OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Citizen Participation and Public Petitions Committee

Wednesday 5 February 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 5 February 2025

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CITIZEN PARTICIPATION AND PUBLIC PETITIONS COMMITTEE

2nd Meeting 2025, Session 6

CONVENER

Jackson Carlaw (Eastwood) (Con)

DEPUTY CONVENER

*David Torrance (Kirkcaldy) (SNP)

COMMITTEE MEMBERS

*Foysol Choudhury (Lothian) (Lab)
*Fergus Ewing (Inverness and Nairn) (SNP)
*Maurice Golden (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sophie Bridger (Chest Heart & Stroke Scotland)
Dr Ron Cook (NHS 24)
Michael Dickson (Scottish Ambulance Service)
Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con)
Professor Mary Joan Macleod (University of Aberdeen)
Professor Arshad Majid (University of Sheffield)
Edward Mountain (Highlands and Islands) (Con)
Ash Regan (Edinburgh Eastern) (Alba)
John Watson (Stroke Association)
Professor William Whiteley (University of Edinburgh)

CLERK TO THE COMMITTEE

Jyoti Chandola

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Citizen Participation and Public Petitions Committee

Wednesday 5 February 2025

[The Deputy Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Deputy Convener (David Torrance): Good morning, and welcome to the second meeting of the Citizen Participation and Public Petitions Committee in 2025.

Our first item of business is to make a decision on whether to take in private agenda items 4 and 5, which are on consideration of evidence that we are about to hear and our work programme. Are members content to take those items in private?

Members *indicated agreement.*

Continued Petitions

FAST Stroke Awareness Campaign (PE2048)

09:31

The Deputy Convener: The next item on our agenda is consideration of continued petitions. The first of those is PE2048, which is a review of the FAST—face, arms, speech, time—stroke awareness campaign. It was lodged by James Anthony Bundy, who joins us in the public gallery this morning.

The petition calls on the Scottish Parliament to urge the Scottish Government to increase awareness of the symptoms of stroke by reviewing its promotion of the FAST campaign and ensuring that stroke awareness campaigns include all the symptoms of a potential stroke.

We previously considered the petition at our meeting on 9 October 2024, when we agreed that, in addition to seeking written evidence from national health service regional health boards, we would hold a round-table discussion on the issues that the petition raises.

I am delighted to say that we have two panels with us this morning to explore those issues. Our first panel includes Sophie Bridger, who is policy and campaigns manager at Chest Heart & Stroke Scotland; Michael Dickson, who is chief executive of the Scottish Ambulance Service; Professor Arshad Majid, who is a professor of cerebrovascular neurology at the University of Sheffield; and John Watson, who is an associate director of the Scottish Stroke Association. I extend a warm welcome to you all.

With the exception of Professor Majid, who joins us remotely, our first set of witnesses have previously had an opportunity to provide written evidence to the committee. If participants are content to do so, we will move straight to our discussion, which will broadly focus on the public awareness campaign on stroke.

How would less-common stroke symptoms be incorporated into a public awareness campaign?

John Watson (Stroke Association): I think that this is a contentious issue. I am sure that all of us who give evidence to the committee today will be of a mind that the current situation is not good enough and that we need to see change. The petition has come about because of a failure in the system, and such failures happen too often for stroke patients.

The Stroke Association has concerns about the idea of bringing the less-common stroke symptoms into public awareness campaigns. From

the beginning, I want to make the distinction between the messaging that we give out publicly, which is primarily the FAST campaign, and the information, training and education that is given to stroke professionals.

Our concern over the idea of changing the FAST campaign is, first, that the campaign works very well. It is simple and memorable, but it is also very focused on the specific symptoms of stroke. It captures most strokes, and it leads to very few false alarms. FAST works well as a triaging tool, but it is not the be-all and end-all; it needs to be backed up by other opportunities for professionals to take more nuanced consideration.

The concern with extending FAST to include wider symptoms is that not only are many of the symptoms vague and related to conditions other than stroke, but adding to them would decrease the propensity of people to remember what the symptoms are. The committee will hear later from researchers, and I think that there is good research evidence of a real risk to people's retention of the messaging, the more the amount of information that they are given is increased.

Sophie Bridger (Chest Heart & Stroke Scotland): I echo what my colleague said. We know that, in general, awareness of stroke symptoms is not as high as we would like it to be. Chest Heart & Stroke Scotland currently co-ordinates the national FAST campaign. Before we started the campaign, we did some polling to ascertain what the general awareness was of FAST as an acronym and of stroke systems. We found that only just over 60 per cent—62 per cent—of the public had an awareness of FAST. That is much lower than we would like it to be.

After the initial wave of that campaign, we were able to raise that to 68 per cent, which we are very pleased with and hope to build on in the coming years. However, it demonstrates just how low public awareness is in general of not just stroke symptoms, either FAST or BE FAST—balance, eyes, face, arms, speech, time—but the need for urgent action. We know that unfortunately, that is one of the last messages to get through. Stroke is always a medical emergency, and too often, we hear that people delay taking action. The awareness of the need for very swift action is, unfortunately, still not high enough.

We know that, as my colleague alluded to, the best health campaigns are built on the repetition—which I am sure will be very familiar to committee members—of short and simple messaging over time. We are not yet advanced enough in that awareness—we need to keep repeating the message to build awareness of key stroke symptoms and of the urgency of acting very swiftly.

Michael Dickson (Scottish Ambulance Service): I support my colleagues entirely. The progress that has been made in FAST is really welcome, but the Scottish Ambulance Service still often sees patients who have delayed contacting us because they are waiting for all the symptoms to present, rather than just one or more of the significant ones. That has been backed up by the research that has been carried out regarding the acceptance of FAST as a process. There is a concern, of course, that adding elements to it could further delay any patients coming forward and seeking urgent support and attention from the Scottish Ambulance Service.

Professor Arshad Majid (University of Sheffield): Research from the United States that was published very recently has shown—we found a similar issue in Sheffield—that if we complicate the message a little bit more, just by adding the two letters B and E to FAST, the retention of what those letters mean at 30 days decreases. If we want to get the message out to the public, and improve its retention and improve action, keeping it as simple as possible is the way to go.

We considered moving to BE FAST in England; I have spoken to a number of my colleagues in NHS England, and the British and Irish Association of Stroke Physicians has considered it. However, we decided not to move forward with that, partly because of the concern about retention of the message and the action that needs to be taken. We also felt that it would increase the number of mimics—cases where symptoms mimic stroke—coming through; I know that that is not what we are talking about just now, but it is a potential consideration. We decided, therefore, not to move to BE FAST, because of the concerns that I have just raised and the concerns that my colleagues have highlighted.

The Deputy Convener: If we were to have a public awareness campaign that included more symptoms, can you highlight what risks you feel that there would be?

Professor Majid: Is that a question for me?

The Deputy Convener: I will let you go first, Professor Majid.

Professor Majid: As I just highlighted, people have looked at that in the United States. In the United States, they want more people to come to hospital so that hospitals make more money. The US researchers found that if you take two groups and you educate one group on FAST and the other group on BE FAST, the retention of the message is decreased in the BE FAST group in comparison with the FAST group. There is research to support that—there are two studies that have shown that simply adding those two letters complicates the message.

Sophie Bridger: Professor Majid touched on the subject of mimics. I will leave it to my more qualified colleagues to speak to the nature of stroke mimics, but there is a concern that, if we widen the net, we will not necessarily catch more people with atypical stroke symptoms, but will instead make them harder to find. That is because of the large number of people who present with symptoms that come, for example, from labyrinthitis, migraine or seizures. Instead of having more people with a posterior circulation stroke presenting at A and E, we would have a much bigger number of other people presenting there who need to be triaged as well. We would make it harder to find the people with stroke.

Professor Majid has already touched on the context. In America, where a lot of the research on this is being done, there is a very different healthcare system from the one here. We know that, despite the very best efforts of stroke clinicians, who work exceptionally hard, stroke healthcare is really struggling. Only just over 50 per cent of people who had a stroke last year received the stroke bundle, which is the package of treatment that we would expect to see being used for someone who is admitted with a stroke. Only half received that, but the national target is 80 per cent, so stroke healthcare in Scotland is already well below where it needs to be. If we widen the net, we risk reducing the probability that someone could get that healthcare in time.

Michael Dickson: From a clinical point of view, for us in the Ambulance Service, FAST is an initial trigger. It is about where we start our triage and assessment processes, from the initial call onwards.

There is a risk that, if we widen the opportunity for people to come forward to raise symptoms that might have another cause, people with stroke will either get missed, which is not what we want to see, or the number of medical emergencies—we do see a stroke as a medical emergency—will start to get diluted, because we will be taking more patients to accident and emergency, as they will have an appropriate presentation for being taken in based on the widened specification.

John Watson: I will briefly hammer home that point. Professor Majid referred to some recent research. When we submitted our written evidence to the committee, we said that there was no clear evidence either way from comparisons of FAST and BE FAST. Two new studies have been published since then, which I looked at yesterday. I will give the one-line conclusions from each of them, because they are very clear. One study said:

"Significantly higher retention and ability to recall stroke symptoms, fully or partially, was found with FAST. Adding B and E to FAST resulted in lower retention of more common symptoms."

The second study said:

"F.A.S.T. outperformed BE-FAST in the ability for people to remember key stroke warning signs ... suggesting the additional letters of B and E hinder memory recall."

The concerns that we have about diluting the message are real and are very well founded, and I think that the research backs them up.

Professor Majid: I think we all agree that we need something better. FAST is good, but there are opportunities to do better.

One thing that we have been researching in England is video triage. When the ambulance arrives at a patient's house, we can use video triage—we can see the patients on our screens via camera. The video is sent to us, and we can assess the patient. The research on that is yet to be published and properly assessed, but we have found that it helped to distinguish strokes from non-strokes and to reduce the burden on the stroke services.

I know that I am talking about something slightly different and not a patient education campaign, but if we want to identify more stroke patients and reduce the number of non-stroke patients who come in and overwhelm an already-stretched service, we will have to think about novel approaches that allow specialists to identify stroke patients who need to get to a centre very quickly. As we all know, "time is brain".

Maurice Golden (North East Scotland) (Con): I will perhaps start with Professor Majid. In relation to your previous point, are you aware of any work around the use of artificial intelligence to triage potential stroke victims?

09:45

Professor Majid: Yes. It has huge potential. In Sheffield, we have been looking at Vision AI, which Tesla is using for self-driving cars. With Vision AI, it might be possible to identify stroke patients—indeed, patients might be able to do that with their camera. However, the research will take time. It is too early to say at the moment.

I reviewed the grant application, so I am aware that work is going on for a blood test that could be combined with FAST to identify patients with large-vessel occlusions—so patients who are potential candidates for thrombectomy. There is opportunity, but the AI and the blood tests are not here yet.

Maurice Golden: I am also interested in BE FAST as a stroke screening tool. What is your view of the current evidence surrounding BE FAST

and other stroke screening tools, and how could the evidence base improve?

Professor Majid: Colleagues might disagree with this, but from my reading of the literature, I think that FAST and BE FAST are very similar in picking up stroke. They have similar sensitivity and specificity—that is, a similar level of identifying false positives. I am not completely convinced that BE FAST adds a great deal—that is my opinion and, as I have said, colleagues might disagree—and it risks increasing the number of mimics that come into the stroke service. However, I would appreciate hearing the views of colleagues.

Maurice Golden: I would like to bring in the witnesses in the room on the current evidence base around BE FAST. Sophie?

Sophie Bridger: I will touch on it briefly and summarise a position that I have read in the clinical stroke guideline, which was reviewed in 2023—so only about 18 months ago. The guideline is for all stroke clinicians across Great Britain, Northern Ireland and the Republic of Ireland, and the working party that pulled it together reviewed the evidence comprehensively and very well, so I am inclined to trust its assessments. It found that there was simply not enough evidence to deviate from FAST for any other screening tool—I say "screening tool" as opposed to "awareness campaign", because the two things are slightly different. The most recent Cochrane review, which considered the stroke awareness screening tools as well, backed that up. FAST is the only screening tool that is mentioned in the clinical guideline, because it is used consistently and has a very good evidence base. Until that changes, there is no reason for any of us to use a different one—there is simply not the evidence at this point. That is not to say that individual papers will not find a particular benefit to a particular screening tool but, in my opinion, the body of evidence as a whole does not justify a move away from FAST.

Michael Dickson: The Scottish Ambulance Service is, first and foremost, clinically led. When clinical research changes and there is evidence for how we should change our practice, we change accordingly. Our view backs the position that the evidence is not there to make that change. Should that evidence come forward, or should a new tool prove to be more effective, we will adopt it.

John Watson: I have nothing further to add about the evidence. I agree with my colleagues on that.

I would, however, like to pick up on what Professor Majid said about other areas of research. We are all, I think, of a mind that the status quo is not okay, that we need to do this better and that we need to do further research. The question is about where we put that research investment. One of the key things about stroke that you need to know is that very little money is spent on stroke research, and we need to be careful about where we spend that money.

For example, the golden hour for stroke—GHoSt—study that Professor Majid referred to is about either a blood test or a saliva test that looks for the protein evidence in the bloodstream that there has been major damage to the brain. That has fantastic potential to be a way of getting around the lack of visible symptoms and identifying what is going on inside the brain, and that work is under way.

We can do research that can help us to bypass a lot of the problems that we have, particularly with identifying posterior strokes that do not have obvious symptoms. We need to focus our energies and more money on those areas of research.

Fergus Ewing (Inverness and Nairn) (SNP): I am sure that all the witnesses will be well aware that the petition arose because of the tragic loss of the life of Tony Bundy. The petitioner stated that, when Tony suffered a stroke, his face and arms were unaffected and his speech was not slurred, and that meant that he passed the FAST test because face, arms, speech and time were not affected. The petitioner went on to say that the family is now raising awareness of the symptoms of stroke, including the inability to stand, which is balance, cold sweats, and eyes struggling to focus. That is where the B and the E come from—balance and eyes.

The evidence that you have all given is consistent: you do not think that, from the available studies and the evidence, the alteration of the awareness campaign from FAST to BE FAST would work. Mr Watson began by stating that there is a problem. To put that problem in layperson's terms, the current system is not identifying all of those who might have suffered a stroke, but you think that FAST is best, and if we are to depart from that, it might make things worse, not better.

I can understand that. I am not a clinician, so it is not for me to second guess anybody. However, the committee wrote to all the health boards in Scotland and the written response from NHS Ayrshire and Arran describes the work that it has already done, which is quite substantial and quite impressive. I will not read it all out because it would take too long, but it says that

"the team at NHS Ayrshire and Arran would very much welcome the opportunity to be a pilot site if this was agreed."

I have a point that I want to try out on you, to see what you say. Studies are one thing, but a health board is willing to carry out a pilot, and the

Minister for Public Health and Women's Health, Jenni Minto, has said that it is up to health boards to do that. As I understand it, she is not standing in the way of a pilot, although I am not sure that she is advocating one. Given all that, would it not be sensible to actually try it out? I do not mean to be impertinent in any way. Your evidence and knowledge come from your experience as professionals and clinicians, but a layperson might say, "For goodness' sake, give it a try."

Studies are one thing and, as has been pointed out, studies from the USA may be of limited efficacy because of different circumstances and the profit element, but surely it would make sense to have a pilot scheme. If it were conducted under scrupulously pre-arranged terms, it might be possible to measure the outcome and see whether it actually works.

I know that that idea was promoted by Stephen Kerr and Alexander Stewart, two other MSPs who have been supportive of the family in this case. I would like to know from all the witnesses whether they think that that might be worth trying.

Sophie Bridger (Chest Heart & Stroke Scotland): If health boards would like to pilot a different stroke awareness test, that is, obviously, entirely their prerogative. We would stress that it would be extremely important to do that in partnership with the Scottish Ambulance Service and to involve their emergency departments, too.

We are aware of pilots that previously took place in another health board, though I note that that board did not mention that in its written evidence, which may mean that it no longer holds records on it. Unfortunately, that pilot lent itself to the false positives that we are aware of.

The other thing I will stress is that we have not yet really spoken about the importance of professional education, which provides the opportunity to ensure that we are picking up on posterior strokes and atypical symptoms across the whole of Scotland. Once again, to build on John Watson's point, we do not accept that the status quo is good enough. Clearly, we must do more to pick up on posterior strokes, and professional education has a significant role to play in that.

Chest, Heart & Stroke Scotland has just begun a new programme of stroke education for the coming year. We hope to reach 1,000 healthcare professionals this year and we have had 950 sign up so far. In that training, we talk about stroke awareness and about FAST as the crux of the clinical guidelines, but we also talk about atypical symptoms and the importance of listening to carers and families. Someone can be FAST-negative and still have a stroke, so there are limitations to using FAST.

Stroke is incredibly complex and FAST is not perfect, but it does an incredible job of distilling a very complex event into something that can be recognised by members of the public. That is challenging and I have a lot of sympathy for colleagues—including my colleagues at the Ambulance Service, who do so much of the triage—who are working around the clock to detect and treat as many strokes as possible. If we can do more to upskill them, increase their confidence and ensure that they, as the people who are often on the front line, are able to detect and recognise strokes—even those with atypical symptoms—that is where we would get the most benefit from our investment of energy.

Fergus Ewing: Which health board were you referring to?

Sophie Bridger: That would be NHS Fife.

Michael Dickson: We are also aware of the NHS Fife pilot.

We seem to be looking at this as an either/or situation. As Professor Majid said, the use of video technology enables us to better assess patients who contact the Scottish Ambulance Service or NHS 24 because something is not right or is different. That is often the reason why people call us. Whether they are based on FAST or on balance or eyesight changes, those are really reasonable justifications for contacting NHS 24 or the Ambulance Service. The use of video technology could be powerful and effective in helping us further triage or stratify why something is not quite right.

I entirely support the point about the wider education of staff, including understanding what could be happening and knowing about atypical as well as typical symptoms. Education can be more powerful than just revisiting a pilot that has already concluded or looking at the wealth of evidence that already exists about the use of FAST as an initial triage tool and then as an assessment tool.

John Watson: For me, the issue of pilots by health boards comes down to what the board is looking to pilot. We would have concerns about piloting public messaging in a particular area because, if the messaging was different, it would have the potential to confuse people. However, a pilot that looked at how professionals within the health board were briefed, prepared and able to give time to more detailed examination of potential stroke patients would be very welcome.

FAST is one tool for us. It is a very effective tool and we think that it should remain on the front line of stroke diagnosis. However, as the petitioner has pointed out, it does not do everything—it misses a lot of people. For the system to work better, we need to look at the next step. For people who do not show obvious symptoms and who are showing

vague symptoms, there is no substitute for having time with a professional who knows what they are doing and who can try to figure out what is going on.

10:00

From the symptoms that somebody is showing, they might have an ear infection, they might be dehydrated or they might be having a stroke. It takes time and expertise to work through that. One way that our system is failing at the moment is that the emergency departments that people arrive at are overloaded. We probably all saw the Royal College of Nursing report a few weeks ago that talked about corridor care now being the norm. We need to have a back-up for FAST, and that is through professionals helping people. That requires the information and guidance that Sophie Bridger has referred to, and it also requires people to have time to spend with patients to figure out what is going on when there is no easy way of doing so.

All of us working in stroke are very conscious that the figures and performance at the moment are absolutely not good enough, despite the excellent efforts by stroke teams. Partly, that is about the resourcing of stroke services, but partly it is because the effective treatment of stroke patients relies on people getting to the stroke team quickly and efficiently. At the moment, emergency departments are an absolute bottleneck for that.

This is going outwith the committee's remit, and it is not a stroke issue per se, but one big factor is that emergency departments are so overwhelmed that they cannot give the time and attention that are needed to identify what is going on when people present with vague symptoms.

Professor Majid: I have two points. My colleagues have eloquently made a lot of important points, but the way that I look at this is that the priority should be to get the right patient into the right place as quickly as possible. I do not think that BE FAST is going to take us there. We need the other things that we have talked about, such as video technology, blood tests and artificial intelligence. Those are not there just yet, but certainly video technology is moving very fast, and we are using it a lot here and in other parts of the world. We will see it being adopted much more frequently in the future.

I want to add to what was said about current services. The current situation is distressing to me, as someone who is involved in the service and as a consumer of the service, having recently had a family member who had a stroke. If you have a posterior circulation stroke, which potentially could be devastating, and if that is correctly identified and you arrive in the hospital at 6 o'clock in the evening, although you would be eligible for life-saving or life-altering therapy, you might be too late because, in many places, you will not get that treatment after 5 o'clock. At the moment, stroke services are so stretched that we are not even able to provide life-saving or life-altering treatment, which patients who get to hospital quickly enough would be eligible for.

My humble suggestion is that our focus should be on looking at technologies or processes that allow us to identify the right patients so that they can go to the right place. I am not sure that we should be putting a lot of resources into BE FAST. Perhaps video technology, which is currently being piloted around England and in other places, is where our priority should be. That is just an opinion.

Fergus Ewing: Thank you all for your responses. I understand that the issue is complex and multifaceted, and that the role of education is vital. A and E facilities not being available after 5 o'clock, where that occurs, is an obvious and very serious failing, and a gap in the service. I do not gainsay any of that: I accept it all. The petition is concerned with one aspect, and one aspect alone, although I am sure that the petitioner would welcome a much improved service in all those respects.

However, I go back to this question: given that what is involved is a potentially life-threatening condition, and one that the petitioner's family lost their father to, does that not, when it comes to determining whether a pilot should be carried out, tend to push the balance towards conducting a proper test, as Mr Watson has said, with a set of pre-arranged and fixed criteria governing both the role of the Ambulance Service and the consultants and other clinicians involved? Surely, if a health board is willing to do that, it would be beneficial.

If, as the consistent evidence that we have heard from all four of you suggests, that does not work, then it does not work, but there seems to be a very strong presumption that people are not quite smart enough to be able to deal with complex matters. That could be interpreted as being somewhat dismissive—or a word that is even stronger than that, to be frank. After all, we are talking about a life-threatening condition. Some people, as Mr Watson said in his opening answer, lose their lives as a result of not coming under the FAST criteria.

Is the idea not worth trying? If it does not work, you will at least have tried it, and you will have a better cohort and evidence base on which to proceed as you focus largely on all the other issues that you have fairly and reasonably brought to our attention.

The Deputy Convener: I will bring in Sophie Bridger, first.

Sophie Bridger: I apologise to Michael Dickson for cutting in.

We would all agree that, as John Watson has said, the status quo is not good enough. We are all acutely aware of the fact that the petition has come about through a tragic loss of life, and I want to recognise what the Bundys have done to raise awareness of posterior circulation stroke with decision makers as well as clinicians. It has given us all a chance to ask how we are making sure that we get this right.

I think that we all agree on the problem—we just do not believe that the suggested approach is the right solution. As I have said before, if a health board wants to pilot the approach, that is entirely its prerogative, but my concern would be that, instead of making it easier for posterior circulation stroke patients and patients with atypical symptoms to get to the right place at the right time—to use Professor Majid's expression—we would lose them in the noise, and we would get too many people with what we call stroke mimics, which make it harder for us to find the people who need to be found and to get them to that right place at the right time.

In its significant adverse event review, which I know has been published, NHS Greater Glasgow and Clyde concluded that BE FAST is not suitable for universal application, which was based on its finding that up to one in six or one in seven of all patients could have some of the BE FAST symptoms at some point. That gives you an idea of the sort of scale that we are talking about. We all very much want to ensure that patients with any kind of stroke are getting the right treatment at the right time, but we are also very concerned about the possibility of creating so many false positives that we cannot find those people and get to them in time.

Michael Dickson: That was a really fair reflection. We work routinely with health boards on innovative projects and different ways of working, recognising the unique nature of health and social care across Scotland. Pilots should be undertaken within well-bounded scope and with a good grounding in evidence, and a decision about whether they are going to make an impact.

However, the core principle of all such studies is that you seek not to cause anyone further harm, and the risks that we are talking about—the wrong patients being identified, and the already limited capacity for stroke teams to be able to see their number being reduced, because of the number of mimics that come forward—are a real consideration for us.

The other thing to note is that a study would have also to consider other factors, such as whether there are alternative methods that could make a greater difference. In that regard, the Scottish Ambulance Service has been exploring the use of video technology. At the end of the day, we are all talking about better outcomes for patients who have been diagnosed with stroke.

I recognise the petitioner's tragic loss and, again, I extend my personal condolences to them, but there are other methods that we should explore, and the evidence is pointing to methods over and above the BE FAST method.

The Deputy Convener: Do other witnesses have any comments?

John Watson: I will perhaps make some of the same comments, but I will wrap them up in the perspective of the Stroke Association.

We are conscious of how much needs to change in stroke care in Scotland, and we are conscious of how little in the way of resourcing is available at the moment. Although I appreciate that we could approach the issue by saying, "Let's test things and find out about this, because any knowledge will be useful to us", we have so many things in front of us that we could test and research, and we have to triage those things, based on our judgment about which appear to be best placed to help us and to have the least negative impact.

One concern that we have about a widespread BE FAST message is that, as Sophie Bridger said, it would flag up a very large number of people as potential stroke patients. What would we do with those people? Our stroke service, stroke physicians, scanners and stroke beds are already under huge pressure just from dealing with the current numbers. If many more priority calls were to go to the Scottish Ambulance Service, every one of them would result in somebody else being deprioritised.

There is real potential for harm by doing what is suggested, and it does not feel to us as if there is evidence or any indication that the likely benefits would justify that.

Maurice Golden: I think that the nub of the issue is that James Bundy's father received video from the Scottish Ambulance Service that ruled out a stroke, so an ambulance was not dispatched. From the evidence that we have heard, the issue appears largely to be about capacity and the need to prioritise patients. Ultimately, the NHS is free at the point of delivery, and, in my view, capacity management should not come into an evidence-based approach to triaging people. Yes, there might be people who present falsely, but that is a matter for the Scottish Government, which can provide capacity and

allow people to access the treatment. I invite the panel to take a step back and answer this question. If there was capacity in the system, would your reflections on BE FAST be the same?

John Watson: We continually come up against the reality of lack of resourcing in stroke care, but, leaving that aside for the moment, the key issue for me is that, if somebody is suddenly very unwell, they should contact medical services. We should have medical services that are well briefed about the obvious symptoms of stroke and about the fact that people who present with general symptoms could be suffering from one of a number of things. We then need to have pathways such that people get to see somebody who is best placed to determine what is going on.

My concern about BE FAST as a general rule is that it would automatically flag a very large number of people as potential stroke victims who would be sent to stroke departments. When we do not know what is going on with someone who is showing very general symptoms, the right place to deal with them is an emergency department, where they will be seen by generalists.

The problem with BE FAST is that we would end up simply transferring a lot of difficult-to-diagnose patients from the emergency department, which is there to deal with them, into the stroke department, which is not well placed to deal with them, and most of them would then be sent back, because most of them would not be having strokes. That would be an inefficient way to treat people, even if we were not worried about resources.

The issue is about getting people to the right place at the right time, as quickly as possible. The emergency department is where people should be going when it is not clear what is happening with them.

Underneath all that is just the unavoidable and unfortunate fact that some strokes do not give obvious physical symptoms that show what is going on and are, therefore, hard to diagnose. In preparation for this discussion, I have spoken to various stroke clinicians and heard the same thing all the time, which was that it is just really hard to identify what is going on.

10:15

I know that we, on the panel, keep jumping on to other issues, but there are other ways that we hope would get around such things, including blood tests and video triaging, to improve people's chances, even if they do not guarantee a good result. The key thing for us is that we get those things lined up.

Foysol Choudhury (Lothian) (Lab): Before I go to the last question, I will ask Sophie Bridger, who mentioned training, a question. Does that training happen only in NHS Fife, or does it happen in other places?

Sophie Bridger: The training that we offer is online, and we are making it accessible to any healthcare professional in Scotland who wants to join. The first session this year was last week, and 250 people joined us from across the country, including people from primary care, the Scottish Ambulance Service, emergency departments and others.

Foysol Choudhury: You talked about resources and getting to patients. Do you have any data on how quickly the Ambulance Service gets to a patient, how quickly the patient is seen after they call and what happens in between?

Michael Dickson: We recognise stroke as a key priority, so it is one of our most urgent responses. The routine is that we pre-alert the hospital to say that a stroke patient is coming in, so that the teams can prep for the patient. That is a well-rehearsed triage process, but I acknowledge the points that have been discussed about the challenges that exist in relation to identifying certain types of stroke. We measure the times clearly, and because all our patient interactions are coded, we can provide more evidence to the committee, if it would be useful, about our turnaround times. There are factors that affect those times, and I do not think that we necessarily want to go into the scope of hospital turnaround times and so on, but we prioritise our most urgent responses, and stroke treatment is considered to be one.

Foysol Choudhury: I guess that you do not have any data on how many stroke patients have to wait and how long they have to wait from the call to the Ambulance Service arriving.

Michael Dickson: I am happy to provide that information to the committee, if it would be useful.

Foysol Choudhury: How could awareness of the symptoms be improved? That question is for all the witnesses.

Michael Dickson: As colleagues have said, awareness has been improved. The public health campaigns are very welcome. We would always encourage patients to come forward and not wait for all the symptoms to line up before contacting the Scottish Ambulance Service, and we acknowledge that it is a continuing messaging process to the public to make sure that the urgency and the impact of the symptoms is reinforced.

Sophie Bridger: On increasing awareness with clinical audiences, including the Scottish

Ambulance Service and healthcare professionals, we are making good progress with the training that we provide. We hope to reach 1,000 people this year, and the vast majority of them have already signed up to a session. We know that healthcare professionals want to know more—they want information and education about what FAST does and does not do, and how to act accordingly for someone whom they suspect is having a stroke, even if they are FAST negative.

John Watson: To reiterate the earlier point, I say that a twin-track approach is needed. There is a definite need for education, training and guidance for clinical practitioners and for people working in the medical profession who will see patients.

Public awareness campaigns need to run alongside that. I hope that we have not given the wrong impression by questioning the idea of BE FAST, but a FAST awareness-raising campaign has not been funded by the Government for some years in Scotland. All the other constituent parts of the United Kingdom have done that. The Stroke Association was part of a working group with NHS England to review the FAST campaigns. It struck me from those reports how quickly public recognition and awareness fade over time. The recommendation was to have a properly funded and visible awareness-raising campaign every couple of years. We have not had a campaign such as that for quite a few years in Scotland. If the public in Scotland is like the public elsewhere in the UK, there will be an on-going decline in awareness because of that.

There is no getting away from the fact that you need to spend some money on it. At a time when money is tight, I point to the fact that the NHS England evaluation found that there was a return on investment of eight or nine to one; so, every pound that was spent on FAST awareness-raising campaigns resulted in economic savings down the line of £8 to £9 because of reduced, earlier and better treatment. That was over and above the benefits to patients.

Foysol Choudhury: Professor Majid, do you have anything to add?

Professor Majid: No, I think that my colleagues have made all the points that I would want to make. A member asked a question earlier about what would happen if resources were not a problem. I understand the question, but the reality is that resources are a problem. As John Watson said, if someone comes in who is not having a stroke, they are potentially using a resource, such as a CT scan or another test, that a stroke patient would be denied.

The Deputy Convener: I have a final question for Mr Dickson and Professor Majid. How are less-common stroke symptoms currently considered when patients are assessed for potential strokes?

Michael Dickson: We have a very detailed triage process when patients contact 999. The first two questions are whether the patient is breathing and whether they are conscious, which triggers a response. Often, we will work the patient in some detail through a range of options that could be appropriate for them, depending on the symptoms that are presented, using either our integrated clinical hub or our teams that are embedded.

If we feel that the patient warrants an ambulance, we will send an ambulance, although it might take some time to get there. If we think that the patient's presentation requires an alternative treatment that could be achieved in a different way, such as by them directly attending an accident and emergency department or going to their general practitioner to access primary care, we will advise accordingly. We have a robust set of triage processes. We acknowledge that no system is perfect and we are always looking to make improvements based on learning when things have not gone as we intended them to go. We understand the impact on individual patients when that occurs.

Professor Majid: It would be useful for the committee to hear what happens in Sheffield. When the ambulance service there arrives at a patient's house, if it is very clear that the patient is having a stroke, they alert us and will bring the patient in. If they are not certain—for example, if they think that a patient is having a stroke but they are unsure about whether they are FAST positive or not—they will set up a video call with us. We have a stroke nurse specialist who helps us to evaluate the patient. If the nurse is unsure, they can ask another colleague to evaluate the patient. That is one way that we can identify patients who present with the less-common, or atypical, symptoms of stroke. We will miss patients, because no test is 100 per cent effective, but that system works very well for us and could be a model for the future.

The Deputy Convener: Before we draw this item to a close, does anyone want to add anything that we have not covered?

Sophie Bridger: I would like to speak to one of the points that the petitioner made in his most recent submission, which was not about FAST or BE FAST but stroke care in general, and specifically thrombectomy, which has been an issue of great concern to stroke clinicians in Scotland, to Chest Heart & Stroke Scotland and to the Stroke Association for a considerable time.

Thrombectomy is a life-changing treatment for stroke and, at the moment, it is not available outside daytime working hours and there is only

one place in Scotland where it is available at the weekend. There is a significant issue around the time availability of that game-changing stroke treatment, which should be available to every stroke patient. That issue, which the petitioner has raised in his most recent correspondence, is particularly important. I suspect that his view is shared by many of us in the stroke community.

The Deputy Convener: Thank you. If there are no other contributions, I thank you for your evidence and suspend the meeting briefly to allow a changeover of witnesses.

10:26

Meeting suspended.

10:27

On resuming—

The Deputy Convener: On our next panel, we have Dr Ron Cook, who is medical director of NHS 24; Professor Mary Joan Macleod, who is a linical pharmacologist at the University of Aberdeen; and Professor William Whiteley, from the centre for clinical brain sciences at the University of Edinburgh. I welcome you all.

Following on from the discussions of public awareness of stroke symptoms, the committee would like to explore more issues around clinical awareness of symptoms. We will go straight to questions, and I will lead off.

How are less-common stroke symptoms currently considered when assessing patients for potential strokes?

Professor Mary Joan Macleod (University of Aberdeen): They are possibly not considered very well, but we usually see them in the emergency department. We are called to see patients if an emergency doctor thinks that a patient might have a stroke. Probably three quarters of the patients whom we see in those circumstances have not had a stroke. About 3 per cent of patients who come to the emergency department will have dizziness as a symptom and, of those, less than 5 per cent will have a stroke, so there are a lot of patients to sift through to pick up the people with stroke. It is important to understand the patient's history clearly, and to conduct a thorough examination using validated tools to try to differentiate stroke from other causes of dizziness or vertigo.

It is mostly a clinical diagnosis, and there is pretty good evidence that a clinical diagnosis is better than imaging for identifying those patients. However, it is still difficult to do. There is a proportion of patients who might just have isolated vertigo, which looks like a peripheral cause, but they have a stroke, and that can be very hard to diagnose.

10:30

Professor William Whiteley (University of Edinburgh): There are people with severe symptoms and people with mild symptoms. As you have heard, there is a range of symptoms related to posterior circulation stroke, however, many people experience such symptoms and they are not related to strokes. If those symptoms are severe and the person has come to the emergency department, they are usually assessed either in triage or after admission by an emergency department doctor or nurse who needs to raise the suspicion of stroke to get the assessment of someone like me or Professor Macleod. Raising that suspicion is the important thing in the case of people with severe symptoms.

In people with mild symptoms—we should remember that mild symptoms are extremely common and are a major source of work for the stroke service—a GP usually refers a patient either by telephone or directly to a stroke physician, and then we see them in out-patient clinics, where the majority of the patients we see have not had either a mini stroke or stroke.

Dr Ron Cook (NHS 24): From my experience in emergency medicine and with NHS 24, I would agree with both of those statements. Key to this point is that tools such as FAST should not be used as exclusion criteria. FAST is inclusion criteria, and that is really important when it is considered in relation to public messaging. It is there to identify very quickly those people who are obviously having a stroke so that they can be availed of life-changing treatment. The key part of FAST is the T—time to call emergency services.

A majority of people who call their GP or NHS 24 or turn up to an emergency department because they are experiencing dizziness or issues with their balance do not have stroke. Similarly, in cases of people who have blurring of vision, that usually results from some sort of a local eye condition. Therefore, in line with previous evidence that you have heard, if you included those people, you would completely reduce the people who would be seen, to the detriment of folk who are having a stroke. It would also affect an emergency department's ability to pick up the unusual symptoms of stroke and the unusual patients.

In terms of assessing the more uncommon symptoms of stroke, the key at front doors—emergency departments, GP practices—is education to raise the awareness of health professionals and the introduction of systems in emergency departments that avail senior doctor review of those patients very early so that they can

muster the appropriate response within the hospital.

The Deputy Convener: On that point, do you feel that there is an awareness of less-common stroke symptoms among clinical staff?

Professor Whiteley: There is a variation in awareness of stroke, as is the case with all conditions, but we have to remember that we are dealing with professionals, and the continuing education of professionals, nurses, paramedics and emergency department doctors is important.

If you speak to any specialist, they will always say that there is under-awareness of their particular condition. Stroke is particularly important and, in my view, there is under-awareness of the symptoms, and we should continue our efforts to raise awareness. However, that is probably the case for most conditions. If we had a cardiologist here, they would say the same.

Professor Macleod: I would reiterate that. Particularly at the more severe end of the spectrum in our emergency department, we had an issue with basilar stroke being missed because a patient presented with a reduced conscious level and nobody thought of stroke. We had awareness sessions with the emergency department, but it was over a year until there was another case. Staff turnover—junior staff in particular in those departments change every four to six months—means that you need to keep re-educating medical staff, as you have to keep re-educating the public. Education is a huge part of what needs to be done, in order to ensure that doctors and, increasingly, nurses are aware of the symptoms.

Professor Whiteley: One thing that is relevant to the earlier point that was made about thrombectomy is that when a very effective treatment becomes available, doctors are much more interested in identifying people who are suitable for it.

Thrombolysis is quite effective if you work in a place where thrombectomy is not available, which is many places in Scotland, but it is simply not as effective as thrombectomy. If doctors or nurses have an effective treatment that they can give, they will work very hard to identify suitable patients, but, as we have heard before, that treatment is not available to most people in Scotland during the weekend and in the evenings or at night.

Dr Cook: There are also far more detailed tools available to health professionals in emergency departments for the assessment of patients who are presenting with stroke. Such tools include details around vision and balance problems. The National Institutes of Health's stroke scale is widely used to assess patients who present for eligibility for thrombectomy and thrombolysis. Although those tools are more detailed than FAST, being able to elicit the physical signs requires training and on-going professional education and development, and it requires reminders in how unusual strokes present.

Information and education are available to the general public through NHS Inform, which is governed by NHS 24. Although our stroke webpages lead with the FAST message, there is information immediately below that about the more unusual details of stroke. That is where FAST is such a useful tool: it is simple, short and punchy and it can be used as a gateway to provide more detailed information about stroke.

The Deputy Convener: Just to let the witnesses know, the technical staff will operate the microphones.

Maurice Golden: The petitioner mentions research from Australia—it has a similar healthcare system to ours—which showed that when BE FAST was used in a live medical setting the result was quicker detection and treatment and better outcomes. What is your assessment of how many strokes FAST might miss? Are we talking about one in five, one in 10 or one in 20?

Professor Macleod: I have looked at that specific issue. FAST misses about 14 per cent of all strokes, and, from some studies, it misses about 40 per cent of posterior circulation strokes. The FAST message is not that specific in relation to posterior circulation strokes, but bear in mind that there is a huge range of posterior circulation strokes, from the very severe to very mild.

Dr Cook: What is key with regard to the application of FAST in a healthcare setting—I made a point earlier about being clear on this to healthcare professionals, junior doctors and clinicians who are triaging patients—is that it is about inclusion, not exclusion. You do not say that someone is FAST-negative then say that therefore they are not having a stroke. Recognising that comes down to the education in your department and board and being aware of different stroke symptoms. The practice of healthcare professionals is nuanced.

I am not aware of the Australian study. On the earlier references to video consultation, I have practised in Australia, where video consultation supports the remote treatment of stroke and where the more nuanced and detailed tools can be employed as an aid in remote consultations.

Professor Whiteley: On the Australia question, I spoke with a colleague in Perth in preparation for this session and I think that the study that you are referring to was done in Perth. The study was carried out over two years and identified 200 people with stroke in the hospital. However, remember that hospitals in Glasgow and

Edinburgh see between 1,000 and 1,500 strokes a year, so that is on a very different scale.

The second thing to consider is how the different assessment scales perform. There are very few studies that look at the real world and consider everybody who comes to an emergency department with symptoms for which there is suspicion of stroke, which is what we are interested in. Where those studies have been done, they find that many of the scales perform very similarly. That was true for my study, which compared FAST with one other scale—not BE FAST. The key thing is not the scales, but the training of the people using them. The scale is there to increase awareness and to make someone think about it. If someone is thinking about stroke and neurological symptoms, that is just as important as the scale that they use.

Fergus Ewing: I want to follow up on what Dr Cook said about making the distinction and FAST not being a measure to exclude people but to include people. I understand the distinction, but the two issues of balance and the loss of fully functioning eyesight—balance and eyes—are not included in FAST, so, as far as the public is concerned, it is exclusive. We are using an information and awareness campaign that does not include two of the factors that, in the case of the individual who tragically lost his life, appear to have been the symptoms that were detectable.

I am playing devil's advocate a little bit but surely, as far as the general public is concerned, FAST is exclusive, not inclusive, by definition.

Dr Cook: The detail of the training of the application in healthcare professionals is that it should not be exclusive.

Fergus Ewing: I am talking about the public. I understand about the professionals.

Dr Cook: The problem with that is the face and speech symptoms are included in FAST because the majority of people who complain of those are having a stroke. That is why they are applicable to the T, which is "Time to phone the emergency services now". The majority of people who complain of being dizzy or having blurred vision are not having a stroke—it is a vast majority. If those symptoms were linked to the advice to call 999 immediately, it would have a significant impact on the ability of ambulance services and emergency departments to respond to strokes.

Fergus Ewing: I have one further question for Dr Cook, if I may. I do not mean to neglect the other witnesses, but the question relates to NHS 24. Many people's experience of NHS 24 is that it is not quick. It can be extremely slow, and there are practical reasons for that. People are often told that they will get a call back from a GP, for example, and that can take quite a long time. I am not really making a criticism, Dr Cook, but I am genuinely curious. What role does NHS 24 have in relation to strokes? Given the risk of very quick death, surely NHS 24 is really not the applicable service for strokes.

In the triaging that goes on in the first interview, how do staff who are dealing with those cases take account of the BE part?

Dr Cook: In identifying life-threatening or life-changing strokes, when someone phones NHS 24, we are very careful about providing information immediately in the recorded message and the information that they receive about stroke symptoms from the outset. If you think that you are suffering from a stroke, you should hang up and phone 999 straight away.

Fergus Ewing: If I phone up and say that my balance and eyesight are affected, what does the triage do? You have protocols and matrices—I do not know what the right word is—that determine the response given by the NHS operatives. However, I am not sure to what extent they are qualified—excuse my ignorance, Dr Cook. If I am asked whether I feel dizzy or I have slurred speech and I say, "No, but my balance is affected and my eyesight has suffered a bit", what would you do then?

Dr Cook: Our decision support system is set up to be used by selecting keywords. The most severe symptom is selected first for analysis, and then the most significant possibility of that keyword is assessed by our clinical staff. If it was visual blurring, the first line in differentiating that would be, "Is this person having a stroke?" If there are balance problems, that would be at the top of our clinical assessment and excluded before we moved on to different things. Under our clinical algorithms and clinical training, those more significant presentations are assessed and excluded first before we move on to others.

Fergus Ewing: Well, that is interesting. "Algorithms" was the word that I was unsuccessfully hunting for.

Dr Cook: We use a limited number of algorithms, because we rely a lot on direct clinical supervision by experienced staff. We use clinical support to enable our initial call handlers to gain as much useful information from the patient as possible, which makes the clinical supervision more efficient and effective.

10:45

Fergus Ewing: Thank you. It would be very helpful, convener, if Dr Cook would follow that up with a letter setting out what the protocols say—just for our information, on a sort of factual, evidential basis.

Foysol Choudhury: Good morning. From your clinical perspective, what are the risks and benefits of including less-common stroke symptoms in clinical stroke assessment guidance?

Professor Whiteley: I just want to follow up quickly on the previous point, which is relevant. If you are looking at communicating messages of uncommon symptoms to the public, you need to make sure that there has already been a lot of effort on FAST, so that there is at least some community awareness. If we decided to change that to a more complicated and difficult to remember algorithm or acronym, work would need to be done to check that people are happy to remember that.

There are also conflicting messages. I was in a pharmacy yesterday and picked up a public health awareness campaign about migraine, which says that you should seek help for migraine if you have nausea, vertigo and visual symptoms. The more complicated we make it, the more there will be all sorts of conflicting issues. Does that answer your question?

Foysol Choudhury: Yes.

Professor Macleod: Can I give you some data from the Scottish Stroke Care Audit report for 2023? There were 28,300 calls to the Ambulance Service that were coded as stroke by the call handlers. On the scene, the paramedics diagnosed 7,891 of those as potential hyperacute stroke, which is less than a third of what the call handlers coded as potential stroke. We know that, certainly in Grampian, potentially half of those actually turned out to be strokes. Hopefully, for this year, we will have all that data linked up in our national report.

One can imagine that if we added B and E into FAST, those 28,000 calls could go up to 33,000, 34,000 or 35,000, with a knock-on effect on the Ambulance Service and the emergency department. Those are huge numbers. If about a quarter of strokes are posterior circulation strokes, that might be about 2,000 across Scotland. The number of posterior circulation strokes in a health board region might be quite small, so there might not be enough data for a meaningful study. It might not be possible to do a study within one health board.

Dr Cook: The question was about including less-common symptoms in clinical training. It comes down to identifying how strokes commonly present, squaring that away, then having a very directed focus. In emergency departments, posterior stroke has recently been an area of priority for increasing awareness and early detection, so that those patients can be availed of therapy. Again, that is through departmental training and process, and ensuring that, in the initial assessment, either at triage or by, say, a junior doctor, if they are FAST-negative, that does not exclude them from being a stroke patient. It also involves being aware of trigger points, which would mean senior staff mustering specialist assessment.

The Deputy Convener: Dr Cook, this question is specifically for you. NHS 24 is a point of contact for most of the public. You are preparing a revised stroke training package. Have you seen it and does it cover the symptoms that we are talking about?

Dr Cook: The symptoms of balance and eye changes are definitely included in stroke education packages. We would be clear in all our education of clinical staff that if there were significant upsets in the algorithms, in keeping with a potential stroke, those would be identified.

The Deputy Convener: Thank you. Do any of the witnesses have anything else to say that we have not covered?

Professor Whiteley: I have just one thing to say. I am also the clinical lead for the Scottish stroke research network. The questions that the committee is asking about the performance of BE FAST and whether there are other scales or other ways of identifying strokes are research questions. There is a recent Medical Research Council report, which came out just a week ago, which Anna Dominiczak, the chief scientist, contributed to. The report really tells us about the decline in the number of clinical researchers—the people whom you need to answer the questions that the committee is asking.

The Deputy Convener: I thank the witnesses for their contributions today. Does the committee agree to consider the evidence that we have heard and the written submissions at a future meeting?

Members *indicated agreement.*

The Deputy Convener: Thank you. We will suspend briefly.

10:50

Meeting suspended.

10:55

On resuming—

Ancient, Native and Semi-native Woodlands (Protection) (PE1812)

The Deputy Convener: Our next petition is PE1812, which was lodged by Audrey Baird and Fiona Baker on behalf of Help Trees Help Us, which calls on the Scottish Parliament to urge the Scottish Government to deliver world-leading

legislation to give Scotland's remaining fragments of ancient, native and semi-native woodlands and woodland floors full legal protection before the 26th United Nations climate change conference of the parties—COP26—in Glasgow in November 2021.

We last considered the petition at our meeting on 17 April 2024, when we agreed to write to the Cabinet Secretary for Rural Affairs, Land Reform and Islands and to the Confederation of Forest Industries—Confor. We have received a response from the Acting Minister for Climate Action, restating the Scottish Government's commitment to addressing biodiversity loss and noting some of the action that it is already taking to deliver nature restoration in advance of the natural environment bill being introduced in Parliament for consideration.

Members will have noted from our papers that, since the minister's response was received, the Scottish Government has published a summary of the responses received on its consultation on the strategic framework for biodiversity, as well its biodiversity delivery plan for 2024 to 2030, which indicates that the new register of ancient woodlands is due for delivery by mid-2027.

Members will also be aware that the programme for government included a commitment to introduce a natural environment bill during the current parliamentary year. The response from Confor notes its commitment to sustainable forestry management and support for efforts to find balanced solutions that respect environmental considerations as part of that.

We have also received two submissions from the petitioners, the first of which draws our attention to a Scottish Environment LINK strategy to tackle invasive non-native species in Scotland, noting that forthcoming legislation offers an opportunity to ensure that commercial forestry plays a responsible role in managing the impact of Sitka spruce spreading from plantations on to neighbouring land. Their second submission welcomes the update on plans to develop the register of ancient woodland, while raising concerns that that will not necessarily result in additional legal protection for ancient and native woodland.

Do members have any comments?

Maurice Golden: I think that we should close the petition under rule 15.7 of standing orders, on the basis that the Scottish Government will take the actions that have been highlighted by the convener. In addition, it has committed to introducing a natural environment bill. On that final point and—I hope—to allay some of the petitioners' concerns, in closing the petition we should write to the Scottish Government, asking it to put on the record its plans and timescales for the natural environment bill. The Government's response said that it will happen in due course, which is similar to the response that I received on the Circular Economy (Scotland) Bill, which was due to be introduced in the 2016-17 programme for government but was not introduced until 2023. That is why I am keen to at least get an update on the timescales for the natural environment bill, which should, in theory, adequately address the petitioners' concerns.

The Deputy Convener: Do members agree to close the petition and to write to the Scottish Government?

Members *indicated agreement.*

The Deputy Convener: We will close the petition. I remind the petitioners that, if the Government does not make progress, they can lodge a new petition in the next session of Parliament.

Child Protection (Public Bodies) (PE1979)

The Deputy Convener: Our next petition is PE1979, which was lodged by Neil McLennan, Christine Scott, Alison Dickie and Bill Cook, who join us in the public gallery this morning. Welcome to you all. We are also joined for consideration of this petition by our MSP colleagues Edward Mountain and Ash Regan. Good morning to both of you.

The petition calls on the Scottish Parliament to urge the Scottish Government to launch an independent inquiry to examine concerns that allegations about child protection, child abuse, safeguarding and children's rights have been mishandled by public bodies, including local authorities and the General Teaching Council for Scotland; to examine concerns about gaps in the Scottish child abuse inquiry; and to establish an independent national whistleblowing officer for education and children's services in Scotland to handle such inquiries in the future.

11:00

We last considered this petition at our meeting on 6 March 2024, when we agreed to write to the Minister for Children, Young People and The Promise, the Scottish Public Services Ombudsman and the Children and Young People's Commissioner Scotland. Copies of the responses that we received are included in the papers for today's meeting.

Members will note that, although the SPSO suggested that there is merit in exploring an independent national whistleblowing officer role for education and children's services, its experiences with the establishment of the national health

service whistleblowing service demonstrate that it is not a straightforward process and "would require careful design".

The response from the Children and Young People's Commissioner echoes that sentiment and notes that, although she supports the exploration of a potential whistleblowing officer role, it is not a role that could be fulfilled by her office, nor does she have any evidence of children and young people wanting the commissioner to take on such a role.

We received two responses from the minister, the first of which refers to the Scottish Government's determination

"to ensure that robust child protection measures are in place across Scotland",

through implementing updated national guidelines.

The minister also indicated her willingness to meet with the petitioners. I understand that that meeting took place on 4 December and that the minister committed to keeping the petitioners updated on her work to support more robust and consistent investigations of specific cases. As the minister noted in her second response, and in response to recent questions in the chamber, that work includes engaging

"with Association of Directors of Education in Scotland representatives about the issue of how safeguarding concerns ... are investigated at local level",

as well as establishing a national public protection leadership group

"to discuss ways public protection process in Scotland can and should improve".

We have also received several submissions from the petitioners, which welcome the constructive and thoughtful submissions from the SPSO and the CYPCS. They highlight continued concerns about fragmented investigation systems and the power imbalance experienced by those raising safeguarding concerns, and the need to ensure that those with lived experience of such issues are part of designing an independent whistleblowing system.

The petitioners' most recent submission comments on their meeting with the minister. Although they

"welcome any action that strengthens the protection of children and young people",

the petitioners remain concerned that the Scottish Government has, so far, failed to address "fundamental points" such as public confidence in child safeguarding when systems, networks and personnel involved in historical and current allegations of abuse continue to be in place.

That is quite a lot of information. I ask my colleagues Edward Mountain and Ash Regan whether they have anything to say before we begin the discussion.

Edward Mountain (Highlands and Islands) (Con): Thank you, convener. I always like to come to the petitions committee because of the wide range of subjects, but this petition is particularly personal for me. It revolves around the question of safeguarding children. The simple question that we seem to be faced with is: what price do we put on safeguarding children, and do we think that what we are doing at the moment is right?

If I may, convener, I will briefly allude to a story that I have been dealing with in my constituency. It relates to a child who was approached by a teacher who was making sexual comments and innuendo to that child. The child made a complaint and left the school before they had finished their schooling. The complaint took a very long time to go through the Highland Council, and the consequence was that the teacher was found guilty. However, there were complications in that some of the investigation was prolonged by the fact that the teacher in question had had a relationship with one of the people who was investigating, and the outcome was that the child failed to complete their education.

It is actually worse than that, because it was all a secret story that resulted in the teacher being dismissed and saying, "I've done nothing wrong" to members of the public and the child being unable to defend themselves because nothing was made clear. I believe that Highland Council misrepresented and did not carry out its safeguarding responsibilities for that child. The council ended up marking its own homework and keeping the results quiet and not publishing them. The long-term consequences happened purely to the child.

I struggled with that and with the parents having to deal with that, because it seems so wrong. I find it difficult to accept, which is why I absolutely believe that we need an independent inquiry and an independent national whistleblowing officer, so that parents can make sure that their children are actually safeguarded in schools. At the moment, in my humble opinion, the situation favours the employee, because the employer is investigating and has a responsibility for protecting the employee, however bad they have been, from the outcomes of any inquiries.

I raised that issue with the General Teaching Council in Scotland and I did not get an acceptable outcome, which is why I believe that the committee ought to consider the matter further and push the Government harder. Frankly, it does not know who will do the role. There was a question about cost, which is unacceptable. What cost do we place on safeguarding people? What cost do we place on safeguarding our children?

Frankly, I do not think that the cost is too high, because we need to get it right.

Ash Regan (Edinburgh Eastern) (Alba): I thought that it might be useful to bring to the committee's attention things that have been going on in the City of Edinburgh Council that are similar to what Edward Mountain has talked about.

I cannot go into details, but a very concerned constituent came to me to explain serious mishandling of whistleblowing and potential breaches of safeguarding of children that had been going on historically, which I believe are still unresolved. That is in Edinburgh, but I can see that the issue goes further across the country. There appears to be an unacceptably high level of safeguarding failure in the system.

We are talking about children, so I suggest to the committee that, as Edward Mountain set out, the cost should not be an issue. I do not think that the failure in the system is being adequately addressed by the current procedures and processes. I believe that certain public bodies are being defensive in the way that they interact with the Parliament and the Government.

Over the past week, we have seen that the Government, unfortunately, does not have a grip on what is going on across Scotland. As Edward Mountain did, I urge the committee to think seriously about the requests in the petition and take them forward.

The Deputy Convener: I thank both colleagues for their contributions. Do members have any suggestions or comments?

Fergus Ewing: I am persuaded by what both of our visiting MSP colleagues say. I profoundly believe that the current system is inherently flawed, as the petitioners have maintained throughout the lengthy sequence of correspondence that I have read in preparation for this meeting.

We have a lot to learn from the Romans, including the first principle of natural justice: nemo iudex in causa sua—which means that no one can be a judge in their own cause.

The current basis of complaints in the health world and in education—for example, the GTC, which has been mentioned—is that the organisations deal with complaints against their employees, but it seems to me that their first instinct is usually to defend the system—the employee—against the complainant. It is almost a genuflection, and I have seen it time and again for 25 years.

I am grateful to the petitioners, because they have highlighted the existence of an inherent flaw. Child safeguarding is probably the most sensitive and important area that we could possibly conceive of, as both of our colleagues have said.

I find the cost argument to be utterly unconvincing. The petitioners have pointed out that the cost of the child abuse inquiry is likely to be £300 million. It seems to me that, in the future, we should try to tackle the cost of the existing system rather than worry about the cost of a national whistleblower's office that will be minuscule in comparison with the cost of the damage that has resulted.

I strongly support the petition and I think that we should write to the minister. If colleagues are similarly minded, I feel that we have a sufficient evidential basis, particularly given the lengthy exchange that has taken place between the minister and the petitioners. There is no point in my rehashing it, but it is full of cogent relevant facts and material that the minister has not addressed in any way. Some of the very modest, minor work that the minister says is going on, such as making inquiries about what is happening at the moment, should have been done long ago, when the petition was first lodged. It is a bit late now.

There needs to be a whistleblower. We should not shilly-shally or dither and swither around but should instead urge the Government to get on with it and make that recommendation to the committee. Given that numerous members have registered their concerns about the issue, our impression is that there is widespread concern across the parties. Therefore we should get off the fence and recommend that there be a whistleblower. That should be considered in conjunction with the petitioners and others who can provide useful information about the whistleblower's role, their remit and how the process would operate. As I have said, the costs would be very modest in comparison with the existing costs.

The Deputy Convener: Do other members want to add anything?

Foysol Choudhury: I agree that we should write to the Minister for Children, Young People and The Promise to recommend that the Scottish Government explore the merits of an independent national whistleblowing officer for education and children's services. We should also seek an update on the action that the Scottish Government is taking to support more robust and consistent investigation of specific child safeguarding cases across Scotland, including what consideration has been given to addressing perceived conflicts of interest for local authorities between their responsibilities as employers and their duty of care to children and young people.

We should seek information on what engagement the Scottish Government has had

with its UK counterparts following the Home Secretary's announcement that measures to make it mandatory to report child abuse will be introduced as part of the UK Parliament's Crime and Policing Bill, including what consideration the Scottish Government has given to introducing a similar measure in Scotland. We could also write to the General Teaching Council for Scotland to seek an update on the Professional Standards Authority's review of its fitness-to-teach process and on the wider work that it is undertaking to review the fitness-to-teach rules, including whether any consideration is being given to perceived conflicts of interests over the role of local authorities as part of that review.

The Deputy Convener: Thank you, Mr Choudhury. Are colleagues agreed that we will take those actions?

Members *indicated agreement.*

Legal Control of Generalist Predators (PE2035)

The Deputy Convener: Our next petition is PE2035, which was lodged by Alex Hogg on behalf of the Scottish Gamekeepers Association, and calls on the Scottish Parliament to urge the Scottish Government to officially recognise the legal control of abundant generalist predators as an act of conservation to help ground-nesting birds in Scotland.

The committee will recall that we took evidence from the petitioner last year and that, at our subsequent meeting on 17 April 2024, we agreed to write to the Minister for Green Skills, Circular Economy and Biodiversity. Due to ministerial changes, the committee wrote to the Cabinet Secretary for Rural Affairs, Land Reform and Islands, and has received a response from the Minister for Agriculture and Connectivity. The committee's letter asked about the proposed ministerial statement, research into different conservation methods, funding, zoning and education.

11:15

The minister's response reiterates that the Scottish Government agrees that predator control can be an important component of species conservation, alongside other techniques such as habitat management and translocation. The response states that there is no specific information available on the costs and outcomes of each conservation method. The response notes that the efficacy and costs of each method or approach to conservation of a particular species depend on a variety of factors and therefore cannot be easily compared on a like-for-like basis.

The Scottish Government is currently reviewing the financial support available for agri-environment and climate schemes and, as the review develops, the Government will be considering the funding available for predator-control activity.

Members will recall that the petitioner suggested the use of zoning to allow for targeted predator control while preventing widespread removal of species. The minister has outlined work on a generalist predator population survey, which aims to better understand the size and impact of predators on capercaillie conservation and native pinewood restoration. The minister explains that the outcome of that work will allow further consideration of whether zoning will be useful to allow targeted predator control while preventing widespread removal of predator species.

The petitioner has provided a written submission, which states that he agrees with many of the points that have been made by the minister and is satisfied with the answers that have been provided. However, he reiterates his call for a ministerial statement.

Maurice Golden: I think that a ministerial statement would be very helpful but, as members will be aware, that is ultimately a matter for the Scottish Government and the Parliamentary Bureau.

The petitioner should be congratulated. I recommend closing the petition under rule 15.7 of standing orders, on the basis that the Scottish Government has, in writing, recognised the importance of predator control in its engagement with the committee, is reviewing the funding for future environment and climate schemes and will consider predator-control funding as that develops.

Fergus Ewing: The petitioner has said that, on some points, he was

"satisfied with the answers given"

by the minister. The minister has taken an interest in the matter, all of which is to be welcomed. I think that the petition has probably gone as far as it should, and I agree that a ministerial statement would be of use. I particularly support the recommendation that, in closing the petition, we write to the minister to draw attention to the importance of financial support being available under future agri-environment and climate schemes in order to maintain and increase predator control.

I should say that I have known Alex Hogg as a friend for 25 years, and there are very few people in Scotland who know more about managing wildlife and the countryside than he and many of his colleagues in the Scottish Gamekeepers

Association, of which I am a member. Indeed, I hope that I have paid my subscription.

The serious point is that Alex Hogg has made the case for funding very well. He says that, over the several decades during which he has worked, there has been a

"change in balance between predator and prey".

Now, the predator has the whip hand, the prey is often unprotected, and there is not much that can be done about it. That results in carnage in the countryside, with the loss of livestock, particularly lambs, from foxes and other predators. It is essential that they are properly controlled. Mr Hogg concludes with the point that, if there is a specific strand in the new agri-environment schemes, that would help not only to control predators, which cause enormous damage, worry and stress to farmers, crofters and land managers, but to protect some of the species that are under threat, too. He makes that point in his submission.

The Deputy Convener: Does everybody agree to the recommendations?

Members *indicated agreement.*

Hire of Public Land (Ministerial Intervention) (PE2056)

The Deputy Convener: Our next petition is PE2056, which was lodged by Stephen Gauld, and calls on the Scottish Parliament to urge the Scottish Government to introduce legislation providing ministers with the power to call in and potentially override council decisions on the hire of public land for large-scale events.

We last considered the petition at our meeting on 6 March 2024, where we agreed to seek the views of the Convention of Scottish Local Authorities, the Association for Public Service Excellence in Scotland, Event Scotland, the Scottish Tourism Alliance, and the Scottish Showmen's Guild, on its ask.

Responses from Event Scotland and the Association for Public Service Excellence are similar to the view that the Scottish Government previously provided to us, which was that local authorities are best placed to make decisions about the hiring and use of public land. Indeed, APSE highlighted that

"such decisions are subject to judicial review ... and ... any disputes regarding decision making would be ... for the court to adjudicate on".

COSLA responded to let us know that it has "no position" on the matter but suggested that we might want to contact the Society of Local Authority Lawyers and Administrators Scotland for its view.

The Scottish Tourism Alliance responded to say that it believes that

"where there is no sound reason given in refusing the hiring of land for events and there is a clear case that it delivers a positive local, regional, and national economic impact … it would be fair that the Scottish Government could have the power granted to challenge the local authority's decision".

The response goes on to state that

"it is important that there is an open and transparent dialogue with local authorities"

and others, including businesses,

"to reach an informed decision if an event is to take place".

We have also received a submission from the petitioner commenting on the various responses and setting out his view that the hire of public land is separate from council licensing procedures, as they come into effect once permission to hire the land is granted.

Do any members have comments?

Fergus Ewing: The evidence that we have had from the Scottish Tourism Alliance, which you helpfully read out to us, deputy convener, should be pursued—namely, the recommendation that the Scottish Government should have power to challenge a local government decision. We need to explore that further.

The petitioner's previous comments state that he was "fobbed off" with various excuses, and there has not really been any answer to that. On one occasion, he was told that he could not use the land because someone else might want it—for goodness' sake, what sort of an excuse is that? I know that the Scottish Tourism Alliance represents a huge range of tourism bodies, so its voice is significant. The fact that it has chosen to respond with that specific suggestion makes me feel that we should pursue the matter further rather than close the petition at this juncture, to be fair to the petitioner. It may be that the Scottish Government will refuse to do that—I would not be surprised if it were to do so—but we should at least ask it.

The Deputy Convener: Are we agreed?

Members *indicated agreement.*

Dog Boarding Kennels (Fire Safety) (PE2058)

The Deputy Convener: The next petition is PE2058, which was lodged by Julie Louden, and calls on the Scottish Parliament to urge the Scottish Government to improve fire safety in dog boarding kennels by mandating the installation of smoke detectors, smoke alarms and sprinkler systems.

We last considered the petition at our meeting on 21 February 2024 and agreed to write to the

Scottish Government, COSLA, the Scottish Fire and Rescue Service, Edinburgh Dog and Cat Home, Dogs Trust, and other relevant stakeholders. The committee has received responses from all of them, as well as from the Pet Industry Federation and the petitioner.

The Scottish Government is considering revoking the act that currently regulates animal boarding and bringing boarding under the Animal Welfare (Licensing of Activities Involving Animals) (Scotland) Regulations 2021. Its response to the committee states that the Scottish Government will consider how to address fire safety under any future licensing scheme.

Dogs Trust stated its support for bringing animal boarding under the scope of the 2021 regulations, noting that it hopes to see the creation of guidance under any new legislation for boarding establishments which mirrors the animal welfare establishments guidance, as a minimum.

The Scottish Government's submission also states that, in light of the incident that is highlighted in the petition, animal welfare officials will seek to engage with colleagues in the fire protection and safety unit to identify appropriate enhanced fire safety measures and how best to incorporate those measures into any future licensing scheme for animal boarding.

Stakeholders raised concerns about the practicalities of requiring sprinkler systems to be installed in dog boarding and rehoming kennels. The Dogs Trust consulted a contractor, which gave a rough estimate of tens of thousands of pounds to install a sprinkler system at one of its centres.

The Pet Industry Federation sought views from kennel and cattery members across Scotland. All respondents said that they had smoke detectors in addition to the fire extinguishers that are required, and none had sprinklers installed. Respondents were open to the suggestion that sprinklers be installed. However, some raised concerns about the cost and economic viability of installing sprinkler systems in commercial boarding premises and said that, in some cases, it would be practically impossible to do so. The federation concluded that the cost of installing such systems was likely to be too high for many and that it would be difficult to support an additional requirement that could put its members out of business.

In its response, the Scottish Fire and Rescue Service provided figures for the number of fire incidents since 2009. Twenty-four fire incidents were recorded under the relevant category for animal boarding and shelter kennels for dogs. Four of the premises involved in those incidents were noted to have had smoke alarms present. The SFRS noted that, under fire safety law, measures need to be taken to address risk, but not to the extent that the cost, effort and other disadvantages associated with the provision of fire safety measures would be disproportionate to the risk to life.

Do members have any comments or suggestions?

Maurice Golden: I think that the committee has gathered a useful body of evidence, and I hope that the petitioner is satisfied with the action that has been taken. Unfortunately, though, we now need to close the petition under rule 15.7 of the standing orders, on the basis that the Scottish Government is considering bringing animal boarding regulation under the Animal Welfare (Licensing of Activities Involving Animals) (Scotland) Regulations 2021 and that, if such regulation is progressed, fire safety will be considered as part of that work.

The Deputy Convener: Do members agree to close the petition?

Members *indicated agreement.*

Pedestrian Safety (PE2065)

The Deputy Convener: Our next petition is PE2065, which was lodged by Shauna Rafferty, and calls on the Scottish Parliament to urge the Scottish Government to improve and prioritise safety for pedestrians by widening pavements and reducing street clutter, introducing a mechanism to report pavement parking and improving the visibility of pedestrian crossings.

We last considered the petition at our meeting on 6 March 2024, when we agreed to write to Transport Scotland and the Convention of Scottish Local Authorities. In its response, Transport Scotland said:

"The National Planning Framework 4 highlights that one of the 6 qualities of a successful place is well connected with networks which make a place easy to move around. This includes designing for pedestrian experience including safe crossing, pedestrian priority, reduced street clutter and more."

Transport Scotland went on to say:

"It is for local authorities to identify streets that are in need of decluttering and utilise available funding to improve safety on these streets."

Similarly, it stated that local authorities are responsible for the day-to-day enforcement of the pavement parking ban, and that it would be a matter for each local authority to decide whether to set up its own reporting system.

Regarding the visibility of pedestrian street crossings, there is UK guidance on the design of crossings that sets out the key points for consideration to ensure that pedestrians are able to see and be seen by approaching traffic.

In its response to the committee, COSLA noted that it supports the shared goal of eliminating road fatalities and casualties by 2050. However, it also noted the unprecedented financial pressure on local authorities, which is having an impact on their ability to implement the necessary improvements.

Do members have any comments or suggestions?

Fergus Ewing: I think that we have probably pursued the issue as far as we can at this stage in the parliamentary cycle, so I recommend that we close the petition under rule 15.7, on the basis of four factors. First, the guidance on the visibility of pedestrian crossings is set out in the UK-wide guidance on the design of pedestrian crossings. Secondly, national planning framework 4 highlights safe crossing, pedestrian priority and reduced street clutter as desirable qualities. Thirdly, the Scottish Government considers that it is for local authorities to identify streets that are in need of decluttering. Fourthly, the day-to-day enforcement of the pavement parking prohibitions, along with consideration of reporting systems, is also the responsibility of local authorities.

Taking account of those factors, I recommend that we close the petition.

The Deputy Convener: Does the committee agree to close the petition?

Members *indicated agreement.*

New Petitions

11:30

The Deputy Convener: We move to agenda item 3, which is consideration of new petitions. Before I introduce the first new petition, I highlight to those who are following today's proceedings that a considerable amount of work has been done in advance of the consideration of a petition. Before a petition is first considered, an initial view is sought from the Scottish Government and a briefing from the Parliament's impartial research service is provided.

Roadside Litter Awareness Campaign (PE2121)

The Deputy Convener: The first new petition is PE2121, which was lodged by Carolyn Philip, who I believe is with us in the public gallery. Welcome. The petition calls on the Scottish Parliament to urge the Scottish Government to run a campaign targeted at companies to raise awareness of the harms that are caused by roadside litter and the penalties that could be brought against responsible parties. We are joined for consideration of the petition by our colleague, Rachael Hamilton MSP—welcome, Rachael.

Keep Scotland Beautiful reports that 50 tonnes of litter are abandoned on Scotland's roadsides each month. The charity's annual Scottish litter survey of 2024 set out that 88 per cent of respondents viewed roadside litter as a problem in Scotland.

The Scottish Government's response highlights the 2023 national litter and fly-tipping strategy and year 1 action plan. The response states that that work recognises the importance of prevention through education and communication and of effective approaches to enforcement. On enforcement, section 18 of the Circular Economy (Scotland) Act 2024, when commenced, will enable the issuing of civil penalties for littering from a vehicle.

The response informs us that the national litter and fly-tipping strategy delivery group has established a communications sub-group that will explore the best ways to deliver effective communication messages on litter and fly-tipping. Proposals put forward in the petition will be shared with the sub-group so that it can consider them as part of its on-going work to look at improving communications at the national level. However, the Scottish Government has indicated that direct mailing to local businesses and roadside signage would be a matter for local authorities or Transport Scotland.

The petitioner's response states that, although her group commends the amount of work that has been done in producing the action plan, she does not agree that the fundamental steps have been taken to address the point that is made in the petition. She points out that the action plan does not mention making companies responsible for securing loose items on open-back lorries. She states that large sums of money are spent each year to clean up litter and suggests that the money would be better spent on applying a workable and enforceable way of reducing litter in the first place.

Before I invite comments from the committee, I ask Rachael Hamilton whether she would like to contribute.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): Thank you, convener. I thank you and the committee for giving me the opportunity to speak in support of petition PE2121 on running a targeted roadside litter awareness campaign.

Like the convener, I welcome to the public gallery the petitioners, Carolyn Philip and Myra Watson, from Berwickshire anti-litter group. The group regularly co-ordinates litter picks throughout Berwickshire, including on the A1, which is one of the main tourist routes into Scotland. I also welcome around 30 other litter and gardening groups who are watching online. Members of the committee will be pleased to hear that groups from their own constituencies and regions, such as West Lothian litter pickers and Dundee litter pickers, are among those watching online.

We all know that volunteers such as Carolyn and Myra give up their free time to pick litter, out of the goodness of their hearts. They choose to do it with very little support from anyone, including the Scottish Government and cash-strapped local authorities.

Between March and April 2024, Keep Scotland Beautiful held its annual spring clean, in which 45,000 people from every local authority across Scotland took part in 3,564 registered litter picks. Those volunteers care deeply about the communities in which they live, and they recognise the importance of protecting Scotland's biodiversity through maintaining the cleanliness of our environment.

Recent statistics reveal that just over four in five people in Scotland—82 per cent—agree that they want to see more efforts to prevent litter in their area. A similar figure—81 per cent—express a desire for increased action to clean up litter locally.

Carolyn Philip, the lead petitioner, has said that, for three years, she and others have been writing to councillors, Government ministers, BEAR Scotland and Transport Scotland. She says that their responses have been patronising, thanking them for their hard work but not providing any positive or constructive solutions that are enforceable.

Despite the Scottish Government publishing the national litter and fly-tipping strategy that the convener mentioned, the landscape of who is responsible for collecting roadside litter, enforcing penalties and raising awareness of the issue remains confused and scattered. Furthermore, the pace of action by the Scottish Government is glacial, meaning that the blight of litter continues to have a significant negative impact on communities and our environment.

Keep Scotland Beautiful admits that we have reached the point at which there is a litter emergency, and that, without increased coordination and attention, the current situation is unlikely to change.

I agree with Carolyn when she says that we need definitive action, not more talk. On that note, I will close by saying that I would like to add my full support to the aims of the petition, and I hope that the committee will give it due consideration.

The Deputy Convener: Do members have any suggestions or comments?

Maurice Golden: There is quite a lot in the petition, and it might help the petitioner if the Scottish Government could provide the context of roadside litter awareness campaigns and say who has been responsible for delivering them over the period in which this Scottish Government has been in charge, since 2007. It would be useful for the committee to have that context.

I would like the Scottish Government to detail who has been responsible for any specific campaigns. I am aware of one that was run by Keep Scotland Beautiful from 2016 to 2019, but I am also aware that there has been varied responsibility for delivering litter awareness campaigns more generally. In 2011, there was the "Dunna chuck bruck" litter awareness campaign in Shetland, which I might have to declare as an interest, as I funded it.

It is important that the Scottish Government tells us how much funding has gone into roadside litter awareness campaigns each year—if it is generous, it might expand that to litter campaigns in general—and who is responsible for delivering them. It should also tell us what the assessment of the dumb dumpers phone line was. That was a national phone line, but if you call it now, you are instructed to call your local authority, which might not necessarily be set up to deal with the issue.

We should also ask the Scottish Government for further information on the national litter and fly-tipping strategy delivery group's communications sub-groups—what a mouthful—including what

actions will be taken at the national level to improve communications about littering. It is important that that action is taken nationally, as this is not purely a local authority issue. We should also ask what engagement has been done with stakeholders. It would also be worth asking whether the littering provisions in the Circular Economy (Scotland) Act 2024 will cover unintentional littering from commercial vehicles—I hope that they will, because the 2024 act will not deliver a circular economy if it does not deliver on litter.

It might be interesting to talk to other stakeholders who might have an interest in the issue. Rachael Hamilton mentioned those that manage our trunk roads, including Transport Scotland. I know from paddle boarding under the Friarton bridge how dangerous roadside litter can be, because lots of individuals will throw various things over the side of the bridge.

Finally, on extended producer responsibility, I would like us to ask how the Scottish Government is engaging with producers to help to co-ordinate litter collection and therefore reduce disposal costs, which I know many of the large companies and small producers are keen to do.

The Deputy Convener: Thank you for that comprehensive submission.

Fergus Ewing: I am impressed by how much Mr Golden knows about rubbish.

The Deputy Convener: Do members agree with the proposed action?

Members *indicated agreement.*

Pensions (Divorce) (PE2124)

The Deputy Convener: Our final new petition is PE2124, which was lodged by Eliza Wiper, and calls on the Scottish Parliament to urge the Scottish Government to change the law so that it no longer considers private and workplace pensions to be part of matrimonial property.

The Scottish Parliament information centre briefing explains that pension benefits that are built up during the period of the marriage or civil partnership are considered matrimonial or partnership property. The briefing also notes that a key principle of financial provision on divorce is that the net value of a couple's matrimonial or partnership property must be shared fairly between them. Fair sharing is usually equal sharing unless special circumstances apply.

The Scottish Government's response to the petition states that it does not support the aims of the petition. In response to the petitioner's view that no contribution is made by the partner to the pension, the Scottish Government highlights an indirect contribution made, such as one spouse leaving or reducing paid work to care for children or other family members.

The petitioner's written submission shares her view that staying at home to look after children is the choice of that individual and highlights the Scottish Government's proposed early years childcare funding. The petitioner is also keen to receive more data on the issues that are raised in the petition.

Do members have any comments or suggestions for action?

Fergus Ewing: I have tried to consider the petition carefully. As a solicitor formerly in private practice for a quarter of a century, I dealt with quite a lot of matrimonial work and the financial settlement on divorce, which, as the minister said in her reply, is covered by the Family Law (Scotland) Act 1985

One understands that both parties to divorce usually have very strong feelings and often feel that the division of the cake is unfair, and one can sympathise with that in certain circumstances. However, the Government has set out clearly that it is not in favour of that policy, and there is really no prospect whatsoever that it will change those principles.

I think that the 1985 act is a very good piece of legislation, and I want to make one specific point clear, which may not be immediately apparent. Under the act, the assets that fall to be divided between the parties are classified as matrimonial property, that is, property that is brought in in anticipation of marriage or property that is acquired or created during the period of the marriage, from the date of the marriage until the date of the separation or raising of the writ, if there has not been a separation.

In other words, the point is that, if you get married at, say, 50 and then divorced at 55, and you took out a pension when you were 25 and you still have that pension, then only the proportion of the pension attributable to the time period relating to the date of the marriage and the date of the separation falls to be taken into account. That is because the law recognises that there needs to be a recognition of the contributions of both parties in bringing up children and so on. If there is one breadwinner, the other spouse—usually, though not always, the female—may often have substantial childcare responsibilities.

The law is quite sophisticated. It seems to me to have stood the test of time. It seeks to be fair and, although the petitioner feels that it is unfair, I am not persuaded by her arguments. Therefore, on this occasion—I have not said this for a while—I agree with the Scottish Government.

The Deputy Convener: Are you suggesting that we close the petition under rule 15.7 of the standing orders?

Fergus Ewing: Yes. I know that the petitioner will be disappointed but, as you said in relation to a previous petition, convener, a lot of work has been done up to this time by the clerks to get a response from the minister and the petitioner. Were there any prospect of any reform, it would be our duty to explore and examine that, but my personal view—members may take a different view—is that there is no prospect at all of the Scottish Government changing its mind. If there is a different Government in the future, the petitioner might bring the issue back, if she so wishes.

The Deputy Convener: Do members agree to the proposed action?

Members *indicated agreement.*

The Deputy Convener: That concludes the public part of our meeting. Our next meeting will take place on Wednesday 19 February. I hope that our convener will be well enough to convene it.

11:44

Meeting continued in private until 12:07.

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