The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 10 June 2015

Session 4

Wednesday 10 June 2015

CONTENTS

Scottish Parliament

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[The Deputy Presiding Officer opened the meeting at 14:00]

Portfolio Question Time

Health, Wellbeing and Sport

The Deputy Presiding Officer (Elaine Smith): Good afternoon. The first item of business this afternoon is portfolio questions on health, wellbeing and sport.

National Health Service Infrastructure (Highlands)

1. Dave Thompson (Skye, Lochaber and Badenoch) (SNP): To ask the Scottish Government what it is doing in the Highlands to ensure that NHS infrastructure is fit for the 21st century. (S4O-04428)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): We have been in discussions with NHS Highland over the future of facilities in the Moray Firth area and it was agreed that a master plan was required in order to ensure that the totality of the investment that is needed in NHS Highland facilities was fully understood. NHS Highland recently presented a master plan to its board that outlines a number of available options taking into account clinical, public and financial considerations. We will work closely with NHS Highland to ensure that the plan delivers the best possible outcome for the people of NHS Highland.

Dave Thompson: I very much welcome that answer. Can the cabinet secretary confirm that the significant investment that is planned for the next decade—particularly at Raigmore—including a potential new build will not be at the expense of the planned state-of-the-art facilities at Fort William with the replacement of the Belford hospital, in Badenoch and Strathspey and on Skye?

Shona Robison: I am happy to confirm to Dave Thompson that the state-of-the-art new hospitals in Badenoch and on Skye will not be adversely impacted by the plans for Raigmore hospital. Those existing capital projects will continue as planned and they will absolutely contribute to an improved infrastructure that will allow NHS Highland to successfully implement the Highland care strategy, which outlines its vision for the future delivery of health and social care services for people in the Highlands for the next 10 years.

NHS Highland will continue to develop its plans for a future replacement for the Belford hospital in Fort William as well.

In respect of Raigmore, the member will be aware that NHS Highland has identified five main options and that it plans to undertake a full public consultation on them. We will, of course, consider the plans when they are submitted, but I am confident that they will tie in with the overall strategy as NHS Highland takes it forward.

Rhoda Grant (Highlands and Islands) (Lab): I echo the comments about the Belford hospital. There has been a campaign for a new Belford for my whole political career in this Parliament, but little progress has been made on that to date. We should not stall that at all. Progress is being made in Badenoch and Skye, but we also need progress in north-west Sutherland, where the facilities are not fit for purpose and there needs to be a change. I understand that NHS Highland is consulting on that, but it will lead to capital expenditure. Can the cabinet secretary assure us that that capital expenditure will not come out of NHS Highland's normal revenue, which has been tight for a number of years? If it did, that would impact on patient care. Will she make funds available for those capital projects?

Shona Robison: I am pleased that Rhoda Grant is pleased that the plans for the Belford are moving forward. There are some exciting developments on that front.

On north-west Sutherland, as I said in my initial answer, NHS Highland has to look at its whole plan in relation to the clinical priorities and its financial considerations. We will wait for NHS Highland's more detailed plans, which will come forward once it has decided what its priorities are and which options it will pursue. As Rhoda Grant said, it is consulting on the proposals for north-west Sutherland, and we will wait to see the plans that it wants to take forward. Capital considerations will be made in the same way as with any capital developments within the NHS in Scotland.

The Deputy Presiding Officer: Question 2 has not been lodged by Murdo Fraser. Although an explanation was provided, it was unsatisfactory.

NHS 24 Performance (Grampian)

3. Alex Johnstone (North East Scotland) (Con): To ask the Scottish Government whether it is satisfied with the performance of NHS 24 in Grampian. (S4O-04430)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): NHS 24 is Scotland's provider of a national telehealth service. There are four national contact centres—based at Glasgow, Aberdeen, South Queensferry

and Clydebank—where trained call handlers take calls from people throughout Scotland. All calls are triaged and directed to the most appropriate healthcare professional within an appropriate timescale, based on clinical need.

The performance of national organisations, including NHS 24, is managed nationally and not regionally. NHS 24's unscheduled care service, which is the first point of contact for most people when general practitioner surgeries are closed, dealt with around 1.3 million calls in 2013-14. Of those calls, 95 per cent were answered within 30 seconds against the target of 90 per cent.

Alex Johnstone: Given that answer, I am sure that the minister will be as horrified as I was to hear of the case of a constituent of mine who, having been assured at 5 o'clock on a Friday afternoon that, if he had any problems, he should phone NHS 24, did so with severe abdominal pain at 7.45 on Saturday morning and again at 11 o'clock. He eventually called an ambulance at 2 o'clock and was seen by a doctor from the associated GMED out-of-hours service at 4 o'clock in Turriff. Will the minister assure me that the resources and staffing are available to ensure that that kind of thing is not likely to happen to any more of my constituents?

Shona Robison: If Alex Johnstone has not already done so, he should write to me about the details of that case. It is not acceptable. We need to ensure that NHS 24 provides a rapid response in every case, and I want to understand more fully the circumstances of why that did not happen in that case. I assure him that I will investigate the case and get back to him.

Child and Adolescent Mental Health Services (North East Scotland)

4. Alison McInnes (North East Scotland) (LD): To ask the Scottish Government what it is doing to improve access to child and adolescent mental health services in North East Scotland. (S4O-04431)

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I have spoken to the chief executive of NHS Grampian to obtain assurances that the health board is doing all that it can to achieve the CAMHS target. As a result of that discussion, I have written to the board asking for a detailed recovery plan by 3 July. NHS Grampian has done significant work in service redesign to increase its capacity to meet the target sustainably. As a result of that redesign, it has already identified where it needs to increase capacity.

Alison McInnes: My question actually relates to NHS Tayside, as figures show that the longest waiting times there have got even worse. In the first three months of this year, only 35 per cent of young people started to receive the treatment that they desperately needed within the 18-week target. That is down from 52 per cent at the end of last year.

Everyone knows that early action is more likely to result in full recovery. It also minimises the impact on other aspects of the development of children and young people, such as their education. I thought that that was why the minister's department had changed the health improvement, efficiency and governance, access and treatment targets from 26 weeks to 18 weeks at the start of the year. However, parents in my region tell me that they are questioning the Government's commitment to the targets. ISD Scotland statistics show that around 250 young people in Tayside will now have to wait more than a year to start treatment.

The Deputy Presiding Officer: Could we have a question, please?

Alison McInnes: Will the minister reassure parents in Tayside? Has he asked for a detailed recovery plan from NHS Tayside?

Jamie Hepburn: I will deal with the latter point first: yes, I have. I have spoken to a representative of NHS Tayside.

I assure Alison McInnes, all other members in the chamber and all their constituents that the Government is still committed to the targets that it has set. Our commitment can be demonstrated through the £15 million that we announced for the mental health innovation fund last year, which is now supplemented by an additional £85 million over five years for mental health, which was announced in May this year.

I am aware of the particular issues in NHS Tayside. It is not the case that the longest waits are getting longer. Part of the challenge in NHS Tayside is that there have been some particularly long waits, which the health board is dealing with first, hence the particular challenge with achieving the 18-week target. However, I assure Alison McInnes of the Government's determination that the target will be achieved.

Seven-day Services (Delivery)

5. Roderick Campbell (North East Fife) (SNP): To ask the Scottish Government what progress the national health service has made with the delivery of seven-day services. (S4O-04432)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): NHS Scotland already provides high-quality, round-the-clock care and operates a range of services across seven

days. However, the Scottish Government is taking forward work to build on that.

The sustainability and seven-day services task force is considering how best to improve the care that our patients receive in the evenings and at weekends and how best to support a sustainable NHS for the future. The task force published an interim report in March this year, which outlined a number of specific actions to be taken. They include: considering the effectiveness of ward rounds at weekends; considering further opportunities for nurses, allied health professionals and healthcare scientists to contribute to developing sustainable services; and co-ordinating further work to support the sustainability of Scotland's six rural general hospitals.

Roderick Campbell: Last week, I visited the Marie Curie hospice in Edinburgh, where I was advised that no back-up is available at weekends for out-patients and that, therefore, some terminally ill patients have to go for emergency treatment at an accident and emergency department. The hospice is seeking to reconfigure its service so that it can provide more of a 24/7 approach and take the pressure off A and E.

I listened carefully to what the cabinet secretary said about the interim report. When can we expect a further report? One of the issues that I believe was raised at the meeting of the Health and Sport Committee on 17 March concerned data collection, so anything further on that would be helpful, too.

Shona Robison: The Scottish Government has committed to developing a palliative and end-of-life framework for action, supporting high-quality palliative care and end-of-life care, by the end of this year. We will ensure that we fully reflect that in our work on seven-day services.

The seven-day services programme is linked into a range of national activity that is being taken forward and is concerned with developing new approaches to and optimising out-of-hours care. The member will be aware of the out-of-hours primary care review, which is being led by Sir Lewis Ritchie, and the unscheduled care programme. We have to ensure that all of that is supporting organisations such as Marie Curie in the development of seven-day services.

We absolutely have to get palliative and end-of-life care right, and I am determined to do so.

John Scott (Ayr) (Con): Although the delivery of a seven-day service is, of course, a laudable aim, can the cabinet secretary tell Parliament how NHS Ayrshire and Arran will cope this winter, when increased admissions are likely, or even later this month, given that elective surgery is being cancelled in NHS Ayrshire and Arran just now, during the summer months, due to the number of medical patients who are being admitted to surgical wards?

Shona Robison: We will ensure that the necessary capacity and resilience is there in all of our boards to cope with winter pressures.

The member has hit upon the need for us to consider new models of care. Obviously, the priority at the moment is focusing on winter and ensuring that the capacity is there. However, as we look beyond that timeframe—the debate later today will touch on some of this—we absolutely need to ensure that we get the models of care right so that we can ensure that there is no knock-on effect on elective capacity from, for example, people coming in through emergency procedures, which happens far too often at the moment.

I am happy to keep John Scott updated about winter resilience and about the wider debate as we take that forward.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Clearly, the Government is taking the issue of seven-day working seriously. However, does the cabinet secretary agree that, as Roderick Campbell alluded to, we need to have confidence in the detail that is being provided by health boards, which would underpin seven-day working? Would she like to comment on the reports today of the whistleblower in NHS Tayside, who seems to have blown a hole in the A and E target figures in Tayside by reporting more gaming in what had looked to be the best practice in Scotland?

Shona Robison: I will answer that in two parts. First, the detail that is being provided to underpin work on seven-day services is absolutely part of the work that the task force is taking forward.

The second issue is a serious one and needs to be dealt with as such. Let me respond to that in detail. Richard Simpson has made a serious allegation in this chamber, and I want to put the few facts on the record.

Dr Simpson: It is not my allegation.

The Deputy Presiding Officer: Order.

Shona Robison: The system that NHS Tayside has for the A and E department—

Dr Simpson: Presiding Officer, it is not my allegation; it is a report in the press.

The Deputy Presiding Officer: Order.

Shona Robison: The member has reported an allegation that has been made. I will deal with it.

The Deputy Presiding Officer: Cabinet secretary, Dr Simpson's question is somewhat wide of the initial question anyway, so perhaps it could be dealt with in some other way.

I call Nanette Milne.

Nanette Milne (North East Scotland) (Con): Has the Government made an assessment of how many more staff would need to be recruited, and at what cost, if the NHS were to move generally to a seven-day service?

Shona Robison: That is part of the on-going work on seven-day services. It is important that the workforce requirements to sustain seven-day working are considered. Obviously, some staff already work across seven days; it is a little bit more challenging when it comes to medical staff, given their contracts. I want to ensure that any change is made in consultation and partnership with the workforce, whichever part of the workforce we are talking about. That is the way in which we do things in the NHS, and nothing will be imposed on anyone.

What is important, though, is that there is a requirement for us to look at new ways of working as we look towards future models of care. Seven-day working is important but, as I have said before in this chamber, it is not about doing complex operations at 4 o'clock in the morning just because we can; it is about making sure that the core services are sustainable and sustained. For example, it is about being able to discharge more patients at the weekend so that we do not have that blockage on a Monday and a Tuesday within our acute hospitals. I am happy to keep Nanette Milne posted on that.

Individual Patient Treatment Requests

6. Elaine Murray (Dumfriesshire) (Lab): To ask the Scottish Government what consideration can be given to individual patient treatment requests for further or repeat courses when the initial treatment has had some success. (S4O-04433)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): We expect national health service boards to have procedures in place to deal with a wide variety of individual patient treatment requests for both medicines and other therapeutic interventions. Decisions on individual treatment are a matter for discussion between the individual and their consultant.

Elaine Murray: I thank the cabinet secretary for her reply. I am asking the question on behalf of my constituent Brian Houliston. Brian and his wife Shona are in the public gallery this afternoon. Brian is suffering from oesophageal cancer and had to fight to receive a treatment that is available on the NHS in England, which has successfully shrunk the tumour and restored his health. He has now been refused funding for the second part of his treatment and will have to raise something in the region of £26,000 for follow-up private treatment.

Can the cabinet secretary please advise what can be done to ensure that Mr Houliston receives his treatment on the NHS, which would prolong his life and provide evidence of possible treatment for other patients suffering from that cancer?

Shona Robison: I am conscious that Elaine Murray's constituent is in the public gallery. I would be very happy to follow up with her some of the detail around the case because obviously there is a limit to how much we can discuss individual cases in the chamber.

I assume that Elaine Murray might be talking about selective internal radiation therapy. It is important to know that selective internal radiation therapy treatment is not routinely provided in the United Kingdom. However, a UK-wide clinical evaluation is currently under way to assess the effectiveness of that type of therapy for a small number of patients.

We would normally say that, if a person wishes to access a certain therapy, they should discuss it with the team that is responsible for their care in the first instance to identify whether their specialist doctor considers that they would benefit from that new treatment. We would expect boards to have processes in place to allow patients who are recommended by their specialist as potentially benefiting from that treatment to be considered for that therapy.

I think that the best way to follow up would be if Elaine Murray emails or writes to me with the particular circumstances of the case. I can then get back to her in more detail.

Neurological Alliance of Scotland (Funding)

7. Alex Fergusson (Galloway and West Dumfries) (Con): To ask the Scottish Government whether it will reconsider its decision to discontinue core funding for the Neurological Alliance of Scotland. (S4O-04434)

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): The Scottish Government remains fully committed to working with all stakeholders to improve outcomes for people with neurological conditions. We will continue to work with third sector colleagues and, indeed, we will be refocusing effort in that area. To that end, we expect to increase funding for specific projects to improve services and experiences for people with neurological conditions. This year we expect to invest almost three times as much funding as last year—up to £210,000—to support robust improvement projects.

Through the chief scientist office, we have currently committed more than £2 million on

projects relating to neurological conditions. In addition, £700,000 has been committed to funding motor neurone disease specialist nurses.

Alex Fergusson: I thank the minister for that response, which I will take as a no to my question. I have looked carefully at Monday's written answer from him to the parliamentary question S4W-25750 lodged by my colleague Nanette Milne on this very subject. The Scottish Government has turned down the alliance's request for just £35,000 of core funding—funding that enables neurological charities to work together to move neurology up both the political and the national health service agenda, which I think most people believe it has done very successfully.

How does the Scottish Government's rejection of that request accord with the cabinet secretary's amendment to this afternoon's debate on health, which talks of fostering a "mature debate" and developing a "consensual approach" to future challenges?

Jamie Hepburn: In the interests of mature debate, I will answer that question. First, it is not the case that funding has been discontinued as such: there was an agreed funding period that came to an end. I am meeting the chair of the alliance soon, and I will be happy to discuss the matter with him.

The Scottish Government already funds the Health and Social Care Alliance Scotland with in excess of £3 million per year. The group has a variety of strategic outcomes and strong experience and expertise in topics such as health and social care integration, which is a key concern for the neurological community.

A number—in fact, a majority—of the member organisations of the Neurological Alliance of Scotland are also members of the Health and Social Care Alliance, and I believe that it is therefore well placed to provide a strong voice for the neurological community.

We also fund the national neurological advisory group, and given the threefold increase in project funding—which I notice was not welcomed by Alex Fergusson—neurological clients will be able to apply for and benefit from that resource.

The Deputy Presiding Officer: Question 8, from Mark Griffin, has not been lodged. Again, the explanation was not satisfactory.

NHS Lothian (Meetings)

9. Gavin Brown (Lothian) (Con): To ask the Scottish Government when it last met NHS Lothian. (S4O-04436)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Ministers and Government officials regularly meet representatives of NHS Lothian to discuss matters of importance to local people.

Gavin Brown: Was sickness absence discussed at the most recent meeting? If so, what is the Government's explanation for the increase in sickness absence in NHS Lothian in each of the past three years?

Shona Robison: Sickness absence is a regular item for discussion between NHS Lothian and officials. It forms part of the annual review process, which looks at the progress that is being made in that regard.

I say to Gavin Brown that we absolutely want to tackle sickness absence. That is against a background of the Government ensuring that there are more staff than ever in our national health service, which I am sure he will welcome. I can certainly tell him that the number of whole-time equivalent staff who are employed in the board increased substantially—by 10.7 per cent—from September 2006 to March 2015.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Oh dear.

Shona Robison: That includes a 34 per cent increase in medical and dental consultant numbers and a 12.6 per cent increase in the number of qualified nurses and midwives. Richard Simpson might not want to hear about that, because he likes to talk about doom and gloom—

Dr Simpson: No, I am tired of hearing about it.

Shona Robison: I am sure that, for the people of NHS Lothian's area, the figures will be welcome news indeed.

Jim Eadie (Edinburgh Southern) (SNP): Is the cabinet secretary aware of the concerns of the National Osteoporosis Society and the clinicians who are involved in the management of osteoporosis and the prevention of fragility fractures that the waiting time guarantee for a DEXA—dual energy X-ray absorptiometry—scan in NHS Lothian is not being met? Some patients are having to wait 15 months from fracture to treatment and are at risk of fracturing again during the time that they have to wait. Will the cabinet secretary commit to raising the matter directly with NHS Lothian to ensure that any specific issues can be addressed and that patients receive the care to which they are entitled?

Shona Robison: I share the society's concern at the suggestion that any patient should have an excessive wait for a DEXA scan, which would not be acceptable. Although a DEXA scan is not one of the eight key diagnostic tests that are covered by the six-week waiting time standard, the Scottish Government expects all boards to ensure that waits for other diagnostic tests are kept as short

as possible and that, if possible, the tests are carried out within six weeks.

We are aware that NHS Lothian's current waiting time for a DEXA scan is well in excess of six weeks and we have made it clear to the board that it must take immediate action to significantly reduce that wait as quickly as possible. My officials will monitor the board's progress closely over the next few months.

Sarah Boyack (Lothian) (Lab): Has the cabinet secretary spoken to NHS Lothian about the problem of general practices? I understand that 26 practices have now closed their doors. Is she prepared to say when the £50 million general practitioner fund will be made available for Lothian to make a bid to?

Shona Robison: The detail of the fund to which Sarah Boyack refers will be made available very soon. The fund is being used strategically in negotiation with the Royal College of General Practitioners in Scotland, the British Medical Association and others to help with some of the immediate recruitment and retention issues and the workforce pressures that have been highlighted by those organisations and others.

I am aware of the issues in Lothian that Sarah Boyack raises. In the short term, part of the reason why a number of GPs are taking earlier retirement than they had planned is that pension changes that have been made have accelerated some plans for retirement. That is unfortunate, but it is a fact. NHS boards are discussing with those GP practices how they can ensure continuity of patient care while further medium to longer-term plans are put in place. I would be happy to speak to Sarah Boyack about those issues in more detail.

General Practice (Resource Allocation)

10. John Mason (Glasgow Shettleston) (SNP): To ask the Scottish Government whether it considers that resources for GP practices should be moved from richer areas to poorer areas. (S4O-04437)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): The Government is committed to investing in all of general practice. The Scottish allocation formula for allocating the global sum for practice funding accounts for about half the current funding and fees of practices. The formula is on the basis of the relative need of patients and the workload and it takes into consideration the relative costs of service delivery.

The formula is weighted to account for the socioeconomic status of the GP practice population. By including that weighting, the formula acknowledges that people from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs.

As the member will be aware, we are reviewing the general medical services contract in Scotland. At the same time, we are reviewing the financial framework that funds general practice, in order to put in place a sustainable and stable method of funding for the future.

John Mason: I am grateful that the system is being reviewed. It seems to me—I wonder whether the cabinet secretary agrees—that, if life expectancy falls so dramatically from the west end of Glasgow to the east end, current funding resources might not be ideal.

Shona Robison: I understand that the member represents constituents from among the most deprived areas of Glasgow, and we know that, across Government, we need to tackle the many factors that cause those health inequalities. This is not just for the NHS to tackle, and the problems cannot be resolved in general practice alone. As we take forward the discussion about new models of primary care, I am keen for us to consider the opportunities to get this right and to put tackling health inequalities at the centre of the discussions. We can do more in primary care to tackle health inequalities.

National Health Service (Skye)

11. Mary Scanlon (Highlands and Islands) (Con): To ask the Scottish Government whether it will provide an update on the review of provision of NHS services on Skye. (S4O-04438)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): NHS Highland undertook formal public consultation between May and August last year on its proposals to modernise community and hospital services in Skye, Lochalsh and south-west Ross. The proposals to build a new hospital in Broadford, alongside the development of Portree community hospital, were endorsed by the board of NHS Highland last December. As the proposals were considered a major service change, they were subsequently submitted to the Government. I carefully considered all the available evidence and representations and I approved the proposals in February. I have been clear that NHS Highland must continue to involve fully all local stakeholders as plans are developed and this important work is taken forward.

Mary Scanlon: In the Highlands, we want a centre of excellence in Raigmore hospital in Inverness, but we also want appropriate NHS services throughout the region. Given the £6 million overspend at Raigmore hospital this year, can the cabinet secretary assure people across the Highlands, and particularly on the Isle of Skye,

that local, accessible NHS services will not be cut and that local voices and concerns will continue to be heard and heard with respect?

Shona Robison: I absolutely agree that local voices should be heard with respect. The board had a difficult decision to make and, had it made a different decision, I am sure that other voices would have been raised by people who were not happy with that. It made a decision based on what it thought was the best available evidence. It has taken that forward, and it continues to engage with local people about that process. It is important to say that the independent Scottish Health Council confirmed that the board's public engagement process was consistent with national guidance.

The decision is made and the board is getting on with the work in hand. It will continue to discuss with local people further enhancements that can be made across the Isle of Skye and beyond.

Telecare (Highlands and Islands)

12. Mike MacKenzie (Highlands and Islands) (SNP): To ask the Scottish Government what assessment it has made of how telehealth could assist in the delivery of healthcare across the Highlands and Islands. (S4O-04439)

The Minister for Public Health (Maureen Watt): The Scottish Government has set out the policy direction and strategic priorities to support the expansion of telehealth and telecare in Scotland in the national telehealth and telecare delivery plan, which was launched in early 2013. That work is supported by the £30 million technology-enabled care—TEC—programme from April 2015, for three years, to support local developments.

It is the role of health boards, local authorities and new joint integration boards to assess and commission appropriate services to address local needs, and that is being facilitated by the national improvement programme for TEC, called delivering our ambitions, which was launched in September 2014. The councils in the Highlands and Islands are active partners in that work and have received specific TEC funding of £407,000 for 2015-16 in order to expand expertise and provision across their local areas.

Mike MacKenzie: Does the minister agree that those opportunities are severely limited by very poor mobile telephone connectivity, and will she join me in calling on the United Kingdom Government to address urgently the very poor 2G, 3G and 4G availability across the Highlands and Islands?

Maureen Watt: Mobile connectivity is an integral part of the Scottish Government's world-class digital ambitions and is of particular importance to rural communities. Many of the coverage problems that we experience in Scotland, particularly in relation to 3G, stem from the UK Government's flawed approach to auctioning spectrum, which allowed operators to focus solely on urban areas at the expense of rural communities.

Ensuring that the same mistakes are not repeated with the 4G roll-out is a key priority for the Scottish Government, so we continue to press the UK Government on digital connectivity issues. Earlier this week the Deputy First Minister met John Whittingdale, the Westminster Secretary of State for Culture, Media and Sport, to discuss the issue.

The Scottish Government is keen to test new models that could extend coverage to areas that mobile operators see as being non-commercial. We recently funded a community-owned mobile telephone mast on the island of Coll, which I am sure Mike MacKenzie knows about. A partnership between Development Coll and Vodafone has brought 3G and 4G services to the island, making it the first island in Scotland to receive 4G.

The Deputy Presiding Officer: Thank you. If we have slightly shorter questions and more succinct answers I might be able to make a bit more progress.

NHS Lanarkshire (Meetings)

13. John Wilson (Central Scotland) (Ind): To ask the Scottish Government when officials last met the board of NHS Lanarkshire. (S4O-04440)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Ministers and Government officials regularly meet representatives of all health boards, including NHS Lanarkshire.

John Wilson: In recent years, much progress has been made in the North Lanarkshire part of NHS Lanarkshire, with new multidisciplinary health facilities in Coatbridge, Airdrie and Kilsyth. Has there been any discussion with NHS Lanarkshire regarding a proposal to build a new multidisciplinary health facility in Chryston, in the northern corridor area of North Lanarkshire? Many of the residents in that area are receiving health services from two health boards—NHS Greater Glasgow and Clyde and NHS Lanarkshire. Having one health facility in that area may resolve some of the issues that are being caused by delivery of services.

Shona Robison: Planning of local services is obviously down to NHS Lanarkshire in consultation with its neighbouring boards. It has not brought to us any proposals on a new facility for Chryston. I am happy to find out from NHS Lanarkshire whether that is in its plans for the

future and I will write to John Wilson with that information.

NHS Fife (Meetings)

14. Claire Baker (Mid Scotland and Fife) (Lab): To ask the Scottish Government when it last met NHS Fife and what issues were discussed. (S4O-04441)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Ministers and Government officials regularly meet representatives of NHS Fife to discuss matters of importance to local people.

Claire Baker: I have been contacted by constituents who recently lost their young grandson in tragic circumstances. They have raised with me concerns about the process of identifying the body and about the mortuary facilities in Fife. I am currently in communication with NHS Fife about those issues, but can the cabinet secretary confirm whether there is consistency across all health boards in respect of mortuary facilities? Is there guidance on minimum standards that health boards are expected to meet?

Shona Robison: It would be helpful if Claire Baker would write either to me or to the Minister for Public Health, Maureen Watt, with more details about the concerns that have been raised in respect of mortuary facilities. Meanwhile, we will provide her with the information about standards for which she asks. It would, given the circumstances of the case that she has highlighted, be helpful to have more detail on the case and the nature of the concerns. We will make sure that she gets a reply.

Deaf People (Support)

15. Nanette Milne (North East Scotland) (Con): To ask the Scottish Government what it is doing to support the estimated 850,000 people in Scotland who are deaf or have a hearing loss. (S4O-04442)

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): The Scottish Government believes that adults and children who have sensory impairment should expect seamless provision of assessment, care and support and the same access to employment, education, leisure, healthcare and social care as everyone else. Sensory impairment includes varying degrees of hearing loss, sight loss and dual sensory impairment.

For that reason we have invested £2 million to drive improvement via our sensory impairment strategy, called see hear. It was launched in April 2014 and is the first strategy of its kind in the United Kingdom, and sets a course towards the step change that is needed to make Scotland a more inclusive place for people with sensory loss.

Nanette Milne: It is important that individuals who require a hearing aid receive one as soon as possible in order to support them to live independently and to reduce their risk of experiencing isolation. The picture across Scotland is very mixed when it comes to accessing specialist hearing services; that could be addressed by establishing local audiology teams. What assurance can the minister give that a postcode lottery is not developing in Scotland? What engagement has the Scottish Government had with the third sector, which already delivers significant community-based basic maintenance and support?

Jamie Hepburn: This Government engages regularly with the third sector on a range of topics. I assure Nanette Milne that hearing services is an area on which we have dialogue. I have recently met Action Hearing Loss, for example, to discuss issues, and we will maintain that dialogue continually.

Where we have any targets in any part of the national health service, we expect them to be met.

Scotland Bill (NHS Funding)

16. Gil Paterson (Clydebank and Milngavie) (SNP): To ask the Scottish Government what discussions it has had with the United Kingdom Government regarding the impact of the proposed Scotland Bill on national health service funding. (S4O-04443)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Negotiation of a new fiscal framework for Scotland is one of the highest priorities of the Scottish Government in the months ahead, and the Deputy First Minister met the Chancellor of the Exchequer on Monday to take forward those discussions. We will seek to agree a new fiscal framework that reflects the needs and interests of the people of Scotland. Our commitment to protecting the NHS remains unchanged.

Gil Paterson: Does the cabinet secretary share my concerns about the chancellor's latest announcement of further cuts, including cuts to public health funding, at a time when we need to do everything we can to protect the health service in Scotland?

Shona Robison: I certainly join Gil Paterson in expressing my concern that the chancellor seems to be intent on additional cuts, including cuts from this year's health funding for England of £200 million that goes towards public health.

This Government will work to mitigate the impact on our budget and to provide further

reassurance on our commitment to the NHS. Since 2010-11 Westminster has cut Scotland's fiscal resource budget by 9 per cent in real terms, but we have increased the health resource budget by 5 per cent in real terms over the same period. This year we have taken total health spending to over £12 billion for the first time.

I will keep Gil Paterson informed of how we will mitigate the cuts to public health funding.

NHS Fife (Consultant Posts)

17. Alex Rowley (Cowdenbeath) (Lab): To ask the Scottish Government how many unfilled consultant posts there are in NHS Fife. (S4O-04444)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Under this Government, the number of consultants in post in NHS Fife is at a record high, having increased by 64.2 whole-time equivalents, from 168.2 in September 2006 to 232.3 in March 2015. Out of an establishment of 281.9 WTE consultant posts in NHS Fife, 52.6 WTE are currently vacant.

The position in Fife reflects the fact that we have some of the highest staffing levels ever across our NHS, including record numbers of consultants. The increase in vacancies is linked to the efforts to increase capacity by recruiting even more staff. We acknowledge the efforts that are being made by all NHS boards, including NHS Fife, to fill any vacancies in whatever way they can.

The Deputy Presiding Officer: Let us have a brief supplementary and a brief answer, please.

Alex Rowley: I thank the cabinet secretary for that answer. I recognise that progress is being made and that hard work is going on. Nevertheless, the situation is still unacceptable. Given how difficult it is to recruit consultants in more rural areas, what proposals and plans is she considering for a long-term solution to the problem?

Shona Robison: I am glad that Alex Rowley welcomes the progress that has been made. I also welcome the tone of his question. He has hit upon an issue that we must consider in order to see how we can help our district general and rural general hospitals, which can find it difficult to recruit to certain specialties. Teaching hospitals have less of a problem with that. We have to consider imaginative solutions—for example, recruiting people to work across networks by spending some of their time in a teaching hospital and some of their time in district general or rural general hospitals. That has already happened, but on quite a small scale. We have to look at more innovative ways of addressing the problem. I am happy to keep Alex Rowley posted on progress.

Health

The Deputy Presiding Officer (Elaine Smith): The next item of business is a debate on motion S4M-13416, in the name of Jenny Marra, on health. I invite members who wish to contribute to the debate to press their request-to-speak buttons, and I call Jenny Marra to speak to and move the motion.

14:41

Jenny Marra (North East Scotland) (Lab): I and other Labour members have approached today's debate in a conciliatory way, hoping to reach a consensus on the way in which we take forward the debate on our national health service. Last week, we were warned by the health professionals who spoke up so articulately that there is no place for political point scoring in this debate.

In that spirit, I drafted a motion that I hoped the whole chamber could unite behind. Indeed, it was designed for the whole chamber to unite behind. It acknowledges the scale of the challenge, it reflects the hard messages coming from our senior doctors and nurses in Scotland, and it gives credit to the cabinet secretary for the constructive and positive tone that she has struck in response to them, especially in Monday's newspapers. I therefore have to express my disappointment that the cabinet secretary has sought to disregard the whole of our motion in the way that she has, replacing it with her own words which, on my reading, make largely the same point as the original motion. She will no doubt set out her rationale for that in her speech, but I do not feel that her amendment has got today's debate off to the best start.

Delivering the healthcare that we want for the people of Scotland in a time of straitened budgets and with an ageing population presents us with one of the country's biggest challenges. We recognise the heroics performed every day by the hard-working staff at every level of NHS Scotland and in our care services, keeping us safe and well in trying circumstances, and we thanked them for that in our motion. However, the people who are working on the front line deserve more than warm words from those in Parliament. They deserve the resources that they need to do their job, and at the very least they deserve to be listened to when they tell us that serious change is needed to preserve and sustain—that was the key word last week—our NHS.

Last week, an independent report commissioned by the British Medical Association's Scottish consultants committee illustrated the full scale of the challenge. The report said that the

balance had tipped too far towards financial decisions dominating over medical need, and that that was linked to

"politicians' promises to the general public to meet increasing demands from an aging population for a better quality of healthcare without being able to fully resource such promises".

In its conclusion, the BMA's report stated that it had

"detected a strong note of pessimism, even fatalism, over how the healthcare system could be improved for the benefit of all stakeholders, without substantial improvements in resources allocated to the NHS in Scotland. These feelings, if left unaddressed, could have major consequences for patient care and the overall sustainability of NHS Scotland."

That was a wake-up call, indeed, but it was followed just 24 hours later by another, this time from the medical and nursing royal colleges speaking for the first time with a single voice, in the report "Building a more sustainable NHS in Scotland: Health professions lead the call for action". They say that funding is unable to keep up with the pressures on the NHS, that tinkering around the edges is not the answer and that it is time for

"a genuine public debate on change".

John Mason (Glasgow Shettleston) (SNP): Will the member give way?

Jenny Marra: I would like to make a little more progress, but I will do so later.

Those are significant and considered interventions from experts who do not use such strong language lightly. When they do, it demands the attention of us all.

I was, therefore, heartened to read the cabinet secretary's response in *The Herald* on Monday. She welcomed the report from the royal colleges and said that she would listen to their concerns, as the First Minister did last Thursday. In her "Agenda" article, the cabinet secretary said that she wants

"to look beyond short-term demands and foster a consensus around how we best manage our NHS to ensure it meets the considerable challenges of the future."

Indeed, her amendment talks of fostering

"a mature debate, involving the public, health and care professionals and MSPs from all political parties",

and states that

"this consensual approach to future changes to Scotland's beloved NHS will help ensure that it evolves to meet the future needs of the people of Scotland."

The cabinet secretary is right if she believes that she cannot do that without working with the public, the professionals and other political parties. I make it clear to the Government that we stand ready to have that debate and to work together to improve our NHS for everyone. Before I set out some ideas about how we can take forward that debate, I will touch on the issue of targets, which the cabinet secretary raised this week.

On Monday, the cabinet secretary said that it is important that we rethink targets and make sure that we have the right targets. Many people must have thought that the cabinet secretary had a crystal ball because, on Tuesday, the Government missed its target for accident and emergency waiting times of 98 per cent of all patients being seen within four hours. That is the 295th week in a row that that target has been missed. The 98 per cent target has been revised down by the Government to an interim target of 95 per cent, but this week the achieved figure was just 92.6 per cent. If we are still so far off the interim target in the middle of June, that suggests that we have a serious problem. In the new south Glasgow university hospital, the figure was as low as 83.2 per cent.

On Tuesday, one of the success stories was NHS Tayside, which met the A and E waiting time target in 99.1 per cent of cases. However, a question mark now hangs over that number in the light of the allegations that have been made by a whistleblower who has claimed that the figures are being manipulated and that patients' safety is possibly being compromised. I expect the cabinet secretary to establish an immediate investigation into those claims in order to restore confidence. The cabinet secretary's response this morning—that she has been assured by the health board in Tayside—is simply not good enough. Whistleblowers need to be confident that the Government will take them seriously, and it is in patients' and the public's interests that the claims be fully investigated, no matter what outcome is expected.

We believe that there is a place for targets in driving up standards and maintaining accountability for performance in our health service. However, when boards do not have the adequate resources, we cannot allow targets to drive perverse behaviours. I would support the cabinet secretary looking at revising the targets so that they are smarter and more sophisticated and drive the right behaviour. That should be part of our debate on the future of the NHS.

We should never lose sight of why we have targets in the first place. Early diagnosis and treatment can lead to improved results, and people should not expect to wait longer and longer when a health service should be improving. Therefore, looking at targets can be part of that genuine public debate.

I will now set out some ideas about how we can have that debate to ensure that it delivers the

results that we all want it to deliver. I look forward to the cabinet secretary doing the same in her speech.

A summit should be held with all stakeholders, including the professional bodies and trade unions that spoke out last week, certainly the patient groups whose experiences are central to this and, of course, the political leaders from across the Parliament, in the interests of democracy and accountability. The consensus that exists among those groups on an NHS that is publicly run and free at the point of need can be built on to agree how to transform our NHS and to deliver our shared ambition of a healthier Scotland. Of course, there is one stakeholder who, above all others, we must involve in the process—the Scottish public. In doing so, I hope that we can learn lessons from the recent past on how we allow people to shape the debate.

In many ways, politics has undergone something of a resurgence in this country, with the referendum reviving the tradition of town hall meetings and bringing to life street politics and unprecedented levels of discussion on social media. Thousands of people stepped up to have their say in the referendum, because they knew that they had a stake in the decision and in the outcome. What other issue could provoke such universal feeling in our country than the future of the national health service? We can take this debate to every town in Scotland, as we set out the choices that must be taken and then listen to the views of patients and the public on those choices.

The BMA report says that the public need to be involved in what are considered to be the difficult decisions about future investment in Scotland's NHS. Unless people are empowered to do that and apprised of the options and the consequences of decisions, we cannot expect to take them with us on any journey of change, and our efforts to bring about change will not be successful.

John Mason: Does the member agree that one of the decisions that must be made and in which the public certainly must be involved is whether we put more resource into preventative spend and less resource into hospitals?

Jenny Marra: There is a great consensus in all the reports that we have seen about the shift to preventative spend. We will approach the public debate with a programme of what we would like to see and to discuss, but I do not think that we can second-guess the outcome of the public conversation that the royal colleges called for last week. However, I think that, as the member knows, the evidence is there on preventative spend.

I have every confidence that the people of Scotland will make the right decisions when presented with the facts about the health service. With the public engaged, the professionals consulted and the politicians in agreement, we could have a process completed in six months, which would set out guiding principles and changes for the future.

We should take cognisance of reports and reviews that have been prepared in past years. We should take our present experience and focus firmly on the health service that we want. Ahead of the 2016 Scottish Parliament elections, we could get agreement across parties on a road map so that, no matter what election result or political outcome, we can have confidence that our NHS will be moving towards a sound and sustainable footing.

The accusation from the BMA report and the royal colleges that, in the past, politics has obscured the best way forward for the health service is one that we should all reflect on. I am sure that we can all think of examples of situations in which populism or political opportunity has overridden the desire to do what we know is best for our NHS, and we should all take some collective responsibility for that. Given the scale of the challenge that we face in reshaping the health service, we can no longer afford that indulgence. An opportunity exists for us to move past that point in the best interests of the people of Scotland, the sick and the vulnerable.

So far, the cabinet secretary has responded in a positive way to those calls and she can be sure that, as health spokesperson for the largest Opposition party in the Parliament, I will do my job of holding her Government to account. When she and her Government get it wrong, it is our responsibility to stand up for those who suffer the consequences, but when she is prepared to be brave and bold in making the changes that need to be made in the interests of Scotland, I will be the first to be in agreement with her. That is the opportunity that this process presents.

I hope that the cabinet secretary will tell us how she proposes to ensure that we have the necessary engagement between the public, the professionals and politicians for the good of the country's health. The challenge that we face is a tough one but one that we should welcome. The fact that people are living longer is a triumph for society and for progress, and we should treasure the extra years with our parents and grandparents, whose experience and wisdom are irreplaceable. We should approach the task of reshaping our national health service to meet the challenges of today with optimism and ambition, in the same way that those who created our NHS did nearly seven decades ago.

I move,

That the Parliament commends the hard work of staff at every level of NHS Scotland and Scotland's care services; recognises that delivering the healthcare that the Parliament would want for the people of Scotland in a time of straitened budgets and an ageing population presents one of the country's biggest challenges; further recognises that NHS boards and staff across the country are finding it increasingly difficult to meet some of these key challenges; notes the recent report commissioned by the BMA Scottish consultants committee, which questions the future sustainability of the NHS unless more resources are found; further notes the report, *Building a More Sustainable NHS in Scotland*, by the medical and nursing royal colleges speaking for the first time in a single voice, insisting that transformation is needed to put the NHS on a sustainable footing and calling for "a genuine public debate on change"; welcomes the comments this week by the Cabinet Secretary for Health, Wellbeing and Sport that she wants to "look beyond short-term demands and foster a consensus around how we best manage our NHS to ensure it meets the considerable challenges of the future", and looks forward to the Scottish Government setting out a process that involves all political parties, professionals and the public in how to improve the health, care and wellbeing of Scotland.

14:56

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): I welcome Jenny Marra's consensual tone. My amendment seeks to build on that tone, and I hope that it will be received in that spirit.

Presiding Officer, I hope that you will give me a little latitude later in my speech to deal with the A and E issue that Jenny Marra raised, because it is important to set out some facts on that matter.

I am pleased to update the Parliament on my announcement on 22 January of a public debate on health and social care. I said then that, among many others, I would work with colleagues across the political spectrum to seek as much consensus as possible on the shape of health and social care by 2030. I am open to all constructive ideas for the future; I hope that some such ideas will be put forward during the debate and that we make some initial progress towards consensus. I will continue to engage with colleagues across the Parliament as I take forward more detailed work that is informed by the wider public debate.

The debate will be based on this Government's solid record on the NHS. We have cemented universal provision, which is largely free at the point of use, and we have rejected the internal market and privatisation agenda. We have protected health funding in the face of considerable challenge—in this financial year, health resource spending has increased by more than £400 million to a record level of £12 billion.

We have made a strong start on integrating health and social care through the roll-out of integration joint boards, and we have provided them with £500 million of investment to help them to develop services that we know will make a difference to local communities by allowing them to take charge of their own health and wellbeing in innovative ways.

In addition, we are performing well above the developed world average in relation to access to healthcare, waiting times and planned care. We have more staff in the NHS than we have ever had—staffing levels have gone up by 10,500. Therefore, we have a good platform on which to build. However, I am the first to acknowledge that the increasing demands on the system require us to look at new, more innovative models.

At this point, I want to respond on the issue of A and E. Targets have their place. I am certainly up for a debate about targets. We have to have the right targets, but targets are important. Before there were targets, people routinely waited 18 months for an appointment and another 18 months for procedures. I remember regularly raising such cases in the early days of the Parliament, so we have come a long way in reaching a position in which we have some of the lowest waiting times.

We still face challenges in meeting some of the targets, and Jenny Marra highlighted the issue of A and E waits. In that respect, I want to respond specifically on the Ninewells issue. As I cannot let it stand without a response, I will—unfortunately—have to take a bit of time to explain things.

It is important to remember that the Ninewells system has been operating since 1998 and that the four-hour target was introduced in 2004. It is therefore quite wrong for anyone to suggest that somehow the Ninewells system has been developed in response to that target; in fact, it predates it.

Moreover, during routine feedback from trainees, the General Medical Council was made aware of some of the bullying issues that were highlighted last year. In response, it looked at the issue in quite some detail and concluded in its report that it

"found no evidence that there was a culture of undermining and bullying in the general surgery and trauma and orthopaedic units"

and that

"Overall, the doctors in training that we met were very positive about their experience at this Hospital."

Nevertheless, the GMC encouraged "improvements to be made", and those improvements have been made to ensure that trainees can get feedback in a safe environment.

That said, when any concerns are raised with me, I want to ensure that we have asked all the questions and that we have seen the situation for ourselves. That is why I have asked the chief

medical officer to visit Ninewells on Monday, see for herself what is happening there, investigate the matter, ask questions, speak to the staff and trainees concerned, and then report back to me. However, we have to be very careful that we do not undermine one of the country's best performing emergency departments or that these concerns do not affect patient safety, which I believe is absolutely key to what is done at that fantastic hospital.

Jenny Marra: I thank the cabinet secretary for her considered response, and I welcome the fact that the chief medical officer is visiting Ninewells on Monday. However, does she agree with the principle that whistleblowers must have the confidence to speak out and know that what they say will be taken seriously and investigated fully?

Shona Robison: Of course. Indeed, that is why we have set up the whistleblowing helpline. However, that does not mean that the concern that is raised is always correct or that it should always be considered to be correct. It is important to get to the bottom of these particular concerns, but there is an alternative view that the emergency department at Ninewells is good, works very well and takes patient safety very seriously indeed. I want to ensure that the concerns that have been raised are investigated and that the issues that the GMC says have been addressed have been.

Presiding Officer, I have had to take some time to explain that matter in what is a debate on the future of our health and social care systems, and I do not want to miss any opportunity to talk about the issue that we are debating.

The Deputy Presiding Officer: I can give you two minutes back.

Shona Robison: We face a number of challenges to our health and social care system including poor patterns of health, health inequalities, rapidly changing demography, high levels of preventable diseases and the tight fiscal conditions. Of course, the statement by the royal colleges clearly outlines the requirement for us to take that longer-term look and develop new models of care fit for the needs of the 21st century. That is something that I am absolutely determined to do, and the view of the royal colleges fully supports my own view that the status quo is not an option and that we need to start planning transformational change now.

That is why I have announced a national debate on how we might make greater strides to improve our health and social care by 2030. I want to give added focus to how we might tackle the country's poor pattern of health and health inequalities and, in that respect, I was heartened by the degree of consensus in the debate on health inequalities that Duncan McNeil led on 26 March. That debate demonstrated that addressing population health and health inequalities, which is vital to our economic success, must involve a cross-sector approach; it cannot be tackled solely as a health issue or by the NHS alone.

As a result, I want the public debate to consider those wider issues. I want to explore how service users and providers can have joint responsibility for a healthier population and how healthcare services can be matched by individuals actively promoting their own health and wellbeing, and I also want the debate to consider more coherent cross-sector working on population health, with firmer links with, for example, housing, welfare and employability to support sustainable economic growth.

I want to reinforce the focus on quality in developing policy and service delivery options, but I want a genuine debate about how models of care can be tailored to individuals' needs, with success measured by improved patient outcomes, not slavish adherence to processes.

I want to make more progress on shifting the balance from hospital care to primary care, to see more care and support provided at or near home where appropriate, and to blur the boundaries between primary and hospital care and between mental and physical healthcare.

We are already taking great strides. Our three-year general practitioner contract has provided much-needed financial stability and reduced bureaucracy. "Prescription for Excellence" charts a 10-year future for the pharmacy profession in Scotland, and the integration of health and social care has provided a rich landscape for new models of care to meet communities' needs. More volume and more complexity are already being seen outside hospital settings, although often resources have not followed. Primary care services are therefore stretched and communities rightly have higher expectations.

I want to transform our approach to primary care to ensure that people see the right professionals more quickly. That is why we will create a new GP contract in Scotland from 2017 and why I have commissioned Sir Lewis Ritchie to review out-of-hours primary care. We need to redesign and modernise primary care in a collaborative and inclusive way, transform and invigorate the primary care workforce, create new roles, and involve communities in considering how best to ensure that the vast bulk of their healthcare continues to be delivered in the local community, but in a more effective way. I will therefore seek views from as wide a base as possible on new models of care, including those that might be delivered locally through cross-professional community hubs, with a shift to regional or national centres of expertise for some acute services that

are founded on quality and focused on improved health outcomes.

I am very conscious that developing new models of care and creating new roles and opportunities will require carefully managed workforce changes and effective forward planning, not least because of the education and training pathways of the professions involved. I want to continue to enhance NHS Scotland's reputation as an exemplar employer that is committed to supporting, developing and involving its workforce in line with the Government's approach to fair work. Again, I pay tribute to the dedication, commitment and drive of all those who work in our health and social care systems.

The workforce must have a key input into the wider debate, and it is absolutely essential that the public also have a stronger voice in shaping the future. My officials and I have begun the process of engagement that I announced in January through regular and tailored meetings with the professional bodies. I met the BMA in February and again last week, and I have visited places across the country to seek views on the GP contract. I have had wide-ranging meetings to discuss the development of a national clinical strategy to underpin local, regional and national planning and to discuss new models of care, and I have had initial engagement through the usual partnership mechanisms with NHS staff representatives.

That has helped to shape the type of wider public debate that I will launch at the annual NHS Scotland event in Glasgow on 23 June, which will be followed on 25 June by the Health and Social Care Alliance Scotland citizens wellbeing assembly in Edinburgh. Those events will reach out to health and social care staff across Scotland, more than 500 individuals who are disabled or who live with long-term conditions, and more than 300 organisations that work with them. That will be the starting point for a wide range of national and local engagement activities.

The Government is also working with the Convention of Scottish Local Authorities, Healthcare Improvement Scotland, the Scottish health council and the Health and Social Care Alliance Scotland to develop a new framework to gather the collective knowledge, wisdom and views of people with real experience of health and social care and to ensure that their voice is heard and understood.

In addition, we will use media events, social media, digital platforms and existing stakeholder groups, networks and other mechanisms to take the conversation directly to communities and individuals. My ministerial colleagues and I will use portfolio events and travelling Cabinets to seek views and contributions to the debate. I will ask health boards to use local events to facilitate public discussion and to feed back to me, and I will, of course, liaise personally with the Health and Sport Committee and the Opposition parties. I will revert to Parliament as often as is required.

The Deputy Presiding Officer: Will you draw to a close now, please, cabinet secretary?

Shona Robison: Yes.

That level of open engagement will seek consensus on a reform plan for health and social care by 2016, with further engagement beyond then on into implementation. I hope that, in the spirit of consensus, this debate will form an important part of the early days of that piece of work.

I move amendment S4M-13416.2, to leave out from first "recognises" to end and insert:

"notes the joint call by the Royal College of Nursing and the Academy of Medical Royal Colleges and Faculties in Scotland for a public debate on what are considered to be the difficult decisions that need to be made about future investment in Scotland's NHS; considers that, while the NHS budget is protected and the number of staff employed by the NHS has increased, demand for care from Scotland's growing and older population has increased; welcomes the plans of the Scottish Government to foster a mature debate, involving the public, health and care professionals and MSPs from all political parties, to develop a 10 to 15-year plan for the NHS beyond the 2020 Vision, and believes that this consensual approach to future changes to Scotland's beloved NHS will help ensure that it evolves to meet the future needs of the people of Scotland."

15:09

Nanette Milne (North East Scotland) (Con): We very much welcome this debate. Like everyone here, Scottish Conservatives greatly value the work and dedication of the staff in NHS Scotland and Scotland's care services. At all grades and in all professions, they perform a tremendous role and are rightly regarded as among our most respected and valued citizens. All those people and the patients whose health and wellbeing are their overriding concern are tired of hearing politicians scoring party political points whenever the NHS comes up for discussion and of the scare stories that we see so often in the media.

We all value our NHS, and most patients have a good experience when in its hands. Almost all the letters that I see in the local press from patients are full of praise for the care and attention that they have received, for which they are grateful. Of course, there are exceptions, and they tend to be the cases that come to our notice as politicians. We would fail in our duty if we did not take them seriously and work towards ensuring that such failures of the system are not repeated.

We are all increasingly aware of the pressures under which the NHS is operating and of the need to take action to ensure its sustainability as the population ages and expensive medical technologies and pioneering medicines continue to become available for clinical use in a publicly funded system in which money will always be tight and every last penny should be used to give best value to service users. The acceptance that we need to look beyond short-term demands is welcome, and the new joint report from the medical and nursing royal colleges on building a more sustainable NHS in Scotland, together with the cabinet secretary's stated desire to foster a consensus to find a way of ensuring that the service can meet the very significant challenges ahead, are like music to my ears.

For many months, if not years, Jackson Carlaw and I have been pleading in the chamber for some political consensus around the health service in Scotland. We had some very fruitful discussions with the previous health secretary about various health matters, not least the need for more health visitors. That resulted in the announcement of an extra 500 of that grade of professional. I am very pleased that the current cabinet secretary is keen to follow that pattern. I listened with interest to her suggestions for future planning.

Of course, we will not always agree about the means to an end, but if we can find a consensus on the way forward for the NHS in conjunction with all stakeholders—including, of course, patients—then I think that we can succeed. Only by having a common goal that can be worked towards whatever the political colour of the Government of the day will we overcome the short-term planning that is currently a feature of political life.

The Scottish Conservatives have been championing a long-term plan for a very long time, and a long-term economic plan under a Conservative Government has meant that the Scottish NHS will benefit from an additional £800 million in the next five years. However, that money must be used wisely, and we have to take notice of Audit Scotland's warning that, if we do not restructure the current running of the NHS, it will struggle to cope with future demands, particularly those of our ageing population. Audit Scotland tells us that the proposed integrated health and social care system is in jeopardy because the Government has so far failed to focus on long-term planning.

Scotland needs a process that involves all political parties and gets beyond the silo mentality that hitherto has hindered co-operation between different professional groups. That is why we are very supportive of the Public Bodies (Joint Working) (Scotland) Bill, which provided a legal framework for the integration of health and social care, on which the future success of the NHS will depend.

We should listen to the advice of the medical and nursing royal colleges and take serious steps to move away from the traditional model of hospitals as the mainstay of the health service. It has been recognised for a long time that care in the home or as close to the home as possible for as long as possible is in the best interests of the health and wellbeing of our population, many of whom are now living into advanced old age with multiple and complex health problems. That point has been backed up by the Marie Curie charity's recent report that indicates that the majority of those who die in Scottish hospitals would wish to die at home or in a homely setting.

Marie Curie also found that 11,000 people living with a terminal illness in Scotland who need palliative care do not have access to it at the present time. Moreover, from a financial point of view, it has been shown that to provide palliative care when needed would generate net savings of more than £4 million annually in Scotland, hence the charity's plea for a clear commitment in the Government's forthcoming strategic framework for action on palliative and end-of-life care to ensure that everyone with a palliative care need has access to it by 2020. I noted from a previous debate that the cabinet secretary is receptive to that.

We increasingly hear of staff shortages in both primary and secondary care due to an ageing workforce and recruitment and retention problems, and at all levels we hear of the need to pull together and work co-operatively along with patients to develop a sustainable service that will adapt to change and cope with the ever-increasing demands that are placed upon it.

Given the high numbers of GPs and nurses who are set to retire in the near future and the fact that not enough young blood is coming in to meet the demand, together with serious problems with the recruitment of carers within many of our communities, the pressures on the NHS and care services will continue to grow unless we introduce new initiatives to sustain them. All parties agree that we need more nurses and midwives, for instance, although we differ on how to pay for them. It is well known in the Parliament that we would pay for 1,000 more nurses by abolishing free prescriptions for people who can afford to contribute to their cost.

We absolutely agree that there has to be new thinking on how to overcome existing problems and deliver a sustainable NHS into the future, and that that will be achieved only if we put the outcomes for patients at the core of our planning and all interested parties work together in an integrated way to make the best use of the

available resources to secure a viable future for a service that is treasured by every one of us.

I close by restating how grateful we are to NHS and care services staff and emphasising our commitment to protect the NHS. I quote the medical and nursing royal colleges:

"The time for talking and political point scoring has passed. We need to take practical action, together, now."

I look forward to that. We will support the motion and the Government's amendment.

The Deputy Presiding Officer: We turn to the open debate. I ask for speeches of six minutes, please. There is not a lot of time in hand.

15:16

Bob Doris (Glasgow) (SNP): I start by referring to targets in the NHS, which was a theme in the opening speeches. The briefing that the royal colleges prepared for the debate specifically mentions targets, and I will quote from it—sparingly. Action point 2 states:

"The current approach to setting and reporting on national targets and measures, while having initially delivered some real improvements, is now creating an unsustainable culture that pervades the NHS."

I might not agree entirely with that, but the royal colleges have a point in relation to how sustainable certain targets are. I will say more about that in a moment.

However, we should not be in denial about the huge transformational change that health improvement, efficiency and governance, access and treatment—HEAT—targets can deliver in the NHS. In that regard, I particularly think of access to psychological services. In NHS Greater Glasgow and Clyde, the waiting time was up to two years when I first became an MSP, but that has been slashed down to something like 20 weeks. I wish that I had dug out the exact figure, but the HEAT target has been transformational. There is a balance to be struck, and we should not throw the baby out with the bath water. That said, the royal colleges have a point that we should listen to carefully.

The point about targets is not new. I do not want to steal the thunder of my convener on the Health and Sport Committee, Duncan McNeil, who has been making it for a while, but I add that our committee has made it in relation to our scrutiny of the NHS budget.

We heard just yesterday about targets for certain surgical procedures that are not a clinical priority—let me be clear that they are a priority to the people who wish to have them, but they are not a clinical priority. We heard that it can cost three times as much to drive the change and get close to meeting the target—perhaps being 1 or 2 per cent away—as it would cost if people waited a few days or weeks longer. We should bear that in mind. I give the example of a success rate of 93 per cent where the target is 95 per cent. If people waited a few days longer, the NHS could save a huge amount of cash, but it would not meet the HEAT target.

Consensual tones have to be two way. As we heard in Jenny Marra's opening speech, the Opposition will be terrier-like in exposing a Scottish Government does not meet its targets, but it will not nuance that by saying that a target was missed by just a handful of patients for a handful of days. We must have a two-way process in the debate if we are to work out which HEAT targets we should revise, where the cost savings are and how the money should be reinvested. The Health and Sport Committee has done a lot of good work on that in the past couple of years.

We have to look at the successes that there have been and admit problems where they exist. For example, there have undoubtedly been problems recently with delayed discharge and, quite rightly, the Scottish Government was chastised for the situation when it appeared before the committee. However, the data show that it is still down by two thirds compared with when we had a Scottish Executive. We have to give credit where it is due; at the same time, we have to challenge the problems that exist and change the structures as and when necessary.

Over lunch, I chaired a meeting of the cross-party group on rare diseases. I will make a couple of points that came out of that meeting. We spoke about the new medicines fund, which was recently doubled to £80 million for 2015-16. We heard at the meeting that 1,000 people have had medicines that they otherwise might not have got, had it not been for that fund. The Health and Sport Committee had something to do with driving Government policy on that. It is a real achievement.

We also heard about an additional £2.5 million for specialist nurses. I pay tribute to Gordon Aikman and the motor neurone disease specialist nurse campaign, as £700,000 will go towards MND specialist nurses. I refer to that because, although members of the cross-party group welcomed that funding, it only scratches the surface in terms of need and the demand that exists. There are 35 Huntington's disease specialists, five for the single gene complex needs service and zero for sickle cell disease. The question is whether we set targets nationally or leave the matter to local health boards. It was drawn to my attention that the moneys to fund specialist nurses have been given to local boards to make priority decisions, but we might have to review that.

That leads me to my key point, which relates to workforce planning. Earlier today, I met representatives of speech and language therapists, who told me that they want a needs-led full care journey to be planned out with multidisciplinary workforce planning, involving not just those in the health or allied health professions sector but those in the social care sector. As we develop workforce and workload management tools for nurses, we must get a lot better and a lot cleverer at creating a matrix for doing such planning right across the health and social care sector. The royal colleges mentioned that as well. We might need dramatic change, although I do not think that it would need to be dramatic, because much of the work appears to be happening already and the royal colleges appear to be calling for things that, I hope, the Scottish Government is already considering.

In these debates, I always talk about raising the status of care staff, increasing the esteem in which they are held and developing their career pathways—I did so in the most recent debate on health and social care integration. Let us make care the profession of choice for many young people when they leave school and college. Perhaps they could go to college on a day-release basis and, after five years in the care sector, could go straight into second year of a nursing or AHP degree.

The Deputy Presiding Officer: Mr Doris, you really must close.

Bob Doris: That is a hobby horse of mine. I hope that the cabinet secretary has listened to my sales pitch for the care sector.

15:23

Lewis Macdonald (North East Scotland) (Lab): The challenge of matching NHS resources to demand for healthcare is tough everywhere, and nowhere more so than in NHS Grampian. I know the service well, not only as a local MSP and as former health minister, but, first and foremost, as a local resident. Like most service users, my starting point is my immense gratitude to all the people who provide the service—and to those who created the NHS in the first place two generations ago.

Ten years ago, it was easy to hold up NHS Grampian as an exemplar of how health services should be delivered. Patients with routine ailments presented to primary care, not to A and E, and hospitals could concentrate on acute care. Budgets were tight then as they are tight now, but NHS Grampian was best in class when it came to getting value for money from the public pound.

Since then, the challenges have only grown. The population in Grampian has gone up faster than in the rest Scotland and more people are living longer and with a greater range of healthcare needs. Resources have gone up too, but not at the same pace. The NHS Scotland resource allocation committee recommended changes to reflect population growth in 2007, but those changes have not yet been implemented in full.

At the time of NHS Grampian's annual review in January, ministers provided an additional uplift of more than £11 million, in the hope of reducing the shortfall to some £8 million, or 1 per cent of what the NRAC formula then said the board's funding should be. The Government's good intentions were welcome, but when the NRAC formula was recalculated to take population growth into account, the difference between NHS Grampian's funding allocation and NRAC parity had gone back up to more than 2 per cent, or £17 million, for the current financial year. I know that that is not what ministers intended and that they were indeed seeking to get Grampian's funding to within 1 per cent of parity. I hope that they will try again, and I would urge them next time to allow for the predicted change in population in advance, so that the gap really can close to no more than 1 per cent in the next financial year.

John Mason: I take the member's point about population being important. Does he agree that need and deprivation are also important?

Lewis Macdonald: Absolutely, and that is exactly what the NRAC formula is intended to reflect—population growth, need and deprivation and urban and rural populations. The Government has signed up to the formula; it now simply needs to deliver it.

Fully funding the health service in Grampian matters. Whole-time equivalent nursing staff numbers went down by 465 between 2009 and 2013, and there are still nearly 400 unfilled nursing posts. That is not just about money, but extra funding would certainly help.

The strain of making ends meet also contributed to the crisis of leadership in NHS Grampian, which reached a head at the end of last year. A number of senior managers have left the board and a number of senior consultants may well follow.

The causes of the crisis were thoroughly investigated by two inquiries in 2014. Health Improvement Scotland looked in general at how secondary health services were delivered, while the Royal College of Surgeons was brought in to examine the professional conduct and standards of consultants in general surgery at Aberdeen royal infirmary. It is for NHS Grampian to implement the findings of the HIS report, and I understand that senior HIS staff believe that good progress in that regard continues to be made.

Incidentally, I am pleased that, after a period of uncertainty, the leadership of the local NHS is now settled in the very competent hands of Professor Steve Logan, as chairman of the board; Malcolm Wright, as chief executive; and Dr Nick Fluck, as medical director. Mr Wright's appointment on a permanent basis was confirmed only a few days ago, and will, I think, be welcomed by staff across the service.

The findings of the report of the Royal College of Surgeons, on the other hand, remain largely shrouded in secrecy. Only the recommendations have seen the light of day; even the conclusions on which they are based have yet to be published. That is a pity, because the people of Aberdeen and Grampian deserve to know what the investigators found. Unlike the HIS report, the findings of the Royal College of Surgeons investigation are not primarily a matter for NHS Grampian. Just as the investigation was undertaken by the relevant royal college, so the responsibility for dealing with unprofessional conduct by medical staff is a matter for the General Medical Council. The GMC will not refer matters to NHS Grampian before deciding whether disciplinary action is required in cases of alleged misconduct.

The problem for staff and patients, however, is that it will take time for that all to become clear. If the Royal College of Surgeons investigation had been undertaken in England, the duty of candour on NHS bodies would have led to the publication of the findings of the report. Until they are published, it will continue to be all too easy for the vacuum to be filled with misinformation instead.

Given the Government's commitment to a duty of candour in the Health (Tobacco, Nicotine etc and Care) (Scotland) Bill, I hope that the cabinet secretary will look again at whether there is a way of making the findings of the report public, in order to protect those who have done no wrong and to let patients know the full facts. Professional reputations are at stake, but there is clearly a balance to be struck in the public interest.

There is an important debate to be had about the future of the NHS across Scotland. I hope that there can continue to be progress in addressing all the issues facing the service in Grampian—and elsewhere—so that the NHS in Grampian can play a full part in that national debate and in delivering for local people.

15:29

Linda Fabiani (East Kilbride) (SNP): I welcomed the text of Jenny Marra's motion when I read it after it was published last night, and I welcome the generally consensual and positive speech that she made. That approach is welcome. It is quite clear that the approach is one that other people are taking up. As outlined in the cabinet secretary's amendment, many patients, members of the public and professionals are recognising that, across the board, we need an honest conversation about the long-term future of our NHS, to ensure that it can meet the considerable challenges of the future.

We often talk about those challenges, and it sometimes concerns me that when we talk about them, they all sound hugely difficult. However, some of them are extremely positive because many of them result from people living longer and from the advent of much improved medical solutions right across the board.

It is also very important that in the discussion, we should not lose sight of the considerable progress that our NHS has made in recent years or the high-quality care that is delivered every single day by the vast majority of doctors, nurses, auxiliaries, assistants, ancillary staff and, of course, administrators, who help the wheels to turn.

We have excellence to build on. The cabinet secretary outlined record funding and staffing and the other improvements that are being made in moving towards the 2020 vision that has been agreed for our health service. That vision for health and social care has prompted the fundamental shift towards more preventative healthcare and care that allows people to remain in their own homes, which is where, in general, they want to be. This week is carers week in Scotland, and we should always remember that part of the integrated care approach is about respect for the needs of carers, of whom there are so many.

In my constituency of East Kilbride, an award-winning NHS Lanarkshire integrated care team is doing sterling work, but we still have a long way to go. There are issues to be tackled, involving bed blocking, home care packages and better working between departments within health boards—for example, between primary care, acute care and mental health services. We also need better working between health boards and local authorities. That has begun, of course, with the Public Bodies (Joint Working) (Scotland) Act 2014, but it is not easy.

Our public institutions are renowned for having a fortress mentality that can lead to intransigence. I do not say that lightly; I say it following years of parliamentary experience on various committees. I do not have time to go into it all but I remember being on the Finance Committee in the previous parliamentary session when we did a very in-depth inquiry into preventative spending, and it was striking just how intransigent some of our public

bodies were when it came to looking after their own budgets.

If we can get beyond the silo mentality that Nanette Milne spoke of—the silos that exist both within and between our public bodies—surely we can get beyond the silo mentality among political parties. I am really heartened by what I have heard in the chamber today. I hope that Jenny Marra and her colleagues take my comment in the spirit that is intended—I hope that this finally marks a move away from the "SNP bad" approach that seems to have dominated Labour thinking for quite a time. Successfully managing the NHS in public hands requires agreement across the parties, as well as across institutions, about some of the key priorities and the key principles.

The SNP Government has made it clear that we agree with the fundamental principle that NHS services should be free at the point of need, and the Labour Party has made it clear that it agrees with that too. There may be discussion about what that actually means but it is a basic, fundamental principle that we can all get behind.

I make a plea to Jenny Marra to spread her approach more widely across her party because our recent experience in East Kilbride has not been encouraging in that respect. For example, her colleagues in East Kilbride condemned us for repairing a seriously rundown health centre; then they condemned us for deciding to build a new health centre; now they are giving us a really hard time for daring to have artworks on the walls of the new centre, now that it has been built. East Kilbride Labour seems to hanker after the days when all public buildings looked the same and all NHS buildings had walls that were painted green and cream. However, on a national level, I think that we are moving beyond that.

I am also pleased that, at a national level, we accept that a new consensual approach to targets is necessary. Over the years, we have not always looked at targets in a helpful way. I remember many targets being abandoned by previous Governments, and other targets coming back again. I would like continual quantitative and qualitative monitoring, so that we constantly strive for improvement. I hope that we can, through the consensus that I have spoken about, fulfil that aim for our health service.

15:35

Jim Hume (South Scotland) (LD): I welcome this debate on health. At a time when we often take a narrow focus and address only separate elements of the NHS, I believe—as the Royal College of Nursing does—that it is time to develop a clear vision for a future NHS that is truly sustainable.

The recent joint statement by the Royal College of Surgeons, the RCN and the Academy of Medical Royal Colleges on the need to re-examine and to develop the sustainability of the healthcare system highlights the fact that the debate is long overdue.

For a long time, we have called for a more robust and overarching strategy that listens to experts and puts patients first. We do not want to go in the direction of making marginal and piecemeal changes in things such as workforce development, access to psychological treatments for children and adults, and primary care for the population. Spending money without recognising the important links between the different parts of the NHS system will lead only to further segmentation of services, to increased pressures on staff and, eventually, to breaking point.

We know that health inequalities exist in Scotland and that they are not just a matter of who has better access to a hospital. Those inequalities can be shaped by housing conditions, by the education and employment opportunities that exist in all parts of Scotland, and by the support that a person can access when those issues lead to depression, to self-harm, and to increased risk of dementia and many more ills in terms of mental health. I highlight once more the Lib Dems' call for equal treatment for mental health and physical health. In the discussion about strained budgets and an ageing population—the biggest challenges that the NHS faces—the inclusion of mental health is crucial to any way forward.

We cannot begin to address problems when almost one person in four—including NHS staff—is living with mental ill health at some point in their lives. I note the important work that is done by organisations and campaigns—for example, the see me programme—to end mental ill health discrimination, but even with that work the fight against stigma is still a long way from being sorted. The inability of so many people to express their need for support affects their productivity at work and can, in turn, touch on other aspects of their lives, including socialising and family relationships. It can also lead to self-harm and, at worst, to suicide, if there is no support.

Our future NHS needs a serious commitment from the Government to address the need for parity of esteem in respect of mental health and physical health. Instead, we have seen a decrease in the mental health research budget, barely an increase in the children and adolescent mental health services budget, and a continued vagueness about a pledge for parity of esteem for mental health and physical health.

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): Mr Hume has raised the issue of mental health valiantly on

many occasions, and more power to his elbow in doing so, but I reiterate the point that parity between mental health and physical health already exists explicitly in Scottish legislation. It was set out in the National Health Service (Scotland) Act 1978, as I have said many times to Mr Hume.

Jim Hume: I have replied that it does not repeat what has been done elsewhere to state the need for parity between physical health and mental health. I am happy to forward the information to Mr Hepburn yet again. I thank him for standing up, but we need to go that one small step further.

It is important that we address the clarion call and state once and for all that mental ill health is no less serious than physical ill health.

Our hard-working staff—the doctors, nurses, allied health professionals, consultants, clinicians, ambulance drivers, GPs, carers and so many more—ensure that Scotland is on its way to thriving health. They and the patients are the fount of knowledge and expertise that we must now listen to, which should drive how we think about achieving the healthcare standards for which we strive.

On the current targets and measures of treatment effectiveness, the joint statement notes that the targets,

"while having initially delivered some ... improvements"

are

"now creating an unsustainable culture ... skewing priorities ... and"

unfortunately

"wasting resources".

We hear GPs' concerns about being overwhelmed with so much work that it affects the quality of their time with patients.

Nursing is so understaffed that private agencies are costing us millions. That money could be invested in the human capital that drives the NHS forward. Instead, the Government has been acting in a piecemeal and reactionary way, rather than implementing safeguards from the start. As has been mentioned previously, the Government must now also recognise the value of preventive healthcare. We expect a lot of changes with the integration of healthcare and social care. This is the opportunity to ensure that that major project is given all the right support with all details being addressed and the provision of relevant safeguards, if we are truly to achieve a future proofed NHS.

If we are to put our healthcare system on the right path we must have an honest debate and face the challenges. The Scottish Government must listen to people on the front line about their calls for this debate and for change. We need a new approach to targets, and new ways of delivering care. That is why we call on the Scottish Government to embrace the bold thinking of long-term solutions for the NHS. I look forward to being part of that debate in the future, not just here but with the people who deliver our health care. The BMA was right to point out research highlighting the frustration at

"the lack of opportunity to express ideas and feelings"

and

"to participate in decision making over issues that directly affected their working lives ... at the expense of effective and efficient patient care."

It is so wrong that people should be driven to feel that way, which is why we need a longer-term strategy for an NHS that is fit for the future.

15:41

Dennis Robertson (Aberdeenshire West) (SNP): Just yesterday, directors of finance from some of our NHS boards gave evidence to the Heath and Sport Committee, and at one point I started to feel very sorry for them because of the complexity of their job—so many people are knocking on the doors of finance directors of our NHS boards. Quite rightly, people put forward their case—just as Jim Hume did a second ago—and the minister responded. That is where we have a problem, however, because everybody wants a slice of the cake; everybody—rightly—wants to be a priority when they knock at the door. Sometimes, however, we need to listen, and even though the legislation is very clear, Mr Hume appears not to be listening.

Jim Hume: Dennis Robertson said that I am not listening, but although the Mental Health (Scotland) Bill states that there should be improvements in mental health, it does not do the same thing as the UK Health and Social Care Act 2012, which specifies parity between mental and physical health. That is my point.

Dennis Robertson: That proves my point to some extent, because we have interpretation. The issue will be about our coming together to try to make improvements. Our nurses—perhaps in orthopaedics or paediatrics—may have particular opinions: some specialist nurses may feel that there should be more of them. Clinicians also say that they should have more facilities and resources. They are probably all right.

At the same time, we must consider ways to improve what we have, and how we can be smarter—I think Jenny Marra used that word and said that we should be smarter in how we provide the service. We have a finite resource so we need to think about how we deliver services. With the

integration joint boards we have an opportunity to meet the challenges that lie before us.

I was a bit concerned when Jenny Marra said that perhaps after the listening, things will come together within six months, because I am not sure that we will have the answers within that time. Some of the business plans for the integration joint boards run for three years. We must ensure that whatever we do, we do it in a manner that will get us the outcomes that we desire. There is no point in rushing in to fix something that is not broken—it is not broken, but perhaps we need to oil the wheels a little better.

Everyone is in agreement. When we talk about the health service—Bob Doris did this when he mentioned carers—we need to ensure that we have a dialogue.

Jenny Marra: Dennis Robertson referred to my remarks on the timescale of the public conversation that the RCN has called for. He is saying that we are looking for solutions, and solutions are always welcome. I agree with Dennis Robertson that we cannot rush to immediate solutions. A bigger priority is what the RCN is calling for, which is a public debate on the principles. Such a debate could consider a range of issues, including resource shifts—

The Deputy Presiding Officer (John Scott): And your point is?

Jenny Marra: —and all those things, rather than running to immediate solutions.

The Deputy Presiding Officer: I will give you a little extra time, Mr Robertson.

Dennis Robertson: Here we are. It is about coming together, how we come together, what we discuss and what we interpret as being the possible outcomes.

We are all trying to say that we want the best possible outcomes for all patients, regardless of their age, because they are important. I would certainly like to see more services in primary care, through GP practices, specialist nurses, practitioner nurses and allied health professionals. We need a switch in our culture and our thinking. For instance, most people think that when they have an ailment they should go to see their GP. Why do they think that they should go to see their GP and not the community pharmacist or the practice nurse?

We need to try to change our thinking so that we understand that we do not always have to go to the GP. In addition, the GP does not always have to refer to the hospital, because there could be alternative referrals. When we look at the changes that we are proposing and the changes that we all want to see happening through integration, we see that referral should perhaps not be to hospital but to social care.

As patients, we all have a responsibility for our own wellbeing. We need the help of our professionals—absolutely—but let us try to help those who provide the service to us. Let us try to help them by changing our approach and our attitude to the services that we need for the future: services that we richly deserve.

15:47

Drew Smith (Glasgow) (Lab): I am grateful to the Labour front bench for providing Parliament with time to discuss the situation of our NHS.

As a new member, I spent some time on the Health and Sport Committee and, like other members, became well used to the calls from health professionals and policy experts for a dispassionate evaluation of what is happening in our hospitals and—most important—assessment of how we can achieve the greatest possible consensus on how the service should be reformed to meet the scale of the challenge that it faces. My party has consistently supported expert opinion on the need for much broader political acceptance of facts and forecasts about the NHS in Scotland. The truth is that continued piecemeal and short-term decision making has the potential to damage the long-term sustainability of many aspects of the service in a manner that would alarm the public, whose expectations are high and—like everything else to do with the NHS—are ever increasing.

We all receive regular representations from constituents about their experience of local NHS issues. It is a fact of political life that publicising of negative experiences will be uncomfortable for a Government that has been responsible for stewardship of the NHS for a decade—just as it has affected previous Governments. The challenge for the Government—the cabinet secretary set out her willingness to engage with that challenge—is to accept an honest appraisal of the record and to welcome a genuinely inclusive debate about the future. That is not always the easiest thing to do. In that debate, the Government should not be distracted by a desire to defend its record in areas where it falls short. I have no problem with its defending a record of achievements, but when problems are pointed out we need to get beyond defensiveness about them.

Whether we were elected as parliamentarians four years or 16 years ago, we are at the point in this Parliament—we are sufficiently advanced through the session—that across the parties we all understand the scale of the demographic challenge, the technological advances and the budgetary pressure that is being faced by the NHS. The challenge is brought to us most clearly

by our constituents, some of whom experience unacceptable waiting times, inequities in access to treatments or refusal of drugs or procedures that they believe might be able to assist them. Therefore it is right, whether we are in the Opposition or on the Government's back benches, to raise those matters, to ask ministers to take responsibility and to pursue remedy.

I do not intend to raise a large number of issues that my constituents in Glasgow come to me with, because that would not fit the tone of this afternoon's debate, but there have been particular problems in the accident and emergency services in the city, and there is a situation at the Southern general that is important to point out. My party and the Government supported the new hospital, and we all want to see it succeed, but we have heard concerning reports that go beyond the teething problems of a new hospital. It was not Labour members but staff and patients a few weeks ago who said in the *Daily Record* that the situation there was akin to "a war zone". I am not going to dwell on that, but it shows the level of concern that exists. To me it suggests that some of the things that are being pointed out are basic problems that we should not be experiencing in a hospital that was—at the end of the day—10 years in the planning. There must be lessons to learn there.

That said, I do not believe that hospitals are where the big changes are needed to get our NHS back on track and, which is more important, properly equipped for the future. We have challenges in respect of underfunding of social care and the lack of time for general practice. As some members have said—including members from the Government party—sometimes we talk too much about the move to preventative healthcare, rather than giving examples of where and how it has been achieved. Those are the real problems. The truth—which we all understand, across the parties—is that too many people are in our hospitals when they do not need to be.

Arguments about which A and E departments are provided will not assist the doctors, nurses and, most important, the patients of tomorrow if we are left without enough specialist staff or beds to provide the quality of care that should be provided in hospitals.

The calls from the RCN, the BMA, the royal colleges, Unison and patient groups are not going away. It will not be good enough in another term of office. I appreciate that members on the other side feel that the Opposition raises concerns too often, and I have to say that sometimes that happens. The frustration on this side is, of course, that those concerns are often batted away. We see that anyone who raises concerns is accused of running down the staff or the service, and then workers can be used as human shields. None of that safeguards the principles that we actually all share with regard to the future of our national health service.

My other point is that the answer to specific problems in the national health service cannot just be the allocation and continual reannouncement of relatively small pots of money, which seem to ameliorate newspaper headlines more than they alleviate the symptoms of the challenges.

In conclusion, I accept that it is Parliament's job to hold the Government to account, but it is both the Government and Parliament's job to ensure that the country that we leave behind for those who come after us is better than the one that we live in. That is the importance of this debate, which is about not just improving the NHS as it exists today but ensuring that it genuinely is sustainable for the future.

15:54

Kevin Stewart (Aberdeen Central) (SNP): We all recognise that all of us in this place have a duty to ensure that our national health service is fit for the future. I am always pleased to have the opportunity to speak in NHS debates and to be able to recognise the hard work of all the NHS staff who deliver vital services across Scotland.

We are lucky to live at a time when people are living longer, when new medicines are being developed and coming on line and when breakthrough medical advances are happening at a fair rate. Unfortunately, we are also living at a time when austerity policies are the order of the day from the Treasury.

Too often, our focus in debates is on hospital and emergency care, and today, in my contribution, I want to concentrate on primary care and prevention, because that area will play a significant role if we are going to achieve the cabinet secretary's aim to

"look beyond short-term demands and foster a consensus around how we best manage our NHS to ensure it meets the considerable challenges of the future."

Beyond that, we also have to have the honest conversation that Linda Fabiani talked about in her speech.

As MSPs, we all receive complaints and hear concerns from constituents about aspects of their NHS care and treatment. Often, people are unhappy with specific parts of that treatment, not the whole package. As a percentage of cases that the NHS deals with, the number of complaints is relatively small and we know that satisfaction rates, in the main, are high. The bulk of the issues that I personally have had to deal with in my time as an MSP are about hospital and emergency

care and, in particular, about areas of specialist treatment.

I receive very few complaints about GPs or primary care, and considering that last year there were, I believe, around 2 million GP consultations in Grampian alone, it seems that the satisfaction rate with that service is very high indeed. Because of that, we rarely discuss the issue in this chamber.

We know that GP numbers rose by 7 per cent from September 2006 to September 2014. However, at a recent meeting that the cabinet secretary attended with members from the north-east, we heard from GPs about some of the difficulties that they may face in future if we do not start planning now. Number 1 on that list was recruitment and retention. There were also some worries about premises and whether they are fit for purpose, and there are obviously concerns about the rising complexity of patient care and workload.

The GPs were practical in their discussions with us, and they gave suggestions about workforce planning, which the cabinet secretary listened to and has taken on board. She has already mentioned the fact that work is on-going in that regard. We have also seen some investment in Grampian to help with premises, and a pilot is going on at the moment in the north-east to look at the complexities of patient care and workload.

Lewis Macdonald: I am interested in what the member said about the meeting that he recently attended. Does he acknowledge that, in the context of Grampian, there are particular concerns about the future of primary care in the city of Aberdeen, and will he join me in urging the Government to look closely at what it can do to address those concerns?

Kevin Stewart: The Government is looking closely at those concerns. That is one of the reasons why the cabinet secretary attended the meeting that I have been talking about, and she has given a clear commitment to continue discussions.

We can continue to talk down aspects of what is going on, but I would rather talk up the very good work that is being done at the moment in combination between GPs, NHS Grampian and the Government in that regard. In doing that, I also want to look at other aspects of life that have an impact on the health service but which we do not often think about. As well as the integration of health and social care, I would like to see integration of thought when it comes to certain issues—in particular, areas of strategic and local planning. Far too often, there is agreement to build huge numbers of new houses, but no thought whatsoever is given to how the people in those houses will be served by GPs and other health services.

We need to get much better at thinking about such things, as the number of folk that we have compared with the number of GPs is one of the reasons why we have a major problem in Aberdeen at the moment. We need to look closely at that in the future, and I will do so in my capacity as convener of the Local Government and Regeneration Committee.

The Deputy Presiding Officer: Draw to a close, please.

Kevin Stewart: The debate has been pretty consensual, and we are all almost in agreement on almost everything. We all have a duty to ensure that we have an NHS and a population that are fit for the future.

16:00

John Pentland (Motherwell and Wishaw) (Lab): Like other members, I value our hard-working and dedicated doctors, nurses, lab staff, porters and other NHS staff. I also value their stand-up-and-be-counted attitude. It is often those health workers who highlight NHS problems, including the 434 who complained in the course of one year about staff shortages in NHS Lanarkshire.

To attack MSPs who take up such issues is to show contempt for the workers who have raised them. Likewise, we should not undermine the public when they express concerns; people know and understand that it is not the front-line workers who are responsible, but those who are in charge of the NHS. Let us therefore stop the diversionary tactics, admit that the NHS has problems and address them.

When I tried to do that, I was accused of scaremongering by NHS Lanarkshire even though I was using its own words, taken from its own documents. It is as though NHS Lanarkshire does not want the public to know what we are talking about. It is okay for Lanarkshire NHS Board to talk behind closed doors about the fragility of services such as A and E and its plans to close departments because of staff shortages, but woe betide anyone else who talks about those things. It is okay for the board to see shortages highlighted in red and amber, but it is not for us to repeat that those are high-risk areas or to question why locums are being flown in from all over the world.

The board should be a scrutiny body, not a defence mechanism, but when I raise staff and public concerns and the chief executive accuses me of scaremongering, the board says nothing. That does not encourage the public or, indeed, others to speak out. The board members are

public appointments who are supposed to represent the public; instead, they dismiss legitimate concerns, rubber-stamp proposals despite public opposition and are rarely heard speaking up except to defend crucial matters such as the chief executive's pay.

However, it is not all about money. The cabinet secretary is well aware of the many problems that have beset NHS Lanarkshire over the past year or so. An independent report backed whistleblowers who raised the alarm over a lack of suitably trained workers in neonatal services. The NHS claimed that the matter was being sorted, but other areas were left depleted. We also see the impact of staffing shortages in the fact that NHS Lanarkshire sometimes has more patients waiting for over 12 hours than the rest of Scotland combined.

The rapid review of NHS Lanarkshire highlighted the problems of Lanarkshire's A and E services. Audit Scotland highlighted NHS Lanarkshire's repeated failure to meet out-patient waiting times and delayed discharge targets. Leaked documents highlighted service configuration problems in Lanarkshire, and mental health services are still dealing with problems following the controversial reconfiguration that was implemented when Alex Neil was the Cabinet Secretary for Health and Wellbeing. A and E services are still under pressure, and the situation will worsen with the disintegration of GP out-of-hours services, which the NHS says

"have reached the point where it is becoming extremely difficult to provide a safe service."

As the cabinet secretary is aware, GP out-of-hours services is a big issue in Lanarkshire, not least because, until July last year, there were five centres, but that figure has now been cut to three. The centres are co-located within A and E departments; according to the five royal colleges, that is the best option, where available. I am pleased that the cabinet secretary described co-location as

"in line with the work we are already doing."

There is a good chance that the review will recommend that.

The cabinet secretary asked the board not to make permanent changes until the national review reports, but that call appears to have been ignored, with the board rebranding the permanent change as an interim measure.

Shona Robison: I hope that the member will be clear about the facts here. There is an interim set of arrangements due to the patient safety concerns raised, which we cannot ignore, but any permanent changes must come to me for approval, and they must be in line with the national review. I hope that the member will accept that those are the facts of the matter.

John Pentland: If it is an interim measure, why are the centres being moved from the hospitals against the advice of the royal colleges? Why are the interim measures identical to the board's proposed permanent solution? Why is NHS Lanarkshire setting up new centres as an interim measure with all the cost that that entails? It will cost even more if the centres have to move back again. That does not make much sense unless the board thinks that the change will be permanent.

The plan will reduce the service to two centres, or even just one centre, for the whole of Lanarkshire, because those were the only two proposals offered in the consultation. Costs and disruption would be involved in making those changes, as well as further costs involved in changing them back again, which makes people suspect that the board wants to make its so-called interim plan into a permanent fixture.

In a vox pop for *The Wishaw Press*, the public were angry and had some not very complimentary things to say about the plan. I have written to the cabinet secretary asking her to intervene. I now ask her publicly to ensure that NHS Lanarkshire is not allowed to subvert her previous request.

I agree with the call for a wide-ranging debate about the future of our NHS. I have called for that locally and nationally, but we should not get away from the urgent action that is also needed.

16:07

John Mason (Glasgow Shettleston) (SNP): There are key words and phrases in the motion, including

"the future sustainability of the NHS"

and

"'look beyond short-term demands'",

which I absolutely agree with. I hope that we are all signed up to those concepts. I would add one other phrase, which again I would hope that we all believe in: preventative spending.

The reality is that there will never be enough resources to do all that we want to with the NHS. As the statement from the colleges reminds us, new drugs and technologies can be very expensive. There is no limit to the resources that could be spent, so there will always be difficult choices about what we prioritise. That is particularly the case now and in the near future, when resources are not likely to increase substantially.

Of course, we could reduce resources in education or housing and transfer those to health, but I do not sense that any party has a huge

appetite for that. Indeed, we have not heard anyone say that today.

I was interested when Theresa Fyffe, the director of RCN Scotland, said:

"putting more and more money into the current system is not the answer."

Therefore, presumably what we are debating is how we better use resources in the health budget. No one is seriously suggesting that there could be greatly increased resources.

Action 3 in the statement talks about supporting people to live at home or in a homely environment. I think that we are all signed up to that. It goes on to say there has not been enough progress towards that:

"Instead, the focus has remained firmly on the traditional model of hospitals as the mainstay of the health service. This needs to change."

I have to say that I agree with that.

We have spent a fair bit of time over the past four years in the Finance Committee—Linda Fabiani reminded us that we spent time looking at this issue before then, too—considering the topic of preventative expenditure. I think that other committees are on board for that as well. Even this morning, we spent time at the University of Edinburgh discussing the issue.

I accept that it can be hard to clearly define exactly what is and what is not preventative spending, because even one medical intervention can have a reactive and a preventative element, but it seems to me that expenditure on hospitals is primarily reactive rather than preventative. Therefore, I think that we must seriously consider reducing the amount of money that we spend on hospitals and putting more resources into GP practices and other more preventative and community-based solutions, which are often less expensive per person than treating someone in a hospital setting.

Seriously making that kind of change would be very bold. If we reduced the resources that are available for hospitals, what would the reaction be from the public, the media and politicians? Such disinvestment has not been easily tackled anywhere else, and there is a view among the public that somehow hospital care is gold plated and that other healthcare locations are second rate, even though we know that older people especially are more likely to be confused if they are moved to an unknown hospital, and they are potentially more likely to fall or to pick up infections than they would be at home.

The royal colleges' statement calls for professions, organisations, politicians, the media and the public to work together on this. Is that actually possible? Surely it must be our aim. We know that if A and E waiting times go up, the politicians, the media and the public all get very excited, and the response is often to provide more resources for A and E, but is that not a sign of failure in one sense? Surely it is the case that too many people are going to A and E who might not need to be there and who would be better treated elsewhere, so should we not move resources from hospitals and A and E into the community? Jim Hume's point about mental health comes into play here, because we do not hear the immediate demands that are made for A and E provision being made in relation to mental health needs. Even if moving resources into the community meant allowing waiting times to rise temporarily, in the longer term that would give us more resources for GP practices, care homes and home care.

The question is, how should we allocate the resources? I do not think that bringing one patient into Parliament who has very expensive needs is the right way of addressing how we spend the NHS's money.

While I am on the subject of GP practices, another question that needs to be asked is whether the resources are going to the right places. If it really is the case that life expectancy reduces as one moves from west to east in Glasgow—it has been suggested that life expectancy decreases by two years per train station—is that not a sign that we are putting too many resources into the richer areas and not enough into the poorer areas? Should we consider cutting the number of GPs in the west of the city and having more GPs in the east? I can imagine that that suggestion would not go down well in certain quarters, but the statement challenges us to do things differently, so surely that is the type of question that we need to ask. The deep-end practices that represent the 10 per cent of GP practices in the most deprived areas have been asking such questions.

I think that we are all very proud of the Scottish NHS, despite its faults. We want the best for it and for our fellow citizens going forward, but I believe that that means that we will have to make hard choices. If we want to invest more in one area, that will mean disinvesting in another area, so my question is: are we brave enough to do that?

16:13

Sarah Boyack (Lothian) (Lab): I welcome the debate, because it gives us the chance to talk about the challenges that have been raised with us by constituents, patients and workers in the NHS.

I want to focus on what is happening in NHS Lothian. It is struggling with huge pressures: it has people who are experiencing ill health as a result

of deprivation; it has people with multiple and long-term health conditions; it has a population that is growing month on month, with no sign of that changing; and its population is changing. As other members have said, more older people are living longer, and they will have many more contacts with our NHS, whether with GPs, our care system or our hospitals. In addition, there is the challenge that the RCN and the royal colleges are asking us to consider. They want us to have a genuine public debate on the change that is needed.

Following on from what John Mason said, from my perspective it is not just a question of moving resources from one place to another; it is partly about managing the transition that we now need. The massive uplift in health expenditure in the Parliament's early years enabled us to do all sorts of new things. It is clear that there will not be the same massive uplift in the future, but it is not as simple as saying that we should just cut resources in one area and move them to another. The transition is key; indeed, that is where I think GP practices are crucial, given that they manage demand and are many people's first port of call. If people are going to A and E instead of their GP, that should be seen as a failure, a waste of resources and an illustration of the problem.

In Lothian, we have not only constant pressure on waiting times but a care crisis. For example, it was estimated this week that 5,000 extra hours of home care are going to be needed every year from already stretched services. For the past 16 years, I have tracked NHS Lothian and have watched the challenge grow as more people have come into the area. I therefore partly take John Mason's point about moving resources on the grounds of health inequalities, but the fact is that people, regardless of their income, are going to need healthcare. We are therefore facing a bigger problem.

We have a GP crisis in which shortages are being hidden by locums. At a meeting last week with the City of Edinburgh Council and NHS Lothian, we were told that, at any one time, six of our 73 GP partnerships are unstable and that, as I pointed out at question time, 26 GP practices have closed their lists to new patients. There is a huge problem with our GPs who, for most of us, are the entry point to our NHS. We are simply not getting the access that we need, and that situation requires new funding.

Another problem is that the GP employment model has changed. More and more women are now working as GPs, and they do not want to follow the profession's traditional career structure. As a result, we need new GPs and more training for them. I also know from personal experience that more and more GPs in their 50s are either leaving practices or going part time. If all our careers are supposed to last until we are 67, we are talking about a 40-year career in general practice, which, given the pressures that are being put on GPs, is simply not sustainable in the long run.

Therefore, we need to find different ways of enabling GPs to work and different employment patterns. The system must not assume that everyone is going to be working the same traditional patterns. Key to all this is more radical thinking about GPs and supporting the development of GP practices in doing different things, but making that happen will require a transition. The £50 million fund that I mentioned earlier will be key in that respect, but it is questionable whether that will be sufficient.

In addition to GPs, the care sector is crucial, as others have mentioned. Part of the problem is that many patients, particularly older patients, are finding themselves stuck in hospital. Their physical needs might have been met and they might be able to go home, but they do not have the care and support that they need in their own homes and there are not enough care homes to look after them. For many older people, being in hospital for a prolonged period of time is, in itself, bad for their health; it might be bad for their mental health, and they might not be getting the nutrition that they need. The fact that people are getting stuck in hospital is giving rise to multiple problems, and that again brings us back to GPs and care home services.

Realistically, I do not think that the answer is to cut investment in hospitals and shift it instantly to care and GP services. There will need to be new investment as we manage the transition process, and that will be challenging, given that the current model for public services and public expenditure is not going to help us with that change. We therefore need to have some bold and honest discussions about this issue. One suggestion is that we bring in volunteers to help with, say, people who have dementia; indeed, I know of many fantastic projects in which older people or people working part time have provided a vital back-up to our care services. The Cyrenians ran a project on dementia—

The Deputy Presiding Officer: You must draw to a close, please.

Sarah Boyack: I am sorry, Presiding Officer. The project provided care to help reconnect older people, and it uncovered a massive unmet need for people with dementia.

Although I agree with the principle of what we are discussing, I want to finish by suggesting that, in some ways, things are a lot harder than people are saying, and having a genuine and honest debate is going to throw up a lot more challenges

that we will need to address. We are already facing huge problems, and all this needs to be added on top.

16:19

Mark McDonald (Aberdeen Donside) (SNP): I appreciate that we have taken a broadly consensual approach in the debate. Given that I am famous for taking such an approach in my speeches, I will continue that theme. Members have made a number of suggestions, and I will contribute some of my own.

I recognise the pressures that the NHS faces—indeed, I think that we all do. My colleague Kevin Stewart referred to the meeting that we held with NHS Grampian, which the cabinet secretary attended, to discuss issues that face the primary care sector in particular in the Grampian area. In my constituency recently, Brimmond medical group announced its decision to withdraw from the provision of general medical services as of 1 October due to upcoming GP retirements and a difficulty in recruiting to the practice. A letter advising to that effect was sent out to the practice's 8,300 patients, of whom I am one. Discussions with NHS Grampian have established that the patients will continue to have a GP service in the area. I am aware that discussions about that are on-going and that a process is being followed.

What that case highlights, and what I will continue to highlight to the health board, is that at the point at which a practice faces pressures or closure and is deciding that the GPs will withdraw from providing general medical services, there is a need for on-going communication and collaboration with the practice as well as consideration of future provision, because there are obviously issues to do with the retention of existing staff and the Transfer of Undertakings (Protection of Employment) Regulations arrangements that could be put in place. There needs to be on-going dialogue.

The case also highlights to me that there is an opportunity to look more closely at what we are doing in primary care and how we access it. I think that NHS Grampian has said that it wants to look at a more confederated model. Instead of individual practices operating in small areas, which can obviously put pressure on GPs to take on partnership roles, the possibility of a practice having a number of premises across communities that deliver services can be looked at. Only a small number of the overall cohort of GPs would therefore be relied on to take on those positions.

An issue that has been highlighted has been the difficulty in attracting—[*Interruption*.]

The Deputy Presiding Officer: The microphone should be on for Mr McDonald, please.

Mark McDonald: I am sure that members missed only a little bit of the quality contribution that I made, but I will rewind slightly and start again.

One of the difficulties being faced is attracting new graduates into general practice, and one of the reasons for that is the view that graduates hold that they would be required to take on some of the responsibilities of partnerships, which many of them perhaps do not want to take on alongside the role itself. On top of that, there is the fact that a larger number of general practitioners are now part time and female. In the previous model, there was a larger number of male GPs who worked full time. That needs to change the way in which general practice is delivered.

When we talk about pressures on accident and emergency services, we talk about people who present to them who ought to be presenting at their GP surgery. We need to drill down a bit further and look at whether people who present at GP surgeries might be better dealt with by another health professional—for example, a nurse practitioner. I have highlighted before in the chamber the good example of the Middlefield healthy hoose in my constituency. The Minister for Sport, Health Improvement and Mental Health, Jamie Hepburn, is coming to my constituency to visit that facility next month, and I look forward to joining him on that visit.

Pharmacists and allied health professionals also have a role to play, and we need to ensure that an appropriate triage process is in place. In many cases when individuals phone their GP surgery, they are given an appointment with the GP without any examination of the issue that they wish to discuss. It is only at the point at which they present to the GP in the consulting room that the GP might think that they should really have gone to the pharmacist instead. We need to get better at dealing with that.

The other issue that faces GP practices—certainly in my constituency but also, I suspect, elsewhere—is the pressure of development as well as the pressure of demography. There are a large amount of planning applications in my constituency, which will add to the pressure on existing GP practices that are at full capacity or getting very close to it. Some practices—for example, Danestone—are operating in very constrained physical premises that have little or no room for expansion. We need to look again at how we utilise planning and the funding streams to develop and expand practices, and whether that needs to be done through a collaborative approach.

On the issue of the care sector, my colleague Bob Doris made some very important points about career pathways. The Bucksburn care home in my constituency was closed and the building abandoned by its owners, Pepperwood Care. I asked the NHS and Aberdeen City Council whether they would consider establishing a step-down facility at Bucksburn, similar to the Clashieknowe one, that could help to deal with delayed discharge. I was advised that the cost of bringing the Bucksburn site up to a suitable standard was too high and that it was not seen as a suitable facility. However, I know that talks are going on between the Scottish Government, NHS Grampian and Aberdeen City Council about possible future uses of the Bucksburn facility that would help to drive improvements in the care sector. I look forward to hearing more about that in the near future.

We have to consider whether there is a way in which we can develop a model or approach in the care sector that can chip away at the difficulties that have been caused by the genie being let out of the bottle and the privatisation element coming into care home provision. We need to consider whether there are ways and means by which we can address the challenges that that has presented.

16:26

Duncan McNeil (Greenock and Inverclyde) (Lab): Like others, I welcome this debate. I also welcome the cabinet secretary's commitment to have a full public debate on the future of the NHS. I discussed that with her and urged her to have such a debate, as I did the previous health secretary. I have been encouraging the Government to have that sort of debate for quite a while, so I am delighted that it will happen.

I lodged a parliamentary motion last week urging the Government to have a debate on the NHS, and Bob Doris supported it, so consensus broke out there. I am confident that the Health and Sport Committee can play an important role in ensuring that we have the widest possible participation in the debate to meet the call by the royal colleges that we bring about changes in the delivery of services in a sustainable way.

We have had a great, consensual debate in the chamber today, so it would be terrible if we split that when voting at decision time. I point out to members of other parties who mentioned the importance of sustainability that the motion mentions sustainability but the amendments do not—I am teasing members, but it would be disappointing to get off to a bad start today with the vote on the motion, because there has been so much consensus during the debate.

We need a public debate on the NHS, which would be valuable. We all know that the NHS has been under pressure for some time. John Mason has left the chamber, but I agreed with much in his speech earlier, including the point that supporting the NHS is not simply about money. Simply protecting the budget does not solve the problems, nor did the approach in the past of throwing money at them. The issues of high bed-occupancy rates, queues at A and E, unfilled staff vacancies, increasing working hours and challenges in providing A and E services out of hours have been with us for the past decade.

We are all committed to the national health service and we know that it comes under particular pressure at certain times, but it seems to be under a lot of pressure generally at this point in time.

Dennis Robertson: Does the member agree that every voice should be equal in the debate on the NHS and that it does not matter whether it comes from a consultant, a porter, a nurse or a patient, because it should be heard in the same way?

Duncan McNeil: Yes. The debate should seek to address the interests of the Scottish people and not those of vested interests in or outwith the national health service. I will come back to that point later.

We have had debates on, and inquiries into, issues in the NHS time and again, and we have spent a lot of time on many individual issues. We now have an opportunity to have a debate about the whole system failure that needs to be addressed.

As others such as John Mason and Sarah Boyack mentioned, a genuine public debate will be a challenge, because to sort this means that we will have to take sides on issues such as the performance-related terror targets, as some people describe them, that drive so much in the health service and skew us away from looking at preventive measures. Preventive measures take a longer time, whereas the pressure on health board managers and the health boards themselves is to deal with the immediate situation of people waiting in A and E. That diverts our time and our commitment in more ways than one.

As the cabinet secretary wrote in her article in *The Herald* this week, there is already consensus in the Parliament, across all the parties,

"that the NHS should remain publicly-owned, publicly-run, and free at the point of need."

Nobody would disagree with that principle. Indeed, it would be a good starting point for getting what Wales has—agreement on the principles. It is much easier for people to agree on certain principles, whereas it is sometimes easy to divide

on target A or target B. The principles are good and we are all agreed on them. Let us build on some of them and hope that that can take us forward to achieve real change.

In discussing targets, day-to-day running and whether we can get this debate going, we have to recognise that we are facing immediate pressures and consider how we can deal with them and move on. If I have a criticism of the *Herald* article, it is that it does what we all do and focuses in too narrowly on the professionals and on the health service as being a hospital. We all know that there is already more care in the community and our ambition is that that will continue to increase with the support of the national health service, but outwith what we usually consider it to be. We all support the move to deliver that care in communities—in the home, or closer to home.

John Mason hit it on the head. We have a gold-plated health service that is under tremendous pressure, while on the other side, more and more people are being dealt with in the community, and the stress on that service is adversarial. The service is prone to the market and in some areas it is driven by profit, which in some cases drives down quality. That impacts on the resilience of carers and diminishes the workers who are delivering that care in our communities.

The Deputy Presiding Officer: You must draw to a close, please.

Duncan McNeil: It is the exact opposite of the health service. We would not accept any of those conditions there, and that must form an important part of our debate. We cannot have two health services in Scotland. We recognise—as does our policy—that health and social care should be treated in the same way, and that should be one of our principles going forward.

The Deputy Presiding Officer: We move to closing speeches.

16:33

Jackson Carlaw (West Scotland) (Con): I am not an evangelist, although I think that I can sometimes be slightly evangelical, but I begin with a "Hallelujah", because while there has undoubtedly been from the Labour benches in recent times—from Duncan McNeil, Hugh Henry and others—a recognition of the need to move forward on a consensual basis, I hope that they will excuse me saying that some of the debates that we have had recently have been much more belligerent and antagonistic in their tone, and fundamentally depressing given the move forward that we need to see.

I hope that I am not being unduly cynical in observing that we are having this debate one month after a general election and not one month before it. It seems to me that the exigencies of the political process in which we all apply our trade allow the cut and thrust of elections and the preparation for them to cut with a scythe right through the conversations that all speakers this afternoon have said we need to have and the consensus that we need to achieve if we are to have a model for a sustainable health service in the future.

A couple of years ago, Scottish Conservatives said that we would have nothing to do with the English health service reforms and that we believed in a publicly funded health service that was free at the point of need and delivery. Some people were surprised at that, but we did it because we recognised that the professional organisations—whether the BMA or the RCN—patients and people on the street said that they had had enough of the interminable antagonistic approach to health that will clearly fall short of creating the environment that is needed if the health service is to be secured for the future.

I hope that the cabinet secretary will note that consensus and a non-partisan approach to the health service are not the same as the Opposition agreeing with everything that the Government says. I was a little dispirited that, when the First Minister was asked about health at First Minister's questions last week, she turned it around to say that that was the end of the consensus for which the professionals were looking. Drew Smith touched on that point. There is a duty and obligation on us to raise concerns even while we try to arrive at the broader consensus on the way forward.

Shona Robison: I agree with that, but the issue is how those concerns are raised. There is always a balance to be struck. For example, when a concern is raised about waiting times, there is always the point to be made about the NHS's successes. That works both ways. There are ways to raise concerns without trying to undermine the fundamentals of our health service.

Jackson Carlaw: I am happy to agree with that. That will be the test of how we take matters forward.

We have tried to contribute to the debate. Some ideas will be acceptable to some people and others will not. We have talked about the need for a GP-attached national and universal health visiting service up to the age of seven because that could help to address health inequalities, which are particularly concentrated in areas of deprivation, and contribute to the broader success in the preventative agenda.

We have talked about the reduction over time—I do not want it to become a cause célèbre in its

own right—in the number of health boards and area drug and therapeutics committees to try to evolve a more universal approach to prescribing that, we hope, will be less of a postcode lottery.

We have talked about the need for investment in the development of a new model of primary care, which came up in several speeches. We know that we have ageing GPs, but we also know that, if we want to prevent people from going into hospitals and into A and E facilities in particular, we need a model of primary care that works. That might mean moving to a more rural model with larger practices or the confederate model that was talked about—I cannot remember who talked about that; I think that it might have been Mark McDonald. That needs to evolve. Perhaps, when we revisit the GP contract, we need to get away from paying people to do things irrespective of whether they are where the priority should lie and come up with a model that recognises the challenges that we have.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Does Jackson Carlaw agree that what Wales is doing in supporting 63 GP clusters, which I will refer to in my closing speech, is exactly the sort of confederate model to which he referred?

Jackson Carlaw: It may well be.

We need to find a way of encouraging people to understand their responsibility for their own health. The cabinet secretary was not terribly keen on the idea of an individual health statement, which I canvassed before, but perhaps we need that because the future sustainability of our health service is something of a national emergency. I do not mean that it is in a crisis, but we want to avoid it ever getting to that point.

Perhaps each health board should send out an annual report to every household identifying the real priorities and the strains and consequences of people not looking after their own health. If we have an ageing population and we want people to enjoy a healthy old age, everybody has to understand that what they do in their 20s, 30s and 40s will have a direct bearing on the quality of life that they can expect to lead later.

We have to find ways of keeping people out of hospital. When the Parliament was founded, type 2 diabetes and dementia hardly registered as issues but they are now enormously financially burdensome on the health service. What issues are we not even aware of today that might prove a similar and equally complicated burden on the health service 15 years from now? The planning for that must take place.

The speeches from Dennis Robertson, Sarah Boyack and John Mason all touched on those matters in different ways but I will finish by disagreeing slightly with Nanette Milne, which is a bit controversial.

Nanette Milne said that she was confident of success, but I am less sanguine. As I said earlier, the exigencies of our political process are the worst enemy of what we have said today we want to achieve. There is an election next year. Are we really saying that, all through the winter and in the run-up to that election, we will not fall back into the trap of shouting at one another about what is happening in health? The Government at Westminster says that more funding will be coming. Are we going to say, “Oh, no it won’t”?

It is going to be incredibly difficult. I want to hear more about how the debate that the cabinet secretary talked about will be conducted. We not only have to get talking; we have to agree about what the shape of that discussion should be, and how we all sign up to the conclusions of it at the end.

I am not looking at this through rose-tinted spectacles. I think that it is going to be difficult and that we are all going to have to work extremely hard if we are going to succeed. The real problem is that we have to.

16:40

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I thank Jenny Marra for securing this debate on what is one of the nation’s greatest assets. It is important to everyone who needs to use the services that are provided by the NHS across Scotland.

I also thank members for their varied contributions to today’s debate and, in particular, for the wide appreciation that has been expressed of the magnificent work and the dedication of those who work in our NHS. I, too, place on record my thanks to those who work in the health service.

I welcome the many constructive comments from the royal colleges but it is important that, as we engage in this process, we hear from everyone, including members of the Scottish Parliament and, crucially, members of the public and anyone who can contribute to our ability to progress issues around our NHS.

We have heard about the joint statement that was issued last week by the Royal College of Nursing and the Academy of Medical Royal Colleges and Faculties in Scotland, calling for a bold, visionary and collaborative approach between Government, public and professions to secure a better future for our health service.

The Scottish Government welcomes that contribution, but we should not lose sight of the considerable progress that the NHS has made in recent years, delivering high-quality care every

day. It has record high funding, record high staffing, historically low waiting times, a world-leading patient safety programme and a clear 2020 vision. Nevertheless, we must be prepared to look beyond that horizon and consider the way forward for the NHS into the future.

To that end, the cabinet secretary set out in January this year the need for change to meet rising demand and the needs of an ageing population, and for a wider debate on the future of health and models of care, and explained our commitment to working with patients and families, health professionals and clinicians, the Health and Sport Committee and Opposition parties—indeed, everyone who wants to contribute—to help to shape the direction of our NHS and clinical strategy for the next 10 to 15 years. She reiterated that commitment today and, in a piece in today's *Herald* that was welcomed by the royal colleges, she set out our desire to foster consensus on our way forward.

Planning for the future must include key elements such as determining what capacity is required where and what the workforce will need to look like to deliver the new services in a different way. The professional bodies and the royal colleges will be key to informing that work.

We agree that the NHS and social care services need to continually innovate and adapt to meet public expectations and the changing nature of demand. This Government legislated to bring forward health and social care integration, with full implementation to be in place by April 2016, in order to help underpin the shift from acute to community delivery of care. We support integration, committing over half a billion pounds of Government investment over the next three years to that end, including £300 million for the integrated care fund, £100 million for delayed discharge and £30 million for telehealth projects.

Sarah Boyack mentioned the issue of delayed discharges in Edinburgh. I know that she has a long-standing interest in that issue, as she has raised it with me in the chamber before. Tackling delayed discharge is, of course, part of the rationale for introducing the integration of health and social care, and I can report to the chamber that, across Scotland, the number of people whose discharge is delayed for more than three days is down from 947 in October to 646 in April, so it is clear that progress has been made.

The cabinet secretary also spoke about the work that is being undertaken with regard to primary care, the new GP contract and Professor Lewis Ritchie's work on out-of-hours care. I know that many members take a great interest in that in particular. Indeed, John Pentland raised the issue of out-of-hours services in the Lanarkshire area. He will understand that I also take an interest in that matter, as I represent a constituency that is covered by NHS Lanarkshire.

John Pentland asked for a commitment from the cabinet secretary today that NHS Lanarkshire's model for out-of-hours care must correlate to the outcome of Lewis Ritchie's national review and the recommendations taken forward by the Scottish Government. The cabinet secretary made that clear commitment to him in her intervention, so I hope that that serves as an indication of the Scottish Government's commitment.

Many members spoke about primary care. Mark McDonald and Kevin Stewart in particular spoke about the situation in the north-east and the meeting that the cabinet secretary went to up there. I say to Mr McDonald that I look forward to joining him on my visit to his constituency.

The new models of primary care that are being looked at are at an early implementation stage in primary care settings, mainly GP surgeries, across the country. What those projects will have in common is that they are bottom-up tests of change across a wide range of communities in Scotland, the learning from which will influence the future shape of primary care. They are a critical element of making our 2020 vision for integrated health and social care real, and they will inform work going beyond the 2020 vision.

We want a new emphasis on care being delivered in the community, which has been expressed as a desire by most members in the debate. We want that care to be delivered by multiprofessional teams to best meet patient needs, and we will be working with the professionals to deliver that. How that shift is better achieved will be a key element of the discussions with the professionals that the cabinet secretary will lead.

Bob Doris spoke about the opportunities for young people through the NHS. The NHS in Scotland benefits from a varied employee base, and the employment of young people represents a great investment in the future. Boards are asked to deliver a national target of 500 new modern apprenticeships by August 2017. Mr Doris also raised the issue of ensuring better career pathways through the NHS. I agree that that has to be part of our thinking.

Jim Hume, as to his credit he does regularly—although I do not always agree with every element—raised many issues around the future of mental health services, most of which I agree with. The need to tackle stigma is very important. That is why we continue to fund the see me campaign. He again referred to the parity between mental and physical health. I reiterate that that already exists legally through the National Health Service (Scotland) Act 1978. I also point out that we have

recently announced an additional £85 million on top of the £15 million that was announced last year for mental health. That new funding will focus on a variety of areas, including further investment in child and adolescent mental health services to bring down waiting times, and improved access to services—in particular psychological services. There is a focus on community settings and better responses to mental health in community primary care settings, including promoting wellbeing through physical activity and improved patient rights.

Nanette Milne raised the issue of palliative care. The Scottish Government has committed to the development of a strategic action framework to provide a focus to support high-quality palliative and end-of-life care by the end of the year, and I will ensure that that is available to all members of the Parliament.

Lewis Macdonald raised the issue of NHS Grampian's funding. In this year, NHS Grampian's resource budget has increased by 6.7 per cent above inflation—the largest increase of any mainland board. However, this Government is willing to look at the issues that he has raised about the NRAC formula more generally.

Of course, it is sadly not possible to respond to every issue that has been raised, but I welcome the fact that we have had the debate and I welcome the fact that it has been consensual. We will continue to work with others in the chamber and, most crucially of all, with the professionals and the public, to ensure that we continue to enjoy a world-class national health service long into the future.

16:49

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I draw members' attention to my declaration in the register of members' interests in respect of my membership of the BMA, the Royal College of General Practitioners and the Royal College of Psychiatrists.

In supporting the motion in Jenny Marra's name, I begin by saying that we are really disappointed that the consensual approach in our motion seems to have required such extensive amendment by the Government. Indeed, I am disappointed by Mr Hepburn's summing-up speech, which did not seem to address the motion at all.

I welcome John Mason's support for the sustainability aspect of our motion, which the Government's amendment would delete; indeed, I welcome his very measured speech, much of which I agreed with.

I also very much welcome the tone of the cabinet secretary's speech and in particular some of her comments on her commitment to, and moves towards, a full, inclusive, open debate.

Perhaps the cabinet secretary would like to make a unique move in the Parliament by following a procedure that takes place in the Welsh Assembly. As an acknowledgement that the Labour motion should be agreed to at decision time given that it refers to sustainability, she could seek to withdraw the Government amendment, as sometimes happens in the Welsh Assembly, rather than have her amendment disagreed to—although, of course, it probably will not be.

I do not believe that anyone who looks at our health service in Scotland today can come to anything other than the following two conclusions. First, the NHS has made significant advances over the past 15 years. All the measures that Labour introduced, which the SNP has continued and amplified while bringing in new measures, have led to huge improvements in the service. Secondly, the service would be in serious difficulty today without the extraordinary efforts, often above the call of normal duty, of the staff. This is not a debate in which to elucidate the long list of problems that are self-evident to any reasonable observer. However, as Lewis Macdonald illustrated, we in the Opposition must ensure that there is transparency and open discussion. As John Pentland said when he described the problems with NHS Lanarkshire, such transparency is vital.

The Government's continued mantra that there are more staff in post and more operations and procedures being undertaken than in 2007 is really getting a little tired. It is of course true, and I have just welcomed the advances that have been made. However, given the increases in Scotland's population and in the number of challenges that face the NHS, there is no doubt that there are serious stresses in the system.

Shona Robison: When I referred in my opening speech to all that additional capacity and the additional staff, I went on to make the point that the increasing demand on the health service is why we need to have the debate. It is difficult for the NHS to keep up with demand: that was exactly my point.

Dr Simpson: I accept that, but it is not a defence of the problems that we currently face. We acknowledge the increases in staff in the service, but the challenges, as evidenced by current NHS vacancy levels, exceed those increases.

There is an increase in the complexity of the problems that those in our older population are presenting with. As was demonstrated in a recent Canadian paper, the level of complexity has

doubled in the past eight years, which is a huge increase.

We also have real problems with waste in the system—waste of resources and of time.

Although we have new medicines and new procedures, we have increasing numbers of people with cancer and large numbers of people with dementia combined with physical illness. Following the lead of Campbell Christie's report for the Government, Labour called in 2011 for a Beveridge-style full review of the situation. We were told that such a review would be too slow and would not be worth while. We are now four years on, and if we had had that review, we might have completed it by now.

Let us look at what has happened in Wales under the Welsh Administration, which the Scottish Government and the Government in London have criticised for its performance. In 2011 the Welsh Administration established the Bevan commission, which has worked out four core principles for the Welsh NHS going forward. It has also suggested some objectives for the NHS in Wales: to fit the need and circumstances of the citizen; to maximise the limited skills and financial resources that can be drawn on; to actively avoid waste and harm; to abandon treatments or care that provide little or no benefit; and to reduce variation—which I go on about in the Parliament quite a lot—and adopting evidence-based medicine at scale and pace. The Welsh Administration has taken the time to establish four principles, and our debate must also start by establishing the principles for a sustainable NHS going forward.

There are things that we can do at the coal face, and I will give some examples. Is a blood test or another test necessary in the first place? If a test has been done, does it really need to be repeated? I had a raft of blood tests done the other day, simply because the consultant could not access the results of previous tests that had been done in another hospital that is in the same managed care network.

Bob Doris: I have been listening carefully to Dr Simpson, and I agree with some of what he says. However, he makes it sound as if there has been no action in the past four years. Would he have held off on introducing the bills on health and social care integration and self-directed support, which were supported by the Health and Sport Committee and passed by this Parliament, to wait for that review? The Parliament has passed two good pieces of legislation in those areas, and they should shape any future debate.

Dr Simpson: As I said, I have no doubt about what has been, and is being, achieved, or about the actions taken, but that does not alter the fact that we are talking about long-term sustainability. As Duncan McNeil made clear, simply putting together health and social integration is not sufficient if we do not address workforce problems, for example.

Let me give some more quick examples. A junior doctor has done a report that shows that massive numbers of unnecessary blood tests are being ordered and carried out simply because it is easy to tick all the boxes. That is an expensive waste of time. Multipacks are opened but only one of the contents is used, with the rest discarded. Patients are followed up unnecessarily when no examination is required and a phone call would do. How often do patients travel long distances when a video consultation would suffice, particularly if it involves a follow-up? How often are patients treated with invasive procedures or given expensive medicines that extend life only by a very short time? Often that is done without proper discussion of and consideration for what the patient might actually want. Those are just some examples of things that I have seen and heard about recently. Last week, I heard about a living will that was ignored by the doctor and the hospital, not because they chose to ignore it, but because it had not been communicated to them. Those are just some examples of areas at the coal face where changes could be made.

It is great for us to have a debate—Jackson Carlaw was right to say that we need to be sanguine about where it will go with the election coming up, but we need to have that big, open debate. However, unless we engage everybody who is at the coal face—the public, patients, families, carers and professionals at all levels—in incremental change in the health service, we will not achieve what we wish.

A number of members spoke about targets, which we have been driven by for 18 years. That was appropriate; targets have been hugely useful and should not be abandoned. However, as Jenny Marra said, we need to rethink them. Bob Doris reported that, on Tuesday, the Health and Sport Committee heard that the incremental cost of meeting some of the targets—particularly the 100 per cent treatment time guarantee—is massive, and there is a question about whether that is worthwhile expenditure. We must consider which targets are vital and which are overly expensive and could be adapted. We must do that within a cross-party debate, because otherwise we will continue to attack the Government about meeting the targets that it has set. I do not think that that is helpful, but it is something that Opposition parties have to do when holding the Government to account.

Kevin Stewart and Mark McDonald focused on primary care, and they acknowledged the

problems of retention and recruitment in Grampian. There is a developing crisis across Scotland—Sarah Boyack illustrated the situation in Lothian—and I have been warning about it for some years. We need a full debate on primary care, as that area is fundamental and key to the delivery of a modern health service. The system that we develop, whether it involves clusters or the use of advanced nurse practitioners, will be critical.

Dennis Robertson and others referred to the use of other practitioners. This Government and the previous Government have developed measures in Scotland on the use of pharmacists. Those measures are quite unique, they are different from what happens in England, and they are very important. However, we must go further. Advanced nurse practitioners are being used in primary care, which is important, but we must consider whether physician assistants can make a contribution and ask what contribution optometrists and others can make to the situation as a whole.

In conclusion, the Government and other political parties now have a consensus on a collaborative and co-operative public service without clinical privatisation. After some years, the BMA, the Royal College of Nursing and the Academy of Medical Royal Colleges are now on board, and I believe that the public are on board too. With all those groups having an equal voice, and by managing vested interests, we must collectively devise and develop an NHS that is fit for the future. As Duncan McNeil said, the NHS must also continue to tackle day-to-day problems. However, unless we consider the long-term future in a consensual way, the NHS could be something that fails, which none of us wants. As Jenny Marra said, the Labour Party has been ready to play its part for some years, and I welcome the Government's stated intention to lead an inclusive, national debate.

Business Motion

16:59

The Presiding Officer (Tricia Marwick): The next item of business is consideration of motion S4M-13434, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a business motion.

Motion moved,

That the Parliament agrees the following programme of business—

Tuesday 16 June 2015	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Stage 1 Debate: Harbours (Scotland) Bill
followed by	Scottish Government Debate: Marine Tourism
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 17 June 2015	
1.15 pm	Parliamentary Bureau Motions
followed by	Members' Business
followed by	Portfolio Questions Culture, Europe and External Affairs; Infrastructure, Investment and Cities
followed by	Stage 3 Proceedings: Community Empowerment (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
7.00 pm	Decision Time
Thursday 18 June 2015	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.30 pm	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Scottish Elections (Reduction of Voting Age) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
Tuesday 23 June 2015	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)

followed by	Stage 3 Proceedings: Prisoners (Control of Release) (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 24 June 2015	
2.00 pm	Parliamentary Bureau Motions
followed by	Portfolio Questions Education and Lifelong Learning
followed by	Stage 3 Proceedings: Mental Health (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 25 June 2015	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.30 pm	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Air Weapons and Licensing (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time—[*Joe FitzPatrick*.]

Motion agreed to.

Parliamentary Bureau Motions

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of five Parliamentary Bureau motions. I invite Joe FitzPatrick to move motion S4M-13436, on designation of a lead committee, and motions S4M-13437 to S4M-13440, on approval of Scottish statutory instruments.

Motions moved,

That the Parliament agrees that the Health and Sport Committee be designated as the lead committee in consideration of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill at stage 1.

That the Parliament agrees that the Provision of Early Learning and Childcare (Specified Children) (Scotland) Amendment Order 2015 [draft] be approved.

That the Parliament agrees that the Education (School Lunches) (Scotland) Regulations 2015 [draft] be approved.

That the Parliament agrees that the Registers of Scotland (Voluntary Registration, Amendment of Fees, etc.) Order 2015 [draft] be approved.

That the Parliament agrees that the Water Environment and Water Services (Scotland) Act 2003 (Modification of Part 1) Regulations 2015 [draft] be approved.—[*Joe FitzPatrick*.]

The Presiding Officer: The questions on the motions will be put at decision time.

Decision Time

17:00

The Presiding Officer (Tricia Marwick): There are four questions to be put as a result of today's business.

The first question is, that amendment S4M-13416.2, in the name of Shona Robison, which seeks to amend motion S4M-13416, in the name of Jenny Marra, on health, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Gavin (Lothian) (Con)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Buchanan, Cameron (Lothian) (Con)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Carlaw, Jackson (West Scotland) (Con)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Fergusson, Alex (Galloway and West Dumfries) (Con)
FitzPatrick, Joe (Dundee City West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Goldie, Annabel (West Scotland) (Con)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hume, Jim (South Scotland) (LD)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (Aberdeen Donside) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Rennie, Willie (Mid Scotland and Fife) (LD)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland Islands) (LD)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow) (SNP)

Against

Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Renfrewshire South) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rowley, Alex (Cowdenbeath) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

The Presiding Officer: The result of the division is: For 77, Against 39, Abstentions 0.

Amendment agreed to.

The Presiding Officer: The next question is, that motion S4M-13416, in the name of Jenny Marra, on health, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament commends the hard work of staff at every level of NHS Scotland and Scotland's care services; notes the joint call by the Royal College of Nursing and the Academy of Medical Royal Colleges and Faculties in Scotland for a public debate on what are considered to be the difficult decisions that need to be made about future investment in Scotland's NHS; considers that, while the NHS budget is protected and the number of staff employed by the NHS has increased, demand for care from Scotland's growing and older population has increased; welcomes the plans of the Scottish Government to foster a mature debate, involving the public, health and care professionals and MSPs from all political parties, to develop a 10 to 15-year plan for the NHS beyond the 2020 Vision, and believes that this consensual approach to future changes to Scotland's beloved NHS will help ensure that it evolves to meet the future needs of the people of Scotland.

The Presiding Officer: The next question is, that motion S4M-13436, in the name of Joe FitzPatrick, on designation of a lead committee, be agreed to.

Motion agreed to,

That the Parliament agrees that the Health and Sport Committee be designated as the lead committee in consideration of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill at stage 1.

The Presiding Officer: I propose to put a single question on motions S4M-13437 to S4M-13440, on approval of Scottish statutory instruments. If any member objects to a single question being put, they should please say so now.

There being no objection, the final question is, that motions S4M-13437 to S4M-13440 be agreed to.

Motions agreed to,

That the Parliament agrees that the Provision of Early Learning and Childcare (Specified Children) (Scotland) Amendment Order 2015 [draft] be approved.

That the Parliament agrees that the Education (School Lunches) (Scotland) Regulations 2015 [draft] be approved.

That the Parliament agrees that the Registers of Scotland (Voluntary Registration, Amendment of Fees, etc.) Order 2015 [draft] be approved.

That the Parliament agrees that the Water Environment and Water Services (Scotland) Act 2003 (Modification of Part 1) Regulations 2015 [draft] be approved.

Carers Week 2015

The Deputy Presiding Officer (Elaine Smith): The final item of business is a members' business debate on motion S4M-13261, in the name of Rhoda Grant, on carers week 2015. The debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes Carers Week 2015, which runs from 8 to 14 June and is supported by Carers Scotland, Carers Trust Scotland, Independent Age, Macmillan Cancer Support and the MS Society; notes that the week aims to raise awareness of carers at national, regional and local levels in order to improve their lives and the lives of the people that they care for; further notes that this year's focus is on building carer-friendly communities that aim to support carers in looking after their loved ones while at the same time recognising that they are individuals with needs of their own; understands that around 759,000 people in Scotland, one in eight of the population, are caring for a loved one, and that many face challenges, including financial hardship and ill health; recognises what it sees as the contribution that they make to families and communities in the Highlands and Islands and throughout Scotland, including saving the NHS a reported £10.3 billion annually; hopes that the week will be a success in promoting both carer and young carer awareness, and considers and values carers as esteemed members of society.

17:04

Rhoda Grant (Highlands and Islands) (Lab): It was a privilege to secure this debate. Carers week is one of the most important weeks that we celebrate in the year. For too long, the work of Scotland's unpaid carers has gone unrecognised and unsupported, and this week gives us the opportunity to highlight and pay tribute to our carers and the tremendous jobs that they do.

Caring is something that most of us will have to do. It is estimated that three in five people will have a caring responsibility at some point in their lifetime. There are more than 759,000 unpaid adult carers and more than 29,000 young carers in Scotland, and they save the Scottish economy more than £10 billion a year. In my region, the Highlands and Islands, there are an estimated 40,518 carers.

Carers can often feel isolated, especially when they are at a distance from services. Many carers have had multiple episodes of caring and are often caring for more than one person at a time, for example caring for a child with disabilities and an elderly parent. It is done with love, but the stress that it causes can sometimes be unbearable. That is why we need to support our carers.

I welcome the Carers (Scotland) Bill. I hope that it will improve the lot of carers and give them entitlements in their own right. I think that we all acknowledge that it is a step in the right direction,

but we also recognise that we will need to take many more steps before we get it right.

Carers are concerned that if the criteria for assistance are set locally, they will miss out because of limited local government resources. Councils are likewise concerned that if the criteria are set nationally without being funded, other services will suffer. Carers must have support services, or they may be unable to continue caring.

We will attempt to amend the bill in a number of ways—far too many to go into here tonight—to improve the lot of carers. One example will be to try to give the Care Inspectorate responsibility for inspecting the standards and provision of carer services across Scotland. That will mean that support groups and information and advice centres for carers will all need to meet national standards. Regardless of who sets the criteria, services will be subject to inspection to ensure that the promises that are made in the bill become a reality.

The theme of carers week is carer-friendly communities. A carer-friendly community is one in which all aspects of the community are geared to meeting the needs of carers, from health services to the workplace, from primary schools to university. Employers can sign up to being carer positive. Schools can allow young carers flexibility and support, for example, by removing the need to do homework while providing additional support at school. Colleges and universities can employ similar policies to enhance learning while they support young carers in their caring role.

We in the Labour Party support the Scottish Youth Parliament's care fair share campaign, which highlights the needs of young people in education. It calls for changes to education maintenance allowance guidance so that carers are guaranteed not to lose their EMA due to attendance issues; extending Student Awards Agency for Scotland dependants grants so that carers get an extra £2,640 a year when they are in higher education; and extending Young Scot concessionary travel to young adult carers until they are 25 years old.

In their briefings for the debate, national carers organisations also remind us that, as MSPs, we are uniquely placed to help carers. They ask us to scrutinise legislation and amend it to make it carer friendly—not just the Carers (Scotland) Bill but all legislation that impacts on carers and their loved ones.

Where they are available, carer information services are a godsend. Carers groups welcome the duty in the Carers (Scotland) Bill to provide advice and information. However, they are concerned that the good practice that is available in some areas will be replaced rather than replicated all over.

Carers are often financially disadvantaged. Many have to give up work, costing both themselves and the economy. That is why having carer-friendly employers is so important. Work is important not just for a person's financial security; it is also often the only respite from caring responsibilities.

Carers need to be able to decide how much time they commit to caring, so that they can also have a life of their own, working and socialising. Where that does not happen, we see carers break under the strain, which means that the state ends up caring for two people instead of one.

For the most part, carers want to care. They do not see themselves as carers first—they are mothers, fathers, sons, daughters, sisters and brothers, and they are often much more distantly related than that. In many cases, they are friends who want to care and protect. We need to help them to do that.

The briefing by Marie Curie for tonight's debate tells us about the needs of carers in palliative care situations. Those can be short term, such as when someone suddenly becomes terminally ill, and can put pressure on work commitments and financial responsibilities.

Gaining power of attorney can often take many months, leading to bills going unpaid, which can put untold pressures on the carer. Carers may also have no knowledge at all about the condition of the person whom they are looking after or how best to look after a person with a terminal illness. They must have support and guidance to help them to do that. There are also many carers whose loved ones have life-shortening conditions, and they may have cared for them for many years. As the condition progresses, their caring becomes more intense and the needs of the cared-for person change. It is important that services adapt their support to meet the needs of both the carer and their loved one.

For those carers, bereavement support is extremely important. In many cases, they have forfeited many aspects of what we could call normal life to dedicate theirs to caring. Therefore, in bereavement they not only lose a loved one; they often also lose their reason for being. The period of time that is given to them to adapt is not long enough for a normal grieving process, far less for someone who has put their life on hold to care. We need to be more compassionate and supporting towards those people.

I pay tribute to the work of unpaid carers—people such as Clare Lally, our carers champion, who is a carer herself but is absolutely dedicated to promoting carers' rights and who, believe me, is

a force to be reckoned with. If we all resolve to be carer friendly and create carer-friendly communities, we can make a real difference to their lives.

17:11

Joan McAlpine (South Scotland) (SNP): I congratulate Rhoda Grant on securing this timely debate on carers, in which I am delighted to speak, as I am a co-convener of the cross-party group on carers, although in this contribution I will be speaking for myself.

I begin by acknowledging the Government's important work on behalf of Scotland's 759,000 carers. The investment in carers since 2007 has now reached £114 million, which includes £14 million for voluntary sector short breaks and an extra 10,000 weeks' respite, delivered by the concordat between Government and local authorities. There is also £28.9 million for health boards to deliver direct support, including the establishment of carer services and carer centres offering advocacy. The Scottish Government also funds the young carers festival each year, and every MSP who has attended the festival knows that it is a transformative experience for those who take part.

In 2011, the Scottish National Party manifesto promised a carers parliament to ensure that this group had a powerful, direct voice. There have now been three such parliaments, and it is the work of those parliaments that has resulted in the Carers (Scotland) Bill. I think that that reflects well on how democracy works in Scotland.

Constitutional change also affects carers. For example, the Smith commission promised that the Scottish Parliament would

"have complete autonomy in determining the structure and value"

of certain benefits, including carers allowances. However, in its current form, the Scotland Bill that is going through Westminster defines carers as being over 16 and not in full-time education or employment. That is completely unacceptable and I am sure that many carers organisations, particularly the ones that represent young people, will find it unacceptable too.

The SNP has said that we could use the new powers to raise carers allowance to the level of jobseekers allowance. However, as the Cabinet Secretary for Social Justice, Communities and Pensioners' Rights, Alex Neil, told the Welfare Reform Committee this week, any additional money that we give to carers will be treated as income under the Department for Work and Pensions system for universal credit, which could be clawed back. That is unfair to carers, disrespectful to this Parliament and contradictory to both the letter and the spirit of the Smith commission.

Finally, I turn to the Carers (Scotland) Bill, which has been warmly welcomed by the sector. It enshrines carers' rights in law for the first time. I have read written submissions to the Health and Sport Committee on the bill and I would like to highlight two of them. Marie Curie Cancer Care suggests that specific measures are required for carers supporting the terminally ill, as Rhoda Grant mentioned. I would particularly like to point out one issue that Marie Curie Cancer Care has raised, which is that some carers may wish to take respite only for a few hours rather than for a few days. That strikes me as a constructive suggestion, as it is easily achievable.

I also highlight the submission from Enable, which raises the issue of emergency planning and future planning for lifelong carers. Those are often the elderly parents of a disabled adult child, and they have considerable worry and concern about their child's future should an emergency arise or should they need to go into hospital in the short term—carers, especially elderly ones, often have additional health needs. Although some local authorities plan well for such circumstances, others do not.

The previous minister with responsibility for carers, Michael Matheson, funded a piece of work on the topic that was carried out by Enable, entitled "Picking up the pieces: Supporting Carers with Emergency Planning". It recommended that emergency planning for carers should be considered within all health and social care policies. However, emergency and future planning does not appear in the Carers (Scotland) Bill. Enable is strongly of the view that it should and believes that provision should be made for emergency planning in the adult carer support plan and the young carer statement, which the bill will establish. The bill will also introduce a duty to provide information and advice, which Enable argues should include the provision of information and advice about emergency and future planning.

I am delighted by the Government's track record on support for carers but concerned that the progress could be undermined by UK Government welfare reform. I also warmly welcome the Carers (Scotland) Bill, which is currently before the Parliament, and would like to see it further improved by the introduction of the different and distinct measures that are advocated by both Marie Curie and Enable.

17:16

Johann Lamont (Glasgow Pollok) (Lab): I, too, congratulate Rhoda Grant on securing the debate and recognise the importance of the

opportunity that is provided by carers week to acknowledge the work that is done by the people who care and the challenges that they face. It is an opportunity to celebrate what people do out of love for those for whom they care, and to celebrate amazing people like Clare Lally and others from across the parties who have spoken out in the interests of carers. They have demanded that we listen and have ensured not just that their needs are met, but that the needs of those for whom they care are met.

The issue is not one for any particular party, so I am very proud of all the work that has been done on it since the beginning of the Parliament—especially the establishment of carers centres. I am especially proud of the south-west Glasgow carers centre, which does amazing work not just in advocacy, but by being a place where people who are under pressure can go for support, and in developing ideas about how we can better support carers and the people for whom they care.

It is a mark of the Parliament that, from the earliest days, carers have insisted that their voices be heard. In the early days, when the Parliament was opening itself up and people already had a clear idea of what needed to be done, that created progress and opportunities. I hope that we can continue that work on a cross-party basis.

It is important that we hear about people's direct experiences instead of allowing ourselves to be drawn—as we too often are—into a competition about how much we care. There is also a challenge for us in not allowing ourselves to patronise carers with warm words but to do nothing more. For instance, I wrote a piece about how people who care for their loved ones are driven by love, and I was chastised by a woman who told me that it was not a choice—that she was caring because she had to and that she felt guilty because she felt trapped. Her situation is as valid as any other, so we should not romanticise care, although we know how much it is driven by love. We should recognise that some people are trapped by their circumstances and need support to do what they feel they need to do without their feeling guilty about it being a burden on them.

Overwhelmingly, however, carers do what they do because they want to, and it is society's challenge to support them in doing that. We should not take advantage of their sense of responsibility and believe that support for a family can be reduced because they will never walk away. There should not be a system of brinkmanship that relies on people's love for those they care for being such that they will accept diminished support; we need to know that the caring process is happening in our communities and we must do all that we can to ensure that such a system does not develop.

It is equally important to understand that, even when there is support and respite, if people are not confident about leaving their loved one in the care of someone else they will not accept that support. That is why it is important to value properly paid carers, because unpaid carers will not trust them unless they see that the quality is there. They will not take time off from the rest of their family if they are not confident that the respite that is being offered is safe and secure. Therefore, it is important that we include that issue in the broader debate about what care should be.

Care is about high-quality respite provision; it is also about flexibility. Indeed, it is the little bits of flexibility that make a difference, which allow people to go to church or to the library, or give them time to shop. Respite also allows families with a disabled child to spend time focusing on their other children. Those little bits of flexibility must be built into the system, too, in order for carers to be able to their jobs.

We must recognise that young people are having to provide inappropriate care. The system is not supporting people who have addictions or drug and alcohol problems, and children are being left to care for people in those circumstances. We must redouble our efforts to ensure that support is put in place for them.

We must recognise the consequence on the educational attainment of young carers. It is important to have provision in schools. We need supports in place that allow a child to come into school, but those are reducing as we speak. We must ensure that such provision is there.

Ultimately, we can prove that, in all the time that we have had power, the Parliament has done great things for carers. My plea is that we look now at what is happening with budgets and the consequences of changes for our communities. There is silent suffering, and an intolerable burden is being brought to bear on carers. We should all be aware of that.

All of us can say that it is someone else's responsibility. We all condemn the cuts at United Kingdom level and the welfare choices that are being made, but we also have a more serious responsibility in this Parliament to look at what we are spending our money on. Are we denying cash to local government and, as a consequence, causing a diminution of the services that people require?

Across the chamber, we respect and admire those who care. Across the chamber, we should take joint responsibility in ensuring that carers do not continue unsupported to do the job that we want them to do. It would be a mark of celebration in carers week were we to unite in ensuring that we talk about what we can do to make a difference

rather than talk about the matters that perhaps divide us.

17:22

Nanette Milne (North East Scotland) (Con): I, too, add my thanks to Rhoda Grant for lodging the motion. It is a timely debate, given that the Carers (Scotland) Bill is going through Parliament and will shortly complete stage 1.

For nearly 50 years, Carers UK has been at the forefront of campaigns to secure a fair and equitable deal for carers, who contribute so much to society. Through successful lobbying, we saw in 1967 the introduction of the dependent relative tax allowance, which was the first time that legal rights for carers had been established in law. That was followed in 1976 by the introduction of the invalid care allowance. Following that, and throughout the past 30 years, changes have been made to recognise carers' needs in their own right, including their pension rights and, in 2013, a safeguard to protect carers' allowances when other benefits faced cuts in tough economic times.

I was interested to learn that the genesis of what may be termed the carers movement was a lady called Mary Webster. In 1954, she gave up her job as a congregational minister to care for her parents. Over the next decade, she made the public aware of the isolation and financial hardship that carers often face. That successfully led to legislative changes, which resulted in much-needed financial support. Despite dying tragically young in 1969 at only 46 years of age, her legacy as a champion for carers' rights continues.

In that respect, we have seen the recent establishment of carers' champions, for example, in Edinburgh and Glasgow, acting as an independent voice listening to carers and working closely with social services.

In my home city of Aberdeen, support, advice and information for carers are provided by VSA, so there seems to be a growing culture of recognition that those who care for a loved one need help in juggling many responsibilities, including continuing in employment.

Many carers still go unrecognised. It is important that carers are identified and made aware of the support to which they are entitled. A particular group of carers who do a fantastic job for their families without statutory support are informal kinship carers, many of whom rescue their grandchildren as babies from chaotic home circumstances, and are then left literally holding the baby, but without the support that is given to carers of children who are identified as looked-after children. I am pleased that efforts are under way to help that group of carers.

Many young people have family caring responsibilities that can take away their childhood if they are not given proper support, so it is important that they are recognised as young carers, shown the understanding that they deserve and helped to lead as normal a young life as possible.

This year's carers week, which Carers Scotland and Carers Trust Scotland have made possible, involves the other charities that are noted in the motion. One charity that plays a huge part in making carers week a success is Marie Curie, which focuses primarily on people who look after loved ones who have terminal illnesses. Marie Curie makes the very good point that those individuals often do not realise or recognise that they are carers; they would rather see themselves as people who are looking after someone they love at the end of life.

The vast majority of people would prefer to die at home or in a homely setting, but more than 50 per cent of people die in hospital. Research has found that having a carer is the single most important factor that makes it possible for a person to die at home, whereas living alone or being unmarried increases the likelihood of a person dying in hospital.

Caring for someone at the end of life can be physically and emotionally demanding, and carers often struggle to come to terms with the loss of a loved one. The health of carers can often be affected, and they might have very specific needs and requirements that must be considered in the care and support that are made available to them. Therefore, Marie Curie has launched the Marie Curie helper service, the Marie Curie support line and bereavement support services to help people to access practical, emotional and financial resources, and to get the right information and support at the right time.

In its briefing, Marie Curie makes a few points about amendments that it would seek to make to the Carers (Scotland) Bill, and I will examine those in discussions with colleagues when we reach stage 2.

As has been mentioned, thousands of events will take place across the country as part of carers week. I wish all who are involved every success in their efforts to raise awareness of the vital contribution that carers make in communities right across Scotland. We must remember that those events can be great fun.

I again thank Rhoda Grant for securing the debate.

17:27

Mark McDonald (Aberdeen Donside) (SNP): I congratulate Rhoda Grant on securing a debate on carers week in carers week. I lodged a motion on carers week, although I did not mark mine for members' business.

I thought about what I was going to say, because Johann Lamont made a very good point—when we speak in debates, people outside who listen in often hear what they consider to be warm words and platitudes. Therefore, I thought that I would say a little about what is involved in being a carer.

I am a carer for my son. I am probably his secondary carer; my wife would be considered his primary carer. On reading some of the comments on social media, I was struck by the impact that caring has on other people and how much of it I recognise. I realise that there is a strong likelihood that my son will require care and support from us for the rest of his life, and many other people are in the situation of having a child they know will be dependent on their care and the care of the state for their whole life. They know that they will not experience some of the things that many parents experience with their children. There is hope that there will be other experiences, but many of the things that people take for granted as parental experiences are not always experienced.

Other issues arise. One thing that is often said is that my situation as a carer is different, because I am an MSP and I have a comfortable income. That certainly helps in a number of areas, and it helps others who are in a similar position. When my mother was caring for my grandparents, she was fortunate that my father was earning an income, which meant that financial support was available. Many people are in that situation, but many people are not.

Income will help only in some areas. Life for me and my wife is one of constantly broken sleep. Indeed, until my son was prescribed melatonin, one of us would have to stay in his room until around midnight or 1 o'clock in the morning so that he went to sleep. If we had not done that, he would have been through waking up his then toddler sister, whose sleep, too, would have been broken. Given that he would then be up again at 4 or 5 in the morning, three to four-hour sleeps were becoming a regular occurrence. That is the same for many people, who have to get up through the night to administer medication to loved ones; indeed, they often have to sleep in the same room, which creates difficult conditions for them.

That is why, although I welcome the Carers (Scotland) Bill, I think that we have to look beyond the young carer's statement and the adult carer support plan and ask: what if support that is identified as being necessary is not available locally? What provisions can be put in place to ensure that that is part of the thinking of local authorities and health boards? Sleep counselling is one such example. Although it is not always available at a local level, it can be absolutely vital in many instances. If the sleep patterns of parents and siblings are being impacted on, sleep counselling can offer important assistance, but what if no trained sleep counsellors are available locally? Listing sleep counselling as something that is required to support an individual is fine on paper, but how do we put it into practice?

We all need to think about that issue as we move forward with the legislation. It is fine to put in place the funding for support measures as well as support plans for carers, but we have to ensure that, when the support plan is in place, the things that are identified as being required by carers can be delivered. What carers expect from the bill is for the support plan to be not only provided but acted upon.

I will draw my remarks to a close by saying that, although I welcome the opportunity to have this debate during carers week, we should not forget that for Scotland's carers every week is carers week.

17:31

Claudia Beamish (South Scotland) (Lab): I, too, thank Rhoda Grant for welcoming carers week into the Parliament through this debate. Every year, I am impressed by the effort that is put in to promote carers' rights and to raise awareness of the fantastic work that carers do. As other members have pointed out, the scope of this year's events across Scotland is brilliant.

As an ex-young carer, I am committed to standing up for carers; indeed, I am, with Joan McAlpine, convener of the cross-party group on carers. The unexpected responsibility that comes with caring for someone can have a detrimental impact on a person's health, education, employment, relationships and every other aspect of life. Carers make a huge contribution not just to the people they look after but to the country, saving the national health service an estimated £10.3 billion a year. As they care for others, so we must care for them.

The theme of this year's carers week—building carer-friendly communities—is fantastic. After all, a compassionate community with a clear understanding of the demands placed on unpaid carers could make the world of difference. According to Scottish Youth Parliament figures, only 45.5 per cent of those in work felt able to tell their employer about their young adult carer status

and 56.4 per cent said that they had less time to be with friends and so could feel isolated.

A carer-friendly community would help carers feel comfortable in identifying themselves as carers, and we should all use this week to raise awareness among employers, general practitioners and local services and systems to ensure that they are accommodating and can alleviate some of the daily pressures that carers face.

In my South Scotland region alone, this week is filled with fundraisers like bag packing with Dumfries and Galloway Carers Centre, activities and workshops with Borders Voluntary Care Voice or a cup of tea with Support in Mind Scotland at its pop-up cafe.

Of course, those organisations operate all year round. I recently visited the South Lanarkshire Carers Network's new facilities to meet its board and some young carers—I believe that the minister, too, has visited those facilities in Hamilton—and I know that, in addition to offering a range of support services for carers, this and other networks have provided the forward thinking that has driven forward some of the national policy.

For example, Borders Voluntary Care Voice holds an annual forum that I have been pleased to attend ever since I became an MSP. It is an excellent place for carers in rural and remote areas to inform MSPs of their issues. One of the issues that came up there was sleep counselling, which Mark McDonald raised. In rural areas, it is often very difficult to find the right support for carers.

Carers have been effective in driving forward change for better recognition and support alongside other organisations. A great example of their successes is the Scottish Youth Parliament's care fair share campaign last year. Thanks to the hard work of Scottish Youth Parliament members, young adult carers in education have more flexible options in funding assistance.

I understand—perhaps the minister will correct me if I am wrong about this—that the education maintenance allowance now recognises young carers as vulnerable and therefore entitled to a more flexible learning agreement. Furthermore, the Student Awards Agency for Scotland now includes carers in eligibility for the dependants and lone parents grants.

Before I make some brief remarks on the Carers (Scotland) Bill, I associate myself with the wise analysis and comments of my friend and colleague Johann Lamont, who is an ex-convener of the cross-party group on carers.

This is indeed a seismic time for Scotland's unpaid carers. The Carers (Scotland) Bill promises to make a significant difference, but carers and their representative organisations have highlighted a number of issues. Last week, I was delighted to welcome the Minister for Sport, Health Improvement and Mental Health to the cross-party group on carers to share some of those concerns.

What seems to be a minor change can be vital to someone who is responsible for a loved one's care. To be consulted in the planning of discharge from hospital would minimise surprise and confusion. A specific duty to enable carers to take short breaks has been shown to make a huge difference to mental wellbeing. That is vital, and support in the creation of an emergency future plan, which has already been mentioned, would defuse the what-ifs that can keep a carer awake at night. Furthermore, carers are calling for consideration of national eligibility criteria to stop the postcode lottery for basic levels of support.

I very much hope that the minister will listen to those points and consider lodging Scottish Government amendments to the Carers (Scotland) Bill. I am sure that organisations and members of the cross-party group on carers would be happy to work on those with the Scottish Government if that was appropriate.

I again thank Rhoda Grant for bringing this members' business debate to the chamber as part of carers week.

17:37

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): I join other members in thanking Rhoda Grant for initiating this debate and welcoming carers week and the contribution of carers to society.

All members who have spoken have done so with genuine respect for Scotland's carers and young carers, but I hope that members will forgive me for highlighting in particular the contribution of my friend Mark McDonald, whose personal testimony in talking about his own continuing experience greatly enriched the debate. I thank all members, but I thank him in particular for his contribution.

Carers week is an important juncture. It is a reminder of our need to focus on the outstanding work that carers do. I was very happy to take part in an event earlier this year with Carers Scotland to publicise carers week. That was atop Calton Hill. At first glance, that may seem a strange place to have done that, but Carers UK celebrates its 50th anniversary this year, and its chief executive, Heléna Herklots, is climbing 50 hills this year—one for each year of the organisation's existence. I pointed out to her that day that Edinburgh, like Rome, has seven hills and that she could get a

few done in one day, but I do not think that she took up my suggestion.

It is right that we recognise that carers and young carers are integral to our society. They provide vital care and support to their families, friends and neighbours often in very challenging circumstances. That is the very reason why we introduced to Parliament the Carers (Scotland) Bill, which I know has been the focus of much of the debate. I will speak a little more about it.

We introduced the Carers (Scotland) Bill because we want to accelerate the pace of change and build on what has already been achieved. Its implementation will help to ensure that carers are given the opportunity to balance their caring responsibilities with their life goals to result in better health and wellbeing and to have a life alongside caring. Johann Lamont in particular spoke very eloquently about the human necessity of trying to achieve that aim.

Through the bill, we will introduce the adult carer support plan, which will be available to all adult carers and will focus on the achievement of each carer's personal outcomes. The young carer statement will do likewise for young carers and will take account of the fact that they have very specific and different needs from those of adult carers.

The adult carers and young carers who are identified as having needs will then be able to access support through the information and advice services that local authorities will be under a duty to provide, and to access general services in the community. If any remaining needs are eligible for bespoke support, services such as short breaks, advocacy and training would be offered to carers whose needs meet the identified criteria.

The bill includes specific provisions to ensure that local authorities must include carers and young carers in discussions about support for themselves and services for the people they care for. Their expertise is invaluable in making sure that adequate and appropriate services are put in place.

Rhoda Grant suggested possible amendments to the bill and Nanette Milne spoke about suggestions by Marie Curie about the bill. Claudia Beamish rightly referred to the fact that Marie Curie came along to the cross-party group just last week, and we had a discussion about changes that people would like to see. Joan McAlpine, who is the co-convener of the cross-party group—I thank both her and Claudia Beamish for their work on it—made a suggestion about emergency planning. I recognise that that is an issue of concern to carers, and I am sympathetic to the arguments by Enable and the national carers organisations.

Scottish Government officials are working with Enable to understand the proposals in more detail and how they would work, and we will consider them in due course. I should point out that I have already committed to making provision for emergency planning in regulations, but we would be very happy to hear what Enable has to say. We are not yet past stage 1 of the bill, but I look forward to seeing what suggestions come forward about the bill and to working with the members of the Health and Sport Committee to take it forward.

Claudia Beamish asked earlier about the education maintenance allowance. To make clear the particular challenges that young carers face, Michael Matheson, in his previous role as the Minister for Public Health, and Angela Constance wrote to all directors of education and college principals highlighting the need for full consideration of flexibility for young carers, so we have already set that out.

The Government's vision is for a flourishing, optimistic and innovative Scotland, and tackling inequalities and promoting equality of opportunity remain our major challenges. We want a Scotland where people have control of their lives and are empowered to make choices. Whatever their circumstances, carers should enjoy the same opportunities in life as people without caring responsibilities and should be able to achieve their full potential as citizens.

Johann Lamont: I wonder whether the minister accepts that there is an issue about carers who want to work. For example, if they are caring for a child but there is no support in school appropriate to the child's needs, the schooling often fails and as a consequence the parent is unable to work. What discussions has he had with the education secretary about such matters? Moreover, what level of support is being offered in schools to children with special needs?

Jamie Hepburn: I commit to taking up that matter with education colleagues, and I will get back to Johann Lamont and let her know where we get to with that contact.

Building carer-friendly communities is the theme of this year's carers week, as Rhoda Grant pointed out, and it is very much in line with the Scottish Government vision that I spoke of earlier. Scotland has a growing population of older people who are living longer but often with a range of complex physical and mental healthcare needs, and there are more children with complex health needs or disabilities. We therefore need to support Scotland's carers so that they, in turn, can support the many people they care for.

We have spent over £114 million since 2007 on supporting carers, 47 per cent of whom live in the most deprived areas and care for 35 hours or

more a week, which is almost double the level in the least deprived areas. Carers experiencing considerable disadvantage need to be supported. Equally, our work to tackle health inequalities in the wider context of tackling economic disadvantage is paramount.

That brings me to the concerns that Joan McAlpine raised about the impact of the UK Government's welfare reform agenda. I call on the UK Government to devolve the powers needed to support Scotland's carers. As Joan McAlpine pointed out, the Smith commission report stated:

"The Scottish Parliament will have complete autonomy in determining the structure and value of the benefits at paragraph 49 or any new benefits or services which might replace them."

That includes carers allowance, but in its current form the Scotland Bill appears to restrict how the Scottish Government can support carers by defining those eligible for support as being over 16 and not in full-time education or employment.

In addition, the roll-out of personal independence payments will impact on carers currently receiving carers allowance and disability living allowance, with some expected not to be eligible for any support under the new system. The Scottish Government has called on the UK Government to delay the roll-out of PIP, and the consequences for carers is a good example of why we have done that.

The agenda of supporting carers will always be important to me and to the Scottish Government. Again, I thank all those individuals and organisations involved in carers week and all those who make great efforts to care for people across the country. This week of activity is hugely valuable for highlighting to everyone in Scotland the invaluable role that carers and young carers play in supporting the people they care for. I thank Rhoda Grant again for securing the debate this evening.

Meeting closed at 17:45.

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