



OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 12 September 2019

Session 5



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Pàrlamaid na h-Alba

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CONTENTS

	Col.
INTERESTS	1
NEW PETITIONS	2
Primary Hyperparathyroidism (PE1726).....	2
Crime (Duty to Report) (PE1727)	3
Crime (False Allegations) (PE1728).....	5
CONTINUED PETITIONS	7
Social Care (Charges) (PE1533).....	7
Scottish Legal Complaints Commission (Review) (PE1660)	9
Legal Profession (Regulation) (PE1661).....	9
Community Hospital and Council Care Home Services (PE1710).....	12
Interstitial Lung Disease and Home Management (PE1714)	15
Tick-borne Diseases (Treatment) (PE1662).....	17

PUBLIC PETITIONS COMMITTEE
15th Meeting 2019, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Gail Ross (Caithness, Sutherland and Ross) (SNP)

COMMITTEE MEMBERS

*Maurice Corry (West Scotland) (Con)

*David Torrance (Kirkcaldy) (SNP)

*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)

Tim Baynes (Scottish Land & Estates)

Alexander Burnett (Aberdeenshire West) (Con)

Donald Fraser (Scottish Natural Heritage)

Dr Sally Mavin (Scottish Microbiology Reference Laboratory)

Kathleen Robertson (British Veterinary Association)

Rupert Shaw MBE (NFU Scotland)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Public Petitions Committee

Thursday 12 September 2019

[The Convener opened the meeting at 09:17]

Interests

The Convener (Johann Lamont): Welcome to the 15th meeting in 2019 of the Public Petitions Committee. I welcome our new—or, perhaps more accurately, returning—committee member, Maurice Corry MSP. Maurice previously sat on the committee and is replacing Rachael Hamilton. I put on record my thanks to Rachael for her work on the committee in contributing to the important discussions around petitions. I wish her well in her new committee role.

I invite Maurice Corry to declare any relevant interests.

Maurice Corry (West Scotland) (Con): Thank you, convener. I look forward to being back on the committee.

I have no interests to declare.

New Petitions

Primary Hyperparathyroidism (PE1726)

09:18

The Convener: Agenda item 2 is consideration of new petitions. The first new petition for consideration is PE1726, on primary hyperparathyroidism, which was lodged by Fiona Killen. The petition calls on the Scottish Parliament to urge the Scottish Government to raise awareness, particularly among general practitioners and other medical practitioners, of the symptoms, diagnosis and effective treatment of primary hyperparathyroidism caused by adenoma; to provide access to minimally invasive surgery in Scotland for the treatment of the condition; and to provide funding for research into PHPT caused by adenoma.

In May 2019, the National Institute for Health and Care Excellence published guidance on the condition, which aims to improve its recognition and treatment, reduce long-term complications and improve quality of life. The guidance recognises that primary hyperparathyroidism is an underrecognised condition among the general population and healthcare professionals.

In a debate on thyroid and adrenal testing, diagnosis and treatment in December 2018, the Minister for Public Health, Sport and Wellbeing, Joe FitzPatrick MSP, stated that the deputy chief medical officer had met with NHS Education for Scotland to discuss the development of a learning module for GPs that would set out helpful steps to diagnosis and pathways of care.

Do members have any comments or suggestions for action?

Brian Whittle (South Scotland) (Con): This is another petition that asks for education of GPs on a condition. We have had quite a few such petitions. In the first instance, we should write to the Scottish Government to seek its view on whether the petition should be taken forward.

The Convener: I have never heard of the condition, despite the fact that we have done a lot of work on thyroid issues—I do not even know whether those are connected issues. There is a theme of people having a debilitating condition who see that there are things that could be done to help, but there is a sense that people do not know what the condition is, so perhaps people do not get a diagnosis early enough, which might have consequences. I was struck by that point. It looks as if some quite practical things could be done in that regard.

The petition raises a broader question about the extent to which GPs, who we know are busy, are properly supported to keep up to date with diagnoses and conditions. That is another area for exploration in itself.

I think that we agree to write to the Scottish Government. Is there anything else that we could do? We might also want to contact other key stakeholders. The petitioner has suggested that we contact Hyperparathyroid UK Action4Change and our paper suggests that we may wish to contact the Royal College of General Practitioners, the Society for Endocrinology and Hypopara UK. We may get a sense of where their expertise lies and the extent to which they recognise the issue. Is that agreed?

Members *indicated agreement.*

The Convener: We will seek those views. When we receive comments, the petitioner will be able to respond to them. We are grateful that she contacted us to give us suggestions of people to contact.

Crime (Duty to Report) (PE1727)

The Convener: The next new petition for consideration is PE1727, on reporting crime in Scotland, which was lodged by Frances Nixon. The petition calls on the Scottish Parliament to urge the Scottish Government to introduce legislation that would ensure that all citizens in Scotland have a legal duty to report any crime that they have witnessed. With some exceptions, there is currently no blanket legal duty imposed on individuals or other bodies to report a crime that they have witnessed or that they suspect has taken place.

The paper for the petition outlines various reasons why the aim of the petition could be problematic. For example, the reporting of domestic abuse cases could be difficult, due to victims perhaps feeling unable or fearful to report that crime. From the perspective of authorities that are tasked with investigating crime, mandatory reporting of less serious criminal behaviour such as littering could lead to a strain on resources and divert resources from investigating more serious crimes.

Do members have any comments or suggestions for action?

Brian Whittle: It is an interesting petition. Every day is a school day for me, because I thought that people had to report crimes, which shows that I do not know much. I totally understand from the paper how difficult the proposal is, especially with things such as domestic abuse, which you mentioned, convener. However, the situation of

people not reporting a crime where harm happens to others is an interesting area to explore.

I would like us to write to some of the stakeholders. Perhaps we could write to the Law Society of Scotland, the Crown Office and the Scottish Law Commission, because the replies could be interesting.

The Convener: We should write to the Scottish Government. A strong case has been made as to why the proposal would be problematic. I am not sure that we should write as broadly as you suggest, but we could ask, "If not this, then what?" That would be a matter for another petition.

I agree that the petitioner's motives are interesting and thought provoking. The committee has in the past dealt with the idea of mandatory reporting where there is a suspicion of child abuse, and we recognised that there was a difficulty with that. The petitioner talks about our sense of responsibility as citizens not to walk by on the other side, which is challenging. However, could the system cope with creating a crime of not reporting crime? I do not know the law particularly well, but in some areas there is an idea that someone can be an accomplice in some way if they have colluded with something, although that is maybe a different area.

Maurice Corry: It is a difficult one. As the paper points out, the proposal could take up more police time with investigations and, therefore, something more serious could slip through the net. We have to be careful about that balance. It is important to talk to the Crown Office and Procurator Fiscal Service to see what it feels, because it is at the front line and it handles whether cases should go forward. We should certainly have a chat with it.

Brian Whittle: We could at least get the views of the Scottish Government.

Gail Ross (Caithness, Sutherland and Ross) (SNP): I agree. It is a difficult area.

The Convener: We could ask the Scottish Government how it responds to what is behind the petition, rather than the practical solution that is proposed. We could ask how the Government encourages the idea of the responsibility of citizens around crime prevention.

Gail Ross: Absolutely. We need to be clear on what the law is at the moment. As Brian Whittle said, he was under the impression that it is obligatory to report crimes. We need to be clear on what the law is before considering whether it could be changed.

The Convener: There are a number of things that can be progressed. Once we have had submissions, the petitioner will have an opportunity to respond to them.

Crime (False Allegations) (PE1728)

The Convener: The final new petition for consideration today is PE1728, on making false allegations a hate crime, which was also lodged by Frances Nixon. The petition calls on the Scottish Parliament to urge the Scottish Government to consider legislation to ensure that false allegations are considered as a hate crime and are dealt with as such in law. Our paper on the petition provides a recent definition of hate crime in Scotland, which is that it is offences

“which adhere to the principle that crimes motivated by hatred or prejudice towards particular features of the victim’s identity should be treated differently from ordinary crimes”.

Under that definition, a false accusation of criminal behaviour could amount to a hate crime if it is motivated as described.

The paper goes on to explain protected characteristics that would fall under the protection of hate crime legislation, which include race, religion, disability, sexual orientation and transgender identity. Current criminal offences relating to false allegations of criminal behaviour include false reporting, false accusation, perjury and defamation.

In recent correspondence with the clerks, the petitioner explains that this petition and her previous petition, PE1727, are a direct result of what she has endured. The petitioner indicates that she wants to turn a negative experience into a positive one by raising her concerns to the attention of Parliament, Police Scotland and the public in order to “inform, provoke thought” and

“change minds and certain aspects of Scottish Law.”

Do members have any comments or suggestions for action?

Brian Whittle: This is another really interesting petition. I am struck by the idea that, if someone is in a trial and wilfully gives false evidence, that is a criminal offence—it is perjury. I understand completely where the petitioner is coming from but, frankly, I am not sure what we do. I would again like to get the Scottish Government’s response in the first instance. The petition opens up a whole train of thought. I have a certain amount of respect for what the petitioner is trying to do.

09:30

Gail Ross: The Scottish Government is currently working up new hate crime legislation so, in the first instance, we need to write to it to ask whether it has considered the issue or if it would consider it.

The Convener: It is not the case that false allegations are never taken seriously. There are examples in which people making false allegations are breaking the law, and that has been broken down effectively for us. The issue is whether that is sufficient to cover all aspects of whether the proposal would assist in any way.

We are minded to write to the Scottish Government. Perhaps we could cover the petitioner’s two petitions in one piece of correspondence, because they are clearly related—they wrestle with an issue that many people have dealt with in their experience of the criminal justice system. We will write to the Government to ask for its reaction to the suggestion in the petition and what it is doing on the issue. We will also ask the Government to comment on the broader issues that underpin the petition. Is that agreed?

Members indicated agreement.

Continued Petitions

Social Care (Charges) (PE1533)

09:31

The Convener: Agenda item 3 is consideration of continued petitions. The first continued petition for consideration today is PE1533, on the abolition of non-residential social care charges for older and disabled people, which was lodged by Jeff Adamson on behalf of the Scotland against the care tax campaign. I welcome Jackie Baillie MSP for consideration of the petition.

The petition was last considered in May 2019, when we agreed to write to the Scottish Government to request further information on data that is used to support its calculations on the extension of free personal care. The committee also requested views on the possibility of the Scottish Government and the Convention of Scottish Local Authorities conducting a joint review of social care charging policy.

Submissions received from COSLA and the Scottish Government highlight the launch of a national programme to support local reform of adult social care, which took place in June this year. The reform programme will have a specific focus on exploring the cost of care and support and how it is paid for. The Scottish Government's submission invites members of Scotland against the care tax to take part in the reform process.

In his most recent submission, the petitioner maintains the view that there remain a number of concerns relating to the extension of free personal care. He reiterates to the committee that Scotland against the care tax is opposed to all charges for social care to help people to live in their own homes and participate in the community as equal citizens.

I invite Jackie Baillie to make an initial contribution, which might inform our thinking.

Jackie Baillie (Dumbarton) (Lab): I thank the committee for listening to what I have to say. What is clear from the submission of Scotland against the care tax is that the landscape is confusing because the Scottish Government and COSLA have decided to adopt a piecemeal approach to this issue. Let me illustrate that with examples from my own constituency. There is Frank's law funding, which is welcomed by all, but it is being used to cover budget shortages in other areas and it is not finding its way to the intended purpose.

The second example that I would give is double charging for the same service by a local authority simply because the person that is being charged is also in receipt of the independent living allowance.

In that case, there was a blurring of charging boundaries. Suddenly, what was acknowledged as personal support became non-personal support in order that those people could be charged.

Then there are examples of, quite bizarrely, charging for respite care. That case and the one that I gave you before are contrary to the legislation as it stands now. The local authorities are finding that following what the Scottish Government is doing even in a piecemeal way is causing them challenges. I think that it would be simpler, more efficient and fairer if the charges were removed.

I have enormous sympathy for local authorities. I know that they are charging rather than cutting services but we have now reached the tipping point at which the charges are causing vulnerable people to cancel services because they cannot afford them anymore. Therefore, at this point, my sympathy is very much with the petitioner. I think that it is time for a root-and-branch review of social care charging.

The Convener: Thank you. Do members have any comments?

Brian Whittle: I am with Jackie Baillie on this and I have huge sympathy for the petitioner. We are looking into this issue in the Health and Sport Committee in quite a bit of detail. I suggest that we write to the Health and Sport Committee and inform it of the work that this committee has done on the petition. That would certainly add weight to the investigation that the Health and Sport Committee is doing.

The Convener: Three things struck me. I think that it would be useful to refer the petition to the Health and Sport Committee formally so it has to take into account all the work that has been done on the issue. A good policy intention, which was responding to Frank's law and this petition, has resulted in money not going into the pockets of people in the way that we would have expected it to.

There is so much detail in the submission about unintended or perverse consequences and about the outcomes being not directed from policy to purpose. It makes the point that there is a figure for the level of cost of administering the system. As the petitioner says, it makes the case that the cost of running the system is hugely expensive. I have always found quite compelling the argument that the purpose of the support is to enable people to participate on a level playing field, but they end up being charged for something that, in other circumstances, they would not have been charged for.

The last point that I would make is that I am troubled by the suggestion in the submission that people are actively choosing not to get the care

they require. Although the policy intention is to support people at home, the charging policy means they are not getting the support that keeps them at home, and that has consequences. I am quite persuaded by the argument that we should not just inform the Health and Sport Committee of the work that has been done on the petition but that we should send it to that committee and say, "This is a live petition with really important information and we want you to respond to that".

The other thing that I thought was welcome was that the Government said that it would want to engage with the campaign and have it involved in any policy development.

Gail Ross: Given that I am new to the committee, this is the first time that I have seen the petition. I was quite shocked at a lot of the stuff that it contained, and also by the evidence from Jackie Baillie. I think that Brian Whittle is absolutely right: if the Health and Sport Committee is doing something on this, that is the right place for the petition to go.

The Convener: Are there any other views?

Maurice Corry: I agree that the petition should go to the Health and Sport Committee.

The Convener: In that case, we agree to refer the petition to the Health and Sport Committee under standing order rule 15.6.2. We thank the petitioners for doing the heavy lifting on this. I do not necessarily think that we will be able to find solutions, but we recognise the scale of the challenge in doing so. The way in which the information is laid out will be helpful to the Health and Sport Committee in the work that it does.

We thank the petitioners for their engagement with the Public Petitions Committee. If, at any point in the future, they wish to bring a petition to the committee again, they may do so. I thank Jackie Baillie for her attendance today.

Scottish Legal Complaints Commission (Review) (PE1660)

Legal Profession (Regulation) (PE1661)

The Convener: The next continued petitions are PE1660, on a Scottish Legal Complaints Commission review, by Bill Tait; and PE1661, on reform of regulation of the legal profession in Scotland, by Melanie Collins. Members will recall that we previously agreed to join the petitions together for future consideration on the basis that they raise similar issues.

At our last consideration of the petitions, we agreed to defer further consideration of the petitions until the findings of the independent review of the regulation of legal services had been published. Although the review findings were

published in October last year, the Scottish Government only provided its response to the recommendations of the review towards the end of June this year, meaning we have not had the opportunity to fully consider the petitions again until now.

The primary recommendation of the review is that

"there should be a single regulator for all providers of legal services in Scotland. It should be independent of both government and those it regulates."

In response, the Minister for Community Safety and Legal Affairs explains that views on that recommendation are "polarised". The Scottish Government intends to issue a public consultation to inform the development of a new statutory framework for a regulatory system for Scotland

"with a view to introducing a legal services bill to Parliament to bring about necessary changes to primary legislation."

The petitioners have provided their written views in relation to the independent review, expressing their disappointment that the review did not engage with consumers directly. Members have also been provided with a number of written submissions in hard copy from people with direct experience of the issues that are raised in the petitions.

Do members have any comments or suggestions for action?

Brian Whittle: I have sympathy with the petitions, because I have a couple of constituency cases that relate to the idea that complaints about the legal profession in Scotland are quite problematic. In my experience, they are quite difficult and quite unwieldy. However, I am trying to work out what we can do with the petitions, given the Government's current position and the fact that it is doing an independent review. I am not quite sure how we can take the issues forward. I have real sympathy for the petitioners, as I have had experience of trying to navigate this system. However, it is incumbent on us to think about what we can deliver in relation to petitions, and I am struggling with that in the case of these ones.

The Convener: I am sure that the petitioners were looking for the implementation of the primary recommendation of the review, which was that there should be a single regulator for all providers of legal services in Scotland that is independent of Government and those that it regulates. There is a separate issue about the extent to which they felt that consumers were engaged, and we could certainly draw that to the attention of the Government.

The challenge for Government is how it implements that recommendation in a way that people can have confidence in. Of course, if you

are somebody who has had a bad experience of a service, the question of how you can build up any kind of confidence and trust in it is challenging. We recognise that and we have seen that in some of the other correspondence that we have received, but we have to think about the extent to which we can take the matter any further forward. I think that the issue will be about how that recommendation is implemented.

Brian Whittle: Would it be reasonable to bring the concerns of the petitioners to the attention of the Minister for Community Safety and Legal Affairs?

The Convener: Yes. My sense is that this committee has reached the point where there has been a recommendation, which is what these petitioners are looking for. The question will be how it is implemented, and there are concerns about various issues in that regard. We could draw the concerns of the petitioners to the attention of the Minister for Community Safety and Legal Affairs so that they can inform any public consultation on what that new framework would be.

My sense is that, having reached that point, we should close the petitions. If the petitioners are not satisfied with how the issue is progressed, they are entitled to bring a petition back within an appropriate period. In that sense, if things do not work out, the petitioners would be able to return to the committee.

Do we agree to draw the petitioners' concerns to the attention of the Minister for Community Safety and Legal Affairs to ensure that the public consultation that will be progressed is informed by those concerns, and to close the petition under rule 15.7 of standing orders on the basis that the Scottish Government is taking action to address the recommendations of the independent review?

Members indicated agreement.

The Convener: As I said, we wish to highlight to the petitioners the opportunity to respond to the future public consultation on the new statutory framework for a legal services regulatory system when it is issued. Of course, it is open to petitioners to bring back a petition at a later stage if they feel that the matter is not being progressed.

In closing the petition, I thank the petitioners for bringing the issue to the attention of the committee and for the work that they have done in relation to this matter. We can see that there has been a response to that through the independent review, and we appreciate the extent to which the petitioners have brought information to inform our thinking as we have considered the petition.

Community Hospital and Council Care Home Services (PE1710)

09:45

The Convener: The next continued petition for consideration is PE1710, by Edward Archer, on community hospital and council care home services in Scotland, which was last considered in December 2018. At that meeting, we agreed to write to the Scottish Government for its views on the action that is called for in the petition.

In its submission, the Scottish Government highlights that the responsibility for community hospitals and care homes now sits with integration authorities. The Scottish Government also explains that it encourages

“all health and social care professionals to take a ‘Home First’ approach to assessing and providing care for people.”

In his response, the petitioner states that integrated services

“cannot deliver the necessary care in order for people with major health issues to live in safety and decency at home.”

He goes on to highlight the important role that community hospitals and care homes can play in the care landscape.

Do members have any comments or suggestions for action?

Maurice Corry: Having been the chair of an integration joint board in Argyll and Bute, I fully understand where this person is coming from. There are fundamental issues in the way that the IJB is set up. It has NHS terms and conditions for staff and it has the council office's terms and conditions for its staff, and it is trying to put the two together. Fundamentally, there needs to be a root-and-branch look at that.

There is a review of integration joint boards coming up shortly, which might catch some of this business. At the moment, most local authorities are running at a deficit on these boards, which is where the problem is coming from, because there is a bit of a shortening of time with the patient at home. It might be 31 minutes or 21 minutes—the time varies around the country.

I think that we should write to the integration joint boards or even the health secretary, because there are some fundamental issues here that need to be considered. The product of what is happening is what the petitioner describes. The problem is solvable but it needs some thinking outside the box.

Brian Whittle: There is a huge amount of work being done now by the Health and Sport Committee, which is looking at IJBs. In fact, we have had nearly every single one of them attend the Health and Sport Committee to give evidence

on exactly what Maurice Corry is talking about. A report on where we think the IJBs are is probably not that far away. I think that Maurice Corry is right, but there is significant work already being done by another committee on that particular topic.

I would be quite enthusiastic about asking the Scottish Government to engage directly with the petitioners on the issue, specifically around the respiratory care action plan. It would be to the benefit of both parties if that happened. Quite honestly, I cannot think of anything apart from that that we could currently do with the petition.

The Convener: What is really interesting about community hospitals being an important resource in more rural and remote communities is that they can be used for respite care and that kind of support.

Another thing that troubles me a bit is that, although I get the fact that people want to stay at home, if people are staying at home without sufficient care, they are not being sustained there—they are just being contained in their homes. To me, the petitioner is saying that there is enough resource in a care setting—there are other people who can keep an eye on them. We will all have examples. Care packages are inadequate: think how isolated someone can be if somebody is coming in only in the morning and then again in the evening.

I worry that people end up in a policy straitjacket that says, “We have decided it is home care” when, as we heard from an earlier petitioner, the care package that is wrapped around people is not necessarily sufficient. Are we pushing away other options? Nobody wants institutional care unless it is necessary, but is there something that the community hospital or care home services could offer? We are saying that we cannot have that because we want people to be at home, but we are not willing the means for that policy to be delivered.

Gail Ross: It is such a sensitive issue that deciding on a preferred option for the whole of society carries with it quite a lot of danger. The family should decide whether they want services delivered at home, in a community hospital or in a care home. Someone’s access to services can also depend on where they live. It should not be like that either.

I think that what the Health and Sport Committee is doing will feed into this, but you are right to say that it is not about the makeup of the IJBs or how they perform; it is about the services that are available to people. The first recommendation is that we write to the IJBs and COSLA to see what the situation is from area to area and from region to region. We need to know

how those decisions are made, so I would go with that suggestion and write to both of those bodies.

The Convener: I agree with Gail Ross. The logical place for the petition to go eventually is the Health and Sport Committee. However, I would like the petitioner to have the opportunity to respond to the very specific question about community hospitals and council care homes before we send it to that committee. I do not want to misrepresent to the petitioner what we can do, but, at least when we refer the petition to the Health and Sport Committee, that further bit of information and response will be there.

We should write to the integration joint boards, as Gail Ross suggested, to COSLA and to the Scottish Government about home care being a spectrum rather than its being only one thing instead of another. You are absolutely right that other services should be on offer. Once we have got those responses and the petitioners have responded, we will want to make sure that the issue is part of the Health and Sport Committee’s work.

Gail Ross: Can I make a quick follow-up point on that? In the Highland Council area, we have taken a different approach and we are using a lead agency model, so the national health service would cover that instead of an IJB.

Maurice Corry: In Argyll and Bute, we take the opposite route, although we are within the NHS Highland area. Again, I am speaking from my experience. One of the biggest problems I had was with step-up, step-down care. The convalescent care home strategy was removed some years ago, and that really is where the void is—that is where the problems lies. We are bed blocking because people do not have the right care package in place. Also, the families might not have power of attorney, court protection orders and things like that in place; therefore, the people are held in hospitals. There is no provision in between.

Sometimes, people are not ready to go home, though opinion on that can be diverse, because there is clinical strategy and home care strategy involved. The clinical strategy is about repairing people quickly and getting them home. It also believes that someone being back in their home is the quickest route to recovery, but there are those who need more than that. That is where we are missing the point about the convalescent home level of care. We now talk about step-up, step-down care. People get some help to prepare for going into hospital, and when they come back out—when they go back into their homes—that is the step down. That is the area that we, in our IJB, identified as really needing to be looked at.

Brian Whittle: It is a big issue. Without question, there is a tension between the desire and the drive to move care towards being more local and community based and what is available in social care. That is the dilemma that we have within many IJBs. I do not know whether David Torrance agrees with this, but it seems to me that rural IJBs are much better and much further down the road in providing that kind of care. That is out of sheer necessity, because they have been doing it anyway. If we end up writing to other IJBs, I am pretty sure that that is what we will find.

The Convener: In that case, we agree to write to the Scottish Government, integration joint boards and COSLA, seeking their views on the action that is called for in the petition and asking them to look at community provision—or, if not that, what else there could be. We recognise that work is being done by the Health and Sport Committee and that it would make sense to come back to our decision on referring the petition to that committee at some point.

Members indicated agreement.

Interstitial Lung Disease and Home Management (PE1714)

The Convener: The next continued petition for consideration is PE1714, on interstitial lung disease and home management, which was lodged by James McLachlan, Ivy Dodds and Jean Watson. The petition was last considered in February 2019, when the committee agreed to write to the Scottish Government and key stakeholders, seeking their views on the action that is called for in the petition. The committee has received responses from the Scottish Government, the British Lung Foundation, the British Thoracic Society, and Chest Heart & Stroke Scotland.

The submissions raised a number of issues including the issue of awareness, among clinicians as well as among the general public, and standards of care. In its submission, the Scottish Government said that it aims to publish the Scottish respiratory care action plan later in the year. It is understood that interstitial lung disease is a key component of that plan. I thought that there were some very high-quality responses in the submissions that we received from the groups that have been identified.

Do members have any comments or suggestions for action?

It is another of those conditions that people do not know anything about until they experience it. One thing that comes out quite strongly is that what the petitioner is saying is right: the condition is underrecognised, and it is important that people

are confident that they will get access to the treatment they require.

Brian, do you have any view on what we should do with the petition?

Brian Whittle: We are almost back to where we started today. It is another condition that we are asking for raised awareness of among GPs in the first instance. We are in danger of bombarding them. Quite frankly, I am not sure what to do with the petition.

The Convener: The Scottish Government is developing a Scottish respiratory care action plan, so we could ask it to engage directly with the petitioners and those around them. That would be useful. There is clearly recognition that there is an issue here—the Government itself has acknowledged that.

We have a choice. We could close the petition on the basis that the Scottish Government is currently developing a Scottish respiratory care action plan and it is understood that interstitial lung disease will be one of the key components of that plan. In closing it, we would be recognising that, if the plan is not progressed in a way that the petitioners feel comfortable with, or if they are not engaged with it or not content with what emerges at the other side of it, they could come back to us.

In the submissions, there is an important recognition of the benefits of the petition having illuminated the issue. We hope that the Scottish Government will engage with the petitioners, and we can write to it in relation to that. However, given that action has been taken, we agree to close the petition under standing order rule 15.7. We thank the petitioners for bringing the issue to the attention of the committee and Parliament, and we highlight to them the fact that, if the Scottish respiratory care action plan has not been developed in a way that they are comfortable with, there will be an opportunity for them to engage with us through a further petition at a later stage. Is that agreed?

Members indicated agreement.

The Convener: We thank the petitioners for the work they have done. As I say, we will be alive to their coming back to the Public Petitions Committee at a later stage if sufficient progress has not been made.

I suspend the meeting briefly to allow witnesses for the round-table evidence session to join us.

09:58

Meeting suspended.

10:03

On resuming—

Tick-borne Diseases (Treatment) (PE1662)

The Convener: I welcome Alexander Burnett MSP, who is attending to participate in this round-table session.

Our final continued petition for consideration today is PE1662, on improved treatment for patients with Lyme disease and associated tick-borne diseases, which was lodged by Janey Cringean and Lorraine Murray on behalf of Tick-borne Illness Campaign Scotland. The petition was last considered in April 2018.

Our consideration will take the form of a round-table evidence session on the petition, in light of the NICE guidelines that were published in April 2018, and what the impact has been in Scotland. I welcome you all here today. The round-table discussion is slightly different from simple evidence taking and I am keen that we have a dialogue across the table rather than members asking questions and witnesses answering. First, I ask everyone to introduce themselves.

Tim Baynes (Scottish Land & Estates): I represent Scottish Land & Estates.

Gail Ross: I am the MSP for Caithness, Sutherland and Ross and deputy convener of the committee.

Dr Sally Mavin (Scottish Microbiology Reference Laboratory): I am from the Lyme disease reference laboratory up in Inverness.

Brian Whittle: I am an MSP for South Scotland.

Rupert Shaw MBE (NFU Scotland): I am a deer farmer and the regional chair for NFU Scotland in Dumfries and Galloway.

Alexander Burnett (Aberdeenshire West) (Con): I am the MSP for Aberdeenshire West.

Maurice Corry: I am a regional MSP for West Scotland.

Kathleen Robertson (British Veterinary Association): I am the president of the Scottish branch of the British Veterinary Association.

Donald Fraser (Scottish Natural Heritage): I represent Scottish Natural Heritage.

David Torrance (Kirkcaldy) (SNP): I am the MSP for Kirkcaldy.

The Convener: Thank you. To my left, we have the official reporters and the clerks who provide the committee with background support.

I am very keen on there being a flow of discussion and exchanges of different views, and you should feel free to engage directly with one

another. If you can help me with managing our time, that would be helpful. We have a good hour to discuss these matters. If you can catch the eye of either me or the clerk, we can organise the discussion in that way. Committee members have a number of questions to ask. Obviously, if your comments have already covered the question we will not feel the need to ask them all.

Our papers show that people have a whole range of challenging issues to deal with, and I am very appreciative of those who have come here today to try to do that. We appreciate your engagement with us.

The committee received a number of written submissions regarding the action that is called for in the petition from many of the organisations that are represented here today. Given that time has passed since then—that was in October 2017—will you outline for us what you see as the current position relevant to the action that the petition calls for from each of your organisations? We want an update on where you think we are in relation to what the petition is asking for.

Rupert Shaw: The NFU is very pleased to have been invited to contribute to this. It is great that a centre for expertise is being set up, or has been set up. The first point is that this is a real issue Scotland-wide. If you look at the statistics you will see, for example, that in Dumfries and Galloway we may only have 6 per cent of confirmed cases. However, one of the problems with Lyme disease is confirmation of cases.

In the union, we feel that the environment in which ticks can thrive—the optimum set-up for the tick—continues to increase. By that, I mean that ticks are happy in longer vegetation, ungrazed grass and bracken, and that the increasing combination of those areas in our uplands—the removal of grazing for much of upland Scotland—is providing an environment that suits ticks. The removal of livestock that would have absorbed the burden of the tick has coincided with that at a time when we are seeking to increase people's access to those areas, without a strategy either to deal with the tick problem or to target information to those who find themselves either working in, or in particular accessing, those areas; often, of course, people bring dogs and other pets, which bring ticks back into the home.

Tim Baynes: We find very much the same situation. We are talking about upland land management, and stalkers and gamekeepers in particular are finding this problem. I echo that the ticks are moving up the hill. That is the common expression that you hear; the tick issue used to be something that happened in the damp, warm bits at the bottom of the hill and now, with climate change, they are moving up the hill and are

affecting people, animals and birds at much higher elevations.

Donald Fraser: I agree, from a Scottish Natural Heritage perspective. I think that there is broad consensus on the issue. One of the key issues is the importance of balancing the health messages with making sure that people are still keen to go outdoors and encouraging them to go outdoors. There are key health benefits and economic and social benefits from that. The drive is to get more consistent advice out there and available to people on the associated risk, but proportionate to the risk. The partnership approach that has been developed to take forward that message is key.

A number of pieces of research and work are on-going to look into the issue, particularly around the spread of the disease and from a nature perspective on how wildlife is part of the distribution and spread of the disease.

The Convener: From the vet's point of view, is there something in how we get that information out to people?

Kathleen Robertson: Yes. It is about awareness of tick-related diseases and tick problems—even simply about the public recognising what a tick looks like. Quite often, in veterinary practice, we have people coming in because they think that their dogs have warts; they do not—they have a tick, which we then remove. It is about getting awareness out there so that people know what ticks look like. A plethora of products is now available for prevention in pets.

Where I live in Forres is a tick-endemic area. We are lucky, in that we know exactly what ticks are. Children at primary school are being told to watch for ticks after long walks and nature walks, but holiday makers and people who are coming into the area are pretty clueless, to be honest. Public perception of the dangers with ticks is not good.

The Convener: That is what we are wrestling with. First, an understanding is needed; secondly, when people have been bitten, we need to ensure that the symptoms can be identified and diagnosed. That is a further area. Do you want to say something about that, Dr Mavin? Where do you think we are in understanding it properly?

Dr Mavin: From the testing perspective? It has been quite difficult recently in the media. A lot of misinformation is being put out there, which is not very helpful. I think that social media plays a huge part in scaremongering and misinformation. It is important that the real message gets out there about the effectiveness of testing.

Where we are in the Highlands, most general practitioners are very aware of Lyme disease and look out for it, whereas in other areas they are not

so aware. The situation is definitely improving, but there is a long way to go.

The Convener: We may come on to this in more detail, but there is the issue about having confidence in the testing. From the paperwork, my sense is that there are people who have lost confidence in it and, therefore, may be looking to other places for testing and that there is a confusion there.

Dr Mavin: Yes. At the risk of being contentious, there is a large number of patients who believe that they have Lyme disease and a good chance that a lot of them do not. Again, because that situation is perpetuated by social media, people go on and say, "I have this symptom, this symptom and this symptom; therefore, I must have Lyme disease." When the tests do not agree with them, they are not happy. They then go for private testing to Germany or America, and the laboratories and the tests that are used do not have a lot of credibility in the scientific community. It seems to me that lots of people send their samples there for testing, which costs an awful lot of money; they get a positive result, which they are happy with, but the validation and verification of the tests are definitely under question.

The Convener: We may return later to how we have confidence in the testing that is being done.

Alexander Burnett: I want to pick up on something that Donald Fraser said. I am a bit concerned about the comment about advice being "proportionate". No one would dispute the health benefits of outdoor access and all the rest of it, but someone who suffers from Lyme disease might take issue with that kind of comment.

Is your qualification about the risk of catching Lyme disease being proportionate in the advice on outdoor access made on a medical basis? Having contacted around 40 organisations over the summer—I am happy to share that correspondence with the committee—I found that many of them have concerns that not enough is being done. Some might conceive the message that you are giving out now to be very worrying.

10:15

Donald Fraser: The intention is definitely not to underplay the risks and effect of catching the disease. I guess that it is about the best way of getting the message out there about the health benefits of being in the outdoors. We know that there are great benefits to being in the outdoors and that it plays an important part in society. It is about getting across the message in a way that allows the risk of Lyme disease to be recognised so that people are aware of the issues and know how to deal with the effect of getting a tick and, in

terms of getting the disease, the medical issues and following that up.

The “proportionate” comment was about taking the issue absolutely seriously but making sure that the other benefits of getting out into the outdoors are not getting lost.

Rupert Shaw: From our perspective, it is not just about concentrating messages on the risks or the potential for Lyme disease. Knowing that our tick population is increasing, we would like to see education being focused on prevention against getting bitten in the first place. Obviously, that would be expensive, but it would be very easy for those areas in which we encourage public access. I do something called conservation grazing for the National Trust for Scotland at one of its sites near Gatehouse of Fleet. We could have a sign up that advised people who are walking to wear trousers and a long-sleeved shirt, to avoid going through very long bits of bracken, and to stick to paths. I would like to see some effort being put into the messages on prevention. That piece seems to be missing in our educative efforts.

The Convener: That would be a useful area that we could explore with the relevant agencies.

Gail Ross: My question follows on from what Dr Mavin was saying about GPs in areas where Lyme disease is more prevalent, especially in the Highlands, where they will look out for the symptoms more than other GPs. The Scottish Government indicated in a submission in 2018 that new NICE guidelines on Lyme disease would be sufficient to enable clinicians to make that initial diagnosis. Has that happened? Do you know much about the new NICE guidelines?

Dr Mavin: Yes, we refer many of our users to the NICE guidelines. We get a lot of phone calls in the laboratory looking for advice on the management of patients and we always refer them to the NICE guidelines. It is good that we have the guidelines now, because there is good evidence behind them and we are quite confident in the message that they put across. GPs and clinicians as a whole now feel much more comfortable because there is something that they can go to in order to see best practice.

Unfortunately, however, we see repeatedly that people are not given the right antibiotics to start with. From the test forms that come through with the samples, we see that they have been on different antibiotics from the ones that they should have been on. Also, we often come across cases where it seems obvious to us what the patient’s complaint is, but it has taken a while to be picked up, so there is definitely still a message that needs to go out. The NICE guidelines are good for patient management, but I would say that they are

not much used as a teaching guide. More teaching is still needed.

Gail Ross: This may have been covered previously, but do we know whether Lyme disease is covered in training for GPs, or in their continuous professional development, so that they know what to look out for? It is all very well having guidelines, but a lot of GPs may not refer to them, may not know about the symptoms or may give the wrong antibiotics, leaving the disease in the body for longer and thereby making it more difficult to treat.

Dr Mavin: I am afraid that I am not aware of what is in the syllabus for teaching GPs.

Gail Ross: I would quite like to explore that.

The Convener: That is one area that we can explore with the Royal College of General Practitioners. We will collate issues from this conversation that we can flag to various bodies.

Dr Mavin: We are about to start a major European project called NorthTick, in which we are forming a network with colleagues from other North Sea region areas in Norway, Sweden, the Netherlands, Belgium, Germany and Denmark. Raising awareness is part of that project. We are planning to work with GPs in Highland as a start. We will hold educational conferences and measure the management of treatment before the conference and again afterwards to see whether it has made any difference. As part of the project, we are also looking to hold conferences for landowners and the different high-risk occupational groups to educate them on the risk of tick-borne diseases and what they can do about it. We have been given about €570,000 for three and a half years to carry out the project. A lot of the issues that have to be addressed will be looked at as part of the project, which is a good start.

Gail Ross: That is just GPs in Highland. How can that be rolled out to the whole of Scotland once the project is finished?

Dr Mavin: I do not know that. That will need to be looked at.

The Convener: Perhaps looking at the gap between the NICE guidelines and other information is a role for Scottish Government.

Brian Whittle: It has been interesting to listen to the evidence from around the table and compare it to some of the evidence that we have heard over the piece. We have heard anecdotal evidence that, once you come down from the Highlands, there are GPs who will not accept that a patient’s symptoms can be Lyme disease because they are not in the Highlands, but we know that that is not the case. It is interesting to listen to the different inputs here.

Dr Mavin spoke about people searching for the diagnosis of Lyme disease. We have heard evidence of exactly that. There is a conflict because of a lack of recognition of Lyme disease in Scotland, certainly in the Lowlands. Those who are suffering are then seeking advice from what they would say are better systems elsewhere. In gathering evidence, we see there is a lot of conflict.

The Convener: It is not unusual for people to feel that they are not believed. If a condition is not recognised, and not treated, there are consequences.

How is awareness raised on a consistent basis so that it is not just at the mercy of whoever happens to be proactive in a particular area? Do you have suggestions about how that could be done?

Tim Baynes: We have tried to do that. For instance, we have included a bit of information about Lyme disease on the “Welcome to the moor” information boards that we have for people coming on to moorlands. There is a little picture of a tick to show what it looks like and some basic advice—“Beware of ticks”—but it is very difficult to know how much to say. One view is that we do not want to put people off taking access to the countryside, which is absolutely right, but on the other hand, we want to alert people to the dangers. There is a dilemma and we do not know what to say on the information boards that would cover it. I wonder whether we might work towards some sort of consistent standard advice that could be given to access takers that would cover both the dangers and, as Rupert Shaw pointed out, the best thing to do, which is making sure that they do not get bitten in the first place by taking sensible precautions.

Donald Fraser: The dilemma is making sure that the messages are right for the audiences. A lot of work has been done on the messaging. For example, work has done by the national access forum and the NHS to get the message out about the prevent, understand and treat approach. There is a range of means of messaging, working with different professional audiences, particularly those who work in the countryside. We have been trying to get the messages across for a long time to raise awareness and understanding of the issues. We are still working on consistency to get the messages right.

Rupert Shaw: I am afraid that I have a slightly different view. I feel that this is an issue at quite a high level. Among organisations working in the countryside, you will find the knowledge—and I have brought these leaflets in to give to your evidence packs—but at any agricultural show, for example in Dumfries and Galloway, where we have a large tick population in the uplands, you

would struggle to find any information being pushed out. The information that exists is often action group leaflets, so if you do not live in an area where the Lyme Disease Action group is active and pushing information out, or if you are not seeing the Borreliosis and Associated Diseases Awareness UK leaflets, the information is not available, because it is not being put out on a Scotland-wide public health basis. There are just one or two actors doing it. There is huge variation in the level of knowledge. Anecdotally, there will be parts of my region where people will say that cattle can suffer red water disease, which is a sign of chronic tick infestation, but that is not read across into the primary schools to warn children off from going up the hill.

Alexander Burnett: I echo that. It is about consistency. When we write to a lot of organisations, they will say that they produce some leaflet or there is some information available, but when you drill down into whether the message is getting out there, you find that it is not, and that is a concern. There are no consistent guidelines and there is no check on how information is being delivered to make sure that those whom we want to encourage to use the outdoors are receiving it. There seems to be no report on that and no analysis.

Gail Ross: I was going to ask a question earlier and then thought that it was maybe a stupid question, before I remembered that there is no such thing as a stupid question. Then Rupert Shaw touched on it and I was glad about that. We are discussing ticks and Lyme disease in humans here, but could we have an example or two of how ticks can affect pets, livestock or other animals? I imagine that that could also be quite a big problem from a veterinary or farming perspective.

Kathleen Robertson: I can give you some experience from practice, which is basically that Lyme disease is always on our differential list for arthropathies in dogs, but there is one very big difference: the lifespan of a dog is 10 to 12 years, compared with the lifespan of one of us, who will hope to live until we are 80 or 90. We tend to approach the arthropathies, or arthritis, as a group, so we very rarely specifically diagnose it. Also, most pet owning is a private arrangement and if we start testing for Lyme disease, or rheumatoid factor or all sorts of other causes of arthritis, that starts to cost the client money, so there tends to be a block on how far we would go with a diagnosis. We tend to treat symptomatically with painkillers. There may well be dogs out there with Lyme disease that we do not know about, as it is not something that we routinely test for. If we are suspicious of something that may be Lyme disease in a younger dog that has a temperature or swollen joints, we may well just reach for an antibiotic and go for doxycycline, which is the

antibiotic of choice for tick-borne disease. However, that is not good practice, because we should not just be grabbing an antibiotic, as it is not a one health agenda approach. That is where we come back to the testing, because even the veterinary side of testing is not believed to be adequate and give reliable results. It is a very difficult position.

We do a lot of education in practice. If people from Ayrshire or Lanarkshire come up on holiday and they come in with a dog with ticks, we often use that opportunity to educate the public. As vets, we very much use our role to sell the little plastic tools to people and to say, "If you get a tick, that is how to remove it." We do a lot of the background education because people do not know what the ticks are.

The Convener: It is appropriate to bring Maurice Corry's question in now.

Maurice Corry: This is a question for Kathleen Robertson. The BVA has advocated a one health agenda approach under which the relevant stakeholders can work collaboratively to tackle the disease, and you touched on that just now. To what extent has the co-ordination been effective between the different sectors? That follows on from what Rupert Shaw was saying about information on the hill.

Kathleen Robertson: I am not entirely sure. We would have to refer that back to our policy group at the BVA to see how it has interacted with the other professions. Certainly we would be keen to work with the NHS on an educational basis.

10:30

Maurice Corry: You are not aware of any co-ordinated effort on this.

Kathleen Robertson: Not specifically, no.

Dr Mavin: There is a Lyme disease sub-group that is co-ordinated by Health Protection Scotland. Dominic Mellor, who is a vet by trade, is on that group, so there are vets involved in the health protection message.

The Convener: Rupert Shaw and others have made the point that there is not a consistent message and that you will get the information only if you are fortunate and have a campaign group locally. Who is responsible for getting a consistent message across? Where should that responsibility lie?

Rupert Shaw: My understanding is that Lyme disease is the most common insect-borne disease across northern Europe, which is no doubt why there is European money available to look at other locations. This is a public health issue. We have to accept that there are difficulties in diagnosing the

disease, mostly because the symptoms could be a number of other things—it could be problems with the heart because of a range of cardiac issues and so on. Also in a farming context, an animal that is being raised as a beef stirk, for example, will be culled at two years old. We do not have a true handle on the amount of disease there is. We know that we have a rising tick population. I feel that the education piece is a Government responsibility.

Tim Baynes: It almost has to be, partly because of this dilemma of how alarmed to make people. There needs to be a very careful message and it probably has to come from the Government.

The Convener: Does Scottish Natural Heritage have a view on this, or do you think that it is broader than that and is maybe a health issue?

Donald Fraser: It is a health protection issue largely. SNH obviously has a role as a partner in getting the right message across but, when it comes to who has the wider lead, I think that it is a health protection issue. We all have a part to play.

Brian Whittle: It is interesting to hear what Kathleen Robertson said about issues with pets. Anecdotally, we hear that there is a rise in the tick population. Every time I come back in with my dog, I look him over.

You touched on how to remove a tick. I think that not many people understand that you cannot just pull it out—it does not work that way. There should be more done around education about Lyme disease and the problem with ticks than just acknowledging the problem. It is a growing issue.

The petitioner suggests that there are five genospecies in Scotland, all of which could be pathogenic, but there is no testing system that would cover all of them. What are the panel's views about that?

Dr Mavin: That is slightly misleading, because one of the species that the petitioner is talking about is *Borrelia miyamotoi*, which is a newly emerging species of *Borrelia*. *Borrelia* is split into two types: *Borrelia* that causes Lyme disease and one that causes relapsing fever. Those are two quite different diseases. *Borrelia miyamotoi*, which has been mentioned, causes relapsing fever. Testing is developing for that—it is a newly recognised disease and it is still a relatively rare condition, but we now offer the testing in the reference laboratory. That is something that we have worked on over the past year because we are now funded; we are an official reference lab so we have more resources.

The Convener: Is that work centrally funded?

Dr Mavin: Yes, the work is funded centrally.

We now offer a molecular test for *Borrelia miyamotoi* that is mentioned in our user's guide. We have written to infectious disease consultants and various laboratories throughout Scotland so that they are aware that testing is now available.

The other strain of *Borrelia* that has been mentioned—*Borrelia valaisiana*—is thought to cause very few cases of disease worldwide. It is very rare; although it is present in ticks in Scotland, we are not sure how much disease it causes. There are just a few case reports. The blood tests that we use cover the main pathogenic strains in Scotland and we are confident that we pick those up. We are not sure about *valaisiana*, but there is a lot of cross-reaction, so if we detect antibodies from one strain of *Borrelia* the likelihood is that we will pick them up from other strains, as well.

This year we have changed the molecular testing for the *Borrelia* that causes Lyme disease; we now cover more strains. We are confident that we can detect *Borrelia valaisiana* using our molecular assay, although that is helpful only in certain situations. If a person has a rash and we take a skin biopsy, we can detect it there. If a person has neurological symptoms—there is a range of brain-related symptoms—we can detect it in the spinal fluid. If a person has joint problems, we can detect it in the joint fluid. However, it is quite restricted to specific conditions.

Gail Ross: Is Q fever recognised as a tick-borne infection in Scotland?

Dr Mavin: No. I am not aware of its incidence in Scotland, or even that it is present.

David Torrance: My question has been partly answered. The NICE guidelines include recommendations for research, including in areas relating to the most clinically effective and cost-effective treatment options for different clinical presentations of Lyme disease, and on laboratory tests to diagnose initial and on-going infection and to determine re-infection in the different presentations of Lyme disease in the UK. Are you aware of any new research that is being done since the establishment of the NICE guidelines?

Dr Mavin: I am about to start some more research using the European funding that I mentioned. A few years ago, I did a PhD on trying to distinguish between current infection and past infection, which is the holy grail in laboratory diagnostics for Lyme disease. Nobody has come up with an answer yet; I am working on that. It is a possibility, but it is still unknown. Various groups are working on that. Using our blood test, when someone tests positive we do not know whether the symptoms from which they are currently suffering are down to their having recently been infected with Lyme disease, or we are picking up

the fact that they were infected 10 or 20 years ago.

The Convener: Can there be false negatives?

Dr Mavin: The result can be negative if the person is tested too early in the infection. In our experience, it can take eight to 10 weeks to develop a positive blood test. When people are tested early, we always recommend that they send a second sample later in the course of the infection. If the person has had symptoms for 10 to 12 weeks or more, the likelihood of a false negative is very low. That is the area that is disputed, unfortunately, by some of the patient groups. I am not saying that it will not happen, but the likelihood is very small.

Alexander Burnett: I believe that the World Health Organization is doing a classification review of diseases and symptoms and that there was a deadline for submission, which has just passed. Has the Scottish Government, or have any doctors or medical professionals that you know of, made any submissions that we could ask the Scottish Government about?

Dr Mavin: I am a member of a European group called ESGBOR—the European Society of Clinical Microbiology and Infectious Diseases group for the study of Lyme Borreliosis—which is a group of clinicians and researchers throughout Europe. The classification review was more about internationally recognised read codes that clinicians can use to determine the various symptoms of Lyme disease. That has been looked at by the group, but I cannot comment on it specifically.

Brian Whittle: I have a question for Dr Mavin. You said that a blood test will be most effective after 10 to 12 weeks of infection. We have had a lot of evidence that early diagnosis is key to recovery. How does that work with the 10 to 12-week period?

Dr Mavin: There should be a clinical diagnosis that should be relatively easy to make if a patient presents with a tick bite and a rash. There is a misconception that it needs to be a bull's-eye rash: that is not the case. We say that it can be any spreading rash—so, a rash of more than 5cm. If a rash is spreading after a tick bite, the patient should be treated straight away and should not be tested, because of the worry that a negative result will come back and the patient will not then be treated. We press the message that patients should be treated early for Lyme disease without testing.

The difficulty is when patients do not present with a rash but with neurological symptoms. Education is still needed about that because, ideally, a lumbar puncture needs to be done because we need to test the spinal fluid of a

patient. That is quite an invasive test and is not something that everybody would want to allow.

The Convener: We are being told that there is an increased incidence for all sorts of reasons. Do you have the resources sufficient to match your capacity to test with the increase?

Dr Mavin: Our testing numbers have gone through the roof. We have extra resources now that we are a reference laboratory. That has been great and has allowed us to accommodate the increase in testing. Because there has been so much media interest this year, we have been incredibly busy; it has been ridiculous. My worry is that that will continue.

I would say that 80 to 90 per cent of the tests that we do come back negative—tests of people who have had a tick bite and are worried but show no evidence of symptoms. There is a lot of worry out there among the public, so the minute that a person has been bitten by a tick, they panic and want to be tested. I can understand that, but it is a strain on the laboratory, because we are only a small laboratory in which there are only a few of us working.

The Convener: There is a challenge in getting consistent information out to people without alarming them to the point at which they create demand that makes it more difficult for people who are really in need.

Kathleen Robertson: It is also important to recognise that not everybody knows that they have been bitten by a tick. I have had Lyme disease and I did not know I had been bitten. I had a rash that was spreading and I went through antifungal creams, steroid creams and all sorts with the GP, before he eventually decided to try doxycycline. I had been on another antibiotic. It is a trial and error diagnosis in many respects. It is also very important to say that not everybody is aware that they have been bitten, so we need to get that awareness out there.

Dr Mavin: We try to promote awareness that it is not just about the tick bite—the people who have potentially been exposed are a large proportion of the population. We would never say that people should rule out Lyme disease because there is no definite tick bite. The person could have been bitten under in their hair, behind their knees, on their back or somewhere else that they might not notice.

Kathleen Robertson: It is important to say that although we have talked a lot about uplands, where I live we get ticks in the garden. They are not just in the hills and the uplands; they exist where children play, in parkland, especially in areas where the grass has not been cut. Where there is long grass, there is tick vegetation. That is very relevant.

The Convener: You are saying that there are ticks where grass grows longer. Is that happening more?

Kathleen Robertson: Yes.

Dr Mavin: Yes.

The Convener: Why?

Rupert Shaw: The tick has evolved to be brushed on to an animal: it has no ability to jump. The tick needs longer vegetation, which it sits on until wildlife—a deer or whatever—brushes past it. In the absence of long grass, there will not be a tick burden because they are not able to jump high enough. They are in lank vegetation such as bracken, famously. There has been an increase in such vegetation and unmanaged areas of grass—for example, uncut verges, which is definitely because we have seen cutbacks on such spending. We have mentioned uplands not because uplands are the preferred habitat due to their height above sea level, but because the NFU's position is very much that destocking of our uplands and hills has definitely reduced the opportunity for ticks to go on livestock rather than on the humans who access such areas.

10:45

The Convener: Farming practice has changed and there are areas that are not being farmed in the same way that they would have been before. I have heard people in my area of Glasgow say, "We do not cut the verges anymore because it is much nicer if it all goes wild", which means, "We do not have the money to cut them, so let us rationalise it somehow". Does that mean that in some communities the risk is increased?

Rupert Shaw: Yes, if you create an environment that is ideal for how a tick operates—an environment that allows it to be at height on damp vegetation. We have heard that the tick is active above 3.5°C and in damp air, so Scotland and other similar northern European countries are the ideal habitat for it. The tick has evolved to be brushed on to a person or an animal going past. Yes, we are creating an environment that suits the tick.

Dr Mavin: A number of studies have been done. One of the most effective prevention measures is cutting grass and removing leaf litter. In our local town, they have stopped cutting the grass in all the parks and I am deeply concerned about that.

The Convener: That is an important area to pursue.

Alexander Burnett: I am glad that we have moved on to the tick itself. Have the witnesses heard anything about any work—we can ask the Scottish Government about this—on reducing tick

numbers? While I have been involved in the petition, I have come across one person who mentioned garlic-based licks for animals, which result in the ticks dropping off sooner, reducing their lifespan and their mobility. Has any member of the panel heard about any work on that? Can we ask the Scottish Government whether it has done any work on it?

Donald Fraser: Some work was done about 10 years ago to look at the effectiveness of that type of method, but it was not conclusive. Small mammals are particularly important in the earlier life stages of the tick and larger mammals are important in the later stages, when the ticks become sexually reproductive. We use acaricides, for instance, to dip sheep to prevent tick infestation. The application of acaricides in wild mammals requires ethical issues to be considered, as well as the practicalities of how you would apply it and how you manage it, given that some of the mammals are food sources. There are quite a lot of challenges there, not least the effectiveness of the method.

Brian Whittle: I have a follow-on question about our habits in cutting, or not cutting, vegetation. My cousin worked with the Forestry Commission and he has Lyme disease. He is in his 40s and he is unable to work anymore. That is one element. I also understand that down at the track, when they did not cut the grass in the middle of the park, one of the kids got bitten and got Lyme disease. You are absolutely right that there is financial pressure on our councils, but not cutting grass in the park is creating a habitat for the ticks. It is as simple as that. You would not think that just some long grass on a running track would be a habitat, but it is.

Rupert Shaw: I feel duty bound to point out that the answer is not to cut all our grass, either. There is grazing by livestock—I mentioned a number of organisations that do what they call conservation grazing. There are other options. For us, however, it goes back to what we hope will be a key strand of what is decided as a result of this petition—prevention, through people wearing appropriate clothing and suitable signs being provided. There will not necessarily be money for cutting or grazing everywhere. We have to see investment in the messaging about what is appropriate clothing in areas where we know there is a tick population.

Maurice Corry: This is probably a very simple question. How do the ticks get on the grass? We know that they shift on to animals, but in the very first place how do they get there? Are they carried by birds, or what?

Tim Baynes: They climb up the grass, or the vegetation.

Maurice Corry: Yes, but are they born in the grass? How do they develop? A caterpillar

obviously becomes a butterfly. Is the tick something that is left, and by what?

Dr Mavin: Yes, they are carried by animals and birds anywhere. The adult females go into the undergrowth and produce thousands of eggs. Then they just disseminate, whether on animals or by just gradually crawling out.

Maurice Corry: I just wanted to understand the basics.

Kathleen Robertson: One of the awareness issues is about making people realise what to do when they have been bitten by a tick but not to scaremonger. You have 24 hours to examine yourself and remove the tick, because it is during the 18-to-24-hour window when the saliva exchange and the blood exchange happen that the risk is there. It is a matter of getting that message across. If you have been out for walk in an upland, woodland, or long-grass area, when you get home that evening, before you go to bed, check yourself. Social media would be brilliant at putting the message out to people just to check. The message is not that people should think, “Oh, I have been bitten by a tick—panic”; it is to be sensible about it. Last week, there was a big joke about the police grab bag. Why do we not have a toolkit for ticks? It is just about making people aware. There is a wee plastic tool to get them off and when you go for a walk in the countryside, it becomes second nature to have it with you.

Brian Whittle: I am listening to what has been said. Some of the petitioners waited a decade before they had the diagnosis of Lyme disease, which is obviously what has driven them to lodge the petition. I get a sense that, certainly since we have been working on this petition, there has been an exponential rise in testing and understanding of this issue. Do we need to look at the education of our medical profession and of the public with reference to pets? I know that the BBC picked this issue up in the programme that it made about Lyme disease and I think that it is planning to do a follow-up. Are we suggesting that the Government taking control of that sort of media and information stream is the best way to deal with the issue?

The Convener: We are coming to a natural conclusion. I would like each of our witnesses to make any last points that they want to make. If they had one ask of the Scottish Government to address the issues in the petition, what would it be? We have a sense of that already, but I will go around the witnesses one by one and invite any final comments that they want to make. Please mention anything that we have missed.

Donald Fraser: I do not have anything to add. Communication and awareness are pretty key. We are a Government agency. We are happy to contribute to that messaging. Given what we have

heard today, one of the key things is getting a consistency of approach across the piece to make sure that we get the right messages out there.

Kathleen Robertson: It would be very useful if the approach were Government led and involved all the stakeholders. If I were to say anything, it would be education, education, education.

The Convener: Where did we hear that before? Happy days.

Rupert Shaw: This is a Scotland-wide issue and, therefore, I want the Government to take ownership of the education function. Media campaigns come and go, but this is an enduring problem for us and it requires enduring education. It should be part of the curriculum at school, and so on.

Dr Mavin: I think that we would benefit from a national strategy. I was involved with the Canadians, who have set up a five-year plan for how they will target Lyme disease, which is looking at education and awareness and the extent of the problem within the tick population—the percentage of the tick population that is infected with different tick-borne diseases—and trying to pull everything together. There are lots of groups doing different bits of work; there is no cohesiveness. I believe that having a national strategy would deal with that problem, but it has to be resourced—and that is the problem.

The Convener: If we cannot afford to cut the grass, we do have a problem.

Tim Baynes: I echo everything that has been said. The issue is relatively recent and given that there is this whole horrible thing about ticks being bloodsucking insects, the education and awareness raising should be fairly matter of fact. We should say, “This is a problem, but ticks are not vampire insects and there are sensible things that you can do to guard against it.”

The Convener: I would want reassurance that the problem is not out of control or completely frightening. Without that, there could be unintended consequences such as people becoming increasingly anxious and not going for walks, or, when they go for walks, getting anxious about what has happened to them and feeling that it is something outwith their control. We have highlighted an important issue, and the problem is more significant than I had realised, with the crossover between the natural world and the medical world. The issue is not just poor diagnosis, and we are hearing from the witnesses that there are practical things that can be done, that the problem is not beyond us, and that we can address the issue.

I do not know whether members want to add anything. We will want to reflect on today's

evidence, which has been extremely useful. I am grateful to everyone for coming along. The session has been useful for education, which we will reflect on at a future meeting.

Alexander Burnett: I thank the committee for continuing to consider the petition. At the risk of repeating what I said last time, I would add that this is a huge and growing issue in Scotland, which we do not seem to be fully on top of. I think that there is a real responsibility for Scotland to get in front of this.

The Convener: We will address the issue again and look at what we will do with the petition. In the meantime, we could ask the Scottish Government to respond to the asks that have been made, particularly the idea that there needs to be a strategy. We want some comment. I do not know how cross-cutting the Scottish Government is on the question of the update of the NICE guidelines and their relevance to Scotland with regard to Lyme disease.

We will also write to the Royal College of General Practitioners to ask about training with regard to Lyme disease. We will want to come back to the area of prevention, because that is about where responsibility lies. As we have heard today, there is a range of areas in which one could intervene and it is a question of how all that is brought together. My sense from the meeting is that the Scottish Government is seen to have a pivotal role, so we will want to get a response on that.

Thank you very much for your contributions today. Having a round-table session is always a bit more challenging, but it has worked very well. We appreciate the contributions that you have all made. If, on reflection after the meeting, there is further information that you want to give the committee, we would welcome it. Indeed, if you are following the petition as it goes through the process and you feel that you could make further input, we would very much appreciate that. We can see that this is an area of interest not just to the petitioners. From what we have heard today, we can see that the issue is significant.

Meeting closed at 10:59.

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