The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC PETITIONS COMMITTEE

Tuesday 10 December 2013

Session 4

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PUBLIC PETITIONS COMMITTEE
20th Meeting 2013, Session 4

CONVENER

*David Stewart (Highlands and Islands) (Lab)

DEPUTY CONVENER

*Chic Brodie (South Scotland) (SNP)

COMMITTEE MEMBERS

*Jackson Carlaw (West Scotland) (Con)
Angus MacDonald (Falkirk East) (SNP)
Anne McTaggart (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*John Wilson (Central Scotland) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jim Eadie (Edinburgh Southern) (SNP)
Alan Kennedy
Jean Kerr (Cumbrae Public Reference Group)
Gil Paterson (Clydebank and Milngavie) (SNP)
Fiona Sinclair (Autism Rights)
W Hunter Watson

CLERK TO THE COMMITTEE

Anne Peat

LOCATION

Committee Room 2

Scottish Parliament

Public Petitions Committee

Tuesday 10 December 2013

[The Convener *opened the meeting at 10:04*]

New Petitions

The Convener (David Stewart): Welcome to today's meeting of the Public Petitions Committee. I ask everyone to switch off their mobile phones and other electronic devices because they interfere with our sound system.

We have received apologies from Angus MacDonald and Anne McTaggart. I welcome Jim Eadie, who is substituting for Angus MacDonald.

Co-location of General Medical Practices and Community Pharmacies (PE1492)

The Convener: The first item of business is consideration of two new petitions. As has been previously agreed, the committee will take evidence from each petitioner.

The first new petition today, PE1492 from Alan Kennedy, is on co-location of general medical practices and community pharmacies. Members have before them a note by the clerk, a Scottish Parliament information centre briefing and the petition. I welcome Mr Kennedy and Jean Kerr, who chairs the Cumbrae public reference group, to the meeting. I invite Mr Kennedy to make a short presentation to set out the context for the petition.

Alan Kennedy: I wish simply to make five main points for the committee to consider in conjunction with what you have already seen in the petition. First, I accept that, in November this year, the Cabinet Secretary for Health and Wellbeing agreed publicly, at last, that the current Scottish pharmacy application legislation is deeply flawed and will be revised. He has promised action soon. However, that process of review actually began in June 2013, following an MSP's meeting with Michael Matheson, the Minister for Public Health, which identified serious problems with the legislation. We are still awaiting action, six months later.

Secondly, although the threat to Benbecula's GP dispensing has been removed for now, two more practices are threatened with unwelcome applications—one in Drymen and one in Aberfoyle, and there may be a third one in Castletown. If a moratorium on further applications is not applied, other applications will follow; some 40 of 101 dispensing practices in Scotland are at risk. The problems and distress that those unwelcome applications are causing in communities and to staff should not be underestimated.

Thirdly, there is a belief in Government and the pharmaceutical industry that each and every existing pharmacist might be adversely affected by new start-ups. Thus, many pharmacists oppose new pharmacies even outwith their local area, whether they be independent or co-located with a medical practice. Government officials have admitted that the legislation is protecting pharmacists when application decisions are being made, regardless of community input. I have used freedom of information requests to determine dispensing income in every pharmacy in Scotland, and with input from an experienced dispensing practitioner, it is clear to me that rarely do such dangers exist. Some pharmacists will go to extraordinary lengths to protect their existing profit margins. Competition, as advocated by the Office of Fair Trading some years ago and rejected by the Scottish Government at that time could, I believe, save tens of millions of pounds in the Scottish national health service budget.

Fourthly, there is little evidence that those who are involved in negotiating and setting down the pharmacy legislation are prepared to take note of what patients in communities all over Scotland have been telling them for the past five years; namely, that patients demand a say on what they want locally, and having imposed upon them an unwanted pharmacy is definitely not part of that demand. Communities, including Whitlawburn, seek to have independent pharmacies; they should not be denied that choice by other pharmacists outwith the area.

Finally, at present, pharmacy legislation operates in a way that brings huge profits for a few and an impoverished health service for many people in the communities that are affected. It should not matter whether the dispensing and other services are provided by GPs, co-located GP surgeries and pharmacies, or independent pharmacies. Input that seeks to deny or restrain democratic choice must be rejected, whether it comes from Community Pharmacy Scotland or any other body that is associated with the NHS dispensing service to patients. It is time to change the legislation to support patient choice.

The Convener: Thank you, Mr Kennedy—in particular, for keeping your remarks under five minutes.

I have a couple of questions to ask before opening up the discussion to other members. I ask Jean Kerr to let me know, please, if she wishes to raise any points.

I am glad that you mentioned that other areas in Scotland are being affected. I represent the

Highlands and Islands and have been heavily involved in the situations in Benbecula and Caithness and have met Alex Neil to discuss the issue. Do you agree that the Wilson and Barber report was helpful and that, if its recommendations are accepted by Government, that will go a long way towards solving the problems?

Alan Kennedy: The Wilson and Barber report has been useful in that it has highlighted the problems. You will have noted that it calls for a moratorium. It is clear that reconsideration of the legislation is long overdue.

The Convener: My final question is probably more applicable to rural areas than to urban areas. Do you share my view that it would be helpful to have a third way whereby there is co-existence of community pharmacies and dispensing GPs rather than the conflict that is set up when a new community pharmacy opens in a rural area and the GP then loses the dispensing pharmacy option?

Alan Kennedy: My reading of the situation from the information that comes in to me is that all GPs would welcome closer co-operation with pharmacies. What they do not welcome is the interruption to GP services that can be caused by a pharmacy coming into a dispensing area. That has to be looked at seriously.

Jean Kerr (Cumbrae Public Reference Group): What has happened in Millport is probably extreme. It has happened mainly because we are an island community. As a result of a pharmacy being imposed on us despite the fact that, in the consultation, patients were very much against a pharmacy coming in, we have lost a first-class service by three doctors who did all the out-of-hours work and their own surgeries, and we are now being serviced by locum doctors 24/7. We have had three adverts out for a doctor’s practice. We had one applicant who was refused interview or consultation to see whether anything could be done. We now face having temporary salaried doctors and our out-of-hours work is going to be serviced by advanced nurse practitioners, who are being trained specifically to deal with an island situation.

We have gone from having a superb service to having a poor service where we do not know the doctors and we never know who is coming. Once the salaried doctors come, it is a known fact that those people will be temporary. We have an elderly population who are extremely distressed about all this, and there will be no continuity for them. The situation has divided our community considerably, because the older ones are feeling the problems while the younger ones are quite happy because they only have minor illnesses and they get their free bits and pieces from the pharmacy.

As Alan Kennedy said, all that we are asking for is to get our dispensary back so that the money that is generated from it can pay for the full amount of doctors that we need. The general anecdotal evidence that we are getting is that the people who showed an interest when the adverts went out withdrew because they felt that the practice was unviable, given what was expected.

The Convener: I am sorry to cut across you, but our time is quite short, so I am keen to bring in my colleagues. I take it from your comments that the root cause of the situation is, in your view, the community pharmacy applications. Is that your argument?

Jean Kerr: Yes. We asked that the dispensary remain open even though the pharmacy was coming in, but NHS Ayrshire and Arran refused that and closed the dispensary. We know that it has the authority to let the dispensary stay open, but it did not do that. As a result, we are unable to attract a GP practice that would be sustainable, safe and affordable.

Chic Brodie (South Scotland) (SNP): Good morning. Clearly, my colleague Mr Carlaw will dwell on the Millport situation in detail. Drugs are a profitable business. Why would three doctors who are committed to customer service and to protecting their clients resign because of dispensing services being withdrawn?

10:15

Jean Kerr: I cannot speak for the doctors, but I note that they were there for almost 30 years and had built up a superb practice for us. We have not had a pharmacy on the island for 40 years. The doctors chose to put a great deal of the money that was generated from the dispensary into paying for a third doctor and their out-of-hours cover.

Alan Kennedy: I add briefly that Millport is not alone in the doctors giving up. We have lost both our doctors in my community. Having started with a wooden shed, they ended up with two purpose-built surgeries, but now they can barely afford them.

Chic Brodie: Let me make it clear that I am very much in favour of as much activity as possible being generated in and by the community, but do you not think that there is potential for, or that there might be, a conflict of interests between the doctors issuing prescriptions and their having a dispensing service that is associated with them dispensing the drugs?

Alan Kennedy: I do not see why there should be a conflict, because the system has worked perfectly well for many years. Another myth that I should dispel is that pharmacies can provide services that dispensing doctors cannot provide. When we examine what happens in rural surgeries that are dispensing, we find that they mirror pharmacies in a certain way, and they are also cheaper. However, I am not here to defend dispensing doctors. I am here to point out that, when we look at the matter, more options are open than may at first appear.

Chic Brodie: I understand that. Thank you for that answer. I asked a question last year about relationships between GPs and pharmacists, be they remote or local. We are losing upwards of £30 million in repeat prescriptions. I am not sure that having dispensing services adjacent to or close by a local practice will eliminate that problem.

Alan Kennedy: Yes, but dispensing—

Chic Brodie: Because GPs are so busy.

Alan Kennedy: If you look at the clawback from dispensing income to GPs and to pharmacists, GPs are actually less costly than pharmacists. There is about a 1.5 per cent difference in the costs to the NHS.

Chic Brodie: Okay. I have one last question on the NHS's role in all of this. What do you think the necessary criteria are for opening a pharmacy? Are NHS boards in general applying the criteria when they receive applications and allow pharmacies to open?

Alan Kennedy: NHS boards would tell you that they are applying the letter of the law, but the legislation is weighted so heavily in favour of pharmacy applications that the needs, wishes and expectations of communities are not recognised. Boards have always argued that dispensing should not continue because the service is inadequate. To be frank, that is wrong and takes no account of what patients consider to be an adequate service.

Chic Brodie: The relationship between the customer and the doctor is a factor, particularly where it has existed for a long time. You made the point about profit margins, and I am sure that that comes into all relationships, whether they involve remote pharmacies or local dispensing pharmacies. We cannot sweep that under the carpet. I return to my earlier comment that drugs are a profitable business.

Alan Kennedy: The ideal solution is a co-located pharmacy and GP surgery, but that is not permitted.

Chic Brodie: Okay. Thank you.

Jackson Carlaw (West Scotland) (Con): Good morning. As a West Scotland member, I am familiar with the situation on Cumbrae. I want to be helpful, but to qualify that with a particular point.

First, on the suggestion that island and rural GPs are squirrelling away huge profits, your point is that the profits that were made from the dispensing GP practice, particularly in Cumbrae, were reinvested by the practice in order to ensure that it could give the most comprehensive service to patients. Is that correct?

Jean Kerr: That is correct.

Jackson Carlaw: I think that we were at a stage where those GPs were set to retire, and they felt that because the change was imposed upon them they were no longer able to offer that service, so their retiral went ahead. The proof of the pudding has been the inability of the practice, or any practice, to recruit new GPs to it, because the GPs who consider it do not see it as an opportunity that they could properly take advantage of.

Jean Kerr: That is correct.

Alan Kennedy: The Scottish NHS has never recognised that cross-subsidising from GP dispensing income to support other services is valid. Dispensing GPs are treated as contractors, which is quite different.

Jackson Carlaw: The difficulty that we have generally is that both island and rural communities elsewhere in Scotland are also finding it difficult to recruit GPs to replace those who are coming up to the point of retirement, so a potential crisis is emerging in the provision of GP services.

I understand the argument in relation to islands in particular, where the loss of a GP service could mean that there is no out-of-hours cover on the island from a GP and where the population is probably elderly and not changing. However, there are communities that are growing, where the original rationale behind a GP dispensing practice was that it would serve a relatively small population base and where the wider population base creates the opportunity to have a sustainable community pharmacy. I am not sure that I share your dismissal of that prospect, Mr Kennedy, quite as much as you do. When it comes to sexual health testing kits and some other areas of healthcare, there is evidence that the anonymity of the dispensing practice as opposed to the GP, where the whole of a family might be involved, means that young people and others will access those things. When you dismiss the additional services as you do, I wonder whether that is entirely fair.

Alan Kennedy: Let me explain, taking the example of Leuchars and Balmullo. When Leuchars was granted a pharmacy, dispensing in Balmullo had to cease because the Leuchars pharmacist objected. We have exchanged a dispensing practice that was purpose built for dealing with dispensing problems, as you have described, and we now have a poky little pharmacy sharing premises with a post office, with difficult disabled access and very limited privacy. We have exchanged an excellent one-stop service for another service that is considered unsatisfactory, not by me but by the local community. I think that the case is unique in that I got five community councils in the area to agree that what we have is unsatisfactory. Usually they barely talk to one another, but they are agreed on that.

Jackson Carlaw: That leads to the impression that we have a universal standard being applied everywhere without the appropriate level of discretion. The minister, Michael Matheson, wrote to Ayrshire and Arran NHS Board and other health boards indicating that he does not regard the provisions as demanding the closure of the GP dispensing practice in the event that a community pharmacy opens. Nonetheless, despite the circulation of that letter, Ayrshire and Arran NHS Board either felt that it had to proceed or disregarded the letter and went ahead with the closure.

Do you think that what is needed from the guidelines that the cabinet secretary is considering is not the swapping of one universal standard with another that says that under no circumstances should there be closures, but something that allows greater recognition of local views based on criteria that are, to some extent, capable of being independently assessed? I am aware that some GPs will lobby their patient base quite assiduously, and that may not be in their interests. However, judged against some independent criteria, that may allow the variable solution that would permit some cohabiting. Would that be a sensible solution?

Alan Kennedy: Yes. It would be sensible, especially where it can be publicly demonstrated that the community wants a service. In my case, the community is not particularly rooting for a dispensing service to be brought back, but it would like a pharmacy service and it cannot get one, despite being the largest village in Scotland.

Jean Kerr: I do not entirely agree with Mr Carlaw. I apologise for that. During the past three and a half years, in which we have been fighting the closure, we have gone to great lengths to converse with NHS Ayrshire and Arran. When we and our local councillor met the chief executive and the chairman of the board on 25 November 2011, we asked them two simple questions. One was why the dispensary could not stay open as well as the pharmacy; we asked that question three years ago.

We emphasise that we are not anti-pharmacy but pro-dispensary. I have only recently gone back to live on the island, having been born there. The service that we were getting—and would like to get—is much more suitable for our community, which is where I agree with Jackson Carlaw. One service does not fit all, particularly in Scotland, where there are so many small and rural communities of people who are now having to travel.

Our pharmacy is in an unsuitable location as it is right beside a bus stop, there is no parking, especially in the summer, and there is a bicycle shop right beside it. The whole thing has not been considered properly—that was our argument with NHS Ayrshire and Arran. The only reason that the board gave us was that Mr Semple, who has the pharmacy, may choose to sue for breach of contract. We think that that is the reason why the board has definitely closed our dispensary, and we would like that to be taken into consideration.

Jackson Carlaw: I do not know that Jean Kerr and I are in disagreement, at the end of the day. The point is that, for whatever reason, the minister’s letter was not seen by the health board as offering the comfort and security that it felt was needed to enable it to agree to the dispensing practice staying open. Therefore, although there was some hope that the practice might stay open, it did not. What is needed from the guidelines is something much more authoritative and clear.

Jim Eadie (Edinburgh Southern) (SNP): I am sure that the petitioners have been clear in expressing their views this morning, but I am not sure that I have understood them correctly. Can I clarify what you mean, Mr Kennedy? Are you saying that the regulations contain a presumption in favour of all pharmacy applications or that the regulations are weighted in favour of existing pharmacies?

Alan Kennedy: I am saying that they are weighted against a pharmacy opening where other pharmacists oppose it. They have the privilege of defining the neighbourhood need with regard to such applications; it does not come from the community, whose view is not accepted.

Jim Eadie: That is clear and it helps to clarify matters. It certainly reflects my experience as an Edinburgh MSP. A pharmacy in my constituency closed and the local community would like it to be reopened, but the local NHS board has refused the application.

If I heard you correctly, Mr Kennedy, you said that competition, as advocated by the OFT, could save the NHS millions of pounds every year. Do you have an evidence base to substantiate that assertion?

10:30

Alan Kennedy: I have looked at the evidence that was provided to me recently by a dispensing

GP, who is aware of the discounts that are being achieved. Currently, the Scottish Government works with pharmaceutical firms to establish what the base price should be. It then deducts a certain amount in reimbursement to pharmacists and GPs, knowing that they will get a small discount. The problem is that the amount of discount that pharmacists are getting is not clear. That needs much more exploration. There was an example in London recently in which a pharmacy was marking up particular medicines by 500 per cent as well as getting a discount. There was a court case about it.

The amount of discount that pharmacies—even small ones—are achieving is in the order of 20 per cent. A larger firm operating in Scotland, such as Boots, can get up to 50 per cent. I am not an accountant, but I would have thought that somebody in Scotland should be picking up on that issue and asking whether we are examining in detail what discounts are being achieved. I am certain that there is money to be earned by doing that. When we consider the overall cost of prescriptions over the past two years—from memory, it is about £2 billion—we can see that there must be savings in there.

Jim Eadie: How do you see a change in the regulations addressing that point?

Alan Kennedy: It almost has to be taken up as a separate matter. It is not something that the pharmaceutical directorate can consider.

Jim Eadie: I thought that that would be the case.

John Wilson (Central Scotland) (SNP): I am concerned about the example of Millport, where a GP practice based its financial projections on a dispensing pharmacy being part of the practice. Given the issues around the security of finances coming into that practice, if it continued to dispense drugs, it would draw down a particular income. However, that income level could be subject to change and, clearly, it changed when another pharmacy opened close to hand. Are there GP practices in Scotland that exist only because they have a dispensing pharmacy as part of the surgery?

Alan Kennedy: Yes—there are 101 of them. Another example is Carstairs. It had a dispensing practice, and a pharmacy was allowed to open opposite. Two GPs left the practice because it was no longer viable. It was recently rescued from being closed thanks to an injection of £50,000 from—I think—South Lanarkshire Council to pay for repairs to the building and keep the place open. Without dispensing income, it would have gone.

John Wilson: I think that Mr Kennedy has made the point that I was trying to get at, which is that some GPs—this is the case in 101 practices, according to him—are able to remain operational only because they have dispensing income. They rely on that income.

We heard that there were two GPs on Millport but that, through the income that was derived from the dispensing practice, they were able to employ a third GP. The issue is how many GPs a surgery would be able to have while remaining viable if it did not have that additional income. Should we be in a position where we have to rely on that income in order to maintain GP numbers?

Alan Kennedy: I repeat that, in Scotland, cross-subsidising from dispensing income is not recognised, whereas in England it is.

John Wilson: I am concerned about situations in which we lose dispensing practices. A number of years ago, the Scottish Government decided to make prescriptions free of charge. If patients are now having to travel elsewhere to pick up their prescriptions, I would like to know the estimated average cost of those journeys.

Alan Kennedy: There is a cost in time, a cost in convenience and a cost in money. Since our dispensing practice closed, people in Balmullo have had to get on a bus or into a car. We now have a situation where we have a pharmacist who is the pharmacist of choice for the community—who would have started in the GP practice in combination—and who is delivering to the surgery. It is a compromise that is working and a lot of people are taking it up, but it is not a pharmacy service; it is simply a delivery service of pre-prepared prescriptions. It is one way round the current impasse, but it is not what our local community would like. It would like to see the pharmacist set up shop.

John Wilson: That is one pharmacy that has decided to make that service available within the GP surgery. Do you have any examples of patients regularly being required to travel to have their prescriptions filled by a pharmacy outwith their area, which adds to the time and, in particular, the cost of prescriptions being fulfilled, as you indicated?

Alan Kennedy: Yes. In addition, you must remember that patients choose which pharmacist they want to supply them if they do not have one in their area. The patient should have the right of choice. In Millport, they would like the right of choice, but they are denied it. Because they choose not to use the island pharmacy, they have to travel to pick up dispensing products from a pharmacy on the mainland.

John Wilson: But, Mr Kennedy, many patients throughout Scotland do not have the right of choice as regards the pharmacy services that are provided. They have to accept what is available locally or, as in the example that you gave, travel anything up to 2 miles or beyond to fill a prescription. In the Millport example, it is quite clear that patients make a choice—they decide to take a ferry to go and get their prescriptions filled.

Jean Kerr: It is not purely a matter of choice because the pharmacy that has now opened is quite a considerable distance from the surgery, which is a particular issue for older people. The surgery has a lift, full disabled access and car parking. We have no public transport on the island, and when the ferry goes off, the ferry bus goes off. It costs our older people the minimum fare in a taxi to go and get their prescriptions collected and take them home.

The Convener: I am sorry, but we are a bit short of time. Unless any other member has other points that have not been covered, we will move on. The procedure now is that the committee will look at the next steps. We are therefore finished with questions, but the petitioners can stay while we consider the way forward.

I think that committee members are aware that the system for approving these community pharmacies seems a bit strange and arcane. I cannot speak for the Government, but I am picking up that it wants to look again at that system. The powers to have a moratorium are also restricted, according to my discussions with ministers.

Members will be aware that the Government launched a consultation—on Thursday, I think—that runs until February. It would certainly be useful for the committee to write to the Cabinet Secretary for Health and Wellbeing and confirm whether the consultation that it is committed to will be open to all members of the public for them to submit their views. Jackson Carlaw made a point about a democracy where it is clear what the public wants but that preference is not reflected in successful outcomes as regards pharmacy applications.

Do members agree that we should continue the petition and seek the cabinet secretary's views?

Chic Brodie: I understand that the Government has launched a consultation, but the scope is a bit narrow. While we should follow the strictures that the convener has set down, we need to consider the wider message. We have not talked about economies of scale; we have mentioned competition, but we have not really understood the implications of having a small community pharmacy that—as Mr Kennedy pointed out—might have margins of 20 per cent. We understand that others have margins of 50 per cent.

The issue comes back to the loss of customer service versus the profit margins that are exercised, which could be exercised by community pharmacies as well. If anything can be done to expunge any notion of a conflict of interest with regard to GPs, it should be done, as that issue is critical. They should stand aside from the instructions that are given in relation to NHS services. I agree that we should go ahead as the convener proposes, but there must be a much wider discussion on the provision of drugs, their costs and how they are purveyed and distributed.

Jackson Carlaw: During my time in the Parliament, there have been only two members' business debates—although possibly more than two debates in general—on community pharmacies and dispensing GPs, and they invariably related to situations in which a particular dispensing practice was at risk.

I note that the Health and Sport Committee raised the issue with the cabinet secretary on 12 November, and I have read his response in the *Official Report*. I support the convener's suggestion, but perhaps we could, at the same time, at least liaise with the Health and Sport Committee with the option of reserving the possibility of inviting the cabinet secretary to come to this committee in due course. I do not want to duplicate any lines of inquiry that the other committee is pursuing, but we could perhaps maintain that option at present.

The Convener: Most definitely. I will not lose sight of Chic Brodie's points either, and if we send a general letter to the cabinet secretary we can certainly incorporate his wider comments on the issue.

I would also like the Government to confirm when it will make a decision on adopting the recommendations in the Wilson and Barber report. My view is that it would solve the problem if those recommendations were adopted. In fairness, I do not think that the Government is far away from making that decision.

Are members agreed on the general thrust of where we are going?

Members *indicated agreement.*

The Convener: The petitioners have probably picked up that we are keen to pursue the petition. We will send it to the Government, and the cabinet secretary may come before the committee to give evidence in future.

I thank Alan Kennedy for submitting the petition to us and for coming along, and I also thank Jean Kerr. We will keep you up to date with developments.

10:42

Meeting suspended.

10:44

On resuming—

Mental Health (Care and Treatment) (Scotland) Act 2003 (Amendment) (PE1494)

The Convener: Our second new petition is PE1494, by W Hunter Watson, on mental health legislation. Members have a note by the clerk, which is paper 2; the Scottish Parliament information centre briefing; and the submissions.

I welcome to the meeting the petitioner, W Hunter Watson, and Fiona Sinclair, the convener of Autism Rights. I invite Mr Watson to make a short presentation of a maximum of five minutes to set the context for the petition, after which we will move to questions.

W Hunter Watson: I am most grateful to the Public Petitions Committee for admitting me to address it.

The petition could well be the most important petition to have come before the committee. The reason is that the Scottish Parliament has legislated to permit human rights abuses in mental health hospitals.

I will explain why that is the case and suggest how things might be improved in decision making in the Scottish Parliament, so that lessons can be learned. There is much wrong with the Mental Health (Care and Treatment) (Scotland) Act 2003, and we will possibly get on to some of those matters during questions and answers. However, I will concentrate first on the human rights abuse that the 2003 act permits—namely, it permits electroconvulsive therapy to be given to patients who resist or object to the treatment.

The World Health Organization recommended in 2005 that, if ECT is given, it should be given with the informed consent of the patient. The transcript of a debate in the Scottish Parliament reveals that the Scottish Association for Mental Health made the same recommendation in 2003.

On 1 February this year, Juan Méndez, the United Nations special rapporteur on torture and other cruel, inhuman or degrading treatment and punishment submitted a report. He drew attention to what happens in psychiatric institutions and, among other matters, he mentioned electroshock—electroconvulsive therapy.

I will say a bit about that. An episode of electroconvulsive therapy consists of a patient, who is already drugged, being taken or dragged to the room in which electroconvulsive therapy is given. The patient is then given two injections and, with the aid of electrodes, a high current of electricity is passed through the patient's brain. That constitutes one episode. A course of electroconvulsive therapy consists of that happening two or three times a week for four weeks.

I ask you to imagine how someone would feel if they did not want that to happen. If you Google "Melissa Holliday ECT", you will find out that that woman was subjected to electroconvulsive therapy. On a different occasion she was raped, and she reckoned that getting electroconvulsive therapy against her will was worse than that.

I am sorry to sound angry about this, but I am angry about it. If you Google "ECT", you will learn that it can lead to significant cognitive impairment and permanent memory loss, and yet people are given it against their will.

Alison McInnes MSP kindly sought some information for me from the Scottish Government. According to the information that was supplied to her, 23 per cent of patients who lack capacity—who cannot give informed consent—did not benefit, and yet they were given ECT against their will. It does not necessarily cure depression, especially as 23 per cent apparently derived no benefit.

In my opinion, when Parliament considers the forthcoming mental health bill, if it does not remove the existing provision about electroconvulsive therapy, it will not be taking human rights seriously.

I have suggested that you should consider what lessons might be learned. MSPs and ministers are busy people. Dreadful constituents such as me keep writing to them, but they do their best for us. Ministers rely largely on officials, and those officials are not giving good advice on care homes—that is another matter—and mental health legislation. That is partly because the advice comes from psychiatrists. It is not at all obvious to me why a psychiatrist can subject a patient to electroconvulsive therapy against a patient's will when an oncologist cannot give chemotherapy to a cancer patient without the cancer patient's consent. What is that all about? Psychiatrists have a lot of power and they want to maintain it.

On more than one occasion, the Mental Welfare Commission for Scotland has given bad advice. In April 2008, it issued guidance on restraint in care homes that said that medication could be used as restraint and concealed in food or drink if necessary. I had a petition about that, but it failed.

The Convener: I am sorry to interrupt, Mr Watson, but you are past your five minutes and I need to allow time for questions.

W Hunter Watson: Right you are. Thank you for letting me sound off—I am most grateful.

The Convener: I will touch on a couple of points and then bring in my colleagues. You raise the issue of ECT and possible breaches of the European convention on human rights. ECT is used across Europe, and you have mentioned some cases. What have you picked up from your studies that would identify a potential breach of the European convention?

W Hunter Watson: In 2002, in the case of Pretty v United Kingdom, a definition was given of inhuman or degrading treatment. As the transcript shows, Shona Robison has spoken to the Parliament about involuntary ECT. I should say that some people are happy to have ECT—I am not saying that it should never happen. I have somewhere in my bag exactly what Shona Robison told Parliament, which was that there are feelings of terror and distress, and that brings it within the definition of inhuman or degrading treatment as given by the European Court of Human Rights in the 2002 case.

The Convener: You mentioned the 2003 act. As you know, we have had the McManus review of that act, which made several recommendations to ensure that tribunals are more effective. What is your assessment of that? Have they been more effective since the McManus review?

W Hunter Watson: I was one of those who responded to the McManus review. Quite apart from that, three reports came out in 2009 that were submitted to the Scottish Parliament. The McManus review had no interest whatsoever in what one of the other reports said. Tribunals let witnesses have their say in support of the patient, but they pay little attention to the evidence that the patient gives. One of the reports suggested that research should be done on that.

We are getting off the main point of my petition, which is that the 2003 act permits inhuman or degrading treatment—that point should not be ignored. However, the tribunal composition is such that tribunal hearings are not fair.

I do not know whether members have my petition in front of them.

The Convener: Yes, we all have it.

W Hunter Watson: Excellent. I refer to a ruling of the European Court of Human Rights. The tribunal proceedings are not fair because one of the members of the tribunal is a psychiatrist and the other two tribunal members are liable to defer to his supposed expertise. That psychiatrist is unlikely to challenge the views of the psychiatrist who wishes to treat the patient in certain ways, some of which may be inhuman or degrading. I will expand on that if you give me the chance.

Fiona Sinclair (Autism Rights): Hunter Watson does not have personal experience of the tribunal system and nor do I, but my members have personal experience of it. Before the tribunals were set up, their view was that the tribunals would be preferable to the courts, but their view is now that the matter should be taken back by the courts. One reason for that is that, as Hunter stated, witnesses at tribunals do not have to give evidence under oath, so they cannot be charged with perjury if they tell a lie.

Some of the experiences of tribunals are disgraceful. I have been told about the health board side holding sessions in camera with the tribunal members and excluding the patient and their representatives. Various things take place that allow witnesses to give defamatory information about the patient and their family and do not allow the patient the chance to come back at them. Moreover, because of the way in which the system works, the patient at a tribunal is often already in the system and stands in front of the tribunal drugged up to their eyeballs. All of that is involved.

One of the problems with the 2003 act is that it is predicated on a mental health system that uses only drugs and, occasionally, ECT—it does not use anything else. There is a push to get more psychological therapies, but that is just not happening in Scotland. In some countries there are alternatives, but they are not being developed here.

There are serious problems with the tribunals. It is difficult for the patient and his or her representative to prove what is going on, because all the paperwork is undertaken by the tribunal system. I should also point out that, if someone has a complaint about the administration of the Mental Health Tribunal for Scotland, the only body to which they can complain is the Mental Health Tribunal for Scotland—they cannot take it beyond that. There is no other body that they can complain to. A patient can appeal a tribunal decision through judicial review, but they cannot make a complaint.

Chic Brodie: Good morning. How many cases involving short-term detention provisions have been taken to the European Court of Human Rights?

W Hunter Watson: I imagine that none has. Can we return to the tribunals?

Chic Brodie: No—I would like to stick with the subject that I raised. You say that there have been no such cases.

W Hunter Watson: Not as far as I am aware, although there would be a case for so doing. It is difficult to take a case to the European Court of Human Rights.

Fiona Sinclair: Is the committee aware that only four law firms in Scotland specialise in mental health? In total, only about 20 lawyers in Scotland specialise in mental health. If we add to that any other diagnoses that a person has, such as autism, it becomes difficult to get a lawyer who has any appreciation of what is happening with the person’s situation and why they have ended up in the mental health system. The Scottish—

Chic Brodie: I think that the McManus recommendations to the Government covered that area.

Fiona Sinclair: What did McManus cover?

Chic Brodie: Let me ask the questions. We heard some emotive statements from Mr Watson about people being dragged. If that is happening, that is unforgivable. However, we require evidence of that.

The key elements of the legislation that regulates the administration of ECT in hospitals are that, if a patient consents in writing, either the patient’s responsible medical officer or a designated medical practitioner is involved; that, if a patient is incapable of consenting, a designated medical practitioner must certify that the patient is incapable of making a decision; and that, if he or she is incapable of consenting but resists or objects to treatment, a raft of urgent medical treatment provisions in the 2003 act applies. Are you saying that all the processes that are there to pre-empt the kind of situation that Mr Watson described are not being followed?

Fiona Sinclair: Yes.

11:00

Chic Brodie: That is a serious accusation.

W Hunter Watson: Under article 3 of the European convention on human rights, inhuman or degrading treatment is prohibited in all circumstances. It does not matter what safeguards there are; the safeguards in the 2003 act are not effective. The designated medical—

Chic Brodie: Are you saying that the provisions are not being followed? In the case of a patient who is to have ECT administered, are the processes not being followed by members of the medical profession?

W Hunter Watson: That is irrelevant. Inhuman or degrading treatment is prohibited in all circumstances. Now, may I get back to tribunals, please?

Chic Brodie: No. I want to pursue the issue, because it is important. I do not think that it is irrelevant at all—it is serious. An accusation is being made that ECT is being applied without the pre-emptive processes in the 2003 act being followed.

W Hunter Watson: They are irrelevant. Inhuman or degrading treatment is prohibited in all circumstances.

Chic Brodie: I have no further questions.

Jim Eadie: Ms Sinclair, you talked about your members’ experiences of the operation of the tribunal system. I was concerned to know about the opportunities to make a complaint under the normal complaints process. If someone complains about their experience of treatment in the national health service, they ultimately have recourse to the Scottish Public Services Ombudsman. Is that also the case in relation to the tribunal?

Fiona Sinclair: Yes. A person has recourse to the SPSO if they are making a complaint about the system. However, if they are making a complaint about the tribunal, which is generally an administrative complaint, they can complain only to the Mental Health Tribunal for Scotland.

I have a copy of a letter that the MHTS sent to a patient, which said clearly that, if he wanted an explanation of what he was being told in the letter, he should seek legal advice. The MHTS did not make any attempt to explain.

Jim Eadie: My point is that if a member of the public has a complaint against the NHS they can ultimately appeal to the SPSO—

Fiona Sinclair: The SPSO—

Jim Eadie: Sorry, may I just make my point? I am concerned to ensure that there is a level playing field for all patients, whether or not they have a mental health problem. The SPSO can uphold a member of the public’s complaint against the NHS, and I want to understand whether that is also the case in relation to the Mental Health Tribunal.

Fiona Sinclair: People can make a complaint. The Mental Welfare Commission is not the complaints body, but it is generally the body to which people turn. People do not generally turn to the SPSO, because the SPSO does not have the expertise. In any case, the complaint has to be made within a year, which is not possible for some people. Plus—this is the important point—a person cannot make a complaint to the SPSO if they intend to go to legal proceedings. The tribunal is a legal proceeding, so the person cannot then make a complaint to the SPSO. That is the whole problem.

As I said, the Mental Welfare Commission is the body to which people generally turn when they want help, but it does not take complaints and it does not have written objective criteria as to which individual complaints it will select. For instance, it will not monitor the position as a whole for people with autism, because people with autism are not classed as a client group under the 2003 act and the pro formas do not fit them. There are all sorts of problems with the system and how the act is laid out.

Jim Eadie: That is helpful—thank you.

John Wilson: Before I ask my questions, I refer members to my entry in the register of interests as a member of the cross-party group in the Scottish Parliament on mental health.

Mr Watson, you referred to 23 per cent of patients being treated against their wishes. What was that statistic again?

W Hunter Watson: According to the information that Alison McInnes received from the Scottish Government, 77 per cent of those who lacked capacity—that was the way in which it was phrased—benefited from the treatment, which implies that 23 per cent did not.

John Wilson: So, 77 per cent of those who did not lack capacity—

W Hunter Watson: Sorry—the figure was 77 per cent of those who lacked capacity and who therefore could not have given informed consent.

John Wilson: That goes to the heart of the issue, which is about the lack of capacity, who determines that and whether benefits are accrued.

You said that the Scottish Government's figures show that 77 per cent of those who were identified as lacking capacity and who were treated benefited from the treatment that they received.

W Hunter Watson: That is right.

John Wilson: By anyone's calculation, that is quite a high percentage of people who have gained a benefit. There are always some people who will not benefit from any treatment that is prescribed to them. I have not looked at the figures to see whether a rate of 23 per cent is about average or disproportionate in comparison with other treatments that are available from the NHS. Given that 77 per cent benefited from treatment, is that not a good sign that more people than might be expected are benefiting?

W Hunter Watson: I do not want you to get away from the point that electroconvulsive therapy almost certainly falls within the definition of inhuman or degrading treatment.

Fiona Sinclair: Can I butt in? In the research that has been done, there is too much concentration on ECT, to be frank. For our members, the drugs issue is pre-eminent.

The research that has been done on ECT suggests that it has limited value. It might have a short effect on people, but that depends. If one surveys the effects of ECT on people who have just had the treatment, they are much more likely to say that it has benefited them, because it sometimes benefits people in the short term. However, in the longer term, it does not. In general, people who have ECT keep coming back—as repeat customers, as it were—for the treatment.

I will throw a couple of other statistics the committee's way. I feel that, too often, when the chief executive of the Mental Welfare Commission for Scotland, who is retiring soon, comes before parliamentary committees, he presents the good side of things and responds by saying, "Oh well—there's room for improvement." However, there is a bad side. The MWC's report on long-stay patients, "Left Behind: report on our visits to people with severe and enduring mental illness", highlighted that, for 34 per cent of long-term patients in mental health hospitals, nobody knows what their capacity is. We do not know whether those people have capacity, and there is no record of their capacity. In addition, 25 per cent of long-stay patients have never had a health check—so not only have they not had a check every 15 months for drugs that are extremely toxic, but they have never had a check.

Is that a system that is working well? I do not think so.

John Wilson: Ms Sinclair, I am surprised that you used the term "repeat customers" in relation to ECT—

Fiona Sinclair: In relation to ECT, yes.

John Wilson: The *Official Report* will, I hope, show that you said that some people regularly receive ECT out of choice—the term that you used was "repeat customers". We must try to examine whether the individual who receives ECT has a medical benefit. If we have—in your words—repeat customers, patients in a certain category must feel that they get a genuine benefit from the treatment. Is Mr Watson asking for the complete scrapping of ECT as a treatment method?

W Hunter Watson: Absolutely not.

John Wilson: So you are happy that ECT is available to some patients.

W Hunter Watson: The World Health Organization has recommended that, if ECT is used, that should be done with the patient's informed consent.

John Wilson: How do we get the patient's informed consent if the patient does not have capacity?

W Hunter Watson: Precisely. The World Health Organization has recommended that ECT should be used only with the patient's informed consent. It can be deduced from that statement that, if a patient is incapable of giving informed consent, ECT should not be used.

Juan Méndez, the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, has identified ECT. He did not refer to involuntary ECT. I am not saying that ECT should never be used. Some people agree to have it and believe that they benefit as a result. However, I state that, if it is given against a patient's will, it constitutes inhuman or degrading treatment.

John Wilson: Are you arguing that, when we have a patient from whom we cannot reasonably ask for consent, the system does not have enough safeguards?

W Hunter Watson: It is time that the Scottish Parliament paid attention to recommendations from the Council of Europe and the World Health Organization, relevant judgments of the European Court of Human Rights and reports from the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. The Scottish Parliament takes advice too much from the Mental Welfare Commission, which persuaded the Parliament that ECT should be given to patients even if they resist or object to the treatment, which was not the position of Shona Robison or SAMH.

Incidentally, I am focusing on ECT not because it is the most important thing—I agree with Fiona Sinclair that medication is the most important thing—but because I wish to point out that the Scottish Parliament has legislated to permit human rights abuses in mental health hospitals.

The Convener: We are here to tackle such issues. We have time for questions from one more member before we conclude.

Chic Brodie: Ms Sinclair makes assertions about people who are in long-term detention not being treated and receiving toxic drugs. Where is your evidence for that?

Fiona Sinclair: A lot of evidence is out there.

Chic Brodie: Where is your evidence?

Fiona Sinclair: Where is my evidence? We have only so much time in front of the committee and only so much time in which we can give you things. How do you provide evidence? There is a big problem—

Chic Brodie: To avoid a long discussion, will you write to us with your evidence for your assertion that people who are in long-term detention are not receiving appropriate treatment?

Fiona Sinclair: I quoted the statistics to the committee. Do they not suggest that such people are not receiving appropriate treatment?

Chic Brodie: Would you mind writing to us to share that information?

Fiona Sinclair: I have shared a lot of information with the Parliament and its representatives down the years. In particular, I made a submission to the consultation on the Scottish Human Rights Commission's national action plan for human rights. Members can look through all the references in that. Much of the section on mental health in the SHRC's participation report was based on my submission on behalf of Autism Rights. A lot of evidence is out there about the extremely toxic effects of the drugs on individuals and particularly people who are on the autistic spectrum.

11:15

Chic Brodie: I hear what you are saying: there is a lot of evidence. All I am saying is that we should provide it internally if we can but, if you have that information, it would be helpful if you shared it with us.

Fiona Sinclair: I have shared it with you. I have attempted to share it with you. You could take a look at the evidence that I put together for Scotland's national action plan for human rights, which is available online, and which I have mentioned in my submission. You will find plenty of evidence there. What more do you expect? How do you actually test evidence? There is a limit to what you can do in a Parliament. The Parliament expects people to present scientific evidence, with a bunch of scientists behind them speaking to that evidence. What are the expectations here?

The Convener: We are not the enemy here.

Fiona Sinclair: I know, but I am wondering how you want to get this evidence put to you? I have put forward what evidence I could.

The Convener: Let me resolve where we are going. To help the committee clerks to understand the position, I am asking for a brief paper that gives the up-to-date position on the evidence. That would be very helpful, and would allow us to do our job better. We are not the Government, obviously; we are here, as a parliamentary committee, to look carefully at the petition. We are now very short of time, but I invite Mr Watson to make a quick point.

W Hunter Watson: I have written a paper on tribunals, and I have studied three transcripts. The first point is that they are dreadful—they operate at an abysmal level. Secondly, there is evidence that antipsychotic drugs given to people with dementia cause many of them to die early or to have a stroke. Yet, they are given to dementia patients in hospitals.

One woman submitted a 51-page report to the health secretary. What happened to her mother was disgraceful. She was given depot injections of the drugs, and they caused her to be semi-conscious for three days or so. She would then recover. After another 21 to 25 days, she would have another injection. Latterly, she could not even hold a glass or suck water through a straw. She had been an active woman before she was detained. Try and get hold of that report.

The Convener: Again, I extend an invite to you, Mr Watson. I know that you have already given us some material, but if there is anything further, please do not hesitate to give the clerks some more written evidence.

As you are probably aware, we are now at the stage when we stop the questions and have a summation period in which the committee comes to conclusions about the next step.

There is a lot of material for the committee to absorb. I certainly think that we need to continue the petition and get advice from the Scottish Government, among other bodies. As always, the committee as a whole has to make the decision. I invite comments from members.

Jackson Carlaw: I feel that there has been a long lead time subsequent to Shona Robison's setting up of a group in January 2008, which was headed by Professor McManus. I do not know if this information came from the clerks, but I noticed that the draft mental health bill is supposedly still to be published before the end of 2013. We are running a bit short of time for that consultation paper to appear. It would be worth writing to the Scottish Government to ask what occasioned that lead time and what timescale the Government now anticipates operating to.

The Convener: That is a good point. Do members agree to do that?

Members *indicated agreement.*

The Convener: The clerks identified some other bodies, such as the Mental Health Tribunal for Scotland and the Scottish Human Rights Commission. Do members agree that we should write to those organisations as well?

Members *indicated agreement.*

John Wilson: I suggest that we also write to the Scottish Association for Mental Health, which has been referred to today, and to the Royal College of Psychiatrists in Scotland. Comments have been made about psychiatrists and their treatment of patients.

Given some of the evidence that we have heard about the use of antipsychotic drugs and their impact, I suggest that we also write to NHS Scotland to get its view on the use of those drugs, particularly in cases where patients have other conditions on which the drugs may impact. I would very much appreciate it if we could write to those organisations.

Jim Eadie: I have a further addendum to John Wilson's comprehensive list of organisations to which we should write, which, incidentally, I fully endorse: the World Health Organization, which has been mentioned repeatedly this morning.

The Convener: Are there any other suggestions? The Scottish health council, which is part of Healthcare Improvement Scotland, is there to be the voice of patients. Is it worth asking for its view on the matter, too?

W Hunter Watson: I suggest the Law Society of Scotland as well.

The Convener: Sorry, but we are finished with questions. However, I will take that suggestion from the side. Does the committee agree on that?

Members *indicated agreement.*

The Convener: Mr Watson and Fiona Sinclair will have picked up that we are going to take a lot of interest in the petition. We will be writing to the various organisations.

W Hunter Watson: I am most grateful to you. I enjoyed the exchanges. I do not mind being challenged, as that is a way of getting to the truth. Thank you very much.

The Convener: I thank both of you.

W Hunter Watson: I am sorry for sounding so forceful, but you will gather that I feel strongly about the matter.

The Convener: Most definitely. I thank both of you for giving up your time to come along. We will keep you up to date with developments.

11:20

Meeting suspended.

11:22

On resuming—

Current Petitions

St Margaret of Scotland Hospice (PE1105)

The Convener: Agenda item 2 is consideration of six current petitions, the first of which is PE1105, by Marjorie McCance, on St Margaret of Scotland Hospice. Members have a note by the clerk, which is paper 3, and written submissions. Gil Paterson MSP, who has a long-standing interest in the petition, is in attendance. I invite him to give a brief summary of where we are with this interesting but long-standing petition.

Gil Paterson (Clydebank and Milngavie) (SNP): Thank you. It is always a pleasure to come to the committee and to be in the public gallery to hear some of the interesting petitions that come before the committee. I have always admired the committee. I am not just sooking up, but I think that it is the best committee in the Parliament for access for the public, which is really good.

I do not have terribly much to say on the St Margaret of Scotland Hospice petition. However, I can sum up the current position, which is that talks are being held about talks. The ground rules are being set. I think that it is being done very amicably. I hope that we are moving towards a conclusion and a point where all parties will be agreeable and can take something from the outcome.

Other than that, I have nothing to say, but I am happy to answer any questions.

The Convener: I thank Gil Paterson for coming along and for his kind comments about the committee. As I understand it, independent arbitration is currently being set up to look at the situation that the petition addresses. It is an important and long-standing petition. I think that the only issue to point out to members is that the petition first appeared before the committee in December 2007. I am keen that we deal with as many petitions as we can but, because so many new petitions are coming aboard, there is an issue about leaving space for that.

Chic Brodie: I have a question for Gil Paterson. As the convener said, this is a long-standing petition. I do not know why these things take so long. Have there been any consequences as a result of it taking aeons to arrive at a decision?

Gil Paterson: The biggest consequence is where there have been funding gaps, because there is obviously an outcome in that regard. In effect, we are talking about the allocation of resources on the basis of differentials between similar institutions or within the same institution. It is frustrating that it is taking so long to get to a resolution and a good end point. However, the people who have been involved in the process are patient and they have an expectation that at the end of the journey we will have a resolution that will satisfy everyone. To be frank, I expect that to happen.

Chic Brodie: That is good and I am sure that it will happen. However, when I look at such issues, I think that, at the end of the day, it will probably cost us a lot more than if we had come to an agreement earlier on. In that case, we would have achieved outcomes that everyone on both sides desired. For the life of me, I just do not understand why some of these things take the period of time that they do.

Jackson Carlaw: Perhaps Mr Paterson can confirm that the potential consequence at one stage was that Greater Glasgow and Clyde NHS Board’s preferred route would have rendered the St Margaret of Scotland Hospice unviable, which could have had enormous consequences for the many people who are nursed through end-of-life care there. I hope that such people will now continue to be nursed. The health board’s preferred option eventually collapsed but, as a result of the suspicion that arose out of that, direct involvement by a cabinet secretary was required to instruct both parties to liaise and negotiate to reach an amicable solution. I wonder whether Mr Paterson agrees that the authority of this committee should stand behind the petition until we see the ink physically dry on an agreement that is acceptable to both parties in relation to the resolution of the dispute.

Gil Paterson: Yes, I concur with everything that you have said. I prefer to dwell on success. I think that there was almost divine intervention with regard to the collapse of the Blawarthill project. If that project had gone ahead, the continuing care beds at St Margaret of Scotland Hospice would have been shifted to a hospital at Blawarthill. I hate to think what would have happened to the hospice in that case. Thankfully, however, that possibility was averted. We have now secured the continuation of what the hospice does extremely well. The next stage is to look at the funding that comes to the hospice from the health board for the other part of the contract and the work that it does on behalf of the health board for the community.

As I said, I am thankful that we achieved the success that we did. I dare say that it was almost an accident, but nevertheless it was good. I feel positive because that happened. We will now move on to try to secure the last bit. I am an optimist about that, because that is my nature. Frankly, I can see no benefit for anyone in there not being a resolution. I think that we can get a conclusion whereby both parties are satisfied and feel that they are in a reasonable place.

Jackson Carlaw: I know that the wider campaigning organisations that support the petition have very much appreciated the contribution that the Public Petitions Committee has made, although I hesitate to suggest that they have placed us in the column marked “divine intervention”. However, convener, I hope that, notwithstanding your strictures on the petition, you will allow it to continue until the ink is dry on the agreement. It has been a long time coming and has proven in the past to be a false expectation, so I think that we would want to see it before we surrender our authority on the petition.

11:30

The Convener: I am always happy to give the member an early Christmas present.

Chic Brodie: It is not divine intervention, but I am not sure whether I am amused or upset to receive a letter from the Scottish Government saying:

> “Both parties also expressed their wish to maintain momentum on this issue”.

The Convener: I will bring in Jim Eadie. I apologise to him for delaying.

Jim Eadie: I declare an interest, which is that my mother was cared for, and died, in St Margaret’s hospice, so I can testify to the excellent end-of-life care that is provided at the facility. There is huge public confidence in the clinicians and nurses who provide it and, to echo the point that Chic Brodie made earlier, huge frustration and bewilderment at the uncertainty that has surrounded the continuing provision of that excellent facility in Clydebank. I pay tribute to Gil Paterson, who has been assiduous in promoting the interests of his constituency and constituents.

The petition should absolutely stay open until the matter is finally resolved.

The Convener: I am sure that all the committee will endorse your comments about Mr Paterson.

John Wilson: I think that I have been with the petition since 2007. I was a substitute member on the committee when the petition first came before it and I think that I have sat on every committee meeting at which it has been considered since then.

Lessons must be learned in relation to Greater Glasgow and Clyde NHS Board’s role and its failure to engage in any meaningful way with the hospice in the early days of the petition. That should have happened but, as Jackson Carlaw said, the health board set out a different approach with Blawarthill hospital as the alternative care provider. That option eventually fell through, despite warnings that it could fall through and that there was already an excellent facility providing such care within the area that could provide it without additional cost to the health board.

Both sides have agreed to have talks about talks—I think that was the phrase that was used—but I suggest that we write to the Scottish Government and ask whether there is any indication of the date by which it expects the talks to be concluded. We are now six years on from the petition originally being presented and I do not want Greater Glasgow and Clyde NHS Board to have the opportunity to drag out further any discussion with the hospice on coming to an agreed settlement.

Many of the times that we have discussed the petition at the committee, there has been great concern and, as Jim Eadie said, frustration that the health board would not sit down and talk. When it agreed to talk, it dragged the talks on and on in the hope that the hospice would go away. The hospice has been tenacious in its struggle and should be applauded for the work that it has done.

I would like to seek from the Scottish Government and, particularly, Greater Glasgow and Clyde NHS Board assurances that there is an end date for the discussions at which we can bring the matter back to the committee and, we hope, get a conclusion that satisfies the petitioners and the many people who benefit from the services that the hospice provides.

The Convener: Do members agree to John Wilson’s suggestion?

Members *indicated agreement.*

The Convener: Members agree that we will continue the petition and write to the Scottish Government. We hope that we will get a conclusion in the new year when the ink has dried on the agreement, to use Jackson Carlaw’s term.

I thank Gil Paterson for coming along. We appreciate his time.

Jackson Carlaw: In the letter to the cabinet secretary, it would be incumbent on us to acknowledge his contribution to date, which has been to intervene directly to ensure that an independent intermediary was appointed. He has taken a significant step that had been called for for quite some time prior to his intervening to do it. We should ally that point to the one on the timetable.

The Convener: Agreed. Thank you for that, and thank you, Gil.

Gil Paterson: Thank you—it is much appreciated.

Access to Insulin Pump Therapy (PE1404)

The Convener: Our second current petition is PE1404, by Stephen Fyfe, on behalf of Diabetes UK, on access to insulin pump therapy. Members have a note by the clerk and the submissions.

You will be aware that I have a particular interest in this issue, as I am co-convener of the cross-party group on diabetes, and I think that we took some evidence on the matter at our Stornoway Parliament day.

I have made it clear that I think that the targets that we got from the Scottish Government for insulin pumps are good. However, Diabetes UK Scotland and I had concerns about the fact that individual health boards were not necessarily meeting the targets. That was a source of frustration. From the answers that I have read to recent parliamentary questions, I think that we are certainly getting on track now. Diabetes UK Scotland is certainly happy with the progress that has been made.

In light of all of that, my recommendation is that we have reached a stage at which we can close the petition, under rule 15.7, unless members have a different idea.

Chic Brodie: I feel relatively comfortable with that. However, reading the Scottish Government's letter raises some concerns. It answers our first question, about slippage, and it gives reasons why the Government is confident that the targets and deadlines that have been set will be met. However, in answers to various other questions, it says,

> "This enables us to promptly identify when boards are not meeting agreed trajectories",

and

> "It is important to note that different Boards have started from different baselines".

It also says that there are no penalties. Basically, it is saying, "We have set up the improvement team and we have set the targets, but it might not meet them." That appears to be planning for failure. That is unacceptable. In closing the petition, we should note that. Either we are setting up teams to ensure that the targets are met, or we are setting up teams with the expectation that certain things might not happen.

The Convener: So, is the point that you are making—

Chic Brodie: Either we have a plan for success or we have a plan that we might have success. Having had the meetings that we have had, and the discussions with the Government that we have had, we should have a plan for success. However, this letter does not fill me full to the brim with confidence.

The Convener: There is a suggestion that we should close the petition, but there are some outstanding issues that Chic Brodie feels we should raise.

Chic Brodie: I am sure that we can monitor the situation on an individual basis. I was just making a general point, and I think that we should close the petition. Again, I feel that we are either taking aeons to complete petitions or leaving them open ended, neither of which is acceptable.

The Convener: I think that there is a wider issue about Government laying down targets and health boards failing to meet them.

Chic Brodie: The penalties should be clear.

The Convener: There are financial penalties for local government when it misses targets. Are you suggesting that there should be financial penalties for health boards?

Chic Brodie: That is not for me to say. I know what penalties I would apply, but I am sure that they are not prescribed.

John Wilson: How do you follow up that comment?

Like Chic Brodie, I have concerns about the way in which the letter concludes, which is that the six-monthly and annual reviews should pick up any issues. I represent an area that is covered by NHS Lanarkshire, which has a poor record on the delivery of insulin pumps. I am not talking about penalties; I am talking about the action that the Government is going to take between the six-monthly review and the annual review to ensure that boards are meeting their targets. Financial penalties on health boards penalise those bodies but do not bring any real benefit to the patients. Certainly, there are many well-paid officials in health boards, so perhaps it is time for us to start looking at financial performance penalties for those individuals if they are not delivering on agreed targets that have been set in place.

I suggest that we close the petition but write to the Scottish Government expressing our concern. No doubt this issue will continue to be monitored locally as well as nationally. We would expect the Government to take immediate, appropriate action to get the targets back on track if they seem to be slipping in any health board.

The Convener: Members are agreed to close the petition but to note some concerns about the performance of health boards. There is also a wider issue that has come up in other petitions about the postcode lottery, when one health board delivers and another does not.

I thank Diabetes UK Scotland for its work on the issue of meeting targets on access to insulin pump therapy.

Chronic Pain Services (PE1460)

The Convener: The third current petition is PE1460, by Susan Archibald, on behalf of the Scottish Parliament cross-party group on chronic pain, on the improvement of services and resources to tackle chronic pain. Members have a note by the clerk and submissions. I think that we all had an email from Susan Archibald saying that she had another engagement today and was unable to attend the meeting. I note that the Scottish Government has placed her on the national chronic pain steering group. I think that we should congratulate Susan Archibald on the work that she has done.

Jackson Carlaw: I do not think that anything would be lost if we held the petition open for one more meeting, until we get the outcome of the consultation and find out the Government's preferred route forward. That would give the committee one last chance, perhaps, to liaise with the petitioner on what she thinks of the conclusion of that. We could close the petition at that point.

The Convener: Is that agreeable to members?

Members *indicated agreement.*

Wind Turbine Applications (Neighbour Notification Distances) (PE1469)

The Convener: The fourth current petition is PE1469, by Aileen Jackson, on neighbour notification distances in relation to wind turbine planning applications. Members have a note by the clerk and submissions. We received a late update from the Scottish Government, which has been circulated to members.

There is a recommendation from the clerks to consider referring the petition to the Local Government and Regeneration Committee as part of its forthcoming work on national planning framework 3 and the review of the Scottish planning policy. It would seem sensible to put the petition to the committee that will be dealing with those areas. As always, I am open to counsel and opinions from members.

Jackson Carlaw: I was slightly surprised by the Scottish Government letter because I thought that it was being more proactive in addressing some of the issues arising from the petition than perhaps had been indicated at an earlier stage. I took some encouragement from that letter.

Given the national position on the subsidy of onshore wind farms and the potential that that might create for an acceleration of applications, if the Government is minded to look at these matters, it is important that it does not do so on an extended timescale. The Scottish Government letter did not entirely convey the timescale that the Government intended to have underpinning it. Can we write to the Government to get some further confirmation of that en route to referring the petition to the Local Government and Regeneration Committee?

The Convener: Yes, we can do that—is that agreeable to members?

Members *indicated agreement.*

Chic Brodie: It is worth noting that the Scottish Government stated in its 20 September letter that its conclusions would be with the committee

> "by the end of November."

I rest my case, as outlined in my previous comments.

Gender-neutral Human Papillomavirus Vaccination (PE1477)

The Convener: The fifth current petition is PE1477, by Jamie Rae, on behalf of the Throat Cancer Foundation, on a gender-neutral human papillomavirus vaccination. Members have a note by the clerk and submissions. I remind members that there are a number of options. One option is to write to the Joint Committee for Vaccination and Immunisation on its plans to reconsider extension of the HPV vaccination programme, because the Scottish Government takes its advice on the introduction of vaccines from the JCVI.

Are members agreeable to that course of action?

11:45

Jackson Carlaw: I am. I am slightly surprised by the progress of the petition given the number of different parties writing to us who seem to be challenging the Government's view and the advice that it has received. We should draw that to the Government's attention, because it is not insignificant in the balance that must be struck in what is a difficult judgment for the Government to make. The advice is not lightly made and some of it has been quite well founded and grounded, so I am in a different place to where I was when I first read the petition.

John Wilson: I agree that we should draw the Government's attention to those views, particularly those in the University of Cambridge's submission, because the evidence provided on the vaccination regime is compelling. Accordingly, the Government should be asked to respond.

The Convener: Do members agree to draw the Government's attention to some of the information that we have received and that we also seek written information from the JCVI?

Members *indicated agreement.*

Primary 1 Class Sizes and Sibling Placing Requests (PE1486)

The Convener: The sixth and final petition is PE1486, in the name of Julie Wales. Members have a note by the clerk and submissions. What are members' views?

Jackson Carlaw: We are at a point—I am not sure whether I did not regard this as inevitable—at which we should consider closing the petition in view of the information that we have received and the Government's review of class sizes in 2014.

John Wilson: Although I agree with Jackson Carlaw that we have reached a place that we knew we would come to, the difficulty is that, even with the class size review in 2014, the placement requests issue will not be resolved, as we have discussed previously in the committee. Family members have to understand that placement requests are decided by local authorities and that they have appeals processes. We would not want to encourage anyone who is making a request to have siblings placed along with their older brothers or sisters in the same school to think that the Government review on class sizes will hold out any hope for them. Placement requests are, in many respects, decided by the capacity of the school or otherwise to deal with those requests. Therefore, we should close the petition.

I hope that the petitioner will read the *Official Report* and see from our comments that we are not holding out hope that the class size review will result in siblings being placed in the particular schools that families wish them to be placed in.

The Convener: As there are no further contributions, do members agree to close the petition under rule 15.7?

Members *indicated agreement.*

Meeting closed at 11:48.

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