# PUBLIC PETITIONS COMMITTEE

Tuesday 15 April 2008

Session 3

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## PUBLIC PETITIONS COMMITTEE
**6th Meeting 2008, 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)
Nigel Don (North East Scotland) (SNP)
*Rhoda Grant (Highlands and Islands) (Lab)
*Robin Harper (Lothians) (Green)
*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:**

Tom Divers (Greater Glasgow and Clyde NHS Board)
Nick Henderson
Billy Hunter (Greater Glasgow and Clyde NHS Board)
Brian Main (NHS Tayside)
Gerry Marr (NHS Tayside)
Paul Martin (Glasgow Springburn) (Lab)
Rob McDowall

**CLERK TO THE COMMITTEE**

Fergus Cochrane

**ASSISTANT CLERKS**

Franck David
Zoé Tough

**LOCATION**

Committee Room 6

# Scottish Parliament

## Public Petitions Committee

*Tuesday 15 April 2008*

[THE CONVENER *opened the meeting at 14:01*]

## New Petitions

**The Convener (Mr Frank McAveety):** Good morning and welcome to the sixth meeting in 2008 of the Scottish Parliament's Public Petitions Committee. Please ensure that all mobile phones and other electronic devices are switched off.

I welcome back to the committee Angela Constance, who has been on maternity leave. Her substitute for that period was John Wilson, who so enjoyed his experience on the committee that he is now a substitute again, for a short period, for Nigel Don. Welcome back, John. John got enough praise at our previous meeting, so I am not going to praise him again for his contribution as a committee member.

We have an extensive agenda, so without further ado we move to item 1, which is consideration of new petitions. PE1136 has been withdrawn by the petitioner, so we now have two new and 22 current petitions before us. Some of the current petitions will be considered together this afternoon. As agreed at our previous meeting on 19 February, we will take oral evidence on the last two current petitions, PE1086 and PE1091, on national health service hospital car parking charges.

### Blood Donation (PE1135)

**The Convener:** The first new petition is PE1135, from Rob McDowall, calling on the Scottish Parliament to urge the Scottish Government to review existing guidelines and risk assessment procedures to allow healthy gay and bisexual men to donate blood.

I welcome Rob McDowall and Nick Henderson to the meeting. Mr McDowall, you have a chance to make a three-minute statement on the petition. I will then invite questions from committee members.

**Rob McDowall:** Good afternoon. Thanks very much for inviting me to come here today. I apologise for the absence of Angela Paton, who was to have accompanied me today. Due to ill health, she could not come.

Each day, 1,000 blood donations are needed in Scotland to maintain the blood stocks that are required to keep Scotland going and to meet our health needs with regard to blood. Dr Moira Carter of the Scottish National Blood Transfusion Service has said that there are not enough donors to meet Scottish health care needs at the moment. Supplies are dangerously low, as committee members will be aware from the multitude of adverts by the blood transfusion service.

"Have a heart", "Give blood", "Save a life" and "Give the gift of life" are all slogans of the National Blood Service in the United Kingdom, which are designed to capture the attention and sympathy of people in the UK in order to convince them to give blood. I ask the committee to consider the position that I was in, when I was 19 years old, as I queued up to give blood. I was full of excitement and wanted to make a difference—to give the gift of life. However, I was told that, unfortunately, I could not give blood due to my lifestyle choices.

Giving blood in the UK is not met with a payment, unlike the situation in other countries. Money does not change hands—unless tea and biscuits are legal tender in Scotland. It is a selfless act, and it is one of the only things left in the world that is done for the good of mankind. The NHS blood transfusion service says that the issue is specific behaviours that put people at risk and that it is not about being gay or bisexual. The blood transfusion service says that there is no exclusion of gay men who have never had sex with another man.

The blood transfusion service refers to being gay as a lifestyle choice that puts people at risk. I would say that being gay is no more a lifestyle choice than being born with brown eyes or a German accent. Our society—and particularly the Parliament, and Scotland as a whole—is one that celebrates diversity and equality. Being gay is recognised as a fundamental part of the human condition. The petition is not about a blood amnesty, and it is not demanding that the doors should be opened tomorrow to everyone who wants to give blood. There are certain people who should not give blood due to their individual behaviour, such as participating in unprotected sex. It is not about pushing a statute to introduce the right for everyone to give blood. The only person who has a right is the person who receives the blood, who has a right to safe blood. We are asking for a commonsense approach on the part of the blood transfusion service. Specific behaviour, such as having unprotected sex, would exclude someone from giving blood. That should be the case for gay and heterosexual males who present themselves at the transfusion service.

Australia, Spain, South Africa, Russia, Italy and Thailand allow men who identify themselves as being gay or bisexual to give blood. In Australia and South Africa, donors are asked whether they have had sexual contact with another male in the

past 12 months. If the answer is no, they can give blood. The UK blood transfusion service imports blood products from Australia, where gay and bisexual men can give blood. I would ask the committee to consider urging the Scottish Government to change its stance and to adopt a more flexible approach, in which we hold people capable of judging their own risk and each person has their individual behaviours assessed. A blanket ban is not the answer. I would love to be able to give blood—I would do it today if I could.

**The Convener:** The committee is quite severe, but we are not asking you to do that.

**Robin Harper (Lothians) (Green):** It is clear that there is a host of anomalies on the issue, and very little common sense connecting them together. The petition should be taken further and referred to the Government or to the Health and Sport Committee—whichever we decide.

**Rhoda Grant (Highlands and Islands) (Lab):** As a blood donor, I am not sure whether I should declare an interest. Is the questioning in the solutions proposed by the petitioners not more intrusive than the questioning that happens at the moment? Is it acceptable to ask people about how they live their lives?

**Nick Henderson:** There is a simple question to ask donors to assess whether they present a risk, which is whether they have participated in unprotected sex. If the answer is yes, they should not be allowed to give blood, but if it is no, and someone has safe sex—it does not matter whether it is with men or women—they should be allowed to give blood. Introducing that question could make blood donation much safer. When Italy introduced that question in 2001 and removed the blanket ban on gay and bisexual men giving blood, there was a drop of two thirds in the number of people who contracted HIV from blood donations. Spain introduced a similar policy and the number of people contracting HIV from blood is now a sixth of what it was before the ban was lifted. Introducing a simple question that asks about unprotected sex will make all blood safer.

**The Convener:** Have you assessed the impact of that? You are depending on individuals to be honest in response to that question. If people are honest, how many folk would fall off the donation numbers?

**Rob McDowall:** Thank you for asking. The blood transfusion service feels that introducing that question may put people off giving blood in the first instance. The current questioning goes into great detail—it asks people whether they have had sexual contact with someone who has been in an excluded country, whether they have had a tattoo and whether they have used drugs intravenously, and it asks men whether they have had protected or unprotected sex with another male. An element of honesty is required to answer those questions. The blood transfusion service asks potential male donors whether they have had sex with another male, but if someone answers that they have not, they could give blood—no polygraph test is run to determine whether that is the case. The system already involves an element of trust.

It is a question of moving forward and recognising that there is a significant shortage in the availability of blood. There are no definitive figures on how many gay, lesbian and bisexual people there are in the UK, so we could not say that there would be a 10 per cent increase in the number of people who donate blood. However, in other countries the lifting of the ban has had a positive impact on the safety of blood tissue and organs—there have been fewer cases of infection from donated blood because donors have been asked about particular risks. Gay donors have not simply been told that they have made a lifestyle choice.

**Nanette Milne (North East Scotland) (Con):** As a former blood donor whose blood is no longer accepted because of the medication that I have been on in recent years, I can understand where you are coming from. However, with my medical hat on, I note that the list of people who are turned down for blood donation is extremely long—potential donors are turned down for all sorts of reasons.

I have a slight difficulty with the petition in that with matters such as blood donation public safety must be paramount, in so far as that is possible. We know that in the past there have been problems with blood infected with hepatitis C, for example, and I am pretty sure that I am right in saying that people who have had a blood transfusion are not allowed to be blood donors because of the extremely small chance that they have picked up CJD.

My difficulty is not to do with any sort of prejudice. There are serious issues at stake, and I can understand the reason for the rules and regulations that the blood transfusion service has in place. That is not to say that we should not seek opinions on the matter or get an update on the present state of thinking and research. The petition deals with an extremely serious issue. Given that we are acutely conscious of public health and the risk of litigation, I think that the service would think extremely long and hard before it changed the rules, but that is just my personal opinion.

**Angela Constance (Livingston) (SNP):** As someone who has given blood, I, like Rob, feel that giving blood is one of the most simple but positive and affirming things one can do.

Even though I have given blood and have gone through the tick-box exercise, I was surprised to learn about the reliance on trust and disclosure. It also surprised me to find out that gay men were excluded from giving blood but that heterosexual men who had slept with prostitutes were debarred from doing so only for a year. The cynic in me wonders how many people will be open about sleeping with prostitutes, for example. Is there a far simpler method that would bypass the need for honesty? I am sure that the vast majority of people are perfectly honest, but is there some way in which blood could be screened for viruses? I am not a medical person, but I know that screening does not necessarily pick up a virus at the time of testing because there is always a window period.

14:15

**Rob McDowall:** In Scotland, the testing mechanism that is used to detect HIV is called nucleic acid testing. In general, there is a window period of three months, within which the antibodies cannot be fully detected. Nucleic acid testing cuts down the window period to about 16 days. I am not a doctor, but I have read about different testing mechanisms that are used in different countries. All blood is screened. The Scottish National Blood Transfusion Service is of the opinion that cutting out people who are seen to have been at high risk will minimise exposure to HIV/AIDS and other infections. That is a preventive measure that relies on trust.

At the moment, there is a campaign in England to enable gay people who are willing to give blood to go to a centre, for example, to be tested for HIV/AIDS. They could be given a certificate to indicate that everything is okay, which they could present when giving blood. That would remove the element of the system that relies on trust. Many people would not be prepared to take such a test, as they would regard it as another hurdle, but I would, as I want to give blood. I would be prepared to be tested and to say that I have not had unprotected sex with anyone, that I have not placed myself at high risk and that I have a certificate that indicates that I have no infections of any description. The campaign in England is suggesting that approach as the way forward.

Nick Henderson has information on the testing that is available in different countries.

**Nick Henderson:** Nanette Milne made the point that the Scottish National Blood Transfusion Service believes that gay men are at higher risk of HIV infection. Department of Health figures show that, in the past year, 2,732 heterosexual people and 2,145 gay people were infected with HIV. Straight people are now more at risk than gay people of contracting HIV, partly because the safe sex message is really getting through to gay and bisexual people. Very few gay and bisexual people would even consider having unprotected sex. That view is much less prevalent among straight people—I do not know how well the safe sex message is getting through to them. I do not think that gay and bisexual men are at any more risk than others of contracting HIV.

The nucleic acid testing window period is the same—16 days—for straight people and gay people. The chance that infection will not be detected is the same for a straight person who has HIV and has not been asked whether they have had unprotected sex as it is for a gay person who has HIV. There is no justification for a blanket ban on gay people giving blood.

**Robin Harper:** Nick Henderson has made many of the points that I intended to make in response to Nanette Milne's point about public risk. The figures that Nick has just presented to us indicate that the risk of getting infections from unprotected sex is exactly the same for gay people as it is for heterosexual people. From my days as a guidance teacher, I remember that there was a time when Scotland was branded—quite unfairly—as the HIV capital of Europe. Later there was a period when the highest increase in the number of HIV infections was among young girls. We should be aware of that history. The numbers are even at the moment, but they could easily move in the direction of more heterosexual people than gay people becoming infected. From the point of view of public risk, it would make more sense for us to ask heterosexual people, especially heterosexual young people, who want to give blood whether they have had unprotected sex.

**Rhoda Grant:** Rob McDowall mentioned the suggestion in England that gay people who want to give blood be tested for HIV and be given a certificate to show that they are not infected. I understand that being tested has insurance implications. If someone takes out new insurance, they must disclose that they have been tested, which suggests to people that they are more at risk and makes it more difficult for them to get insurance, mortgages and the like. Much as people would like to give blood, it would be asking a bit much to have them put their future financial viability on the line.

**Rob McDowall:** I accept the point that you make. I have been told that if someone goes to their general practitioner to be tested for HIV/AIDS, they are demonstrating that they have behaved in a way that has put them at risk.

There are different screening centres, including confidential screening centres that are aimed at the lesbian, gay, bisexual and transgender community and which try to offer more discreet testing. Instead of having to ask their GP for a test a person can go to the screening centre for a

general MOT. Various providers offer such a service and, as I understand it, they do not go back to the GP and say, "We tested this person for X, Y and Z."

**The Convener:** Is there a uniform view among pressure groups and organisations that assist gay and bisexual individuals? There is evidence that the Terrence Higgins Trust thinks that on balance the current formula is not discriminatory, although it acknowledges the concerns of individuals such as you who have presented themselves to donate blood. Do you understand why the Terrence Higgins Trust arrived at its conclusion?

**Rob McDowall:** Nick Henderson and I have spoken to various organisations throughout the campaign. The Terrence Higgins Trust has said that currently it is satisfied with the epidemiological data and that it is happy with where we are. Every service provider has its own agenda and aims and objectives, and all seek to promote holistic health among gay and lesbian communities, but the THT focuses on education and awareness. I have considered the information and asked questions and, in all honesty, I am not sure how the THT, which represents a large number of people in the gay and lesbian community, reached its conclusion. Its policy document seems to have been produced in response to a request from the blood transfusion service for a position statement. The THT has said, "This is where we stand."

Many of my friends in the gay and lesbian community and many other people to whom we have spoken throughout the campaign fail to understand why the THT has come to its conclusion and why there appears to be no uniform approach. It has been suggested that people could get personal health certificates, which would show that they are not at risk, or that people who have abstained from sexual contact for 12 months could give blood, as happens in Australia. Many suggestions are flying around.

For me, the issue is individual behaviour. Someone who has multiple sexual partners or unprotected sex puts themselves at high risk. The risk should be measured, as opposed to refusing someone because they belong to the LGBT community. Of course, the blood transfusion service says that the issue is not the person's being gay but their lifestyle choices. As I said, being gay is not a lifestyle choice. It is certainly not a lifestyle choice for me or for many members of the gay community; it is about who we are.

**The Convener:** I do not think that anyone on the committee disagrees with that—that is a legitimate position. The issue is the risk and the evidence from the blood transfusion service and others on higher-risk groups, which is to do with the choices that a person makes and their behaviour, rather than who a person is. I accept that there are people in the heterosexual community whose behaviour is equally high risk, but the figures per head of population show markedly higher risk in the male homosexual community, primarily. The issue is how you reassure the likes of the blood transfusion service that there are processes that are worth adopting. The Terrence Higgins Trust said that it would be happy for there to be a review of the procedures, given that there are different approaches internationally.

Nanette Milne, who has a medical background, asked a legitimate question about litigation. If no action was taken to address the risk and someone was given contaminated blood, the person might have reasonable cause to take legal action against the blood transfusion service. That would undermine the wider commitment of you and everybody in the committee to donate blood, because we would worry that we could be part of that. Navigating through that is difficult.

You raise legitimate and critically important issues about personal rights. How do we engage with the agencies—the blood transfusion service and others—to address those concerns? Is there a better way to operate? The information that we have asks pretty challenging questions. That is what I am trying to draw out from you.

**Rob McDowall:** I agree completely with what you have said and Nanette Milne made a really good point. The issue is a talking point. No matter who someone is in this world, everything is about safety, and not just because people might make a legal claim against the blood transfusion service. The demand for blood is significant. I accept that gay people and others might put themselves at high risk through individual behaviour. When we started the petition, I saw the position as discriminatory and almost homophobic, but I have now reached the view that the point about safety is strong. No one around this table is homophobic—the issue is not as clear cut as that.

Many questions need to be answered. When I lodged the petition, I wanted first and foremost to raise members' awareness of the issue and to get it out there for people to consider. There are always differences of opinion among doctors. I am not a GP or a doctor, so I cannot say specifically what we could do.

**Nick Henderson:** The question was asked how we sell the proposal to encourage people to agree with it. Thailand has set an example. In that country, 30 per cent of gay and bisexual men are HIV positive, but it has instituted a policy of asking all donors whether they have had unprotected sex and has lifted the blanket ban on gay and bisexual men giving blood. I return to Rhoda Grant's point that people who have been tested for HIV must pay a higher insurance premium, which shows the

fear about the issue. In addition to the gay blood campaign, much more must be done to tackle HIV.

Thailand has managed to institute the policy that I described, as have other countries such as Russia, South Africa, Spain and Italy, as we have said. Asking the simple questions of all donors and allowing other people to give blood improve health, blood stocks and the safety of blood stocks.

**The Convener:** We will now determine the next stage for the petition. I am open to committee members' suggestions on progressing the petition and obtaining further information.

**Nanette Milne:** How can we find out the scientific detail of the situation and the standard of research or results in the countries that Nick Henderson mentioned? I am not sure who would find that out. Would the National Institute for Biological Standards and Control cover that? I ask because I do not know. Some scientific body—perhaps the blood transfusion service itself—must have information.

**The Convener:** Having such information would be worth while. Perhaps we could ask the Scottish Parliament information centre to obtain information on standards throughout the world. The pressures are different. Thailand and South Africa, which have been mentioned, have particular social and behavioural structures. In South Africa, heterosexual carriers of HIV are the predominant problem. Nuances in each country need to be reflected. It would help to get SPICe on to that.

I imagine that organisations that are involved in the gay and lesbian community, such as BloodBan, have gathered information. The Terrence Higgins Trust has its view and BloodBan has its view but, underneath that, pretty good evidence will be available. We should gather that before we obtain further information.

We should write to ask the responsible minister whether the health department has undertaken any review, because the issue is not new. In my brief period as the Deputy Minister for Health and Community Care, one issue was that newcomers to Scotland could be in high-risk groups, because of the countries from which they came. Some evidence suggests that that has had an impact, particularly in west central Scotland. The service is aware of those pressures, so we would be happy to get its views. Is there anyone else from whom members think it would be worth getting further information or views?

14:30

**John Farquhar Munro (Ross, Skye and Inverness West) (LD):** What about the Advisory Committee on the Safety of Blood, Tissues and Organs?

**The Convener:** We will get a balance between health organisations that are specialists on blood and tissue and a cross-section of campaigning organisations that represent the diversity of the LGBT community. We will also contact the health department and the responsible minister. Is there anyone else?

**Robin Harper:** What about the blood transfusion service itself? It should be consulted.

**The Convener:** That would be useful.

I will explain the process to the petitioners: stage 1 was the petition; stage 2 is to gather other views on the issue—objective and subjective, as some of them will be. Then we will come back to the committee with recommendations on what it can do next—whether it can take direct action or whether it should ask the Health and Sport Committee to explore the issue, if it has a remit to do so. The petitioners will be kept fully informed. They have raised a critical issue that people do not often think about. The question is how we explore and try to address it.

I hope that we have been helpful enough today and that it has not been too intimidating. The petitioners are relatively young to come to the committee, so it is good to see them here raising an issue that is of concern to them. I hope that, should it ever be resolved, they will both be donors in future.

**Rob McDowall:** It has not been as nerve-wracking as I was expecting it to be. I was expecting a "Dragons' Den" type of experience.

**The Convener:** We are just back from recess so we are in a good mood this week. Next week, we will be hellish. I thank you both for your time.

## Bond of Caution (PE1134)

**The Convener:** I had hoped to have two verbal presentations, but the petitioners for the second one had to cancel due to circumstances that we will discuss later. Instead, we come to petition PE1134, by Bill McDowell, which calls on the Parliament to urge the Government to amend the law of succession to end the requirement for a bond of caution for an executor-dative when seeking confirmation to any intestate estate.

The papers are before us. Do committee members have any comments or observations?

**Nanette Milne:** I did not know anything about this before I looked at the papers, but I noticed that the Scottish Law Commission has recently carried out a consultation on whether to retain the bond of caution. The commission is not due to report until early next year, so I do not know whether there is any point in us trying to do anything further until such time as we hear the result of those deliberations.

**The Convener:** Paragraph 6 of our note on the petition gives the timescale for the commission's report as being early 2009, which is a long time away when the consultation ended in December 2007; it is a year and a bit. Is that an inordinate time or is it naive of me to think that the commission could move more quickly? Is that just lawyers for you?

**Angela Constance:** I can understand where the petitioner is coming from and the arguments against having a bond of caution, but I am not clear about the arguments for it. Will somebody explain them to me? It is a sort of insurance bond. Is it to prevent people from running off with money? Is it some sort of back-up, in case they do?

**The Convener:** Probably. That is my summary of the mumbled discussions that I have just had with the clerk.

**Rhoda Grant:** My understanding is that if someone leaves a will a bond is not needed, whereas if somebody has not left a will it is—but what makes an executor of an unwilled estate more liable to be corrupt than an executor of an estate where there is a will? Can we pass the petition to the Scottish Law Commission for its consideration as part of the review?

**The Convener:** The clerk to the committee will inform us accurately on the issue.

**Fergus Cochrane (Clerk):** Members may formally refer the petition only to another committee of the Parliament. If you wish to get the views of the Law Commission, you will have to approach it formally in the usual way, but the petition would be retained here.

**Rhoda Grant:** If we write to the commission to ask for its views, it will say that it is reviewing the matter and will report early in 2009. I am not suggesting that we ask for its views on the petition, but we could ask whether it is aware of the issues that the petitioner raises. One imagines that it must be, if it is carrying out a review. What I am getting at is that we could close the petition, but ensure that the Scottish Law Commission is aware of it. We could tell the petitioner that the Law Commission will report in 2009. If, thereafter, there are issues with what the Law Commission comes up with, the petitioner would be able to resurrect the petition with the committee quickly. I am not sure that asking the commission for its comments at this stage would gain anything.

**The Convener:** The point that you made just before that final one is right. We are waiting for the consultation and the final review to take place, and if the petitioner is still not happy, or if further issues are raised, they have the perfect right to pursue the matter. However, in the context, we can probably close the petition and await the conclusion of the review process. Can that be done?

**Fergus Cochrane:** You can close the petition as long as you demonstrate a reason for doing so. It would be acceptable then to pass a copy of the petition to the Law Commission for it to consider.

**The Convener:** That is a reasonable course of action. Issues will come out of the review, and I would have thought that the petitioner or others will raise some, too. Are we happy with the proposed course of action?

**Members** *indicated agreement.*

**The Convener:** The next petition was to have been PE1136, by Mr George McAulay, but it has been withdrawn, so we will move on to the next item.

# Current Petitions

## Criminal Memoirs (Publication for Profit) (PE504)

14:37

**The Convener:** There are quite a number of current petitions. I hope that we will get through as many of them as we can in the time that we have; we have an important evidence-taking session on two of them later in the afternoon.

PE504, by Mr and Mrs James Watson, calls on the Parliament to take the necessary steps to stop convicted murderers or members of their families profiting from their crimes by selling accounts of those crimes for publication.

The petition has been in the system for a considerable period of time. At previous meetings, I have expressed concern about the amount of time that some petitions have been in our system. This is a very old one: it is a six-year-old petition about an issue that has been around for a long time and this is the 15th occasion on which it has been considered. I invite suggestions on how the committee might deal with it.

**Nanette Milne:** The petition has been bounced around between the UK Government and this committee. It might be worth asking the Cabinet Secretary for Justice to appear before the committee to probe him a little about what is going on between the two Governments.

**The Convener:** The petition has been around for a long period. Such a request is not unreasonable. Does that have committee members' broad consent? If so, we can move the petition on, as we need to do. There needs to be some conclusion to the matter. There is a role for the cabinet secretary and the Scottish Government, but there are also UK legislation issues. Let us see if we can cut through some of that. Are we happy to support Nanette Milne's suggestion?

**Members** *indicated agreement.*

**The Convener:** Okay—that will be our course of action.

## Institutional Child Abuse (PE535 and PE888)

**The Convener:** The next two petitions are on the broad topic of institutional child abuse. PE535, by Mr Chris Daly, calls on the Parliament to urge the Scottish Executive to make an inquiry into past institutional child abuse, particularly in respect of children who were in the care of the state and under the supervision of religious orders, to make an unreserved apology for said state bodies, and to urge the religious orders to apologise unconditionally. The petition was lodged quite a while ago; in fact, it is the second-oldest petition in the system.

PE888, which is also by Chris Daly, calls on the Parliament to urge the Scottish Executive, in the interests of people who have suffered institutional child abuse, to reform Court of Session rules to allow fast-track court hearings in personal injury cases, to review the implementation of the Prescription and Limitation (Scotland) Act 1973, and to implement the recommendations of the Scottish Law Commission report on the limitation of actions.

We have considered the information that has been submitted, and there have been fairly extensive debates and discussions on the issues that have been raised—indeed, ministerial statements have been made. I recollect the former First Minister and ministers with responsibility for education and children making statements on institutional child abuse.

Do members have any views on how the committee should deal with the petitions?

**Rhoda Grant:** We should close consideration of them. The petitions have been successful in bringing a grave issue into the public arena and ensuring that things have happened. There has been great movement, and people have taken seriously the concerns that have been expressed, as they should have done. What has happened shows that submitting petitions to the committee works.

**The Convener:** Do members agree that we should follow the course of action that Rhoda Grant suggests?

**Members** *indicated agreement*.

## Vulnerable Adults (Medication) (PE867)

**The Convener:** PE867, by W Hunter Watson, calls on the Parliament to provide adequate safeguards against vulnerable adults being given, by surreptitious means, unwanted, unnecessary and potentially harmful medication. We have the relevant papers in front of us. Do members have any comments on how we should deal with the petition?

**Angela Constance:** The matter has been dealt with. Two distinct issues are involved. There are people who have the capacity to give consent to receiving medication and people who do not have that capacity. The Adults with Incapacity (Scotland) Act 2000 was an innovative piece of legislation in Scotland, and the code of practice under that act was recently revised to take account of covert medication. There will be issues

for the Scottish Commission for the Regulation of Care if it appears that an offence has been committed by giving medication surreptitiously—against someone's will or without their knowledge—to people who have the capacity to consent to receiving medication.

I am not sure what else can be achieved. I note the petitioner's latest comments, but the powers of the care commission and the revised guidance on the Adults with Incapacity (Scotland) Act 2000 are sufficient to deal with the matter.

**The Convener:** I think that members received other information on the use of medication.

**Nanette Milne:** I happen to know the petitioner, as he was a neighbour of my mother years ago. He has put a huge amount of work into following up his real concerns.

I am not sure where we should go with the petition. The petitioner has suggested that we should ask the Health and Sport Committee to consider the issues surrounding covert medication, but I do not know whether its agenda would allow it to do that this session. I know that Mr Watson still has strong concerns, and I am slightly reluctant to let the matter go.

**John Farquhar Munro:** Perhaps the revised code of conduct that was laid before the Parliament in December 2007 meets the petitioner's concerns.

**The Convener:** To put it bluntly, the petitioner is still unhappy, even given the care commission's structure and the code of conduct. We need to be accurate about where he stands on those issues, and to try to arrive at a view today if we can, regardless of whether or not that view will benefit the petitioner.

14:45

**Nanette Milne:** I do not know whether what the petitioner seeks to achieve will ever be achieved. Whatever guidance is in place, some people will always slip through the net. It is an extremely difficult situation.

**Rhoda Grant:** That is true. The safeguards that have been put in place should be sufficient. The important issue is how to legislate for people who ignore those safeguards or try to get round them—how to deal with people who are not following the guidelines. It seems that the petitioner is concerned about how the care commission acts when cases are reported to it—whether it investigates and takes the necessary action.

**The Convener:** I get the impression from the contributions so far that people think that, on balance, there is a framework in place—we would hope—to address some of the concerns that the petitioner raises. There is a reference to the care commission and the code of conduct in respect of legal protection for individuals. Given that information, we should think about closing the petition, as there are more appropriate safeguards than there were before the petition was submitted that can, we hope, address the concerns. Was that what you were suggesting, Angela?

**Angela Constance:** Yes, absolutely. I appreciate that the petitioner has an individual case, and I have had experience of constituents who have been unhappy with investigations by bodies such as the care commission. If the petitioner remains unhappy on the issue of human rights, he will perhaps have to pursue legal recourse on that basis. I am not sure what the committee can add that will be useful at a practical level.

**Nanette Milne:** I am inclined to agree with that. It is almost a case-by-case issue. I have little doubt that there are cases that cause problems.

**The Convener:** On that basis, do members agree to close the petition and to indicate that we believe that there are now frameworks in place that can address some of the concerns that the petitioner has raised?

**Members** *indicated agreement*.

## Victim Notification Scheme (PE899)

## Stewart Committee Report (PE1106)

**The Convener:** The next item concerns two petitions that are linked together: PE899 and PE1106. The first is by Hazel Reid, calling on the Parliament to urge the Scottish Government to review the operation of the victim notification scheme to ensure that victims of serious violent and sexual crimes are given the right to receive information about the release from prison of an offender who has committed a crime against them. PE1106, by Jamie Webster, calls on the Parliament to urge the Government to review those aspects of the Stewart committee report, "Keeping Offenders out of Court: Further Alternatives to Prosecution" that relate to the rights of victims of crime to obtain information on the handling of a case.

Do members have any strong views on how we should deal with the petitions? I understand that there has been a review of the victim notification scheme. The reality is that, as elected members, every one of us will have a case involving individuals who have been victims or their family members that throws up some of these concerns. We have a sense that there is an issue, but I seek members' views on whether the review process that has been undertaken addresses those concerns sufficiently for the moment. A review of

the policy on warning is still outstanding, so members might want to wait until that is complete.

**Rhoda Grant:** Can we close PE899, given that the review has taken place? We need to see how it beds in and whether it has the desired outcome, so we could leave the petition open and wait and see, but that has not been our policy. Usually if there has been a review and a new policy has been introduced, we close the petition. After all, if anyone experiences any difficulty in future, they can always come back to us.

**The Convener:** I am happy to accept that recommendation in relation to PE899. However, as there are still some issues outstanding with regard to PE1106, we should keep it open at least until the Crown Office and Procurator Fiscal Service updates us on the review of the policy on warnings. In too many cases, people think that an offender has been released too early or is involved in other matters that might cause problems for family members.

Do members accept the recommendations to close PE899 and to keep PE1106 open?

**Members** *indicated agreement*.

## Disabled Parking (PE908)

## Local Authorities' Traffic Orders (Procedure) (Scotland) Regulations (PE909)

## Disabled Parking Bays (Improper Use) (PE1007)

**The Convener:** PE908, PE909 and PE1007 all relate to provision for disabled parking bays, including, for example, the use of dropped kerbs, to prevent their misuse by those who do not have disabilities and ways of ensuring that only registered disabled users can access them. Again, these petitions have been in the system for a while. I should say that a proposal for a member's bill on this issue by a colleague from my own political group has gained cross-party support, but I do not know what stage it has reached.

I am happy to hear members' views.

**Nanette Milne:** It would be interesting to know where things stand with the proposed member's bill.

**The Convener:** So we will keep the petitions open to find out what stage the proposed bill has reached.

These petitions also raise issues about the broad guidelines issued by the transport division and local authorities on the use of such parking bays. I recall that, in the early days of the Public Petitions Committee, members examined how blue or green badge schemes were being implemented in different cities—one of which, of course, was Aberdeen. However, these petitions raise much wider issues about the misuse of disabled parking bays.

**Nanette Milne:** Have the Government and the Convention of Scottish Local Authorities met to discuss the matter? I cannot remember whether our papers make that clear.

**The Convener:** The Government met COSLA, but I do not know whether anything emerged as a result.

**Nanette Milne:** We should certainly find out.

**The Convener:** I am sure that tons of good things will come out of the new, historic concordat. As you can see, I am on-message. I am getting the language and everything.

By the way, I am being ironic, just in case there are any misunderstandings.

**Angela Constance:** I was surprised by COSLA's view that, apart from a few hot spots, this was not a problem.

**The Convener:** Are you saying that that is not your experience?

**Angela Constance:** Certainly not as an MSP and not in my 10 years as a local government councillor. This is a recurring problem, and I am interested to find out what is happening to Jackie Baillie's member's bill. We should also get in contact with the Government on the issue.

**The Convener:** So we will seek an update on the result of the Government's discussions with COSLA and on any courses of action that the transport directorate—and, indeed, the directorate responsible for equalities—might be planning to take.

Do members agree to keep these petitions live?

**Bashir Ahmad (Glasgow) (SNP):** Why have the petitions been grouped together? Surely they are different. Petition PE909 is about dropping kerbs; it is nothing to do with disabled parking bays.

**The Convener:** You are right to say that although petitions PE908 and PE1007 are broadly similar, petition PE909 is about dropped kerbs, which comes under the remit of local authorities. However, it raises concerns that can be dealt with alongside the other two petitions.

**Fergus Cochrane:** As the three petitions deal with broadly the same topic, we grouped them together for the committee's convenience. However, they are stand-alone petitions.

**Bashir Ahmad:** So we are dealing with all three in one go.

**Fergus Cochrane:** The committee will invite the Scottish Government to respond to the issues highlighted in each petition, but in future the petitions will be considered together for the committee's convenience.

**Bashir Ahmad:** So there will be three different ways of dealing with the three different petitions.

**The Convener:** Essentially, there is a symmetry between items in the petitions. We will make inquiries about the issues and ask whoever we raise the issues with to respond to the specific concerns that each of the petitioners has raised. I understand that you are saying that you do not want to lose sight of one particular element, because it is not the same as the parking-bay issue. As we know from our time in local government, dropped kerbs are a big issue in many communities, particularly communities with a growing elderly population or with individuals with disabilities. Are you worried about that issue getting lost?

**Bashir Ahmad:** Yes.

**The Convener:** I assure you that we will pursue the issue with great vigour and vigilance.

**Bashir Ahmad:** I am getting old, too, you know.

**The Convener:** I am a long way away from that, but you can declare an interest.

Broadly speaking, we thought that, rather than having a hotch-potch of petitions, we would try, where possible, to adopt a thematic approach.

Do we agree to take on board the comments that members have made, in particular those about the need to ensure that issues are not lost in the general process?

**Members** *indicated agreement.*

## Skin Cancer (PE931)

**The Convener:** PE931, by Helen Irons, on behalf of Skin Care Campaign Scotland, calls on the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland. Do members have any suggestions on how we should deal with the petition?

**John Farquhar Munro:** How is Ken Macintosh's member's bill on sunbeds coming along? That is an issue that causes a lot of concern.

**The Convener:** There is an issue about access to sunbeds increasing the incidence of melanoma.

**Rhoda Grant:** I am on the Health and Sport Committee, and I know that sunbeds will be dealt with in the Public Health etc (Scotland) Bill. The Government has been working with Ken Macintosh and is considering lodging amendments at stage 2 to incorporate some kind of process for dealing with sunbeds. I am not clear about what that will be, but I know that there is a commitment.

**John Farquhar Munro:** So the issue is moving forward.

**Rhoda Grant:** Yes.

**The Convener:** The petition raises specific issues other than the sunbed issue.

**Nanette Milne:** Is the Health and Sport Committee aware of the petition? It might be worth drawing the petition to the attention of the committee and Ken Macintosh.

**The Convener:** We can do that. It would be useful to make the committee and the member who is pioneering a member's bill on the subject aware of the petition. There is an issue for the health department and the Cabinet Secretary for Health and Wellbeing about progress on diagnosis. There has been substantial progress over the past four or five years on tackling cancer in Scotland. The investment in the area has been higher than before and new treatment centres have been developed. Those developments were much needed. It would be useful to hear from the Government about waiting-time targets and so on.

Do we agree to follow the suggested course of action?

**Members** *indicated agreement.*

## Elderly People (Residential Care) (PE1023)

**The Convener:** PE1023, by Dr H I McNamara, on behalf of Highland Senior Citizens Network, calls on the Scottish Parliament to urge the Executive to ensure that a greater proportion of residential care places for the elderly are provided for and staffed by the statutory sector, particularly in rural areas.

I invite comments from some of the younger members who represent the Highland area. John Farquhar Munro? [*Laughter.*] I was actually thinking of Rhoda Grant—do not get too presumptuous.

**John Farquhar Munro:** The petition merits a lot of support, as it suggests that places in such establishments should be allocated on a fairer and more regulated basis. I see nothing wrong with that.

15:00

**Rhoda Grant:** There is also an issue about access to residential care in remote rural communities when care is provided by the private sector, which the petitioner underlines. Economies of scale cannot be made when the population is small, so care provision often comes under threat.

We should maybe pursue with the Government issues to do with accessibility and standards of care. Not so long ago, people on Mull had to move to the mainland for residential care. Couples who had been married for 50 years were parted and made to live in different parts of the country. There is a fundamental need in rural areas for local government or the Government to step in and provide care when other sectors cannot continue to provide it, given the population level.

**The Convener:** The review of free personal care, which the Cabinet Secretary for Health and Wellbeing announced early in the new Administration, presents an opportunity. It might be useful to draw the petition into that. I was briefly involved with the elderly care and community care sectors when I was a minister, so I am aware that in rural Scotland it is not easy to find private sector providers who will fill the gaps that are left when local authorities pull out. There is much pressure on councils in relation to how they look after and support older people. It would be useful to seek the Government's views on the issues that are raised in the petition.

## Elderly People (Provision of Care) (PE1032)

**The Convener:** PE1032, which is similar in theme to PE1023, was brought by Elizabeth McIntosh on behalf of Renfrewshire Seniors Forum. The petition addresses in particular care provision for the housebound elderly and calls for seniors forums to be fully consulted in relation to the provision of care for the elderly.

As I said, a review of free personal care is going on and consultation should be taking place with older people about the quality of care provision, particularly for people who want to stay in their own house rather than go into a care home. We can raise the issue directly with the Government as part of the review process. Members have no comments, so do we accept the recommendations on PE1023 and PE1032?

**Members** *indicated agreement*.

## Employment Opportunities for Disabled People (Public Procurement) (PE1036)

## Employment Opportunities for Disabled People (Home Working) (PE1069)

**The Convener:** We link petitions as much as we can do. If members are unhappy about that, they can say so. PE1036 was brought by John Moist on behalf of the Remploy consortium of trade unions and calls on the Scottish Parliament to urge the Scottish Government, in partnership with Remploy and other sheltered workshop employers, to promote employment opportunities for disabled people by reserving local authority and/or Government contracts for supported businesses, as permitted by article 19 of the European Union directive on public procurement.

PE1069 was brought by Clive McGrory and calls on the Scottish Parliament to urge the Scottish Government to encourage employers to provide home working opportunities for people with disabilities that prevent them from accessing the workplace. Do members have comments on how to deal with the petitions?

**Nanette Milne:** On PE1069, the issue is how to get the message to business that people with disabilities want employment at home. We all know that able-bodied people work from home, but people with disabilities also want such opportunities. Is it worth approaching the Federation of Small Businesses Scotland or the Scottish Chambers of Commerce, which have a handle on business and might disseminate information among their members?

**The Convener:** That is a reasonable suggestion.

**Nanette Milne:** We could approach Scottish Enterprise, too.

**The Convener:** Okay. The Cabinet Secretary for Finance and Sustainable Growth gave evidence to the Parliament's Equal Opportunities Committee. It would be helpful to get a summary of the key points on how the Government is encouraging access to employment for people with disabilities and ensuring that people who perhaps struggle to get out of the house but can still work have opportunities for employment at home.

**John Wilson (Central Scotland) (SNP):** It might be worth while contacting the National Group on Homeworking to find out about some of the issues that arise from home working. In a previous existence, I dealt with concerns that arose because of the way in which employers treated individuals who worked from home. We need to safeguard those individuals' rights. Three or four years ago, several high-profile cases arose in which people who were working from home were regarded by employers as low-cost employment. Those people were not guaranteed their right to the national minimum wage and other conditions. It would be useful to contact the National Group on Homeworking to find out whether it has concerns over the proposals. The group produces useful information for people who undertake home working to ensure that they are guaranteed their rights. If we move down the road that is suggested, there is a danger that rights may be eroded by certain unscrupulous employers.

**Nanette Milne:** An issue arises with supported employment, too. The situation in Aberdeen,

where the former Blindcraft organisation could be under threat, has been all over the press, although I know that that is not mentioned in the petitions. A lot of work is being done to ensure that the organisation does not close. A suggestion has been made—I have approached the Government about it—that it might be better if some supported employment organisations were brought under an umbrella organisation, to allow them to cut administrative costs by having central procurement and administration personnel. That would allow the organisations to work as individual units, but more efficiently than they can at present, given that they have to look after all aspects of the business. I have been trying to explore the idea and I wonder whether it would be worth while for the committee to emphasise it.

**The Convener:** I am happy to take on those points.

**John Wilson:** I want to raise a concern about Nanette Milne's suggestion. Some organisations such as Remploy and the Blindcraft organisations—particularly Blindcraft in Glasgow—have taken and continue to take different approaches to how they recruit people. An issue might arise if we tried to get those organisations to work together to cut administrative costs, as they have different philosophies and outlooks in relation to whom they work with and why they work with those groups. Remploy is a UK-wide organisation, whereas the Blindcraft organisations are usually local authority based. Blindcraft in Glasgow does a lot of good work—not just with people who have a visual impairment, which is what the name suggests, but with individuals with various disabilities. It takes a different approach to its work from that taken by similar organisations. I would be concerned if we suggested that those organisations should be brought together under one umbrella, because there are different philosophies and outlooks and different approaches to how the organisations treat individuals with disabilities.

**Nanette Milne:** I was not necessarily suggesting that we should do that; I was purely wondering whether the idea was worth exploring to see what response we would get.

**The Convener:** We will handle the idea with care.

**Rhoda Grant:** I will try to be helpful. Nanette Milne seemed to moving towards the idea of having a system in which companies that offer supported employment are assisted in bidding for Government contracts. I understand John Wilson's point—indeed, many of the companies employ folk in their administrative back-up services who need assistance, too. Perhaps we need an advisory group that helps those companies to bid for Government contracts.

Can we ask the Government about its meeting with supported employment businesses? Many of the action points arising from that meeting were about setting up various projects. We should ask for an update on progress on the action points and what results have been achieved.

**The Convener:** That is helpful. Do members accept those comments and recommendations?

**Members** *indicated agreement*.

## Physiotherapy Graduates (Employment) (PE1044)

**The Convener:** PE1044, by Kate Mackintosh, on behalf of the student members of the Chartered Society of Physiotherapy in Scotland, calls on the Parliament to investigate the merits of extending the one-year job guarantee employment assistance for newly qualified nurses and midwives to include newly qualified physiotherapists in Scotland, with particular reference to the benefits for patient care. The petition has been in the system for a while—the issue emerged in early 2007. I understand that a working group was set up to try to address some of the issues raised just before the elections last year. Do members have any strong views on how to deal with the petition?

**Rhoda Grant:** Given that the Chartered Society of Physiotherapy in Scotland is a member of the national solutions group for physiotherapy, perhaps we could close the petition. The petitioner is now in a position to work towards a solution.

**Nanette Milne:** I do not disagree with that, but it is important that workforce planning for physiotherapy is done properly and that there is investment in the area. I have been having physiotherapy for a back problem, and I would hate to think that people with physiotherapy skills were unemployed and unable to treat people who experienced the sort of agonies that I have been experiencing for the past little while. The issue is important, but I am not sure that the committee can take it further at this point.

**The Convener:** Thanks for those comments. Do we agree to close the petition on the ground that the issues of concern raised in it can best be addressed through the national solutions group for physiotherapy?

**Members** *indicated agreement*.

## Land Reform (Scotland) Act 2003 (PE1061)

**The Convener:** PE1061, by Mr and Mrs Mark J Lochhead and Mr and Mrs Henry McQueen Rankin, calls on the Parliament to urge the Scottish Executive to ensure that measures that are taken by communities to tackle antisocial behaviour in urban residential areas are not

restricted by the duty of a local authority to uphold access rights under the Land Reform (Scotland) Act 2003. I invite comments from members.

**Angela Constance:** The recent clarification by the Minister for Environment that

"measures to tackle anti-social behaviour in urban residential areas are not restricted"

by duties under the 2003 act is helpful. I hope that it will give the petitioners some satisfaction.

**Nanette Milne:** It seems to me that the minister and COSLA have slightly different interpretations of events.

**The Convener:** Never—that is the first crack in the armour.

**Nanette Milne:** Perhaps we should get clarification. I totally agree with Angela Constance about what the position should be, but perhaps the guidance should be clearer. I do not know how we can achieve clearer guidance, apart from by writing to the minister about it.

**The Convener:** Do members wish to close the petition but draw to the petitioners' attention the statement by the minister that duties under the 2003 act should not be an inhibitor? A neighbouring local authority to East Renfrewshire Council has chosen to take a different course of action. I am happy to close the petition on that basis.

**Claire Baker (Mid Scotland and Fife) (Lab):** Do we not need to draw to the attention of East Renfrewshire Council the letter that we have had from the minister?

**The Convener:** We could do that. We could refer the council to the minister's statement. We are talking about a local decision, but the council will need to consider what it does in the light of the statement. I would not want to interfere with the right of local government to make decisions locally.

**Claire Baker:** When we took evidence, it seemed that East Renfrewshire Council was saying that its hands were tied on the issue and that it could not allow the gates that had been put up to remain in place.

**The Convener:** Yes.

**Claire Baker:** It would be helpful if the committee were to get in touch with East Renfrewshire Council.

**The Convener:** I am happy to do that, but I will take the clerk's advice on whether we can also close the petition now, or whether we have to wait to do so.

**Fergus Cochrane:** You have to wait.

**The Convener:** Okay. I understand the procedural issue that concerns Claire Baker, and I thank her for raising it.

## Ambulance Services (PE1099)

15:15

**The Convener:** PE1099, by John Grant, on behalf of the community councils of highland Perthshire, calls on the Scottish Parliament to urge the Scottish Government to monitor the provision of ambulance services such as those in the highland Perthshire area. Given our previous discussion on the subject and that no concerns were raised in the responses from the organisations that were involved in the decisions to restructure the ambulance provision in the highland Perthshire area, how should we deal with the petition?

**John Wilson:** We should close it.

**The Convener:** The recommendation is that we close PE1099 on the ground that no further concerns have been raised. Are we agreed?

**Members** *indicated agreement*.

## Motorcycle Facilities (PE1100)

**The Convener:** PE1100, by Bob Reid, on behalf of the Scottish Auto Cycle Union and North Lanarkshire Scramble and Quad Bike Club, calls on the Scottish Parliament to urge the Scottish Government to review planning and environmental regulations to allow for the provision of safe local and national off-road motorcycle facilities, including a centre of excellence in North Lanarkshire, as a way of tackling antisocial behaviour.

Thus far, we have received no response from the Scottish Government. Its response is now overdue. In raising matters with the Government, the clerks indicate that we expect a response from the appropriate department or minister. By and large, we get appropriate responses on petitions that relate to other policy areas, so it seems strange not to have a response in this instance. Perhaps the clerk can enlighten us.

**Fergus Cochrane:** We have sent reminders to the Scottish Government, but to no avail.

**The Convener:** After my comments today, there may be a mad scramble to respond. I look forward to that. We still await a response from the Government, so I suggest that we write again. We want to be fair to the petitioner, particularly given that the petition has been in the system for a while. Is that okay?

**Nanette Milne:** I assume that the Government has a copy of the report that is in our papers.

**The Convener:** Yes.

The clerk has the look of disappointment on his face that clerks have when things are not going the way that they should in the seamless process of governance. He is non-committal, but his face tells it all. We should try to get the matter sorted. The real issue is not that our noses are out of joint because we have had no response from the Government, but that the lack of response is fundamentally unfair to the petitioner.

## Psoriasis and Psoriatic Arthritis (PE1109)

**The Convener:** PE1109, by Janice Johnson, on behalf of Psoriasis Scotland-PSALV, calls on the Scottish Parliament to urge the Scottish Government urgently to develop clinical guidelines on the diagnosis and treatment of psoriasis and psoriatic arthritis; to develop national standards of care for people who suffer from those conditions; and to define them as chronic conditions that should be included in the list of conditions that are exempt from prescription charges.

The basis of the petition is clear. It is right that we should raise it with the Scottish Intercollegiate Guidelines Network. We should ask whether there are clear clinical guidelines on psoriasis and psoriatic arthritis, which are common problems. Many of our constituents have had to navigate the difficulties set out by the petitioners when they or a family member are found to suffer from those conditions. How should we take forward the petition?

**Nanette Milne:** In her response of 31 March, Mrs Johnson makes a number of valid points, including points about the need for clinics and nurses. If we are to write to the Government on the matter, will we automatically include a copy of the letter? If not, we should.

**The Convener:** We will forward a copy to the Government.

**Nanette Milne:** Mrs Johnson makes important points, which the Government should consider.

**The Convener:** We will contact SIGN and the Government's health department on what procedures and guidelines are in place. We will review progress once we receive the responses.

## Foreign Teachers (Recruitment) (PE1110)

**The Convener:** PE1110, by Kevin O'Connor, calls on the Scottish Parliament to urge the Scottish Government to review the policies, guidance and procedures that apply to the recruitment of foreign teachers and the right of recourse to investigate claims of discrimination.

I should declare an interest: I am a member of the General Teaching Council for Scotland. I think that Robin Harper should also do so—just in case.

**Robin Harper:** Yes. I think that I am a member.

**The Convener:** Okay. Does any member who does not have a personal interest in the regulatory framework for teachers want to comment on the petition? I have a view, but I would prefer to hear the views of other members.

**Rhoda Grant:** I understand that a person has to be registered with the GTC to carry out teaching activities in Scotland. The GTC has in place screening and checks. That should provide enough security. We should close the petition.

**The Convener:** Are members happy to accept that recommendation?

**Members** *indicated agreement*.

**The Convener:** I am conscious of the time. We scheduled the next session with the health boards for 3.30 pm. Staff from NHS Tayside are with us. They win the gold star for getting to committee before their NHS Greater Glasgow and Clyde colleagues—perhaps they are having trouble parking their motors. We will take a 10-minute break.

15:21

*Meeting suspended.*

15:32

*On resuming—*

## Parking Charges (Hospitals) (PE1086 and PE1091)

**The Convener:** I thank everybody for their patience, as we are resuming a few minutes later than intended. The next petitions are PE1086, which calls on the Scottish Executive to issue new guidance to health boards to remove excessive charges for car parking, preferably for those staff who work shifts and for whom public transport alternatives are limited; and PE1091, by Mary Murray, which calls on the Scottish Parliament to urge the Scottish Government to review the levying by NHS boards of car parking charges at NHS hospitals, such as that proposed by NHS Greater Glasgow and Clyde at Stobhill hospital.

With us today are Tom Divers and Billy Hunter, on behalf of Greater Glasgow and Clyde NHS Board, and Gerry Marr and Brian Main of NHS Tayside. Thank goodness I was at the optician recently so I could read those names with reasonable accuracy.

The petitions have been before the committee for a considerable period. As convener, my concern on behalf of the committee is that charges were introduced—especially by NHS Greater Glasgow and Clyde—even though the petitions

had been lodged. Part of today's discussion will be an exploration of the background and rationale behind the issues.

Paul Martin, who is the member for one of the affected areas, is also present.

Today, we are trying to find out why charges have been introduced in acute hospitals across Scotland, particularly in the greater Glasgow and Clyde area. The three fundamentals are: first, the principle behind charging and whether it is acceptable—committee members wish to explore that; secondly, the impact on not only hospital grounds but residential areas adjoining hospitals, about which MSPs and members of the public have raised concerns; and thirdly, the impact on staff or their personal safety, especially the disproportionate impact that charges may have on the staff in many parts of the NHS who get by on relatively low incomes.

Those are the issues that have come to our committee through the petitions process. I invite individuals from the health boards to make opening statements or comments on any of them. After that, I will invite questions from members.

**Tom Divers (Greater Glasgow and Clyde NHS Board):** I will say something briefly. From the guidance that we were given, I did not expect that we would have the facility to make opening statements.

**The Convener:** I am a nice guy.

**Tom Divers:** As ever, convener.

The fundamental reason why we embarked on charging arrangements was that patients, their relatives and visitors were not getting a fair crack of the whip. We received a number of complaints from individuals who were unable to get to clinic appointments or who drove around a number of our urban sites trying to get parked and were late for appointments or visiting times. We concluded that we needed to introduce arrangements within the urban setting in Glasgow city to redress the balance and to try to ensure that patients, visitors and relatives got a fairer crack of the whip—a fairer share of access to the available parking spaces.

The reality is that there is simply not enough on-site parking capacity at the hospitals in Glasgow to accommodate even the numbers of staff who wish to park on the sites, let alone to give patients, visitors and relatives a fairer crack of the whip. We embarked on charging to try to address that imbalance and we sought to develop criteria as fairly as we could, particularly to recognise staff who required access to their cars as part of their continuing clinical commitments. Those staff had commitments at more than one hospital site, had commitments within hospital and community settings, or were required to visit patients at home.

There was previously much debate at the committee about the charging structure. Initially, we introduced a maximum daily charge of £7, not because we wanted to charge anyone £7 to park but to try to ensure that the staff who parked on site had permits and were entitled to park there. In our financial modelling of the affordability, we made no material assumptions that we would derive a lot of income from a £7 charge.

When the committee dealt with the petitions previously, we were asked to defer implementation of the next phase of the plan, which covered the introduction of the charging arrangements at the Stobhill and Southern general hospital sites. We did that until the interim guidance was issued in the form of the chief executive letter. Then we adjusted our charging arrangements to take account of the interim maximum charge that the letter introduced. We also reconsidered our access criteria for staff, to reflect points that were made in that letter, and submitted the necessary initial compliance statement to reflect the fact that we had done that. Our arrangements have moved on substantially since then.

Paul Martin has been in correspondence with me again recently about one of the other points that you raised with me, convener—the impact on those who live in the locality. It would be fair to acknowledge that, although our original consultation covered community councils and some other locality interests, my sense is that we paid less attention to some of that interaction than we might have done with benefit, so we have sought to step up our game. Billy Hunter has recently been involved in the locality meeting with the local police and the community councils around the Southern general site to talk about the issues and concerns that residents there have raised. We would be happy to pick up similar arrangements in other parts of the city.

**Gerry Marr (NHS Tayside):** There is a slightly different history in Tayside. There are two chargeable parking areas there—at Perth royal infirmary and Ninewells hospital. Chargeable parking has been the subject of a private finance initiative contract, which was set for 30 years in 1998, so it still has another 20 years to run with respect to the Ninewells site.

A year ago, we asked for an independent review of car parking arrangements on the Ninewells site, which was undertaken by the retired chief constable of Tayside Police, Bill Spence. Significant findings emerged. For members who are not familiar with the site, there are two car parks adjacent to its entrance. There was clear evidence that the parking spaces were being abused. Staff were using them and leaving their cars in them for their entire shifts. Indeed, people were parking their cars on the site and jumping on

buses to go to their work in Dundee city. The 250 spaces that were meant to be for patients and relatives were therefore not turning over.

We maintained the £1.60 charge that applied across the NHS Tayside area, including at Ninewells, but applied a punitive penalty of £10 if a person stayed for more than four hours. That was deliberate, because we wanted to make the car parking spaces available to our patients and their relatives. As a consequence of that decision, the car park spaces, which we have monitored, now turn between three and four times a day, and, for the first time in recent years, patients are getting access to car parking as a priority.

The other issue for us was disabled parking. We involved disabled groups in the review. They wanted more disabled parking and better access, but they were content that we would continue to charge for disabled spaces.

Bill Spence's group also reviewed our travel plan. We have a well-developed travel plan on the Ninewells site, which has a bus terminus and good transport links. Our travel plan is geared towards encouraging cycling and walking through providing more footpaths in the hospital, encouraging car sharing and trying to minimise the number of cars on the site. We work closely with the council, because on-street parking is a real difficulty for residents in the areas around PRI and Ninewells, as it is in Glasgow. We are working hard to minimise its impact, but it would be disingenuous to say that it is not a significant problem for residents near those hospitals.

**The Convener:** I open up the discussion to questions or comments from members of the committee.

**Robin Harper:** I presume that the staff in your hospitals arrive in shifts. Many staff may arrive at 1 o'clock in the morning and another lot may arrive at 3 o'clock or 4 o'clock or whenever. Have you developed travel plans for them that encourage car sharing? I presume that such plans would nicely free up spaces.

**Brian Main (NHS Tayside):** That is one of the initiatives in the Ninewells travel plan. We have become a joint subscriber with Dundee City Council and the University of Dundee to the web-based liftshare.com car-sharing initiative. This week, we are analysing the results of a travel plan staff survey. We carried out such a survey four years ago and another one last month to find out whether there has been a shift in how people travel. The early indications are that fewer single-occupancy cars are coming on site and that car sharing has increased, which seems to be helping us.

**Robin Harper:** Are you encouraging that in any specific ways?

**Brian Main:** We publicise the scheme in NHS Tayside staff newsletters. We focus on the Ninewells site, but taking part in the lift share scheme is open to anybody in NHS Tayside.

15:45

**Billy Hunter (Greater Glasgow and Clyde NHS Board):** We operate a lift share system in greater Glasgow and Clyde, too. It has been operational since earlier this year, and it operates in a similar way to the one in Tayside. On uptake, several hundred people have logged on to the site. I am not sure how successful things have been with shared journeys, but we do operate the lift share system. We have also considered other incentives, such as a bike loan scheme, reduced-rate ZoneCards and other travel cards. We are working closely with Strathclyde partnership for transport to consider other benefits that we could make more affordable and accessible to staff who need to access our sites at various times of the day.

**Robin Harper:** Do you have figures showing the percentage of staff who now travel by car and what improvement there has been over time?

**Billy Hunter:** We are working on that. We have been working closely with the Energy Saving Trust, and a company called JMP has recently audited all our acute sites. We are forming and rationalising our travel plans now, and we will consider the detailed audit document—which arrived only this week—as we decide how to take forward its recommendations. The document goes into particular detail on localised journeys and how staff go to and from work.

**Tom Divers:** We will be happy to go over that information with the committee once we have had the opportunity to analyse it and ascertain what improvement has been possible.

**Rhoda Grant:** Have car parks always been oversubscribed, and is that why charges were introduced? Are there other reasons for introducing charges?

**Gerry Marr:** The history of the situation in Tayside goes back some time. The decision to charge for car parking was not based on income generation—there was no income generation for the health trust, as it used to be. We estimated that if car parking was not charged for, there would inevitably be a cost to the NHS in running the car parks efficiently and effectively. In Tayside, we reckoned it would come to about £0.5 million a year. It was decided in Tayside in 1998 to offset the cost to the NHS of administering car parking and to make the money available for patient care. That was the basis of the decision at the time.

**Tom Divers:** As I hinted earlier, the best ratio of available spaces at any of our urban sites in greater Glasgow and Clyde where we introduced the policy was 1:1. That covered staff parking alone. The worst ratios were 5:1 and 6:1. We were oversubscribed before we started to make arrangements for fairer access for patients, visitors and relatives.

As a working principle, when we embarked on the arrangement we considered a ratio of something like 60:40 for spaces for patients, visitors and relatives as opposed to spaces for staff. We have had to tune that figure, because of the different levels of capacity at individual sites. It is fair to say that a substantial body of responses to the original consultation exercise that we embarked upon in greater Glasgow before we introduced the original policy acknowledged that it was unlikely that we would be able to improve things unless we introduced more managed car parking arrangements.

As Gerry Marr said in respect of NHS Tayside, none of the arrangements that have been put in place in greater Glasgow has been about generating income per se. All of the income that will be generated will be explained and laid out in an annual statement and it will be reinvested in further improvements to the scheme. Given that we were oversubscribed before we started on each site, we concluded that charging was an inevitable step that we had to take to effect improvement and put in place a better-managed arrangement.

**Rhoda Grant:** I want to be quite clear about that. Are you saying that at every site where car parking charges have been introduced there were difficulties in getting parked because too many people were using the car park?

**Tom Divers:** Yes—at each site that has been covered in the roll-out thus far. As I said, our entry point into the exercise was that patients, visitors and relatives were not getting fair access to parking and we needed to change the balance. Immediately on changing the balance, even the site that had the greatest number of spaces was substantially oversubscribed.

**Rhoda Grant:** There is much shift working at hospitals, and public transport is not always available at the end of a night shift or the start of an early shift. The health service's workforce is predominantly female. What risk assessments have been performed and what steps have boards taken to ensure that staff are safe when they make their way to and from work?

**Gerry Marr:** We were fortunate in getting European funding for our integrated travel plan a couple of years ago. On the Ninewells hospital site there is comprehensive public transport infrastructure—it is like a bus station. We work closely with Dundee City Council to match the timing of buses to our shift patterns. That is where we have concentrated our efforts, but there is always room for improvement.

In addition, with the parking management company we have invested significant income to improve pathways, lighting and security on site, particularly in the evenings. If a female member of staff requests an escort, she can be escorted by one of our portering security staff. We take the issue seriously on the Ninewells and PRI sites. Staff have not complained or drawn our attention to the issue through our staff partnership forum: they seem relatively satisfied with the arrangements that are in place.

**Rhoda Grant:** I understand that you take steps on site, but the bus will probably not take everyone to their front door—or anywhere close to it—and people might have to take a bus to the town centre to catch a connection, which are disincentives for people who have to travel alone late at night. Have you considered such issues?

**Brian Main:** The bus interchange at Ninewells, which is outside the front door, is completely undercover. It is all glazed, so it is virtually internal. We have fitted it with intensive closed-circuit television coverage, to try to give confidence to staff—

**Rhoda Grant:** Sorry, but that is not what I meant. I understand that you have taken steps on site, but given that the buses that come to Ninewells do not deliver everybody to their door, people probably have to travel into the city centre to catch a transfer that takes them home. Have you given thought to people's safety while they are hanging round the town centre bus station late at night?

**Brian Main:** We work closely with the Tayside and central Scotland transport partnership and we are in close discussions with bus operators at bus strategy meetings to try to get operators to make changes. It is clear from responses to our travel survey from people who travel from outwith Dundee that buses from Blairgowrie or Forfar tend to go to the city centre before they go to Ninewells. We suggested to the bus operators that buses should go to the hospital before going to the city centre. We are fairly confident that the operators are looking favourably at changing schedules to save staff from having to pick up connections.

Another big success is that from the start of the month we introduced our hospital bus link, which is an hourly scheduled bus service between the two main acute sites—PRI and Ninewells. The service is operated by Stagecoach and the journey takes 40 minutes. Quite a lot of staff, patients and visitors are using the service between the two

centres. Stagecoach is also working with us on a salary sacrifice scheme that will encourage staff to use the bus and provide them with some savings on their bus travel.

**Angela Constance:** I prefix my questions by saying that I am vehemently opposed to hospital car parking charges, which I believe are a tax on the sick and on those who work with and visit them. Such charges go against the founding principle of the NHS, which is that services should be free at the point of delivery. That view is based on my experience of car parking charges at St John's hospital in my constituency. I cannot comment on experiences in Tayside and Glasgow, of course, but I would be interested to know what thought was given to ways of controlling access to car parks other than by the imposition of fees.

A few times this afternoon we have heard that car parking fees are not used to generate income and that money raised in that way will be reinvested. How will local stakeholders be able to scrutinise information about the income that is generated by car parking charges? How will that money be reinvested? Will car parking charges that are raised from a particular hospital be reinvested on that site or will they be used to subsidise other services, such as transport to other hospitals? At St John's hospital, car parking charges are used to fund transport to take people to the Edinburgh royal infirmary, which has proved to be politically unacceptable locally.

One of the gentlemen from Tayside said that not imposing fees would have led to a cost to the NHS of £0.5 million. Why are car parking facilities different from other aspects of the NHS estate? All aspects of the NHS estate, such as buildings, store rooms and so on, generate a cost. Why is car parking treated differently from other activities?

I am also interested in the issue of cost to staff. Cleaners and nurses are paid less than consultants and I would be interested to know how that is taken into account.

**Tom Divers:** We have tuned the levels of charge to reflect different levels of salary and, indeed, the fact that some people work part time. One of the issues that has been raised and will be considered as part of the review is whether the differentials are at the right levels to ensure that those who are the highest earners pay sufficiently more for their space than others do. In the implementation of the policy, we have sought to recognise those differences in income and have set the charges accordingly.

On the issue of the transparency of the information that is made available to stakeholders about the income that is raised from parking charges, we have made it clear, since the inception of the charges, that we will publish a detailed annual account of the charges that have been levied and how that income has been used to pay for the maintenance of the existing arrangements or, indeed, their enhancement, as our sense is that there are bound to be enhancements that need to be made in the course of a year to improve the arrangements. Such transparency and the publication of that separate set of accounts will make explicit how that money has been directed and the fact that the charge has been levied for no purpose other than that of providing that service.

16:00

Gerry Marr touched on your fundamental point in his introduction. We have faced the issue for years—nay, decades. A colleague embarrassed me in the margins of a meeting a few months ago by showing me an article from the *Health Service Journal* in 1982, when I was the administrator of Glasgow royal infirmary, which showed a picture of me and my deputy and said that we were discussing the car parking problems at that hospital. Over decades, we have tried many ways—from employing attendants to using barriers—of achieving some control, but we have been unable to introduce a system that gives patients and others fairer access and allows staff who have a priority claim to park without having the managed set of arrangements.

Like Gerry Marr, I think that if we used mainstream NHS resource to fund such arrangements, that would be at the expense of providing direct care. In our society, we pay for car parking in many other parts of our lives. Our sense is that if hospital car parking became a charge on the public purse, that would drain spending that should be made on providing direct patient care.

**Gerry Marr:** Very similar arguments were advanced in Tayside. In 1998, the Ninewells decision was governed by the opportunity to obtain, through a PFI contract, significant capital investment that had not been available to the health board. The PFI contract was not about just car parking charges, but about building an infrastructure for car parking, which included a multistorey car park.

We are absolutely able to be transparent about what happens at Perth royal infirmary, because that is not a PFI scheme—we run it, so we can show the books openly. However, the perennial problem is that the PFI contract restricts our ability to make a similar disclosure about the Ninewells site. We require the company to disclose to us the income level and we work with it so that it returns sufficient money monthly to allow us to release about 2,500 spaces a month to high-priority patients, such as those who use renal services or who have cancer. The company works closely with

us to regenerate funding and we declare that openly and transparently, but we are restricted by the PFI contract with that private company.

As Tom Divers said, people adopt a position in the debate and that must be respected. We take the view that the convention of charging for car parking provides one way to offset costs, which allows money to be released for direct patient care. We stand or fall by that argument.

**Nanette Milne:** I do not know the Glasgow hospitals at all; I know the Grampian ones best and the Tayside ones reasonably well. The system in Grampian is not dissimilar to that in Tayside—the first half hour of parking in Grampian is free, then £1.50 is charged for up to about five hours, after which the price goes up. I visited Ninewells two or three weeks ago and was relieved to find a parking space close to where I wanted to be. When I was there, I was struck by the turnover. When I parked my car, I saw three or four cars leave that bit of the car park, and when I returned to collect my car, the same thing happened. I accept what has been said about turnover, which was obvious from my short visit.

I am interested to know whether you have a system in place to cope with the revised Government guidelines that have been issued recently about concessions, free parking and so on. The guidelines say that concessions must be provided to people on low incomes and to frequent attenders, such as visitors to long-stay patients. In Grampian, as far as I know, the ward sister or someone in the office can issue a voucher so that people can get their money back, but I am interested to find out how you are managing to cope.

**Billy Hunter:** In Glasgow we have worked closely with our clinical colleagues and out-patient departments to identify those categories of patients who would qualify for concessionary parking, which is free. Whether they qualify depends on the nature of their care and is detailed in the Executive guidance. We have also worked closely with the company that manages our car parks and we link that with the clinical service to issue a permit either for a single journey or a group of journeys, so that a range of patients—whether oncology, renal or other patients—receive free parking. That arrangement is extended to cover visitors of patients who are in intensive care units, cardiac care units, or who are receiving longer-term care. We also have arrangements in place to cover people who are in receipt of low-income benefits. We manage that through CP Plus, ensuring that the arrangement is made available to users of our sites as they come and go. That has worked successfully and, as it stands at the moment, that has been a particular success of our operational policy.

**Nanette Milne:** Is it seen to be hassle free by the people on the receiving end?

**Billy Hunter:** Yes, it is absolutely hassle free. To be fair to us, we put a lot of effort and time into making it a success—it did not happen by accident. Prior to the implementation of the policy, we spoke to our clinical colleagues and we identified the key groups of people who would be affected so that we could have in place the mechanism and the policy at the front end to help us on our way. That particular aspect of the policy has been successful.

**Tom Divers:** Regarding your point about turnover, we have sought to be sensitive to that in the way in which we have structured the pricing charges. For the first two hours we charge a flat rate of £1. You were struck by the rapidity of turnover—for a lot of the high-volume attendances, not least the out-patient clinics, two hours will cover a significant majority of attendances.

We have sought to do that, and as part of our earlier review we stepped back from levying charges overnight and reduced weekend charges to a flat rate of £1 to reflect the fact that there was lower pressure on access and utilisation. We keep each of those elements under review as we move forward with implementation. As members of the committee will know, each of the NHS systems in Scotland is required to produce a material report by 30 June this year, in relation to the implementation of the arrangements.

**Brian Main:** In Tayside, we have similar arrangements for patients who need free permits. We work closely with our clinical colleagues, clinical team managers and senior charge nurses. The patient population that benefits from the permits is mainly oncology and radiotherapy patients, renal patients and such like. Those departments almost get a regular supply of permits—they know what patients are coming in. Other clinical groups can ask for permits as and when they are required; equally, they can recommend and request free-parking permits for relatives of patients who, for particular reasons, have long stays or need particular care. It works very well—although I did wonder how it could work without being abused, because as soon as a system is put in place, someone is on to it and trying to work a fast one.

If any of you have been to the fair city of St Andrews and tried to park your car, you will know that you need to buy a wee scratchcard from a shop. We thought that that was a good idea and we went ahead with it in conjunction with Vinci Park UK Ltd. The company does the printing and provides us with approximately 2,500 vouchers per month. We issue them to the clinical groups and pass them on to patients. We give a week's

supply to relatives who need them: seven cards for seven days. In order to use them, you scratch a card, after which it becomes invalid. The system has worked a treat for patients who are in regular receipt of permits.

We examined whether we should have fixed criteria. For example, we could have decided to give a card to an applicant who ticked the box for six out of 10 conditions. The clinical groups decided that there could not be hard and fast rules and that the merits of each individual patient's situation had to be considered. They wanted to take responsibility for trying to manage the system with us and that has been one of the great successes of our systems.

Gerry Marr mentioned that we consulted disabled users about charging for car parking, because they were fed up with folk abusing their space. People were parking all day using blue badges that did not belong to them, which meant that disabled people could not get to park. Although we have a PFI contract with Vinci Park UK, it did not want to be associated with any increased profit or income from charging disabled people to use the car park, so we have a clean set of books in which that income is declared and we have used it to fund free permits for other patients and relatives. In addition, we introduced a new hospital mobility system similar to those in shopping malls where disabled people can sign up as members of the scheme to use electric scooters. People can phone ahead and book a scooter or order one online so that when they arrive at the disabled car park at the main entrance they can pick up an electric scooter. The car park is manned all day by a supervisor. All those benefits, including free permit parking, have come from that. It has been a good result for us.

**Nanette Milne:** Have you carried out any customer satisfaction surveys?

**Brian Main:** We use them a great deal. A patient partnership group, consisting of members of the public, regularly comes to Ninewells to carry out surveys and speak to relatives and visitors on a range of subjects. We usually encroach on the group and ask them to include a few questions on car parking. There has been a vast improvement in the response from patients and, especially, visitors, since we introduced the changes approximately a year ago.

**The Convener:** Paul Martin has also raised this issue and he has attended the committee a number of times for that reason. I invite him to ask a question.

**Paul Martin (Glasgow Springburn) (Lab):** I wish to take Tom Divers back to his earlier remarks to the effect that the inspiration for the introduction of car parking charges was due to the number of complaints received from both patients and visitors. Can he provide us with the number of complaints in respect of Stobhill? I would not like to think that he introduced the charges as a result of anecdotal evidence, but that the decision was evidence based.

**Tom Divers:** I do not have the numbers with me today but I am happy to get them. Many of the complaints from people who have had difficulty parking are handled by the clinical staff who see patients at a clinic or patients' visitors. I have received a small number of approaches and letters. I am happy to get further evidence.

This is not a trivial issue. It relates to a range of clinics where individuals had repeated difficulties getting there in time for their appointment. One of the most distressing aspects is that further upset and anxiety was created for patients and their relatives beyond the anxiety that many of them already experienced in attending for a hospital appointment. I am happy to source further figures.

**Paul Martin:** That is an important point. For any professional organisation to implement a policy it would need to be evidence based; it cannot be anecdotal. It has always been expected of me that I would return to your office with evidence of complaints that I receive. You cannot provide anecdotal evidence alone to the committee—that is not sufficient. We need evidence of how many complaints have been received and of other difficulties. My experience of Stobhill hospital, both as a local resident and as a user, is that until the construction of the ambulatory care and diagnostic facility there were never any car parking difficulties. Prior to the ACAD project, I received no complaints about parking at Stobhill and never wrote to Greater Glasgow and Clyde NHS Board about the issue. I am not aware of other elected members having received such complaints.

16:15

**Tom Divers:** The concentration of major capital projects around Stobhill has been greater than that at any of the other sites in greater Glasgow. Ideally, we would not have planned for four significant developments to be under way at the same time. We examined whether there was an opportunity for us to stagger the developments, without having a detrimental effect on the service improvements that we were keen to make, but that was not possible—not least because the prioritisation at United Kingdom level of the new Marie Curie hospice by one of the major funding partners, Marie Curie Cancer Care, was dependent on funding being accessed at a particular time. I know that Paul Martin is in touch with that development. The combination on one site, at the same time, of four major projects was always going to be substantially disruptive.

**Paul Martin:** With the convener's indulgence, I will ask two further questions concerning the local community. You referred to a public meeting on the south side of Glasgow. I understand that that meeting took place at the behest of the local community and was not initiated by the health board—representatives of the health board were asked to attend the meeting. I am not sure whether you were trying to make that clear.

What is the point in contact being made with the local community after the policy has been implemented? Surely the matter should have been discussed with the local community prior to the implementation of the charges. Have you not dealt with the car parking problem on the Stobhill campus by dumping it on the hospital's neighbours, as traffic has been transferred from the Stobhill site to the community surrounding Stobhill?

**Tom Divers:** I would hate it to be thought that we were dumping the problem on anyone. The policy is a really important aspect of the provision of high-quality patient care and is designed to provide patients and their relatives with better and fairer access to the hospital. In my opening comments, I sought to acknowledge that in the original consultation that we undertook prior to the policy's introduction we may have underestimated the importance of engaging with community interests. It is not the case that there were no such interests—we received comments from a number of them—but the situation that has unfolded since implementation has given me pause for thought about how we can conduct such interactions better in the future.

As an example, I mentioned the recent community engagement that took place south of the river. The meeting was held at the behest of a community group, but from 2002 I recruited a community engagement team to NHS Greater Glasgow and Clyde. Paul Martin knows that, because I did so partly at his request and at the request of other elected members. The team spends much of its time engaging with community interests and is actively engaged in the debate about car parking charges. We need to raise our game on the issue, because it is not our intention to dump on local residents. We must ensure that we find the best solutions—solutions that meet the requirements of both parties.

**Paul Martin:** The health board said that it has introduced these charges partly because of the green transport policy. However, how does reducing the charge to a maximum of £3 help to implement that? Given that that is what a return bus journey to the south side of Glasgow costs, surely the volume of traffic to Stobhill hospital—I have been using that as an example, but I am sure that the same can be said of the Southern general and other hospitals—will remain the same. Such a reduction is simply a token gesture. After all, if the aim is to implement the green transport policy, the charge might as well be reduced to zero.

**Tom Divers:** The green transport policy is simply one part of what has driven the development of this strategy. As Paul Martin, who has closely followed our regular briefing sessions on the implementation of various service strategies in greater Glasgow, will know, we have been required to submit a campus plan for all the sites in the city of Glasgow that are covered by our acute services plan. That also involves meeting the requirements of the green transport policy. However, that is but one aspect of what has caused us to take this route.

We settled on the figure of £3, because it was the interim maximum charge. As I have said, we have aimed to ensure that patients, relatives and visitors get a fairer crack of the whip, to calibrate our charges for visitors and staff to reflect that and to continue to give staff who need permits and access to their car during the day the facility to move on and off site.

**Paul Martin:** But do you accept that the volume of car traffic going to and from the hospitals will remain the same? Making the parking charge the same as the cost of a return bus journey will simply not prohibit people from taking their cars to the hospital.

**Tom Divers:** I am not in a position either to accept or to disagree with your point. As we made clear earlier to Mr Harper, we are still weighing up evidence from a series of measures.

Obviously, we will regularly review the arrangements not just to find out how the income raised has been used but to look at—and, if necessary, recalibrate—the balance between the number of permits given to staff and the number of spaces that have been made available to patients and relatives. Members would properly expect us to undertake such on-going calibrations, and to review what is happening on different sites at different points in time to find out, for example, whether a situation in which four major building contracts are under way at one time requires a materially different set of arrangements from a situation in which there are no such contracts.

**John Wilson:** As the witnesses from both NHS Greater Glasgow and Clyde and NHS Tayside have made clear, the health boards came up with the idea of car parking charges after considering alternatives, such as introducing parking restrictions at car parks. However, as Angela Constance has pointed out, the move does not sit well with the principle of the health service being free at the point of delivery. Why was it felt that there was no option other than to introduce such

charges? Indeed, according to certain statements, NHS Greater Glasgow and Clyde initially considered charging £7 a day for parking. In that light, is the £3 maximum, as set out in the revised guidance, delivering dividends for NHS Greater Glasgow and Clyde? I realise that I have asked a couple of questions, but I hope that they can be dealt with.

**Gerry Marr:** In Tayside, the issue is straightforward. The decision to charge for car parking and to do so through a private finance initiative was taken to mobilise significant and rapid capital investment on the Ninewells site and to free up capital for schemes for direct patient care. That was absolutely the reason for mobilising the contract.

On the ideological aspect, I will advance our argument, with which you will either agree or disagree. Our view is that we are making an overt charge. The public are familiar with the convention of paying for parking. We do not view the charge as an additional tax because, in reality, if there were no car parking charges, we would have to spend £0.5 million and that money would be drawn from the health float, so members of the public would still pay for car parking. The issue is whether we should use an overt charge to free up money for other resources. That is the argument that we advance and, as I said to Angela Constance, it is the argument that we will stand or fall by.

**Tom Divers:** As I said, the £7 charge was, in essence, a deterrent. We did not want to charge anyone £7 a day for car parking, but we wanted to ensure that staff who did not have a permit did not bring their cars on site. As I said, the fact that the interim maximum charge has been set at £3, whereas we had £7 in our policy, has not impacted materially on the financial model that we developed, because we had no expectation that we would collect large numbers of £7 charges and no desire to do so.

I had an interesting talk to David Hastie earlier about the challenge that a maximum levy of £3 may pose for us. There is now evidence from some sites, not just in NHS Greater Glasgow and Clyde, that patients are finding it difficult to access spaces. As part of implementation of the arrangements, we will continue to consider whether we can, by some means, create more protected zones in which patients can park.

**Gerry Marr:** We imposed a £10 surcharge in Tayside—we have now removed it because of the new guidance—because of the evidence that surcharging stops people parking. We were determined to put our patients and their relatives first and foremost. The evidence from our patients and their relatives is that that was enormously successful.

**John Wilson:** I will follow that up, as it leads me straight to the issue about the permits that have been issued to staff. I take on board Mr Marr's point that it is vital that patients and relatives who visit hospitals have parking spaces, but it is also vital that some staff who work in hospitals have access to parking, where necessary. Although there has been movement on pay scales in the NHS, it still has some of the lowest-paid workers in the country and charges are being levied on their low wages. I am concerned about the proportional impact on those individuals of the permits that are being issued. Do health boards take into account the type of workers when permits are issued? Is an economic impact assessment made when NHS boards levy charges from staff who work in hospitals, to ensure that the lowest-paid workers are not adversely affected?

**Gerry Marr:** I take on board that comment, but we have not yet considered that issue in NHS Tayside. We apply a flat-rate charge of £1.60 for parking for the day. We have 1,400 staff permits and the monthly charge is £25. We have not differentiated between low-paid workers and higher-paid staff. However, I would not rule that out; it merits some examination.

16:30

**Billy Hunter:** Earlier on, we discussed how we apply our permit charges. We have permit charges that start at £5 per month and go up to £25 or £40 a month, depending on an individual's earning capacity. For people who earn up to £10,000, the maximum charge for a permit is £5 per month. In addition, we acknowledge that many of the low-income staff on our sites do not have a business need to travel between sites and so that group of staff are less likely to need a permit to fulfil the requirements of their post. That is part of the allocation criteria and, so far, the logic that we have applied has appeared to be reasonable and fair.

**John Wilson:** I have another question for Greater Glasgow and Clyde NHS Board on travel between sites. I recently spoke to someone who travels between sites, although not between hospitals that currently have car parking charges in place. They said that travel from the Western infirmary to the dental hospital could be charged at a taxi rate. I know that this is outwith the issue of parking fees, but it goes back to Robin Harper's point about greener transport. Has the board considered getting people who are working off site to take public transport between sites rather than clock up car mileage? That might have an impact on who would require car parking spaces at various sites.

**Billy Hunter:** In certain parts of the board area we operate shuttle buses between various sites.

Those buses are managed to a rigorous, tight time schedule and run frequently. There are good connections between the majority of our acute sites. Staff can access those services and thereby avoid the unnecessary use of cars or taxis. We also have in place a shuttle bus that connects certain sites with Glasgow Central station. That is another mechanism to reduce the need for car journeys. We are focused on that. We are looking at improving the car-share scheme and rolling out a pool-car system across certain sites to reduce the need for taxi travel and encourage shared journeys between sites.

**Brian Main:** We have piloted a pool-car scheme at Ninewells, which has been a great success and which we plan to expand. People do not have to come to work by car; they can use public transport, but there is a car available if they need to travel between sites. We have even put in two pool bicycles, but we are still waiting for the first one to go.

**John Wilson:** I have another question on the Ninewells PFI car park. The figure of £0.5 million was mentioned. Would that be the cost per annum to the health board?

**Gerry Marr:** Yes. Because of the nature of the contract—which I was not involved in—we reckon that the penalty for buying out the PFI scheme would be a one-off payment of somewhere in the region of £10 million.

**John Wilson:** Is that because the scheme still has 20 years to run?

**Gerry Marr:** Yes.

**Bashir Ahmad:** I see that £3 per day is the cost for a full day's parking at hospitals in Glasgow. What is the minimum?

**Billy Hunter:** The minimum charge is £1 for the first two hours. Then the charge rises on an incremental scale to a maximum of £3 for more than four hours, up to 24 hours.

**John Wilson:** Just so that we are clear, is it correct to say that Greater Glasgow and Clyde NHS Board charges by the hour, in effect?

**Tom Divers:** The first two hours cost £1; between two and three hours costs £1.50; between three and four hours costs £2.50; and more than four hours costs £3.

**John Wilson:** That is because the rates are capped at the moment; it is not the rate that you initially wanted to introduce. If a patient attends a clinic that runs late, the patient will be penalised for the clinic, not them, running late. Is any account taken of the late running of clinics when a patient has waited longer than the designated time or has been directed to another clinic while they visited the hospital?

**Billy Hunter:** Yes. That could happen daily. The car park service is managed by our facilities staff, who are closely linked to our management company, which is called CP Plus. We recognise any detrimental effect on the patient or visitor in the event of a clinic overrunning or the appointment schedule running late and we ensure that no punitive measure is taken as a consequence of it. We manage that through our internal communication system.

**John Wilson:** Are patients notified that penalty charges can be claimed back or they can be exempted from them, whichever is the case?

**Billy Hunter:** Yes. Patients are notified at the point of service, generally by our clinical colleagues. If a clinic is running late, we tend to be informed by other colleagues and we pass the information on to CP Plus. If there was a slippage of communication for some reason, we would look favourably on any patient on whom a penalty was applied and ensure that we withdrew it.

**Tom Divers:** The only element of our charging regime that was changed as a consequence of the CEL was the maximum daily charge, which was reduced from £7 to £3. The other elements of the pricing structure remain, including the fact that the charges do not apply beyond 9 o'clock at night. We have now altered the weekend position.

**The Convener:** I have been quite patient today and I have allowed lots of questions to be answered, but I have a wee list myself. Is there any acute hospital site at which Greater Glasgow and Clyde NHS Board does not charge?

**Billy Hunter:** We apply charges to all the sites in Glasgow. That saw us through phases 1 and 2. We are now considering phase 3.

**Tom Divers:** That is the city of Glasgow, at this stage.

**The Convener:** The guidance that you have from the Government says:

> "The Review Group concluded that the provision of car parking at NHSScotland hospitals is a service for patients and, in general, should be provided free of charge."

However, there is no hospital parking free of charge in the city of Glasgow—or there is unlikely to be.

**Tom Divers:** The assessments that we have carried out on each of the sites thus far show that each has a level of car parking pressure that is not replicated in a number of the other non-acute hospitals. Between 45,000 and more than 80,000 patients come to their accident and emergency units each year and, between them, they have more than 1 million out-patient attendances. They are heavily used sites. As we work through the programme, the guidance requires us to carry out

a structured appraisal on every site for which we believe that that is necessary. We will follow the guidance in the later stages of the process.

**The Convener:** You and the other witnesses represent greater Glasgow and Tayside, so my worry is that citizens in our two poorest cities will be going to hospitals where there is charging. That is the reality of the evidence that we have heard, although I understand the history and why we have arrived where we are, due to a combination of assumed free access and the impact of the PFI programme.

My second question is: what income does charging generate? You are not charging to generate income, but what income do you get as a percentage of your overall annual spend?

**Billy Hunter:** NHS Greater Glasgow and Clyde is running a monthly trading account and we are looking at expenditure versus income. As of the year end, our surplus was just short of £90,000. That—

**The Convener:** I am sorry to interrupt; I will rephrase my question. If you were to provide parking free of charge, how much would it cost as a percentage of your overall budget? The figure must be pretty low.

**Tom Divers:** It is. It is £1.3 million against £1.8 billion.

**The Convener:** Okay. I am not very good at counting, but I think that that is not a big figure in percentage terms.

**John Wilson:** It is 0.1 per cent.

**Tom Divers:** But—

**The Convener:** I am sorry to talk over you, Tom, but charging is an issue. Our case load as elected members tells us that.

**Tom Divers:** It is an issue, but there is also what else we can do for direct patient care with £1.3 million.

**The Convener:** I concede that point, but only as a debating point. You, as the health boards, and we, as elected members, are getting grief and all for £1.3 million. Surely the good will that free parking brings is part of the glue that binds people to the health service. As Gerry Marr said, the debate is an emotional and philosophical one. You have had to come before a parliamentary committee to defend a spend of only £1.3 million. We are interrogating you because our constituents are—rightly—interrogating us on charging as a percentage share of overall budgets. Given what constituents have told me and other members, what patients are telling you, and what staff have said in the submissions that we have received from trade unions, is charging really worth while?

**Tom Divers:** Contrary to public perception, guys such as Gerry Marr and me do not set out to create upset and unhappiness. That is not what brought us into these roles.

**The Convener:** Thank God for that.

**Tom Divers:** You are right about the merit of the point as a debating point—£1.3 million is a significant sum. Our view is that it should be used to deliver direct patient care. I say that notwithstanding the fact that, as you said, I and Gerry Marr have responsibility for some of the poorer parts of Scotland. Our policies are designed so that we do not penalise those who are on income support or incapacity benefit. We try to make our policies as sensitive as possible to the issues. However, £1.3 million buys a lot of direct patient care.

**Gerry Marr:** I endorse what Tom Divers said. We have implemented car parking charges on the two sites in Tayside that require intensive traffic management—which is an issue that must not be underestimated. Other sites in rural parts of the region or city-centre psychiatric hospital, learning disability or elderly units do not require the same level of traffic management. We have restricted charging to car parks where traffic management is required. The question is: do we provide such traffic management on the NHS or by levying a charge? As I have said, we determined that we should do it by way of a charge, and that decision has released funds for, for example, somewhere between 70 and 80 hip replacements a year.

**The Convener:** Okay, but surely £1.3 million is not an overwhelmingly significant figure given overall NHS expenditure on bureaucratic elements such as administration. What would you say if you were engaging with Government ministers on the subject? In Wales, the Administration has chosen to go down the path of not having charging at hospitals. Would you welcome the Scottish Government making that commitment if there was no impact on your overall budgets?

**Gerry Marr:** We would be placed in severe difficulties because of the nature of the PFI contract.

**The Convener:** But you could seek discussions with Government on how to address that over a long period of time. For example, it could be managed through the grant allocation. Have you raised that with ministers?

**Gerry Marr:** We have not raised that as yet.

**The Convener:** Should you?

**Gerry Marr:** This is the first time that the issue has been raised with us. I need to reflect on it, although I do not discount the suggestion. You make a valid point, convener. We need to consider it.

16:45

**The Convener:** When I was a student, I worked at Stobhill during the summer holidays. My mother was a cleaner and my father was a porter at the hospital, so I have an emotional interest in the debate. One of my duties was to work as the gateman, which was a fantastic overnight shift, given the slice of life that one encounters in Paul Martin's constituency. We had a boom system. My duty was to ensure that no one whom we did not know got in or out. I know that you will say that that was 25 or 30 years ago, but the important point is that good behaviour was expected of residents and visitors when they entered hospital grounds.

The tragedy is that to stop on-street parking in Stobhill you have spent a fair amount of money to install high-quality bollards from the bottom end of the hospital to the hospital gate, next to Springburn park. Never mind the fact that they are unsightly; punters say to Paul Martin, other members and me that a lot of money has been spent just to stop people parking there when more imaginative solutions could have been tried. I am repeating a point that my mother has made to me and that I promised to raise in Parliament.

Stobhill hospital is different from the Royal hospital for sick children and the Victoria infirmary, which affect my constituents. Can there not be more flexibility in the system?

**Gerry Marr:** Car park charging is an essential component of intensive traffic management. We know what the volume of traffic is. When I left Ninewells hospital to come here this afternoon, I drove past cars that were queueing to park. This morning I was at PRI, where I drove past cars that were queueing to park. I have no doubt that if we did not have car parking charges, the car parks would be full before the first patient arrived for a 9 o'clock out-patient appointment. I see car parking charges as part of a traffic management system.

**The Convener:** We are having a notional debate about car parking. Is the important issue not managing access to the space, which need not include an element of charging? The point is for your structures and for the staff who are employed at the hospital to have the capacity to manage access. I am thinking aloud. The period to which I referred may have been a golden age, but management by staff prevented excessive misuse of car parks.

**Gerry Marr:** We are keen to learn from the Welsh experience. We are intrigued by how the Welsh have managed to address the issue. I know that many car parking schemes in Wales were private finance initiative schemes, so I would be interested to find out from those in the Welsh Assembly how the measures that have been introduced were managed fiscally, which must have been a significant challenge. We do not have that information.

**The Convener:** It was important for me to put to you the questions that I have asked, as those are the questions that the public ask us all the time. People see accessing hospitals as different from accessing multiplexes and other public spaces. They have a powerful sense that when they are trying to visit people who are unwell, they should not be harassed by guys in yellow coats.

Members have no further questions. Would you like to add to the comments that you have made so far?

**Tom Divers:** I do not think so. I hope that our exchange has been of value to the committee. We acknowledge entirely that car parking charges are a difficult, sensitive issue. I hope that both of us have indicated that we will keep the arrangements under review. I have promised to follow up on one or two specific issues that Mr Harper and Mr Martin raised. I am sure that the committee will look forward with interest to the series of reports that NHS Scotland will make early in the summer.

**The Convener:** Are you obliged to respond to the Cabinet Secretary for Health and Wellbeing by 30 June?

**Tom Divers:** That is the point to which I was alluding.

**Gerry Marr:** I reinforce Tom Divers's comments. We are grateful to have had the opportunity to rehearse the debate in public during this afternoon's exchange. We will take members' comments on board.

**The Convener:** Thank you for your time this afternoon. I hope that your car parking charges have not expired.

**Tom Divers:** Not on the train, convener.

**The Convener:** Your office is right in the city centre.

We have spent a fair amount of time on these petitions. How do members wish to take them forward, based on the information with which we have been provided this afternoon?

**Angela Constance:** It is important that we continue with these petitions. In my experience—I say this with no disrespect to the gentlemen before us today—getting transparency on the income and expenditure associated with car parking charges at hospitals has been rather fraught and difficult. Collectively, we would be doing a good service to our constituents if we were to give the issue some scrutiny. All NHS boards have to reply to the minister by the end of June, so it would be good to get a flavour of that and to find out how the minister responds.

**Rhoda Grant:** Could we find out from Wales how the matter is managed there? It must have the same problems with the size of car parks, the number of people trying to park and people using the free parking at hospitals as cheap parking for the day while they go off elsewhere, because there are usually good bus services. We cannot take those issues lightly, and it would be good to find out how people in Wales have overcome, or are working to overcome, such problems.

**Nanette Milne:** The discussion will be in the *Official Report*, but we need to ensure that the Government gets the complete record of what has been said this afternoon, so it can consider that as part of the review.

**Paul Martin:** We must pursue with vigour the issues that Mr Divers assured us he would follow up on, in respect of the complaints received. I am concerned about how he will present his response to us. I do not have any difficulty with his providing a copy of the complaints and redacting the names and addresses of the individuals. I would like committee members to see quality evidence that large volumes of complaints about car parking were received. I am not saying that I do not believe Mr Divers, but he must provide the evidence.

On Angela Constance's point, I submitted a freedom of information request for the contractual arrangements for enforcement, and was advised that I would not be provided with a copy of the contract. The contractual arrangements for enforcement have an impact on the possibility of the health board having to meet a possible deficit, which is probably unlikely, but cannot be ruled out. That is where the examination of successful tender documents comes in.

On community engagement, I do not know how the committee would take this forward, but it is not good enough for witnesses to come to the committee and say, "You know what? We've implemented this policy, but we're happy to have a chat with the local community about it." On what terms will engagement take place? Will Mr Divers consider reversing the policy, or is it just about having a cosy chat with the local community? I am not sure whether he will get such a chat, but if so does he hope to advise the community or to persuade them that car parking charges are the way forward? People want to see genuine engagement.

The issues must be taken forward, and the Health and Sport Committee has a role in managing that and in scrutinising the actions of the Welsh Assembly.

**John Wilson:** Paul Martin is right—we need to get some indication of the level of complaints that brought about the introduction of car parking charges in greater Glasgow. We also need information on the level of usage of the car parks, because we need to get that in proportion to the level of complaints. It is easy enough to say that a number of complaints were received, so car parking charges were introduced.

On Paul's other point about public consultation, the issue concerns not just the user groups—the people who use the hospital and the staff who work there—but the wider impact. Convener, you indicated that a substantial amount of money was spent on erecting bollards to stop on-street parking. Who is paying out public money for that—the health board or the local authority? These decisions have consequences; indeed, in some cases, the consequence might be that another body—in Glasgow's case, the local authority—has to pick up the charge. Unfortunately, the witnesses have gone, but it would have been useful to find out more about discussions within the health boards about the introduction of charges and whether anyone was aware of the impact that the decision might have on surrounding communities, for example, in relation to on-street parking in the area around the hospitals. The health boards claim that they have resolved their problem, but the fact is that they have simply transferred it to the communities living around the hospitals, and we need to find out whether those communities were fully consulted.

**The Convener:** Those suggestions are helpful.

The first point that I want to make is that the existing guidance explicitly indicates that the preferred option is that there should be no charges; however, in our major conurbations, charging seems to be a regular feature. We should raise that issue with the Government, particularly in view of the 30 June deadline that the cabinet secretary has set.

Secondly, the cities under discussion—Dundee and Glasgow—have some of the most economically disadvantaged communities in the country. Although there might well be a lower rate of car usage and ownership in those areas, charges still have a disproportionate impact on those people.

Thirdly, as John Wilson and Paul Martin have made clear, there has been no formal impact study of this issue. All we have heard so far suggests that any such studies have been informal.

Fourthly, Gerry Marr raised an interesting point about the consequences of PFI contracts. No matter where we stand on PFI, the fact is that aspects such as buy-out clauses will have an impact, and the question is how such matters can be managed by the grant authority, the health board and the health directorate. However, I am

sure that those people can find some intelligent way of managing out such matters without impacting on patient care. In fact, it struck me that the major driver for the key executives is that they do not lose any money that could notionally be spent on patient care.

We should also highlight the percentage share of the budget that charging accounts for compared with the impact of such matters on public confidence. As Angela Constance pointed out, what about the feelings of people who have to go to hospital either as patients or as visitors? It is one of the last places where you want someone to put a price on things. As Nanette Milne said, we must submit the core of today's discussion to the Cabinet Secretary for Health and Wellbeing, members of the Health and Sport Committee and the rest of the Parliament.

**Bashir Ahmad:** Hospital car parks are being misused. As one of the witnesses made clear, if there are no charges, the car parks will simply fill up before the first patient turns up. The fact is that the management of the car parks is not working properly; if it were, we would not have this problem.

**The Convener:** Have I missed anything in my summary? I hope that the evidence session has been useful. This is one of those issues that tend to bop around without anyone getting a chance to examine how we reached this point.

The clerk has made a note of the various points, which we will pursue with vigour. We should work to the 30 June deadline so that we can submit evidence to the process. In the meantime, we will be happy to receive any information that members such as Paul Martin—who I am sure will continue to pursue the issue locally—get from local residents and staff.

# New Petitions (Notification)

17:00

**The Convener:** The penultimate item is notification of new petitions that have been lodged since the previous formal meeting. As before, we will identify the two or three preferred petitions for oral submissions and I will ask members whether they are happy with the recommendation. I should say to Angela Constance that the process has changed slightly since she last attended the committee, after one or two petitioners expressed concern that those chosen to give oral submissions were a matter of alleged authoritarian executive decisions taken by your convener. By seeking members' input, we can say that the decision has been taken by the committee—which protects any of us who might get lobbied.

# Commonwealth Games 2014 (Consultation)

17:01

**The Convener:** Item 4 is consideration of a letter from Nicola Sturgeon on the Government's consultation paper "Glasgow 2014—Delivering a lasting legacy for Scotland". The letter has been sent to all committee conveners and, although other subject committees will have more of an interest in the issues raised, I felt that our committee might want to comment on one or two matters.

Do members have any comments?

**Nanette Milne:** The only point that I have noted is the on-going revenue implications of capital spend on facilities for the games. As someone who comes from Aberdeen, where we are dealing with quite a few revenue issues, I wonder whether the Government should set up some kind of fund to address the matter.

**The Convener:** I understand that after what happened at the Scottish cup semi-final at the weekend a special fund is being set up to provide counselling to Aberdonians.

That said, Mrs Milne's comment is helpful. After all, the games will have revenue implications for any local authorities in partnership with those who are developing facilities.

I am happy to take members' views after the meeting, and we can discuss them at our next meeting. At this point, I should perhaps declare an interest, in that the games village will be located in my constituency.

That concludes today's meeting. The committee will next meet on Tuesday 29 April, when, as a result of a petition that we have received, we will have an oral evidence session on the availability of cancer drugs.

*Meeting closed at 17:03.*

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