The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Tuesday 15 December 2015

Session 4

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Scottish Parliament

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

Time for Reflection

The Presiding Officer (Tricia Marwick): Good afternoon. The first item of business is time for reflection. Our time for reflection leader today is the Right Rev Stephen Robson, the Bishop of Dunkeld.

The Right Rev Stephen Robson (Bishop of Dunkeld): Thank you very much, Presiding Officer and members. I bring you the good will of the Catholic people of the diocese of Dunkeld. Thank you very much for inviting me.

My father was 90 yesterday. He has been badly traumatised by many of the developments in the world around him. Like so many of the elderly, he is ill at ease with modernity; he has had enough of drastic change in his life. So, sadly, on his 90th birthday last night after dinner, he said to me, "Son, I'm glad I'm on the way out."

It was not the threat of a war or terrorist violence that caused him to feel like that but, rather, the endless cultural changes in contemporary society. It brought it home to me that my father and countless others like him are in culture shock. Sociologists tell us that

"Culture shock is the personal disorientation a person feels when experiencing a trauma caused by a clash between unfamiliar world-views."

In the last decade, cultural change has arguably been Scottish society's greatest challenge—or one of them, at least. It is not so much social changes that are the problem as the increased pace of those changes, which have left many people, and not only the elderly, straggling behind. The result for some has been cultural disorientation.

Furthermore, in a highly globalised world when all the world's social challenges and cultural problems appear as if they are sprouting in our own back yard, we cannot just tackle them all at once; we need time to absorb change if culture shock is to be avoided.

Each one of us constructs our reality from the building blocks that our parents, families, communities and society provide us with. Of course, there are times when our understanding of reality must be challenged, but please may you as legislators be compassionate about the effects of change—not everyone can absorb it at the same rate. There will always be the wayfarers, the stragglers, the reluctant and the downright stubborn. Win minds and hearts first, rather than coerce by force of law.

May legislators be mindful that for believers, man-made positive law, such as that made in this chamber, can and does bind bodies but not necessarily souls. For if, perchance, positive law is found to be in serious opposition to God's law, for example, or to the natural law written on human hearts, God's law, for the believer, will always trump man's. That is the first lesson, I suppose, in religious freedom. As Thomas More once said, quoting the gospels,

"What does it profit a man to gain the whole world but to lose his soul?"

Point of Order

14:04

Willie Rennie (Mid Scotland and Fife) (LD): On a point of order, Presiding Officer. At 3.30 this morning, Police Scotland's Bilston Glen call centre stopped taking calls due to technical difficulties. That was admitted by Police Scotland nine hours later. Police Scotland says that all calls were diverted and there was no disruption to the service, but a constituent told me at 7.20 am that he had tried and failed to get his 101 call answered.

The matter of police control rooms is one that the Parliament has spent considerable time scrutinising. It would be right for us to hear from the Cabinet Secretary for Justice on this today. It appears that there is no Parliamentary Bureau motion to alter the order of business today to allow for a statement from the cabinet secretary. The precedent from 2004 is that ministers cannot be compelled to make a statement to Parliament even if time is allocated for that by a vote to change business. Presiding Officer, have you received any indication from Government ministers under rule 13.2.2 that they propose to offer an urgent statement to Parliament this afternoon and, if so, when do you expect the statement to be taken?

The Presiding Officer (Tricia Marwick): Thank you for your point of order, Mr Rennie. I have had no indication from the Government that it wishes to make a statement, but the Minister for Parliamentary Business has heard what you have had to say, and I am sure that he will, as usual, reflect on it.

The Minister for Parliamentary Business (Joe FitzPatrick): We had a Parliamentary Bureau meeting this morning, and there has been no approach from then to now. Obviously, I heard what Willie Rennie said, but there has been no contact with my office.

Topical Question Time

14:05

Paris Climate Conference (Scottish Government Response)

1. Tavish Scott (Shetland Islands) (LD): To ask the Scottish Government what its response is to the outcome of the Paris climate conference. (S4T-01248)

The Minister for Environment, Climate Change and Land Reform (Aileen McLeod): The Scottish Government warmly welcomes the historic Paris agreement on climate change. The agreement has, as we hoped and argued for, set certainty about the global low-carbon future in the same way as we set certainty about Scotland's low-carbon future in our legislation in 2009. We hope that the agreement will avoid the worst impacts of climate change falling on the global poor and vulnerable.

I thank Tavish Scott and his party for supporting my calls ahead of the Paris summit for a cross-party approach to securing an ambitious deal. I particularly pay tribute to the efforts of the French Government which, against the background of the shocking terrorist attacks in Paris, displayed resilience and skill in guiding a particularly challenging international negotiation to a successful conclusion.

Tavish Scott: I recognise the minister's commitment in the area and the considered remarks that she has made.

The Paris climate change deal, which spans 195 countries, is an important step towards combating global carbon emissions. The agreement that was reached, which was brilliantly marshalled by the French Government, is more ambitious for limiting temperature rises than the Parliament's Climate Change (Scotland) Act 2009. Does the minister accept that her Government must detail how it will reverse missing the statutory annual emissions targets for four years running? Does she also accept that WWF and many others now see tomorrow's budget as an acid test of the Government's commitment? What new domestic policies will the Government introduce to ensure that Scotland really is at the cutting edge of action on tackling climate change?

Aileen McLeod: First, I am not in a position to pre-empt the discussions on the budget statement tomorrow but, obviously, I can say to Tavish Scott what I have said in previous statements, which is that we have to ensure that climate change is embedded as part and parcel of our budget process.

To meet Scotland's targets in the future, we are developing the third report on proposals and policies. That will also make up for the excess emissions resulting from revisions to the greenhouse gas inventory. The draft RPP3 will be published after the next batch of annual targets, covering the period for 2028 to 2032, is set out in legislation no later than 31 October 2016. The advice on the next set of greenhouse gas annual targets is expected from our independent adviser, the Committee on Climate Change, in March next year, and that will be based on the latest evidence, including international policy.

Tavish Scott: I thank the minister for that detail. She will be aware that figures that were published just this morning show that 35 per cent of Scotland's households were fuel poor in 2014 and 9.5 per cent were in extreme fuel poverty. This morning, the director of Energy Action Scotland said that, unless tomorrow's budget allocates greater funding,

"the desperate situation of hundreds of thousands of households living in cold, damp homes will continue."

What is the Government doing to fulfil its statutory requirement to abolish fuel poverty by November 2016 when 845,000 households across Scotland are still in fuel poverty? In light of those figures, can the minister say how a national infrastructure priority will contribute to Scotland's climate change ambitions and whether tomorrow's budget will at least invest more in tackling fuel poverty than the investment in the current financial year?

Aileen McLeod: Quite a lot of detail is required to answer that question. I am more than happy to write to the member with that detail following tomorrow's budget statement. However, I can say that we are reducing fuel poverty levels. Since 2009, the Government has allocated more than half a billion pounds to a range of fuel poverty and energy efficiency programmes, with a budget of £119 million in the current financial year. In June, I announced that this area would be a national infrastructure priority for the Government.

Rob Gibson (Caithness, Sutherland and Ross) (SNP): It is clear from the commentary around the Paris climate summit that Scotland's actions and ambitions on climate change have widespread international support. It is a pity that that international enthusiasm was not mirrored at home by some Opposition politicians. How will the Scottish Government's climate justice policy further help to reduce the impact of climate change on the world's poorest communities?

Aileen McLeod: We know that the most vulnerable are those worst affected by climate change—the very young, old, ill and poor. Women are suffering disproportionately as they are often the main providers of food, fuel and water. The people who have done the least to cause climate change and are the least equipped to cope with the consequences are those who are being hit the hardest. The scale of that injustice is massive.

In 2012, we became the first national Government in the world to establish a climate justice fund. The Scottish Government is doing its part to foster the trust between developed and developing countries by pledging £12 million over four years to climate justice. Over the past five years, the climate justice fund has invested £6 million in 11 projects in four sub-Saharan African countries. In Malawi, for example, about 30,000 people now have access to safe, clean drinking water, and more than 100 committees have been trained in natural resources rights and management. Our Scottish national action plan on human rights commits us to continue to champion climate justice.

Sarah Boyack (Lothian) (Lab): What changes does the minister envisage the Scottish Government putting in place in light of the new commitment to a rise in global temperatures of no more than a 1.5°C? How will those changes particularly focus on the 900,000 fuel-poor households—single pensioner, single adult, small pensioner and lone parent households—who are struggling the most to pay their energy bills? Given the whole focus in Paris on climate justice, what new initiatives will she put in place?

Aileen McLeod: We certainly warmly welcome the Paris agreement's aim of limiting the global temperature rise to 1.5°C. That is a major victory for the climate vulnerable and the poor around the world.

The expert Committee on Climate Change will be visiting Scotland in January 2016 and we will receive further advice from it in March before setting future targets. We will be looking afresh at what opportunities there may be to advance some of the actions that we need to take and develop. Some of that will be set out in RPP3.

Patrick Harvie (Glasgow) (Green): Limiting global climate change to 1.5°C above pre-industrial levels might have been easy had we not had 20 years of global delay before reaching this point. The Scottish emissions targets are based on a desire to contribute Scotland's fair share to limiting global climate change to 2°C. How can the 2°C targets goal still be correct in light of the 1.5°C goal? Will the Scottish Government revisit its targets?

Aileen McLeod: As I said, the advice on the next set of annual greenhouse gas targets is expected from our independent adviser, the Committee on Climate Change, in March next year. The committee will be visiting Scotland in January 2016. The targets will obviously be based

on the latest evidence, including our international policy.

Trade Union Bill (Presiding Officer's Ruling)

2. Margaret McCulloch (Central Scotland) (Lab): To ask the Scottish Government what its response is to the Presiding Officer's ruling on a potential legislative consent memorandum regarding the United Kingdom Government's Trade Union Bill. (S4T-01233)

The Cabinet Secretary for Fair Work, Skills and Training (Roseanna Cunningham): Although we remain disappointed by the Scottish Parliament's views last week on the lodging of a legislative consent motion, it is essential that the Scottish Parliament is able to express its opposition to this poorly thought out piece of legislation in the clearest possible terms to the United Kingdom Government. The general policy memorandum that was sent last Friday to the Devolution (Further Powers) Committee for its consideration will provide an opportunity to do that. That consideration will be followed by a debate of the whole Parliament.

Yesterday, the First Minister raised the Scottish Government's very clear opposition to the Trade Union Bill with the Prime Minister. We will continue to make the case to the UK Government that the bill is unnecessary and potentially damaging, and that banning check-off and facility time in Scotland impinges on our responsibilities to our employees.

It is our view that the best solution would be for the United Kingdom Government to devolve industrial relations to the Scottish Parliament. We will work across party boundaries in that regard. Indeed, we are delighted to be part of a broader coalition on the issue, which includes the other devolved Administrations, the unions and wider civic society.

Margaret McCulloch: This Parliament overwhelmingly spoke out against the Trade Union Bill, and Labour members welcomed the Government's first attempt to lodge an LCM against what is a draconian piece of anti-trade union legislation. As a consequence of the bill and last week's ruling on the LCM, a private employer could choose to retain practices such as check-off when ministers of the Scottish Government will not be able to do so.

Does the minister think that ministerial executive competence is compromised by the proposed legislation? On what grounds has the Government come to its view? What action will it take?

Roseanna Cunningham: As I think that I indicated, our view is that banning check-off and facility time in Scotland impinges on our responsibilities to our employees. We are adamant that that is the case, and that view formed part of the evidence that I gave to the House of Commons Public Bill Committee on the Trade Union Bill. What is being asked for is simply not required—it is absolutely clear that there is no evidence whatever to support the position that the United Kingdom Government has taken.

The Deputy First Minister confirmed last year that the Scottish Government will continue to offer check-off, and that position remains unchanged—also, we do not intend to use agency workers. We will continue to do what we think is right for our employees.

Margaret McCulloch: For clarity, on the basis that the Scottish Government believes that ministerial executive competence is compromised by the proposed legislation, what consideration does the Government think the relevant committee should give to the issue?

Roseanna Cunningham: It is not for me to dictate to a parliamentary committee what it chooses to do. I look forward to hearing from the committee and hope that it will accept the Government's invitation to look at the policy memorandum. As the member knows, what action the committee takes is entirely a matter for it to discuss. I very much hope that it will come to the same view as we have come to.

The purpose of our approach to the Devolution (Further Powers) Committee is to present an opportunity for a policy memorandum and a motion to be lodged for debate in this Parliament. That is an outcome for which I think we all wish.

Mark McDonald (Aberdeen Donside) (SNP): The cabinet secretary has been having discussions with trade unions. Will she update the Parliament on those discussions?

Roseanna Cunningham: Ministers have held meetings regularly with the Scottish Trades Union Congress. We meet to discuss a number of matters, of course, but the Trade Union Bill has been to the fore. Last week, the First Minister and Deputy First Minister had their biannual meeting with the STUC and the bill was discussed.

As most members probably know, the FM addressed the STUC anti-Trade Union Bill rally last Thursday night. Indeed, on 24 November she gave the keynote address at the Jimmy Reid memorial lecture and the bill formed a large part of what she had to say. I have met the STUC and Unison to discuss the bill on a number of occasions recently.

I do not think that there is any sense that this Government is not taking the issue extremely seriously. We have huge concerns about the bill's impact on the Scottish Government's industrial relations. In my view, the bill will endanger industrial relations in Scotland, although we have

a better record on industrial relations than anywhere else in the United Kingdom.

Forth Road Bridge (Closure)

3. Mike MacKenzie (Highlands and Islands) (SNP): To ask the Scottish Government what regular assessment it is making of the operation of the plan to minimise the disruption to journey times since the closure of the Forth road bridge. (S4T-01250)

The Minister for Transport and Islands (Derek Mackay): Regular discussions continue to take place between transport delivery partners on the travel plan's effectiveness. The plan is reviewed daily, and following feedback from businesses and communities we have already relaxed the restrictions along the dedicated transport corridor on the A985. The plan must have the ability to adapt and to respond to need.

Through the travel plan, we are supporting communities, commuters and businesses as best we can do during the closure of the Forth road bridge. Key interventions have been made and promoted. Partners include Transport Scotland, Fife Council, Police Scotland, ScotRail and Stagecoach.

Mike MacKenzie: Does the minister agree with the Federation of Small Businesses and the Fife Chamber of Commerce that enhancements to the Scottish Government's travel plan, allowing all light goods vehicles to use the corridor on the A985, will be particularly beneficial to local small businesses, as they will enable journeys to be made in a shorter time and will support the supply chain while the bridge repairs are carried out?

Derek Mackay: I welcome those comments. We are continuing to monitor the travel plan's effectiveness and to listen to those who are affected by the closure. We are doing everything that we can to reopen the bridge in time for people who are returning to work in the new year. We must be able to adapt the travel plan in light of new circumstances, and that is what we are doing. We are ensuring that we mitigate as best we can the impact on the local and regional areas.

Mike MacKenzie: Will the minister comment on whether the enhanced public transport provisions are being effective?

Derek Mackay: Everyone would accept that it is incredibly difficult to address all need in terms of the displaced traffic from the closure of the Forth road bridge. However, there has been a massive move to strengthen rail capacity—an extra 10,000 seats have been provided—and extra bus seats have been provided. Both those things have been subsidised, and bus provision has been further supported with the priority route in order to give better journey times.

There has clearly been a shift on to public transport, and I appreciate the patience and forbearance of the travelling public as they have adjusted to the necessary closure of the Forth road bridge. We have ensured that the action plan is fully conveyed to the public through the dedicated website, and we meet regularly with stakeholders, including Police Scotland, which we meet to discuss enforceability and its intelligence and understanding. We also meet local authorities and businesses to do everything that we can to mitigate the impact of the closure of the Forth road bridge.

Incidentally, the repairs to the bridge are very much under way and the reopening time is very much on track.

Murdo Fraser (Mid Scotland and Fife) (Con): Fife Council is advising businesses that have lost money as a result of the closure to direct compensation claims to Transport Scotland. How will those claims be dealt with?

Derek Mackay: My priority is to ensure that the bridge is reopened as quickly as possible and to mitigate the impact of its closure. The travel plan has been largely effective in that. Do not take just my word for that: even Alex Rowley has praised my work on the travel plan.

On the wider question of compensation, the Deputy First Minister has held useful talks with businesses. In fact, some constructive ideas from those talks have led to changes in the travel plan. I am sure that Mr Swinney will consider the issue of compensation further, but it remains the case that our priority must be to repair the bridge and reopen it as quickly as possible. Businesses and everyone else tell us that that must be the number 1 priority, and that is exactly what I am focusing all energy on.

Claire Baker (Mid Scotland and Fife) (Lab): The minister will be aware of the pressures that are being faced in Fife, as outlined by Mike MacKenzie, member for Highlands and Islands. I welcome ScotRail's huge efforts, but crowding on trains on recent days has been particularly difficult. Sometimes there have been only two or three carriages on rush-hour trains coming from Kirkcaldy. What assurances can the minister give that that issue will be addressed?

Derek Mackay: ScotRail has mobilised as much as it can. As I said in my parliamentary statement last week, we have located carriages from south of the border and some have been displaced from other parts of Scotland.

I also pointed out that the issue is of national significance. It is right that we put extra carriages and effort into the Fife area, even though some Labour members felt that that was the wrong thing to do, because it impacted on their areas. Given

the national recognition of the stress and pressures on Fife, it has been the right thing to do to locate extra carriages and trains there and to enhance the timetable with an earlier morning train. ScotRail's approach has been helpful in mitigating the impact of the closure and has enhanced the provision during peak periods.

I have repeatedly identified the extra capacity that exists on the bus routes, and I encourage more people to look at the availability of bus provision. ScotRail has ensured that stations are staffed and that there is adequate information out there.

I say again that it was always going to be a huge challenge to manage the displacement of everyone who normally crosses the Forth using the road bridge. We made every effort possible, with rapid decision making and rapid intervention, to ensure that, by Monday morning—[*Interruption*.]

The Presiding Officer (Tricia Marwick): Order. Let us hear the minister.

Derek Mackay: Labour members laugh, but I think that people appreciate the action of the Scottish Government to ensure that there are 10,000 extra seats of rail capacity and thousands of extra seats of bus capacity. I say again that, if there is any more that the Government can do, we will do it. We will get on with action while the Labour Party carps from the sidelines.

The Presiding Officer: That ends topical questions.

Points of Order

14:26

James Kelly (Rutherglen) (Lab): On a point of order, Presiding Officer. I rise to make a point of order in response to the statement from the cabinet secretary that the Trade Union Bill will be referred to the Devolution (Further Powers) Committee—a move that I welcome.

I make my point of order on the back of your ruling last week, Presiding Officer, that the legislative consent memorandum is not competent. I have taken legal advice on that ruling, and I believe that the advice is open to challenge. I do not think that the ruling was correct, in terms of executive competence—

The Presiding Officer (Tricia Marwick): And your point of order is, Mr Kelly?

James Kelly: I am coming to my point of order.

The Presiding Officer: Let us have it, then.

James Kelly: If you let me speak, I will make my point of order.

The Presiding Officer: Mr Kelly, get to your point of order, please.

James Kelly: If you please let me make my point of order, I will get on with it.

The Presiding Officer: I want to know what the point of order is.

James Kelly: If you keep interrupting me, Presiding Officer, I cannot—

Members: Oh!

The Presiding Officer: Mr Kelly, please sit down.

James Kelly: I am not going to sit down.

The Presiding Officer: Mr Kelly, please sit down.

James Kelly: I will not sit down. I want to make a point of order.

The Presiding Officer: Mr Kelly, please sit down.

James Kelly: I want to make a point of order, and I was not allowed to make the point of order because you kept interrupting me.

The Presiding Officer: Mr Kelly, please resume your seat.

James Kelly: I am not going to resume my seat. I want to make a point of order.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): On a point of order, Presiding Officer.

The Presiding Officer: Sit down. I am speaking.

I remind the member of the requirement to conduct himself in a courteous and respectful manner and to respect the authority of the chair. I am asking you to sit down—will you please do so?

James Kelly: No. I am not going to sit down. I want to make a point of order.

The Presiding Officer: I remind the member of the powers that I have under rule 7.3 of the standing orders, which gives me the power to exclude a member from the chamber. I ask you now to desist and to apologise.

James Kelly: I very reasonably rose to make a point of order—

The Presiding Officer: I ask you to desist and apologise, Mr Kelly.

James Kelly: No, I am not sitting down. I want to make a point of order.

The Presiding Officer: The member has been repeatedly warned against his conduct and asked to desist and apologise. The member has refused to do so. Under rule 7.3, I hereby require the member to leave the chamber.

Neil Findlay (Lothian) (Lab): On a point of order, Presiding Officer.

The Presiding Officer: Sit down, Mr Findlay. I am speaking.

I also exclude the member from participating in the remainder of business in the chamber today and on the next sitting day. [*Interruption*.] I ask security to please escort Mr Kelly from the chamber.

I suspend the meeting until Mr Kelly has left the chamber.

14:29

Meeting suspended.

14:29

On resuming—

The Presiding Officer: Mr Findlay, you had a point of order.

Neil Findlay: At topical questions—

The Presiding Officer: I am sorry, Mr Findlay. Dr Simpson had a point of order first.

Dr Simpson: Presiding Officer, we are in a difficult situation, in the sense that we are now being invited to have one of the parliamentary committees consider a motion that you have declared is illegal, or not competent.

I wonder whether it is practical and possible for you to consider suspending your ruling on the matter until the committee has had time to consider it. At that point, of course, you would be perfectly entitled to re-impose your ruling, but that would allow the committee to consider the matter unfettered, unhindered and not under a ruling from you that what they were discussing was actually not competent.

The Presiding Officer: Dr Simpson, you are factually wrong. What the committee is discussing is a policy memorandum, and that in no way impinges on the ruling that I have made.

Mr Findlay, you had a point of order.

Neil Findlay: Presiding Officer, at topical questions, the Cabinet Secretary for Fair Work, Skills and Training said that she was disappointed with the Parliament's view on the decision to reject the legislative consent memorandum on the United Kingdom Government's Trade Union Bill. The Parliament has not expressed a view on the legislative consent memorandum, so I wonder whether there will be an opportunity for the cabinet secretary to say whether she agrees with Scottish Labour that your ruling on this matter—

The Presiding Officer: That is not a point of order, Mr Findlay.

Neil Findlay: I am coming to the point.

The Presiding Officer: Will you get to the point of order, please? So far, I have not heard a point of order.

Neil Findlay: Presiding Officer, I believe that I have up to three minutes to make my point of order.

The Presiding Officer: Please come to it.

Neil Findlay: I wonder whether the cabinet secretary will be able to express her view as to whether your ruling is wrong. Finally, I understand that you have legal advice on this matter. Would you kindly publish that legal advice?

The Presiding Officer: No. In common with other Presiding Officers, I have absolutely no intention of producing the advice that I may or may not have been given. Whether the cabinet secretary is disappointed by the ruling is a matter entirely for her, and I do not intend to ask her to say any more.

The next item of business is a debate on motion—

Ken Macintosh (Eastwood) (Lab): On a point of order, Presiding Officer. Can I ask for your guidance? [*Interruption*.]

The Presiding Officer: Order. Let us hear the member.

Ken Macintosh: I ask for your guidance on the standing orders and on how they allow members from this Parliament to question any guidance that you might have been given and then give the chamber? Is there a procedure under which we can challenge the competency of the guidance that you have been given? If so, do members have up to three minutes, as I understand they do, to make a point of order?

The Presiding Officer: It is certainly true that members have up to three minutes to make their point of order, but what I need to know first of all is what that point of order is. Once—

Neil Bibby (West Scotland) (Lab): On a point of order, Presiding Officer.

The Presiding Officer: Sit down, Mr Bibby. I am speaking.

Once the point of order is clear, members are then allowed to take up to three minutes on discussion of it, but what I have not heard so far is the point of order, and I need to hear that first.

Neil Bibby: On a point of order, I ask for your guidance, Presiding Officer. Why was Mr Kelly not allowed to make his point of order? [*Applause*.]

The Presiding Officer: Mr Bibby, I asked repeatedly for the member to make his point of order. He did not come to his point of order. If he had explained to me what his point of order was, he could then have had up to three minutes to make that point of order.

Redesigning Primary Care

The Presiding Officer (Tricia Marwick): The next item of business is a debate on motion S4M-15172, in the name of Shona Robison, on redesigning primary care for Scotland's communities.

14:33

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): I am pleased to be opening this afternoon's debate. I want to take the opportunity to describe my longer-term vision for primary care, building on Sir Lewis Ritchie's recent report, and the many innovative new ways of working that have been springing up across the country. I want to explain our delivery plan, setting out how we are going to make the vision a reality, and how all parts of the system will need to work together to make it happen.

First of all, though, I want to take the opportunity to thank all those who work in our health and care systems, particularly at this time of year with the pressures that winter brings. I know that our staff work particularly hard over this period. Although we are talking about primary care today, I take the opportunity to thank our hard-working health professionals in our accident and emergency departments, which have today delivered on the four-hour target. That is a huge achievement that I am sure will be welcomed by members on all sides of the chamber.

Within our primary care sector, we have a huge number of people who work very hard. I absolutely understand some of the challenges involved, which we will hear more about this afternoon. However, it is important that we are clear on the way forward to ensure that our primary care services are robust and sustainable and are able to change and develop to meet the changing demands that will be required as we go forward.

Sir Lewis Ritchie's "Main Report of the National Review of Primary Care Out of Hours Services" was published on 30 November, and I warmly welcomed its findings. We have, of course, announced an initial investment of £1 million to begin to test his new models of care, which I will come back to later. Through our programme for government commitments, we identified 10 examples of test sites for change in primary care, and work is progressing across all of those; for example, the Lothian headroom initiative is focusing on improving outcomes for people in economically disadvantaged areas of Edinburgh. In addition, I am going to test two community health hub sites—in Fife and Forth Valley—where we will focus on the interface between primary and secondary care.

We will also achieve change in primary care through trusting our general practitioners and delivering on our commitments. When I spoke at the Royal College of General Practitioners conference on 1 October, I promised GPs that I would remove the outdated quality and outcomes framework—the QOF—from their contract. This morning, I was delighted to announce that, working closely with the British Medical Association in Scotland, we have delivered on that promise and that the QOF will cease to exist from April next year. That will help to free up more time for GPs to focus on essential patient care.

We have moved to implement some developments very quickly, but obviously more must be done. We need to go further and faster because Scotland is changing and the people who need healthcare are changing. We are living longer, which is a good thing, but all too often a longer lifespan brings with it more complex health needs and reduced quality of life. Meanwhile, people quite rightly expect to access quickly the right care by the right professional when they need it.

I hear our primary care practitioners when they say that they sometimes feel that they have too much to do and not enough time to do it. Statistics published today show that although the number of GPs working in Scotland has increased by 9 per cent since 2005, the number of patients over 65 has increased by 18 per cent over the same period. Our out-of-hours primary care services are relied on by hundreds of thousands of patients across Scotland each year.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I welcome the publication of those figures today, but it is regrettable that we do not have the full-time equivalent numbers. The headcount does not reflect the FTE figure, which is critical. Does the cabinet secretary have that figure?

Shona Robison: No, but a survey will take place that I think will provide more in-depth analysis of some of the data to which Richard Simpson refers.

I accept that there are significant GP recruitment and retention challenges, and that we need to build and maintain the existing workforce. That is why from 2016 we will increase the number of training places for GPs by 33 per cent and why we are investing in a programme to encourage GPs who have left general practice to return to the workforce, with investment in that this year. Of course, we are investing in GP recruitment and retention more broadly in order to make general practice a more attractive career option.

As we move forward into next year, health and social care integration presents us with a huge opportunity to do things differently. My vision puts primary and community care at the heart of the healthcare system, with highly skilled multidisciplinary teams delivering care both in and out of hours, and a wide range of services that are tailored to each local area. That care will take place in locality clusters, and our primary care professionals will be involved in the strategic planning of our health services. The people who need healthcare will be more empowered and informed than ever, and will take control of their own health. They will be able to directly access the right professional care at the right time, and remain at or near home wherever possible.

We are already heading in the right direction. We know that up to a quarter of the people who see GPs are suffering from soft tissue injuries, and that is why every person in Scotland can now call NHS 24 and get advice or be referred for physiotherapy if that is required. That is an example of the kind of change that we need across the system.

I will now set out my plan for making the vision a reality. I have mentioned Sir Lewis Ritchie's review of out-of hours care, and again I record my thanks to Sir Lewis for his work. I know that he worked closely with many stakeholders including the BMA, the Royal College of Nursing, pharmacy representatives, national health service chief executives and others.

Sir Lewis told us that we need to do more, and be better at, multidisciplinary working, with more investment in the workforce and in infrastructure, and a drive towards changing the culture, centred on a model of urgent care resource hubs. He said that we need large-scale tests of change, moving quickly to whole-system change, and he is right. My initial investment of £1 million will allow us to begin the process of testing, and we will publish the national implementation plan in spring next year. That will coincide with the integration of health and social care, further enabling just the sort of joint working that we need.

Our detailed budget plans will be published by the Cabinet Secretary for Finance, Constitution and Economy tomorrow, so I will not pre-empt that—I certainly would not dare. However, I can say that I am determined that primary care expenditure will rise. We have already announced the new £60 million primary care fund, and I want to go further than that, with the balance of health spending changing over time so that a greater percentage of funding goes to primary care. That change is not short term but will continue throughout the current process of transformation.

More than £20 million of the £60 million primary care fund will provide a kick start to some of those major tests of change that Sir Lewis said that we needed. Some of the first things that we are going to test are fundamental changes to the GP

contract. We are working with our key partners across the Inverclyde health and social care partnership area to develop and test new ways of working. I hope very shortly to be able to announce to Parliament the details of that work, which will draw on the knowledge of those working locally to identify the changes that can be made. That will help us to realise our vision for the future role of GPs and others in primary care and ensure improved outcomes for everyone. That will make a difference not just in Inverclyde but throughout Scotland.

We are investing £100 million in mental health over the next five years in the run-up to 2020, of which £10 million will go towards primary care settings to develop new ways of working such as the distress brief intervention.

I will move on to look at changes that we are making that affect GPs and other parts of our valued workforce. We value family doctors incredibly highly, and we want them to stay in the profession. As I have said before, the time has come to start talking up Scotland's general practice; to encourage more doctors to stay; and to ensure that medical students choose a career in general practice.

The future for GPs lies in their having high-quality jobs that are focused on undifferentiated presentations, or working out who may need further assessment, investigation or referral; caring for people with multiple conditions; and quality and leadership. Other health or social care professionals will provide the care that they are best placed to provide. That future is a win for patients, who get to see the right person at the right time, and for all our healthcare professionals, who can make the most of their skills and knowledge.

We have been working with the Scottish general practitioners committee to redesign the GP contract, and I thank Alan McDevitt and his colleagues for their work. As I said earlier, we have removed the QOF system as of 2016, and we will take the opportunity that the process presents to focus on tackling inequalities more effectively, which I know is something that members on all sides of the chamber support. We will have the first version of the new Scottish contract in place by April 2017, and by then we will have made significant progress on changing the way in which general practitioners work.

We will remove the annual churn of contractual change and introduce the next version of the GP contract three years later in 2020, when the transformation in the way that GPs work will be nearing completion.

Our model of multidisciplinary working has implications right across the workforce, for community nurses and advanced nurse practitioners, allied health professionals, pharmacists, practice staff and those who work in new emerging roles. Our community nurses can lead and co-ordinate care management and specialist services, and in many instances are already doing so. I want to see more of that, and the chief nursing officer has recently begun work to transform and develop nursing roles so that they meet the current and future needs of Scotland's people.

Let us not forget the important role that pharmacists play as clinicians in their own right and as a crucial part of multidisciplinary working. Up to March 2018, more than £16 million will be invested from the primary care fund to recruit up to 140 additional whole-time equivalent pharmacist independent prescribers, who will free up GP time to spend with other patients.

We also need to get the basics right. We need information technology systems that are fit for the future and flexible premises. For the period to March 2018, I have allocated £6 million of funding to the primary care digital services development fund, which will initially focus on increasing the availability and uptake of online appointments and repeat prescriptions.

To summarise, the transformational change plan is multifaceted and ambitious and it will take us a long way down the road that we need to travel. However, the changes will not achieve anything without the people who really make our Scottish NHS what it is.

I end where I started, by thanking all those who are involved in the journey so far. I also want to put on record my thanks to Richard Simpson. I had a helpful meeting with him the other day. He has brought a lot of experience in primary care to the chamber and that will be missed after the election. I hope that he might, in some way, continue to share his experience with us as we move forward with such important changes. I look forward to hearing what members have to say in the debate.

I move,

That the Parliament commends the good work of the dedicated health and care professionals who embody the community health services; agrees that effective frontline community healthcare is vital to helping people enjoy life at home, or in a homely setting, for as long as possible; recognises the challenges being faced in the recruitment and retention of GPs; supports the current work to agree a new GP contract for Scotland from 2017, which will see bureaucracy reduced for GPs to give them more time with their patients, presenting the opportunity to go even further to tackle health inequalities in communities; welcomes Sir Lewis Ritchie's review of out-of-hours primary care and the Scottish Government's commitment to work with partners to implement his findings; further welcomes the planned increase in GP training places and support for return to practice schemes to aid retention and recruitment in

general practice, and endorses the aims of the £60 million Primary Care Fund to test new models of care, support the primary care workforce and enhance patient access.

14:46

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I draw members' attention to my declaration of interests as a member of the BMA and a fellow of the Royal College of General Practitioners.

The debate is welcome and I thank the cabinet secretary for her kind remarks. I am slightly regretting the fact that the first third of my speech will be quite negative, but the remainder will be quite positive, so she could dwell on that.

The Government motion does not recognise the extent of the urgency that the cabinet secretary conveyed in her speech. The Government remains slightly complacent. The current national conversation is similar to what Labour proposed in 2011 as a Beveridge commission for the 21st century, although such a commission would have been more independent of politicians. The Scottish National Party rejected our proposal out of hand on the ground that it would take too long, and yet here we are.

My first call for a new GP contract was made in 2010, when the Government and the BMA rejected it. There were two reasons for making that call at that time. One was that the Tory plans in England were creating a totally different approach to general practice with commissioning groups. In Scotland, I was hearing anecdotally that the number of applicants for partnerships in general practice had reduced to a level that had not been seen since the early 1970s.

The Labour Government in Wales set up the Bevan commission, which was similar to what we proposed. The result has been that Wales now has 64 funded clusters. I have no doubt that the Scottish Government will have studied the Welsh Government's document "A Planned Primary Care Workforce for Wales" on the further development of those clusters.

In the meantime, Scotland has experienced an increasing population; an increase in the birth rate; an increase in the number of over-75s who have multiple and complex conditions; increasing demand, as evidenced by the year-on-year growth in the number of GP consultations; and a largely unresourced transfer of work from secondary hospital-based care to GPs. There is also an increasingly bureaucratic quality and outcomes framework, which I am delighted to hear that the cabinet secretary has agreed to remove early, before the new contract. That is a welcome move.

In the past few years, the SNP's response to preparing for this transformational change, which I think we all agree will be worth while, has been to cut the nursing student intake. However, nurses will be vital to the transformational change. The midwifery student intake has also been cut.

I recognise that this is not an easy area. The establishment of the out-of-hours review by Sir Lewis Ritchie was a welcome first step and, as is usual for Professor Ritchie, it has resulted in a thorough piece of work with achievable objectives. I welcome the pilot that will be undertaken, although I am slightly concerned about the level of funding, which I have queried before.

The Government's announcement of £60 million to fund the testing of new models of general practice is welcome. The 140 pharmacists are also welcome, although I would like to know how GPs will apply for them. GPs are phoning me and saying, "We would like one of those. How do we get one?" and I am finding it difficult to respond, so some detail as to exactly how the pharmacists will be put in place would be welcome. I know that they are going into the 2C practices—those that have been taken over—and that tests the model, which is excellent.

The delay over the past five years in recognising and acting on the deterioration in general practice recruitment and retention means that we need further action urgently. Increasing the number of GP training places sounds good, but I would like to know how the cabinet secretary will get people into posts when 20 per cent of them are currently unfilled.

Action on the deep-end practices is urgently needed. The cabinet secretary alluded to that, but we need a lot more detail. The discrepancy in funding for those practices was made evident in the paper that was published last week, and it needs to be addressed urgently. I am told that, although those practices have not yet collapsed as some others have, they are extremely fragile and their sustainability is quite questionable.

In her answer to my written question about a risk register for general practice, the cabinet secretary said that she believes—I do not doubt her belief—that there is a risk register in every health board. I have to say that I have subsequently repeated my freedom of information request. The response to my first request was that seven or eight boards do not have such a risk register, and I have to tell her that three still do not have one. NHS Greater Glasgow and Clyde has said that it will start on one, but that is another recognition of the fact that the problem has really not been followed through on.

I have some suggestions, many of which are in a paper that I produced. The cabinet secretary was kind enough to discuss that paper with me and I think that we are to discuss it more. It is a

Labour paper that is based on our survey and review and on consultation with GPs.

The health boards should start to contract banks of retained GP locums and other primary care staff. Where are they to come from? There are a lot of sessional doctors out there and doctors who have almost retired or who have taken a break to have a family; they could be recruited into a bank of locums to provide cover at least for short-term sickness absences.

Evidence of that approach is already materialising. With the Bannockburn practice closing, the practices in Stirling have rallied round; the sessional doctors there are providing some locum cover already. Colleagues are willing to support other local practices that are in difficulty, and that needs to be built on.

We need a national performers list today, tomorrow or certainly this week—we cannot wait. That is in Lewis Ritchie's report, and it should be acted on now. Local performers lists, to which doctors have to apply through individual boards, are outdated and outmoded and must be done away with.

We should have a reversal of the cuts in medical undergraduate places. We should establish a graduate-entry medical course—that will take a little longer.

Nurses are critical. We have 1,900 vacancies. The family nurse partnership originally needed another 350 nurses, not all of whom have been recruited yet. The Royal College of Nursing reckons that we need another 500 for the named-person requirement. That comes to about 2,500, yet 640 fewer nursing students have enrolled in universities since the start of this parliamentary session.

That is one area in which the cabinet secretary cannot stand up and say, "We are doing better than Labour did." The recruitment numbers this year are 476 down on the year when Labour left office. We cannot have the transformational change without having an adequate number of students. The increase in the number of nurses who are returning to work is welcome, and I hope that it will be built on.

We need to have negotiations now, if they are not already taking place, on how to incentivise senior GPs not to retire. We need moderation of the bureaucratic revalidation scheme, which is work intensive and is a particular problem for senior and experienced GPs, who do not need that level of revalidation. I strongly suggest that we have discussions with the General Medical Council immediately about moderating that bureaucratic process.

We need an immediate revitalisation of the GP retainer scheme. Given the gender shift that we have had, one would expect there to be more GPs in the scheme—originally, when we were less politically correct and more gender specific, it was called the women's retainer scheme—but there has been a 40 per cent drop. That is despite the fact that women as a proportion of those who qualify in medicine are up from 10 per cent in my time to more than 50 per cent today.

There should be post-registration work placements for every allied health professional. I know that the Government does not control the intake, but putting those people into work placements now would help with some of the elements that the cabinet secretary mentioned.

The essential workforce, training and contract measures must be underpinned by a national infrastructure programme that uses a combination of non-profit-distributing programme and GP-backed finance. An example of that is the innovative scheme in Tayside to close the Aberfeldy community hospital but to open beds in a care home that is going to be built. That sort of combination might work in Portree, where there are problems. Stirling's care village is another example of a joint venture between the NHS and a local authority, which is welcome.

The cabinet secretary mentioned information technology. Improving the IT links to pharmacies should be an immediate priority, along with the links to optometrists who are prescribing.

The system of clusters that the royal colleges advocated nine years ago and which the King's Fund has endorsed is essential. The Commonwealth Fund's survey of 10 countries reported that the system is essential to achieving greater satisfaction with and improved delivery in general practice. The clusters need to be established quickly. I know that we have 10 pilots, but we have to look at and adapt what has happened in Wales.

I have only about 30 seconds left, but I still have a way to go, Presiding Officer.

The Deputy Presiding Officer (Elaine Smith): I can give you an extra minute or so.

Dr Simpson: That is kind of you—thank you very much.

Such practice or locality groups are variously referred to in different documents as clusters, networks, federations and family care partnerships. They are showing themselves to be crucial to delivery. The work in Tower Hamlets over seven or eight years has been extraordinary in making changes to one of the most deprived communities in the United Kingdom.

We need support for specialist nurses, advanced practitioners, physician assistants, allied health professionals and pharmacists in dealing with issues such as diabetes, chronic obstructive pulmonary disease, asthma, heart failure, end-of-life care and polypharmacy. I ask the Government to publish the details of what it is doing in relation to the clusters so that we can fully discuss that and see how it is going.

The objective is a fully resourced shift in the balance of care from acute hospitals to a modernised and integrated community health and social care service that is fit for the 21st century and is designed to reduce admissions and prevent a return to growth in the number of acute beds. Clearly, there are funding restraints. In the next session, Parliament will need to consider how we address the reduction in the primary care share of the budget and the effect on the infrastructure in the community of the capital cuts that we have had to sustain. Shifting the balance of care cannot be achieved without a significant shift in the balance of resource.

I have one suggestion that does not involve money and therefore does not need approval from the finance secretary. The efficiency savings are still running at 3 per cent, which is difficult. Part of the non-recurring aspect of those savings should be designated for and applied to primary care. That would achieve a shift, because the majority of the savings will come from the major part of the budget, which is still in the acute sector.

The Deputy Presiding Officer: I need you to close now please, Dr Simpson.

Dr Simpson: Finally, I hope that the Government will publish a set of principles that it seeks to use to underpin any new contract. The task is daunting but, if we all work together, I hope that we will achieve a transformational change.

I move amendment S4M-15172.2, to insert at end:

"; notes however that, while there has been some shift in the balance of care from secondary to primary services, there has been a reduction in the primary care share of the overall health budget despite an increase in population and in patients with complex needs, and believes that the new models being tested with new roles for nurses, pharmacists and allied health professionals as well as GPs require appropriate core funding over the course of the next parliamentary session and an open and transparent debate at all levels regarding differential funding to tackle health inequalities".

14:59

Jim Hume (South Scotland) (LD): I associate myself with the cabinet secretary's comments about Richard Simpson. I hope that he continues to have an active role, and I am sure that he shall. I also praise the extraordinary work that front-line community health and care services professionals do, day in and day out, across Scotland.

The debate is timely. We want to increase the importance of primary health services, which are a valued asset that needs urgent attention. Investment of £40 million under the primary care fund was announced in November 2014, but it took the best part of seven months for words to be put on paper to solidify that action, and it turned out to involve reducing the amount that would be invested in primary care from £40 million in 2015-16 to £16.6 million per year over three years.

However, that aside, it is obvious that the cabinet secretary wants to talk about redesigning primary care for Scotland's communities. I am sorry that I have to start by being slightly negative, but I will go on to be constructive. Some £26.5 million has been cut from primary medical services since 2009-10, and almost £30 million has been cut from the total spend on GPs in that period. Out-of-hours GP funding was cut from £95.7 million in 2008-09 to less than £80 million in 2013-14. The cabinet secretary provided me with those figures just this month in response to a parliamentary question.

It is clear that a redesign is on the Government's mind, but I do not want it to be of the wrong kind. One thing that the Government acknowledges is the challenge in recruiting and retaining GPs—a challenge that has been brought on by a lack of investment in primary care—and in establishing the recruitment practices that are needed. The chair of the Royal College of General Practitioners has said:

"There is no question that the consistent underfunding of general practice has contributed to the difficulties the service faces. RCGP has been warning for over two years now of the results of year on year cuts to the percentage share of NHS Scotland funding allocated to the service. General practice, which sees 90% of all patient contact with the NHS, received just 7.6% of the budget. Such imbalance is a plan for failure."

New figures that are out today show that average GP practice list sizes have increased by 10 per cent since 2007. Perhaps that goes some way towards answering Richard Simpson's questions on full-time equivalents. I will be interested to see the figures that the cabinet secretary finds. We do not want the Government just to pay lip service.

There continues to be little success in attracting GP trainees in the necessary numbers. I welcome the announcement of 100 more GP training places, but I would like an assurance from the Scottish Government on what plans it has made to fill them. If the current places cannot be filled with GP trainees, as Richard Simpson said, what is the plan for the 100 additional places?

In September, the cabinet secretary told us that only 237 of the 305 GP specialty training posts that were advertised in Scotland in 2015 were filled. Research that was presented in the *British Journal of General Practice* shows that the majority of GP trainee places were in the least deprived 25 per cent of practices, with the most deprived 25 per cent having just over half that number. In those deprived areas, multimorbidity and premature mortality are real problems, mental health problems are a factor in a third of GP consultations, and funding does not match clinical need.

The general practitioners at the deep end warn that the flat distribution of GP resources in Scotland does not benefit those who most need GP care—that is, the 8 per cent of the Scottish population who live in the most deprived areas. Unless a drastic shift is applied to address inequalities in the resource distribution methods, we will see no change in health inequalities.

I am not saying that we should throw money at the problem and expect solutions to magically appear. A guided and educated approach is needed that takes into account the needs of both practitioners and patients. The call for a fully resourced workforce that works in the right way and in the right place is also backed by the Royal College of Nursing and the out-of-hours primary care review. As the cabinet secretary will be aware, recommendation 8 in that review's report states:

"A national primary care workforce plan should be developed and implemented without delay".

The redesign of primary care for Scotland's communities must be precisely that—a redesign for the communities. Next year, we face a project of an enormous scale—the integration of health and social services, which will jointly manage £8 billion-worth of assets and resources. We need a redesign that takes into account the localisation of services and the ability of integration authorities to plan their workforce needs and be supported while they do so. The Ritchie report pointed out that

"Robust workforce planning ... needs to be urgently replicated at NHS Board"

and integration authority level

"to secure a sustainable and empowered multidisciplinary workforce".

The Scottish Government has to redesign services to meet the needs of the populations in different communities across Scotland. Unless change happens in a way that enables and empowers practitioners to plan for their patients, we will see little progress on reducing inequalities and putting our NHS on the right footing for progress. We need a strong, future-proofed NHS.

I move amendment S4M-15172.1, to leave out from "supports the current work" to end and insert:

"considers that there is a GP crisis, caused in part by the failure of the Scottish Government to invest in primary care; notes that real-terms spending on GP services has fallen year on year since 2009-10, decreasing from £888 million to £858 million in 2013-14; understands that funding pressures are particularly acute in practices serving the most deprived areas, which receive less funding per patient than average, despite the vital role that they can play in reducing health inequalities; notes that the Royal College of General Practitioners has stated that 'there is no question that the consistent underfunding of general practice has contributed to the difficulties the service faces' and that the body has previously warned there will be a shortfall of up to 740 GPs by 2020; understands that, of the 305 GP speciality training posts advertised in Scotland in 2015, only 237 were filled, and therefore calls on the Scottish Government to explain how its increasing the number of posts available to 400 will increase uptake and lead to more GPs in local practices; welcomes Sir Lewis Ritchie's review of out-of-hours primary care and considers that it is an important contribution to the debate on how best to deliver these vital services, and supports efforts to reduce bureaucracy through the new GP contract for Scotland from 2017 in order to give GPs more time with their patients to provide quality care."

15:05

Jackson Carlaw (West Scotland) (Con): Like the cabinet secretary, I begin by paying tribute to the staff who will be working extremely hard over the winter and the Christmas season. As I noted in a previous debate, I doubt very much that they will be watching our debate this afternoon—they will likely be far too harassed and, if they are not, I hope that they have better things to do—and I hope that they understand that my tribute is heartfelt and well meant. Over the past two or three winters, we have come to appreciate that the demographics are changing so rapidly that any pandemic or major health concern that emerges places enormous strain on hospitals and our NHS staff.

I thought long and hard about it and I decided not to lodge an amendment. Instead, the Conservatives will support the Government's motion. I made that decision because there is no point in my going to meetings with nurses, allied healthcare professionals and doctors and saying that I will take the politics out of health, only to come here and be highly belligerent about the situation that we are in. There is a distinction between the day-to-day health issues, around which I might have issues with the Government, and the strategic plans for the future of the health service, in relation to which it is necessary that we stop being partisan and seek to find as much common agreement as we can.

Since it is Christmas, however, we will also support Mr Simpson's amendment, even though I read Labour's "Fit for the Future" document and felt that it had a whiff of, "Labour said this, Labour

did that, Labour thought the other," and "If only we had listened to Labour—yada yada yada—we wouldn't be where we are today." I do not think that that entirely gives us a measure of the issues and problems that we collectively face.

Although Professor Sir Lewis Ritchie's report concerns out-of-hours care, its themes reach right across the primary care debate. Towards the end of it, it lays out age demographics. I noticed that, in 2039—when I would be 80, if I were to live that long; I have previously cheered the chamber by informing members that Carlaw men do not—there will be twice as many people of the age of 80 than there are today. My sons will be in their 40s and there will be just as many people in their 40s then as there are today. We constantly fail to paint a picture that people properly grasp of just how huge a shift in the demographics of the Scottish population lies ahead and the revolution that is required in our approach to primary care, with those elderly people becoming part of a detailed patient cohort that will need a great deal of individual attention and just that bit more time.

I have spoken to people in the professions and know that they can get into that approaching-old-man syndrome where they say, "The trouble is all these new doctors coming through now just don't have the same commitment and work ethic that we had when we came in. We believed it was a vocation and we would work through the night if it was necessary, and this new lot—my goodness—you can scarcely drag them out of their beds to get them to the shift that they're supposed to be on." However, I was encouraged last week when I met the leaders of the Scottish junior doctors committee and the Scottish student doctors committee: I was enormously impressed to find that that attitude is absolutely not the case. What has changed is that there is a different perception of work-life balance across all of Scotland's workforce. We must ensure that the contract renegotiation and the structure for GP primary care that we put in place attract people, because we cannot dragoon them into it. That is why the job that the cabinet secretary has ahead of her is so important.

When Professor Sir Lewis Ritchie says that the funding will not grow in line with the service demand, he makes an important point. As I will touch on in my closing remarks, much more focus must therefore be put into the preventative agenda to stop people having to see a doctor in the first place and much more effort must be put into the whole NHS asset, beginning with community pharmacy care and the role that it can potentially perform to alleviate the pressure on GPs.

I am very attracted by the concept of the resource hub. I also like the emphasis that Sir Lewis Ritchie puts on the definitions of "urgent" and "emergency" care and our job as politicians, and within the health service, to educate the public about the difference. At the moment, too many people are—rightly or wrongly—dissatisfied with the level of primary care provision as they see it and the opportunities that there are for that.

It was very interesting to read in the report patients' reasons for not accessing various services. Although many of those reasons were prejudicial rather than based on fact, some real things need to change there, too. It was interesting to see that, in people's minds, we are driving them—not literally—to hospitals rather than using the whole network. It reminded me that the Scottish Conservatives have advocated that, along with the annual council tax bill, there should be a health board statement in each region. Such a statement would not only detail what has been happening, in general terms, with health care in that region but would educate people and direct them to the correct access point for the service need that they have at any given time.

I will come back later to other issues. I finish now by saying that this is the great health debate—it is the big strategy decision that we have to make and it will dominate the next session of the Scottish Parliament. It is worth getting it right.

15:12

Nigel Don (Angus North and Mearns) (SNP): I start, as some other members have, by thanking the staff who work in our health service. I speak as someone who represents fairly widely-flung communities throughout Angus North and the Mearns. I am conscious that the staff who work in my local facilities have transport difficulties when everybody else has a transport difficulty and that they, too, suffer health issues. Somehow or other, in their various communities, they make it all work, and we are very grateful.

I thank Jackson Carlaw for his approach. I entirely agree with the idea that we really should be able to agree, across the Parliament, on our strategic planning. If we cannot, we have got it wrong. The timescales are so long and the inertia in the system is so big that we have got to get this right in principle and understand each other's position.

My communities contain a number of hospital facilities; sadly, even in the time available, I do not have time to discuss them. However, I bring it to the attention of members and, in particular, the cabinet secretary that folk like a local facility. The cabinet secretary will be well aware that Brechin infirmary is under some threat. The infirmary is next to a GP practice that, for its own reasons, is

unable to sustain that local cottage hospital—or community hospital, if I may use that term.

Community hospitals are a necessary add-on to GP practices. I have five of them in my constituency. My folk like a local community hospital. They are used to local hospitals, they value them, and they recognise that they have a cost. The costs arise in two ways. First, because there is a relatively low occupancy—sometimes the facilities are not occupied at all—there is a significant unit cost, if I may use that term to describe how we look after a patient. Far more important, where staff are in effect underutilised they are also very rapidly deskilled. That is a point that health boards need to get across to communities. It is a problem that I first met a long time ago when we were looking at ambulances up the rivers, in particular up in Braemar and Ballater. We can have an ambulance at every stop, but the people do so little that they rapidly become deskilled. We need to ensure that folk understand that.

I will pick up one or two of the important points that Sir Lewis Ritchie raised in his review—I am sure that members will pick up many others. I see the huge potential for shared records as an opportunity, but I am also a bit concerned, because, given that I sit on the Public Audit Committee, I get the impression that records are not always as shareable as they should be. We recognise that the boundaries between health boards are artificial—in the middle of my constituency they are wholly arbitrary—and we must make sure that the IT systems work in such a way that records can be accessible.

Sir Lewis Ritchie's report refers to video links and recognises that there are often cultural barriers to their use. It seems to me that if a doctor cannot come to someone's bedside, it might be entirely reasonable for a nurse to do so, with the appropriate video link. We do not seem to be making as much use of that as we should.

I turn to what I see as the biggest risk. I commend the cabinet secretary and the Government for what they are trying to do. However, it seems to me that integration joint boards come with a risk. I am not alone in saying that; the Auditor General for Scotland took that view in one of her recent reports. I have absolutely no doubt that everybody concerned wants to make integration joint boards work. I am concerned, however, that the people at leadership and governance level, who will come from one or the other organisation that might well have primary responsibility for aspects of what we are trying to integrate, will find it very difficult to know which hat they are wearing at any point in time and for the integrated services to become the dominant factor in their thinking. The leadership of our integration joint boards will be absolutely crucial.

It is relatively easy to come up with a vision statement, but turning that vision into changed processes, changed expectations of both staff and patients and increased satisfaction levels as a result of those expectations having been absorbed, is a huge challenge.

I hope that we can find leaders who will make that work and that we can instil in them the idea that this has to be for the whole population, not just the small section whom they previously looked after. I am concerned that we get the governance right. I have no doubt that the Government's intentions are entirely correct and that the legislation is right, but leadership is crucial.

The doctors, nurses, pharmacists, physiotherapists, advanced nurse practitioners in particular, district nurses and social service and care workers who will be part of the integrated services that we rely on in future come in well motivated. As Jackson Carlaw said, I am absolutely sure that people want to do a good job. I find it inconceivable that anybody who goes into those caring professions does not want to do a good job, develop their skills and provide care.

The Deputy Presiding Officer: Could you draw to a close please?

Nigel Don: All the Government has to do is provide those people with an opportunity to contribute. Our job is to make sure that they can do so effectively by ensuring that the governance around them is effective. I commend the Scottish Government's determination to make sure that they can do so.

The Deputy Presiding Officer: Thank you. I am afraid that there is not a lot of time in hand this afternoon, so I ask members to keep to six minutes.

15:18

Margaret McCulloch (Central Scotland) (Lab): I put on record my appreciation for the hard work and dedication of GPs. We as a society depend on their skills, experience, hard work and sense of duty to others. They are an invaluable profession; they are essential and their dedication should be acknowledged by the whole Parliament.

Before I deal with issues concerning the reform and redesign of services, I draw the Parliament's attention to the members' business debate that Patricia Ferguson secured at the end of last month.

In that debate, we heard about the challenges that face so-called deep-end practices, where the consequences of health inequalities are most

acute and severe. The life expectancy gap is a stubborn and stark reminder of the extent of health inequality in Scotland. Labour's amendment allows me to repeat the point that I made in the chamber last month that we need to do much more to understand the financial consequences of health inequalities for our public services and health budgets and we need to properly support practices on the front line in our struggle with health inequality.

There is no doubt that the causes of health inequality are complex. Tackling those root causes is not simply a question of resourcing GP practices; it is also a question of redistribution, regeneration, education and economic opportunity. However, the BMA and researchers from the University of Glasgow and the University of Dundee have shown that practices in the most deprived areas have 38 per cent more patients with multiple morbidity. They have also shown that the average spend per patient in those practices is lower than the spend in more affluent parts of the country and that GPs in deprived areas tend to have a higher workload. That is why many of us have called on the Scottish Government to examine the allocation of funding.

There is no doubt that our health services, including primary care, must overcome significant challenges if we are to make them fit for the future. There is consensus on that point across the chamber, in our healthcare professions and throughout the wider public sector. Demographic change, a rising workload, developments in medicine and medical technology, and pressures on funding all necessitate change in healthcare.

There is also a broad consensus on the principles that should drive the necessary reforms: preventative spend; shifting the balance of care; delivering new models of primary care closer to the community while developing specialisms and expertise in acute settings; and making better use of our pharmacists, nurses and allied health professionals. All that is common sense and none of it is new.

I will quote some recommendations from a report by one of the United Kingdom's leading health experts. He said:

"In planning the future of the NHS in Scotland we need to;

ensure sustainable and safe local services; redesign where possible to meet local needs and expectations—specialise where required having regard to clinical benefit and to access.

view the NHS as a service delivered predominantly in local communities rather than in hospitals; 90% of health care is delivered in primary care but we still focus the bulk of our attention on the other 10%".

He recommended

"preventative ... care rather than reactive management"

and developing

"new skills to support local services; generalists as well as specialists, nurses and allied health professionals as well as doctors".

That could have been an extract from the minister's speech or from a recent briefing from the BMA, but it is not; it is from a report by Professor David Kerr for the Scottish Executive that was published over a decade ago.

The pace of change that we have seen in the years since that report was published does not match the scale of the challenges before us. If it did, we would not be where we are now. Thirty-two per cent are considering retiring from general practice; 92 per cent say that their workload has negatively impacted on the care that patients have received; primary care's share of the budget is going down; and in acute care, we also have reports of a crisis in medical recruitment and in A and E.

In NHS Lanarkshire, even out-of-hours primary care services are being centralised under a Government that promised to keep health local. The health board is not driving reform from a position of strength; it is reacting to a shortage of GPs who are willing to work in that service. It is all reactive and it has been reactive for too long.

Many of the challenges that our health services face, whether in primary care or acute care, are related, and they have been foreseeable for some time. Negotiations over the new GP contract are of the utmost importance, as are questions of resources and training. I commend Richard Simpson's work on those issues. We need to shift the balance of care, but we cannot do that unless we support our GPs with models of care that are fit for the future.

15:24

Sandra White (Glasgow Kelvin) (SNP): I am pleased to be able to take part in this important debate. Like Jackson Carlaw, I thank the Scottish Government for the content of the motion, particularly the recognition that it is challenging to recruit and retain GPs. I also welcome the cabinet secretary's commitment to tackle that issue.

I want to reply to the comments of Dr Simpson—who appears not to be here—and Margaret McCulloch. We have heard about the Labour Party in Wales. I think that we should hear about what is happening here in Scotland and the care that we are providing. Primary care in Scotland is outperforming others parts of the UK. I wonder why the Labour Party has not mentioned that. A survey in 2013-14 has shown that 87 per cent of people in Scotland rated the overall care

provided by their GP surgery as good or excellent compared with 85 per cent of people in England.

I could go on about how good the health service is here, but I will not be petty, which is how the Labour Party appears to be acting today. Its members' behaviour earlier could point towards some form of healthcare for themselves rather than anything else. It was a dereliction of duty to attack this Parliament and the Presiding Officer, but maybe they will grow up in time. I will leave that thought with the Opposition Labour members and let them get on with things.

I welcome Sir Lewis Ritchie's report and his 28 recommendations. I think that Professor Mercer was involved, too. Recommendations 1 to 4 reflected the need for better, innovative models of care that will improve co-ordination and communication. That is absolutely correct, and communication is important.

Recommendations 8 to 19 reflected the need for compelling and pressing action to shore up and rapidly enhance the capability of an increasingly diverse and multidisciplinary workforce. I think that that has been mentioned in the debate. We must work and learn together more closely and effectively around patients and carers' needs. That is important, because we are talking about the needs of patients and carers. I would emphasise the word "carers", because they have not been mentioned much at all in the debate. Carers need help, too. Indeed, some are not in the best of health themselves. Sometimes, they have to care for elderly parents; sometimes, they have to care for young disabled children. Carers are an important part of the equation.

The most important recommendations, which Nigel Don touched on, are on the potential roles of health and social care partnerships and integration joint boards. South Lanarkshire has been mentioned, and Greater Glasgow and Clyde NHS Board is in my constituency. We do not have a level playing on health and social care integration across local authorities or on what is delivered. In Glasgow, a huge number of people are being kept in hospital. Glasgow City Council social care services has told me that each area service is given a set target number of placements that it can make in each month. That does not happen across the board.

Health and social care integration is needed to ensure that we do not have bed blocking. The NHS should not have to pick up the tab. Although that is not how it is supposed to work with integration, that is how it works in Glasgow. That is sad, because people who could be being cared for at home are instead languishing in hospital beds and not getting the proper care or treatment. Basically, the hospital wants to get those people out because they would benefit from staying at home or in a care home.

Neil Findlay (Lothian) (Lab): Will the member take an intervention?

Sandra White: No, I am sorry, but I will not take an intervention.

When we look at primary care and integration, will we have data from each local authority to show that the bodies are working together? I know that in South Lanarkshire they work well together and the practice is very good; that is also the case in West Lothian. However, for an unknown reason, Glasgow seems to be lagging behind. Whether that is by choice or not, I do not know. I have certainly tried to ask why that is, but I have not been able to get any answers, apart from the admission that targets are looked at each month. I would ask the cabinet secretary to pick up on that particular issue.

As part of its inquiry into age and social isolation, the Equal Opportunities Committee heard that some people, particularly elderly people, turn up at their doctor's surgery not because they are unwell but because they are very lonely and have no one else to talk to. The committee talked about using link workers in practices, who can identify such patients and ease the pressure on doctors' time by pointing people to a voluntary service—the voluntary sector is important in the integration of health and social care—that might be beneficial to their mental and physical health. Perhaps when the Government is considering primary care and the lowest common denominator in that regard, it will consider whether there is a role for link workers.

15:30

Drew Smith (Glasgow) (Lab): The report from Professor Sir Lewis Ritchie is a good one, which makes sensible points about the reform of out-of-hours primary practice.

I agree with much that members, including Richard Simpson, said about the extent of the primary care crisis. That said, I will also support the Government motion and the Liberal Democrat amendment.

Rather than focus on out-of-hours care, I want to talk more broadly about GP provision, in particular in the poorest places. I am assisted in that regard by an email that I received yesterday from a constituent, who is in general practice in Glasgow and has expertise in homelessness and addiction heath services.

Margaret McCulloch was right to talk about the concerns that GPs at the deep end have expressed throughout this parliamentary session. I have met the deep-end group several times, as

many members have done, but I have always been somewhat at a loss to suggest what practical changes have been proposed that will resolve some of the problems that those GPs face. My constituent got in touch with me yesterday because she wanted to highlight comments that Peter Cawston made on behalf of the deep-end group. I hope that it will be helpful to members to hear some of those comments later.

At the beginning of this month, Professor Graham Watt published a paper in the *British Journal of General Practice,* which showed that the poorest 40 per cent of the population, with 47 per cent more complicated multimorbidity—that is, either five or more conditions or the combination of mental and physical health problems—receives 8 per cent less GP funding per patient per year.

Not only is that a matter of social justice but it has a profound effect, in that it inflates the cost of running the national health service and undermines the prosperity of the whole country. When the people with the poorest health cannot access the same level of preventative and long-term care in the community as is enjoyed by the more affluent, they become sicker sooner and end up costing far more in hospital admissions and A and E attendances than they would otherwise do. If the average age at which the workforce develops long-term illnesses in some communities is 10 years before the age of retirement, there is a devastating effect on the local and national economy.

At First Minister's question time a few weeks ago, I was interested to hear the First Minister say:

"I welcome Professor Watt's findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula ... The new GP contract, on which we are in the early stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices".—[*Official Report*, 3 December 2015; c 21-2.]

That day, the First Minister quoted figures that show that the least deprived 10 per cent of practices receive a slightly lower level of payment per patient—£7.65 less per patient per year—than the most deprived 10 per cent receives. However, that is correct only when we compare the extremes. Professor Watt's paper compared the poorest 40 per cent with the most affluent 60 per cent, so he covered the whole patient population in Scotland. What the First Minister did not say was that complicated multimorbidity is twice as prevalent in the most deprived 10 per cent as it is among the most affluent. None of that is reflected in how general practice care is funded.

Dr Cawston has said that it is time to move on from debating points about small differences in funding and to recognise the huge differences in premature morbidity across the social spectrum and the need to account for them, on a pro-rata basis, in the new contract formula. The issue is not necessarily about taking funding from affluent areas to give to poorer areas. All practices have common cause in highlighting that during the last decade there has been a 20 per cent reduction in NHS funding of general practice relative to the rest of the NHS budget.

Quite simply, the NHS's focus has been on additional investment in the most expensive part of healthcare—acute care—while there has been disinvestment in preventative general practice care. The GP contract and the change to integrated health and social care must rectify those mistakes and ensure that general practice as a whole is funded in such a way that we do not need to withhold care from the poorest in order to ensure that we can continue to provide care across all areas of the country. If we do not get that right, we will continue to fund an NHS that contributes to health inequalities and becomes less and less sustainable in the long term.

Sandra White talked about the reality of what is going on the health service. She might be interested to hear about my constituent, who is a Glasgow GP who has worked in an economically deprived area for 16 years. She says:

"In many ways I believe we provide a very good service and we have a high level of satisfaction among our patients. We recently surveyed patient calls and found that we had a 25% higher demand for appointments than the number expected nationally. While we also found that we were providing 10% more appointments than the nationally recommended level, it is no solution to expect those of us working in poorer areas simply to work harder. These are not the figures that worry me however. I am especially aware of all the people who aren't calling for appointments, or who have so many things to talk about when they see me that they neglect to mention those things that really matter, like an early symptom of cancer. Many of my patients have learned to survive adversity by having very low expectations and by accepting that they are 'old' when in their fifties. They are the people who are paying the true price, with their lives, for maintaining the status quo."

Unmet need is what we should be focusing on, and I commend to members the work of the deep-end group. Unlike the Government motion, Dr Simpson's Labour amendment mentions differential funding, so I will support it at decision time, and I commend others to do so.

15:37

Bob Doris (Glasgow) (SNP): We all know that there are significant challenges to delivering healthcare, given the demographic trends that present us with an ever ageing and increasingly frail population. We celebrate our longer life expectancy, but we must show determination to boost poor statistics on healthy life expectancy, as members have mentioned.

We know that, as they grow older and frailer, the vast majority of older people wish to stay in their homes, with support as required, for as long as possible. It is true that, as part of the process, we want to see a shift from spend on the acute sector to spend on primary and community care.

Strangely, I commend what on first glance looks like an entrenchment of spending in the acute sector. I refer to the £200 million investment to enhance capacity at the Golden Jubilee hospital in Clydebank and the creation of six elective surgical hubs across the country. As we have an increasingly ageing and frail population, cataract surgery, knee replacements and hip replacements become increasingly important to sustain older people in their homes for longer. If we do not take the strategic decision now to increase capacity, whoever the Government is in five or 10 years' time will be told that planning just was not in place five or 10 years ago. That spending decision has been taken now. Fundamentally, it is connected to ensuring that we can sustain people in community social care for longer. I wanted to put that on the record.

We need to do better on the interaction between health and social care integration and acute sector spend. I note that only two of the integration joint boards—Dumfries and Galloway, and Argyll and Bute—have acute sector spending as part of their combined budget. Other integration joint boards are missing a trick. After all, they will be looking at rehabilitation and enablement services for older people in communities. They will be looking at prevention of slips, trips and falls at home. In the acute sector, whether it is emergency treatment through the door of A and E or early intervention and preventative surgical interventions through the new acute hubs, there has to be a better integration of funding. I do not think that we have the balance right, although I accept that that is a decision for the integration joint boards.

I welcome the real progress that has been made in Glasgow in relation to the integration of health and social care. Sandra White gave us the specific example of care homes qualifying to provide free personal care for the elderly, and I recognise the issue that she raises. On delayed discharge, Glasgow has done well in recent months. David Williams, who gave evidence to the Health and Sport Committee this morning, talked about that. He is the chief officer designate for the shadow integration board in Glasgow and the head of social work at Glasgow City Council. That shows that, when there is a real focus, drive and determination on an integrated basis within the city, we can get it right. Indeed, the targets in Glasgow are being exceeded in some cases.

We need health and social care integration to similarly improve community health and social care, alleviate pressures on GPs and see the development of integrated health and social care teams that are attentive to the needs of the community and are shaped in a way that is meaningful to the integration joint boards via locality planning.

GPs are central to that process. I am delighted to see that QOF is going—that is a significant achievement—but what will replace it? The negotiations that are taking place in the vacuum that is left are just as important as the fact that QOF is going, and the new GP contract is a real opportunity to direct funding where it is most needed. Will it allow us to focus on tackling health inequalities, particularly in our most deprived communities? Will the integration joint boards be able—preferably in a co-production model with GPs at the most local level—to shape a more localised model of GP provision and how that interacts with the wider health and social care integration within communities?

Whether it is community pharmacists, physiotherapists, speech and language therapists, care-at-home staff, occupational therapists, nurse specialists or whoever, they will have to be part of a combined health and social care team, and GPs will have to have confidence in those teams irrespective of whether they are employed by GPs, health centres, the integration joint boards or whoever. If they do not have confidence in those teams, GPs will continue to refer directly to the acute sector, and that is part of the issue. We want GPs to have more tools in the box and to be able to refer to community disposals for health and social care needs.

People say that not enough is going on, but there is a huge amount going on, and there are a huge number of successes. I have not dwelt on the successes in my speech because the Opposition would have called that being complacent. Nevertheless, significant structural change is taking place and the benefits are starting to emerge. I am glad that there has been a significant degree of consensus in the debate, and I hope that that continues going forward.

15:43

Nanette Milne (North East Scotland) (Con): I am pleased that we are being given the opportunity today to discuss the way forward for primary care in Scotland. Throughout my time in Parliament, we have heard of an impending crisis within the NHS as more people are living longer, with many people in their senior years coping with complex health problems.

The Scottish Government's 2020 vision is what we all wish for—being able to live at home or in a homely setting for as long as possible, avoiding

hospital admission unless we really require specialist in-patient care and then returning to the community as soon as possible with the support services that we need in place. However, the system is currently creaking at the seams due to doctors retiring early, an ageing nursing workforce, young medical graduates being unwilling to face the stresses of general practice and difficulty in recruiting the good home carers that are essential if the frail elderly are to sustain a reasonable quality of life within the community.

I supported the 2004 GP contract because of the difficulty at that time in recruiting young doctors who were prepared to undertake the 24/7 on-call responsibilities of their predecessors. That contract has now run its course and recruitment has fallen again—this time because the demands on the service are leaving GPs with too little time for face-to-face contact with the patients who really need their expertise, and a workload that is stressful and which is leading to a less than satisfactory work-life balance.

Because of the undoubted challenges that are facing the system, it has been all too easy for opposition political parties to attack the Government on health issues which I frankly think—as Jackson Carlaw does—is not good either for patients or for the NHS staff who, in the vast majority of cases, provide a tremendous service for patients, most of whom are very grateful for the care that they receive. I am therefore glad that there now seems to be some consensus developing on the way forward.

The excellent report that was published recently by Sir Lewis Ritchie on out-of-hours care gives an in-depth analysis of the current situation and a comprehensive assessment of what is needed for a sustainable and—to quote Sir Lewis's report—"seamless service" that not only meets the needs of patients but offers

"a valued working and learning environment for all those delivering health and care Services—whether that be NHS, local authority social services"

or the third sector.

The thrust of the recommendations is that there is a need to develop multidisciplinary teams that include GPs, nurses, AHPs, community pharmacists, social care and other specialists all working together to secure the best out-of-hours care for patients in urgent-care resource hubs across Scotland.

Sir Lewis Ritchie's recommendations for out-of-hours care would sit well with the daytime integrated health and social care service that is envisaged by most experts who have considered the issue, and with the Scottish Government's plans to transform primary care services in the light of the demands of an ageing population, and as health and social care services are integrated. I look forward to the Government's detailed response to the out-of-hours report early next year, and to how it proposes to implement it nationally. I also look forward to hearing the detail of the new general medical services contract that is currently being negotiated with the profession. I am pleased that the Government has now announced the end of the QOF, which has undoubtedly outlived its usefulness.

The future of primary care is clearly at a crossroads at the present time, and the BMA and others point the way forward by stating that the role of GPs and other primary care professionals must be to make best use of the unique skills of each, with proposals that GPs become more involved in complex care and system-wide activities, and that the more routine tasks become more reliant on other health professionals in the wider community team. As senior decision makers, GPs would be seen as the expert generalists in their communities, able to support their local teams where their specific expertise is required.

As has been emphasised by the BMA, the core of general practice that is expected by patients and is the basis for learning the necessary skills has to be personal contact with patients who are, or who see themselves as being, unwell. However, because of limited capacity, there will have to be a balance struck between access to GP appointments, access to other health professionals including nurses and community pharmacists where that is more appropriate, and encouraging supported self-care where appropriate, aided by the use of modern communications technology.

For that to be acceptable to the public, effort will be needed to explain why the changes are required and how they will work. Practices would become the patients' gateway to appropriate services, and would be overseen and managed by GPs to ensure that patients get the care that is best suited to their needs. For that to be effective, GPs must be at the core of health and social integration at locality level. Indeed, if they are not significantly involved and engaged with integration joint boards, I cannot see integration being successful. As I understand it, that involvement is currently patchy across the country.

It is never easy to change the way we work, and health and social care professionals come from different cultural backgrounds. They will need support to learn different ways of working together with mutual respect for each other, as they seek the best outcomes for the patients in their care. That is already beginning to happen, and there are many good examples of professional co-operation, not least in my region.

For example, the NHS Grampian out-of-hours model employs a significant number of advanced nurse practitioners—all of whom are, or are training to be, independent prescribers—in the main centre in Aberdeen alongside GPs, team members from the Scottish Ambulance Service, community psychiatric and district nurses, Marie Curie nurses and on-site pharmacy provision, and are collocated with NHS 24. Different arrangements apply in the rural centres, where help is available from the main centre via video and telephone links.

If primary care is once again to attract and retain young medical graduates, every indication is that we have to develop team working involving all health professionals, including nurses, AHPs and pharmacists working together with social care and the third and independent sectors. If we can achieve that—at the moment, there is the will, but there is a long journey ahead—we can build a sustainable system of good care in our communities. I think that we are on the cusp of some exciting developments in primary care. I am just sorry that I will not be in Parliament when they come to fruition.

15:50

Mike MacKenzie (Highlands and Islands) (SNP): I am pleased to speak in this important debate. I know from the opposition parties' amendments that the core of their argument seems to be about allocation of resources: they want more resources to be allocated to primary care. I agree with them—it would be good to allocate more resources to primary care. It would be good to allocate more resources to healthcare in general; in fact, it would be good to allocate more resources to every aspect of expenditure that is devolved to this Parliament. That is why I opposed, and will continue to oppose, the economically illiterate austerity policies of the Opposition.

The fact, however, is that we are living in an era of austerity. We saw austerity under the previous coalition Government in Westminster; now that the spending review has been published, we are seeing yet more austerity going on into the future. It might be said that that is what the people voted for in the recent Westminster election and that that was their democratic choice. It is, indeed, what the people of the United Kingdom voted for, but it is not what the people of Scotland voted for. Overwhelmingly, the people of Scotland rejected austerity.

Jim Hume: Will Mike MacKenzie take an intervention?

Mike MacKenzie: No, thank you.

Jackson Carlaw: Will the member take an intervention?

Mike MacKenzie: No, thank you.

Mike MacKenzie: However, thanks to the democratic deficit in our constitutional arrangements—Smith or no Smith, Scotland act or no Scotland act—we are stuck with austerity. I remember that in the last Scottish election, the Scottish National Party Government made a manifesto commitment to ring fence health spending—something that Labour, which is the main Opposition party, refused to do. That is what the SNP committed to do in this Parliament and that is what we have done. The Labour Party refused to commit to ring fencing the health budget, but neither did it promise to increase it.

Jackson Carlaw: On a point of order, Presiding Officer. I wonder whether Mike MacKenzie intends to address himself to the terms of the motion that is before us for debate this afternoon.

The Deputy Presiding Officer: As Mr Carlaw knows, that is not a point of order. However, the point has been made.

Mike MacKenzie: In noting that, I urge patience, because all will become clear.

The Labour Party refused to commit to ring fencing the health budget, but neither did it promise to increase it; the Labour Party amendment is therefore disingenuous.

With regard to primary healthcare, very good arguments can be made for increasing resources.

Dr Simpson: Will Mike MacKenzie take an intervention?

Mike MacKenzie: No, thank you.

There are also good arguments that can be made to increase funding for every other aspect of healthcare. However, what the Opposition members fail to do—as always—is say where the cuts will fall in order to fund increased allocation of resources to primary care.

Jim Hume: Will the member take an intervention?

Mike MacKenzie: No, thank you.

Jim Hume: Please.

Mike MacKenzie: Perhaps later, but not just now.

Against that background of austerity, falling public budgets and cuts to our block grant, I am pleased and proud that the Government has maintained health spending. I am pleased that it has been possible to increase primary care spending by almost £80 million and I am pleased that we have recently announced a further

£60 million for the primary care development fund. I am pleased that the number of GPs in Scotland is at an all-time high, and I am pleased that we are increasing training places for GPs from 300 to 400 a year from next year. I am also pleased that we already have fewer patients per GP than either England or Wales—I think that Sandra White touched on that fact—and that the Scottish Government has announced that it will work with the BMA to dismantle the quality and outcomes framework system of GP payments, thereby reducing that bureaucratic burden on all of our GPs. I am pleased that the Scottish Government has recognised the teamwork approach to delivery of primary care and the vital role that is played by nurses, community pharmacists and physiotherapists.

Jim Hume: Will the member take an intervention?

Mike MacKenzie: No, thank you.

Primary health care is important. Health care is important. As we move increasingly towards patient-centred delivery of health care, it is important to realise that the patient, too, has a role to play in remaining healthy and maintaining a healthy, active lifestyle.

In terms of healthcare, we are fortunate to be living in the 21st century. Looking back, many of the big improvements in public health outcomes have been made by improving lifestyles and the environment in which we live. For example, public water and sanitation systems delivered huge improvements in health. That is why we must maintain our momentum in the drive to reduce smoking, to improve our relationship with alcohol, and to encourage active lifestyles.

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

Mike MacKenzie: Most of all, we must recognise that the biggest current threat to better public health outcomes is rising inequality. We must renew the fight against austerity which—with cuts falling, as always, on the shoulders of those who are least able to bear them—inevitably has the effect of increasing inequality and all the health problems that go along with it.

15:56

Neil Findlay (Lothian) (Lab): I am pleased, too—I am pleased that Mr MacKenzie's speech lasted only six minutes, and that we did not have to listen to another second of it. I was going to say that it is a pleasure to follow Mr MacKenzie, but I would be lying, so I will not.

In response to the appeals from some members that we should not make the NHS political, I have to say, "Get real." The fact that we have a socialised healthcare system that is funded via taxation is hugely political in itself, and always will be. For politicians to say that health should not be political is at best naive and at worst downright stupid. They should try telling that to the people in America, who have been tearing each other apart over the future of their healthcare system.

The backbone of our healthcare system is the dedicated and committed staff on the front line. We all acknowledge that—as many members have said—we owe a tremendous debt to social care workers, community nurses, midwives, community psychiatric nurses, AHPs and GPs. Those are the folk who hold the system together, and without them our hospitals would be even more full and under more pressure than they are at present.

However, those people do not want patronising warm words: they want action. Those very same people are coming under pressure as never before. The ageing population and patients with multiple complex needs, combined with a crisis in GP recruitment and cuts to student numbers, have created the perfect storm. In my area, the clinical director of the West Lothian health and social care partnership has said:

"there is a serious nationwide ... crisis in general practice."

I wonder whether the cabinet secretary agrees with that statement. Perhaps in her summing up she can answer the question whether she believes that there is a "crisis in general practice". "Crisis" is the word that I would like her to address.

A system that is working well should have sufficient GPs, nurses and home care staff all working seamlessly and taking actions to ensure that people are treated appropriately and in the right place. If someone can be treated at home with the right care package put in to support them, that takes pressure off the GP surgery and allows the doctor to address more pressing and complex cases.

That is part of the solution in Sir Lewis Ritchie's report, but I would like to it to be taken a step further so that it matches the approach that we in West Lothian have taken for many years, where we have different services coming together in partnership centres. For example, we have GP practices, dentists, pharmacies, sport and leisure facilities, Jobcentre Plus, libraries and housing offices all together in new, modern state-of-the-art buildings to provide services, and services cross-referring to each other to address the needs of local people.

That is the vision that we should have for our public services. All that working together will improve people's health and wellbeing. Too often, staff shortages of one kind or another prevent that from happening. Last year, I spoke to a practice

that operates in one of the poorest communities in Scotland and it had gone for a whole year without having a health visitor. That is almost criminal and I do not believe that it would have happened in a community that has a different socioeconomic profile.

In the past few years, I have spoken to doctor after doctor in my region. Either they have contacted me and asked to speak to me, or I have contacted them because of problems that have been experienced by patients who have contacted me for assistance. Those doctors have been only too willing to raise their concerns and I thank them for their candour.

In the past year, we have seen 42 practices taken under the control of NHS boards as they buckle under pressure. Last year, in Lothian, the count was one in six practices having some sort of restriction on taking in new patients. Some of those practices' lists were completely closed and local residents were forced to go elsewhere to access a GP. That was in an area where the population is increasing significantly and the situation is going to get worse, especially as more than a quarter of GPs are within five years or less of retiring.

Dr Simpson: I want to update Neil Findlay on the restricted practice element. The figures that I received today from Lothian show that 32 out of 125 practices are now operating restrictions. That is a quarter of all practices in Lothian.

Neil Findlay: I thank Dr Simpson for showing the extent of the problem. When a GP retired a decade ago, their practice would have a healthy list of people who wanted to take on a partnership. Many practices now have zero applicants. If they are lucky enough to secure locum cover, they think that they have won the lottery and cling on to that locum like a limpet. Doctors tell me about coming into work early, working late, working through their lunch breaks, taking work home and working on their days off just to stand still. The reduction in bureaucracy will be welcomed because many doctors are at breaking point.

It is also getting worse for patients. Surgeries operate all sorts of systems to address pressures. We have doctors operating like supermarket butchers where a patient takes a ticket and they sit for as long as they have to until they are called. Others are now assessing people on the phone. That might be necessary to deal with a short-term problem, but we could end up with that being embedded in our system and I do not think that it is acceptable.

I am sorry, Presiding Officer. Time was tight so I will finish there.

16:03

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I am almost certainly the third speaker in the debate whose naissance predates the founding of the health service. When we are talking about redesigning primary care, it is as well to think about the process of change that there has been.

Family tree research is one of my interests so I regularly see death certificates from the 1880s and 1890s and, under cause of death, they simply say "old age", "senility", "decline", "decay" and "no medical attendant". Access to medical advice and doctors has come in relatively recently. In 1908, Lloyd George set in process the legislation that ended up as the National Insurance Act 1911, which meant that a little contribution was taken from each wage packet to pay for healthcare. Indeed, to this day, my records, and those of many other people, are kept in medical folders that some of the older GPs still call Lloyd Georges because that is when they were introduced.

In the 1930s, the Highland health service set the pattern for much of the health service; post war, the Labour Government's greatest achievement was the establishment of universal healthcare free at the point of supply. My father was a GP in that service; he retired in his 70s in the 1970s.

The world has changed dramatically since my father was a doctor. In those days, it is interesting that we had only doctors, hospitals, nurses, dentists, chemists and opticians; we did not have urgent care centres, primary care emergency centres and community unscheduled care nurses. There are a whole plethora of other definitions, which are confusing to patients when they are exposed to them. The world—and care—would be rather better if we used simple titles for people. Page 64 of the report mentions

"Knowledge of who to turn to, what to do in the event of feeling unwell when the doctor's surgery is closed and which service to turn to first"

as a "common theme" in feedback from local discussion groups. There is considerable confusion because of the complexity that is presented to patients. Although we might need complexity under the surface to deliver the care service, we should look for simplicity in how we deliver it and talk to patients about our health service.

When my father was a doctor, it was incredibly easy. You just needed to know one telephone number, which was Cupar 3182. As luck would have it, the cottage hospital was Cupar 3128, so if you got the numbers muddled, you got one or the other and that was okay.

The world was, of course, different in all sorts of ways. My father used to write his prescriptions in

Latin, so it was “ter in die” rather than “three times a day”. The quantities were written in Greek in minims, so you had “deka minims” of whatever it was. Fortunately the pharmacist also spoke Greek.

My father was a rural doctor, and to this day rural issues remain a key problem for the health service. I am fortunate not to know the name of my GP because I have no need of contact with them, but in rural areas GPs are often distant from their patients and are isolated from the kind of help that many doctors in urban areas have. We must look at that further.

Out-of-hours provision, which has been referred to repeatedly throughout today’s debate, is more complex for the patient. I have only discovered while reading the material for this debate that the phone number for NHS 24 is 111. I did not know that; I have never had to use it or to consider what the number was. Previously I would have just looked it up in the phone book. At least I now know that.

Out-of-hours care is the area of the health service with the lowest satisfaction rating. Perhaps that should not be surprising, because when someone wants out-of-hours care, it is related to a crisis in their personal health. They are at a point where they are less likely to be tolerant and more likely to be critical. They feel a sense of urgency.

Technology is helping doctors and patients. Nowadays the health service is asking us all to do some health checks. I have just completed one of the regular health checks for those of us of my age, and I got the all-clear again, which is good news. My watch can tell me what my heartbeat is, and I checked it just before this debate. It was sitting pretty much where it should be, and the data is already being stored on a server in California so that it can be available to others.

However, the report says that information about people’s health history is not broadly available. Perhaps we should do something very simple: just take all the handwritten notes and scan them in. We are focusing on doing difficult things such as translating them into words and interpreting them, but there are other things that we perhaps ought to do.

Presiding Officer, in the last 10 seconds that you might grant me, I will say that I think that we are doing very well. The quality of care is incomparably better than it was 50 years ago, and when I was born. We can always do better, and as us old wrinklies get older, we will demand more. That is inescapable, but it is just one of the challenges that we are going to have to rise to.

16:09

Duncan McNeil (Greenock and Inverclyde) (Lab): I welcome the debate, which I think is the second debate on the issue in recent times, outwith debates on legislation. The more we have such debates, the better.

As has been described, we are on a journey of health and social care integration, and the redesigning of out-of-hours primary care is part of that journey. As Bob Doris rightly says, there is a lot going on, but there is frustration—although there is not the sort of carping from the sidelines that Jackson Carlaw mildly referred to—and we are all concerned about the lack of progress. Certainly, Audit Scotland is concerned and has identified a lack of progress on health and social care integration. It has identified risks in relation to governance and accountability, budgets, strategic plans and the workforce.

The Government can draw confidence from the fact that anybody who has been interested in the debate in the committees and the Parliament has supported it in dealing with the challenges that we face. There is the demographic challenge, which is complicated by long-standing health inequalities and the fact that people are living longer but with more complex conditions and ill health. That situation has not been brought about by the recent austerity; there has been a failure to deal with it over a period of time. As Campbell Christie once said, we have had lots of money during the Parliament’s life but some issues have not been dealt with. The issue is not simply one of money—of course it is not.

We are dealing with the workforce challenge, and the significant challenge of spending money on locums and a temporary workforce. That is not a good use of the finances that we have; it would be better to spend the money on prevention. We are concerned that the health workforce of the future—the workforce that will work in the community and deliver health and care at home—has not even been visualised yet. As far as the Parliament is aware, there has been no real discussion about what that workforce will look like in the future.

Of course, there is the financial challenge, which is ever present. We could not have picked a worse time to be on this journey. There was a time when the Parliament had more money—if only we had been wiser in using it.

There is also a cultural challenge. Some people find change difficult, whether they are professionals or care workers. It is challenging for people to have to work in a different area or to avail themselves of education or new experiences and training. It is challenging for someone to have to work out of a building that they have been

working in for 30 years. Nobody should underestimate those challenges.

It is interesting that we are celebrating what is a no-brainer. The people who work to provide our care and health services should work together. That is revolutionary stuff, we are told, but they should work together using all the skills to the maximum of their licence to ensure that our health service provides a quality service. What is revolutionary about that? Of course, underlying all that is difficult cultural change, so we should not dismiss it.

The Government must have confidence that the Parliament supports it on this journey. Those who are expected to make the changes must have the confidence that they will be supported to make them, that the appropriate investment will be placed where it needs to be placed and that the service will be supported to make change happen.

GPs are central to that, of course, but it is not solely their responsibility. They need to be confident, or we will not reach the objective of redesigning emergency out-of-hours services. If GPs are not confident that we have highly skilled care workers and social workers who are delivering quality services in our communities, they will not refer the patients they meet out of hours to community services. They all stand together. Unless we can give GPs confidence that the decisions that they make about people's care will be satisfied within the community, they will not refer people.

We have a big problem in that, in recent years, while we have protected the health budget, we have not protected local government budgets.

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

Duncan McNeil: In some cases, a workforce is being inherited that is demoralised, untrained and poorly paid. That needs to change.

16:15

Alison Johnstone (Lothian) (Green): I am pleased that we are debating this important issue this afternoon. It is so important that everyone in Scotland has the means and services to enable them to enjoy optimal health, and a properly resourced health service that is there for them when they need it. Without health and wellbeing, it is difficult to make the most of life's opportunities, and we know only too well the impact of inequality on health.

It really is essential that we do all that we can to ensure that everyone in Scotland has access to a GP when they need one, yet, as we have heard, that is becoming more of a challenge than ever before. This year, here in Lothian, practices in Ratho and Bangholm have struggled to provide primary care to patients. At the time, a constituent who lives in Ratho village wrote to me and told of the

"extraordinary position that we find ourselves in living in Ratho Village",

stating:

"We will have no doctor in the surgery for the next week. We have only had a doctor for two days a week for the six weeks beforehand."

My constituent advised that he had been offered an alternative surgery in Leith, which involves a journey of about 10 miles one way. In terms of cost and travel time, not to mention time off work or school, it is difficult to imagine a less convenient option.

Like many people, my constituent wants to understand the events and circumstances that led to that, and he asks that the local health board provides an explanation of the systems and planning that have led to the situation. He asks:

"Why has this happened?"

He used the word "extraordinary", and the lack of access to a GP is indeed unexpected, unusual and extremely worrying. There are many reasons why it has happened, but I am pleased to say that there are solutions.

We have moved from a position where there was intense competition for GP positions and several applicants for each post to one where, as reported in MSP meetings with NHS Lothian, interview dates have been cancelled due to a lack of interest in and candidates for an advertised post.

As GP vacancies increase, the burden on existing staff increases, adding to workloads that the BMA describes as being "already unsustainable." The BMA tells us, too, that morale among GPs is at an all-time low, that more GPs than ever before are leaving mid-career and that senior GPs are retiring early. I know one such GP, who told me recently that the bureaucracy that he was dealing with meant that he simply could not do the job that he had been doing before and the job that he wanted and needed to do. Unfortunately, he felt that he could not carry on. He worked in a practice in an area with many social challenges, and the loss of his skill, passion and experience will have a negative impact. I am pleased that the burden that is QOF is being removed.

We have heard, too, that there are practices with restrictions on their lists. For example, potential patients may be able to register only on certain days of the week. Lack of access to primary care often results in patients seeking assistance at hospitals, sometimes heading

straight to accident and emergency departments. In some cases, because patients have been unable to access primary care, an initially non-serious illness becomes acute and requires attention in hospital.

I welcome the Government's commitment to address the issue and the on-going work to agree a new GP contract from 2017, because it is clear that action is required. It is really important that we listen to and work with the profession to ensure that we get the change right. The Royal College of General Practitioners, the BMA and the Royal College of Emergency Medicine have been working hard on engaging with Government and parliamentarians.

Martin McKechnie, the vice president of the Royal College of Emergency Medicine, asks us to invest in GP training and retention in order to ensure that fewer patients head to accident and emergency departments for care. He credits the Government with increasing consultant numbers and asks that even more is done so that every hospital in Scotland can provide a 365-days-a-year service. He highlights the loss of graduate emergency registrars, a lot of them to Australia, and the RCGP tells us that many qualified GPs are leaving to practise abroad, and that insufficient numbers are undertaking GP specialty training. The RCGP has told us that GPs want to look after their patients and not the books. They want a more appropriate replacement for the QOF to evolve—one that works for patients and GPs. Further, the BMA asks us to recruit, train and value doctors and wants all parties in this chamber to work with it to support Scottish general practice.

We need to make being a GP in Scotland a really attractive career that attracts people in the way that it did before and to which GPs who take a break will return. I hope that the current work on agreeing the new contract will take those factors and more into account.

GP practices have worked on a small-business model since the 1960s. That might be the preference of many practices, but more and more GPs do not want to be partners and do not want to work full time; they might prefer to be employed by the practice or by the NHS. New models and changing contracts could make being a GP a more attractive career to a greater number of people.

Working with and listening to health professionals in this country will give us the possibility of developing and delivering a healthcare model that will better support those working in the NHS, helping them to keep our growing and ageing population well. Sir Lewis Ritchie's out-of-hours model makes a lot of sense and fully involves a range of allied health professionals in primary care in a transformative way that will have positive impacts on in-hours care.

It is important that, foremost in all debates on health, we focus on the need for a preventative approach. In that regard, the BMA's suggestion of providing a portion of fruit or vegetables to all primary school children in Scotland every day is well worth looking at, as is the living wage.

16:22

Richard Lyle (Central Scotland) (SNP): I start by commending the good work of dedicated health and care professionals in Scotland. They provide a vital service to ensure that the people of Scotland are healthy and receive the best care possible.

Effective front-line community healthcare is vital in helping people to enjoy life at home or in a homely setting for as long as possible. However, we currently face a challenge around recruiting and retaining GPs, and we need to address that problem to ensure that the people of Scotland receive the care that they need.

I support the current work to agree a new GP contract for Scotland for 2017, which will see bureaucracy reduced for GPs—I hope—to give them more time with patients, and will present the opportunity to go even further to tackle health inequalities in communities.

I will now talk about the integration of health and social care that is under way in North Lanarkshire. Integration is about local teams of professionals working together alongside partners, including unpaid carers, the third sector and the independent sector, to deliver quality sustainable care and services. The focus of integration is on ensuring that people get the right advice and support in the right place and at the right time.

Yesterday, a new timeline was published with key plans for how integration will be delivered in local areas. North Lanarkshire health and social care partnership is striving to ensure that the process is as understandable as possible. The aim of the timeline is to bring further clarity around the integration process.

Janice Hewitt, the chief accountable officer of North Lanarkshire health and social care partnership, said that the overall vision of integration is to ensure that the citizens of North Lanarkshire achieve their full potential through living safe, healthy and independent lives in their communities. She added that the partnership wants people to receive

> "the information, advice support or care they need, at the right time, every time, efficiently and effectively."

I hope that that example from North Lanarkshire sheds some light on how integrated health and social care at a community level can be achieved,

and I applaud the work of everyone in North Lanarkshire who is making that integration possible.

As a former councillor, I dealt with many patients who, unfortunately, could not get out of hospital on the day of their release because nothing was in place at their home. I also dealt with the fact that the hospital and the social work blamed each other for the delay. I am sure that, with integration, those problems will finally be resolved.

I turn to the out-of-hours service. People may not know that, from Monday to Thursday in an ordinary week, the out-of-hours service comes into play from 6 pm till 8 am the next day. On Friday, it comes into play at 6 pm and goes through the weekend till Monday morning at 8 am. The work of out-of-hours staff, doctors and drivers often goes unnoticed. As I have previously said, for more than two years before I came to the Parliament, I had the experience and honour of working part time as a driver for the out-of-hours service. I saw for myself the hard work done by all the staff who worked for the service. They were all well trained in customer service and dedicated to their work.

Next week, we will see our out-of-hours service put to the Christmas test once again. In the two years that I worked for the service, I worked the festive period—Christmas eve, Christmas day and boxing day—for the first time in my working life. It was not as quiet as many people think—it was very busy. It was an eye-opener for me to convey patients to their appointments. I saw for myself what the staff in our NHS have to cope with. Four and a half years on, I am sure that they will be even busier. When GP surgeries close next week, A and E and out-of-hours services will come more into play. During the period 1 May 2014 to 30 April 2015, almost 1 million contacts were made with primary care out-of-hours services and NHS 24 dealt with 1.3 million calls. I compliment NHS 24 on its triage work and its work to arrange appointments for patients. NHS 24 is the front line. Also during that period, A and E coped with more than 900,000 attendances and the Scottish Ambulance Service dealt with 500,000 999 and general practice urgent calls. The annual cost of delivering primary out-of-hours care reported by Scotland's NHS boards in 2014-15 was £81.8 million and NHS 24 incurred costs of £40.4 million, making a total of £122.2 million.

Staff working in hospitals and out of hours deal with many difficult pressures, particularly when they are delivering care during unsocial hours and through the night. Some staff work in isolated areas. I have been in areas of hospitals where the only people there were the out-of-hours doctor in the consulting room and me in the waiting area, along with patients. I suggest that some doctors do not want to work out of hours due to safety concerns, although I note that those concerns are being addressed.

I thank all who work in our health service. I wish them well over the coming festive period, and a merry Christmas and a happy new year. They look after Scotland's health and they deserve our support, all year round.

16:28

Jim Hume: We have had a good debate for the most part. It is encouraging that there is agreement throughout the chamber that we need to act urgently on primary care. We have different views on how, and on progress to date, but we agree that change is needed. As Bob Doris said, we need to see action from whoever is in government. One SNP member—I cannot remember which—mentioned austerity and what they would be able to do if they had—

Mike MacKenzie: Will the member take an intervention?

Jim Hume: I doubt that I will take an intervention from someone who did not take an intervention from me.

They failed to mention the £347 million—as reported by Audit Scotland—unspent by the Scottish Government in the past year. The SNP cannot really use that old, out-of-date excuse.

GP numbers are already fewer than they should be. Just today, we saw newly released information showing that the size of the average GP practice list has increased by 10 per cent since 2007. The Government has simply not done enough to avert a crisis. We are already seeing practices not accepting new patients on their lists. The cabinet secretary acknowledges that

"there is an increasing awareness of practices facing sustainability challenges across Scotland".—[*Written Answers*, 13 November 2015; S4W-28198.]

With more than a third of GPs set to retire within the next decade, the mid-point for recruiting GPs to replace those exiting the profession is about 740, but to further guarantee that general practice is sustainable we probably need 915 GPs. The Government needs to plan for demographic changes both among GPs and in the wider population—a point that many members made today.

The announced dismantling of the quality and outcomes framework for GP practices is a welcome step forward that will allow GPs to spend more time with their patients. It is a step in the direction in which we in the Liberal Democrats have wanted to move for a long time in order to allow doctors to do their jobs and put professionalism back in the profession. However,

it still leaves unaddressed the role that general practice and primary healthcare professionals will play in the integration plans this coming April. With only a few months to go, the last I heard was that only six of the 31 integration areas have agreed their plans, which is worrying—although of course we all wish integration to be a success.

Professionals in primary care services need reassurances, and they need proof of those reassurances. The Royal College of Nursing provides helpful recommendations on how to better redesign primary care. Nurses are already a vital part of primary care teams, delivering services in in-hours and out-of-hours settings, and they will naturally be affected by the GP contract changes. We can take this opportunity to bring about radical changes that empower nurses and make the most of their vast knowledge and skills. There are of course advanced nurse practitioners, whose role, working alongside other health professionals, can be beneficial to the whole community. They also offer the great benefit of freeing up time for other medical professionals to focus more on patients. In some remote areas, district nurses are the only providers of face-to-face healthcare.

While we are looking at using that resource, we must keep in mind the worrying trend of increasing nursing and midwifery vacancies. There are now more than 2,400 vacancies for nurses and midwives, 500 of which have been unfilled for more than three months. The RCN continues to warn about unsustainable vacancy levels, and we must listen to it. Last week, the NHS staff survey showed that 75 per cent of nurses said that there were not enough staff for them to do their jobs properly. Overworked staff are clearly the last thing that we want to see, not just for patient safety but for the wellbeing of those already hard-working NHS staff. However, almost 90 per cent of the staff in the survey said that they are willing and happy to go the extra mile at work when required, which shows that the first priority of health professionals is patient care.

The Scottish Government has to recognise the importance of health professionals and must support them to do their jobs. The Ritchie report should offer guidance on what steps should be followed. Although it is welcome that the Scottish Government brought this debate to the chamber, there is no point in our having it if the Government refuses to face the facts and rejects the realities on the ground. NHS staff, left and right, are warning us that the NHS is becoming unsustainable.

Nurses, GPs and pharmacists note that embracing and utilising the skills and clinical expertise of staff can provide innovation. Making the NHS a good place to work in and be treated in takes not only considerable financial investment—where such investment is necessary—but smart and practical guidance.

NHS staff are the most important asset in the NHS. We Liberal Democrats want to see any recruitment problems pre-empted and prevented. When the Scottish Government talks about redesigning primary care for Scotland's communities, it should start with redesigning its own approach to best serving the needs of staff working in our communities.

There is a critical need to align spending on health services with clinical need and capacity levels. Health and social care integration requires primary care to be put at the centre of integration. We need to do that by first recognising the risk to GP services. Health inequalities are a national disgrace and we need to address recruitment across the board in the NHS. Announcing an extra 100 GP training positions is not enough, and it means nothing when we can fill only 237 of the existing 300 positions at the moment.

We need to recognise the importance of GPs. They are a key part of delivering healthcare in Scotland. The Liberal Democrats will strive to ensure that Scotland has a robust NHS for generations to come.

16:35

Jackson Carlaw: There has been almost the first whiff of nostalgia this afternoon as we come to the end of the year and with just 11 working weeks of the session left. We heard from three of the self-appointed cheerio squad in the Labour Party: Drew Smith, Duncan McNeil and Richard Simpson will all leave us voluntarily at the end of the session. We heard from my colleague Nanette Milne, who is also retiring, and we heard twice from Jim Hume, whom the electorate of South Scotland will show good sense in retiring.

Possibly the most bizarre contribution was from Mr MacKenzie, who is not known to us in health debates. As far as I can recall, he has not participated regularly in them. It is clear that high command decided that a vital contribution was needed from him. I was reminded of my old maths teacher, who used to look at my homework and say, "Bilge. Supreme bilge." That is the best that could be said of Mr MacKenzie's contribution.

Mr MacKenzie ignored the fact that his colleague the former Cabinet Secretary for Health and Wellbeing, Alex Neil, confirmed in response to a written question that the health service in Scotland has received an additional £1.3 billion in consequentials arising from increased health spending at Westminster during this session. There has been no cut in health spending from Westminster and no austerity on health. By the

end of the next five years, we should see an additional £800 million annually for the health service in Scotland. However, that in itself is not the solution to the crisis.

Mike MacKenzie: Will the member take an intervention?

Jackson Carlaw: No. I am trying to help Mr MacKenzie, not to hinder him further.

Mr Stevenson interjected and I got worried, because I thought that he was traducing the reputation of his family somewhat when he concluded by saying that healthcare is "incomparably better" now than it was when his father was a GP. I am sure that that was not meant to be a personal observation; I will take it at face value.

We have come to a broad consensus that primary care is the key area of the health service that needs attention, investment and leadership. Nigel Don touched on the concept of leadership, which we discussed last week in relation to the integration joint boards. We talk about leadership as if it grows on trees, but it is difficult to nurture and to have it in something that is as huge and complicated as the NHS is. However, much of what we are looking to achieve will require political leadership as well as leadership in the health boards.

We need to educate the public. When young people come of age, having been covered by the health service since birth, I wonder whether the curriculum should include a proper session that educates them about what they can expect from the health service and about their responsibilities to their own healthcare as they go through life. As I have said, should we ensure that households have a proper annual statement that correctly directs them to where in their health board region the services that they need to access are? We assume that many people understand and know that, but they often do not. We talk about multidisciplinary teams operating in potential GP hub facilities, but I wonder whether the public know what we mean when we talk about multidisciplinary teams.

We need to ensure that first responders are encouraged. Conservatives believe—we make no apology for repeating this—that we also need to look carefully at GP-attached health visiting teams in a universal service across Scotland, with an additional concentration of that resource in areas of greater inequality, as Drew Smith and the fellow at the back of the chamber whose name I have forgotten—[*Laughter*.]

The Deputy Presiding Officer (John Scott): It is Neil Findlay.

Richard Lyle: Dr Findlay!

Jackson Carlaw: Mr Findlay also referred to that. In providing a second-to-none GP healthcare service, we also need to use it to assist in reducing inequalities.

The reality in Lewis Ritchie's report is that we are looking to a potential GP shortfall by 2020, and making the service into one that attracts new recruits is a challenge. We know that a considerable number of GPs are set to retire in the next five years. We also know—I do not in any sense mean that this is a cut—that the increase in overall health spending has masked a reduction in primary care funding from 9.5 per cent to about 7.5 per cent. That reduction needs to be reversed if what we are saying is to be given effect and meaning.

Of course, the health service funding issues would be resolved completely if we had £1,000 for every time Mr Doris said, "I want to put this on the record." He repeats that favourite phrase of his so regularly that it could save the NHS finances.

All parties understand that primary care is the principal challenge of the next parliamentary session. It is not that other areas of the health service do not need attention, too, but we need to get GP primary care services right for the future. We have talked about the 2020 vision for the health service. For a while, that date always seemed as though it was way off in the future, as 2001 did when "2001: A Space Odyssey" was released. However, 2020 is now four years away. We are close to it and we still have a lot of work to do to have a health service, and within it a primary care service, that will succeed in the face of the challenges ahead.

16:41

Rhoda Grant (Highlands and Islands) (Lab): I pay tribute to the staff. Those who work in the NHS, as well as those in local government who provide health and social care, are our most valuable asset. We need not only to tell them that they are valued but to go further and show them that they are valued. If we do not give them the right support, and if we ignore the needs of health and community care services, we do not show that we value staff. We must stop creating boundaries between healthcare and community care; we must give them parity of esteem.

We agree that people should live independently for as long as possible at home or, if that is not possible, in a homely setting. Regardless of where they are, they should receive high-quality care. However, primary and social care have been underfunded while we concentrated on funding acute care.

Mental health and learning disabilities services have also moved out of the hospital and into the

community without an adequate transfer of resources. That has had the unintended consequence of increasing pressure on acute care because, when people reach crisis point, there is no cheaper or easier intervention in the community. We must redesign services to stop that happening. Margaret McCulloch said that 90 per cent of healthcare happens in primary care and only 10 per cent happens in acute care. We must redesign our culture, which gives acute care greater esteem, in order to make the necessary change.

Back in 2011, we called for a full-scale review—a Beveridge 21, as Dr Simpson said—to create a health service that is fit for the 21st century. We were made aware of problems in the NHS by our constituents. Some were patients and others were staff, but they all had concerns about the direction of travel and the impending disaster. The Scottish Government rejected our calls and said that it knew what was wrong and how to fix it and that a review would take too long.

Had a review started in 2011, it would have been finished by now; instead, the Scottish Government has belatedly realised the scale of the problem and, four years later, has called for a national conversation. In the meantime, we set up two commissions—one was on health inequalities; the other was on social care—which have reported. Jackson Carlaw might think that that is yada yada yada but, sadly, it is the truth.

We raised concerns in good faith. Consensus politics works in both directions. Through raising our genuine concerns, we wanted to instigate change and improvement, yet that was dismissed as carping from the sidelines. Respect works both ways. I see raising our constituents' concerns not as being partisan but as being our duty. Therefore, I welcome the cabinet secretary's change of tone today.

I join the cabinet secretary in her fitting tribute to Dr Simpson. We will all miss his wise counsel and his knowledge of the health service. The fact that the cabinet secretary met him to discuss his paper, which is detailed, thought through and suggests positive solutions and ideas, shows a change of heart. I hope that she will give the paper the attention that it requires, because it shows a way forward for general practice, which is in crisis, as Neil Findlay, Alison Johnstone and other members said. We need to resolve the crisis in general practice if we are to deal with primary care.

Members talked about health inequalities, and Drew Smith talked about investment in preventative care and about the imbalance in resources for the most deprived areas, where resources are most needed. We have heard the deep-end GPs talk about the inverse care law, whereby the more need there is in an area, the less funding is received. Practices in deprived areas get more calls and requests for appointments, but they get less funding.

Drew Smith also made a point about something that we often miss when we talk about the inverse care law. We know that those who shout the loudest get the service, but we sometimes forget what low expectations people in deprived communities have, because they have been taught over a lifetime not to expect much. Because of those low expectations, people do not call for services. We need to change our approach to the services that we give people throughout their lives, so that we raise people's expectations and ensure that they get fair access to services, especially when they become unwell.

Duncan McNeil talked about demographics, which impact on health inequalities. It is good that we have an ageing population, because we want people to have longer, healthy lives. It is unfortunate that in deprived areas people's lives are shorter and the proportion of life that is spent in poor health is greater. That is surely wrong and we need to do something about it.

We need to invest in community care to relieve pressure on GPs, as Neil Findlay said. It is important that community care fills the gap, in relation not just to general practice but to acute care.

Richard Lyle talked about bed blocking. That happens because there are not the services in the community to enable people to get home from hospital or to prevent them from having to go into hospital in the first place.

Members mentioned the impact that Sir Lewis Ritchie's report could have. He talked about things that we know are required to keep people at home, such as resource hubs, as well as joint working and multidisciplinary teams—as Duncan McNeil said, that is the revolutionary approach of people working together. Surely that is almost a no-brainer. It is a bit sad that we need a report to tell us what is staring us in the face.

Duncan McNeil said that GPs need to have confidence in solutions in the community. If they are not confident about keeping patients at home, they will continue to refer people to acute care.

We need to look at new models of care. A number of members spoke about models in their constituencies. In Skye, in the context of palliative care, Macmillan Cancer Support and Boots the chemist have worked together and with care homes and GPs who look after patients at home to ensure that medications are right and that the right interventions are made quickly. That has saved a huge amount of money but, more than that, it has

provided good-quality patient care, which is what we are all striving for.

A number of members talked about staffing and the decrease in training over the past few years. In its report "Health and social care integration", Audit Scotland said that the staffing profile for joint working reflects past cuts rather than current need. The issue needs to be addressed quickly if integration is to work.

We welcome the debate. We need a step change in how healthcare is delivered. We have known for years that we need to move to preventative and community care, but we are still talking about it. There is consensus: we need a strategy and we need delivery.

16:49

Shona Robison: I welcome what has been a largely consensual debate.

I want to put on record my appreciation of the life of Dr Brian Keighley, whose memorial service I attended yesterday along with Richard Simpson and many others—in fact, it was a full house. Dr Keighley was a former chair of the British Medical Association in Scotland, and his involvement in medical politics went back many years. His death was certainly a big loss to Scotland; I pass on my condolences to his family.

I want to respond to as many comments as possible, but I apologise if I do not cover them all. Rhoda Grant mentioned Richard Simpson's paper and the fact that we had a productive meeting. It is fair to say that by and large what is in Richard Simpson's paper is already being done or is planned to be done. If that was not the case, I would be a bit concerned, given Richard's knowledge and the expertise of the people we have asked to build up the plan. There is synergy there and that is to be welcomed.

Richard Simpson asked a number of questions. He mentioned risk registers. I am told that every health board has one in place, but he can rest assured that, me being me, I will check that and ensure that that is the case. He also referred to the role of nurses. Although there has been an understandable focus on general practice, it is absolutely the case that the issue is about the wider primary care workforce, and the nursing workforce is of course critically important in that.

Richard Simpson will be aware that, in the past year, we have seen an increase of more than 500 whole-time equivalent nursing and midwifery staff, and we are projecting an increase of more than 600 whole-time equivalents over the course of this financial year. If he looks at investment in health visitors, he will see that a total of £41 million will be invested over the four years to 2018, which will increase the workforce by 500. A lot of investment is going into the wider workforce, but, as ever, there is more to be done, and we recognise that.

Jim Hume talked about the level of investment. He mentioned £40 million in one year becoming £60 million over three years. I think that £60 million is greater than £40 million, but there is always more to be done. I am sure that Jim Hume will recognise that that is a key priority for the Scottish Government when we look at the budget and beyond tomorrow.

Jim Hume also mentioned the percentage share of investment into GPs, as did a lot of members. Jim Hume asked me quite a lot of questions. I am always happy to provide answers to him, but the answer that he cited was a figure that was net of dispensing and reimbursement of drugs, and of course that figure can go down, sometimes because of more efficiencies being made in the system.

Jim Hume was also provided with an answer on expenditure on GP services in both cash terms and real terms from 2007-08 to 2013-14. He will recognise that in 2007-08 the amount of expenditure in percentage terms was 8 per cent, whereas in 2013-14 it was 8.1 per cent. I say that to show there has been continuity in the level of investment in percentage terms. However, the point has been made—which I accept—that, if we want to do more in primary care and ensure that people can get more of their treatment in primary care, we need to spend more on primary care. I hope that we can unite around that as a point of agreement.

I cannot allow Jackson Carlaw to get too carried away with the supposed largess of the UK Government when it comes to health. Jackson Carlaw said that the Scottish Government is due to receive £800 million over the next five years. However, I presume that he is referring to the figure of £8 billion that was widely understood in terms of UK investment. He will fully understand that in the budget—the UK Government's spending review—a good chunk of that £8 billion is a movement of resources within health. The UK Government has removed a big chunk of investment in public health and nurse bursaries to the NHS and has redefined what it means by the NHS to quite a narrow view of it. There are no consequentials flowing from that particular resource, so we envisage the basis for the consequentials to be around £4 billion, not £8 billion. I am happy to follow that up in writing with Jackson Carlaw, because it is important that we understand that there has been that in-year movement of resources, which affects what we will receive here.

Drew Smith talked about Professor Watt's report, deep-end practices, the Scottish allocation

formula and the need for us to ensure that there is more reflection of the needs of deprived communities in the resources that go to them through the formula. All those things are subject to negotiation in relation to the GP contract. However, we need to ensure that all the challenges that are faced by those practices operating in more deprived communities are recognised in the resources that are provided to primary care. I correct Drew Smith's reading of the motion. The motion clearly says that the new contract

"the opportunity to go even further to tackle health inequalities in communities".

I deliberately put that in the motion in order to recognise that point.

Duncan McNeil: The cabinet secretary has rightly said that more will be expected from primary care services and that there will be increased investment. How will we measure the outcomes, given that QOF is disappearing? How will people know that we are getting the outcomes for that increased investment and activity?

Shona Robison: Duncan McNeil will appreciate that there will be an interim set of arrangements for the transition year because the new contract is still subject to negotiation. That will be an important part of the negotiation. I think that, in the health service more generally, we need to move to a more outcomes-based approach, not just in primary care but in acute services, as we move forward. I assure Duncan McNeil that that work is on-going, and I am happy to keep him and other members apprised of progress.

The experience that Nanette Milne has brought to the Parliament as a former GP will be missed in the same way as Richard Simpson's experience. Although Duncan McNeil was not a GP to trade, he has, over the years, developed a real knowledge of healthcare services, and, as the convener of the Health and Sport Committee, he has brought a great deal of experience that will be missed. I am sure that this will not be the last health debate in which all those retiring members will take part—I do not want it to sound like that; I just thought that it was appropriate to pay tribute.

Neil Findlay talked about the situation in NHS Lothian. It is fair to say that some parts of the country face particular challenges and that those challenges are more of a focus in some parts of the country than in others. We would not be debating the future of primary care if I did not think that we had a challenge that needed to be addressed, and I am absolutely determined to address it. We have already made progress with the investment of £60 million over the next three years and the rapid dismantling of the QOF. All of that sends the important signal that we want Scottish general practice to be a success story.

I think that it was Nanette Milne who said that we need to be promoting Scottish general practice as a good place to come to work and train. It is important that we send out the message that, despite some of the many challenges that we have heard about this afternoon, with the plan, the support and the right investment we can make Scottish general practice a place where doctors want to come and work and, importantly, that young medical students who are choosing which specialty to go into will choose general practice and that we will see the results of that choice in the coming months and years.

The Presiding Officer (Tricia Marwick): That concludes the debate on redesigning primary care for Scotland's communities.

Point of Order

17:00

Sarah Boyack (Lothian) (Lab): On a point of order, Presiding Officer. My point of order relates to the stage 1 proceedings on the Land Reform (Scotland) Bill tomorrow. Our debate on land reform is taking place at 4 pm and we have yet to receive the response to the committee's stage 1 report from the Scottish Government. That does not aid our scrutiny of that important bill. Will you ask the Scottish Government to ensure that we have that important report to aid our scrutiny as soon as possible? It is now less than 24 hours before the debate.

The Presiding Officer (Tricia Marwick): Thank you, Ms Boyack. I saw that the Minister for Parliamentary Business was listening intently to your point of order. You are well aware that I have said on numerous occasions that I want as much information in the hands of members as possible to allow debate to happen, so I would like the Minister for Parliamentary Business to consider Ms Boyack's request urgently.

Business Motion

17:01

The Presiding Officer (Tricia Marwick): The next item is consideration of business motion S4M-15186, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a revision to the business programme for Wednesday 16 December 2015. I call Joe FitzPatrick to move the motion.

Motion moved,

That the Parliament agrees to the following revision to the programme of business for Wednesday 16 December 2015—

after

followed by	Stage 1 Debate: Land Reform (Scotland) Bill

insert

followed by	Financial Resolution: Land Reform (Scotland) Bill—[*Joe FitzPatrick*.]

Motion agreed to.

Decision Time

17:02

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

The first question is, that amendment S4M-15172.2, in the name of Richard Simpson, which seeks to amend motion S4M-15172, in the name of Shona Robison, on redesigning primary care for Scotland's communities, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Renfrewshire South) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stewart, David (Highlands and Islands) (Lab)
Wilson, John (Central Scotland) (Ind)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine 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)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
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)
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)
McArthur, Liam (Orkney Islands) (LD)
McDonald, Mark (Aberdeen Donside) (SNP)
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)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Rennie, Willie (Mid Scotland and Fife) (LD)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Scott, Tavish (Shetland Islands) (LD)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (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)

The Presiding Officer: The result of the division is: For 46, Against 63, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The second question is, that amendment S4M-15172.1, in the name of Jim Hume, which seeks to amend motion S4M-15172, in the name of Shona Robison, on redesigning primary care for Scotland's communities, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (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)
Findlay, Neil (Lothian) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Henry, Hugh (Renfrewshire South) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Hume, Jim (South Scotland) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Buchanan, Cameron (Lothian) (Con)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Carlaw, Jackson (West Scotland) (Con)
Coffey, Willie (Kilmarnock and Irvine 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)
Finnie, John (Highlands and Islands) (Ind)
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)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
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)
McDonald, Mark (Aberdeen Donside) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
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)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Liz (Mid Scotland and Fife) (Con)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (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)
Wilson, John (Central Scotland) (Ind)
Yousaf, Humza (Glasgow) (SNP)

The Presiding Officer: The result of the division is: For 36, Against 73, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The final question is, that motion S4M-15172, in the name of Shona Robison, on redesigning primary care for Scotland's communities, 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)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Biagi, Marco (Edinburgh Central) (SNP)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Buchanan, Cameron (Lothian) (Con)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Coffey, Willie (Kilmarnock and Irvine 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)
Dugdale, Kezia (Lothian) (Lab)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Finnie, John (Highlands and Islands) (Ind)
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)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Renfrewshire South) (Lab)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hilton, Cara (Dunfermline) (Lab)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Johnstone, Alison (Lothian) (Green)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Macdonald, Lewis (North East Scotland) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Malik, Hanzala (Glasgow) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McCulloch, Margaret (Central Scotland) (Lab)
McDonald, Mark (Aberdeen Donside) (SNP)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McMillan, Stuart (West Scotland) (SNP)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Liz (Mid Scotland and Fife) (Con)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, David (Highlands and Islands) (Lab)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (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)
Wilson, John (Central Scotland) (Ind)
Yousaf, Humza (Glasgow) (SNP)

Against

Hume, Jim (South Scotland) (LD)
McArthur, Liam (Orkney Islands) (LD)
McInnes, Alison (North East Scotland) (LD)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scott, Tavish (Shetland Islands) (LD)

The Presiding Officer: The result of the vote is: For 104, Against 5, Abstentions 0.

Motion agreed to,

That the Parliament commends the good work of the dedicated health and care professionals who embody the community health services; agrees that effective frontline community healthcare is vital to helping people enjoy life at home, or in a homely setting, for as long as possible; recognises the challenges being faced in the recruitment and retention of GPs; supports the current work to agree a new GP contract for Scotland from 2017, which will see bureaucracy reduced for GPs to give them more time with their patients, presenting the opportunity to go even further to tackle health inequalities in communities; welcomes Sir Lewis Ritchie's review of out-of-hours primary care and the Scottish Government's commitment to work with partners to implement his findings; further welcomes the planned increase in GP training places and support for return to practice schemes to aid retention and recruitment in general practice, and endorses the aims of the £60 million Primary Care Fund to test new models of care, support the primary care workforce and enhance patient access.

Perth (City of Culture 2021 Bid)

The Deputy Presiding Officer (Elaine Smith): The final item of business today is a members' business debate on motion S4M-14481, in the name of Liz Smith, on the Perth bid to become the United Kingdom city of culture 2021. The debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes Perth's bid to become the 2021 UK City of Culture; believes that it has a thriving arts, cultural and entertainment scene and a unique place in the history of arts and culture in Scotland, including the Perth Festival of the Arts, which was founded in 1972; understands that the bid will include the promotion of projects already in place, such as the Perth Theatre redevelopment and the Mill Street regeneration, as well as other proposals, including the redevelopment of the Perth Museum and Art Gallery and the development of new cultural attractions; believes that it is home to some of Scotland's finest collections including the Fergusson Gallery, and wishes Perth and Kinross Council well in taking forward the bid.

17:07

Liz Smith (Mid Scotland and Fife) (Con): I am grateful to have the opportunity to bring this motion to Parliament, and I immediately put on record my thanks to all the members across the chamber who have given the motion their support.

The UK city of culture competition, which is run by the UK Department for Culture, Media and Sport is—I think we all agree—a great opportunity for any UK city to both celebrate and promote its unique culture. Judging by what has been achieved to date by cities in the competition—for example, Derry/Londonderry in 2013, which I thought was absolutely fantastic—and what is planned for the future with Hull in 2017, the potential benefits are significant, so it was very welcome news that Perth and Kinross Council was putting together a bid for Perth for 2021.

Perth is, of course, at the very heart of Scotland's story. Once just beyond the very northern edge of the Roman empire, it is where ancient Scotland and the kingdom of Alba were forged; and it was, of course, once the capital and the crowning place of Scottish kings. Scone palace—immortalised in "Macbeth"—remains a lasting symbol of Perth's historic and royal connections, and was the most fitting venue when Her Majesty the Queen bestowed city status on Perth just a few years ago, in 2012.

In economic terms, Perth, intimately tied with the River Tay, has always been an important focus for employment, investment and trade. However, its rich cultural heritage is now becoming just as important. The fair city is the place that inspired Walter Scott to write "The Fair Maid of Perth", which inspired George Bizet's opera of the same name. Perth has therefore had plenty of reason throughout history to celebrate its culture, but it is ambitious to do so much more and to build on the highly successful Perth festival of the arts, which was founded in 1972; and on the magnificent art collections in the museums and galleries, including the Fergusson gallery, which celebrates the life and work of the celebrated Scottish colourist, John Duncan Fergusson, whose wife, Margaret Morris, was the pioneer of modern dance.

The city was home to glass producers including Vasart and Monart, which during their heyday of the 1930s were Scotland's answer to the French art-glass movement. The glass was celebrated for its vivid spiralling colours in the fashionable emporia of London and New York, and it put Perth—and Scotland—on the world arts map. Even today, Perth museum and art gallery is home to one of Europe's most important collections of glass, including the highly valued Vasart and Monart paperweights.

Perth is home to two theatres: Perth theatre, and the concert hall, which—apart from attracting Scotland's political parties for their conference seasons—has a remarkable record in hosting some of the finest international artistes in the world of music and drama. Perth theatre, which was constructed in 1900, is one of Scotland's oldest and most historic repertory theatres. We are all looking forward to the £16 million state-of-the-art redevelopment, which by 2017 will have built a new complex to house studio and art space, a youth theatre, a construction workshop and a series of front-of-house performance areas in addition to the main focus of the conservation and restoration of the historic Edwardian auditorium.

That is all part of Perth and Kinross Council's effort over the past two years to set out a long-term approach to develop the city's unique cultural assets and strengths, and to bring forward an investment programme that is focused on Perth becoming a cultural hub for the central part of Scotland.

Alongside the Perth theatre redevelopment, there is the Mill Street regeneration, and there are new proposals to further develop the Perth museum and the art gallery and exciting plans to develop a city cultural quarter. In short, it is a plan to ensure that Perth city becomes the most desirable place in Scotland in which to live, work, invest and enjoy a rich diversity of cultural experience, and a plan that will improve connectivity, develop the knowledge economy and strengthen the opportunities for business and tourism.

Being named UK city of culture brings with it the opportunity for the winning city to host UK cultural events such as the Turner prize, which was

awarded in Scotland for the first time in Glasgow's Tramway arts centre; the Man Booker prize; and the Stirling prize.

If the bid is successful, the whole of Perthshire and Kinross-shire could benefit from thousands of additional visitors, which could lead to an estimated £60 million boost for the local economy. Importantly, the bid has the potential to act as a catalyst for key regeneration projects. It is hoped that there could be long-term help for some of the neglected areas such as Bridgend, and a long-term future for St Paul's church.

As I mentioned earlier, it is only three years since Perth had its city status restored to mark Her Majesty the Queen's diamond jubilee in 2012. Perth's bid for the city of culture represents an exciting opportunity to put Perth, and Perthshire and Kinross-shire, firmly on the culture map of the United Kingdom, and to raise Perth's international profile.

I know that, to some extent, the UK city of culture 2021 competition is set to pit two of Scotland's great cities beginning with P against each other. I am pleased to see the member for Paisley sitting in the chamber, because I know that the bidding process, although it will be very competitive and intense, will nonetheless be good for all the cities that compete, as it will make them focus on what the future can deliver in terms of a diverse and vibrant arts culture.

As members will know, Perth is a relatively small city, with the population standing at approximately 47,000. However, I believe that that is not the important thing. The deciding factor ought to be what a city can offer in terms of important cultural diversity. The former Secretary of State for Culture, Media and Sport, Ben Bradshaw, said something very interesting when he announced the launch of the UK city of culture initiative. He said:

"Culture is something that we are incredibly good at in the UK. But excellence and innovation in the arts does not begin and end inside the M25 and I believe we have been too London-centric for too long in our cultural life."

I agree entirely with that comment.

The quality of the cultural organisations that are based in the area is exceptional. Those include Horsecross Arts, Pitlochry Festival Theatre, Perth Festival of the Arts and many more. Culture is central to the city's future aspirations, in terms of the economic benefits that it can deliver and its wider transformative power to improve the quality of life and build a sense of identity and civic pride across the communities.

I look forward to working with colleagues on all sides of the chamber, and I hope that Perth will be well considered in the competition.

17:14

Claire Baker (Mid Scotland and Fife) (Lab): I congratulate Liz Smith on securing today's debate on Perth's bid to be the city of culture in 2021. Liz Smith has expertly detailed the strengths of the Perth bid and it is fantastic to see that level of ambition from a city in my region. Perth is a beautifully located city that is investing in its arts infrastructure.

We increasingly recognise the cultural and social value of arts festivals across Scotland. Our arts and culture are hugely important for tourism, with visitors increasingly looking for an experience and engagement with a country's cultural programme when they visit.

The Perth festival of the arts was founded in 1972 and is now in its 45th year. It is one of the oldest continuous arts festivals in Scotland and has grown in strength in recent years with a much broader programme. The investment in the Perth theatre development and the Mill Street regeneration demonstrates a commitment to cultural investment by the city, building an identity for the arts and a commitment to a home for Scotland's talent. The redevelopment of the Perth museum and art gallery also gives improved opportunities to showcase their collection in the best possible way and builds on Perth's reputation as a cultural city.

Of course, Perth's cultural programme serves many more people than those in Perth alone and it acts as a hub for the surrounding area, so a successful bid would bring wider benefits to the Perthshire economy. This is a significant undertaking for Perth and Kinross Council and I wish it well in developing its bid proposal. As a member for Mid Scotland and Fife, I would be delighted to see Perth win the award and I offer my support for the bid.

The city of culture programme was launched in July 2009 by the Labour United Kingdom Government. It built on the success of Liverpool as the European city of culture in 2008 and demonstrated how a cultural award and focused investment bring cultural, economic and social benefits. Culture can be really transformative for an area, bringing rewards particularly for areas that have been hit by economic and industrial decline.

In the first year, 14 cities applied and Derry/Londonderry became the first city of culture in 2013. The title is held for a year with an award made every four years. The most recent winner was Hull, although Dundee was considered in the final four. It is interesting to consider what television producer Phil Redmond, chair of the city of culture panel, said. He said that Hull was the unanimous choice because it put forward

"the most compelling case based on its theme as 'a city coming out of the shadows'."

That demonstrates an important aspect of the competition, which is that it supports regeneration of a city and looks for transformational change when awarding the title.

There are other Scottish bids. I recently visited Paisley at the invitation of Neil Bibby MSP and met Mark Macmillan, the council leader, to talk about Paisley's bid and its aim to combine Paisley's heritage with a cultural vision for the future. There might be other bids from Scottish cities still to come. The cabinet secretary will know that the last time the award was bid for, Dundee and Aberdeen entered the competition. Although Dundee was considered in the final four, there is debate about whether Scotland should support one bid that could gather support from the Scottish Government. It would obviously not be a Government bid—the competition is for city authorities—but support from the Government might give more weight to a bid and lead to a successful Scottish bid.

I wish Perth well in its campaign. It has a significant base to build on, it has shown commitment to investing in its cultural capital and it would be fantastic to see the city being awarded this status.

17:18

Willie Rennie (Mid Scotland and Fife) (LD): I also congratulate Liz Smith on securing the debate. This is the first members' business debate that I have ever taken part in. It is such an important issue that I decided to speak in the debate.

The status of city of culture in 2021 would fit well with the city of Perth. It is the city of my birth and the city of my youngest son's birth. It is also the city where my oldest son attends college to study for a higher national diploma in technical theatre, which brings me neatly to the benefits of the Perth bid.

The city has such a thriving cultural community that it would live up to the aspirations of city of culture status. We can see clearly that it has some fantastic facilities in the concert hall, the museum and the art gallery. Perth Theatre is going through quite a significant period because of investment of £16 million, which shows the commitment of Perth and Kinross Council to the development of arts in the city and the wider area. There is also the Fergusson gallery, which Liz Smith mentioned.

However, I think that it is the deep heritage of the city that would make it a spectacular winning nominee for city of culture status. We have heard about its great history and the fact that modern Scotland was forged in Perth. It was the ancient capital of Scotland, where many kings were crowned—it competed with the great city of Dunfermline for that status. Perth also played a very important part in the Scottish renaissance, with Fergusson, Geddes and Soutar all linked with the city.

One of the strongest elements of Perth's bid is its community arts scene. Ad-Lib Theatre Arts is a drama school that encourages people of all ages to participate in the arts and music—I have seen its work first hand, and I know how good it is. That is just one example of many that exist in the city. Therefore, Perth would be a fitting winner of the competition.

As Claire Baker suggested, however, it is not only what Perth could do for the whole process, but what the process could do for Perth. Despite Perth's façade, it has pockets of poverty. The opportunities that are created from the process and the investment that would come with it would lift up many hundreds of people in Perth and the wider area who could do with a helping hand.

The combination of the facilities in Perth, its great community spirit and arts community and the potential of what becoming the city of culture could do for Perth and for the wider area makes the city a winning competition contender.

17:21

George Adam (Paisley) (SNP): I thank Liz Smith for bringing the debate to the Parliament. Some members may not be aware that I worked in the fair city of Perth for a number of years, so I am only too aware of its thriving arts, culture and entertainment scene. There is much to commend in Perth's bid to become UK city of culture 2021. However, in this week of all weeks, I will paraphrase the "Star Wars" saga by saying, "There is another." That town is the town of Paisley, which on 13 November this year launched its bid in Paisley's historic abbey. Perth may be the heart of Scotland, but the great town of Paisley is the centre of the known universe and its buddies have their eye on the prize.

It is interesting that Willie Rennie seems to have forgotten the university years that he spent in the great town of Paisley—he may not find himself a pint in the student union when he goes back to any alumni events at the University of the West of Scotland.

The two bids have many similarities. When we look at Liz Smith's motion, we see that redevelopment and regeneration are a major part of Perth's bid, and the bid from Paisley—with its museum and various venues—is the same.

Redevelopment and regeneration are, for me, the most important part of any bid, because they

have to do with what actually comes out of a bid—its legacy is the most important aspect. A successful bid would create the capital investment to ensure that Paisley has the capacity to have such an event. I am aware of Perth's concert hall because I have been there for various party conferences—although not recently, because the membership has become a wee bit too large now. We all miss going to Perth for conference, but Paisley has many venues too, including Paisley town hall, the abbey—which is also now being used as an arts venue—and the arts centre. They demonstrate Paisley's history and legacy and the importance of Paisley to Scotland in general.

We lack one major piece of capital investment. I am talking about a cinema and performance area, and the Paisley 2021 Community Trust plans to create a £40 million cinema and performing arts centre in the heart of Paisley—a 500-seat main theatre, five cinema screens, a cafe, a bar and a restaurant. That is on the back of work on the bid as well. The trust is using the model of the Glasgow Film Theatre. The screen machine, which normally goes around rural areas, was in Paisley County Square yesterday, showing "It's a Wonderful Life". I did not go to see it, because Stacey and I tend to leave that for a wee greet on Christmas eve, but it was good to see kids and everybody back in the heart of the town instead of at some out-of-town cinema and shopping centre.

As we have all said, any bid needs to ensure that it has public backing—it has to be owned by the people in the town. Our local newspaper, the *Paisley Daily Express*, has urged all buddies to back the bid by running a social media campaign using #WhyILovePaisley. We all know that I tend to come here just to say that, but I have been taking to social media to do it as well. What is not to love about Paisley, its history and the bid? What is not to love about the people and their passion for life or about what we have given the world, historically and culturally, from David Tennant to Gerard Butler, from Gerry Rafferty to John Byrne, from the weaver poet Robert Tannahill to the Rev John Witherspoon, who signed the American declaration of independence, and of course the world-famous Paisley pattern? All those things will be part of the bid that Paisley is pushing forward.

Regardless of who is successful in 2017 in bidding to become 2021 UK city of culture, I believe that the most important thing is regeneration. From looking at previous bids, it seems that that was the case for Derry and Hull—their bids were about what they could show for the future. Two of Scotland's great towns are bidding to become the UK city of culture. I wish Perth every success in its journey during the bidding process but, for me, the best option will always be the great town of Paisley. Watch this space and, as Benjamin Disraeli said,

"keep your eye on Paisley."

The Deputy Presiding Officer: Thank you, Mr Adam. I am glad that you briefly returned to Perth at the end.

17:26

Murdo Fraser (Mid Scotland and Fife) (Con): Perhaps I can bring the debate back to Perth from George Adam's galaxy far, far away in Paisley. I congratulate Liz Smith on securing the debate and thank her for the opportunity to contribute.

It is just three years since Perth was awarded city status as part of the Queen's golden jubilee celebrations. I believe that the city is well placed to be named UK city of culture 2021. I remember the long-fought campaign for city status for Perth, which was fought with cross-party backing, and it is good that the current campaign also has cross-party support. To have politicians from all sides unite in support of the bid to become UK city of culture will be hugely important in taking that forward.

Despite becoming Scotland's newest city, Perth is actually one of the country's oldest. The birth of our nation and Perth's story are closely wrapped together. In a tale so gruesome that it could feature in an episode of "Game of Thrones", Kenneth MacAlpin slaughtered his Pictish rivals at the dinner table in Scone and therefore became first king of Scots. For the next 800 years, Scone palace served as the coronation location for all Scotland's monarchs. Perth's interesting and sometimes bloody history is well represented throughout the city thanks to the museums and other cultural hotspots.

As we have heard, one attraction that traces Perth's history through the ages is the museum and art gallery. Perth museum has all bases covered, from the Romans to Scottish art, including a recent acquisition of an Alison Watt piece, and it is also facing the exciting prospect of a new redevelopment. The Black Watch museum, which is near the city centre, recently underwent a massive restoration programme.

In terms of culture, Perth is of course the birthplace of John Buchan, one of Scotland's greatest writers. He is famous for, among other things, his biography of the first Marquis of Montrose, who I believe is still a popular subject for biographers, especially those with a Perth connection.

History is everywhere in Perth. Richard III was famously dug up from underneath a car park in Leicester, and many historians believe that Perth also has a dead monarch lying underneath the streets. Following his murder in Perth, historians have long argued that James I lies buried under

the streets of Perth. I perhaps would not advocate digging up the streets to search for him—although some people have proposed just that—but shovels will hit the ground near the city centre as part of a major leisure and arts redevelopment. As Liz Smith mentioned, the Mill Street car park is set for major private sector investment in a regeneration project that is likely to bring a leisure complex complete with a cinema, gym, restaurants and shops. Encouraging such private sector investors to get involved will be incredibly important.

Despite all those future plans and existing attractions, Perth is in many ways Scotland's forgotten city. As other areas across the country have been handed generous support and investment, Perth for the most part has been left to its own devices. People in Perth have looked on with envy as Dundee has received substantial public investment by way of the Victoria and Albert museum and the waterfront development. Perth needs similar support, and attaining UK city of culture status would be the perfect springboard to attract more investors.

Finally, digital infrastructure must also improve if Perth is to be a serious contender. A modern city is online and interconnected. Google maps, TripAdvisor and Yelp are today's guidebooks, and Perth must be able to deliver them to visitors on demand and on the move. Sadly, however, too much of Perth continues to lag behind, with broadband and internet speeds falling way behind what is expected in the 21st century. That needs to be improved.

The speeches from members across the chamber have demonstrated that Perth has the attractions to make it the perfect UK city of culture. History, culture and art ooze from every corner. As Liz Smith mentioned, Londonderry/Derry in Northern Ireland has benefited tremendously from city of culture status, and forecasters have predicted that about £60 million could be generated in the local economy from a successful Perth bid. There are many challenges to overcome before that becomes a reality, but I look forward to working with colleagues across the chamber to further Perth's case for being named the next UK city of culture.

17:30

The Cabinet Secretary for Culture, Europe and External Affairs (Fiona Hyslop): I thank members for their speeches. As Murdo Fraser pointed out, Perth's bid has cross-party support.

Local authorities have a crucial role to play in delivering cultural activity, and I welcome Perth and Kinross Council's clear ambitions to use culture and creativity as a catalyst to promote regeneration. I am mindful that, as George Adam pointed out, other Scottish cities and areas have indicated—or may still indicate, given that the process is in its early days—a desire to bid to become UK city of culture 2021. I recently met Renfrewshire Council to hear of its ambitions for Paisley. There is a strong case for Scotland in the competition and our cities are in a strong place culturally. May the competition be constructive, and advertise our country's cultural successes and potential collectively.

Claire Baker might be interested to know that the Scottish Government and our agencies, including Creative Scotland, EventScotland and Scottish Enterprise, provided significant support for shortlisted Dundee's 2017 bid, which, although it was ultimately unsuccessful, helped Dundee to put forward a subsequent successful bid to become a designated United Nations Educational, Scientific & Cultural Organization city of design. It was the first city in the UK to do so. The Scottish Government and our agencies, therefore, have recent valuable experience that we can use to help to advise future bidding cities through the process. My officials have also been in contact with the Department for Culture, Media and Sport at Westminster, which runs the competition, to ensure that details of the bidding process will be finalised to help Scottish cities and areas to develop their plans.

Let us focus on Perth. As Liz Smith set out, Perth is at the heart of the story of ancient Scotland and the kingdom of Alba, and it was the crowning place of Scottish kings. As Willie Rennie mentioned, Perth also shaped modern Scotland, with key figures from the 20th century Scottish renaissance including the modernist and colourist painter John Duncan Fergusson, Patrick Geddes and William Soutar all being linked with the city.

Perth has a vibrant cultural scene, with exceptional cultural organisations based in the area including Horsecross Arts, Pitlochry Festival Theatre, Perth Festival of the Arts and many more. We heard about the central importance of the Fergusson gallery and the extensive archives that it holds, which exhibit great talent and creative energy. The 1,200-seat Perth concert hall is one of the most significant Scottish public buildings of this century and is renowned for its first-class acoustics. I have been pleased to attend youth brass band championships there in previous years.

The city plan for Perth sets a new level of ambition for the city in improving connectivity, developing the knowledge economy and strengthening the business and tourism offers. As Claire Baker set out, it is clear that culture is central to Perth's future aspirations in terms of both the economic benefits that culture can generate and its wider transformative power to

improve quality of life and build a sense of identity and civic pride across communities in our newest city.

The transformation of Perth theatre, which involves the renewal and enhancing of the existing Edwardian theatre, is under way. The transformation of that much-loved building into the most modern and exhilarating theatre space in Scotland in the heart of Scotland's newest city will perfectly complement the international-standard Perth concert hall. Within the theatre, Horsecross Arts will increase and diversify audiences through inspiring programmes, collaborations and the nurturing of new talent. A paved civic space is to be created adjacent to the new theatre development, and the vennels that link Mill Street and the High Street are to be significantly improved. Within the Perth city plan, Mill Street and its surrounding area is identified as a cultural quarter.

Next year, as a part of the town centre planning pilots, we are supporting the council to develop an innovative lighting project that is designed to help tell the story of Perth and attract visitors into the town centre. It will be launched in 2016, the year of innovation, architecture and design, which will spotlight, celebrate and promote Scotland's heritage and modern attributes in architecture, engineering, renewables, fashion, textiles, science, technology and more, through an exciting programme of activity to inspire the people of Scotland and our visitors and to boost tourism in every corner of Scotland.

Creative Scotland has invested more than £3.29 million in individuals and organisations based in Perth and Kinross through 15 awards in 2014-15, including one of the highlights in Scotland's cultural calendar—Perth festival of the arts, which celebrated its 44th year in May this year. Highlights of the festival included the Proclaimers, Jools Holland and his Rhythm and Blues Orchestra and "La Bohème" by English Touring Opera—something for everyone. I am sure that the 45th festival next year will be some celebration.

In recent years, all five of our national performing companies have performed in and engaged with communities across Perth and Kinross. Those activities have ranged from offering practical ideas for music making for local nursery staff and teachers to taster sessions for all ages in modern ballet. The Royal Scottish national orchestra inspired a 50-strong community orchestra to help Horsecross Arts to celebrate its 10th birthday this summer, and it also chose Perth to present its inaugural "Notes from Scotland" initiative, with five new works from young composers who were inspired by National Trust for Scotland locations around the country.

The National Theatre of Scotland has also now announced the first part in a brand-new cycle of three music pieces commemorating the first world war—"The 306: Dawn", written by Oliver Emanuel with music composed by Gareth Williams. This work will be co-produced with Perth theatre and 14-18 NOW, in association with Red Note Ensemble, and will be directed by Laurie Sansom. The first part of the trilogy explores the stories of the 306 men who were shot for cowardice and desertion during the first world war. "The 306: Dawn" is set around the battle of the Somme in July 1916, and will be ambitiously staged in the Perthshire countryside from May 2016.

Our national collections and Museums Galleries Scotland have extensive learning and community engagement programmes, and there has been a recent increase in visits to the national museum of Scotland from schools in the Perth area—there were 10 in 2013-14, and the number increased to 15 in 2014-15.

Perth museum and art gallery and the Black Watch museum are among 10 partners in the "Next of Kin" touring programme, which commemorates the centenary of the first world war across Scotland. Each contributes stories based on local collections and they have developed a digital resource that is used by schools and community groups.

From what we have heard today and from what I have set out, we can see that Perth is on a journey. Earlier this year, it was announced that Perth had beaten off competition from 19 other Scottish locations to land its own customised game board to celebrate Monopoly's 80th anniversary year. Scone palace was crowned as the Mayfair of Perth. It joins St Johnstone FC's ground, the Perth museum and art gallery, the Black Watch museum, Perth College, the Fergusson gallery, the Fair Maid's house and the concert hall on the board's 22 squares. *The Courier* features on the spot that is normally occupied by Fleet Street, the traditional home of the newspaper industry, while Old Kent Road is taken over by the North Inch.

Perth is going places—not just on a Monopoly board—and I wish the city well on its cultural journey.

Meeting closed at 17:38.

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