The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC PETITIONS COMMITTEE

Tuesday 9 February 2016

Session 4

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PUBLIC PETITIONS COMMITTEE

3rd Meeting 2016, Session 4

CONVENER

*Michael McMahon (Uddingston and Bellshill) (Lab)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Jackson Carlaw (West Scotland) (Con)
*Kenny MacAskill (Edinburgh Eastern) (SNP)
*Angus MacDonald (Falkirk East) (SNP)
*Hanzala Malik (Glasgow) (Lab)
*John Wilson (Central Scotland) (Ind)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Harpreet Kohli (NHS Lanarkshire)
Professor Graham Leese (NHS Tayside and Chief Medical Officer Specialty Adviser)
Alpana Mair (Scottish Government)
Professor Alex McMahon (NHS Lothian)
Gil Paterson (Clydebank and Milngavie) (SNP)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
Elaine Smith (Coatbridge and Chryston) (Lab)
Dr Hugo van Woerden (NHS Highland)
Maureen Watt (Minister for Public Health)

CLERK TO THE COMMITTEE

Catherine Fergusson

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Public Petitions Committee

Tuesday 9 February 2016

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Michael McMahon): Good morning and welcome to the Public Petitions Committee's third meeting in 2016. I remind everyone present, including members, that mobile phones and BlackBerrys should be turned off completely as they interfere with the sound system, even when they are switched to silent.

The first item of business is consideration of whether to take agenda items 5 and 6 in private. Those items are discussions of our approach to our legacy paper and a witness expenses claim. We would normally consider such items in private. Do members agree to take those items in private?

Members *indicated agreement.*

Continued Petitions

Thyroid and Adrenal Testing and Treatment (PE1463)

The Convener: Our second item of business is consideration of PE1463, on effective thyroid and adrenal testing, diagnosis and treatment. We will take evidence from the Minister for Public Health, who is accompanied by four officials. We are also joined by Elaine Smith MSP, who has taken a keen interest in the petition. We will allow her an opportunity to join our discussion. I welcome the minister and her officials and invite the minister to make a short statement, after which we will move to questions.

The Minister for Public Health (Maureen Watt): Good morning and thank you for inviting me to give evidence. At the outset, I make it clear that I have not only an on-going interest in the petition as Minister for Public Health but a personal interest, as I have previously made public. I was substituting at the Public Petitions Committee in 2013 when the petition was discussed.

I am aware that many people are affected by thyroid problems and that some of them have been unwell for some time, having experienced difficulties in obtaining diagnosis and appropriate treatment. I am sympathetic to the challenges that they face. First and foremost, I stress that we take the petition and what the petitioners are saying very seriously.

Although I have an understanding of the issues that will be raised today, I recognise that the committee may ask questions of a more clinical nature, so I may require to refer some questions to Professor Graham Leese, who is the chief medical officer's specialty adviser on diabetes and endocrinology and is also an honorary professor in diabetes and endocrinology at the University of Dundee.

As the committee is aware, the Scottish Government commissioned a listening exercise to be carried out by Thyroid UK on the experiences of hypothyroid patients. An online survey was carried out during the summer of 2015 across the whole United Kingdom. Respondents were invited to complete the survey from a variety of sources, including the Thyroid UK website, a forum, Facebook and Twitter. There were approximately 5,000 respondents to the survey and just over 4,000 surveys were fully completed.

The purpose of the listening exercise was to obtain a comprehensive picture of what was happening in patients' experiences of diagnosis and treatment. The survey was aimed at patients who have been diagnosed with hypothyroidism, as well as those who have symptoms of hypothyroidism but have not yet been diagnosed. A number of questions were asked to cover patient experience, diagnosis, treatment and general practitioner knowledge. The results of the survey are available on Thyroid UK's website and I take the opportunity to thank the charity for carrying out that useful work in helping us to obtain a better understanding of patients' condition, diagnosis, treatment and experience.

Committee members will be well aware that the Scottish Government's role is to provide policies, frameworks and resources to national health service boards to allow them to deliver services that meet the needs of their local populations. In that context, the provision of healthcare services is the responsibility of local boards, which take into account national guidance, local service needs and priorities for investment.

It should be recognised that progress in clinical science has been, and should continue to be, based on properly conducted, scientifically based trials that strive to eliminate any error or unrecognised confounding issues. It is appreciated that progress can sometimes be frustratingly slow, but that is the consequence of trying to get things right and ensure patient safety, which is paramount at all times. Anecdote and clinical observation can be useful to raise scientific questions, but such questions need to be tested rigorously; otherwise, the approach can be potentially detrimental and dangerous to patients, as well as wasteful of NHS resources, not just for thyroid disease but for all other medical conditions.

The position statement by the British Thyroid Association, which was published in May 2015, clearly sets out its recommendations on the management of primary hypothyroidism on the basis of the current literature and a review of the published positions of the European Thyroid Association and the American Thyroid Association, and it is in line with best principles for medical practice. The recommendations have been endorsed by the Association for Clinical Biochemistry and Laboratory Medicine, the British Thyroid Foundation, the Royal College of Physicians and the Society for Endocrinology, and they therefore reflect current best practice in the management of primary hypothyroidism, about which Professor Leese will be able to speak more if needed.

The British Thyroid Foundation is a patient support group that has worked since 1991 with medical professional bodies, such as those that I just mentioned, to provide guidance for all patients—and their relatives—who have thyroid disease, including those with underactive thyroid, overactive thyroid, thyroid cancer and thyroid eye disease. The foundation has endorsed the British Thyroid Association guidelines. In addition, the foundation has written a frequently asked questions sheet for patients and published it on its website. Guidance that has been written for GPs is expected to be published later this year in a GP-oriented medical journal.

I am aware that the petitioner has met representatives of the Scottish intercollegiate guidelines network and that an outcome of that discussion is that the SIGN council hopes to determine, in conjunction with the Royal College of Physicians, whether it may be helpful to produce a good practice guide on the topic for general practitioners. Ultimately, that will be a decision for the SIGN council, and the Scottish Government cannot influence that decision, although I welcome SIGN's consideration of the proposal.

The Convener: Thank you—that was a comprehensive overview of the situation from your perspective. As you said, the petition has been running for a substantial time. Committee members have gained an in-depth understanding of the matter as the petition has gone forward and I know that some of them are keen to ask questions to follow up the work that has been done. I invite the deputy convener, David Torrance, to ask the first set of questions.

David Torrance (Kirkcaldy) (SNP): The Thyroid UK survey report shows that 42 per cent of respondents considered that their clinician was not open to discussion about treatment options and that more than 50 per cent considered that their GP's knowledge of hypothyroidism was poor. How does the Government react to those findings and what recommendations will it put in place?

Maureen Watt: As I said, the survey was UK wide, so we cannot extrapolate the Scottish situation from it. It did not involve a randomised sample, as one would normally expect in, say, a clinical trial. The people who responded are very involved in the issue and the figures quoted are likely to be an overestimation of the situation. GPs and endocrinologists generally follow evidence-based diagnostic guidelines, which are agreed in the specialist community.

As I said, the Government cannot intervene directly, but SIGN is proposing to develop a good practice guide for general practice. Professor Leese is involved in that and can say more.

Professor Graham Leese (NHS Tayside and Chief Medical Officer Specialty Adviser): I am not directly involved with that, but we have been involved with the British Thyroid Association. As the minister mentioned, the British Thyroid Foundation, which is the patient group, has developed a number of responses to frequently asked questions, which will be useful for patients and GPs. In response to what is happening, a number of steps have been taken to increase awareness of such issues among general practitioners and specialists.

The Convener: Elaine Smith has a question—is it a supplementary on this specific point?

Elaine Smith (Coatbridge and Chryston) (Lab): My question is relevant to the point. I might have asked it later, but it is perhaps better if I ask it now, if you do not mind.

The Convener: We will take your question now, then I will come back to David Torrance.

Elaine Smith: The petitioner has told me that the British Thyroid Foundation changed its advice online as recently as this week. My question is directly for Professor Leese, if you do not mind, minister. The foundation is now saying that it would be okay for some people to try T3, and I would like to know your opinion on that. It is obviously okay to try it, but a person has to be referred to an endocrinologist by their general practitioner first—GPs will not prescribe T3.

Secondly, it is now being said that it is okay for T4 to be slightly over. That is now acceptable.

Finally, it is being said that whatever medication someone is taking should resolve their symptoms. That brings up the whole issue of desiccated thyroid hormone, which may be prescribed on a named-patient basis, although very few GPs will prescribe it.

I would like to hear comments on those points, please.

Professor Leese: I cannot comment on the British Thyroid Foundation document that you refer to, as I am not sure that I have seen it. However, it probably refers to the British Thyroid Association guidelines, which suggest—this is nothing new—that the blood tests are not the whole picture. Placing someone on thyroxine involves a balance between treating symptoms and treating the blood tests. The blood tests give a range that a person should be within in terms of safety. Within that, the dose of thyroxine can be moved around, as long as the figures are kept within the safe range. That is perhaps more explicit in the document, but that has always been the case.

On the use of T3 or liothyronine, there is scope in the British Thyroid Association document that was published in May 2015 for the use of liothyronine in exceptional circumstances. That is also stated in the European and American guidelines—it can be used if, in exceptional circumstances, it is felt that it will benefit the patient. As you said, a referral to an endocrinologist might be needed.

Elaine Smith: Will you also comment on the range? The committee has been looking into it. It is different in different countries. We have heard evidence that, far too often, general practitioners rely just on the blood tests and do not look at the patient’s symptoms. There are a lot of patients who are on many other medications for various symptoms but, if their thyroid was treated correctly, they would not have to be on all those other medications, which include drugs for depression, drugs for fibromyalgia, painkillers and so on.

If there was better treatment for thyroid patients—treatment that was more centred on them, in the same way as with diabetic patients—there could be moves forward for patients and for the NHS. There is scope for the NHS to save money. Why is care for people with diabetes, which is a fellow endocrine neighbour of hypothyroidism, provided on a person-centred basis, whereas those with underactive thyroid are simply put on levothyroxine? There is one medicine for them.

Professor Leese: The evidence suggests that patients who are on thyroxine are treated very much at an individual level. The guidelines, and most GPs, try to adapt the levels according to the symptoms, as long as they are within the safe range according to the blood tests.

Maureen Watt: I say, perhaps for people who are not so involved in the issue, that anybody who is on levothyroxine gets tested. They get a thyroid-stimulating hormone—TSH—blood test every year. If there are abnormalities in that test, they are tested for T4. If there are still abnormalities, there may be a test for T3. That is my understanding. Routinely, patients who are on levothyroxine get an annual blood test to see whether there have been any changes. The dosage may be increased, or it may be reduced, according to what the blood tests show.

10:15

Professor Leese: It is worth noting that there is a wide range of what is deemed to be acceptable TSH, so there is scope for moving doses, perhaps to small amounts, to maintain patients within the wide range of TSH that is thought to be safe.

David Torrance: The minister said that new guidelines for GPs would be published later in the year. Will you expand a bit on what is in the guidelines and how quickly SIGN will implement them?

Professor Leese: There needs to be increased general awareness of the guidelines. That comes down to educating GPs and advertising the guidelines. Each year, every GP must do a certain amount of professional development, so there are opportunities to educate GPs. They have a huge number of areas to cover, but thyroid disease could be included in that training.

Maureen Watt: The condition is something that most GPs will come across in their practice.

Just as Diabetes UK's website includes information on tests for people with diabetes and what they should be getting from their GPs, there are websites, including the British Thyroid Foundation's website, that people who take levothyroxine should be aware of. Patients' awareness of such websites is important.

Hanzala Malik (Glasgow) (Lab): I accept what the minister said about the figures in the survey report being UK based, which means that the true picture in Scotland is not clear. Perhaps she will consider doing a report of her own to determine the figures in Scotland.

Making doctors aware is important. I am not getting a sense of the timescales by which you intend to circulate the information for GPs so that they are equipped with the information and the support that they need.

Professor Leese: The guidelines, which have been available since May, are not a one-off. As with any advertising campaign, it comes down to continuing to promote them—to increase awareness, we have to keep at it. We must keep educating GPs in the philosophy of treating patients within a range of TSH, along with the need to perhaps change doses. The information is not new; it is simply re-emphasised in the guidelines.

Hanzala Malik: You are stepping around the issue and you are still not giving me a clear guide on how you are focusing on it. How will we assess the success of the advertising campaign? Surely you will be looking for facts and figures on that. What are the timescales in which you are looking to achieve the outcomes? I seek further clarity on how quickly you hope to deliver on the ground.

Maureen Watt: There are already SIGN guidelines for GPs. We are talking about whether there will perhaps be revised SIGN guidelines.

One of the petitioners has been involved in seeing whether the current—and any future—SIGN guidelines should be altered. As a result of discussions, it was discovered that the current guidelines are pretty good and that, if things had been left to the petitioner, she would probably have come up with more or less what is out there now. [*Interruption.*]

The Convener: I ask for order in the public gallery, please. I ask the minister to stop for a moment while the matter is dealt with. [*Interruption*.] I am sorry for the disturbance, minister. Please carry on.

Maureen Watt: As I said, my understanding is that the petitioner was involved in discussions about SIGN guidelines—I do not know whether anyone else wants to come in on that—and that the Royal College of Physicians will issue new ones through the SIGN council in the near future.

Hanzala Malik: I accept what you say and I am sure that you will try to ensure that the guidelines are fit for purpose, but I have been pressing you on the matter—I will stop after this, which is my third attempt. I am looking for some sort of timeframe for when you hope to achieve that because, without a timeframe, the process will be open ended, which is surely unhelpful.

Maureen Watt: As I said in my opening statement, the timing is not up to the Scottish Government. It is up to the SIGN council—we cannot really determine its timeframe.

Professor Leese: The guidelines are being distributed at the moment. You talked about measuring their success, Mr Malik, and I would welcome your thoughts as to how we do that.

Hanzala Malik: Shall I respond to that, convener?

The Convener: If you are being asked a question, you can respond if you have an answer.

Hanzala Malik: I am happy to do that in a bid to help. I have already indicated that we do not have Scottish figures.

Professor Leese: Figures for what?

Hanzala Malik: For how many patients there are, how many benefit from the service, how much information is available to GPs and whether the service is being delivered successfully. At the end of the day, this has to be measured. Everything must be measurable. If it is not measurable, we cannot judge its success or failure and we do not know whether we need to change things or leave the status quo.

The Convener: I would like to know that as well. Hanzala Malik is making a good point that you have not clarified. We are relying on the Thyroid UK survey—

Professor Leese: Can I answer the points that have been made?

The Convener: I am just enhancing the question, if you do not mind. If I make a point, you can respond. I am not stopping you from responding. I just want to add to what my colleague said because I want clarity as well.

You are relying on Thyroid UK's survey, which has evidence that people have been refused T3 treatment. You accept the survey and that there are issues in it. The question that is being asked—or the question that I would like to add to the one that has been asked—is: given that we do not have a full picture in Scotland and that you are dependent on a survey that you consider not to be complete, why are we not trying to complete the picture? You are working on the basis of a survey that does not give you the answers but, from what I can see, you are not doing anything to find the answers. Why not?

Professor Leese: First, we know exactly how many patients are on thyroxine in Scotland. We also know how many are on liothyronine.

The Convener: Do you know how many have been denied treatments for which they have asked?

Professor Leese: No, we do not. We do not know that from the Thyroid UK survey either.

The Convener: That is the point that I am making. We do not know that from the survey, but you are not telling us how you will try to find it out.

Maureen Watt: There are about 6,500 prescriptions in Scotland for T3. That involves 1 per cent of people who are on thyroid medication. However, there is no evidence to support the routine use of thyroid extracts—the T3 monotherapy or the compound thyroid hormone. You are giving the wrong impression that a patient can just ask for T3 and routinely be put on it. That is not the same—

The Convener: With all due respect, minister, I am not giving any impression. I am asking why, if all the work that we are discussing and all our understanding of the situation is based primarily on a report that you consider to be incomplete, you are not trying to complete the understanding of the situation.

Maureen Watt: We did not say that the survey was incomplete. We undertook to do a listening exercise and we commissioned Thyroid UK to undertake it. It did that across the whole UK.

We know from that survey what patients think about their treatment, and as a result the specialists have taken forward the SIGN guidelines.

Elaine Smith: Convener—

The Convener: I will let you in again later, Elaine. I know that you have a lot of questions, and I will not let you miss the opportunity to ask them, but some of your colleagues have been waiting for some time now. Angus MacDonald will go next.

Angus MacDonald (Falkirk East) (SNP): Minister, you mentioned that there are currently 6,500 patients on T3. We know that there have been supply issues with the medication in recent months. As Mercury Pharma is the only licensed manufacturer of T3 in the UK, there is clearly an issue with its monopoly on supply.

In light of those supply issues, is the Government aware of any action that has been taken to evaluate improvements to Mercury Pharma’s process for manufacturing T3 tablets? Is it likely that another UK manufacturer of T3 will come forward in the near future, which would assist with the supply? Is the number of people on T3 limited to 6,500 because of the supply issues? Could more people be given T3 if more of it was available?

Maureen Watt: There have previously been supply issues with T3, and action has been taken to evaluate the improvements to Mercury Pharma’s process for manufacturing the tablets. However, as members will know, regulation of supply is reserved to the UK Government and enforcement of the regulations on supply is a matter for the Medicines and Healthcare products Regulatory Authority. We are not aware of any issues with the supply of T3 tablets at present. The chief pharmacist may want to come in at this point.

Alpana Mair (Scottish Government): For clarification, we know that the number of prescriptions dispensed for T3 is 6,500 at present. Our Scottish officials are in regular contact with colleagues in the Department of Health, who will work with the manufacturers on improving their processes to ensure that there is continuity of supply for patients and that we do not experience the same problems that arose a couple of years back. Work has been undertaken to try to resolve some of those issues, and there were no supply issues at all in 2015.

As for Mercury Pharma being the only company that produces the drug, that is a commercial decision for a company to make. The number of T3 prescriptions is small in comparison with the 2.5 million T4 prescriptions, and it would be a company, not the UK Government, that would decide to produce the medication. As I have said, there were no supply issues in 2015, and active steps have been taken to improve the manufacturing process to ensure continuity of supply for patients.

Angus MacDonald: The other part of my question was about whether you were aware of any other manufacturers who might be looking at producing the medication. Of course, you might not be.

Alpana Mair: We are not aware of that from our colleagues. A company will make a commercial decision about whether to manufacture the drug.

Angus MacDonald: My next question might be a bit naive. The current issue with natural desiccated thyroid is that personal liability lies with the prescriber or the GP, and the onus is on them if there is any comeback. Would a solution be to approve the product and allow it to be used without any comeback on the GP? The current situation might be one of the reasons that very few people are currently prescribed natural desiccated thyroid; in fact, I believe that people are even buying it off the internet because of the current issues.

10:30

Maureen Watt: There are some physicians who prescribe liothyronine, because it has a licence, but there is no robust clinical evidence of its benefit, and significant theoretical concerns have been raised about its long-term safety.

Angus MacDonald: Out in the wide world, there is evidence that it works.

Maureen Watt: I think that the professor would say that that evidence is anecdotal, but I will hand over to him.

Angus MacDonald: I am sure that the patients would vouch for the fact that it works.

Professor Leese: I will put a few of the issues together to try and get clarity.

Everyone would agree that there are patients on thyroxine who do not feel well. That is recognised by everyone in the profession, and it is highlighted in the Thyroid UK survey. The issue is not so much the number of people or whatever but what we can do about it. As has been said, it all comes down to anecdote versus clinical evidence. The original statement said that 11 out of 12 trials showed no benefit from liothyronine for patients feeling unwell on thyroxine, and one randomised control trial with desiccated thyroid showed no benefit.

That said, there are anecdotal reports and, as a professional group, we try to listen to those anecdotal reports and take them forward in a scientific way. That is what happened with the randomised control trials, but when they have been carried out in a controlled clinical environment, they did not support the use of those other agents.

That is where we are at at the moment, but that will not stop us doing more clinical trials and perhaps trying to look at specific patient groups that might benefit from those drugs. All the guidelines that I have mentioned are evidence based, because that is the way that clinical practice works.

Maureen Watt: The guidance advises that patients who remain symptomatic should be referred to an endocrinologist for further investigation, but some people who live with hypothyroidism or thyroid problems will see that that is not happening. However, the committee held an evidence session with SIGN in November 2014 and agreed to invite SIGN to consider developing further guidance and guidelines as a result.

John Wilson (Central Scotland) (Ind): I have a couple of questions about the work of Thyroid UK and the survey that was produced. We know from the preface—and from the minister, who also mentioned this—that it was the Scottish Government that commissioned the research. How much did it cost?

Maureen Watt: I do not have a figure for that, but we can get it to you.

John Wilson: When the research was commissioned, was Thyroid UK given no guidance on including the extrapolation of Scottish patient experience in the survey? The minister and Professor Leese have both said that the experience of patients in Scotland cannot be extrapolated from the report, because the Scottish Government commissioned the report without asking specifically for the details of Scottish patients' experience. The petition is asking the committee to deal with the experience of Scottish patients. I hope that the minister provides the committee with details of the cost of the piece of work that was commissioned from Thyroid UK, but there is also a clear issue here with regard to who commissioned the work and why it did not focus on Scottish patients' experience of their treatment and the existing diagnosis regime in Scotland.

I hope that Thyroid UK will be able to take the report to the UK Government and make a good case for better treatment regimes in the UK and in England and Wales, but this committee is concentrating on the experience of patients in Scotland, and it would have been extremely useful if whoever had drawn up the commissioning document had asked Thyroid UK to break the information down and give us Scottish figures in relation to the areas that have been identified. Clearly, that never happened. I hope that the minister can come back to us with not only the cost of the research but the reason why she did not specifically ask in the commissioned piece of work for information on the treatment and diagnosis experience of Scottish patients in relation to the petition that we are dealing with.

Maureen Watt: Let us go back a step. I think that some people were under the impression that a short-life working group would be set up, but my predecessor advised the committee in a letter dated 5 February 2014 that there was no evidence base to support the changes that were being sought by the petition at that time.

Instead, we asked Thyroid UK to carry out a listening exercise, which resulted in the survey that it undertook. As I have said previously, the survey was conducted through the Thyroid UK website, Facebook and Twitter. It was not a survey in the sense that a specific group of people were asked questions; that was not what the exercise was meant to do in the first place. We can certainly send you details of the cost.

John Wilson: My colleague has just said to me, “Why not?” in relation to the exercise and the situation that we are looking at. We heard earlier about the petitioner’s frustration with some of the minister’s responses about decisions that have been made since the committee received the petition in 2012, and we as a committee will examine that matter further.

However, with regard to the Scottish Government’s decision to commission a piece of work to identify the issues, you mentioned a listening group. How do you establish a Scottish listening group if what you do is take examples from the rest of the UK? We are trying to deal with examples of Scottish patient experience. We know that across the UK there might be different experiences in different health boards where different guidance has been issued. You have mentioned the SIGN guidance that will be issued, but the fact is that you cannot instruct SIGN on how to give that guidance. Clearly, though, the Scottish Government has a role to play in that matter.

The point is that the committee asked the Scottish Government to examine the patient experience, the medication that is being provided to patients and its benefits, and you have spent money—we do not know how much yet, but we hope to get the figure—asking an organisation to conduct a survey that, quite frankly, was not worth the money that was spent on it. I am paraphrasing what you have said about it. It gives us nothing conclusive that will allow us to try to take forward the issues that have been raised in the petition.

Maureen Watt: I am not aware of the parameters for the listening exercise that was undertaken. I have said that I will write to the committee about how much the research cost and what the parameters were. However, I doubt that the experience of patients across the UK will be all that different in relation to the issues at hand. Given the state of the health service south of the border, it might actually be worse there.

Jackson Carlaw (West Scotland) (Con): Like one or two colleagues, I have been following the petition since it was launched in 2012, and I know that the aim of the petitioner was to give endocrinologists the ability to diagnose thyroid and adrenal disorders accurately and provide the most appropriate treatment. That was where we began.

Professor Leese, your words are very carefully couched, but I have to say that you seem to be branding the solutions that patients are looking for as nothing more than quackery. However, thousands of women are clearly not benefiting or are being made unwell from the routinely prescribed treatment of T4 in Scotland.

You have said that the evidence is only anecdotal. I would love to hear a definition of “anecdotal”, because it could mean a little woman at the bus stop who said that she read something in the *Daily Express* or *Hello!* magazine or the first-hand experience of thousands of women who, after being prescribed with one of these solutions, have said that the allergic reactions or symptoms that they previously had have been alleviated and that they are now well.

I do not want to call it professional conceit, but it almost seems that there was a predetermined establishment position in a survey that was meant to be part of a listening exercise, but which now seems to have been the listening exercise, and which I understand involved multiple patient groups with diseases, not just the one that we are looking at. I was a little astonished by this, but I think that the minister said at one point that those who responded to the survey were very involved in it, which might explain why it was weighted as it was. What would have been the point of the survey if it did not involve people who were very involved in it? Naturally, I would expect that to be the outcome.

It seems to me that, after three and a half years, there is an establishment position. I have heard that in relation to other things, and nobody wants people to be prescribed things that are unsafe, but let us look at this charge of anecdotal evidence. You talked about clinical trials. Where and when were they conducted? How many people were involved in them? What is the real substance in the face of what is not trivial evidence to us as politicians, but the real-life experience of many women, which seems to me to direct that there ought to be a process by which we try to do more by way of prescribing alternatives?

Professor Leese: You are giving the impression that you think that there is a conspiracy theory behind all this. In reality, I think that if you speak to any clinician—or 99 per cent of them—they will—

Jackson Carlaw: Where does that 99 per cent come from? That is like my saying 99 per cent of the Parliament.

The Convener: If 6,500 people are being prescribed, doctors are clearly making decisions to give particular women the medication, so how can you come up with the figure of 99 per cent of people believing that the survey that you have is the accurate position?

Professor Leese: I am sorry, but I do not think that you are listening.

The Convener: Oh, okay.

Jackson Carlaw: I asked you where the 99 per cent came from.

The Convener: Where did the 99 per cent come from? We have had figures bandied about all morning about the number of people who are being prescribed, and you have just plucked a figure out of the air to justify your position.

Jackson Carlaw: Was 99 per cent perhaps an anecdotal percentage?

Professor Leese: I said that the majority of clinicians are actually—

The Convener: That could be 51 per cent, not 99 per cent. It could be closer to 51 per cent.

Professor Leese: I am not quite sure what I am being asked and whether anyone is interested in the answer.

Jackson Carlaw: I am asking you where your figure of 99 per cent came from.

Professor Leese: Of what?

Jackson Carlaw: You said that 99 per cent of clinicians agree. Where is that 99 per cent established?

Professor Leese: Did I say that? I did not say 99 per cent agree.

Jackson Carlaw: You did.

Professor Leese: No, I did not.

The Convener: We will move on. We are not going to agree on the figures, so can we just get the position clarified?

Professor Leese: What I was saying or what I was trying to say was that the majority of clinicians—I said perhaps 99 per cent, because there may be the odd one who is not, and I was then interrupted—

Jackson Carlaw: Where does that figure come from?

Professor Leese: That is just typical.

Jackson Carlaw: No. I am asking you where your 99 per cent comes from.

Professor Leese: Every time that I try to make the statement, I am interrupted. Can I start again?

Jackson Carlaw: No. I am asking you specifically—

Professor Leese: Can I finish my statement?

Jackson Carlaw: No. You are actually responding to my question.

The Convener: Jackson—

Jackson Carlaw: I am asking you—

Professor Leese: I am not even being asked.

Jackson Carlaw: —where your 99 per cent figure comes from.

Professor Leese: What?

Jackson Carlaw: You have said that 99 per cent of clinicians believe. Where is that 99 per cent verified?

Professor Leese: No. I never said that 99 per cent of clinicians believe. I said—[*Interruption*.] What? Can I please finish the sentence this time, for the third time?

The Convener: Yes, if you do not mind.

Professor Leese: I said that the majority of clinicians are compassionate—that is what I was trying to say—

The Convener: No, you did not say that.

Professor Leese: No. That is because I kept getting interrupted.

The Convener: No, you did not. I think that it was a good while after you had made your point that Jackson Carlaw asked you to clarify what you were actually trying to say.

10:45

Professor Leese: Well, I hope that this is on tape, because that is not—

The Convener: It is. It is all recorded.

Professor Leese: I talked about the majority of clinicians, and I was about to say that there might be the odd one who is not, but 99 per cent of clinicians—this is when I got interrupted, but this is what I was going on to say—will be very compassionate about the problems that patients are facing. That is what I was trying to say and that is what I am trying to get across.

Comments about conspiracy theories and quackery are not fair. The majority of clinicians will be upset when they have patients in front of them who have on-going symptoms, despite being on thyroxine. There are a number of different possible reasons for such symptoms, which I can go into if the committee wants me to do so. The other thing that we need to think about is that clinicians do not want to do any harm with the treatments that they prescribe or recommend.

The other point that I want to get across, in relation to what was said about anecdote, is that anecdotes often raise good clinical questions, which is exactly why we listen to anecdotes. Those questions then need to be tested, as I have said, in a clinical trial, to ensure that a therapy will have benefits.

I can give you an example from a completely different disease area: painful neuropathy. We do trials in which we give drugs for pain. That involves giving half the patients in the trial the active drug and half the patients a placebo drug; it is a blinded study, so that people do not know who is getting what. In those kinds of trials, up to 50 per cent of patients will get pain relief from the placebo.

That is why we need to do clinical trials—we need to see whether drugs really do benefit people or whether there are other aspects of the care that help patients. That is why I come back to the compassion that clinicians want to show—and in the majority of cases do show—to their patients.

Those are the points that I wanted to get across. I am sorry if I got mixed up in all that.

Jackson Carlaw: Let me pursue your point about clinical trials. Where were they conducted? When were they conducted? How many women were involved?

Professor Leese: I cannot tell you the exact number. Thousands of patients were involved in the trials—

Jackson Carlaw: Is this an anecdotal response?

Professor Leese: No, it is just my—

Jackson Carlaw: You do not know—that is the answer. Perhaps you could write to the committee, giving us full details of the clinical trials. I do not want to know what you think; I want to know what you know. When were they conducted? How many women were involved?

Professor Leese: I said that I do not know the exact numbers involved. The trials were conducted between 1999 and 2008—I think that that was the last one—and thousands of patients were involved. One trial showed a benefit but the other 11 randomised controlled trials did not show a benefit. There have been four meta-analyses undertaken—

Jackson Carlaw: Where were the trials conducted?

Professor Leese: Across the western world; in America and in the United Kingdom. The four meta-analyses that combined the trials did not show a benefit.

Jackson Carlaw: Are you going to forward that information to us?

Professor Leese: I can do that.

Maureen Watt: May I answer Mr Carlaw’s question about the listening exercise? We have to remember that hundreds of thousands of people who have thyroid problems and who are probably on thyroxine live perfectly healthy lives. In relation to the listening exercise, we said that the people who were most motivated to respond to the questions that Thyroid UK posed were likely to be those who were most unwell and most unhappy with the service that they were getting from their clinicians. We are trying to establish the best way to take forward the concerns of the patients who are still feeling unwell and who are suffering from thyroid problems but might be suffering from other problems.

Elaine Smith is right—most clinicians look at the whole person. The drugs that a person needs might not necessarily be related to their thyroid problem. I accept that totally. I hope that such issues will be highlighted to GPs in the guidelines and through the various thyroid organisations. That will help patients in the appointments and discussions that they have with their GPs and—if they are passed on to secondary care—with the endocrinologists.

Elaine Smith: I really do not know where to start. If the minister thinks that I said that most clinicians look at the whole person, that is a mistake. I said that GPs tend to look at blood test results and not at the whole person. Dr Anthony Toft made the point that medical professionals should not just look at the blood results but should look at the patient, listen to their symptoms and work out from there what they should be doing. That is one issue. Another issue is the other drugs that people are on. Often, people are on those drugs because of their thyroid problems. If they were on the right medication for their thyroid, they might not have to be on antidepressants, pain medications and so on.

Obviously, the petitioner was rather upset by what the minister said earlier. Perhaps the minister was wrongly briefed, because, as I understand it, the petitioner did not come to any agreement about guidelines. In fact, she is not aware that there are guidelines for thyroid conditions. Like me, she is interested—I do not know whether the committee would be interested as well—in getting a copy of the guidelines that are in existence at the moment. I think that it would be interesting for everybody to see them.

The Convener: Yes.

Elaine Smith: The next issue is whether the minister is confident that the current treatment for hypothyroidism can be considered safe when it is admitted that 10 per cent of patients remain unwell on levothyroxine. Personally, I think that the figure is a lot higher. The professor talked about people on T4 never coming back and saying that they are unwell, but I know lots of people who feel unwell but do not think that it is related to their thyroid because they are told, “Here’s this little pill. Take it for the rest of your life and you’ll be absolutely fine. We’ll test you once a year to see how your bloods are.”

It is not routine to test T4, and it is certainly not routine to test T3. What can you say to the 10 per cent—which is a modest estimate—who are not doing well? What are we going to do for them? What can we say to the people who are not being diagnosed because they are slightly outwith the ranges? If they were in America, they would be getting diagnosed. What do we say to all the people in this country—we do not even know how many of them there are—who are buying desiccated thyroid hormone off the internet? Why was desiccated thyroid hormone fine until a pharmaceutical company invented T4? Those questions about how patients are going to be treated in the future really have to be answered.

Maureen Watt: I do not think that I, as a politician, should say what the medical profession should do. That is up to the medical profession. However, I make it clear that there is guidance for patients and for GPs and endocrinologists at the moment. There are no SIGN guidelines but there is guidance, and SIGN guidelines are being developed, as Professor Leese said. There is a difference between guidance and guidelines. I will let Professor Leese answer your other questions.

Professor Leese: There were a lot of questions, and I hope that a lot of the answers may be within the British Thyroid Association guidelines, which are very similar to the European and American ones. You are shaking your head, Ms Smith—you do not think so.

Elaine Smith: I am afraid not. I do not know how you will feel about this—it is anecdotal, as you would put it. You said earlier that people could go back to their GP if they were unwell. The problem is that lots of people—mainly women but some men—go back when they are unwell and are told a list of different things. I have been through this myself, which is why my evidence is anecdotal. First, you are told, “It sounds like depression—here are some antidepressants.” You are then told, “Oh, it’s probably your weight. Let’s see if you can go on a diet.” Next, you are told, “Oh, we can give you co-codamol for your fibromyalgia,” and so it goes on. It never comes back to the fact that the problem is your thyroid.

For me, that process went on for two years. In those two years, I had brain scans and blood tests, and I was tested for Lyme disease—I was tested for lots of things. I was also put on heart monitors. It must have cost a fortune. That was because, instead of being sent to an endo, I was sent to a neurologist. I did not have an endo at that point. I was eventually told that I had ME, but I did not accept that. Even though I was ill, I was quite assertive and demanded that my GP send me to Dr Anthony Toft. After one session with Dr Toft, a blood test showed that I was not converting T4 to T3. I was put on T3 and, six weeks later, I was much better although it has taken until now to get the dosage of T3 right.

That is happening to a lot of people. I know women on T4 who tell me about all those other symptoms and say, “I’m all right on my thyroxine—my T4,” but they are not. All those other symptoms are down to the fact that they are not on the right dosage or the fact that they should be on T3 or desiccated thyroid hormone, which was the previous treatment for a lot of people and was considered safe at that time.

Women—and, I suppose, the petition—are looking for patients to be listened to and for GPs to use the named-patient basis to prescribe what is best for the patient so that patients can try out what they want to try out without having to buy things off the internet, which is extremely dangerous. How do you feel about that? You talk about trials, but there are many people whom you will not reach because they are not in the group that you will examine.

Professor Leese: With regard to your personal case, there is provision for what you went through. The modern guidelines address your issues, although the previous ones might not have done. Now, in an ideal setting, someone would go down the line that you eventually went down.

Elaine Smith: I understand that around 20 per cent of people—that figure is, perhaps, anecdotal but I do not have the figures before me—have been diagnosed with ME but have an underlying thyroid condition. Do you think that those people should be tested to see whether they are not converting T4 to T3?

Professor Leese: If they were not converting T4 to T3, their TSH would go up.

Elaine Smith: TSH is not the be-all and end-all. The minister said earlier that GPs can test T3 and T4, but they do not do that routinely. My TSH—I am going into all the details now—is not at a level that anyone other than the endocrinologist who has been dealing with me for years would let it be at. Nevertheless, I am doing well on the T3 that has been upped and the T4 that has been taken down. It is not my TSH blood tests that are being looked at but me and how I am dealing with it.

Professor Leese: That is good.

The Convener: I do not think that we are going to get any further by pursuing that line of questioning. We have given the issue a good airing. I suggest that, because we have received a lot of information and a lot of questions have arisen from that, we need to write to the minister to get some clarification of those points so that we can discuss the matter at a future meeting. We are beginning to run out of time in which to have meetings before the dissolution of Parliament. However, given the questions that have arisen from the evidence this morning, there is still some distance to go with the petition and we must pursue the matter diligently.

We are pressed for time. Our clerks and the Scottish Government officials can discuss the timescale for getting answers, but we need to get them reasonably quickly. I do not think that we will have time to invite the minister back. Perhaps our legacy paper can suggest that we need to keep an eye on the petition given the number of questions that keep arising and the failure to reach a conclusion. I know that everyone came here this morning to be as helpful as possible, but I think that we ended up with more questions than answers. Despite the best of intentions, the information that we received just led to more questions being posed by the committee.

I will not comment on the style of the evidence-taking evidence, but there be might be some dissatisfaction will that, too. If we were to get the answers in a written form, that might help us to make progress. We did not get exactly what we were looking for, which leaves us disappointed, but we must continue to pursue the petition.

Elaine, do you have a suggestion?

11:00

Elaine Smith: There was some misunderstanding about the difference between the guidelines and the guidance from endocrinologists and others. Sometimes, it is better to get things in writing. Given that the petitioner has been pursuing the matter for nearly four years, I wonder whether she could be afforded an opportunity to come back and give evidence on the information that you have received.

The Convener: It would be difficult to suggest such a course of action to a future committee. We will have to wait and see, but that option is always on the table. Further consideration of the petition is certainly merited—I think that we can guarantee that—but it would not be for me to tell a future committee whom it should and should not invite to give evidence. That would not be appropriate. We can continue the petition and suggest in our legacy paper that further work needs to be done on it.

As I said, if we can get written answers to the questions that arose this morning so that we can consider the petition further in this Parliament, that will help us, in drafting our legacy paper, to direct the future committee to continue to look at the matter.

Maureen Watt: I undertake to answer those questions as soon as we can after we get them.

The Convener: Thank you very much, minister. I also thank your team for coming before us this morning.

I suspend the meeting for a few minutes to allow a changeover of witnesses.

11:01

Meeting suspended.

11:05

On resuming—

NHS Centre for Integrative Care (PE1568)

The Convener: Our third item of business is evidence from health boards on PE1568, on access to, and funding and promotion of, the NHS centre for integrative care. I welcome to the meeting Catriona Renfrew of NHS Greater Glasgow and Clyde, Dr Hugo van Woerden of NHS Highland, Dr Harpreet Kohli of NHS Lanarkshire and Professor Alex McMahon of NHS Lothian.

Members have the usual briefing and background materials on the petition, which will allow us to ask questions. Before that, I point out a correction to paragraph 4 of our briefing note, which should refer to “inpatient integrative care beds”, rather than “homoeopathic beds”.

With that, we move straight to questions. Does any member want to kick off?

Okay. A question has been raised with me about the new facility at Gartnavel. If health boards have decided not to put funding into supporting the CIC and there are people with chronic pain from within your health board areas who are already being treated, where will they now be treated?

Catriona Renfrew (NHS Greater Glasgow and Clyde): There are a number of different strands around the centre for integrative care. A new national chronic pain service is being developed, which will be available to all health boards. There is also the homoeopathic service, which is part of the centre for integrative care at the moment. There is a range of other services, including mindfulness, cognitive behavioural therapy and allergy treatments, but the chronic pain service is the specific service that boards will expect to get from the centre when the new contract is in place with the Scottish Government.

The Convener: Is that what health boards have decided they specifically do not want to fund?

Catriona Renfrew: That question would be better put to the three other health boards. There are shades of difference.

Dr Harpreet Kohli (NHS Lanarkshire): NHS Lanarkshire's board took a decision in December 2014 to end referrals of patients to the centre for integrative care, whose services include a range of interventions, including homoeopathy.

The Convener: Why? What was the rationale for that decision? Was it to do with funding or making better use of money? Is there a clinical reason underpinning the decision?

Dr Kohli: The decision was absolutely not to do with costs, as the papers that we have given to the committee make clear. The board's decision was based on the totality of the evidence on homoeopathy and on other interventions that are provided by the centre for integrative care. The decision was based on evidence, rather than on cost.

The Convener: Can I get clarification on the decisions of the other two health boards?

Professor Alex McMahon (NHS Lothian): NHS Lothian still refers patients to the centre for integrative care. We did not take a decision to stop as part of our process of consulting on homoeopathy. We have a service level agreement with NHS Greater Glasgow and Clyde on that. NHS Lothian has a referral process that is done case by case.

Dr Hugo van Woerden (NHS Highland): NHS Highland took a decision in 2010. A board paper took the position that homoeopathy would not continue to be funded by NHS Highland. We have a clinical advisory group that looks at all referrals, so there is an opportunity for individuals to make a case to be referred anywhere; if agreed to, those cases are referred. Over the past five years we have made about two referrals a year to the centre for integrative care. However, those referrals have not been for homoeopathy. A few requests—four or five per year—have not been supported by the clinical advisory group. There has been no recent change in NHS Highland's position, which goes back to the board paper of October 2010.

John Wilson: Dr Kohli said that NHS Lanarkshire does not make any referrals to the CIC. Can you clarify whether you were talking about new referrals? We have heard in previous evidence that NHS Lanarkshire would continue to allow treatment of patients who had previously been referred prior to the board's decision. Is that the situation?

Dr Kohli: I confirm that that is true, as is the case with other service changes. If patients are already receiving a service, we continue that service.

John Wilson: On that basis, what evidence did the board hear that was conclusive in respect of its decision to stop future referrals to the CIC?

Dr Kohli: As part of the process, we undertook a review of the world literature on the interventions that are provided by the CIC, including homoeopathy and a range of other interventions, and we had discussions with the CIC, which was represented on our review group. We looked at evidence in other reports, and we undertook surveys of GPs and a selected sample of out-patients attending the two out-patient clinics in Lanarkshire. We made available to those who attended the CIC literature about our process of consultation. We took on board comments from the CIC and clinicians, and from patients who attended the CIC. Beyond that, the board decided to carry out a wider consultation to which just under 6,000 individuals responded.

The board considered the totality of the evidence, including the evidence of the effectiveness not only of homoeopathy but of the other interventions that are offered by the CIC. We came to the decision—which was not easy—that we should stop new referrals to the CIC from NHS Lanarkshire.

John Wilson: You mentioned a number of groups and organisations from which the health board sought advice, information and reports. What was the response from patients in the surveys that the board carried out? The health boards and the national health service talk about a patient-centred approach to care and treatment. It would be interesting to find out what the patients themselves thought about the services that they were receiving, and the decision—or potential decision—by the board not only to withdraw referrals to the CIC but to withdraw homoeopathic treatment services completely in NHS Lanarkshire.

Dr Kohli: As the board's paper—to which you have access—and the minutes of the meeting make clear, we were open and transparent about the feedback that we had received not just from patients but from the public in general. It is undoubtedly true that homoeopathy and the other interventions that are provided by the CIC are popular and acceptable among patients and the public, but that does not mean that they are effective. Otherwise, there would be no need for organisations such as the Scottish Medicines Consortium.

John Wilson: You said that the treatments are not effective. Who determines whether or not a treatment is effective? Is it the patient or the clinician?

Dr Kohli: On how the effectiveness of interventions is measured, we need high-quality and unbiased studies, and we need to look at the literature that exists not just in Scotland and the UK, but worldwide. That is one part of the evidence that the board took on board.

11:15

The board also looked at the feedback from patients. As I have said, we made it absolutely clear that patients and the public find homoeopathy popular and acceptable, but that does not mean that it is effective. I point out that, if that was the case, there would not be a need to have organisations such as the Scottish Medicines Consortium, and there would not be a need for organisations that produce guidelines, such as the Scottish intercollegiate guidelines network or the National Institute for Health and Care Excellence. Those organisations assess the effectiveness of interventions. It is important to take on board the views of patients and the public, but if we are assessing effectiveness, we need to do it properly.

John Wilson: If you had been here for our previous evidence session, you would have heard the committee unanimously agreeing that some guidance, including SIGN guidance, does not deal with the issues that patients deal with. The committee is trying to assess the benefits to patients in terms of their treatment and care in relation to how they feel, which allows them to participate in life as actively as possible.

I wish to move over to discuss the situation at the centre for integrative care and its continued viability. Given what we have heard today—that, with the exception of NHS Lothian, health boards are withdrawing or not making referrals to the centre—how financially viable is it for Greater Glasgow and Clyde NHS Board to maintain the level of services for patients who may desire those services, despite the fact that other health boards are not making referrals?

Catriona Renfrew: There are two different elements to that. One is the routine business that we call cross-boundary flow, in which other health boards fund us for the services that their patients use. We need to consider the loss of income and how we will reduce costs to reflect that lost income, but the view that we have given the committee is that the centre and the services that it provides are still viable, because the majority of them are used mainly by NHS Greater Glasgow and Clyde residents, anyway. There is a question around cross-boundary flow and the centre.

We have also indicated our intention to review ourselves the centre's services and their costs. As part of our financial planning for 2016-17, we will run about 40-45 service reviews over the next few months to set our budgets for that year. There are two different processes in play, but we have been clear that the viability of the centre is not threatened by the loss of cross-boundary-flow income. It means that we need to reduce costs, because we cannot afford the service to run exactly as it is running at the moment, so we are doing a wider service review for financial planning for next year.

The Convener: How many health boards have signed up to make referrals to and will be providing funding to the CIC?

Catriona Renfrew: I think that only two or three boards send no referrals at all. As colleagues have said, other boards have cost-per-case arrangements, whereby their residents can flow through on an assessed basis.

NHS Greater Glasgow and Clyde's population is nearly a third of that of the whole Scottish health service and uses about half the capacity of the centre for integrative care. In our view, the viability of the centre will continue while NHS Greater Glasgow and Clyde continues to commission it, although the CIC may provide a smaller service because fewer patients are coming in from elsewhere.

We have confirmed to the committee our view that, despite that loss of income, we will be able to continue to run the service, subject to our own review of the service as part of our work around what services we provide.

The Convener: It cannot be a satisfactory situation that Greater Glasgow and Clyde NHS is providing the core funding, essentially, to have the facility there when some health boards are using it, or buying into it, only on a case-by-case basis and others have decided not to refer patients to it at all. That makes it very difficult for you to plan future funding and to maintain the funding that is required to ensure that the service is there, should anyone from another health board wish to access the services that are provided.

Catriona Renfrew: We work with other health boards on three-year arrangements in order to give some stability to the flow of finance and referrals. We have cross-boundary-flow arrangements with all the boards that use our services. An arrangement whereby some boards buy one aspect of a service and others do not, and in which there are different volumes from different boards, is not unusual. There is nothing unique about the cross-boundary-flow arrangements that the centre runs.

Jackson Carlaw: By way of introduction, I want to ask Catriona Renfrew a question of clarification. In 2014, the cabinet secretary confirmed to Parliament that the new national centre for chronic pain will be located at the facility in Gartnavel. What stage of development is it at?

Catriona Renfrew: Detailed planning is being done, literally as we speak. There have been a series of discussions this week, and there has been engagement with the public and with patients. That work is going ahead.

Jackson Carlaw: The Scottish Government does not have a national position on whether homoeopathic medicine is a good thing or a bad thing, or on whether it should be provided. Therefore, every individual health board has been left to take a view as to whether this is something that they wish to support. We are focusing on Dr Kohli, whose board supported homoeopathic medicine and has now chosen not to, but some health boards never supported it. I am interested in the inherent contradiction in all that.

It is clear that Greater Glasgow and Clyde Health Board believes that homoeopathic medicine has merits. In essence, Dr Kohli's position was that the board had taken peer group studies of the effectiveness of homoeopathic medicine across the wider world, rather than the desirability—I will come back to him regarding his patients' judgment—and concluded that it was not effective.

There seems to be an essential contradiction between the views of different health boards. If Glasgow is committed to continuing to provide that service at the centre for integrative care, it must have concluded that it is effective, otherwise it would not have done that.

Catriona Renfrew: As Dr Kohli said, I think that any health board that is doing such a review looks at a whole range of factors, which includes public opinion, patient opinion and an evidence review. The board will weight those factors when it makes its decision. Different boards weight those factors in different ways on a range of services, so you will find a different pattern of health services in greater Glasgow than in other areas. When you take on board patient opinion and public opinion and so on, there is no single scientifically correct answer. The evidence base, as Harpeet Kohli described it, is clear. NHS Lanarkshire considered that factor in making its decision.

We will review the services at the centre again. We said that it is financially viable as it stands, because the majority of its work comes from NHS Greater Glasgow and Clyde, but we need to look at the decisions and reviews that other health boards have done and revisit whether our position is correct. We will do that.

Jackson Carlaw: I am not quite sure where that leaves us in relation to the commitment that I understood you were giving to the centre. Given that NHS Greater Glasgow and Clyde financed this treatment, is the treatment effective, in its view?

Catriona Renfrew: I suspect that we last looked at the service in detail about 10 years ago. At that stage, we concluded that we would stop providing homoeopathy. The board reviewed that decision as part of a process in which there was a great deal of anxiety and anger on the part of the public and patients. The board took the view that we would continue to provide it.

On the strict definition of effectiveness, I think that the evidence—in the way that Dr Kohli described it—supports NHS Lanarkshire's position. However, there are a number of other factors that were considered in reaching that decision, which is now several years out of date. When we revisit our conclusions, we will look at the work that other health boards have done. I made the point that the centre is financially viable. That does not mean that it is not subject to review—along with everything else that we do—as we go into 2016-17, when we will need to set a balanced budget.

Jackson Carlaw: I appreciate that. Considering the pressures on NHS resources, I would be concerned if we invested in services that you ultimately concluded were not effective, if I can put it that way. I find that that is a difficult conundrum.

Dr Kohli talked about all the international evidence. He then said that he had taken advice from the patients whom he had referred for that treatment. How many of them said that the treatment they had received had been ineffective?

Dr Kohli: Did you say ineffective?

Jackson Carlaw: Yes.

Dr Kohli: Most of the patients whom we contacted said that they thought that the treatment was effective.

Jackson Carlaw: Did you say that they thought that it was effective?

Dr Kohli: That was their opinion, yes.

Jackson Carlaw: So you came to the conclusion that you did in spite of the evidence from the patients whom you had referred to the centre. That conclusion was drawn largely from the various other peer groups that you read.

Dr Kohli: As I said earlier, the board took on board a variety of evidence, including the literature on effectiveness. What individual patients say is important in terms of acceptability and whether they want such treatment, but it does not show that the treatment is effective.

Jackson Carlaw: However, the majority of them said that it was.

Dr Kohli: They felt that they had benefited from it and the board took that on board. That is noted in the paper that we presented to the board but the critical point is that the board considered the totality of the evidence not only for homoeopathy but for other interventions that the centre for integrative care provides.

Jackson Carlaw: I understand the argument that goes on about homoeopathy. I guess that, when I am presented in a committee such as this with professionals who are taking such decisions, I find it slightly ironic that the patient base that was referred to the centre, from whom you can take direct evidence about the treatment that they received, said that it was effective but you discontinued the treatment notwithstanding that fact because there was a totality of evidence from elsewhere that said that it was not effective.

Dr Kohli: That is precisely the reason why there are organisations such as the SMC, SIGN and NICE to assess effectiveness. It is important that feedback from patients and the public form part of that, but it does not answer the question about effectiveness.

Jackson Carlaw: I suppose that I would conclude that what the patient said was not important at all, but that is just me.

Dr Kohli: Absolutely not.

Jackson Carlaw: At the end of the day, it was set aside. The patients’ views were set aside in favour of the broader evidence. Is it just that you needed to save money and that discontinuing the treatment seemed like an obvious way to do it?

Dr Kohli: No. The decision was not about cost; it was about evidence. As a doctor and a director of public health, I can state that emphatically. It was not an easy decision for board members to make, because two elements of the quality strategy were in dissonance: the evidence that we have about the effectiveness of interventions, and patient-centredness. The board members’ discussion reflected the difficulties that that poses.

Jackson Carlaw: I respect that. What has been the consequence of not referring patients to the centre for integrative care? They must have been given some alternative treatment, which must have had its own consequence for the various services of which those patients will now be taking advantage. I refer not only to their initial appointment but, as I know that that can often be given within a timescale, the subsequent treatment that they receive. What is the prognosis for all the patients who would previously have been referred to the centre?

Dr Kohli: We made it clear in the consultation document that, if the decision was not to refer new patients to the centre for integrative care, such patients would have access to other services. We have ensured that they have access to psychological services, the chronic pain management services and self-management programmes within Lanarkshire and we have monitored those since we stopped new referrals to the centre for integrative care.

Jackson Carlaw: What has your monitoring told you? I understand that the patients have access. We all have access in the sense that that is the health board’s provision. It is easy to say that the patients have access, but what has the monitoring suggested is the practical impact on the timeousness of the treatment that they receive?

Dr Kohli: Our monitoring has shown that people who may previously have been referred to the centre for integrative care have been referred to those other services and that there is no additional pressure on those services.

Jackson Carlaw: Okay, so all those patients will be treated without any additional delay having being created in their treatment or the treatment of others.

Dr Kohli: Yes, they have been offered alternatives.

11:30

Elaine Smith: I am getting a bit of déjà vu about the thyroid petition.

On the point that Jackson Carlaw was pursuing, more than 80 per cent of responses to the public consultation wanted the services to remain. I am particularly interested in the situation in Lanarkshire, because the clinic in Coatbridge stopped. In relation to democracy and the patient charter, do you think that it is right to ignore that number of people?

Dr Kohli: That was a consultation and not a vote on treatments provided by the centre for integrative care. When the board made its decision, it took on board the point that it has a duty of best value, including investing public funds on interventions that are based on sound science and evidence. It was not a vote. The board had to make a difficult decision that was based on the totality of the evidence and it was mindful of its duty of best value.

Elaine Smith: You are saying that you did a consultation and the people who responded were ignored because it was not a vote, it was just a consultation. It seems to me that you just ignored the people who responded.

Can I move on then to—

Dr Kohli: No, we did not ignore them. It was brought to the attention of board members and it is noted in the minutes of the meeting. That is why it was such a difficult decision to make. You are weighing up evidence from a range of different sources.

Elaine Smith: That is why I think that the issue should have been referred to Scottish ministers. MSPs who represent people should have been more involved in the decisions that were taken.

The other issue is about the conventional services where the patients now have to go. I have seen a response letter from Heather Knox to a plea from a Lanarkshire patient. It says:

> "Regrettably there is continued increasing demand for chronic pain services in Lanarkshire which is outstripping the current available capacity."

Does that mean that, because more people are forced to go to those other services, the delays are becoming commonplace? Is it acceptable for people to experience delays in their repeat treatment?

Dr Kohli: You are right that our chronic pain services face challenges, just as there are challenges in a range of other services. We have improved that service but there is more work to do on that. I can let you know about a range of things that we have undertaken to improve access to that service.

Psychological services is the other main service. Lanarkshire is the best-performing board in terms of patients who are waiting for treatment. They have access to a wide range of services, including self-management services.

However, you are right that we face challenges in providing a range of services. That is true not just of those services that patients who would have been referred to the centre for integrative care have been referred to, but of other services, too.

Elaine Smith: Are you aware of how many patients the chronic services are having to cope with since the withdrawals in April 2015? If you have extra staff to deal with the demand, how many extra clinicians and nurses do you have?

Dr Kohli: To get the precise number of patients, we would need a review and survey of patients, which is not possible. However, we have taken on board the comments from the service itself about the pressure it is under. We have employed additional staff—a nurse specialist—and created additional capacity in medical input. We have revised, reviewed and remodelled the service model so that it is a community-based model rather a hospital-based service. We are also piloting a community service with three GP practices.

Elaine Smith: Did you look at the extra costs that the other services would face before you took the decision not to refer?

You said that it is not possible to do a review. I just wonder why it is not possible.

I know that new patients will be given the guaranteed waiting time, so they will be dealt with—and that will include the patients who are moving over from the CIC's services. Is that why repeat patients are not being considered?

Dr Kohli: I said that the decision was not based on cost. We considered the impact on other services, and that is exactly what we have been monitoring.

The Convener: That does not sound like a meeting of MSPs with NHS Lanarkshire.

We have witnesses here from other health boards, and I am interested in hearing how they arrived at their conclusions, which appear to be different. What I want to understand is whether those boards carried out similar consultations. Did you have the same access to extraneous considerations? Can you suggest why you arrived at a different conclusion, other than to say that there is something in the air and the water in Lanarkshire that led it to a different conclusion? I want to understand why there seems to be a difference.

Professor McMahon: When we did our consultation in 2012, we opened it to the public, staff and any other stakeholders, and almost 4,000 people responded, of whom 75 per cent said that we should not provide homoeopathic services in NHS Lothian. Similarly to Dr Kohli's experience, the evidence that was presented to the board was the totality of the evidence. Not just the evidence from respondents to the consultation but the worldwide literature on the issue informed the board's decision.

The continuation of our SLA with NHS Greater Glasgow and Clyde in relation to the CIC related to specific therapies, not the totality of homoeopathic remedies. The majority of the patients whom we send currently are receiving mistletoe therapy, which is more for end-of-life-care. That is a specific service that the CIC offers.

We would not deny a patient the opportunity to be referred to the CIC, but we do not uphold every referral. Referrals are looked at clinically, individually. There is a slight difference in that regard, but the process was very similar to the one that NHS Lanarkshire undertook.

Dr van Woerden: The issue was discussed at the board in 2010. Since then, NHS Highland has set up a clinical advisory group, and any patient who wants to be referred outside Highland for a specific treatment goes through that group. There is an application process, and each case is considered on its merits.

I am aware that there were a couple of cases on which there was extensive focus in 2013, which NHS Highland referred to the Scottish health technologies assessment group, in relation to two specific forms of therapy by homoeopathy. As I said, we have a process for consideration of each individual case.

The Convener: In the context of the original decision to continue to refer, did you conduct a consultation that was similar to the ones that other boards conducted? What was the level of support from people who were receiving or might potentially receive support from the CIC? Did they want support to continue? Were the results similar to those in Lanarkshire and Lothian?

Dr van Woerden: I have been in NHS Highland for only a year, so I am not part of this history, but I understand from the chief executive that there was support from the GP community for the decision to be made and for there to be consultation with wider groups. I do not think that there was a formal patient consultation. The decision was made to set up a committee that would consider each request, so NHS Highland took a slightly different approach.

Hanzala Malik: Dr Kohli, I do not want you to think that I am targeting you, because I am not doing so. Your responses have been clear and I respect the board’s decision in the context of it having to deal with a lot of other issues. I am not looking for Catriona Renfrew to get business from your board, either.

People who attended the centre for integrative care in Glasgow were happy with the services that they received. Are the patients who are not being sent to the CIC equally pleased with the services that you provide in Lanarkshire? Have you carried out a survey of patient satisfaction in that regard? Do you get value for money by keeping patients in-house? I do not know whether you have that information to hand, but it would be helpful.

Dr Kohli: As with all our services, we monitor that. With regard to those patients who might have been referred to the CIC, short of following up individuals in a range of services, it would be impossible to track them down. It would be impossible to try to identify them. However, as I say, we monitor the services across all the care that we provide.

Hanzala Malik: A fuller assessment of the failure or success of a change to any service would determine whether the patient was benefiting from the steps that the authority has taken. In the absence of that, it is difficult to assess whether what the board decided was prudent from the point of view of the patient or in terms of resources. It would be interesting if we could get some follow-up information on that in due course.

An important aspect of all this concerns the satisfaction levels of patients who are receiving the service. As I say, without evidence in terms of facts and figures, it is difficult to judge whether the decisions that were made were fair and accurate. Further, it becomes difficult to assess how the CIC will continue to be a viable operation in the west of Scotland. Are you in any position to go back and get us that information? If so, what sort of timescale would we be looking at?

Dr Kohli: It would be difficult to undertake a study of patients who may have been referred. Considering the issues of identification and the difficulties of trying to follow that up, I think that it would be almost impossible to do in the context of NHS Lanarkshire. It might be possible to get that information through a research project that could be undertaken over a long period of time. That would require a significant amount of resources.

Hanzala Malik: Assessing whether the decisions that were made were wise, whether the patients benefited from the service and whether the service represented value for money is possible only if we have figures to substantiate what is being said about the end result of the delivery of the service.

Dr Kohli: As I said earlier, we monitor the services, particularly with regard to the places where those patients who might have been referred are being referred, which is to chronic pain management services and psychological services. That monitoring is not done specifically in relation to those who might have gone to the CIC; it is done more generally.

It is important to note that we have been monitoring complaints about the decision that was taken to stop referrals to the CIC. We have had three such complaints.

Hanzala Malik: I think that I have made my point, convener.

John Wilson: I am sorry to come back to you, Dr Kohli, but you implied in response to Jackson Carlaw and Elaine Smith that the decision that you made was not down to financial issues. However, you made reference to best value. I often ask authorities and others who cite best value as a reason for doing something what their definition of best value is. What is your definition of best value?

Dr Kohli: As I said earlier, best value is investing public funds in interventions that are based on sound science and evidence. It is clear in relation not just to homoeopathy but to other interventions provided by the centre for integrative care that that evidence was lacking. It may be that such evidence will increase in the future, and we made that clear during the board discussions.

11:45

John Wilson: Ultimately, the decision was based on sound science rather than on the patients' experience of the treatment that they were receiving. This is where we get into the debate that I mentioned earlier about patients' experience of the health service versus what clinicians and decision makers think is in the best interests of the patient. You have made the comment that you based your decision on sound science—as you see it—rather than on the patients' point of view.

In response to a question from my colleague Hanzala Malik about whether you can measure the effectiveness of alternative services that Lanarkshire NHS Board is offering to those patients who felt that they may have benefited by being referred to the CIC, you said that you measure the services in general but that you cannot specifically measure the services that are offered to an individual patient in their course of treatment. You said that to do that would involve a large research project. Why can you not measure that? If you and your clinicians decide to refer patients on to services other than those provided by the CIC, why can you not measure those patients' journeys of experience and the effectiveness of the treatments that they are offered instead of being referred to the CIC?

Dr Kohli: I see a practical difficulty in identifying patients who may have been referred to the centre for integrative care if we had not taken the decision. The board has already made the decision. It would be an almost impossible task to identify those people from information from GPs because the policy has changed.

John Wilson: You said that you received three complaints from patients who were disappointed by the decision that Lanarkshire NHS Board took not to allow them to be referred to the CIC. The difficulty for many patients is that they accept the clinical judgments of the medical professionals because they do not know what other options may have been open to them. In effect, the health board has closed down the route for many patients to receive alternative treatments at the CIC.

The view of the professionals is that it is sound science for individuals to receive only treatments that the professionals believe are appropriate in their medical opinion, rather than their taking a patient-centred approach to treatment. We talk about the patient being at the centre of the treatment that they feel they require in order to make them better and allow them to live a better life.

This is a wider issue and it is one for the other health boards, too. They need to try to understand where the patient fits into the process. If we only take decisions based on the medical opinions of clinicians and GPs, many patients' views, opinions and wishes will be denied. As Elaine Smith said in our discussion on a previous petition, there is a sense of déjà vu here. The health boards seem to be closing down an option that was previously available for a number of decades.

Dr Kohli: Our decision was based not on clinical judgments but on the totality of the evidence that we have. We undertook a review of all the evidence. We did a survey of GPs, and we made it clear in the board report that some favour homoeopathy. However, the decision was based on the totality of the evidence.

As I said, there are really difficult issues here, and different elements of the quality strategy run contrary to each other. The board needed to look at the totality of the evidence, including feedback from patients and the public. It was a difficult decision for the board to make, but it made the decision by weighing up all the evidence that it had.

John Wilson: Convener, I should have declared an interest in the matter. Twenty-two years ago, my daughter, who was two years old, was referred for an operation to have her adenoids dealt with and her tonsils removed because she continued to present with streaming colds and blocked sinuses. The medical profession's response was that it would remove the adenoids and tonsils to resolve the problem.

At the time, my wife was attending a homoeopathic clinic in Glasgow, and the individual there said that perhaps we should keep our daughter off dairy products and see how she got on. Up to that point, my daughter had been in constant receipt of antibiotics to deal with the problems that she was having. When she went for pre-op, the doctor who saw her said that they could not carry out the operation because she had been on antibiotics within the past six weeks. After we took my daughter off dairy products, at the following visit for the pre-op, the doctor said, "This is a different child you are presenting to me. This child is clear of all the problems that we had identified and were going to operate on."

I base my view on my experience of what happened to my daughter when she was two years of age. She would have had her adenoids and tonsils removed, but she still has them today and she knows how to manage the problems that she had—she stays clear of dairy products. That is a practical example that I know of. The operation would have cost the NHS money and time, but my daughter was treated in a fairly simple and straightforward way by someone outwith the medical profession telling us to keep our daughter off dairy products and see how she got on.

That is an example of why we need alternative options for many patients. Closing down those alternative options closes down a raft of alternative treatments that would save the NHS money and time and save patients hardship and frustration.

Dr Kohli: I respect your experience and views. Over time, the evidence changes. In fact, we are now carrying out fewer tonsillectomies as the evidence base on tonsillectomy has grown. There are alternatives for patients who are not being referred to the centre for integrative care, and we have provided an outline of those.

Elaine Smith: I have a short supplementary question on that point, but first I will make an observation. Dr Kohli said that NHS Lanarkshire had made the decision, but we know that, in the past, if a board has made the wrong decision, ministers have overturned it. We know that that can be done.

In these times of stretched budgets, why did NHS Lanarkshire not carry out a cost assessment of the impact of switching the patients to conventional services, which will have involved additional staff and so on?

Dr Kohli: We were quite clear that it was not about the cost but about the effectiveness of the service. We identified costs of around £200,000, which we made clear in the board paper, but that was the best estimate of the centre for integrative care. That forms part of the service level agreement that we have with NHS Greater Glasgow and Clyde.

Elaine Smith: It could be more cost effective to keep the services, and the patients want them, but the board decided not to keep them.

Dr Kohli: A fundamental point about cost effectiveness is that the service or the intervention needs to be effective in the first place. That is why we did not—[*Interruption*.]

The Convener: Quiet, please. Members of the public are not allowed to intervene in the discussion.

Dr Kohli: That is why our focus and the board's position were quite clear. We were interested in examining the effectiveness of the interventions that were offered by the centre for integrative care, among other things. We looked for cost-effectiveness studies relating not just to homoeopathy but to other interventions, and we found that they were very few and far between. As for work by Healthcare Improvement Scotland that considers evidence on homoeopathy on a clinical and cost-effectiveness basis, it was not possible to find that.

Notably, the decision on the evidence has been backed up by an Australian review that was undertaken just under a year ago, in March 2015, which concluded:

> "there is no good quality evidence to support the claim that homeopathy is effective in treating health conditions."

John Wilson: For clarification, can you tell us who commissioned the Australian study?

Dr Kohli: The Australian study was commissioned by a healthcare organisation in Australia. Evidence was examined from throughout the world.

John Wilson: Is that a private healthcare organisation?

Dr Kohli: No—it is a Government organisation. I can provide the details should the committee wish to have them.

The Convener: Ms Renfrew has been wanting to make a point for a while now.

Catriona Renfrew: The issue around homoeopathy goes much wider than the balance between evidence and patient opinion. It is an incredibly complex area. To take the tonsillectomy example that was raised, we changed our policies on tonsillectomies and we stopped doing them. For people of my age, no child got to the age of five with their tonsils intact. The policy was that, if someone looked at somebody the wrong way, their tonsils were removed. Your daughter was extraordinarily lucky to live in a different era.

We changed that policy on the basis of new evidence, quite rightly, and we stopped doing tonsillectomies. Parents objected and petitioned health boards saying, "My child's off school again—I want their tonsils out." However, the clinical evidence was that that was not the right thing to do.

It is a difficult area of debate. There are many things that patients want that the health service does not provide. We are very focused on homoeopathy today as it is the subject of the petition, but there are a raft of alternative treatments that the NHS does not provide because they are not evidence based. As NHS boards, we try to cling to evidence as a basis for making decisions, because if we did not do that, we would have enormous difficulties in engaging with patients about what we deliver for them.

The Convener: We have occasionally been sucked into the idea that this is about the delivery of homoeopathic services, but it is not. [*Interruption*.] I do not need applause from the public gallery for saying that. It is about the delivery of integrated care.

You represent the health board—Greater Glasgow and Clyde NHS Board—that provides the facility that we are discussing. How widely do you promote it to ensure that people are aware that the services are available, so that they might put pressure on their GP to be referred?

Catriona Renfrew: I do not see it as part of our role to market services. The GPs in our area know the range of services that we have available, and they will make decisions with patients about which services to refer to. We have enough demand for healthcare in NHS Greater Glasgow and Clyde without actively seeking referrals, but we ensure that GPs are well aware of the range of services that exist.

As I have said, we need to review the centre as part of our review of all the services that we provide, and that will be happening over the next few weeks and months.

Elaine Smith: Will you clarify whether the review of the future of the centre for integrative care is happening in light of the reduced cross-border flows?

Catriona Renfrew: We are commissioning the review on the basis of our overall planning for next year across all our services. As I have said, we are carrying out 44 or 45 different reviews to determine how we can set a balanced budget and meet the needs of our patients in 2016-17. The review is not provoked solely by the cross-boundary flow issue, although that is part of the financial issue that we have. That issue is explicitly part of the reason for doing the review, as we have less income, but we would be doing it in any event.

The Convener: I thank all our witnesses for coming and answering the questions that we have put to them.

Some further questions have arisen as a result of our questions, and I think that we need to give the petitioner an opportunity to hear the evidence that we have taken this morning and to respond. If colleagues agree, we will continue the petition and look at the response that we receive from the petitioner and any other correspondence that we receive. A lot of people who are following the petition will have contributions to make to our discussions.

I appreciate your answering the committee's questions this morning. Thank you very much.

12:00

Meeting suspended.

12:05

On resuming—

St Margaret of Scotland Hospice (PE1105)

The Convener: The next item of business is consideration of 15 continued petitions, the first of which is PE1105, by Marjorie McCance, on St Margaret of Scotland Hospice. As members know, Gil Paterson has taken an interest in the petition. I will give him the opportunity to comment.

At our last meeting, we asked for an update on when a meeting would take place between the Scottish Government, representatives of the health board and the hospice. I understand that that meeting has now taken place and that all parties appear to be content with the progress that is being made even if a solution has not yet been found. That is the context in which we will discuss the petition this morning.

Does Gil Paterson want to raise anything in particular to add to our consideration?

Gil Paterson (Clydebank and Milngavie) (SNP): I will highlight some points. Thank you very much for the opportunity to come here again.

The accountancy review must be undertaken sooner rather than later because there is an in-built disadvantage—I will come to that again in a moment or two. My big concern is about the joint boards. What will be the boards' notional way of deciding on the appropriate funding, remembering that each hospice is in a different place? If there is an in-built disadvantage, it will be very difficult for St Margaret's to come up with a cohesive argument for an individual joint board, so the situation must be sorted very soon.

There have been difficulties with the choice of accountancy firm. Looking at what has been presented to you, I know that it seems that we are getting somewhere, but we have not yet decided on an accountancy firm. The last time that I was at the committee, I suggested—maybe the committee will endorse this—that we use our weight of opinion to tell the Government that, if it wants to look outside Scotland for an accountancy firm, that is fine but it might be difficult. Perhaps we should suggest that a chair be put in place who would take the matter on board. We could, for example, approach a retired High Court judge who may have had some contact or contract with the Government or the health board to appoint an accountancy firm. That is just me speaking—I am not speaking on behalf of the hospice and I have not been briefed on that possibility, but I think that that might be a solution to move the matter on so that it does not get stuck.

I just went through some of the information that I gathered previously. If you will indulge me, convener, I will quote from a paper from 10 July 2015. These are the figures for the funding per bed at hospices that are all in NHS Greater Glasgow and Clyde. The figure for Accord Hospice is £159,891; the figure for Ardgowan Hospice is £153,083; I do not have a figure for the Marie Curie hospice; the figure for the Prince & Princess of Wales Hospice is £140,471 per bed; and the figure for St Vincent's Hospice comes in at £131,377. The figure for St Margaret's is £53,328.

The formula is crucial, but nobody that I have contacted, including the health board, can tell me what the formula is. The only way that we can get to the bottom of it is to have a proper review by an accountancy firm. I have posed the question, and you can clearly see that the formula is not based on the number of beds. The number of beds at the other hospices that I have mentioned is, respectively, 8, 8, 14 and 8, whereas it is 26 at St Margaret's.

The petitioner's letter says:

> "The appointment of a firm of accountants was discussed in light of the fact that many of those accountancy firms approached by St Margaret of Scotland Hospice felt unable to participate in an accountancy review due to a conflict, by having carried out work in the past for either the Scottish Government or NHSGGC."

I do not want that to block progress. If we cannot find someone, my suggestion might get round that. It is good that there is a willingness to share information. However, we are talking about public money and, if there is information on each of the hospices, it should be published. That will let the committee see the figures and make a judgment.

We are coming to the end of a parliamentary session and there might be pressure on the committee to close the petition. Before it is closed, though, we should see that the outcome of the review is published. After that, I will be content and I will not come back to the committee to ask it to keep the petition open.

The Convener: Thank you, Gil. The committee is under no pressure to close a petition because we are coming to the end of a parliamentary session. Petitions can be carried over, so that is not part of our consideration. The consideration for members is what the committee is usefully contributing to achieving an outcome. Is there anything else that we can do to allow a solution to be reached in this case?

I should also make it clear that we do not adjudicate in individual cases. It is not in our remit to do that. We are trying to identify where there might be problems that can be brought to the attention of the Scottish Government or any other authority over which the Parliament has any jurisdiction in order to improve administration, resolve wider issues or correct policy. It is about not whether the petition could be continued but whether the committee can usefully contribute to the outcome of any decision that is made. That will be a matter for the Government, the health board and the hospice.

Gil Paterson suggested that the committee could recommend that a chair be put in place or that an independent way of assessing the matter be found. I am not sure that we have the capacity to do that. We could suggest that the Government consider that, but it would not be for us to make that decision. We could do that and then not do anything else with the petition. Our final say on the petition would be that there should be some independent assessment.

Things have moved on since 2006, when the petition was first lodged, in that the Government is now committed to a review of hospice funding in its strategic framework on palliative and end-of-life care. The individual dispute over the financing of the beds at St Margaret's has not been resolved, but the overall policy and structure in which it is all taking place is clearly different from what it was when the petition was lodged. Do committee members think that there is something useful that we can contribute to resolving the situation?

12:15

Gil Paterson: I think that keeping the petition open has brought us to where we are. I fear that, if it had been closed when the Government recommended that it should be, we would not be where we are now. It would be extremely useful to keep it open for the simple, straightforward reason that the power of this committee and the regard in which it is held by the Parliament are what have got us where we are. That is what I really believe.

The Convener: I appreciate that that is your consideration. It has just been brought to my attention that the suggestion of seeking an independent arbiter or chair to draw things together has already been put to the Scottish Government by the committee. I am not sure that we got a conclusive answer, but that suggestion has already been made and it did not meet with a positive response.

We have tried the suggested option before but it has not been taken forward. However, Gil Paterson seems to believe that just keeping the petition open is making a difference. Do the members of the committee believe that that is the case?

Angus MacDonald: I certainly see the merit in Gil Paterson's request to continue to monitor the situation prior to closing the petition, with a view to keeping a watching brief and waiting for the outcome of the review of the technical accounting issue that is in dispute. However, I think that the committee has come to the end of any influence that it has on the issue. It might be worth waiting to see the outcome of the review before we consider closing the petition.

Jackson Carlaw: I pay tribute to Gil Paterson and the previous constituency member, Des McNulty, both of whom have pursued the issue and led on the petition—with the support, I hope, of other MSPs. There was undoubtedly a deeply ingrained suspicion that there was a prejudice in the health board, which then led to a mutual animosity between the parties. That meant that, although there was a working agreement previously in place, albeit in theory, nothing ever materialised from it and time continued to pass.

The committee sought to get the cabinet secretary with responsibility for health more directly involved in the issue. However, both previous cabinet secretaries who held the position after the petition was lodged were reluctant to take that direct role and very much sought to have the various parties continue to negotiate to a point. The current cabinet secretary, Shona Robison, has intervened more directly and the Scottish Government has become more directly involved. I understand Gil Paterson's point about the historical suspicion. At certain points during the progress of the petition, the fact that this committee continued to take an interest in it was politically resonant.

I am not sure what I would invite the committee to do other than simply keep the petition open on the basis that that might still be a productive thing to do. The way is open for a future petition to be lodged in the event that all of this goes pear shaped. However, it seems to me that, because the sword of Damocles that was hanging over the hospice no longer hangs there and the direct involvement of the Scottish Government that we sought is now secured, the efforts of Mr Paterson and others in relation to the future of St Margaret's have been, in many ways, successful. I am not a cheerleader for either proposition, but I find it difficult to see what I would be asking the committee to do—that is the key point.

The Convener: That is exactly my point. I should probably declare an interest in that I am the convener of the cross-party group on palliative care and want to see the advancement of the hospice movement. However, much as I want to see the matter resolved, the committee cannot get involved in an individual dispute between any given health board and a particular hospice, although we can seek to ensure that any issues that come out of that dispute are addressed by the Government.

Having looked at all the correspondence and the actions that have been taken so far, I suggest that we, as a committee, are doing nothing useful. Anything that is progressing the issue is in the hands of the parties concerned. Even Gil Paterson's suggestion is something that the committee has looked at before and tried to get on the table. To my mind, there is nothing else that the committee can usefully do at this time that would make the situation better.

As Jackson Carlaw said, if things go wrong and there is a failure to agree, the petitioners are at liberty to come back again to raise the issue. Also, given that the Scottish Government has a framework in which the totality of funding is being considered, the issues have moved on. Although there may be an individual dispute, I genuinely believe that we are at the end of the road in relation to what the committee can do.

Angus MacDonald: I bring the committee's attention to the final sentence of Shona Robison's letter of 19 January:

> "I hope to be in a position to update the Public Petitions Committee more fully soon."

An update is to come, so we should keep the petition open until that is received—unless I am told otherwise.

The Convener: The information that I have is that the action points on which the petition was raised have been progressed. Therefore, any response to a query from us would be a continuation of a discussion on the action points, and we are not progressing those action points; rather, they have been acted on.

Angus MacDonald: I see that, convener, but—

The Convener: We have closed other petitions on similar grounds. I am trying to be fair to every petitioner, not just to one. Other people out there would say that the committee closed a petition in similar circumstances, because it had usefully arrived at the end of what it could do, and they accept that even if they are disappointed. Those people might ask why we were keeping a petition open in exactly the same circumstances and not asking for anything more to be done. If nothing else, we must be consistent. Occasionally, we will leave people disappointed, but we do not necessarily help ourselves if we are inconsistent in disappointing some people and not others.

Hanzala Malik: With all respect, we have done a lot. We have gone out of our way with this petition. I recall supporting it on at least two occasions when I thought that it would be the last time that it came before us. The matter seems to be dragging on without our achieving anything other than what we have achieved already. I therefore concur with your suggestion, convener. The petition is past its sell-by date.

The Convener: Do other members have a view? Other than Angus MacDonald, who suggests that we continue the petition, everyone else believes that the petition has come to the end of the road. I do not want to divide the committee; I am trying to get a consensus. However, if we cannot get agreement, we will have to make a decision.

Angus MacDonald: I sense that I am in the minority. Reluctantly, I agree to close the petition.

John Wilson: I am in the same position as Angus MacDonald. However, I have seen the petition almost all the way through the process and there is a point at which we must say, as a committee, that we need to stop because we cannot progress it any further. We must also bear in mind the fact that the Scottish Government has committed to doing things with the hospice and the health board.

I am not asking for the petition to remain open; I am asking that, in closing the petition, we remind the petitioner that they are at liberty to lodge a new petition within the specified period and that we write to the Scottish Government, advising it that we have closed the petition but reminding it that there are certain things that it committed to undertake in conjunction with the health board and the hospice. We should state that we hope that the board that has been established by the Government recognises the issues that have been raised by St Margaret of Scotland Hospice in relation to the allocation of resources to hospices in Scotland. As you said, convener, a number of hospices might find themselves in a similar situation. I would support closing the petition if we were to ask the Government to take on board those other issues and seek assurances.

The Convener: We have closed petitions on those terms before.

Jackson Carlaw: Given the sentence in the cabinet secretary’s letter to which Angus MacDonald has referred, we might close the petition but ask the cabinet secretary whether, instead of writing to the Public Petitions Committee more fully on the progress that is taking place, she could write to the constituency member and to the regional members for West Scotland who are directly interested in the progress of the petition so that that progress could be kept alive by the political representatives in the region if not by the Public Petitions Committee.

The Convener: I see members nodding. We appear to have reached an agreement.

I offer Gil Paterson my personal thanks for the effort that he has put into supporting the petition. It is to your credit, Gil, that you have stuck so doggedly with it that we are still here, so far on, making this decision. There may still be issues that the committee will have to look at in the future, but they will have to be new issues—that is the point that we are trying to make. Nothing that the committee is actively doing at present will resolve the issue, and we have closed the petition on that basis. Nevertheless, your determination is the reason that we are still discussing it, and I thank you for that.

Gil Paterson: I am disappointed, convener. You knew that I would be disappointed. Nevertheless, it would be remiss of me to go away from here without thanking John Wilson, Jackson Carlaw and all the other members of the committee for supporting me and the petition. You have seen what is wrong and that something needs to happen, and it would be wrong of me to walk out of here and not place on record my thanks. Although I am disappointed, I really appreciate the time that has been spent considering the petition and the due diligence that you have brought to it. I thank you for that.

Alzheimer’s and Dementia Awareness (PE1480)

Social Care (Charges) (PE1533)

The Convener: The next petitions are PE1480, by Amanda Kopel, on behalf of the Frank Kopel Alzheimer’s awareness campaign, on Alzheimer’s and dementia awareness, and PE1533, by Jeff Adamson, on behalf of Scotland against the care tax, on abolition of non-residential social care charges for older and disabled people. Members have a note by the clerks and copies of the submissions. Amanda Kopel has written to the clerks to say that she would welcome clarification as to who will be responsible for administering the £6 million fund announced for local authorities to provide free personal care to those aged under 65 years, and that the objective of her petition remains the same. We could get an answer to that question and get back to the petitioner if we get a speedy response from the Government. If we can get clarification on that, we can look at it before the end of the session. Is that agreed?

Members *indicated agreement.*

Restraint and Seclusion in Schools (National Guidance) (PE1548)

The Convener: The next petition is PE1548, by Beth Morrison, on national guidance on restraint and seclusion in schools. Again, members have notes and submissions from the petitioner. If members have no comments, is it agreed that we should go back to the Government seeking an assurance that the views of the petitioner and other stakeholders are taken into account?

Jackson Carlaw: We are at a point where it is open to political parties to decide if they wish to make any specific commitment in the forthcoming election in relation to the suggestions that are being made. It is not just an issue for Government; it is an issue for the political process, too.

The Convener: That is a fair point. We will write to the Government and ask for clarification. Is that agreed?

Members *indicated agreement.*

Concessionary Travel (War Veterans) (PE1549)

12:30

The Convener: The next petition is PE1549, by Alan Clark Young, on concessionary travel passes for war veterans.

Kenny MacAskill (Edinburgh Eastern) (SNP): I think that we have reached the end of the road on this one.

The Convener: Yes, I think that we have tested this one to destruction.

David Torrance: I am quite happy to close this one, because the Government is not going to change its mind.

Hanzala Malik: I wish to support the petition on the ground that it is an important one. We recognise the physical and mental contribution that armed forces personnel make to this country. It is a good petition.

However, I am not sure how far we can take it at this point. The Government might need to explore the possibility of getting transport providers to provide the service without getting remuneration from the Government for it. Perhaps the provision of the service could be a licence condition. I know that it is not the job of the committee to suggest that, but I would be interested to hear whether the transport minister would be inclined to explore that possibility.

Kenny MacAskill: I think that, if the Government were going to do that, it would have suggested it. The negotiations that Hanzala Malik is referring to concern financial transactions, unless he is suggesting that the Government should write to private companies—and one public operator, Lothian Buses, which I should mention, as an Edinburgh resident—to ask that they provide the service voluntarily and free of charge, which would have implications for other service users. I think that the Government will have considered that issue.

Hanzala Malik: We do not know what it has considered.

The Convener: I take your point, Hanzala. I support the premise of the petition and I think that there is merit in the suggestion. However, to be honest, the reality is that we have asked the Government for its position, we have checked out alternatives and made suggestions to the Government about them, but we have not moved the situation forward. I do not know whether there is much more that we can do.

Hanzala Malik: With all due respect, I do not think that we have specifically asked the Government to consider the angle that I have raised. I think that it is worth giving it another shot to see whether the Government takes up that opportunity. If it says no, that is fine, but the fact remains that that is an unexplored avenue.

If anyone deserves to travel for free on our buses, it is the group in our population about whom we are talking. Therefore, I think that it would not be bad to pursue a plea to the Government to support the policy. I am sure that we could make this petition last another meeting.

Kenny MacAskill: We might not have specifically asked about that issue, but I am with you, convener. Throughout my tenure as a regional MSP and as a constituency MSP, my experience of asking bus companies to continue running what they view to be unprofitable routes has been fraught with failure—I am thinking about particular bus routes that are used by the elderly; a valid example is that of pensioners in Edinburgh being able to access Seafield crematorium. We have not been able to achieve success in any of those cases. We might not have heard back from the Government on the issue raised by Hanzala Malik, but my experience tells me that all the bus companies will say, “We only run commercial routes, unless you subsidise us.”

The Convener: It is the purpose of the Public Petitions Committee to try to change Government policy. However, we are not going to change Government policy on this. We have given the Government suggestions and have been told that is not going to change its policy. Hanzala, you are asking us to ask private companies to adopt the policy, and I do not think that we can do that.

Hanzala Malik: I am not asking for that at all. I am asking the Government to ask the transport providers to consider it. I do not think that that option has been considered. Many off-peak buses are half empty. There is no harm in asking the companies to consider adopting the policy, and I would be grateful if they could be asked to do so. I am asking that we suggest that the Government explore that possibility.

The Convener: Okay. Do other members have a view on that? I think that you are in a minority of one, Hanzala.

Hanzala Malik: I am quite happy to die in a ditch.

The Convener: As I have said, I do not want to take this to a vote—I always try to get a consensus.

Hanzala Malik: Convener, we tend to underestimate the sacrifices that our armed forces make around the world, and we are demanding more and more.

The Convener: I do not think that anyone is underestimating that. We have had that discussion. I think that everyone accepts the premise of the petition; our problem is that we have asked the Government to support a concessionary travel scheme, but essentially it has said no. We have given the Government other options and we have investigated what other options are available. If the only option available is to ask private companies to support a scheme, what we are doing in effect is asking the Government to fund private companies to operate a concessionary travel scheme, but it has already said no to that. Whatever way we look at it, the Government would be providing the funding. For the current concessionary travel scheme, the Government provides money to private companies to run bus services. If we widened the scope of the scheme to veterans, which I support doing, it would be the same concessionary travel scheme, but the Government has said that it is not widening it. You are therefore just asking the same question, although you are asking it in a different way.

Hanzala Malik: No, convener. I am asking for something totally different. I want the Government to ask the transport providers to provide a service free of charge. I am not asking the Government to make a payment.

The Convener: But that is how the concessionary travel scheme works.

Hanzala Malik: At the moment, yes.

The Convener: Okay.

John Wilson: There are wider issues around the concessionary travel scheme than just whether someone travels for free. For example, there are the cards and the administration behind them. There are a number of factors for the Scottish Government to consider, and there would be additional cost if it was a Scottish Government scheme. However, the Government has made it quite clear that, at the moment, it does not support adding veterans to the concessionary travel scheme.

As I said, it is not just about asking bus operators whether they will allow veterans to travel for free. Some administration behind that would have to be carried out and verified by the Scottish Government, but it has said that it is not going to do that. Like Kenny MacAskill, I have dealt with some of the bus operators and I know that they are certainly not going to say, “Right, we’re going to let these individuals travel free of charge as long as they produce a card.” If they were that magnanimous, surely they would be saying that anybody over the age of 75 or anyone with certain conditions could travel for free as well.

Every bus operator that operates the transport concessionary scheme gets a contribution towards every passenger who travels, and I doubt very much that they would allow one group of individuals to travel free of charge while the Scottish Government has to pay for everybody else to travel.

Jackson Carlaw: I am in agreement with your position on this, convener: we have asked the Government and it has said no. It is clearly open to individual members of the committee to make representations to their own political party with regard to including such a commitment in the manifesto that will be put to the electorate in the forthcoming election. However, I think that what the committee can do has now been exhausted, because we have asked the Government and it has said no.

The Convener: That is the point, Hanzala. I do not know whether you want to take the issue to a vote. David Torrance wants to make a contribution to the discussion; then I will give you the final word.

David Torrance: I am fully supportive of your stance, convener. I support the petition but, as Jackson Carlaw said, the Government said no and the petition is not going anywhere else.

Hanzala Malik: I take on board what very experienced members are saying, but I feel quite strongly about the issue. I suggest that the Government might want to speak to the armed forces to see whether their charities want to engage with it to take the petition forward. I think that there is still an opportunity to do that.

Is this the final meeting of the committee this session?

The Convener: No. Our final meeting is on 8 March.

Hanzala Malik: I do not see what damage it would do if we took one final opportunity to write to the Government to find out whether it would be prepared to speak to the armed forces to establish whether they would be willing to come on board and engage with it to take forward the proposal. If the Government and the armed forces are not willing to take it forward, I will accept that.

The Convener: I have to say that I think that that would just be a futile gesture, and I do not think that the committee is into doing that kind of thing. Sometimes we leave petitioners disappointed, and I am sure that Alan Clark Young will be disappointed that he has not got the outcome that he wanted to get.

Hanzala Malik: As a compromise, could I suggest that we write to the petitioner to say that he might want to engage with the armed forces to see whether—

The Convener: I think that we do that type of thing: we make petitioners aware of our conclusions. In this case, the conclusion is that we have tried our best, the Government has made clear its position and we cannot get the solution that the petitioner seeks. On that basis, we must close the petition, and that is my suggestion to the committee.

Hanzala Malik: Could I suggest that we add a small paragraph to the letter that we write to the petitioner to say that, if he wishes to engage with the armed forces to find out whether they are willing to engage with the Government to take forward his case, that might be an avenue and a different angle for him to pursue?

The Convener: I suggest that you write to the petitioner to encourage him to do that.

Hanzala Malik: If you send me all the details, I will do that. Thank you.

The Convener: So, we agree to close the petition.

You went down fighting, Hanzala; the armed forces would be proud of you.

Child Abuse (Mandatory Reporting) (PE1551)

The Convener: Our next petition is PE1551, by Scott Pattinson, on mandatory reporting of child abuse. Members have a note from the clerk and the submissions that have been received. I invite comments from members. There might be a bit of distance to go on this one.

David Torrance: Given that the UK Government has not yet launched its consultation on the issue, we should keep the petition open, so that we can find out what responses are made to the consultation.

Angus MacDonald: I agree.

John Wilson: I think that the petition will be one of those in our legacy paper, because the UK Government does not expect to report until September 2016. There is no point in the committee considering it further until the next session of Parliament.

The Convener: That is fine—that is a valid point. We will continue the petition and include it in our legacy paper.

Disabled-friendly Housing (PE1554)

The Convener: Petition PE1554, by Jacq Kelly on behalf of Leonard Cheshire Disability, is on improving the provision of disabled-friendly housing.

Kenny MacAskill: I think that we have reached the end of the road with this one.

The Convener: Yes, I think that we have taken it as far as we can.

Angus MacDonald: It is unfortunate, because I felt at the time that the petition had some merit, but given that there is a lack of support from stakeholders, I do not think that we have any option other than to close it.

The Convener: I am surprised, but I think that that is the reality of the situation. If we cannot get support from those who are involved in the area, there is not much that we can do to take forward the petition.

We will close the petition.

American Signal Crayfish (Trapping) (PE1558)

The Convener: The next petition is PE1558, by John Thom, on behalf of the RNBCC Crayfish Committee, Ken-Dee catchment, on the American signal crayfish. Members have had some additional papers on the petition, so they are fully briefed on it. Is there anything that we can do with the petition? I hear mutterings.

Jackson Carlaw: I am with Mary Berry. I watched “Mary Berry’s Foolproof Cooking” last night, and American signal crayfish were a specific item on the programme. She invoked the nation to catch and eat American signal crayfish. I think that she is right and I defy the committee to stand against the wisdom of Mary Berry on the issue.

I feel that the weight of officialdom is against the proposal in the petition, so—Mary Berry’s intervention notwithstanding—there is probably nothing more that we can do, although I am deeply unpersuaded. We are being asked by officialdom not to pursue a petition—officialdom has suggested no effective measure to resolve the issue that the petition seeks to address.

I feel deeply frustrated, because I can see that the petition is not going to proceed but I suspect that, in another five years, the issue will be just as alive as it is today. Notwithstanding officialdom and any action that we might take today, I encourage the nation to follow Mary Berry’s advice, catch the signal crayfish and enjoy consuming them.

12:45

The Convener: I know that politicians do not like to be seen to be out of touch with the public. I have heard of Mary Berry, but I have absolutely no idea which television programme you are referring to.

Jackson Carlaw: Signal crayfish are obviously not part of your normal diet, convener, and you perhaps do not need the advice of Mary Berry in "Mary Berry's Foolproof Cooking", such are your culinary skills. Nevertheless, I think that the nation takes its cue from her expertise and advice.

Angus MacDonald: Perhaps we should follow our Nordic cousins and have crayfish parties in the summer.

I take on board the advice that we have received that commercial trapping could result in adverse effects such as an increase in crayfish numbers or their presence in areas where they do not live just now. I think that we need to close the petition. In doing so, we should acknowledge the work that the Scottish Parliament information centre has done on the issue, as we have had some good papers on it that have been extremely helpful.

John Wilson: We have received some good information, and the petition has highlighted an issue that is a problem in many tributaries, including the pond in Coatbridge. I was surprised to hear that signal crayfish have migrated there.

In closing the petition, we need to make the Scottish Environment Protection Agency and other agencies aware that the issue must be monitored. SEPA's response to the committee refers to the European Union's regulation on the keeping, sale and use of signal crayfish. However, when SEPA gave evidence to the committee, I was concerned that it does not seem to have any solutions at all apart from allowing the American signal crayfish population free rein to continue to grow to the detriment of every other thing in the ecosystem.

In closing the petition, we must make the agencies and the petitioner aware that a future committee may be interested in monitoring the expansion or depletion of the population of American signal crayfish. It is very worrying that our environment protection agency seems to be throwing its hands up, saying that there is nothing that it can do about the situation and not allowing anybody else to do anything about it. That may result in a major detriment. The salmon season opened just last week, and great play is made of the amount of money that salmon fishing brings into the economy. If we allow the population of American signal crayfish to continue to grow as it is doing, we will not have a salmon industry or a trout industry. In fact, most of the rivers and streams in Scotland that are currently populated with salmon and trout will become devoid of anything but American signal crayfish.

I reluctantly agree to close the petition, but I think that we need to make SEPA, the Scottish Government and others aware that they need to keep monitoring the situation so that, in the near future, we can get a solution to the problem.

The Convener: We will close the petition, but we take on board John Wilson's points and we will write to those organisations to make them aware of the issues that have arisen in our consideration of the petition.

Sewage Sludge (PE1563)

The Convener: The next petition is PE1563, by Doreen Goldie, on behalf of Avonbridge and Standburn community council, on sewage sludge spreading. Members have information on the petition.

Angus MacDonald: I thank the petitioners for bringing the issue to the committee's attention. As the local member, the issue was on my radar, and I have been lobbying the Government for some time, as has our colleague on the Tory benches Margaret Mitchell. There is no doubt in my mind that the petitioners' tenacity helped to ensure that the Scottish Government undertook a review of sewage sludge spreading in the first place. I also acknowledge the proactive stance of Scottish Water and SEPA. Through their actions, they have helped to limit the inconvenience and distress experienced by my constituents in the Upper Braes area.

The Scottish Government's review has a number of excellent recommendations, including a fit-and-proper-persons test for anyone holding an operator's licence; tighter regulation, which is overdue; tighter monitoring of operator practice by SEPA, and it being allowed to intervene where necessary; and the problem of waste mobile plant licensing being addressed, which I am particularly pleased to see. That is a result for the petitioners, the committee, SEPA and Scottish Water, as well as for the Scottish Government. I look forward to the legislation being updated sooner rather than later.

We should keep the petition open and ask for the petitioners' views on the review. I know for a fact that they have views. The committee should listen to them and feed them back to the Government, although I understand that the petitioners will be feeding back directly to the Government. I recently held a multi-agency meeting, and so I know that the petitioners have been given direct access to the Government, which they will use.

John Wilson: I support Angus MacDonald's comments on the work of the petitioners. Although the review is useful and its recommendations will be extremely useful for organisations, we must tease out other issues relating to the consultation process and particularly with communities. Although a local community council has progressed the issue, a number of communities that may not be automatically represented by a community council are affected by the spreading of sewage sludge. There must be clearer guidance on how the Government will make the public aware of the reporting mechanisms that will be in place and to whom to report. An issue that came up in our evidence was that people were going to the environmental health services in Falkirk only to be told to speak to Scottish Natural Heritage or Scottish Water. The review has gone some way to addressing those issues.

The review says:

> "an updated version of this study should be commissioned as soon as possible, and published by winter 2016."

Can the review be carried out more quickly? Given that we are in February and one of the biggest problems of sewage sludge spreading is during the summer months, working to that timescale might mean that communities have to put up with the situation for another summer. Can we not have the commissioned work carried out more quickly, so that they can have a solution sooner?

I was also surprised that the review made reference to there being only one site in Shetland for the dumping of sewage sludge. My understanding is that such dumping is taking place in other areas. We should tease out from SEPA or Scottish Water what is happening and ask for guarantees that illegal dumping will be dealt with appropriately. It is fine to have licensed sites, but unlicensed dumping must be resolved. We need to have in place a proper process so that the public can report dumping and so that we have assurances that, when an issue is reported, the appropriate action will be taken and the individuals or companies carrying out the dumping will be dealt with.

The Convener: As John Wilson and Angus MacDonald have highlighted, there are still a lot of issues to be addressed. It is entirely legitimate to pursue the matter in the way that they have set out. Do members agree to keep the petition open?

Members *indicated agreement.*

National Service Delivery Model (Warfarin Patients) (PE1566)

The Convener: Our next petition is PE1566, by Mary Hemphill and Ian Reid, on a national service delivery model for warfarin patients. Do members have a view on this one?

If not, I suggest that we close the petition, given that we have taken it as far as it will go and there have been some developments in relation to what the petitioner is requesting. Do members agree?

Members *indicated agreement.*

Scottish Red Ensign (PE1569)

The Convener: Our next petition is PE1569, by George McKenzie, on the reintroduction of the Scottish red ensign.

Kenny MacAskill: We have reached the end of the road on this one.

The Convener: Yes—it has been given a good airing.

Jackson Carlaw: I agree. I express disappointment at the Scottish Government's timidity in taking forward Scotland's interest in this respect, although I wish to remain under the United Kingdom umbrella with regard to the ensign that we fly. However, it appears that, as the Government has said that it does not wish to pursue the matter, we have no option but to close the petition.

The Convener: I knew that I was going to open a can of worms—thank you, Jackson. Angus MacDonald can go next, followed by Hanzala Malik.

Angus MacDonald: I will keep it brief, convener. It might be worth suggesting to the petitioner that he could bring the issue to the attention of the Secretary of State for Scotland directly if he wishes to pursue it.

The Convener: We can write to him and make that point.

Hanzala Malik: I, too, am very disappointed. There are countries that some would argue do not even have a navy but that still have their own flag, and yet that is not the case in Scotland. Shipping and boating people—particularly those who do it as a hobby—who would be proud to fly their own flag have been denied the chance, simply because the Scottish Government is not interested in pursuing the matter. I like the idea of writing to the secretary of state to see whether he is willing to do anything with it. However, the petitioner should perhaps be advised that there are other avenues open to him to take the matter forward.

The Government may feel that there are more important things to do than pursue this issue, but I think that it is very important. A lot of people will genuinely feel deeply disappointed, and I suggest that they look at ways of bringing the issue back as a new petition.

The Convener: As I said, we can write to the petitioner and advise him of the committee's thoughts in that regard, including the views of Jackson Carlaw and Hanzala Malik. It may be a matter for a future petition, but we need to close this one. Are members agreed?

Members *indicated agreement.*

Child Contact (Parental Rights) (PE1570)

Post-separation Child Contact and Financial Provision (PE1589)

The Convener: We will take the next two petitions together. They are PE1570, by Alan Lee, on parental rights to child contact, and PE1589, by Stewart Currie, on an independent review of child contact and financial provision post separation.

The suggestion is that we write to the minister with the committee's views on issues for inclusion in the family justice modernisation strategy. If the committee agrees to do so, we could send a letter based on the issues that are highlighted in the petition and wait to see whether the minister writes back.

Kenny MacAskill: I can see where that suggestion is coming from, but I can also see great difficulties there. We have not taken evidence from Scottish Women's Aid, for example, which might very well have a view on the issue given the harassment that can follow in a minority of cases. Considerable issues have been raised, and I am aware of those as an MSP and previously as an agent in some heart-rending cases. However, I do not know that we have gathered sufficient evidence to say anything other than that there is an on-going issue. Beyond that, to come down on one side or the other without having taken evidence from Scottish Women's Aid and Mairead Tagg, among others, where there could be implications around domestic abuse, would not—

The Convener: I am not sure that we would be taking a view for or against the petition itself. We would say that the petition has raised a few issues—

Kenny MacAskill: I am comfortable with that, then.

The Convener: The Government is carrying out a review, and I am sure that the organisations that you mention will have the opportunity to make a contribution. We are simply saying, "We've heard evidence on the two petitions and highlighted the issues that came up—it's over to you." Is that okay?

Kenny MacAskill: I am fine with that.

Members *indicated agreement.*

Food Banks (Funding) (PE1571)

The Convener: The next petition is PE1571, by John Beattie, on food bank funding. We might just seek clarification on when we expect to see the social justice action plan, to which we referred when the petition was first submitted. We could ask for a response on the date—I do not think that we will get the outcome that the petitioner seeks but, if we can get clarification on when we will see the action plan, that might help the petitioner to see what might be coming further down the road. We can look at the petition again in a couple of weeks.

Members *indicated agreement.*

Scottish Vaccine and Immunisation Advisory Committee (PE1584)

The Convener: The final continued petition today is PE1584, by Angus Files, on a new Scottish vaccine and immunisation advisory committee. Do members have a view on the petition?

John Wilson: Although I have a lot of sympathy with the petitioner, it is clear that no one else is listening and no one will take any further action, so we have no option other than to close the petition.

The Convener: Yes—it is clear what everyone else's views are, and we know what Mr Files's view is, so we will not make any progress on the matter. We will close the petition.

Members *indicated agreement.*

The Convener: As we agreed earlier, we will take items 5 and 6 in private.

13:01

Meeting continued in private until 13:11.

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