; however, I am never there on my own—there are always two of us, just as in the NHS there are always two midwives present. It is a well-proven model that takes into account sickness, maternity leave, education needs, and so on.

Jayne Heron: And the midwives at the Albany practice get 12 weeks' holiday a year.

Rhoda Grant: With the best will in the world, someone cannot be guaranteed the same midwife all the way through. If it is their month off—

Cassy McNamara: If Jayne Heron and I were working with the same client who was one of my primary clients and her baby was due in May but I was off in May, Jayne would not be off in May. At the Albany practice, in 94.6 per cent of cases the woman has her primary midwife present at the birth; in the other cases, the woman's secondary

midwife is present. That applies for both hospital and home births.

Rhoda Grant: Let us return to the main question. You are saying that you would like that service to be offered on the NHS.

Cassy McNamara: Yes.

John Farquhar Munro: I am getting rather confused. What do you find unacceptable about the midwifery services that are provided in the NHS?

Jayne Heron: Where do I start? The biggest issue for me is continuity of care. Throughout a woman's pregnancy, she has a number of antenatal appointments. After she has given birth, she receives postnatal visits from a midwife, as well. For me, having a woman see a different midwife at every appointment, however many midwives are on duty during the birth and different midwives for postnatal appointments—all of whom are strangers to her—is an unacceptable way to handle birth. Giving birth involves the woman placing a huge level of trust in her care givers. She and they will make decisions about the birth together as the pregnancy unfolds and she has to trust that they are well informed as to what is happening and what level or course of action to take at the time.

Our mothers told us not to trust strangers—that is the basic premise of the argument for me. When a woman is giving birth, the birth runs a damned sight more smoothly if she knows the person who is caring for her and she completely trusts their opinion, than if she does not know whether she is being given the best advice.

Cassy McNamara: I worked for the NHS for 10 years before working independently. Without doubt, there are wonderful midwives in the NHS. By and large, the NHS can do a great job and many people are grateful to the service and happy with it as it is. However, every area of the NHS has its problems. The petition is not about solving all the NHS's problems; it is about giving people another option.

If the Government had not suggested that it would introduce legislation to require us to have insurance, I would keep working as I do. I would meet some women who could pay me and some who could not and I would decide what I was prepared to do and could afford to do. I did not work for free in the NHS and cannot afford to do so now. There is nothing wrong with my being paid to provide a service to people. However, the point of the petition is that, in 18 months, I will not be able to do that, Jayne will not be able to have the care of an independent midwife and the NHS will have lost the option unless we can find a way around the lack of indemnity insurance.

Suggestions have been made for a way around it: we have been told that we could subcontract. I have put a proposal to one health board and have written to every one of them—we all have—to say that there is an existing model as a precedent, but I cannot get a response from them one way or another. We are asking for the committee's support in asking health boards to give proper consideration to subcontracting. They should at least respond to us and, if they say no, give us a reason why rather than just saying no, so that we know where to go from here.

John Farquhar Munro: I am not particularly surprised that you do not get a favourable response from the NHS for what you propose. Did you both train under the NHS?

Jayne Heron: I am not a midwife.

Cassy McNamara: I did. All midwives must train with the NHS.

John Farquhar Munro: Now you want to take that expertise into the private sector and offer the service in various communities at a cost to the individual.

Cassy McNamara: That is what I do now.

John Farquhar Munro: That, to me, is not a medical service, it is a business. Because you want to go into that sort of business, you expect the NHS to indemnify you against any problems that may arise. That is quite unreasonable.

Cassy McNamara: No. I think that there is a general impression that that is what we are asking the NHS to do, but I am not asking that I should be able to keep working the way that I do and the NHS should foot the bill for my insurance. That is not why we are here. We have been told that a way round the lack of indemnity insurance would be to subcontract. There are women who want the services of an independent midwife, women who need those services and women who cannot have them for many reasons. Subcontracting would be cheaper than the cost to the NHS of a hospital birth—even with the way that I charge now, I am about £1,300 cheaper than basic care and a hospital birth. We are not asking the NHS to fund some plush service but to provide a service for women who might really need it.

Co-incidentally, I agree: why should the NHS provide us with insurance? I am saying that subcontracting is a way round the problem. If women want our services and if some midwives want to work that way, are cost effective and have good results, why not allow it?

The Convener: It has been a fairly torrid discussion. Well done to the witnesses for taking on some pretty rigorous questions from the committee members. You have raised many big issues that might require more examination.

People need to be persuaded. I have the sense that, when you leave the committee you will say, "Ooph! That was a toughie this afternoon."

Do committee members have any strong views or suggestions about what to do next with the petition? Does Tricia Marwick have any healing words?

15:00

Tricia Marwick: It seems to me that the problem has arisen partly because the UK Government, which is responsible for the registration of midwives, wants to bring in legislation that will insist that midwives have professional indemnity insurance. I understand that the view of Ivan Lewis, who is a Parliamentary Under-Secretary of State at the Department of Health, is that the Government at Westminster does not want to put independent midwives in an impossible situation. If that is the case, we should write to the UK Department of Health, which is responsible for the registration of midwives, to ask what suggestions it has for overcoming the situation that has been created by its legislative proposal.

I remain concerned that the professional organisation—the Royal College of Midwives, which is Cassy McNamara's trade body—is not prepared to indemnify its members who are independent contractors. I find that astonishing. We need to find out more about why that is the case.

I remain wholly unconvinced by the plea that has been made today for the NHS to be able to subcontract independent midwives. It seems to me that the petitioners are trying to find a solution to a problem that has been created by other bodies. Before they start to explore other options, it might be worth their while going back to the UK Department of Health and the Royal College of Midwives to find out what the stance of those bodies is and what solutions they can come up with. If there were other options available, the petitioners would not have suggested to us that independent midwives be subcontracted by the NHS. Their point is about insurance, on which we must go back to first principles. I suggest that we approach the UK Department of Health.

Cassy McNamara: I have in my bag a letter containing the Department of Health's suggestion, which was that independent midwives should be subcontracted. All independent midwives have had the same letter, from the Department of Health in England and from the chief nurse in Scotland. That is what we have been told.

Robin Harper: The convener asked for strong views. I have the strong view that midwifery in Scotland and the UK should be getting more support rather than less support. It is clear that we

face the possibility of a diminution of services, so something needs to be done.

I agree that, regardless of the letters that independent midwives have had, the committee should seek further views from the Scottish Government, the UK Department of Health and the other appropriate organisations that have been mentioned.

Rhoda Grant: I can understand where Tricia Marwick is coming from, but I do not think that anyone would suggest that a private practitioner should not be insured. I can also understand where the petitioners are coming from. There must be some comeback if something goes wrong when someone is in the hands of a private practitioner. If something goes wrong at a birth, the consequences can be serious for the rest of the child's life and for the mother. I am not sure that we should argue that indemnity insurance should not be allowed.

By the same token, we cannot turn round and say to health boards that they must contract private practitioners. It is up to each health board to decide whether the use of independent midwifery services would be beneficial in particular cases. I am sure that there is nothing to prevent a health board from contracting such services. Perhaps we could ask health boards and the Scottish Government whether independent midwifery services could be incorporated into the NHS so that people could be offered a choice. Such choice exists already because midwife-led teams provide maternity services in many hospitals—that is certainly the case throughout the Highlands. I would be happy for us to ask about that.

We could also write to the Association of British Insurers to find out why insurers will not provide indemnity insurance to midwives when virtually any private business provider can get insurance services. It may be that, historically, insurers have not offered such provision because the RCM provided coverage, so there might be a need for that to be revisited. Those are my suggestions.

Cassy McNamara: Members of the Independent Midwives Association have tried all the major insurance companies and the reason that we have been given for not being offered insurance is that our numbers are small and that any claims against us could result in high payouts over a long period of time. I agree that we do not want to have no insurance. The fact that we are allowed to work without having formal insurance does not mean that we cannot be sued. Quite frankly, I would rather not lose my house but, as things stand, those are the conditions under which I work. I want insurance.

We have made huge efforts to approach insurance companies both in the UK and abroad

and to go back to them. They tell us that, for insurance purposes, they class us in the same category as obstetricians, who do caesarean sections and a great deal of complicated high-risk surgery. Midwives are experts in normal birth and more low-risk pregnancy, whereas obstetricians are experts in high-tech procedures, but the insurance companies say that they put us in the same bracket, which is why they will not provide cover for us. There are too few of us, any payouts could be large and people have 25 years to sue us.

The Convener: I am conscious that we are running short of time. We have a number of other petitions to consider and we need to take a five-minute break. We must obtain information from a range of agencies because the issue is fraught with complications and it gives rise to strong personal views. I get the sense that the committee has strong views about preserving the ethics of the NHS as regards public provision. Understandably, that is one of the discussions in which the petitioners have been caught up.

The committee has made a range of suggestions about how to proceed. We will formally seek the positions of the insurers, the Department of Health and some of the other organisations with which the petitioners have been in contact. We must get that information before we determine how best to progress the petition. A number of suggestions have been made about agencies to which we should write. We will explore the possibilities. As I said in relation to the previous petition, we will keep the petitioners informed of progress and will involve them in the discussion about what we should do next. I thank the petitioners for their time.

15:08

Meeting suspended.

15:15

On resuming—

Physiotherapy Graduates (Employment) (PE1044)

The Convener: Welcome back. Our next new petition is PE1044, which was lodged by Kate Mackintosh on behalf of the student members of the Chartered Society of Physiotherapy in Scotland. The petition calls on the Scottish Parliament to investigate the merits of extending the employment assistance that is given under the one-year job guarantee for newly qualified nurses and midwives to include newly qualified physiotherapists, with particular reference to the benefits for patient care. Before being formally lodged, the petition was hosted on the e-petition

system, where it gathered 1,748 signatures between 14 December 2006 and 9 February 2007.

We had a chance to speak to some of the students before today's meeting and some of them are present this afternoon. I welcome them to the meeting; they can relax in the knowledge that they will not get a grilling from committee members.

Do members have comments, questions or observations on the petition? I know that members have been lobbied on the matter during the past half year. In the period before the parliamentary elections in May, there was strong lobbying by student physiotherapists on opportunities for training years and so on.

Robin Harper: I listened to that lobby, and I was enormously impressed with the students who came to lobby us.

The fact that students suddenly find that there is no employment for them is not just a problem but an awful waste of their commitment to training. The issue is wider than the problem that is faced by the students this year. The bodies that train people for public services should think about taking on numbers for which they are reasonably certain there will be jobs. The cohort of young people who came through this year is fully trained and could and should be working in Scotland.

We need to do everything that we can. I recommend that we seek views on the petition from the Government, the Scottish Further and Higher Education Funding Council, Universities Scotland and the national workforce committee. The latter might have views on future planning and the other three might comment on what we should be doing now.

Tricia Marwick: Like Robin Harper and the convener, I remember the lobbying before the election. I declare an interest in that I was lobbied by my nephew, who comes into the category that we are discussing.

There are a number of problems, one of which is universities' expectations regarding the number of young people whom they hope to place in the NHS and the difficulty of the NHS actually employing those people. Questions must be asked by the Scottish funding council and the universities, which continue to recruit young people with the promise that there will be NHS jobs at the end of their training. That is not the case. We need to find out the situation for people who are starting their training this year.

Secondly, we should write to the Scottish Government, which is responsible for the NHS. Hopefully, it will be able to get soundings from the NHS boards about how many folk can be employed. It is appalling that young, well-qualified people who want to be part of the NHS are being

denied jobs. For most of us who have had experience of the NHS in the past wee while, the idea that we can have too many young people qualified as physiotherapists is simply ridiculous when the NHS is crying out to meet current demand. We should speak to the funding council, the universities and the Scottish Government.

Rhoda Grant: When we write to the Scottish Government, we should ask about access to physiotherapy. I understand that there is a long waiting list but many problems can be sorted out if patients are seen early, and some of the health problems that come from not getting the right physiotherapy do not arise. If people who are off work with back problems have quick access to physiotherapy, that might have a knock-on effect on them getting back to work quickly. There would also be less of a drain on public services as a result of people claiming benefits when they are off sick.

Some time ago, my doctor's surgery ran a pilot in which people could self-refer for physiotherapy; they did not have to go to see their GP first. People had almost immediate access to physiotherapy, which was great. I have to declare an interest, because I used the service. My problem was dealt with really quickly, and although it had not kept me off work, I can imagine that someone in a different situation would have found themselves getting back to full health quickly. I do not know why we should not pursue such ideas, which would reduce waiting lists and cut the cost to the public sector of people being off work for long periods of time.

The Convener: A number of suggestions have been made. There is also an issue of looking at the expertise and asking whether special pilot projects or initiatives could be introduced in the period that would involve a range of different providers, such as the health service and social workers, to target intervention work or to reduce waiting times for physiotherapy or support.

We have covered all the organisations that we think we should contact. With that, we need to say to the petitioners that the next stage is gathering the information to see whether anything can be done. The petition asks for a one-year job guarantee model, which has been put in place for other professions. That would have major cost implications and the committee can explore those issues to raise a debate on costings.

I suggest that the petitioners continue to raise the matter with individual MSPs and the Parliament to get support. The lobby was reasonably productive. The petition has been in for a while and this is the first time that it has come before the committee formally. There might also be some regional variations, which the petitioners might be aware of. Particular health board areas

might have resources in local structures that could be freed up through lobbying and which could be used to address the issue. I encourage them to continue to do that, alongside the work that the petition has raised for the committee.

Is the committee happy with the recommendations on who should be contacted next?

Members indicated agreement.

The Convener: We will be in contact subsequently with those who submitted the petition. I thank you for your time. If you have anyone to sort out, you can leave now. Could you come and see me after my knee operation?

Charter for Grandchildren (PE1051)

The Convener: The next petition is PE1051, by Jimmy Deuchars, on behalf of Grandparents Apart Self-help Group Scotland. The petition calls on the Parliament to urge the Executive to make the charter for grandchildren legally binding to ensure that the rights of children are recognised by all public agencies and families and are enforced by law. Before being formally lodged, the petition was hosted on the e-petition system; between 27 February and 14 April it gathered 277 signatures. A further 95 signatures have been provided in hard copy.

Do members have any views on the petition?

Tricia Marwick: I declare yet another interest, in that I am a grandma.

The Convener: I do not believe that.

Tricia Marwick: I know, but I was a child bride, which helped in the first place.

I cannot imagine a circumstance in which I would not have access to my little grandson. I sympathise deeply with those who have no contact with their grandchildren. I took my grandson to the park yesterday and I know full well the important role that grandparents play. On whether the charter for grandchildren should be legally binding, we should write to the Scottish Government to ask what plans it has to make the charter more robust than it is at the moment. I am not sure that we can make it completely legally binding, but there is some way for it to go. We should seek the views of the Scottish Government.

Rhoda Grant: I agree. Grandparents play a huge role in the lives of their grandchildren. I know of a lot of cases in which grandparents have taken over the care of grandchildren. In some cases, grandparents are not consulted and are left battling in the dark. I would agree with anything that would help grandparents get support. I know that Children 1st has groups of grandparents and supports family groups. It would be worth

consulting it on the issue, as well as asking the Scottish Government for its thoughts.

The Convener: I believe that the petitioner is present in the public gallery. We will ask the Government for its position on the issues raised and on the legal framework. The petitioner has heard from members of the committee that there is general sympathy with the petition. We have to consider the legal interpretation and which rights are paramount. I hope that we will get a response; once we do, we will continue the process for the petition.

Supermarket Developments (PE1058)

The Convener: I welcome to the committee Sandra White MSP who has expressed interest in the next petition. I know that Bashir Ahmad has to leave now; he has to deal with another commitment unexpectedly. He kindly sought permission to leave, which I have kindly granted. Thank you for your contribution, Bashir.

Bashir Ahmad (Glasgow) (SNP): Thank you.

The Convener: The next petition is PE1058, by Samer Bagaeen. I genuinely apologise if I have pronounced that wrong; I have had a lifetime of people mispronouncing McAveety, so that is my wee bit of revenge. The petition calls on the Scottish Parliament to consider and debate the traffic, environmental and sustainability impact on existing communities in designated town centres of large 24-hour supermarket developments. Before being formally lodged, the petition was hosted on the e-petition system between 8 March and 11 May, where it gathered 594 signatures.

Sandra, do you wish to comment on the petition?

Sandra White (Glasgow) (SNP): Thank you for allowing me to come and speak in support of the petition, convener. You said that the petition was hosted on the e-petition system between March and May. The reason for that is that Tesco changed the application, so objectors had only that short time to start objecting and picking up names for the petition. The situation has been on-going for a number of years. The petition relates to an area in Partick with which you might be familiar, convener. Given certain aspects of planning legislation, the petition should be taken forward, although that is up to the committee. Scottish planning policy 8 relates to how an application affects communities, shopping and the environment and SPP 17 relates to the traffic implications of a development.

15:30

I am concerned that, to date, Glasgow City Council has not done any traffic impact

assessment on the implications of the extra traffic that will result from this huge development, which will include not just shops but student accommodation. There will obviously be great traffic implications, as the site is in a very congested area of Partick with no direct bus route. Buses go along Dumbarton Road, but they do not necessarily go down into Beith Street.

Another cause of concern—for me and for the petitioners—is the lack of consultation between Tesco and local residents. At the moment, Partick is a thriving community with lots of shops that sell white goods as well as groceries. The proposed Tesco development will have huge implications because it aims to sell something like 40 per cent white goods and 60 per cent groceries. We believe that that will lead to the decimation of Dumbarton Road and other areas. There is already a huge Morrisons supermarket just along the road from the proposed development. Around the corner and up the road—in Byres Road—there is an Iceland, a Sainsbury's and a Marks and Spencer's.

We feel that a traffic impact assessment should be done; I would like to hear more from Glasgow City Council about that. I do not know whether there are implications for the Government and for planning law, but I think that the issue is pertinent not just to Partick but to other areas. Without wanting to sound too bad towards Tesco, I am aware that some areas have been described as Tesco towns. I know that various committees have considered the issue previously, but I wanted to put forward my concerns, which are shared by the vast majority of the community in Partick.

I will leave it at that, convener.

The Convener: Do any other members have comments or observations?

The constituency member—Pauline McNeill—has also engaged with the petitioners and been in contact with me. Her principal concerns, amidst other details, were about the broader issue of the impact of 24/7 opening and the wider environmental factors. A series of public meetings on the issue has been held in the locality.

The committee is anxious not to intrude on a planning application, but I think that the petition raises broader issues not just about the application per se but about the general principle of the need for a framework for assessing large applications. I am sure that we have all been involved in applications from retailers—not just Tesco but Scottish Co-op and others—that fit in well with local developments but need a bit more constructive engagement in the process. We need to be cautious about the issue.

Do members have any strong views on how we should respond to the petition that is before us?

John Wilson: Convener, I seek a point of clarification. Sandra White mentioned that there are a number of large retail outlets nearby, but she did not say whether any of those open all day. Do any of those outlets have 24-hour opening?

Sandra White: The store in Crow Road—just up from Dumbarton Road, where Crow Road leads into Anniesland—has 24-hour opening. The local residents have complained about being wakened at 4 and 5 in the morning. The store is not open for shopping 24 hours a day, but people are woken up at 4 and 5 in the morning because deliveries take place 24 hours a day. That store is just up the road from the proposed development. Also, the Asda store just over the river is open 24 hours a day.

John Wilson: A traffic impact assessment needs to be done. Clearly, there are issues with allowing such shopping developments to go ahead in a built-up residential area. I am sure that residents in many towns and cities throughout Scotland have similar complaints about the traffic impact, in particular of heavy goods traffic. As Sandra White indicated, if the level of white goods that will be sold in the outlet requires heavy goods vehicles to move through a built-up area 24 hours a day, that will have an impact on the amenity of the area for local residents.

Robin Harper: I will try to refrain from referring to any development to which I have objected in the past. Instead, I will stay with the general concern about the huge power of supermarkets to change the entire shape and social fabric of our cities and towns. It is long past the time when the Parliament should have given the issue its serious attention. The Government needs to produce a planning framework that allows the survival of what is left of our town centres and the social fabric that they represent.

Rhoda Grant: In normal circumstances, I would say that we should leave the matter to the local authority, given the strictness of the planning guidelines and the fact that this is a local authority issue.

Although I am sure that the local authority will deal fairly with the matter, my concern is that the process must also be seen to be fair. I note the conflict of interest in this case: the local authority owns the land and it is the planning authority. Planning is a legalistic process. It is therefore only fair that, if an authority may benefit from the approval of a planning application, its decision on the matter should be independently reviewed. We should write to the Scottish Government to ask whether there is a process under which another local authority can overview planning decisions.

John Farquhar Munro: That makes sense. It is a good idea.

Tricia Marwick: Two issues are involved: out-of-town supermarkets that open 24 hours a day and supermarkets in built-up areas that also open 24 hours a day. The decision that is the subject of PE1058 has broader implications. I am not sure whether either the current planning guidelines or the provisions in the Planning etc (Scotland) Act 2006 make a distinction between out-of-town supermarkets and those that are located in built-up areas.

We should write to the Scottish Government to ask whether it is satisfied that the current planning guidelines and regulation, including those that will be put in place once the 2006 act is fully implemented, are sufficient to deal with the concerns that people are expressing about the location of 24-hour supermarkets in built-up areas. The two types of supermarket should not be treated equally under the planning framework, but that may be the case at the moment.

A 24-hour supermarket may be acceptable in an out-of-town area, but it is not acceptable in a built-up area. As I said, I am not convinced that the planning framework gives local authorities the discretion that they need to make a distinction between the two. The broader issues involved mean that we should write to ministers, particularly given the possibility of similar future applications.

I make no comment on the planning application or whether the authority owns the land; I simply voice my suspicion that the authority may find that its hands are tied in terms of rejecting the application. There may be no planning guidance that gives it comfort and support in that regard.

The Convener: As has been mentioned, it would be helpful to get the present position—although that is dependent on the democratic structures of the planning committee and the process that is being engaged by the local authority for the application—as some of the issues that are being raised are critical. As a broader submission, we should also seek views on whether there could be a conflict of interests because local authorities have a dual role in the process and on whether a neighbouring authority could use its professional judgment to oversee the effectiveness of the process.

I will get information from the Convention of Scottish Local Authorities on some of the issues that have been raised, as COSLA was helpful in its response to consultation on the Planning etc (Scotland) Bill. I will also get information from the Scottish Retail Consortium. The issue is contemporary and will continue to be a challenge for towns and neighbourhoods across the country over the next five to 10 years, given retailing's present direction. That will be a reasonably good cross-section of agencies and organisations from which to seek further information.

I thank Sandra White for her attendance and I thank committee members for their suggestions.

Legal System (Fee Arrangements) (PE1063)

The Convener: The next petition is PE1063, from Robert Thomson, which calls on the Scottish Parliament to investigate the apparent conflict of interests that exists between solicitors or advocates and clients in the present system of speculative fee arrangements—commonly known as no win, no fee arrangements—and to urge the Scottish Executive to overhaul the existing speculative fee arrangement framework and procedures to make solicitors and advocates more accountable to their clients. Before being formally lodged, the petition was hosted on the e-petition system between 11 December 2006 and 8 June 2007, where it gathered 15 signatures.

Do members have any strong views on how we should deal with the petition?

Rhoda Grant: I have some sympathy with the petitioner, but I cannot see how we can do anything to give him comfort. If no win, no fee arrangements were not available, the people who use the service would not be able to take the cases that they want to pursue through the legal process. If someone does not pay a fee to a solicitor, the case proceeds on the basis that the solicitor will try to recoup a fee somewhere in the process. If that person were to say that the solicitor could not take a certain action, they would be preventing the solicitor from recouping their fee.

It is a complex issue and I am happy for us to seek further views on it, but I am not sure that we will find a solution. If we say that solicitors cannot operate in this way but must represent the wishes of their clients, the solicitors will withdraw the service if they feel that they have no way of recouping their fee. I do not know what other committee members think about that.

Claire Baker (Mid Scotland and Fife) (Lab): I accept Rhoda Grant's position and I agree with her. I am interested in whether there is sufficient guidance for people who decide to enter into a no win, no fee arrangement. Citizens Advice Scotland does some work in the area. If we were to ask for other views on the position, I would like us to explore whether it is made clear to people what they are entering into with a no win, no fee arrangement.

Rhoda Grant: Perhaps we could write to the Law Society of Scotland, asking what guidance solicitors give when they operate on a no win, no fee basis and whether it is made clear to the person on whose behalf they are operating that, at the end of the day, the solicitor must find a course of action that will enable them to be paid a fee.

It needs to be pointed out at the beginning that, if there is a risk of the solicitor not getting their fee, the action that they take could be detrimental to the needs of their client. The person can then have the option of employing a solicitor whom they can tell what they want to do or not do on a different basis.

The Convener: That is a helpful suggestion. We should also write to the Scottish Consumer Council, asking for its views on the appropriateness of the available information about the service and the enforcement and commitment issues. We can write to those two organisations. Do members have any other suggestions of organisations to which we could write?

15:45

John Wilson: We should also write to Citizens Advice Scotland.

The Convener: That is not a bad idea. Writing to the three organisations that have been mentioned would be a reasonable starting point.

Rhoda Grant: We should also write to the Faculty of Advocates, as it is mentioned in our briefing and operates under a different system.

The Convener: Fair enough. I thank members for those suggestions. We will process the petition in the way that has been outlined.

Scottish Prison Population (Catholics) (PE1073)

The Convener: The next petition for consideration is PE1073, from Tom Minogue, which calls on the Scottish Parliament to investigate and establish the reasons for the apparently disproportionate number of Catholics in Scottish prisons. Before the petition was formally lodged, it was hosted on the e-petition system between 28 November 2006 and 15 June 2007, where it gathered 131 signatures. Do members have views on how the petition should be taken forward?

Robin Harper: The figures that the petitioner cites seem anomalous, but they should inspire a piece of sophisticated social research. It does not strike me that the anomaly has anything to do with religious persecution. If the figures that have been cited are accurate, a sophisticated piece of social research should be commissioned.

The Convener: As someone of that persuasion I am nervous about dealing with the petition, on the basis that I might find myself in jail. There is concern about the fact that the number of Catholics in prison is disproportionate. Some would argue that there are powerful sociological, class and economic reasons for that, but the discussion on the e-petitions system indicates that

some people are still strongly of the view that the figures should be investigated. It is obvious that there is not much information on the issue, so we should explore it further. How do members think we can get to the bottom of the matter, so that we can reassure people that the judicial process is fair and not discriminatory, as we would be concerned if there were evidence of discrimination? We should send out a strong message that we are tracking the phenomenon and that we will deal with it appropriately, where possible.

John Wilson: I suggest that we widen the discussion. The petition suggests that the number of Catholics in prison is out of kilter with the percentage of Catholics in the population, but the figures that are before us show clearly that the same is true of other ethnic groups. If we are to make approaches to anyone, we need to seek responses that address the wider issues that relate to those categories of prisoners and to investigate why the differences that have been identified exist. The Muslim population of Scotland is 0.8 per cent of the total, but Muslims make up 1.7 per cent of the prison population. Clearly, the number of Muslims in prison is out of kilter with the percentage of Muslims in the general population. Instead of confining the discussion to one religious group, we should widen it out and ask whether any research into the issue has been done, what its findings were and what impact the phenomenon has on society in general.

Rhoda Grant: I am happy with what has been suggested.

Robin Harper: When I proposed that there should be sophisticated research, I meant that it should be wide ranging—as John Wilson has suggested—and that there should be statistical analysis of the entire prison population to establish the commonalities that exist. Something else may be behind apparent commonalities that have been identified.

The Convener: As for how best to respond to the issues that have been raised in the petition and in the committee's discussion, one option is to write to ask the justice department what information it has. Some statistical research or academic work could be useful. I am wondering off the top of my head who would be best to call for that. We may well see a gap or an anomaly. Could we ask the Government whether, in its research models or its commissioning of research to influence policy frameworks and development, it has considered religious affiliation in examining where the numbers in the prison population are coming from? Much work is done on the social class and the economics of the prison population. Is religious affiliation considered in relation to the prison population and sentencing policy? Are like-for-like comparisons made between ethnic groups

and religious groups in relation to sentencing policy?

The process has two stages. We will initially ask the justice department for its views. After we have that response, we need to determine whether it is adequate or whether we require further explanation.

Road User Charging (PE1074)

The Convener: The next petition is by Nancy Gardner and calls on the Scottish Parliament to urge the Executive to reject road user charging or national road pricing on Scotland's roads. Do members have views on that?

Tricia Marwick: I am not aware that the Scottish Government has any plans to introduce road pricing on Scotland's roads. I suggest that we note the petition and close it.

The Convener: Are members happy with that recommendation?

Members indicated agreement.

The Convener: That was quick—sorry, did Robin Harper want to speak?

Robin Harper: I want just a tiny word. I put it on the record that I am reluctant to let the petition go.

The Convener: I assure the member that I do not want the Government to be involved in any difficult political situations in the near future but, if it pops up with that idea, I am sure that the member will have a view. What Robin Harper said is in the *Official Report* now—it was a bit green of him to miss the opportunity.

Current Petitions

Mental Health Services (Deaf and Deaf-blind People) (PE808)

15:52

The Convener: PE808 is by Lilian Lawson, on behalf of the Scottish Council on Deafness, which calls on the Scottish Parliament to urge the Executive—sorry, the Government—to develop and establish a specialist in-patient mental health unit for deaf and deaf-blind people and to provide resources, such as training, for mainstream psychiatric services in the community to make them more accessible to deaf and deaf-blind people in Scotland. The petitioner's letter of 17 April is available for committee members.

Do members have suggestions for how best to deal with the petition? A couple of years ago, there was an effective lobby of the Parliament on similar issues. It reminded members that we might not notice the impact of poor-quality services on people whose needs are slightly different from those of people who fit into more conventional boxes.

Rhoda Grant: We should write to the Scottish Government. It is difficult enough for deaf and deaf-blind people to access NHS services when they have a physical problem, but when a mental health issue is involved and communication is at the crux of finding the solution to the problem, obtaining support is even more difficult. Someone could sign for a deaf person or whatever, but the situation would be really difficult.

We should flag up the issue again and find out whether funding support is available or could be provided. I read about a facility in England, but that is a long way for people to go from their support base and their families. People do not seem to receive the help and support that they need in such a situation.

John Farquhar Munro: Perhaps we should find out what funding is available in the current financial year. What support is the Scottish Government giving to health boards to promote and support services for deaf and deaf-blind people, particularly those who have a mental health problem?

The Convener: The petition raises a number of issues, not just about the money that is available but about the quality of services and their capacity to be flexible. I have been lobbied on the issue, so I am aware that discussions have taken place at Greater Glasgow and Clyde NHS Board level about how to put together a more appropriate package of services—such a package might not be ideal but would start to meet needs that are identified in the petition.

We should write to the Government to ask about the current position. What has happened as a result of the July 2006 research? Has good practice been developed? Have health boards introduced new measures that are meeting demand, where demand is concentrated? How are boards tailoring services and taking into account concerns, in particular about people who have a mental health issue that is associated with their experience of being deaf or deaf-blind? For example, are equality impact assessments taking account of such issues? Are members happy to ask the Government's health department a range of questions and to review the petition in the light of the responses that we receive?

Members indicated agreement.

Vulnerable Adults (Medication) (PE867)

The Convener: PE867, which was brought by W Hunter Watson, calls on the Scottish Parliament to provide adequate safeguards against vulnerable adults being given, by surreptitious means, unwanted, unnecessary and potentially harmful medication. Members have the submission dated 23 March from the Scottish Executive and submissions from the petitioner dated 23 June and 20 September. Do members have strong views on how we should proceed?

The petitioner raised a number of issues on which we need a response. Perhaps we should write to the Government about the role of the code of practice on the administration of medicines in the context of the ethical framework that is provided under the Adults with Incapacity (Scotland) Act 2000.

Claire Baker: There is a difficulty in that we must await the review of the code of practice. Perhaps we should seek more information from the Government about the timescale for publication of a revised code.

I was not a member of the Parliament when the 2000 act was passed, but I know that the act does not explicitly mention covert medication. It would be worth our asking the Executive whether the issue will be dealt with in the revised code.

John Farquhar Munro: I am sure that there is a strict code about the administration of medicines to vulnerable people—indeed, to all people. However, what controls are there on what happens inside care homes and institutions? That is where the problem exists.

The Convener: There have been recent sad cases in the press about the quality of care in one or two institutions, where there has been neglect as a result of failure to follow through on medication.

We should ask what impact the revised code will have on care standards that have been developed as a result of legislation that the Parliament has introduced in relation to the Scottish Commission for the Regulation of Care and the Mental Welfare Commission for Scotland. We want the Government to give us a clear picture of the applicability of standards and of how the issue links to those agencies. I, too, am interested in the timescale for the publication of a revised code.

If members have no strong views on the petition, I think that by asking about such issues we will make progress on the issues that are raised in the petition. We will await a response from the health department and take it from there.

Neurological Services (Post-polio Syndrome) (PE873)

16:00

The Convener: The next petition, PE873, is by Helene MacLean on behalf of the Scottish Post Polio Network. It calls for the Parliament to urge the Scottish Executive to join the international community in recognising post-polio syndrome—PPS for short—and to conduct a much-needed national review of neurological services to take account of the needs related to PPS and all other long-term neurological conditions with a view to establishing multidisciplinary centres of excellence to assess, treat and research such conditions, which affect the lives of many thousands of individuals in Scotland.

Our papers include written submissions from the chief scientist on 2 March 2007 and from the petitioner on 8 February, 2 June and 25 June. Do members have any views on how to proceed with the petition?

Rhoda Grant: The petitioner was supposed to meet the chief scientist's office. Do we know whether the meeting took place and what the outcome was? We could perhaps write to find out about that.

The Convener: Like a lot of the petitions that we have dealt with today, the petition is about the exchange of information and the guidance and guidelines that are available. It also concerns the role of NHS Quality Improvement Scotland on neurological standards. Are there any other key issues that committee members feel strongly about?

Rhoda Grant: If we are writing to the Scottish Government, we could also ensure that there is consistency across NHS boards in how they deal with PPS.

The Convener: So we want to write to the Government asking about the outcome of the

meeting and discussions with the chief scientist's office, the guidelines that are made available to NHS boards, the consistency across those boards in assessing patients' needs, and whether any networks have been developed across NHS boards to meet the needs of people with the condition in question. We can also ask NHS QIS about the development of its document on neurological standards. Are there any other observations?

Robin Harper: I have a general point. This is the second time that consistency across NHS boards has come up this afternoon. It is in the back of my mind that it might be appropriate to have a wider investigation into consistency of approach among NHS boards in Scotland.

The Convener: That is a fair call. I do not envy those who have to deal with that, because the NHS is a complex organisation with lots of different tensions at different levels and lots of lobbies to deal with. We have experienced as elected members—and I am sure that we will continue to experience this in the next four years—how some boards provide a range of services for particular illnesses while others that are cheek by jowl with them are still in the dark ages in their provision.

Rhoda Grant: There must be some cross-cutting of expertise and knowledge among boards. I know that there is a management structure, but surely clinical networks should be in place.

The Convener: Okay. That was a helpful suggestion. Are we agreed on what we want to do with that petition?

Members indicated agreement.

Railway Infrastructure and Services (Inverness, Thurso and Wick) (PE894)

The Convener: The next petition is PE894, in which Rob Gibson has expressed a particular interest. It is by the association of Caithness community councils, and it calls for the Scottish Parliament to consider investment in infrastructure, rolling stock and timetabling as part of a strategic root-and-branch review of the provision of rail services between Inverness, Thurso and Wick, with unrestricted thinking—that is a lovely phrase—on how best to shorten journey times and ensure the continuing future of the railway to those destinations. Thought should also be given to ensuring that the existing communities of the Lairg loop are provided for.

Committee members received written submissions from the Highlands and Islands strategic transport partnership on 25 April 2007, from Caithness Partnership on 4 and 15 June and from the petitioner on 22 September. We have

also received a number of unsolicited responses that support a Dornoch rail link and draw attention to the consultation process undertaken by HITRANS.

Do members have any strong views? I am sure that, as the Green committee member, Robin has a view.

Robin Harper: As someone who has travelled frequently on the network in question and who intends to travel on it during the coming break, I sympathise with the petitioners. Network Rail is making general improvements to parts of the line that runs along the coast, but a reduction in journey times, in particular, would meet with considerable approval in the Highlands—I speak as a visitor, rather than a resident, although I was born in Thurso.

Rhoda Grant: Substantial work is needed on the petition. The speeding up of journey times would be a huge improvement and would open up the north. Much work is going on to consider economic development in the area in the context of the decommissioning of Dounreay. The rail line and journey times are important.

I have concerns about the Lairg loop. It would be wrong to have a crossing of the Dornoch Firth that bypassed Lairg, because the Lairg area needs good transport links. Sutherland is probably more economically deprived than other areas.

We should refer the petition to the Transport, Infrastructure and Climate Change Committee. I know that the Public Petitions Committee does not often refer petitions, but the work that is needed falls outwith the scope of this committee and would benefit from the scrutiny of a subject committee.

John Farquhar Munro: The issue has been on the agenda of Highland Council and Network Rail for many years. I am sympathetic to the implementation of any measure that could cut journey times between destinations. It is estimated that the journey time between the far north and Inverness could be cut by half an hour or more.

Like Rhoda Grant, I am conscious of the problem that would be created by a crossing of the Dornoch Firth that cut out the Lairg loop, which has been served by rail for many years. However, we cannot halt progress. There is a strong lobby for a rail crossing of the Dornoch Firth in the communities of Caithness, Sutherland and the wider Highlands. We could support such a crossing. I am not sure to whom we should refer the petition, but I note the suggestion that it be referred first to the Transport, Infrastructure and Climate Change Committee of the Scottish Parliament.

The Convener: If no other member of the committee wants to comment, I will bring in Rob

Gibson, who has expressed an interest in the petition.

Rob Gibson (Highlands and Islands) (SNP): Thank you. I have been involved with the issue for a while, but now that I am a member of the Transport, Infrastructure and Climate Change Committee I am aware of discussion about the Scottish Government's tier 3 rail projects, which are being costed. Of course, other projects must form a queue.

The issue that the petition raises has been discussed since the 1980s, but it is becoming more urgent as a result of the decommissioning of Dounreay and the development of the far north, as Rhoda Grant said. The 45 minutes that could be saved by building the Dornoch rail link between Tain and Golspie, via a new station at Dornoch, would start to make rail competitive with road. In the context of climate change, that is more relevant than it has ever been.

There have been many arguments about the Lairg loop, which affects 2,000 or 3,000 people. Those people's interests must be looked after. However, there are commuter links between Lairg and Inverness. The 50,000 people who live north of Golspie, in east Sutherland, Caithness and Orkney, are greatly disadvantaged by a service that takes well over four hours to make a journey of 100 or so miles. It takes longer to get from Wick to Inverness than to get from Inverness to Edinburgh, although the distance is far shorter. The Transport, Infrastructure and Climate Change Committee could consider what studies are required, because often the Government, through HITRANS, has asked the wrong questions. That has forced the Dornoch link action group to commission its own studies, the first of which cost £15,000, from Corus rail engineering. That showed the intent of people in the far north to find the money for such studies. A second study, which will consider the potential impact of the project on passenger numbers, is to follow.

I do not want to take up too much of the committee's time, but it would be a good idea for the Transport, Infrastructure and Climate Change Committee to consider the complex issues that have been raised. It would help the discussions of how tier 3 rail projects stack up if this project were put into the pot. We have an opportunity to do that and to take the issue forward. At present it is in the hands of the Public Petitions Committee and is unresolved.

The Convener: There is a reasonable consensus on what the next stage should be. I am sure that I will endear myself further to the Transport, Infrastructure and Climate Change Committee by referring another petition to it; I await the committee's letter with interest. The Public Petitions Committee has been cautious

about referring petitions to other committees when we think that we can take up the issues that they raise. However, given the detail of this petition and the fact that major organisations such as the local authority have been involved in the history of the transport network in that part of the country, it strikes me that a policy committee would bring more rigour to the process. Do we want to draw attention to particular issues that the petition raises, or should we allow the Transport, Infrastructure and Climate Change Committee to determine the matters that it wishes to pursue?

Rhoda Grant: We should allow the committee to take on the petition without any constraints.

John Farquhar Munro: Plenty of information has been gathered over the years, so there is no scarcity of documentation.

The Convener: I note with interest that the members for the Highland region did not declare an interest before we discussed the petition, but what can we expect? I thank Rob Gibson for his time. We will refer the petition to the Transport, Infrastructure and Climate Change Committee. That is a Glaswegian's response to such issues.

Disabled Parking (PE908, PE909 and PE1007)

The Convener: We have grouped together PE908, PE909 and PE1007. PE908, from Connie Syme, calls on the Scottish Parliament to urge the Executive to ensure that traffic regulation orders are applied to all disabled parking bays and that such bays are used by registered disabled users only. PE909, from James McLeod, on behalf of the Inverclyde Council on Disability Ltd, calls on the Parliament to review the Local Authorities' Traffic Orders (Procedure) (Scotland) Regulations 1999, to allow for speedier provision and enforcement of dropped kerbs and disabled parking bays to prevent their abuse, ensuring greater and easier access for disabled, elderly and other users. PE1007, from Catherine Walker, on behalf of the Greater Knightswood Elderly Forum, calls on the Parliament to urge the Scottish Executive to prevent the improper use of disabled parking bays and to ensure that they are used by registered disabled users only.

There may be nuances to each of the petitions—I am sure that the petitioners bring to their petitions aspects of their experience that concern them—but we thought it best to pull them together. How do members wish to approach the petitions? I have been careful to use the plural—without an apostrophe, as there are a couple of former English teachers in the room.

Rhoda Grant: We discussed a similar petition last week. Can we consider it with this week's petitions? There needs to be consistency, as

people travel between local authority areas. We should write to the Scottish Government to ascertain whether it has made progress on achieving consistency across local authorities.

16:15

The Convener: That sounds reasonable. Previously, we queried whether COSLA has guidance for local authorities on the subject. Given our constituency case loads, I am sure that we all understand the issues that are involved in PE908, PE909, and PE1007, and are aware of enforcement agencies deciding, despite clear byelaws, not to deal with an infringement because it considers it not worth while or productive to do so, or because it has other priorities. I am in correspondence with agencies in a couple of cases where they have ignored issues that were raised at the community level.

The clerk has asked me to highlight the other concern, which is the blue badge scheme.

Rhoda Grant: It is similar. The blue badge scheme is not consistent with other schemes, which leads to the question how we can get a consistent approach.

The Convener: We agreed to write to the Scottish Government on the research review. We have also discussed how issues that the review may raise can be brought forward, either through the role of the minister or the policy framework, and we have discussed consistency. We will write to COSLA to ask for its position and to query its commitment to meeting the disability legislation. Does any member have a further comment to make?

John Wilson: I seek your guidance, convener. I understand that there should be consistency among—or uniformity between—local authorities in how they deal with the blue badge scheme and other disabled parking measures. Are we saying that the local authority should be the enforcing agency, or are we suggesting to the Government that it should consider other aspects of the enforcement of blue badge and disabled parking bay usage?

When local authorities, including the City of Edinburgh Council and Glasgow City Council, mounted high-profile campaigns in this area, they found fraudulent use of the provisions. From recent press reports, I understand that blue badges can change hands for large sums of money, such is their value. Widening the enforcement role, instead of simply leaving it to local authorities, is another issue for consideration. We may want to raise that with the Government in terms of its overall enforcement of the operation of such schemes.

The Convener: At present, the committee's position is that we cannot take an absolute position until we have all the information to hand. At this stage, we are exploring the reality of people's experience and seeking to discover what assessment of enforcement is in place, if any, whether by the Government—including the justice department—the police, or the various tiers of local government. We feel that it is helpful to seek COSLA's view on where we are on that. Obviously, we expect a response on the blue badge scheme, which might be helpful in terms of this range of petitions.

Claire Baker: Until we get responses from the relevant councils, I would be a bit cautious about including the issue of the blue badge scheme.

The Convener: I am happy to concede that.

Claire Baker: Is it worth making contact with Jackie Baillie MSP, in view of her proposed bill, the disabled persons parking bays (Scotland) bill? Her consultation on the bill may have highlighted some of the issues on which we seek answers.

The Convener: Okay.

The consultation process on Jackie Baillie's proposed bill ended in February 2007. We do not know whether she plans to reintroduce the bill, but I am sure that she will have engaged with many of the organisations that campaign for effective enforcement. I am not sure of the procedure by which we advise a member that the Public Petitions Committee has received a petition and ask them to comment in light of their experience.

The clerk has just advised me that Jackie Baillie is aware of our consideration of PE908, PE909, and PE1007. That is helpful.

Local Authorities' Traffic Orders (Procedure) (Scotland) Regulations 1999 (PE934)

The Convener: I am conscious of time, so I will try to get through the remaining petitions as quickly as possible—with apologies to the remaining petitioners.

The next petition is PE934 by Dr J W Hinton on behalf of the metered parking organisation. It calls on the Parliament to urge the Executive to review the Local Authorities' Traffic Orders (Procedure) (Scotland) Regulations 1999 to ensure that the local authority consultation in relation to traffic orders is full, meaningful and democratic.

Committee members have written submissions from Glasgow City Council on 11 June and from the petitioner on 30 July and 25 September. Are there any recommendations on how we proceed with the petition? It is similar to previous ones. I think that the best course of action is to write to

the Government to ask about the research that has been undertaken so far on the impact of the traffic orders regulations and of schemes under the Transport and Works Act 1992 and about the outcome of any discussions that it has had with the petitioner. Are there any other strong views on how best to deal with the petition?

Robin Harper: The council's executive director of land and environmental services gave a very detailed response to the 10 points made. What more can we do?

The Convener: If members are happy with the recommendations, we will take the petition to the next stage.

Sleep Apnoea (PE953)

The Convener: The next petition is PE953 by Jean Gall on behalf of the Scottish Association for Sleep Apnoea. It calls on the Scottish Parliament to urge the Scottish Executive to increase awareness, promote proper diagnosis and treatment, and provide sufficient resources, including adequately funded sleep centres, to tackle the health problems associated with obstructive sleep apnoea. I will do my best on the pronunciation—it is one of those words that will confuse me for the rest of the afternoon.

We have a copy of the written submissions from the Executive on 22 March 2007, from NHS Scotland on 19 April and from the petitioner on 11 June. Also present is Christine Grahame, who has expressed an interest in the petition. If there are no views from committee members on how to proceed with the petition, I will ask Christine Grahame to comment.

Christine Grahame (South of Scotland) (SNP): I am looking at the *Official Report* of the committee meeting in February 2007, when the committee agreed to write to the then Executive on producing guidelines for health boards to follow, given that what was once a national service has become a local service and that at least 55,000 people suffer from something that is entirely manageable. Have you had a response to that?

The Convener: We received a response. I apologise to members, as this is the first time I have seen it. It was sent on 22 March by the then Deputy Minister for Health and Community Care, Lewis Macdonald. I will try to summarise it as best I can.

The letter refers to the study on screening for the sleep apnoea/hypopnoea syndrome and driving impairment in professional drivers. It says:

"Difficulty in obtaining access to professional drivers and other factors meant that the survey achieved a smaller than expected sample size and it was deemed therefore inappropriate to move on to the more detailed sleep studies

in the second stage of the project. A significant minority of drivers surveyed reported falling asleep while driving, or having had an accident or near miss due to sleepiness while driving. Symptom reports suggest that around 8 per cent had Obstructive Sleep Apnoea/Hypopnoea Syndrome, which is within the range reported by other studies of professional drivers”.

In a sense, the letter is not that substantial. That is where we are.

Christine Grahame: This is a serious issue. In road traffic accidents, we are unable to determine whether somebody has fallen asleep at the wheel, but many drivers will admit that they have dozed off while driving, and lorry drivers are in particular danger because of their sedentary lifestyle. On top of all the other issues, a road traffic accident with fatalities costs about £1 million to the public purse.

At the committee’s meeting on 6 February, one question that Jackie Baillie posed was:

“Are you going to produce guidelines for health boards to follow?”

She said:

“The Executive is to be commended for setting up the Scottish sleep forum, but there is still a lack of a framework for health boards to take this forward. Perhaps we could pose those questions.”

The convener replied:

“We should ask those questions. Is that agreed?”—[*Official Report, Public Petitions Committee*, 6 February 2007; c 3087-88.]

The committee agreed to that, but Jackie Baillie’s question has not been answered, has it?

The Convener: My impression from the notes that are in front of me is that the question has not been answered.

Christine Grahame: I understand that, given the change of Government, it would be unfair or too cruel—

The Convener: I do not want to blame the Government.

Christine Grahame: Not yet, convener—give us time. As a new minister is in place, we should emphasise that the petition has been on the go for 18 months. The committee worthily pursues issues for the public, but perhaps some ministerial responses are not being provided crisply and promptly enough. That question needs to be answered.

The Convener: I suggest that we reinvigorate that inquiry, particularly on what plans the Government has for Scottish intercollegiate guidelines network guideline 73 to be revised and updated and what plans it has to address the issues that the petition raises, such as whether resources are being made available for health boards and others to address the concerns.

Christine Grahame: When Jackie Baillie made her commendable suggestions, she said:

“I note that my health board, NHS Greater Glasgow and Clyde, is not included.”—[*Official Report, Public Petitions Committee*, 6 February 2007; c 3087.]

That means that a substantial area of Scotland was not included. We need clarity from the minister about the resources and the guidelines for referral to sleep centres, so that we can draw together a picture of what is happening. Some people wait a year for an assessment.

Rhoda Grant: This is another issue on which we need to find out whether cross-cutting information on the same treatment is being issued across health boards, regardless of the health board area.

The Convener: I hope that nobody in the health department has been asleep on the job on the issue.

Christine Grahame: If you saw the *Official Report* of the meeting on 6 February, you would realise that I must have been asleep, because I could not remember what to call an air traffic controller.

The Convener: Committee members have made helpful suggestions. I thank Christine Grahame for coming to express her views on the petition. We want to ask several questions about the response and we will cover Rhoda Grant’s point about consistency across health boards.

I thank Christine Grahame for her time. She is welcome to stay for the rest of the meeting if she wants to.

Christine Grahame: I will listen to what the committee says about the petition on high hedges, on which many of us have been lobbied.

The Convener: That is fair enough.

Plants (Complaints) (PE984)

The Convener: The next petition is PE984 by Dr Colin Watson, on behalf of Scothedge, which calls on the Scottish Parliament to introduce legislation to provide local authorities with the power to deal with complaints about vigorous growing trees, hedges, vines and other plants. We have a letter of 22 September from the petitioner and several unsolicited letters have been sent to the committee to call for action to be taken. Do we have strong views on how to proceed? Does Robin Harper have strong views as a Green member?

Robin Harper: I backed Scott Barrie’s bill. The suggestion of using the antisocial behaviour strategy is interesting and worth considering, because blocking the sun from a neighbour’s garden is extremely antisocial.

Would the Government like to issue guidance to local authorities and to follow up what guidance, if any, local authorities give on the care and maintenance of hedges on public and private land?

Claire Baker: I understand that the UK Government has taken steps to address the issue. Could we write to it to find out how successful those measures have been? I think that steps were taken as part of addressing antisocial behaviour. If the clerks could look into that, that would be appreciated.

Christine Grahame: I think that UK legislation on high hedges has been passed—it was mentioned when attempts were made to amend the Planning etc (Scotland) Bill to deal with the issue. I stayed to say that I understand that the Minister for Community Safety, Fergus Ewing, is prepared to consider legislation on the matter. I do not remember whether I was told about that in an e-mail or a parliamentary answer. It might be useful to ask the minister to clarify whether the issue is being investigated with a view to producing legislation, which I think is being considered.

The Convener: That is helpful. I thank members for those suggestions. We will pursue the petition through the suggested measures. Okay?

Members indicated agreement.

The Convener: I thank Christine Grahame.

Accountant in Bankruptcy (PE1008)

16:30

The Convener: The final petition is PE1008 by James Ward, who calls on the Parliament to urge the Executive to review the operation of the Accountant in Bankruptcy, particularly in relation to the implementation of section 187(1) of the Social Security Administration Act 1992. We have the Government's letter of 29 June 2007 and the petitioner's letters of 11 and 26 July 2007. Do members have strong views on how to deal with the petition? The subject is complex and members probably do not have expertise in it, but do we want further information from any agencies?

Claire Baker: I am interested in the petition. In its letter, the Accountant in Bankruptcy cannot say how many refunds have been made in cases in which individual trustees are appointed. I am not sure whether that body could give us more information on that, but we could try asking. I would like to know more about the number of individual trustees and whether they are aware of the existing guidance. That seems to be a gap in knowledge.

The Convener: That would help. Do members have other strong suggestions?

Rhoda Grant: Does the Bankruptcy and Diligence etc (Scotland) Act 2007 contain relevant provisions? If so, we could ask the Scottish Government when such provisions will come into force.

The Convener: We will write to the Government about the timetable for the 2007 act and about whether any guidance is required to address the concerns that the petition raises. Claire Baker suggested writing to the Accountant in Bankruptcy about the number of cases that involve individual trustees, and we can also ask it about relevant statutes. If we are happy with those recommendations, we will process the petition.

Members indicated agreement.

The Convener: I thank members for attending that fairly extensive meeting. We try to keep meetings within two hours when we can, but we had an awful lot of petitions to consider today. That concludes our consideration of the petitions on the agenda. We will next meet on Tuesday 23 October 2007.

Meeting closed at 16:32.

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