OFFICIAL REPORT
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CONTENTS

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[The Deputy Presiding Officer opened the meeting at 13:15]

Eliminating Hepatitis C

The Deputy Presiding Officer (Linda Fabiani): The first item of business is a members' business debate on motion S5M-10402, in the name of Tom Arthur, on "Eliminating Hepatitis C in Scotland: A Call to Action". The debate will be concluded without any question being put. I call Tom Arthur to open the debate. You have up to seven minutes, please.

Motion debated,

That the Parliament notes the publication of the report, *Eliminating Hepatitis C in Scotland: A Call to Action*, by the Hepatitis C Trust; understands that this follows an inquiry supported by a cross-party group of hepatitis C parliamentary champions; believes that Scotland has an ambitious commitment to eliminate the condition by 2030, which an estimated 34,500 people in the country have, 40% of whom are undiagnosed; recognises the challenges to achieving elimination; believes that the report makes a positive contribution to achieving this through both identifying barriers to treatment and making recommendations, and looks forward to a future where hepatitis C is eliminated and no longer a public health concern for people in Renfrewshire South and across Scotland.

13:15

Tom Arthur (Renfrewshire South) (SNP): I am grateful for the opportunity to open this debate on the report "Eliminating Hepatitis C in Scotland: A Call to Action", and I put on record my thanks to all those who contributed to the report and to colleagues from across the chamber who signed my motion enabling this afternoon's debate to take place.

The report was produced by the Hepatitis C Trust in collaboration with clinicians, support workers, representatives of the pharmaceutical industry and MSPs from each party that is represented in the Scottish Parliament. As such, the report reflects the views of a representative cross-section of those who are working to treat and to eliminate hepatitis C.

The objective of the inquiry, as described in the report, was

"to map progress toward the Scottish Government's world-leading commitment to hepatitis C elimination, and develop recommendations to ensure elimination is achieved."

In both of those areas, the report makes an important and considered contribution to our understanding of both where we currently stand and where we need to get to if elimination of hepatitis C is to be achieved. Before considering some of the specific recommendations that are made in the report, I will give an outline of what hepatitis C is, who it affects and why elimination is an important public health goal that warrants our attention and continued support.

Hepatitis C is a blood-borne virus that, if left untreated, can lead to degeneration of the liver and severe liver disease, potentially resulting in the need for a liver transplant. In Scotland and across the United Kingdom, the virus is predominately spread through the sharing of unsterilised equipment used to inject recreational drugs. Sharing needles for the injection of steroids also presents a risk of transmission, as would the use of unsterilised equipment for tattooing, acupuncture or body piercing. Other means of transmission are possible, such as unprotected sex, but they are less common. It is estimated that 35,000 people in Scotland carry the hepatitis C virus, of whom 15,000 are thought to be undiagnosed. We can compare that to the estimated 6,000 individuals in Scotland who are HIV positive, of whom 800 are believed to be unaware of their status.

In both testing and treatment, there have been significant advances in recent years. Dried blood-spot testing offers a simple and accurate way to determine one's hepatitis C status. Treatment is now highly effective and safe and of a relatively short duration. However, that was not always the case. Prior to the introduction of all-oral direct-acting antiviral therapies, treating hepatitis C commonly required a long and demanding regime of interferon, which was often ineffective and could cause severe and debilitating side-effects. Therefore, it was not uncommon for people with hepatitis C to be unable to complete a treatment regime. Indeed, some chose actively not to seek treatment due to the potential for an adverse reaction. That is understandable, particularly given that many people with hepatitis C are initially asymptomatic.

Unfortunately, despite the availability of new treatments, many of the fears that dissuaded people from having a test or seeking treatment persist. It is, therefore, vital that we, as individual MSPs and as a Parliament, send a clear message: if you think you may have been exposed to hepatitis C at any time in your life or are concerned about your status, please reach out and seek support. That could mean reaching out to a general practitioner or other health professional or to one of the excellent support charities such as Hepatitis Scotland, the Hepatitis C Trust or Waverley Care. Whatever way people wish to engage and seek support in, the important thing for them to remember is that there is no need to worry in silence.

That last point speaks to the first area of focus in the report: the need to raise awareness. As I have indicated, it is estimated that over 40 per cent of those who are living with hepatitis C in Scotland do not know their status. Some may suspect, while others may have no indication at all. For those who are concerned that they may have been exposed to hepatitis C, one of the key barriers to testing is stigma. Although the report recognises that stigma has decreased in recent years, it states that stigma

"was reported as being still highly prevalent, and considered more significant among some groups than the stigma attached to HIV."

It goes on to say:

"The effect of such stigma can be to prevent individuals from accessing testing for the virus, with some refusing to even consider the idea that they could be infected due to fear of being stigmatised if diagnosed."

That stigma stems directly from the fact that hepatitis C predominately affects people who have previously injected, or who currently inject, drugs for recreational use. The report reinforces calls to recalibrate our thinking on substance misuse and understand it as a public health issue.

The report also highlights the need to raise awareness among lesser-known at-risk groups, such as users of image-enhancing and performance-enhancing drugs; men who have sex with men—a group in which awareness of hepatitis C is often lower than awareness of HIV; and the south Asian community, in which the prevalence of hep C is greater than in the wider population as a result of the widespread reuse of needles and razors in some south Asian countries.

The report makes a series of recommendations to address those challenges. First, it asks

"The Scottish Government to investigate the feasibility of a national awareness campaign."

Secondly, it calls on

"High-profile public figures to use World Hepatitis Day",

which takes place each year on July 28,

"as an opportunity to speak out, publicly highlighting risk factors, the importance of testing and ease of treatment."

Thirdly, the report recommends that we target awareness-raising messages to lesser-known at-risk groups: in gyms, to users of image-enhancing and performance enhancing drugs; in sexual health services, to men who have sex with men; and in religious and community centres that are attended by members of the south Asian community. The report also recommends additional awareness training and support for GPs, particularly given that the symptoms that are associated with hepatitis C can be easily misdiagnosed.

All the recommendations that I have just outlined would have a positive impact in raising awareness and changing attitudes towards hepatitis C. In the context of broader public health challenges, it would be relatively straightforward to implement them.

In my remarks concerning the report, I have focused on the issue of awareness. However, the report presents evidence and recommendations on prevention, testing and diagnosis, linkage to care and access to treatment and funding. I look forward to hearing the thoughts of colleagues on all sides of the chamber on those aspects of the report, and I strongly encourage anyone who has not yet done so to read the report.

In concluding, I make clear my view, and the view of all those who were involved in producing the report, that Scotland has a truly great opportunity to continue to be world leading in the treatment of hepatitis C and to achieve elimination by 2030, or perhaps even sooner. We must not let the chance slip from our grasp. Let us redouble our efforts, make elimination a reality and consign hepatitis C to history.

The Deputy Presiding Officer: I remind members that time is limited for the debate, so it is essential that they stick to no more than four minutes.

13:23

Miles Briggs (Lothian) (Con): I congratulate Tom Arthur on bringing the debate to the chamber. As one of the Hepatitis C Trust's parliamentary champions, I am very pleased to contribute today. I thank the trust for its briefing for the debate, and I welcome the publication of the report "Eliminating Hepatitis C in Scotland", which is a positive and useful piece of work that makes valuable recommendations around prevention, testing and diagnosis, linkage to care and access to treatment and funding.

As Tom Arthur said, it is estimated that around 34,500 of our fellow Scots are chronically infected with hepatitis C and that more than 40 per cent of those cases are undiagnosed. In addition, too many of those who have been diagnosed are not connected to treatment services. In 2016, 1,739 people began treatment for hepatitis—a slightly lower number than in the previous year. However, the fact that the rate of incidence among people who inject drugs—a key risk group—has risen significantly in recent years, almost doubling between 2011 and 2016, is a real concern.

Its prevalence among prisoners is particularly high, with a 2012 study indicating that almost 20 per cent of prisoners were found to have hep C. More recently, the Parliament's Health and Sport Committee undertook an inquiry into prisoner

health, which highlighted a number of areas in which we are still failing as a country to identify those who are infected and look towards treatment pathways.

The Scottish Conservatives welcome and support the Scottish Government's commitment, in the sexual health and blood-borne virus framework, to eliminate hepatitis C. However, the challenge is how we develop and then expand the innovative solutions and approaches that will make that a reality in the years ahead, given that current treatment rates are broadly in line with the number of new cases. Clearly, a step change will be needed if we are to meet the new annual national minimum targets for hepatitis C treatment initiations of at least 2,000 for the current year, 2,500 for 2019, 3,000 for 2020 and 3,000 for each subsequent year.

Work is currently being undertaken that will inform the elimination plan that the Government has promised to publish later this year. Getting that plan right is vital as we seek to extend best practice across all health board areas and to roll out successful initiatives to other parts of the country. NHS Tayside—which has not had its troubles to seek in recent months—is leading the country in looking at how we can feasibly meet that target. Moving testing, screening and treatment out of hospitals and into community settings—particularly community drug and alcohol services—will be extremely important, and I hope that lessons will be learned from that.

I hope that, in closing the debate, the Minister for Public Health and Sport will be able to update Parliament on when the strategy will be unveiled and on what engagement she and her officials are having with key stakeholders, including patient groups, third sector providers and the pharmaceutical companies that are involved. I hope that that engagement will include, in my own region, close collaboration with Waverley Care, which is undertaking an important pilot project that has embedded a community link worker in Her Majesty's Prison Barlinnie, in Glasgow, to engage with and support prisoners with the hepatitis C virus while they are in prison and on their release into the community, to ensure that they get care in the future.

I also hope that the minister will give details of the funding that the Scottish Government will provide to support the elimination plan. Stakeholders are anxious for budgets to be protected and, crucially, for the savings that arise from the reduced costs of treatment to be reinvested into the redesign of services and increased efforts to identify and treat more people with HCV.

I again welcome today's debate and the focus that it has brought to tackling HCV in Scotland. We have a genuine and rare public health opportunity to effectively eliminate a disease, and we need to grasp it. We eagerly anticipate the publication of the elimination plan. I and other hep C parliamentary champions, as well as other colleagues across the Parliament, look forward to scrutinising that plan and working with the Scottish Government to ensure that it is delivered on the ground. Scotland used to lead the world in our determination to eliminate hep C—it is time that we did so again.

The Deputy Presiding Officer: I remind members that they might be disadvantaging colleagues if they go over their time.

13:28

Mairi Gougeon (Angus North and Mearns) (SNP): I thank Tom Arthur for securing the debate and for bringing this important topic to the chamber for discussion. I thank him for the work that he has done and recognise the work of all the other contributors to the "Eliminating Hepatitis C in Scotland" report. I also thank him and other colleagues for their work in their role of Scottish parliamentary champions for hep C. There are parliamentary champions across the chamber and from all parties.

I read the report with great interest, and I have followed the work because half of the constituency that I represent rests within the NHS Tayside area. I was glad to hear Miles Briggs mention that health board today. Like other members in the chamber, we, as elected representatives, have regular meetings with our local health board. When I attended a meeting with NHS Tayside last year, it gave us a presentation on the work that it had been undertaking on hepatitis C. I found that work incredible, and it is why I wanted to speak in the debate today.

As we have heard, Scotland has been considered a global leader in the area, and NHS Tayside has very much been at the forefront, leading that work. NHS Tayside has been under intense scrutiny of late. Although it has its issues, which need to be resolved, we must give credit where credit is due. We should credit the team that has been working on the issue and recognise what it has achieved so far.

To give members an idea of the impact of that work, I note that Professor John Dillon, a consultant hepatologist at NHS Tayside, has stated that the project that is being undertaken there

"is on course for Tayside to be the first region in the world to have eliminated HCV".

That is hugely important news, and it is largely due to their pioneering approach to tackling the virus, which uses treatment as prevention in the testing

and treatment of hepatitis C through community pharmacist-led care. That approach has won the team a number of plaudits over the past few years.

As has been outlined, hepatitis C is a blood-borne virus that can be contracted in a number of ways but most commonly through the sharing of needles via intravenous drug use. The largest single group that is most affected are those who have been prescribed opioid replacement therapy. Treatment for hepatitis C previously relied on those who came forward for treatment because they had been identified as having used drugs in the past or were accessing other health services, but the NHS Tayside project aims to prevent the spread of the illness by focusing on active drug users, who are most likely to pass it on.

Professor John Dillon attended a meeting of the Parliament's Health and Sport Committee at the start of the year and outlined the project's rationale:

"In your career as an injecting drug user, you might inject for two, four or six years before moving on to recovery, but if you become infected with the virus during that time, you will potentially pass it on to six or seven other people you interact with ... If we can offer treatment at an early stage, when people who are infected are still actively injecting, when they have contact with other drug users and share equipment with them, the chances of transmission disappear because the person is no longer infected. That is the idea of treatment as prevention."—[*Official Report, Health and Sport Committee,* 23 January 2018; c 9.]

Given that those on opioid replacement therapy receive it from a community pharmacist, the team focused on community pharmacies as a means of engaging with patients and of patients accessing testing and treatment. It is estimated that around 80 per cent of those with hepatitis C in the Tayside region have now been diagnosed, and transmission rates, which currently sit at around 5 to 10 per cent, are expected to reduce to 1 per cent over the coming years.

The Hepatitis C Trust report says that

"hepatitis C is preventable, treatable and curable for the vast majority of people. New treatments are now available, with short treatment durations, limited side-effects and cure rates upwards of 95%."

Scotland is a world leader in this area, but, with current testing and treatment rates suggesting that we might not hit the target of eliminating hep C by 2030, we need an elimination strategy. We have projects that are working, and we have the capacity to do it. However, we need the focus and strategy to get us there, to help us to maintain our world leader status and, more importantly, to eliminate the virus.

13:32

Anas Sarwar (Glasgow) (Lab): I recognise that I have a long afternoon ahead in the chamber, so I will not incur your wrath, Presiding Officer, and I will stay strictly within my four-minute limit.

As other members have done, I thank Tom Arthur for securing this important debate and the Hepatitis C Trust for supporting all the hepatitis C parliamentary champions and putting the report together. I thank members for the collaborative and cross-party approach that was taken to this important work, which unites us across the chamber. I suppose that that is the purpose of today's debate: how we can unite behind the target of eliminating hep C in Scotland.

The report is ambitious, and it is right that we should try to meet the Government's target of eliminating hep C by 2030. We have more than 35,000 hep C sufferers in Scotland, but at the moment we treat far less than 10 per cent of them. I agree with the Government's target of eliminating hep C by 2030, but it is important that, behind that, there is a full, detailed and deliverable strategy for how we will achieve the target.

A big part of the challenge is that up to 40 per cent of cases in Scotland are undiagnosed, and fewer than one in five affected people in Scotland receives the treatment that they need. Finding, testing and treating patients in accessible locations is essential. Given that 90 per cent of those with hep C are people who previously injected or are currently injecting drugs, and given that there are issues with substance misuse more generally, how our drugs strategy relates to our hep C strategy is also extremely important.

The report says that Scotland is falling behind. None of us wants that; we want Scotland to be the beacon and pinnacle for eliminating hep C. That is why we should look to England and France, which have set target dates of 2025 for elimination, and to where there is best practice that we can learn from and improve on so that we can eliminate hep C here in Scotland.

We want a detailed and deliverable strategy that has a focus on two areas: first, on finding and diagnosing a greater number of cases, working collaboratively with organisations to find new patients; and, secondly, on removing barriers to treatment, with clinicians having the freedom to select the most appropriate treatment method.

It is important that we look at partnering with prisons. There are patients in our prisons who could start treatment but who might miss part of it because of the length of their sentence, or who might not begin treatment because they do not have support in their communities when they leave prison. Working collaboratively with the Scottish Prison Service, the national health service and in community facilities is important.

The cost of treatment has fallen significantly, which should encourage us to go further in treating

more people for less money. We should recognise that, if we treat people earlier and eliminate hep C, that will result in a net saving to the NHS in all the associated conditions.

I promised that I would finish well within four minutes. I hope that we will continue the collaborative work and bring forward a meaningful strategy. I also hope that the minister will set out in more detail what that strategy will look like, when it will be published, what funding will be behind it, and what measurable targets there will be so that we can test that the strategy is being delivered and we can eradicate hep C in Scotland.

13:36

Emma Harper (South Scotland) (SNP): I congratulate my colleague Tom Arthur on bringing this important debate to the chamber today. Mr Arthur has been involved as one of the cross-party hepatitis C champions, whose work led to the production of "Eliminating Hepatitis C in Scotland: A Call to Action" with the Hepatitis C Trust. I also acknowledge the other MSP hep c champions—Anas Sarwar, Alison Johnstone and Miles Briggs, who are in the chamber today—as well as the other champions.

The report brings together the views of leading clinicians, services, charities and patients who participated in the inquiry, and I thank everyone who was involved in the work. The report is not lengthy and I encourage folks across health and social care and wider society to read it, so that everyone can be further informed of ways in which the rate of hepatitis C in Scotland can be tackled and reduced. The report's 30 recommendations support proposed work under the seven different categories of elimination, awareness, prevention, testing and diagnosis, linkage to care, access to treatment, and funding. Those areas are all clearly laid out in the report.

I will use my time to address the testing, screening and diagnosis aspect of the report. Testing or screening has previously been done using a simple blood sample that is tested to look for antibodies to the hep C virus, which is the body's response to exposure to virus. There is also a polymerase chain reaction test, which establishes whether the virus is still active and needs treatment. The dry blood spot testing that Tom Arthur mentioned is now available and is offered by NHS Dumfries and Galloway. It was interesting to read that testing rates have increased in recent years, but that the number of persons diagnosed decreased in 2015 and 2016. That might suggest that efforts to find undiagnosed patients are stalling.

I am especially interested in hard-to-reach persons. Most new blood-borne hepatitis C viral infections are the result of the sharing of injecting equipment among people who inject drugs. Problem drug use is a national public health concern and members recently debated and agreed to a motion that proposed the introduction of a safe drug consumption site in Glasgow. The report supports innovative approaches, so I suggest the SDCS as one of the potential innovative approaches to finding undiagnosed persons. That relates to action 16 in the recommendations.

As outlined by the minister in the previous debate, safe drug consumption sites would help us to reach some of the most marginalised and at-risk people in our communities who inject heroin and have potentially shared, even once, injection equipment. Sharing equipment even once could lead to hepatitis C infection. Provision of such places would enable us to offer screening and testing, which could lead to diagnosis and treatment for hep C. Adequate sterile injecting equipment needs to be made available in places such as community pharmacies and substance misuse services. The report also supports hep C screening in GP clinics in areas in which there is a high hep C prevalence.

As Tom Arthur said, and as the report states, by implementing a combination of the recommendations we have an "extraordinary and ... achievable opportunity" to eliminate hepatitis C by 2030. I ask the Scottish Government to analyse the report's recommendations and support the motion.

13:40

Alison Johnstone (Lothian) (Green): I, too, thank Tom Arthur for securing the debate. This is absolutely a public health issue, and I am very proud to be a hepatitis C parliamentary champion.

Like colleagues, I strongly believe that it is time that we did as much as we possibly can, and much more, to diagnose and treat people. As we have heard, it is thought that about 45 per cent of people in Scotland with hepatitis C are not even diagnosed. That is not acceptable when treatment is so effective and can play such an important role in prevention.

I, too, thank all the experts who have taken part in hepatitis C meetings and who contributed evidence for the report, which is indeed a call for action, and action now. In particular, I thank those patients who shared their experiences with us.

I share my sincere admiration for the incredible work that the Edinburgh access practice does to diagnose, treat and care for people with hepatitis C. By building fabulous, strong relationships between staff and patients, with the help of a fantastic outreach specialist, the practice is able to

get people the diagnosis and treatment that they need in a setting that suits them. I have learned that that specialist even knows which sofa a patient is sleeping on on a particular night of the week. That is what I call outreach. That is really important.

We often hear about treating people who are "hard to reach"; I understand why people use that phrase, and I am sure that I have used it in the past myself—probably too often. However, I am reminded today that people are not hard to reach; it is our services that can be hard to reach.

Stigma is still a barrier, and some people who are not diagnosed have many other complications in their lives. I will never forget meeting a patient at the Edinburgh access practice and hearing about their joy on making a recovery. They told me that they now felt clean. There was a clear impact on their mental health and wellbeing, and they felt that they had a productive life ahead of them. That is really important, and we must not underestimate the opportunity that we have to make that difference to many more people in Scotland.

When the Health and Sport Committee heard evidence on treating blood-borne viruses, we were told time and again that we needed to get out into community settings to ensure that people are diagnosed and treated. We have heard from Tom Arthur and other colleagues that treatment used to be notoriously debilitating. That was scary and off-putting, so treatment would be avoided. However, we have come a long way since then. The more people we can diagnose and treat, the better.

It is not long since we had an important debate in the chamber on the need for safe drug consumption facilities. Such facilities would provide a further opportunity for us to test and treat people. In preparing for that debate, I read NHS Greater Glasgow and Clyde's report, "Taking away the chaos", and I was really alarmed when I read that people who injected drugs considered hepatitis C to be

"ubiquitous and therefore inevitable",

so that sharing

"communal batches of drugs or ... needles stored at public injecting locations – was commonplace."

We need safe drug consumption facilities to reduce new cases of hepatitis C and to treat those who already have it.

Dr Ken Oates raised a point at the Health and Sport Committee that we would do well to consider today. He suggested that, while there will always be diverse views on ring fencing, some protected funding can be of real benefit to vulnerable people. He gave the example of funding streams for alcohol and drug partnerships.

Anas Sarwar is right: prison testing rates remain too low. We should have an opt-out basis for testing there. When people are released from prison, the treatment should follow them from where it has started.

Parliament has a fabulous opportunity here. I associate myself with Mairi Gougeon's comments. In my view, the NHS Tayside treatment model should be rolled out as quickly as possible.

We have already made a commitment to eliminate hepatitis C in Scotland. That is achievable. This is an area in which Scotland could easily be leading. Let us lead. I look forward to hearing from the minister about how Scotland will take action now to eliminate hepatitis C.

The Deputy Presiding Officer: The final two speakers in the open debate are Ivan McKee, to be followed by Brian Whittle.

13:44

Ivan McKee (Glasgow Provan) (SNP): Like other members, I thank Tom Arthur for bringing this important debate to the chamber, and I thank everyone who was involved in the preparation of the Hepatitis C Trust report.

It is not often that we have the opportunity to eradicate a disease in its entirety, but today we are debating the possibility of doing just that. If the correct steps are taken over the coming period, Scotland could be at the forefront of global efforts to eliminate hepatitis C, making a huge difference to the lives of thousands of individuals and their families—current sufferers as well as those who are yet to be diagnosed or to contract the disease. In addition, elimination would save the health service many millions of pounds that are currently spent on treatment and care, which could be diverted into other priorities.

There is much talk in healthcare of the preventative agenda—the concept that spending extra money now results in lower costs to the system later. Often, the problem with executing preventative spend opportunities is the difficulty in understanding and demonstrating the link between the extra upfront spend and the consequent savings, which often, for many reasons, do not materialise as anticipated. However, in the case of hepatitis C, the relationship is more clear cut. Every year, a number of cases are treated and, although new medicines have significantly reduced the treatment cost, the total spend is still high. However, increases in treatment rates that are delivered now will result in lower rates of incidence. The numbers can be modelled, and the resulting future costs of treatment in each scenario can be evaluated. Over and above the savings from lower future treatment costs for the condition itself are the savings in the costs of consequent

conditions, such as liver disease, and the costs of care.

Often, preventative health measures can actually exacerbate health inequalities, with the middle classes listening to healthy lifestyle messages and acting accordingly. However, the elimination of HCV will serve to reduce health inequalities, as it more often affects vulnerable and deprived groups in society.

I would like to take this opportunity to raise awareness of the work that is being undertaken by Waverley Care and AbbVie in Barlinnie prison in my Glasgow Provan constituency. I have visited and witnessed the project at first hand. The prevalence of hepatitis C among the prison population is estimated at 19 per cent. As part of the project, a community link worker is embedded in the prison. They engage with and support prisoners with an HCV diagnosis while they are in prison and when they are liberated into the community. That ensures that there is continuity of care and that the individual is not lost to the system, as is often otherwise the case. The pilot is proving successful and is now being extended to other prisons.

The report from the Hepatitis C Trust makes proposals for the inclusion of a Scottish Government implementation plan for the elimination of the disease. That plan needs to provide robust modelling of the numbers of people who require to be treated annually if we are to reduce infection rates to the point where elimination is achievable. It also needs to model the financial impact in order to determine how much more needs to be spent each year—and for how many years—to increase treatment levels, and how much that will save in the long run.

It is estimated that elimination can be achieved within the existing budgets for HCV, but doing that will require a different approach that involves adopting flexible budgeting models that support NHS boards to deliver multiyear budget plans, and having a ring-fenced budget for HCV with a minimum, rather than fixed, treatment target. Negotiations with drug suppliers for a fixed cost for elimination over a given period could dramatically reduce costs per treatment.

There needs to be a whole-system approach that will ensure that implementation and funding are co-ordinated at a Scottish level, and that savings that are achieved are monitored and reinvested to accelerate the elimination process.

By taking the steps that I have outlined, we can look forward to the day when hepatitis C has been eliminated in Scotland.

The Minister for Public Health and Sport (Aileen Campbell) *rose—*

The Deputy Presiding Officer: I can see that you are really keen to start, minister, but the final speaker in the open debate is Brian Whittle.

13:48

Brian Whittle (South Scotland) (Con): A bit of a false start there, Presiding Officer.

I thank Tom Arthur for bringing this debate to the chamber and for the work that he and other MSPs, including Miles Briggs, Alex Cole-Hamilton, Alison Johnstone and Anas Sarwar, have done to highlight the cause of eliminating hepatitis C. I also want to congratulate the Hepatitis C Trust on its report, "Eliminating Hepatitis C in Scotland: A Call to Action", which highlights the challenges that we face as we work to eliminate hepatitis C, and shows how we can get there.

Aiming to eliminate any disease is a big ambition, but, as we see in the report, it is achievable—not by any single grand gesture or proclamation, but by targeted interventions that are backed up by political will in this place. As has already been mentioned, the Health and Sport Committee has done quite a lot of work on this area. It has heard about the issue that Mairi Gougeon raised in relation to what is being done in Tayside to eliminate hepatitis C up there, and about what Alison Johnstone discussed in relation to safe injection houses.

Members are prepared to stand up in the chamber and debate some really hard topics, and this is one of them. It is clear from the report that one of biggest obstacles to eliminating hep C is in the area of early diagnosis. Because people infected with hep C can show few or no symptoms for years, it is difficult to detect the virus before it causes serious liver damage. That also increases the risk of people unknowingly spreading the virus to others, as has been mentioned.

The majority of new hep C infections result from intravenous drug users sharing injection equipment. Many contributors to the report felt that the best way to address that was through preventing drug taking in the first place by supporting opioid substitution therapies such as methadone. Again, we have debated that issue. I will caveat it by saying that I do not think that methadone is the solution in itself, but it is certainly part of a much bigger solution.

It is important to raise awareness and provide opportunities for testing. When we are discussing prevention, the peer-to-peer awareness programmes in prisons and substance misuse services are really key. When members of the Health and Sport Committee were out in communities looking at drug use, it was obvious that the most effective way of persuading people away from injecting drugs were peer-to-peer

programmes, so it is important that such services continue. It is also important to highlight the lack of symptoms to people who may in the past have engaged in behaviour that could have put them at risk of having the condition. This debate is part of that.

The Hepatitis C Trust report identifies a fall in the number of patients being diagnosed in 2015 and 2016, despite increasing testing rates. That emphasises the need to ensure that testing is being targeted effectively, and we know where to look for that. Clearly, one of biggest opportunities for testing comes when drug users visit needle exchanges or addiction support services. I would like to hear from the minister how the Scottish Government will look to continue that kind of support. However, that can only be a viable option when it is combined with awareness-raising programmes that seek to normalise testing and ensure that no one is put off using such services as a result of stigma, which has been mentioned several times.

Lastly, I will address the need for barriers to testing to be brought down. There is a need for more testing in non-clinical settings, where staff have strong personal relationships with clients and can be better placed to encourage them to be tested and support them in the event of a positive diagnosis, as Alison Johnstone highlighted.

The Deputy Presiding Officer: You must close, please.

Brian Whittle: Presiding Officer, I will sit down at this point.

The Deputy Presiding Officer: Thank you very much, Mr Whittle.

13:52

The Minister for Public Health and Sport (Aileen Campbell): Like others, I thank my colleague Tom Arthur for bringing this important matter to the chamber. It has provided us with an opportunity to reflect on Scotland's track record in tackling hep C. I will respond directly to some of the recommendations of the Hepatitis C Trust report, and outline how the Government's strategy to eliminate hep C as a public health concern in Scotland is very much in line with today's motion.

Over the past decade, Scotland has been at the forefront of efforts to tackle hepatitis C. That is acknowledged in the Hepatitis C Trust report, which recognises that Scotland has long been regarded as a world leader in tackling hepatitis C. Indeed, Scotland's hepatitis action plan was a model that informed the World Health Organization's approach to national action plans for viral hepatitis, and a Scottish NHS expert was seconded to the WHO to help it develop its thinking on that. That led to the first ever world hepatitis summit being jointly hosted by the Scottish Government and the WHO in Glasgow in 2015.

It was also in 2015 that we announced our intention to eliminate hepatitis C as a public health concern, and this Government remains committed to that intention and ambition. Hepatitis C disproportionately impacts on some of the most vulnerable people in Scotland, but it is a disease that can be cured and effectively prevented. That means that we can eliminate it—a point forcibly made by Mairi Gougeon.

Mairi Gougeon and others raised NHS Tayside's work, and I will be visiting NHS Tayside on Tuesday for a meeting with professionals, including Professor Dillon, who are involved in the board's leading work on the learning on this issue that we can share and replicate.

I turn to the Hepatitis C Trust report's recommendations. I recognise that there is a clear desire for a strategy to eliminate hepatitis C infection in Scotland. Our current focus is on eliminating the serious disease that is associated with the virus, on which we have seen real progress. I have recently asked Health Protection Scotland to provide recommendations on how we might eliminate the virus; on receipt of that advice, I will make sure that members are updated as the work progresses.

In the meantime, in January I increased the annual treatment target for hepatitis C to 2,000 per year for 2018-19, and we will keep that under review over the coming years. It is important to recognise that the figure represents the minimum number of patients who should be treated, which is a point that others have mentioned. The figure is not a cap, but the minimum number of people whom we expect to be treated. We are treating more people and treating them successfully, but we must increase treatment capacity in a safe and sustainable way to keep us on track with the good work that we celebrate today.

I agree with the Hepatitis C Trust report's emphasis on the importance of combating the stigma around hepatitis C, and Tom Arthur eloquently articulated the barriers, concerns and fears that surround it. In the "Sexual Health and Blood Borne Virus Framework 2015-2020 Update", the Government reconfirmed its commitment to tackling stigma and the negative attitudes towards those who are affected by blood-borne viruses. That is why we are providing £1.9 million over the next three years to third sector organisations to support innovative work to tackle sexual health challenges and reduce blood-borne virus transmission. That will include work to challenge stigma and activities that will specifically

target the most at-risk groups, such as vulnerable young people and those who inject drugs.

Members will recognise the report's recommendations on awareness. In response, the Scottish Government is considering the feasibility of a national awareness campaign, and funding has been given to Hepatitis Scotland to lead national awareness-raising activity and raise awareness among professionals, including general practitioners. I hope that those activities give comfort that we are going through the trust's recommendations. We will consider them fully and act on them, where it is feasible.

The report notes that prevention measures are crucial to any elimination strategy, with which I whole-heartedly agree. As we know, the infections are primarily passed on via injecting drug use, so it is crucial that we tailor our support and interventions to that vulnerable and complex group. We are funding third sector colleagues to better understand that population's specific needs by engaging directly with them. Miles Briggs, Anas Sarwar and Ivan McKee correctly mentioned concerns around prisons, and I have witnessed some of the great work that has been undertaken through Waverley Care at Barlinnie and the support that is given to prisoners who face incredible challenges. A lot of good work is going on, but we still have a lot to overcome. We will continue to work with Waverley Care to understand what more we can learn as that work progresses.

Miles Briggs: Throughout the debate, we have heard about the progress that has been made by NHS Tayside. How is that being rolled out across other health boards? What learning can they take from NHS Tayside's work to date?

Aileen Campbell: I am visiting NHS Tayside on that matter on Tuesday, to make sure that we can properly understand the good work that is going on. It is worth pointing out that this morning I was at a meeting of our national sexual health and blood-borne virus advisory committee, at which David Goldberg gave a presentation on the work that is going on across the country. He specifically cited the work of NHS Tayside. That group's membership includes people from NHS Tayside who, through their advice to me, continue to make sure that we understand the work that is going on there, so that it can be effectively taken forward in other parts of the country.

Other members have mentioned issues around the work by Glasgow City health and social care partnership on safe consumption rooms, which is why we need to ensure that the work around hep C is complemented by the work on the substance misuse strategy—a point that was raised by Anas Sarwar.

It is important to recognise that we are working from a position of strength. For example, Scotland was recently recognised at the 2018 international liver congress for the success that we have had in reducing serious hep C-related liver disease. Health Protection Scotland data shows that, between 2013 and 2016, we delivered a 39 per cent reduction in the incidence of decompensated cirrhosis in those with chronic hepatitis C. That is a clear indication that our approach of targeting those who are most unwell is working.

I congratulate all the members who have spoken the debate. We look forward to continuing our work.

Portfolio Question Time

Health and Sport

14:00

The Deputy Presiding Officer (Christine Grahame): The next item of business is portfolio question time. I say again that, in order to get in as many people as possible, I want short and succinct questions, and answers to match. I am in a good mood at the moment.

Mental Health Services (Involvement of Young People)

1. **Fulton MacGregor (Coatbridge and Chryston) (SNP):** To ask the Scottish Government how it ensures that the voices of young people are heard during the development of mental health services. (S5O-02057)

I remind members that I am the parliamentary liaison officer to the Cabinet Secretary for Health and Sport.

The Minister for Mental Health (Maureen Watt): When we published our mental health strategy in March 2017, a consistent theme was engagement and co-production with young people. I valued the opportunity to hear young people's views first hand through the work that we carried out in conjunction with the Scottish Youth Parliament, Young Scot, Children in Scotland and many others. Those views were crucial to informing the final strategy.

We continue to put young people's voices at the heart of the strategy, and we have several strands of on-going work that directly involve young people. They include: the youth commission on mental health services, which is run by Young Scot; a review of personal and social education in schools, which is strategy action 1; an audit of rejected referrals to child and adolescent mental health services, which is being run by the Scottish Association for Mental Health and is strategy action 18; and work on transitions between CAMHS and adult services, which is being run by the Scottish Youth Parliament and is strategy action 21. All that work is really valuable, particularly given that 2018 is the year of young people.

We will continue to ensure that young people's voices are heard and acted on, particularly as mental health is consistently mentioned as one of the top priorities—if not the top priority—for young people.

Fulton MacGregor: A couple of weeks ago, I held a round-table meeting with the cross-party group on children and young people, in which a range of stakeholders contributed on the subject of mental health and young people. There was a particular focus on the transition period from CAMHS to adult services for young people between the ages of 16 and 18, which the minister mentioned. How is the Government ensuring that young people have a say in the services that are available for that particular group?

Maureen Watt: I thank Fulton MacGregor for his interest in the issue. It is good to hear that there is a focus on transitions between CAMHS and adult services. That is one of the central themes that emerged during the Scottish Youth Parliament's speak your mind campaign on mental health, which has been crucial to informing our strategy.

As I mentioned in my first answer, the Scottish Youth Parliament is taking forward work on transitions. We want to focus on how anticipatory care plans can best be used to support young people who transition between CAMHS and adult services, between different child and adolescent mental health services or, indeed, out of CAMHS altogether. The Scottish Youth Parliament's work will ensure that the final anticipatory care plan has been designed by young people for young people.

The Scottish Youth Parliament held a discussion day event on 24 March, which I attended. I look forward to the final product being finalised and rolled out in the coming months.

Oliver Mundell (Dumfriesshire) (Con): In Dumfries and Galloway, we have seen a 10 per cent rise in the number of temporary staff who work in child and adolescent mental health services. Does the minister agree that that represents a huge challenge for the running of child-centred services? What action is the Scottish Government taking to address the issue?

Maureen Watt: The key is early intervention and prevention. We see increasing numbers coming forward for CAMHS, but we want to ensure that people are properly referred and that, if CAMHS specialist intervention is not required, intervention at tiers 1 and 2 is available.

"Scotland's Digital Health and Care Strategy"

2. **Richard Lyle (Uddingston and Bellshill) (SNP):** To ask the Scottish Government how the digital health and care strategy will help to deliver person-centred care. (S5O-02058)

The Cabinet Secretary for Health and Sport (Shona Robison): "Scotland's Digital Health and Care Strategy", which was published last month, highlights the opportunities that technology offers to empower citizens to better manage their health and wellbeing, to support independent living and provide access to services through digital means and to support a shift in the balance of care. The

external expert panel highlighted that Scotland is an international leader in technology-enabled care and our strategy sets out an ambition to widen and extend such services.

Richard Lyle: How does the strategy contribute to the on-going work on the integration of health and social care in our communities? Does the cabinet secretary agree that the use of a mix of technology, as well as traditional methods, is key to delivering sustainable care now and in the future?

Shona Robison: The strategy recognises the benefits of a focused approach to delivery. The eight national health boards' new collaborative approach to offering improvement and transformational change by working alongside the Convention of Scottish Local Authorities, the local government digital office, the Scottish Social Services Council and the Care Inspectorate, will be key to delivering on those ambitions. This is not about technology necessarily being the solution; wider service transformation will bring together expertise and knowledge, with technology being integral to helping such change to happen.

Anas Sarwar (Glasgow) (Lab): The cabinet secretary will cover some of this later, but what consideration has been given to using technology in crisis mental health situations, so that people can have rapid access to a councillor or a psychologist in order to avoid a really tragic circumstance?

Shona Robison: Of course there are already important services for those suffering crisis, such as breathing space. NHS 24 has been involved in providing services that people can use online, which have been well evaluated. There is probably more that we can do in that space, particularly for people living in remote and rural communities, which I am certainly keen to explore.

Air Pollution (Health Impact)

3. **Patrick Harvie (Glasgow) (Green):** To ask the Scottish Government what work it is doing to assess and reduce the health impact of air pollution. (S5O-02059)

The Minister for Public Health and Sport (Aileen Campbell): The Scottish Government takes the issue of air pollution very seriously and is committed to the protection of public health from the effects of poor air quality. Compared with the rest of the United Kingdom and other parts of Europe, Scotland enjoys a high level of air quality, but we cannot be complacent about that.

Our "Cleaner Air for Scotland" strategy sets out an ambitious programme of action to promote air quality and Scotland is the first country in Europe to pass legislation based on World Health Organization guidelines for fine particulate matter.

We are also providing practical and financial support to financial authorities in tackling local air pollution hot spots. Plans are under way to have Scotland's first low-emission zone in place in Glasgow by the end of 2018.

Patrick Harvie: The situation, particularly in Glasgow, is not as rosy as has been suggested. I think that the minister said that Scotland has great air quality. There are areas of Scotland that have consistently, over many years, failed to meet basic air quality standards. As someone who lives in one of those pollution hot spots, I agree with the opposition councillors who have called for the low-emission zone to be implemented more rapidly than the council proposes. That is the council's decision, but what support will the Scottish Government give Glasgow City Council to assess the difference in health impact that would be achieved by more rapid implementation of the LEZ, for which the opposition parties in the council are calling?

Aileen Campbell: We are working with local authorities on low-emission zones. I do not think that it is overstating things to say that, compared with the rest of the UK and other parts of Europe, Scotland enjoys high levels of air quality. However, I never suggested for a minute that we are not working hard to make sure that we do more where we can. We are absolutely not being complacent. Some £10.8 million in funding has been allocated this financial year to support the implementation of local low-emission zones, with a particular focus on set-up costs and bus retrofit, for example. We will continue to work with our local authority partners to make the improvements that we need to make.

Kenneth Gibson (Cunninghame North) (SNP): Around 1.5 million people in Scotland smoke, and cigarette smoke contains more than 4,500 compounds. Those include acetaldehyde, a carcinogen, acetone, which damages the liver and kidneys, and ammonia, a cause of asthma and high blood pressure. Does the minister agree that if we are serious about breathing clean air we must continue to do everything possible to persuade people to quit smoking?

Aileen Campbell: Absolutely. We must continue to do everything possible to persuade people to stop smoking. Our efforts in Scotland on smoking rates have been bold and progress to date has been good. We are also among the first in the world to set a target of being tobacco free by 2034. Quitting is the best thing that smokers can do to improve their health, and we would encourage any smoker to try quitting in their own way and to make use of the free stop-smoking support that is available to them. I point the member to the quit your way campaign that we have taken forward to ensure that people

understand the many different ways in which they can get support to help them to quit the habit.

Minimum Unit Pricing of Alcohol (Impact on Health)

4. **Clare Adamson (Motherwell and Wishaw) (SNP):** To ask the Scottish Government what impact it expects minimum unit pricing of alcohol will have on health. (S5O-02060)

The Cabinet Secretary for Health and Sport (Shona Robison): Last week saw the introduction of a minimum price of 50p per unit of alcohol. The University of Sheffield modelling estimates that, in the first year, that will result in 58 fewer alcohol-related deaths and nearly 1,300 fewer alcohol-related hospital emissions, and that, over a five-year period, we could expect 392 fewer alcohol-related deaths and 8,254 fewer alcohol-related hospital admissions. The monitoring and evaluation plan for minimum unit pricing, which is being led by NHS Health Scotland, includes examining the impact on alcohol-related harms.

Clare Adamson: Recent figures show that, in 2016 in North Lanarkshire, there were 122 alcohol-related deaths, which cost the national health service in North Lanarkshire an estimated £116 million, so I am pleased to hear the cabinet secretary say that minimum unit pricing should go some way towards reducing costs. Does she agree that the minimum unit pricing model that Scotland has introduced is one to which other countries will be paying close attention, with a view to rolling out the model elsewhere?

Shona Robison: The Welsh Assembly introduced legislation for minimum unit pricing of alcohol in October last year. The Government of Ireland's Public Health (Alcohol) Bill includes a provision for minimum unit pricing, and passed the second stage in the lower house in March this year. On Tuesday, the Parliamentary Under Secretary of State for Public Health and Primary Care, Steve Brine MP, confirmed that the United Kingdom Government is commissioning Public Health England to review the evidence for minimum unit pricing in England. I also understand that the Northern Territory in Australia is currently considering a minimum floor price for alcohol. It is a landmark Scottish policy, which other countries around the world are watching with interest.

David Stewart (Highlands and Islands) (Lab): The cabinet secretary will be well aware that the Parliament has already agreed to legislative provision for a social responsibility levy and that it is up to Government to further its implementation. Will she look again at that levy? It could help to fund third sector groups at local level to try and fight the issues caused by drink-related problems.

Shona Robison: The additional revenue that was predicted by the University of Sheffield is very much an estimate. Through the evaluation, we will see where any additional revenues fall, which is important, as we have explored at the Health and Sport Committee. The social responsibility levy was always considered to be a local mechanism that could be used to address local circumstances. However, as I told the committee, we will keep those things under review as the policy goes forward, and that is something that I am happy to keep members informed about.

Fife Health and Social Care Partnership (Suspension of Out-of-hours Services in Dunfermline, St Andrews and Glenrothes)

5. **Claire Baker (Mid Scotland and Fife) (Lab):** To ask the Scottish Government what discussions it has had with Fife health and social care partnership since its decision to suspend overnight out-of-hours services in Dunfermline, St Andrews and Glenrothes. (S5O-02061)

The Cabinet Secretary for Health and Sport (Shona Robison): The decision to move to contingency measures for the provision of the out-of-hours service in Fife was taken for reasons of patient safety. Officials are in regular contact with Fife health and social care partnership regarding those measures and the on-going situation.

Claire Baker: Following the closure of the out-of-hours services, the director of health and social care highlighted growing difficulties in securing clinical cover by both general practitioners and nurses, as a result of national shortages. In Fife, those are well-known difficulties, with many practices struggling to get GPs during the day, never mind at night. Does the cabinet secretary accept the Government's responsibility in creating that situation? Given those concerns, is she confident that the services in Dunfermline, Glenrothes and St Andrews will reopen in two months' time, when they are up for review?

Shona Robison: As Claire Baker knows, and as I said in my initial answer, the changes to out-of-hours primary care services are a short-term measure that was adopted in the interests of patient safety. NHS Fife is reviewing its longer-term arrangements for out-of-hours care and has undertaken an options appraisal exercise. A public consultation will commence in June, prior to any permanent decisions being made, and we will continue to liaise with NHS Fife throughout the review process.

In Fife, there are significant issues with GP recruitment, which Claire Baker has spoken about, and GP retention. We believe that the new GP contract, along with the £110 million investment in primary care that there has been in this year alone will help to make general practice more attractive

and to build on local innovation that has taken place over the past few years. For example, we think that the recruitment and retention fund will be of assistance to local areas that are seeking to recruit. I should also say that the workforce plan that was published recently has a commitment to recruiting an additional 800 GPs over the next 10 years.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Does the cabinet secretary share my concern that no equality impact assessment was carried out prior to the temporary closure of Glenrothes hospital's out-of-hours service, especially given that such an assessment was a key recommendation of the Ritchie review and that one in three children in Glenrothes lives in poverty?

Shona Robison: I understand that an equality impact assessment was not completed due to the emergency nature of the contingency arrangements, which were put in place as a result of clear clinical advice. Although a formal assessment was not carried out, I have been advised by the Fife health and social care partnership that the impact on various communities and groups was part of the decision-making process in relation to the contingency. Such an assessment has been completed in relation to the longer-term plans for the service, and that will continue to be updated.

Access to Healthcare (Funding for Travel Expenses)

6. **Gail Ross (Caithness, Sutherland and Ross) (SNP):** To ask the Scottish Government what funding packages are in place to meet the expenses of people who have to travel considerable distances to access healthcare, including outside their own national health service board area. (S5O-02062)

The Cabinet Secretary for Health and Sport (Shona Robison): A range of options is available to patients who require financial assistance with travel costs. They include the Scotland-wide patient travelling expenses scheme, for those on qualifying benefits, and the Highlands and Islands travel scheme, which provides assistance to all those who live in remote areas. In addition, all health boards have discretion to reimburse patient travelling expenses where they are viewed as an extension of treatment costs and are deemed to be clinically necessary.

Gail Ross: The cabinet secretary will be aware that some people in Caithness, Sutherland and Ross have had to travel for miles to access specialist care at Raigmore hospital in Inverness, with some having to take days off work, often for minor appointments. Can she tell me how the introduction of the NHS near me videoconferencing service will change that, and whether we will see it rolled out to other remote and rural areas?

Shona Robison: NHS near me uses the nationally available attend-anywhere video consultation service that is funded by the Scottish Government's technology-enabled care programme. It provides a secure video consultation environment for any service delivery organisation and can be accessed anywhere, by a member of the public using a web browser or app on their laptop, tablet or smartphone.

In Highland, near me's initial focus has been on supporting the Caithness area while developing the service, but it is now working closely with the Scottish centre for telehealth and telecare to roll it out to further areas in the region. Uptake of the service continues to increase and can, of course, prevent people from having to travel unnecessarily.

Edward Mountain (Highlands and Islands) (Con): Given that we are now 18 months after a major service redesign at Caithness hospital, does the cabinet secretary believe that the 200-odd mothers and their families who travel to the maternity unit at Raigmore should be provided with suitable accommodation at a hospital that, sadly, is still below what has been agreed as being suitable?

Shona Robison: Edward Mountain will be well aware of the reasons for the change of status of Caithness maternity unit, which was made by NHS Highland on the ground of safety, and informed by the review that it commissioned after the death of a child in September 2015.

Making sure that accommodation at Raigmore is suitable is an issue that has been raised with NHS Highland on a number of occasions, and its importance has been impressed on the board. I understand that it has taken action to make improvements on the Raigmore site, and I will continue to press it on that.

New General Practitioner Contract (Consultation with People in Remote and Rural Areas)

7. **Rhoda Grant (Highlands and Islands) (Lab):** To ask the Scottish Government what action it is taking to consult people in remote and rural areas on the impact of the new GP contract. (S5O-02063)

The Cabinet Secretary for Health and Sport (Shona Robison): The Scottish Government commissioned the Health and Social Care Alliance Scotland to engage with patients across Scotland, including those in rural areas, on the new contract. The alliance will soon publish a report on that engagement, which will provide valuable feedback

to local health and social care partnerships, which are developing their primary care improvement plans. Those plans will set out how the new GP contract will be implemented locally to best meet the needs of patients.

Rhoda Grant: A contract that is based on the number of appointments does not take account of travelling time for rural GPs, who make more home visits due to the lack of public transport in rural areas, meaning that frail elderly people cannot come to the surgery. The contract shows no recognition whatsoever of the difference in rural practice. Similarly, the Scottish index of multiple deprivation, which is used, does not show rural deprivation, meaning that rural GPs miss out again.

The Scottish Government has not heard rural GPs, far less their patients—

The Deputy Presiding Officer: Ask a question, please.

Rhoda Grant: How will the Scottish Government rectify the situation and ensure that everyone has access to a GP?

Shona Robison: The Scottish Government, in collaboration with the Scottish general practitioners committee of the British Medical Association, is establishing the rural short-life working group, which will work with rural stakeholders to assist in the implementation of the new GP contract. I understand that the first meeting of the group will take place later this month.

Liam McArthur (Orkney Islands) (LD): Following on from that response, can the cabinet secretary advise Parliament on the timeframe for that short-life working group? Will she also ensure that the group includes island representatives to reflect the specific issues that arise in island communities?

Shona Robison: As I said in my previous answer, the group will meet later this month. A lot of effort has been put into looking at the group's membership and, as I understand it, there is island representation on it. I am happy to write to the member with further details of who those people are.

Drug and Alcohol Services (Quality of Service)

9. **Ruth Maguire (Cunninghame South) (SNP):** To ask the Scottish Government how it ensures that quality is embedded and evidenced in drug and alcohol services. (S5O-02065)

The Minister for Public Health and Sport (Aileen Campbell): In 2014, we developed the quality principles that define the standards that people can expect when using a treatment service. The principles put the person at the centre and build a recovery plan around their strengths.

In 2015, the Government commissioned the Care Inspectorate to support alcohol and drug partnerships to evaluate service quality against those principles. We were assured that quality is embedded in our services and that they work for recovery, but there is always room to do more and local improvement plans are in place to evidence that.

Ruth Maguire: Is the minister aware of the high-quality cafe solace in my constituency? A huge part of its success comes from a whole-population approach being taken to tackling the challenges that our community faces, including food poverty and providing people who are in recovery a way to build skills and to give back locally. Will the minister join me this summer on a visit to cafe solace to meet peer mentors to see first-hand its high quality and Convention of Scottish Local Authorities gold award winning work?

Aileen Campbell: I am happy to meet Ruth Maguire in her constituency and to visit the cafe so that I can learn more about, and see first-hand, its excellent work. I understand that, last year, cafe solace also won a COSLA excellence award.

I have been fortunate to visit a number of recovery communities across Scotland—there are more than 120—and to have had the opportunity to speak to many people for whom those communities act as the foundation of their recovery from drug and alcohol use. Those community initiatives are incredibly important, so I would welcome the opportunity to see the good work that is happening in the member's constituency.

Neil Findlay (Lothian) (Lab): Global Drug Survey's report "GDS2018 Key Findings Report" today shows the extent of drug use in Scotland, with users taking more cocaine in a single session than people anywhere else in the world, and drugs being delivered quicker than a pizza. I am coming across more and more people whose mental and physical health are seriously affected by cocaine use. If we are looking at having evidence-led policy, is not that evidence, and the level of drug deaths in Scotland, evidence enough that our policy is failing?

Aileen Campbell: We have made a number of advancements through our strategy. A low number of young people are taking drugs and, overall, the number of people taking drugs is declining.

Neil Findlay is shaking his head. I absolutely recognise his point about the issue of cocaine that has been raised in the press today. I also absolutely accept that we see drug deaths every year. That is why I decided to refresh our current

approach. That will build on our existing strengths but do more to recognise the changing landscape of drug use.

If Neil Findlay wants to bring constructive ideas to me, as opposed to criticising continually from the sidelines, my door is open. The issue is important. I do not want to get hung up on party politics, so I ask him, please, to come to my office to meet me and tell me his ideas, which we will make sure are part and parcel of the new strategy that I am developing.

Mental Health Strategy (Implementation)

10. **Mairi Gougeon (Angus North and Mearns) (SNP):** To ask the Scottish Government whether it will provide an update on the implementation of its mental health strategy. (S5O-02066)

The Minister for Mental Health (Maureen Watt): In the summer, I will present to the Scottish Parliament an annual report on the mental health strategy's actions. Progress reports for all 40 actions that are in the strategy were uploaded to the Scottish Government's website in December, when we also uploaded a report that summarised progress on key deliverables. I would be happy to provide Mairi Gougeon with links to those reports.

We held the second biannual forum of stakeholders on 6 December. The forum is intended to track progress on the actions that are in the strategy, and to help to develop new actions in future years that will help us to meet our ambitions. At the meeting in December, I spoke about our achievements over the previous half year, the challenges that lie ahead and the roles of everyone involved, going forward.

Mairi Gougeon: I was contacted by a pressure group from Mackie academy in Stonehaven that is concerned about the support that is available for teenagers and children who are struggling with mental health issues. The group particularly mentioned lack of training for general practitioners, who have told some children that they are "going through a phase", and it asked for mental health training to be included as part of teacher training, for early intervention.

Given that early intervention is vital, will the minister outline how funding for the mental health strategy is being targeted in that regard? Are measures such as having on-site counsellors or community psychiatric nurses in schools being considered?

Maureen Watt: I completely agree that focusing on prevention and early intervention is fundamental if we are to achieve our mental health strategy's vision and aspirations. Training has a central role to play, which is why action 2 of the strategy is to

"Roll out improved mental health training for those who support young people in educational settings."

Since 2014, the Scottish Government has provided £6,000 per annum to Education Scotland for the roll-out to local authorities of Scotland's mental health first-aid training for children and young people. The aim is to train staff in secondary school communities so that they are more confident about approaching pupils who might be struggling with a mental health problem. The training complements a range of mental health strategies that are in place in local authorities.

Mary Fee (West Scotland) (Lab): To ensure that the mental health strategy, which covers the period from 2017 to 2027, is delivering for people, it would be beneficial to know when each action should be implemented. Why are very few timescales attached to the actions that are set out in the strategy?

Maureen Watt: As Mary Fee rightly said, the strategy covers a 10-year period. Some actions have already been implemented. The Scottish Government certainly has a timeline for each action, which I use to monitor progress on each action closely. I can provide the member with further details on that, if she wishes.

Antidepressants (Overuse)

11. **Michelle Ballantyne (South Scotland) (Con):** To ask the Scottish Government what its position is on concerns regarding the overuse of antidepressants. (S5O-02067)

The Minister for Mental Health (Maureen Watt): People who experience mental ill health should expect the same standard of care as people with physical illnesses, and they should receive medication if they need it. The prescription of any medication, including antidepressants, is a clinical decision that is made in discussion with the patient, and there is good evidence that health professionals assess and treat depression appropriately.

In addition, we are committed to improving access to alternatives, such as psychological therapies, that increase choice and best accommodate patient preference. The Scottish Government supports the breathing space and NHS living life services that are provided to people who experience depression. That work is a key element of wider work across Scotland to intervene early and to prevent problems from becoming worse, and it aligns well with our policy of improving prevention and intervening early, which is one area of focus for our new 10-year mental health strategy.

Michelle Ballantyne: The number of children under 18 being prescribed antidepressants

doubled from 2,748 in 2009-10 to 5,572 in 2016. Although that might reflect an increase in the demand for child and adolescent mental health services, it potentially highlights a worrying reliance on pharmacological solutions to mental health problems. Does the Scottish Government agree that 10-minute general practitioner appointments, combined with a lack of appropriate mental health services, is leading to overdependence on pharmacological solutions that is having a devastating impact on countless lives across Scotland?

Maureen Watt: As I said in my first answer, the prescription of antidepressants is a clinical decision. It is not for Government to intervene in such decisions. However, I also said that it is important to have alternative therapies and quick responses for people, including young people, who have mental health problems. That is why, in the shift to placing more emphasis on primary care, we are ensuring that counsellors are available early, instead of young people having to wait longer on CAMHS. However, I am also ensuring that those services are moving towards meeting their waiting time targets.

Sport (Support for Participation in Renfrewshire South)

12. **Tom Arthur (Renfrewshire South) (SNP):** To ask the Scottish Government how it supports participation in sport in the Renfrewshire South constituency. (S5O-02068)

The Minister for Public Health and Sport (Aileen Campbell): The Scottish Government remains committed to encouraging more people to take part in sport and physical activity at all levels. Sportscotland invests directly in East Renfrewshire Council and Renfrewshire Council, which cover the parliamentary constituency of Renfrewshire South, to support a number of programmes and outcomes in school sport, club sport and coaching and volunteering. For example, in 2016-17, there were 412,180 visits to active schools activities across East Renfrewshire and Renfrewshire and there are now 11 community sports hubs up and running.

Tom Arthur: Barrhead Youth Football Club has recently increased and expanded the number of its girls teams at various age levels, which I know are already hugely popular. Will the minister join me in congratulating Barrhead YFC on its fantastic work and can she outline how the Government supports opportunities for girls and women to participate in football?

Aileen Campbell: Absolutely. I join the member in congratulating Barrhead YFC on its work and I congratulate all those involved in the work that is going on in football the length and breadth of the country. We had the opportunity a couple of weeks ago to celebrate in the Parliament some of that good work and recognise the effort that is being made to ensure that women and girls get the chance to participate in the beautiful game. The Twitter hashtag that is used for that is #OurGirlsOurGame, and anyone who looks at the Twitter world will see exactly how much fantastic work is being done, driven by volunteers and supported by the Scottish Football Association and others, to ensure that girls get the opportunity to play football.

Brian Whittle (South Scotland) (Con): Is the minister working on delivering a physical literacy pathway that goes from pre-school physical activity into school physical education and then on into the third sector and communities, so that we can ensure that opportunities to access sport and physical activity are as easy as they can be?

Aileen Campbell: We are working on a physical activity plan for all ages and stages and ensuring that all efforts and policies for those ages and stages are linked appropriately with the work that we are taking forward. For example, the on-going work on play makes a very good link with the work that we want to take forward to ensure that young people in particular get the co-ordination skills and the fine motor and gross motor skills that they require to enable them to continue to be active or to proceed into participation in sport at all levels. We hope that some might be on a podium, as the member was a few years ago.

NHS Greater Glasgow and Clyde (Meetings)

13. **Rona Mackay (Strathkelvin and Bearsden) (SNP):** To ask the Scottish Government when it will next meet NHS Greater Glasgow and Clyde. (S5O-02069)

The Cabinet Secretary for Health and Sport (Shona Robison): Ministers and Scottish Government officials regularly meet representatives of all health boards, including NHS Greater Glasgow and Clyde, to discuss matters of importance to local people.

Rona Mackay: There is a campaign in my constituency to have an out-patient chemotherapy service at Stobhill hospital, as was originally planned when the new hospital opened in 2010. Does the cabinet secretary agree that that service should be available, where appropriate, closer to home in order to avoid patients having to make tiring journeys before and after treatment?

Shona Robison: I am familiar with the campaign and I have, over the years, met some of the campaigners. However, I understand that the expert clinical view is that local people are best served by receiving treatment at the specialist Beatson oncology centre in Glasgow. That said, I know that the health board has assured local

campaigners that it will keep the service under review and consider what other local provision would be possible and appropriate.

Multiparametric Magnetic Resonance Imaging Scans (Prostate Biopsies)

14. **Mark Griffin (Central Scotland) (Lab):** To ask the Scottish Government what plans it has to ensure that all eligible men receive an mpMRI scan before a prostate biopsy. (S5O-02070)

The Cabinet Secretary for Health and Sport (Shona Robison): Multiparametric magnetic resonance imaging scans are currently being trialled to examine their feasibility and safety as a diagnostic tool in men with prostatic disease. The initial results of the study indicate that MRI could be used as a diagnostic tool in the future, and that it might in time decrease the need for traditional prostate biopsies. Our national advisory groups, such as the national cancer clinical services group, will keep such studies in mind when they are developing future cancer services in Scotland.

Mark Griffin: In December 2016, the cabinet secretary announced the formation of a urology cancer services review, in recognition of the fact that prostate cancer is the most common cancer among men and will be the most common cancer in the country by 2030. That review has not yet reported back. In September 2017, the cabinet secretary also created the ministerial cancer performance delivery group, but it will not report back until the urology service review has reported. When will the urology services review report back and will the scope of the review cover the adoption of mpMRI?

Shona Robison: I will write to Mark Griffin with an update on the timeline for the urology services review, as he has asked me to do. It is very important that we get urology right in Scotland, especially given that urology services are experiencing the greatest difficulties in recruiting staff—that is currently one of the challenges that we face in delivering on our cancer targets. I will get back to Mark Griffin with a timeframe for the services review.

As I said in my first answer, a study is under way to ensure that we gain the relevant clinical evidence on mpMRI. We would rely on groups such as the national cancer clinical services group to advise us on whether it should be rolled out. Again, I am happy to keep Mark Griffin updated as further information comes forward.

Out-of-hours Dental Care

15. **Alexander Burnett (Aberdeenshire West) (Con):** To ask the Scottish Government what action it is taking to ensure that all national health service boards provide out-of-hours dental care. (S5O-02071)

The Cabinet Secretary for Health and Sport (Shona Robison): The responsibility for ensuring access to out-of-hours emergency care for patients who are registered with a dentist under the NHS rests with their dentist. The Scottish Government has provided additional funding to NHS boards to put in place out-of-hours services, with appointments being triaged by NHS 24 in line with national clinical guidance. The specific arrangements for providing any required out-of-hours care for patients who have been triaged are for the relevant NHS board to make, in conjunction with practitioners who have a responsibility to their patients.

Alexander Burnett: I represent a rural constituency, and many of my constituents understand the need for some travel to reach health appointments. However, a constituent of mine was told two weeks ago that the only available out-of-hours dental care was at a centre that would require him to make a 110-mile round trip. Will the cabinet secretary ensure that out-of-hours dental care can be made available without requiring people to make such a lengthy journey?

Shona Robison: I am aware that NHS Grampian is conducting a review of its out-of-hours dental care. No decision has been made at this stage, but the board is currently looking at how to deliver the most effective service provision for patients, and I will ensure that Alexander Burnett is kept informed of the outcome of those discussions.

The Deputy Presiding Officer: I call Tavish Scott to ask question 16. Mr Scott, you have managed it this time—you are very patient.

National Health Service (Regionalisation)

16. **Tavish Scott (Shetland Islands) (LD):** You caught me cold there, Presiding Officer.

To ask the Scottish Government, in light of reported comments by the health secretary regarding co-operation between national health service boards that “there will be a regional structure in place”, whether it will provide further details of this policy, and what the implications are for regional NHS boards. (S5O-02072)

The Cabinet Secretary for Health and Sport (Shona Robison): We have been clear that there are no plans to reduce the number of territorial health boards. Our focus is on ensuring better joint working between national health service boards and other partners through more effective regional planning of services. As part of that, three regional implementation leads have been selected from the existing cohort of NHS board chief executives. Working collaboratively with NHS boards and their

partners, they are leading the overall design and planning of services at a regional level to provide better patient outcomes and more efficient and sustainable services.

Tavish Scott: I am grateful for that clarification. Is Shetland NHS Board in the north area that the cabinet secretary described? Is there a regional plan? If so, has that been submitted to the Government? When will it be published?

Shona Robison: We have received draft plans from the regions. Over the summer, they will be embarking on public engagement to discuss some of the details in those plans. I hope that Tavish Scott will have the opportunity to attend one of those events.

The Deputy Presiding Officer: That concludes portfolio questions, and I am still in a good mood.

NHS Tayside (Mental Health Services)

The Deputy Presiding Officer (Christine Grahame): The next item of business is a debate on motion S5M-12107, in the name of Anas Sarwar, on the NHS Tayside public inquiry. [*Interruption*.] Quiet, children! I call Anas Sarwar to speak to and move the motion. You have eight minutes, Mr Sarwar.

14:41

Anas Sarwar (Glasgow) (Lab): It is a relief to hear that you are still in a good mood, Presiding Officer.

Last week, the Parliament heard about the tragic case of David Ramsay. David hung himself four days after his second emergency assessment at the Carseview centre. David's case is sadly not an isolated one. In the past year, there has been a 61 per cent increase in the number of suicides in Dundee. However, it is not about the statistics; it is about people's lives. Many of the families that have been affected join us in the public gallery today. They have been campaigning for an inquiry into mental health services in Tayside for more than three years.

On Thursday, Richard Leonard raised the case of David Ramsay and the demands of the families at First Minister's question time. On Friday, NHS Tayside announced a review into Carseview. Today, the Government's amendment goes further, with a commitment to a wider inquiry into mental health and suicide prevention services across the region.

It should not take raising such issues in Parliament to get action. I hope that the debate will mean that our Parliament can genuinely unite in solidarity with the families' campaign, after its three-year struggle. That will demonstrate to the families that we have listened and we have acted. I cannot begin to imagine the pain and suffering that they have gone through, so we cannot thank them enough for turning that absolute grief into a campaigning effort. It has been an effort to get answers about what happened to their loved ones, but, equally, it has been an effort to deliver change in order to prevent it from happening to anyone else. I thank each and every one of them. We cannot thank them enough.

Labour members are minded to support the Government's amendment. However, like the families, we still have questions, and we need further reassurances and commitments from the Government. Crucially, the independent inquiry needs to be exactly that—a genuinely independent inquiry. The Government must recognise that

there are clear trust issues with NHS Tayside, so it must appoint a genuinely independent chair. The families must also be included in the process of agreeing the terms of reference of the inquiry. We must ensure that the families are part of the process throughout the inquiry and that they feel included. The inquiry must be open and transparent, and it must include a public call for evidence. I emphasise that it cannot be those things only in words. The inquiry must be visibly independent, visibly inclusive, visibly open and transparent and visibly supportive of the families' demands.

The Cabinet Secretary for Health and Sport (Shona Robison): I can say yes to all those questions. I have had assurance from the chair of NHS Tayside, John Brown, that that will be the case.

Anas Sarwar: I thank the cabinet secretary for her intervention. Everybody inside and outside the chamber knows that, at times, there is no love lost between me and the cabinet secretary, but I hope that we are genuinely as one on this issue. If that is the case, I thank her, and I thank her for listening to the voices of the families. I hope that, in her speech, she will set out in more detail how the five principles will be delivered in practice, so that the families will have the comfort of a genuinely independent inquiry and of being part of the process. We must learn the lessons of previous inquiries and ensure that those who have been affected are involved in the process. It would be an absolute tragedy if any inquiry did not have the full support and confidence of the family in its process and its final report. Confidence is crucial—we cannot allow this to become a repeat of the mesh inquiry.

The inquiry has national significance. As today's report by Professor Rory O'Connor found, one in nine young people in Scotland has tried to commit suicide and, at some point in their life, one in six young people in Scotland will self-harm. The lessons from this inquiry, if it is done right, could help to better inform and design services not just in NHS Tayside but throughout Scotland. One in three people will have a mental health issue at some point in their life. The number of children with recorded mental health problems in our schools has more than doubled between 2012 and 2016. That is why we must ring fence mental health budgets to ensure that resources reach the front line, where they are needed most. We need to guarantee access to a school-based counsellor for every pupil in Scotland.

An area that needs specific investigation in NHS Tayside and right around Scotland is emergency mental health services. The reality for too many patients is that they cannot wait for days to see a general practitioner and then wait weeks or even months to see a counsellor or psychologist. We need to build emergency services that are supported by better use of technology so that people can speak to a counsellor quickly. That can be the difference between life and death for many individuals.

I have spoken about the wider challenges with mental health and of the importance of having the confidence of the affected families, having an open and transparent process, taking the families on a journey and giving them the answers that they want and need and the closure that they deserve, as well as delivering for the many families in Tayside that are concerned about the situation. It is also important to highlight that this is not just an issue in Tayside. I have been struck by the number of families that have said that this is about what happens across Scotland. We must make sure that we speak for them.

I will conclude by reading an email that I received from the niece of David Ramsay a couple of weeks ago. It tells the story of the families in their own words, explaining what they have gone through, what they demand and why they will not give up until they get what they want. It does that better than I or any other member in this Parliament could ever do. The email opened my eyes, and I struggled to read it because of the raw emotion that it contains.

David Ramsay's niece, Gillian Murray, wrote:

"There is no doubt in our minds that David has been failed. My family is now another sad statistic in Dundee. There are so many of us in the same situation that it is terrifying. David was not just my uncle, he was my best friend, so watching him literally lose his mind in front of me with no support from the national health service fuels the anger that I feel that he was let down. Carseview Centre passed on any responsibility to myself and family. We tried our best but it wasn't good enough. I was having to Google how to care for a suicidal individual since Carseview and NHS Tayside took no ownership. It is no wonder I now suffer from post-traumatic stress disorder. It is a living hell knowing that I asked the NHS for help and David asked the NHS for help, as well as other members of my family, and we were repeatedly ignored, resulting in David's death. The advice David got was that they had 'nipped it in the bud, go out and do normal things like walk the dog'. The guilt plagues us every day. I ran around Templeton Woods for over two hours. By the time I got to David, it was too late. David took the advice; he did go and walk the dog. He hung himself with the dog lead. No other family should have to go through this sheer agony knowing that their loved one's death was preventable. David's life has been taken from him and my life has been destroyed in the process, as have the rest of my family's lives, and those of other families in Dundee. This crisis cannot continue and will not continue. I will not stop. We cannot grieve and we cannot move on with our lives without some form of justice. You wouldn't expect a murder victim's family to simply 'move on', so why should our families, whose loved ones have lost their lives, be any different?"

The answer to Gillian's question is that they should not. I hope that this Parliament stands

united with her and all the families in their pursuit of justice. [*Applause*.]

I move,

That the Parliament notes the catalogue of concerns regarding mental health services in NHS Tayside raised by campaigners and families of people who have died by suicide in the region; understands that Dundee has had a 61% increase in its suicide rate in a year, and agrees with the families' call that the Scottish Government must instigate a public inquiry into mental health services in the region.

The Deputy Presiding Officer: I say very gently to the members of the public who are in the public gallery that we do not permit applause. I understand why you want to applaud and I have every sympathy, but it is not permitted.

14:50

The Minister for Mental Health (Maureen Watt): I recognise the strength of those who have raised the cases of their loved ones who have been lost to suicide, and I thank them for their determination to prevent the pain and suffering that they are experiencing being visited on others. I commend them for coming to the gallery to be with us today and I look forward to meeting them soon. Their efforts have led to the new leadership team of NHS Tayside setting out that it will commission an independent inquiry.

I commend Anas Sarwar for his moving remarks. As he said, on Friday, John Brown and Malcolm Wright, the chair and chief executive of NHS Tayside, announced the inquiry into mental health services at the Carseview centre. They have since broadened the inquiry to cover mental health services across Tayside.

Miles Briggs's amendment sets out that the inquiry should cover the whole region and that the families who have been affected must be involved in the establishment and remit of the inquiry. I agree, so we will support his amendment as we will Anas Sarwar's.

As we know, mental health services do not operate in a vacuum. Their quantity and benefit depend on meaningful and coherent links between community, specialist and crisis services. I support the commitment that has been made by NHS Tayside to ensure that the findings and recommendations of the recent reports by the Mental Welfare Commission and Healthcare Improvement Scotland are fully considered through the inquiry.

I am also pleased to see the commitment to work with staff and to hear from patients and families. It is vital that their voices are clearly heard and responded to. I am confident that the newly appointed chair and chief executive of NHS Tayside will create the environment for an effective and independent inquiry. That will allow the inquiry to be established and undertake its work quickly, ensuring that any necessary changes are expedited. However, should it be apparent that the inquiry is not independent or that barriers to its work exist, the health secretary will use the statutory powers available to her to make that happen. As the cabinet secretary said, the answer all of Anas Sarwar's asks is yes.

Within the recent debate around mental health services, there has been a specific focus on the tragedy of those who have died or attempted to die through suicide. We are currently working with people and organisations from across Scotland to conclude a new suicide prevention plan, which will be published in the summer. Progress has been made in the past decade, with a 17 per cent reduction in the number of deaths from suicide, but I want us to go further. My view is clear: suicide is preventable.

We need our services to work more closely with each other so that the support that is given to those in crisis is coherent and effective. That is important not only for those who are in contact with health services but for developing new approaches to reaching those who are considering suicide but are not in contact with any service. Around a quarter of suicides are carried out by those who have not been in contact with health services.

As part of the suicide prevention plan work, I want to see a national suicide prevention leadership group established to drive the required changes. The plan will support the development of appropriate reviews into every death from suicide. I want a process that, where necessary, involves multidisciplinary reviews and that ensures that learning and knowledge from every suicide is shared and considered and that improvements are made.

The Parliament has already legislated for a review of the arrangements for reviewing the deaths of people who were receiving mental health treatment under section 37 of the Mental Health (Scotland) Act 2015. That review will report in December this year. I want the development of a process to review all deaths by suicide to take account of the recommendations of the section 37 review, which will help to drive local and national learning.

I also want a more consistent and coherent approach to supporting those who have lost a loved one through suicide and those who are themselves at risk of suicide. Bereaved relatives and friends have told me of the improved support that they require while they are involved in the review.

I note that the Samaritans welcome the proposals in our amendment. We will continue to work with the organisation on this and on other issues that it highlights, not least isolation and loneliness.

We all know that there is rarely any single identifiable causal factor for individual deaths by suicide. However, through sharing knowledge and learning and by ensuring that services and support are effective and joined up, and that all those who are at risk of taking their life through suicide get the help that they require, we will deliver the changes that are required. The independent inquiry in Tayside will be an important part of that learning and of the improvement of services.

I move amendment S5M-12107.3 in Shona Robison's name, to leave out from "understands" to end and insert:

"welcomes the decision of the new chair of NHS Tayside to commission an independent inquiry into mental health and suicide prevention services across the region; believes that this inquiry must be an opportunity to capture the concerns of the patients and families who have felt let down by services; considers that the inquiry should also help ensure that recommendations from recent Health Improvement Scotland and Mental Welfare Commission inspection reports are fully implemented; believes that, if the NHS Tayside-commissioned inquiry is hindered in its undertaking by either non-cooperation by providers or by lacking appropriate independence, the Scottish Government should subsequently convert it to an inquiry under the auspices of the Inquiries Act 2005; supports calls for the forthcoming Suicide Prevention Strategy to help deliver more constant crisis support for people who have lost a loved one to suicide; approves of the creation of a national suicide prevention leadership group to help support the creation and delivery of local prevention action plans, and endorses the inclusion of the development of reviews, where necessary multi-agency, into all deaths from suicide as part of the new Suicide Prevention Strategy."

14:57

Miles Briggs (Lothian) (Con): I grew up in Perthshire, and I know many individuals and families who have experience of NHS Tayside's mental health services. In the majority of cases, they have received help, support and treatment, which has helped them to get their lives back on track. However, I also know of cases and individuals who have been failed, and questions remain over what has gone wrong. NHS staff in Tayside work hard to deliver the best mental health services that they can in the fact of huge resource pressures and patient demand.

I pay tribute to the families who have joined us today in the public gallery and to all those who have spoken out. It cannot be easy for them as they seek the answers that they so desperately need about how their loved ones have not been given the care and support that we all expect our NHS to provide.

It is right to condemn the personal attacks that the campaigners have faced, mainly on social media, simply for speaking out. That has been shocking to witness. I particularly pay tribute to Gillian Murray and the lost souls group for the campaign that they have undertaken to seek the answers that families in Tayside so desperately need.

Last Friday, when NHS Tayside announced a limited inquiry into Carseview in Dundee, I said that it was clear that that was not acceptable to families across Tayside. I made that view known to the Scottish Government.

It is clear from many families across NHS Tayside that there remain many unanswered questions. From the outset, it has been clear that a wider independent inquiry is needed to find out what went wrong in so many cases at a number of facilities across the region. That inquiry must truly address the problems and get answers, ensuring that we prevent such mistakes from ever happening again in the future.

I know from my colleagues who represent the Mid Scotland and Fife and North East Scotland regions in the Parliament that they have cases of individuals and families where mental health services have failed. In some cases, suicides have taken place in NHS facilities, when individuals have meant to be under the safe care and supervision of NHS Tayside.

From the outset, Scottish Conservatives have focused attention on supporting the families and ensuring that their voices are heard. That is what my amendment seeks to achieve in securing a wider independent inquiry across NHS Tayside—one that will allow for concerns to be investigated comprehensively in order to restore faith in services among patients and their relatives and friends. The prevalence of suicide in Scotland, especially among men, should focus all our minds.

Like the previous two speakers, it is my belief that there will be learning for other parts of our health service from such an inquiry's findings—lessons that must be learned and services that must be improved. No more individuals should face crisis and then be denied help.

I say to the cabinet secretary that it is imperative that families who are seeking answers are included in the establishment and remit of the wider inquiry. I would like to endorse Anas Sarwar's points on the five principles of the inquiry.

We know that we face a crisis in our mental health services across Scotland. The cases that have come to light in NHS Tayside have demonstrated that in the most concerning of ways. Those who have campaigned to make today's debate happen and for this Parliament to listen

should be valued for what they have done to open up the issues to the rest of the country.

Above all, today cannot be about shutting down concerns; it must be about opening them up. That is what I have sought to deliver today and it is what I hope our Parliament will deliver.

I move amendment S5M-12107, to insert after "the Parliament":

"notes the concerns expressed by families regarding the treatment of their loved ones within mental health services in NHS Tayside, access to facilities and the limited scope of the inquiry announced by the board; believes that a wider independent inquiry across the region would allow for these concerns to be investigated comprehensively in order to restore faith in these services among patients and their relatives and friends; further believes that it is important that families seeking answers are included in the establishment and remit of a wider inquiry;".

15:00

Alison Johnstone (Lothian) (Green): The most serious matters bring us to the chamber today. In Scotland, we have made new commitments to see that people are treated with dignity and respect when they need help from the social security system, and those principles apply to healthcare, too.

I know that every day our healthcare system relies on the skill, professionalism and compassion of doctors, nurses, pharmacists and all other healthcare professionals. However, there are times when people—vulnerable people—reach out for help and do not get it. That should never happen. We talk easily—at times, too easily—about parity of esteem between mental health and physical health. However, we know that that is far from the reality. I, too, give my sincere condolences to the family of David Ramsay. We in this Parliament must work together to ensure that every lesson is learned and that we begin to treat mental health with the urgency that it requires.

It is right that NHS Tayside has commissioned an independent inquiry into mental health and suicide prevention services. However, I join others in stressing that any inquiry must be truly independent, involve families from the very start to the very finish and be prepared to go wherever necessary.

It would not be right for me or for any of us to prejudge what the remit of the inquiry should be. The families must help to guide those decisions. However, in considering the Government's amendment, I reviewed the recommendations from Health Improvement Scotland and the Mental Welfare Commission, and I was struck by the high turnover of locum psychiatrists in NHS Tayside. That cannot be good for continuity of treatment, for sharing information about support and treatment, for building relationships with patients and for building good relationships between staff. I note, too, that there were also long waiting lists to see a clinical psychologist. I would be grateful if the cabinet secretary could, in her closing speech, discuss what steps the Government has taken to support the recruitment and retention of psychiatrists and clinical psychologists in Tayside.

We are all concerned about the fact that, outwith acute services, people are waiting far too long to access psychological therapies in Tayside. Only 54.7 per cent of people started treatment within 18 weeks of referral, and only 41.5 per cent of children and young people were seen by child and adolescent mental health services within 18 weeks of referral. Those figures are shameful. It is clear to me that, as well as investigating specific failings at Carseview, we must ensure that community services are well supported and that people have access to psychological therapies when and where they need them.

Healthcare Improvement Scotland's review also indicated that the crisis resolution and home treatment team has not always been able to work well with community mental health teams in different localities. That is concerning. If there are systemic or organisational issues at work, they must be addressed now.

The actions on suicide prevention that are addressed in the Government's amendment include creating a suicide prevention leadership group and establishing multiagency reviews into all deaths by suicide. Those steps are necessary and are welcomed by the Samaritans in Scotland, which I thank for its expert briefing.

Like colleagues, I agree that any inquiry must be as wide in scope as necessary and must absolutely begin and end with family involvement.

15:04

Alex Cole-Hamilton (Edinburgh Western) (LD): I thank Anas Sarwar and the Labour Party for using the party's debating time to bring this issue to Parliament this afternoon. I also thank Anas Sarwar for the measured tone that he struck at the top of the debate, which has been picked up by other speakers thus far.

This is not a debate about personalities on either the Government or the Opposition benches in the chamber; it is a debate that is very much steeped in human tragedy. I thank David Ramsay's family and the other campaigners from the lost souls group who are with us today for their courage in bringing the issue to Parliament and for being here to support us in our deliberations on it this afternoon.

It says a lot about the state of the public policy response to suicide in this country that we need

campaigns such as the lost souls group's campaign—and, indeed, that this debate is being held in Opposition time. Self-harm, suicidal ideation and suicide completion represent the very nexus of human crisis—the limit of endurance that affects all too many lives in Dundee and in the regions beyond it, where that crisis is met too often with silence and a void or gaps in service provision.

I pay tribute to Richard Leonard for his question to the First Minister last week. It was one of those pin-drop moments when every member in the chamber could not help but feel huge compassion for David Ramsay and his family. At the age of 50, David very sadly joined the ranks of the all too many young men in this country for whom suicide is the leading cause of death.

I wish to associate myself and those of us on the Liberal Democrat benches with Anas Sarwar's call for the five tests to be met by the independent review into what happened in NHS Tayside, and I very much welcome the cabinet secretary's positive response to that. On that basis, I can assure her of our support for the Government's amendment tonight.

Confidence in that review is absolutely key, not only to the families represented here, but to everybody in the Tayside area. The review will need transparency if it is to enjoy that confidence and give reassurance to the families in the area who are affected by suicide. The independence of the review is critical, as is the public call for evidence, and it will be vital for the review to hear the stories and about the lived experiences of those families who are steeped in tragedy in order to learn from them and ensure that progress can be made in this critical area.

What happened in Dundee and Tayside is symptomatic of a wider problem and wider deficiencies in our country's public policy response to suicide. Suicide has been trending down across the country—something of which we should all be justifiably proud—but we are seeing an uptick and resurgence, with an 8 per cent rise last year alone.

I have mentioned many times the concerns of those of us on the Liberal Democrat benches about the 18-month delay in the production of the suicide prevention strategy and the fact that the draft—now that it has been published—has been met with some derision from the sector. The Samaritans talked about the fact that the strategy lacks resources, timescales and ambition, and the Scottish Association for Mental Health, which delivered suicide prevention training in the Parliament this very week, said that without an understanding of what will be in the plan and the Government policy response, it cannot use the strategy to underpin its planning for such events.

I close by again thanking the lost souls group, and particularly David Ramsay's family, for having the courage to come to the Parliament today and be part of the debate. If anything can come from that abject human tragedy, let it be positive action and concerted consensus across the chamber, to ensure that David leaves a lasting legacy.

The Deputy Presiding Officer: We move to the open debate, with speeches of four minutes.

15:08

Jenny Marra (North East Scotland) (Lab): Mental ill health is a human crisis in the city of Dundee. For years now, I have listened to families who are concerned about the support and treatment that their loved ones receive. I find it difficult to find the right words when parents come to me, having lost their children, asking why their son was turned away from Carseview, why he was not admitted and why they could not make contact with any services that weekend. Words seem futile as grief overwhelms the room.

There is no doubt in my mind that we have a particular problem with the services in Carseview. That was confirmed in no uncertain terms when I visited the Carseview centre in September 2016, after calling publicly for a full review of the Carseview unit. The presentation that I received was possibly one of the most offensive accounts of public service that I have ever heard. After having meetings with the then chairman of NHS Tayside to raise public concerns about mental health services, on 9 April this year, at a meeting with the new chair and chief executive on their first day of work, I asked them please to prioritise two issues for our community: mental health services and deaths from drugs.

Like the cabinet secretary and Labour's health spokesperson, Anas Sarwar, I am therefore relieved that the new management has undertaken to review Carseview and mental health services at last. I am also heartened that the Government amendment agrees with Labour's call and says that a public inquiry is appropriate if we do not get the answers that we need. We will hold the Government to that if necessary. I have raised these issues time and time again with NHS Tayside, and if I feel powerless, I can only imagine how powerless the families feel and how the lack of answers or redress compounds their loss and grief.

I am grateful to Richard Leonard for elevating Labour's call to a level at which it has been heard and answered. However, the services concerned are—and should be—wider than those at Carseview. NHS Tayside's recent mental health review resulted in the closure of the Mulberry unit in Angus and, consequently, further pressure on

Carseview. The reason that MSPs were given at the time was that there were insufficient numbers of psychiatrists to staff the unit safely. No politician can turn their face from that advice, but I believe that we have got to this place because of poor workforce planning by the cabinet secretary's team. We have a growing crisis but declining capacity and services that are ever further from communities and people.

Increasing problems with mental health are not unique to Scotland. Other post-industrial countries report the same, which is why, as well as conducting a full review of the services that are available to support people, the Government has a moral duty to look closely at prevention.

Following a meeting with the lost souls parents group in Dundee a couple of years back, I met the head of mental health at NHS Tayside and her team at the Murray royal hospital. After discussing the services that the families had received, I asked how we could prevent escalating problems and crisis. Resilience in children was the answer, and we have a duty to start looking at that seriously. Early intervention in mental health is so poor in Dundee; only 40 per cent of children on the CAMHS waiting list in NHS Tayside are being seen within 18 weeks. SAMH has recently commissioned a survey to find out how many children are being turned away from CAMHS after being referred by their GP. I have raised on a number of occasions in the chamber the declining numbers of educational psychologists, and Government changes to the path and cost of training are depleting that essential workforce further.

I welcome the review and the commitment by the Government to look again if we do not get the answers that we need. However, this is not job done. There is a huge and escalating problem with mental health from childhood and we need to think about ways to tackle it as early as possible.

15:13

Ash Denham (Edinburgh Eastern) (SNP): Suicide prevention is such a serious subject and I am glad that we have chamber time today to discuss it. I agree with a number of things in the Labour motion; if people have trouble accessing services, that needs to be addressed, and people should never be afraid to call out failings in service and try to get them fixed.

In any sphere, be it international development, a large corporation or a health board, those areas all demand continuous learning in order to improve. We all need to be able to learn from a variety of situations in order to move forward. An important part of any system is constructive challenge. If people have the courage to come forward, they need to be listened to and the feedback that they give needs to be acted upon.

I welcome the fact that the new NHS Tayside chairman, John Brown, has commissioned an independent inquiry into the mental health services that are delivered at Carseview and now also the entire region. The inquiry will speak to the families who have experience of the centre and review the recommendations that have already been set out in reports by Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland. If it is found that things need to change, that should be undertaken as a priority. Continuous improvement is what we should all strive for.

I was encouraged to see that the Government has consulted on a suicide prevention action plan with the goal of producing an ambitious strategy that is informed by the views of families with experience of suicide and of the front-line services that work in the area. I am informed that the consultation has received 280 responses, and I look forward to seeing the responses feeding into the finalised action plan.

Part of the plan is the development of a world-leading suicide prevention plan for employers. That is ambitious, but it should be achievable. I know that, in the Parliament, a training session has just been run for staff on the subject of mental health and suicide prevention. My own staff from my office attended the session. That type of thing is useful in itself, but it also has a potentially more important effect: it sends out the wider message that that is something that we care about, that there should be no stigma around talking about mental health or suicide, and that support is available for those who need it, if required.

The new action plan is key but, more than that, we need to ensure that the implementation does justice to the plan. That is why the Government's setting up of the forum of stakeholders to track the real progress on real actions in the real world is welcome and will provide a vital oversight.

No Government can ever get everything right, but the Scottish Government is committed to doing more and doing better on both mental health and suicide prevention. That was signalled particularly clearly by the First Minister's appointment of Scotland's first Minister for Mental Health. If those who have experience can inform the Government's approach, I have every faith that we will begin to make improvements.

I conclude with a quote from "The Letters of Gratitude" from this year:

"Just a reminder in case your mind is playing tricks on you today: You matter. You are important. You are loved. And your presence on this earth makes a difference whether you see it or not."

15:17

Liz Smith (Mid Scotland and Fife) (Con): The tone of the preceding speeches speaks volumes about why this debate is taking place and its importance. I pay tribute to all the previous speakers.

I add my welcome to the genuine commitment to an independent review, and I agree with the comments that others have made about its being vital that we take with us the families of patients who feel that they have had a raw deal or that they have been badly let down and not listened to. If we do not do that, we will not make any progress at all.

The Mental Welfare Commission for Scotland has stated that it is every patient's right and, indeed, every family's right to expect the highest standards of care when someone is in a very vulnerable situation. Exactly the same expectation should be evident in any part of the health service.

In that context, I come to this debate from my constituency work across three parliamentary sessions. I am sorry to say that, in several cases, it has been very clear that patients did not receive the highest standard of care. Obviously, I cannot speak about the individuals concerned because of the need to maintain confidentiality, but I want to highlight three areas in which reform is needed and which, as it happens, tie in with the findings of the Mental Welfare Commission's report.

As Alison Johnstone and Jenny Marra have rightly said, there are staffing issues. We know that there are significant pressures on staff across Tayside. The result is that there are currently 21 locums in place, with the additional expense that that brings. More important, there are the difficulties of patients not having a consistent link to a member of staff who can deal with their specific problems, so that they end up having to retell their story several times over. Obviously, that adds to the stress of the situation.

The issue of care plans and their lack of consistency is related to that. The Mental Welfare Commission reported that there was very variable information in patients' care plans. Although some were described as "excellent", one patient told the commission about having to fill in forms with no assistance from any member of staff, because the staff were too busy doing other things. That was certainly the experience of two of my constituents, whose care was very patchy in its quality. The recommendations made by the commission in that respect are extremely important and I hope that they will provide essential support to patients and their families at their most vulnerable time.

Like many other professions, mental health care can bring with it a great deal of time-consuming paperwork, which often prevents the carers from spending time with their patients. That is just another reason to hasten the improvements in the electronic records system.

We all understand the desire to help patients at home and in the community as far as possible. However, for the 6 per cent who require hospital treatment we need to ensure that there are better standards of care across the board. We also need to understand that there is much more work to be done to improve the situation when there are crisis admissions. I hope that the independent commission, which was brought in to review matters, will ensure that there is greater liaison with the police, who are almost always in the front line of such cases.

The recent Samaritans report, which says that suicide is not being treated seriously, could hardly be a starker warning to us all.

I will finish on the issue of the conflicting requests from health and social work. It comes down to mental health management and, again, I think that it is relevant to the problems within the structures of integration joint boards, which I spoke about in last week's debate about NHS Tayside. MSPs discussed the issue yesterday with John Brown and Malcolm Wright. I hope that we can address the matter soon. Good-quality mental health care depends on clear lines of responsibility and accountability for staff, and on patients and families knowing exactly what they are.

There is no time at all to waste. I support the motion, the Government's amendment and the amendment in the name of Miles Briggs.

15:21

Clare Haughey (Rutherglen) (SNP): I refer members to my entry in the register of members' interests, in that I am a registered mental health nurse and currently hold an honorary contract with NHS Greater Glasgow and Clyde.

There can be no denying that the death of David Ramsay and others in NHS Tayside is a tragedy. I will repeat the phrase that has been used today already—that does not diminish its veracity—by saying that one suicide is one too many. I extend my heartfelt sympathies to Mr Ramsay's family and friends. I pay tribute to the tenacity of the lost souls of Dundee campaigners in ensuring that their campaign is rightly being debated in the Scottish Parliament today.

As a mental health nurse for more than 30 years, I know all too well the effect that someone's suicide can have on their loved ones. Therefore, I sincerely hope that the families present here today are able to find some comfort in the months ahead.

I have raised the issue of suicide and, in particular, male suicide on a number of occasions in the Parliament. In the same year as Mr Ramsay's passing, another 727 suicides were registered in Scotland, 71 per cent of which were of men. Although the suicide rate in Scotland has fallen by 17 per cent over the past decade, and the five-year rolling average shows a downward trend, that is little comfort to those whose family member or friend has already passed away. However, we owe it to them and to the others to continue working to ensure that the number of people taking their life continues to fall.

Suicide is not unique to Tayside. Sadly, 44 people took their life in South Lanarkshire in 2016, a number of whom will have been from my constituency. However, if NHS Tayside has been letting down its patients, it is correct that it is closely looked into. I therefore welcome the announcement that an independent inquiry into mental health and suicide prevention services across the region has been launched. That is testament to the decisiveness of the new leadership, which was installed by the cabinet secretary, and I am sure that the health board will move in the correct direction under the leadership of John Brown and Malcolm Wright.

Within that investigation, the delivery of services at centres such as Carseview will be closely examined. If the report highlights areas for improvement or raises issues on which lessons can be learned, NHS Tayside must make the necessary changes immediately.

I sincerely hope that the families who are concerned about mental health and suicide prevention services in NHS Tayside will not be let down by this process. However, if they are, they can be reassured that the Scottish Government will convert it into an inquiry under the auspices of the Inquiries Act 2005.

The families will be anxiously awaiting the conclusions of NHS Tayside's investigation, and I hope that time is given to ensure that all relevant details are thoroughly scrutinised. I was heartened by the cabinet secretary's comments today on "Good Morning Scotland" that the families are to be at the heart of the inquiry and will be involved with its terms of reference, and that they should have confidence in its chair.

Although the investigation is under way, it is worth while pointing out that the Scottish Government and health agencies have already been looking into concerns regarding mental health services in NHS Tayside. The Mental Welfare Commission for Scotland carried out an unannounced inspection of Carseview in November and made a number of recommendations regarding care planning and the availability of responsible medical officers; Health Improvement Scotland carried out a similar examination in December 2017.

More widely, the Scottish Government has published a 10-year mental health strategy, and the new suicide prevention action plan will be published soon. As a mental health nurse, I am incredibly proud that Governments, politicians, health services and the public are beginning to see mental health as being equal to physical health. However, we are not there yet, and we must all continue to work together until tragic deaths such as Mr Ramsay's are a thing of the past.

15:26

Lewis Macdonald (North East Scotland) (Lab): Everyone has acknowledged that we are having this debate because of failures in the provision of mental health services to the people of Dundee, Angus and Perth and Kinross. Those failures are to be the subject of the independent inquiry that was announced last week, and it is essential that the terms of reference of that inquiry are broadly drawn and that those who have been affected by the failures have a say in the process from the outset. The five principles that Anas Sarwar laid out today, and the cabinet secretary's positive response to them, are very welcome.

The previous review of mental health services in Tayside led to decisions to cease to provide general adult psychiatry in either Perth or Angus. Those decisions, and the process of reaching them, must be looked at again as part of the new inquiry. At the time of the previous inquiry, the board's view was that its existing model for delivery of

"acute admission inpatient services was not sustainable and could pose a significant clinical risk to patients and staff."

As Jenny Marra said, its response was to close the Mulberry unit at Stracathro and to deliver those services only at the Carseview centre in Dundee. There needs to be reconsideration of whether that was the right answer and, if it was not, we must consider what else must be done to deliver safe and sustainable services.

We have already heard some of the concerns around Carseview, so I am glad that the remit of the independent inquiry will now go beyond that unit to look at mental health services across Tayside as a whole. Patients from neighbouring board areas may also be affected, because some specialised mental health services are planned and delivered on a regional basis.

Other boards are also involved, of course, with the chair of NHS Greater Glasgow and Clyde and the chief executive of NHS Grampian taking on equivalent roles for the time being in NHS

Tayside. Although John Brown and Malcolm Wright certainly bring fresh pairs of eyes to the problems that will face them, they acknowledge that, for the planned inquiry to be credible, the appointment of a genuinely independent chair and advisers will be crucial. I welcome their plans to engage with the Mental Welfare Commission and others in seeking to identify the best people, and I look forward to hearing who will lead the inquiry, which I hope will be in the course of this week.

The inquiry must also provide a platform for those who have been most directly affected to have their voices heard. I join those who have paid tribute to the people who have attended the debate this afternoon. I know that patients and families do not just want to hear the answers; they want and need to be part of framing the questions. One constituent who contacted me yesterday evening put it succinctly when he said:

"I would like to know if I (and the rest of the general public) will be given the opportunity to provide evidence of the failures I have experienced through supporting friends who have been admitted"

and

"if past and existing patients will also be given the opportunity to provide evidence".

We know, since Grenfell, that the public demand to be part of the process, not simply its victims or beneficiaries, and that principle must apply here too.

I hope that one result of the inquiry will be to put in place clear clinical leadership and effective management of mental health services. Achieving that clarity can help to deliver the best possible mental health services in Tayside, including in particular the best hope of reducing the incidence of suicide. The Health and Sport Committee has agreed to take evidence on the Government's suicide prevention strategy before the summer recess. Such evidence could influence the final form of the strategy if ministers are open to that.

Although the timescale is necessarily different, the independent inquiry in Tayside also has the potential to influence national policy on suicide prevention. If lessons can be learned from the experiences of families who have been affected in recent months, perhaps other families will be spared that pain. That is why those who have been affected must be at the front and centre of the inquiry. I look forward to NHS Tayside and ministers laying out exactly how that will be achieved.

15:30

Bill Bowman (North East Scotland) (Con): I suspect that my remarks will duplicate what others have said, but today's subject is such that I do not think that apologies for that are necessary.

Suicide is preventable. Last week, we heard Richard Leonard highlight the case of David Ramsay, who took his own life after being turned away from the Carseview centre—a tragic case that speaks to a wider problem in Dundee and Tayside. The campaign group lost souls of Dundee has identified at least 10 such cases that could have been prevented if better care had been available at Carseview. Just one week on from Mr Ramsay's case being highlighted, we now have an NHS Tayside inquiry moving forward, for which the health secretary has signalled her support. I am pleased to see that swift response, and I welcome any move to provide answers and prevent further deaths.

Those answers must now be sought and lessons learned, but I note the words of Gillian Murray, who is part of the lost souls group and David Ramsay's niece, concerning the inquiry. She said:

"I'm pleased at this announcement but it is not the end—this is just the first step."

I could not agree more, because research shows that 70 per cent of people who take their own lives do so within a year of having contact with healthcare services. Thus, the proposal to look at Carseview alone was never sufficient to provide the answers that are needed. We must ensure that the inquiry covers all mental health needs, resources and provision at NHS Tayside.

I was reminded of the importance of that yesterday, when I was contacted by a constituent outwith Tayside, who raised some very serious concerns about mental health care at NHS Grampian. It was a timely reminder that failings in mental health care are not confined to a particular treatment facility or, for that matter, a particular health board. For NHS Tayside in particular, though, a wide-ranging inquiry is vital because it can offer more reassurance to patients and their families that the issue is being taken seriously.

Let us be clear about how serious an issue it is. Around two people die by suicide in Scotland every day. As we have heard, in Dundee alone, suicide deaths rose by 61 per cent recently. Almost unbelievably, almost two out of every three Scots have some experience of suicide—a worrying statement to which I am sure the ministers will pay heed. It also reflects local concern that, in Tayside, there is a lack of focus on improving mental health outcomes. For example, as I think that we have already heard, fewer than half of Tayside children who are waiting for mental health treatment are seen within 18 weeks. The target is for 90 per cent to be seen within that timeframe, whereas, at about 42 per cent, NHS Tayside's performance was the second worst in Scotland.

The list of problems in NHS Tayside goes on. Staff are facing difficulties in accessing training; there is a lack of permanent psychiatrists, with patients seeing up to four different consultants during their time in hospital; waiting times for clinical psychologists exceed the 18-week target; and, as we have heard, one patient was even given a blank recovery care plan form to fill in themselves.

Treatment is of course crucial but, equally, we must be prepared to tackle the underlying reasons why so many people take their own lives. For example, those who live in the most deprived areas are more than three times as likely to die by suicide than those who live in the least deprived ones. That is a particular challenge in Dundee, which has levels of deprivation that are among the highest in Scotland. We must stop simply offering apologies and platitudes, and get to work to make sure that no more individuals and families suffer. Let us never forget that talk may be cheap but lives must be held dear.

The Deputy Presiding Officer (Linda Fabiani): We now move to closing speeches. I call Annie Wells. You have about four minutes.

15:34

Annie Wells (Glasgow) (Con): I echo Liz Smith's comments about the tone of today's debate. We have been frank; we have let people know that the Parliament takes mental health and suicide seriously. I, too, pay tribute to the families in the gallery and the staff who work tirelessly in difficult circumstances.

With mental health services in NHS Tayside having fallen seriously short of the standards that are expected, I welcome the minister's comments that the investigation will cover the whole of NHS Tayside and all its facilities. As we can see from the extremely tragic case of David Ramsay, it is the families and the friends who ever after live with the consequences of services that fail their loved ones.

NHS Tayside has come under the media spotlight for good reason. Bill Bowman said, as an MSP for the area, that fewer than half of Tayside's children waiting for mental health treatment are seen within 18 weeks, and NHS Tayside's performance of 41.5 per cent being seen within the referral period is the second worst in Scotland. As Anas Sarwar and others have stated, suicides in Dundee have risen 61 per cent in a year.

I, too, pay tribute to the bravery and the work of the lost souls of Dundee group. It has identified at least 10 suicides that could have been prevented, had better help been available at Carseview.

Four minutes is a short time for which to speak about such an important topic, but I will round off the debate for the Scottish Conservatives by looking at how NHS Tayside sits within the broader context of mental health services struggling to meet growing demand.

We know that mental health services across Scotland, are being pushed to their limit, with more than a quarter of adults waiting too long for psychological therapy and more than a quarter of children waiting too long for mental health treatment. We have not seen the promised step change following publication last year of the Scottish Government's mental health strategy. Mental health charities have stated publicly that the strategy lacks the ambition and the investment that are needed. As we see in NHS Tayside, the current model is not working.

When it comes to suicide, which is an incredibly sensitive topic, I am concerned that we are not seeing the ambition that is so desperately needed. In 2016, 728 people in Scotland died from suicide, which was a rise of 8 per cent from the previous year. Despite that, we have not had a suicide action plan in place since 2016. The draft plan that was published in March was met with open disappointment from Samaritans Scotland, which had engaged with the Scottish Government prior to its publication. Samaritans cited the draft plan's scarce detail on targets, timeframes and the resources to be allocated. There was also no information on how groups who are disproportionately affected by suicide—men, people in middle age, people in deprivation and people who live alone—would be supported. The lack of detail is worrying. I hope that the final strategy, which will be published in the summer, will clearly outline how suicide will be tackled.

To finish, I echo my colleagues' calls for a wide inquiry into mental health services in NHS Tayside. Mental health awareness week begins on Monday. It is time that strong words on the topic were backed up by urgent action. If we do not act now, mental health services will continue to lag behind physical health services when it comes to investment and resources, which will have potentially far-reaching consequences.

The problems in NHS Tayside have vividly highlighted that, when we are not disciplined in tackling mental health issues, we badly let down the families and friends of people with mental health problems. Members across the chamber would be failing in our duty if we did not do everything in our power to improve the situation for some of the most vulnerable people in our society.

15:39

The Cabinet Secretary for Health and Sport (Shona Robison): I, too, welcome the families to the gallery, and thank them for getting us to this point. The new leadership team at NHS Tayside has listened; it has come in with a fresh pair of ears, heard the calls from the families and, with the chair's announcement last Friday, responded appropriately.

As other members have pointed out, it would be wrong to focus the inquiry purely on Carseview; it is right and proper that the inquiry will look across all of NHS Tayside. As others have said, lessons for improving mental health services in Tayside might well apply elsewhere in Scotland, which is an important point.

As I hope I said in my intervention on Anas Sarwar's opening speech, it is important from the start that the independent inquiry is just that—independent. It is most important that it has the confidence of the families, who should be involved from the start in developing the terms of reference. The inquiry's chair, who will have a challenging job in progressing this important work, must have the right skill set and inspire the families' confidence. All those things are important.

Last night, I had a further discussion with the chair of NHS Tayside, John Brown. I assure members that he absolutely appreciates the importance of every one of the issues. He will put a lot of thought into the process. Families might wish to be involved in different ways, but they should all have the opportunity to be involved and to be heard.

Anas Sarwar: Will the cabinet secretary confirm that the inquiry's chair will not be an employee of NHS Tayside or of the NHS Scotland organisation, and that the chair will be truly independent of the health board and of the Scottish Government?

Shona Robison: Yes. That will be important. The chair of NHS Tayside and I have discussed the point that the inquiry's chair must not just have the right skill set but be independent of the health service and the Scottish Government. It is important that the inquiry's chair inspires confidence in the families and in the public at large that the inquiry will make positive changes. I will come back to that.

Miles Briggs made the important point that we must recognise the efforts of the staff who are involved. We must put it on the record that many people have had good treatment from mental health services in NHS Tayside. I agree with Miles Briggs's comment about personal attacks on Gillian Murray. Families need to be able to speak out without being criticised on social media or anywhere else. I have made my views about that clear.

Alison Johnstone made an important point about recruitment and retention and the high turnover of locum psychiatrists. This will be a difficult time for NHS Tayside, especially as it tries to attract new staff to mental health services in the region. It is my aspiration that the independent inquiry will be seen as a force for good, and that it will help to bring new staff to NHS Tayside. The inquiry needs to be seen as a positive thing.

Miles Briggs: The Mulberry unit has been mentioned. Will the Scottish Government, together with NHS Tayside, look at whether it would be appropriate to reopen that unit for patients in Angus?

Shona Robison: I do not think that it is appropriate to start to establish the independent inquiry's remit this afternoon. We all agree that an independent chair must lie at the heart of the process, and that there must be consultation of others and of affected families. We should not attempt to establish the remit today.

What I will say, though, is that I hope that the most important thing to come out of the debate is that the families who are here today, and those who are not, are given confidence that we all agree that we must use the independent inquiry to seek answers to the very pertinent and serious questions that many families have and, importantly, that we will ensure that the changes that come out of the inquiry will make NHS Tayside's mental health services among the best in Scotland and beyond these shores. If that is what comes out of the independent inquiry, then the collective efforts of everyone in the chamber will have been worth while.

15:45

Mary Fee (West Scotland) (Lab): In closing the debate, I begin by thanking the families and campaigners who have been at the heart of the debate. Their dedication to tackling and highlighting the problems in NHS Tayside will help to save lives. I also thank members throughout the chamber for their thoughtful and considered contributions to what I think has been a powerful debate.

The Government's amendment to the motion is an indication that it has listened to the campaigners. The stigma of mental ill health and the lack of support and understanding for people who suffer with mental ill health still, unfortunately, pervade our society. We cannot allow that to go on; we must change it.

Many of the points that I will make in my closing remarks have been made by other members, but they are worth repeating. A number of colleagues have praised the lost souls of Dundee group. My colleague Lewis Macdonald, who was contacted

by a constituent about the issue, said that patients and families do not just want to hear answers, but want and need to be involved in framing the questions.

Jenny Marra spoke of the crisis in mental health and drug-related deaths in Dundee. Along with Richard Leonard and Anas Sarwar, I welcomed the review into the Carseview centre that was announced last week. However, we knew then that that would not go far enough and that a wider and fuller public inquiry into NHS Tayside was required. I am glad to see in the Government amendment the commitment to an inquiry, but that inquiry must be open and accountable and must fully involve all the families.

Public services are at the core of what the Government provides, and those services should always be accessible when they are required, and be transparent and accountable when things go wrong. It should not take a question being posed to the First Minister for the Government and NHS Tayside to sit up and listen. Families such as those who are in the gallery today have been demanding answers for far too long. The death of David Ramsay is tragic not only because of the missed opportunities to prevent it, and his niece and father should not have had to travel to Parliament to be listened to.

Although the focus of the debate is NHS Tayside, there are problems across Scotland with mental health services, particularly for children and young people. We know that waiting times are on the increase for an initial appointment for child and adolescent mental health services, and that more than a quarter of children are not being seen within the 18 week waiting time target. Recent statistics show that 10 out of 14 health boards are not meeting CAMHS targets. I hope that the Audit Scotland review of CAMHS, which is due to be published this autumn, will show that improvements are being made. If they are not, action must be taken immediately to support our young people. The tragic loss of Lee Walsh has brought about a campaign for better mental health services in Tayside. Lee died of suicide last year and the website “Not In Vain for Lee” tells us that Lee suffered

“mental health problems on and off for over nine years, being prescribed various alternative medications, but never actually receiving a particular diagnoses.”

I close by focusing on the Government amendment, which commits to a full inquiry, and on the comments that were made by my colleague Anas Sarwar in his opening remarks, when he said that an independent inquiry must have an independent chair, must include the families in agreeing the terms of reference and must ensure that the families are part of that process. The inquiry must be open, transparent and inclusive. Those steps will be a starting point in rebuilding trust and confidence in mental health services.

My final thanks and admiration must go to the families. Parliament has listened to them, and I am confident that we stand united in our desire to achieve justice for them all. Thank you. [*Applause*.]

National Health Service (Waiting Times)

The Deputy Presiding Officer (Linda Fabiani): The next item of business is a debate on motion S5M-12108, in the name of Anas Sarwar, on waiting times.

15:51

Anas Sarwar (Glasgow) (Lab): In March 2012, the then Cabinet Secretary for Health, Wellbeing and Cities Strategy—who is now the First Minister—enshrined in law a legal guarantee for patients in Scotland. The guarantee was clear—I will read it out to members. It said:

"You have the right to start to receive agreed inpatient or day case treatment within 12 weeks of agreeing to it ... Some examples of treatments include hip or knee replacements ... If your agreed treatment has not started within 12 weeks, your Health Board must explain the reasons for this, and ... Your Health Board must also take steps to ensure you start your treatment at the next available opportunity".

The document "Your health, your rights: The Charter of Patient Rights and Responsibilities" is explicit and clear. There is no ambiguity, unless you are the Scottish Government or a health board. When is a guarantee not a guarantee? Apparently, it is when you are given that guarantee by this Government and this health secretary. As we now know, tens of thousands of Scottish patients are waiting longer—much longer—than the 12-week guarantee that they were promised by Shona Robison and Nicola Sturgeon. Since Nicola Sturgeon made that promise—gave that legal guarantee—to the people of Scotland in 2012, it has been broken nearly 120,000 times. That equates to 120,000 broken promises to individuals and families across our country.

What is the consequence of that failure? Patients are in limbo, waiting on treatment. They are told by their health board that there is a 12-week guarantee, and yet, in some cases, they are still waiting 20, 30, 40 or more weeks later. That impacts on their family life and social life, and on their ability to work. In some cases, we are actively prolonging people's time off work, which impacts on their income and further encourages their isolation. It also impacts on their physical and mental wellbeing.

For many patients, not knowing is worse than if they knew they had to wait longer than the 12 weeks in the first place. Every single day, the health secretary and the Scottish Government break that law. Every single day, individuals are let down and left in limbo. That is a shocking breach of a guarantee that is enshrined in law.

I will share just one shocking example of a lack of honesty and transparency with patients. In a recent case, one of my constituents was referred for orthopaedic surgery. He received the following statement in writing from NHS Greater Glasgow and Clyde. It said:

"Under the Patient Rights (Scotland) Act 2011 you have a guarantee to be admitted for treatment within 12 weeks. This is the maximum you should wait. We will of course endeavour to see you sooner."

He thought, "Great", but he waited for 12 weeks and heard nothing. When he spoke to his general practitioner, the GP called for an update and was advised that the actual wait would be 40 weeks. That would be laughable if it were not so serious. Why was my constituent not simply told the truth? Why was he deliberately misinformed?

Sadly, we know that that is not an isolated case. Nearly 120,000 patients will have received similar letters, which will have given them false hope. They will have read the word "guarantee" and taken it at face value. That is a breach of a guarantee and a breach of trust. There has been a lack of transparency that has been surpassed only by a clear lack of honesty on the part of health boards. There has been a complete failure to communicate honestly with patients.

That behaviour has been condemned by the Scottish Public Services Ombudsman. Over the past decade, the number of complaints to the ombudsman that relate to the national health service has trebled. At the weekend, Rosemary Agnew said:

"Increasingly our public reports seem to be about health matters and the theme that has emerged to me is one of communication. That is clinicians to patients and communication across different parts of the NHS."

It is simply not good enough for patients to be treated that way.

We need to recognise the stress and the impact on staff, too. With the rise in complaints, staff often bear the brunt of concerned patients expressing their frustration at their delay in treatment. Staff are under increased pressure and being overworked, undervalued and underresourced by the Government.

Therefore, I welcome the Scottish Government's commitment to amend "The Charter of Patient Rights and Responsibilities" to ensure that health boards are open, transparent and honest with patients at all times. That is a real win for patients across the country, but the Government should commit to delivering that by the end of the month. I accept, in good faith, the Scottish Government's amendment and its new commitment to ensure that patients receive honest communications from health boards on waiting times, but it is absolutely unbelievable that the Scottish Government is

admitting today that patients have not always been able to expect that honesty.

There is a wider point. The amendment of the charter cannot just be a fig leaf for a much greater failure by the Government. Tens of thousands of patients in Scotland's NHS are being forced to wait longer for treatment than they should. If the Scottish Government was not failing patients and Scotland's NHS, it would not need to worry about changing guidance on patient communication in the first place.

The charter sets out six clear principles by which patients should be treated, and the Government is in breach of at least three of them. Number 1 is:

"Access: your rights when using health services".

That is not being met by the Government and the cabinet secretary. Number 2 is:

"Communication and participation: the right to be informed, and involved in decisions, about health care and services".

The Scottish Government's own amendment recognises that there has been a complete failure in that regard, with that principle not being met by the Government and the health secretary.

Another principle is on respect. In that area perhaps more than any other, patients are being disrespected by the system, by health boards and by the Government and the cabinet secretary. That can no longer go on. We must stand shoulder to shoulder with all our patients who are being failed by the Government, and with all our NHS staff who continue to go above and beyond in the most difficult of circumstances.

I move,

That the Parliament notes that the Patient Rights (Scotland) Act 2011 establishes a legal 12-week treatment time guarantee for eligible patients who are due to receive planned inpatient or day case treatment; further notes that Audit Scotland has shown that this has not been delivered for all patients; acknowledges the impact that long and unknown waits can have on an individual's work, family life and mental and physical wellbeing, and believes that, in the interest of patient care and the principles of honesty and transparency, NHS boards should communicate an accurate expected waiting time range to patients.

The Deputy Presiding Officer: I call Shona Robison to speak to and move amendment SM5-12108.1. You have up to six minutes, cabinet secretary.

15:58

The Cabinet Secretary for Health and Sport (Shona Robison): Our NHS is a remarkable institution. It is our nation's largest employer, and its staff, along with those in the care sector, work day in and day out to provide care for the people of Scotland. As I said last week, it is a large and complex system, and sometimes things go wrong and fall below the standards that we would expect—I am sure that we will hear examples of that today. Those challenges are not unique to Scotland, but we are committed to doing all that we can to address them.

Since the introduction of the 12-week treatment guarantee on 1 October 2012, more than nine out of 10 patients—1.5 million people—have been treated within the target. That is down to the tremendous effort of NHS staff—not only doctors and nurses but porters, administrative staff and cleaners, who all contribute to the running of our hospitals and community services every day.

We want to drive improvements in acute performance and shift the balance of care where possible. That is why we are taking forward the twin approaches of investment and reform of our NHS to meet the rising demand and challenges now and into the future. Throughout that, clear engagement and communication with patients is vital, whether on the subject of their wait for treatment or in the broader design of services. That is why we are happy to support the motion today, and we make clear in our amendment the actions that we will take.

All parties in the chamber have been consistent in recent years in their support for and advocacy of shifting the balance of care and spend towards community health services, to help people live longer, healthier lives at home or in a homely setting. That is one of the reasons that, by the end of this parliamentary session, we will ensure that at least 11 per cent of front-line NHS spending is on primary care and, as a result, 50 per cent will be outwith acute settings for the first time.

Boards around the country are working very hard to try and deliver the waiting time standards and the guarantee. I have made it clear to boards that exceptionally long waits must be eradicated and improvement must be made on delivery.

We are actively working with all boards to implement better demand and capacity planning and delivery. We also have specific work under way with clinicians and managers in a number of specialties that are experiencing the most significant pressures, for example orthopaedics and ophthalmology. In the past year, that was supported by £50 million across the whole patient pathway.

On communication of waiting times, boards are required to advise patients by letter that they are covered by the legal guarantee. We also expect that, if a board experiences difficulties in seeing patients within 12 weeks, it advises the patient of the reason for the delay and an indication of the likely wait. Communication is very important in a

patient-centred NHS, and patients should be kept informed of any changes or delays in treatment. We will address that through the revision of "The Charter of Patient Rights and Responsibilities", and we will work with boards to ensure the communication of the revised guidance.

Neil Findlay (Lothian) (Lab): What advice would you give my constituent who waited 44 weeks just to see an orthopaedic specialist—not even to receive treatment—and, in that time, was threatened with dismissal by her employer?

The Deputy Presiding Officer: I remind you to speak through the chair, Mr Findlay.

Shona Robison: As I have already said and will shortly say more about, we recognise that long waits have an impact on not just patients, but their families. That is why we are taking action to address the increasing pressures on the system.

Last autumn, in partnership with patient representation, the Academy of Medical Royal Colleges and Faculties in Scotland and health service leaders, a new Scottish access collaborative emerged. That clinically led initiative is designed to make the connections between existing services, put patients more in control of their care and ensure that primary and secondary care clinicians and patients lead on service reform. I have committed £4 million to support the development of that programme, which will ensure that people experience timely care with the most appropriate staff in the most effective place. Further, as part of our programme for government commitments, £200 million will be invested during this parliamentary session to expand elective capacity for routine operations at the Golden Jubilee hospital and in new treatment centres around Scotland, including in Neil Findlay's region in the east of the country.

The Labour motion talks about honesty, and I firmly believe that that is vital. However, that works both ways. In the past week, Labour has sought to actively misrepresent a report on waiting times that was recently produced by cancer clinicians. As the report makes clear, the 31-day and 62-day targets for cancer care are being retained and, sadly, a number of cancer clinicians are very angry that the report was misrepresented. Leading cancer doctor David Dunlop, from Anas Sarwar's home city of Glasgow, said in response to his comments last week:

"It is disappointing that Labour has sought to cherry pick from the text of the remit and report of the group and seek to exploit the sensitivities of patients and the public in relation to cancer waiting times. The report states from the outset that the agreement was to retain the current standards, and the intention was to improve them. The remit was to source professional opinion on whether the standards could be improved to better select patients for the urgent suspicion of cancer pathway and consider whether additional cancer types should be subject to the cancer waiting times target of 31 and 62 days, actually potentially increasing the number of referred patients subject to the standard. Wide cross-professional engagement has taken place."

So there has been no scrapping of cancer targets, but rather a potential extension of those who are covered by those cancer targets.

Anas Sarwar: Will the cabinet secretary take an intervention?

The Deputy Presiding Officer: No, she is just closing.

Shona Robison: I would like there to be some honesty in the debates that we have about our health service. Our clinicians and patients deserve nothing less.

I move amendment S5M-12108.1, to insert at end:

"; supports the Scottish Government making any necessary changes to the Charter of Patient Rights and Responsibilities and guidance to NHS boards to ensure that this is delivered, and believes that, to meet the evolving needs of the people of Scotland, NHS and care services must be supported to shift the balance of care from acute to primary and social care where possible, and that effective engagement with the public will be key to this being achieved."

The Deputy Presiding Officer: Before I call Miles Briggs, I remind those who wish to take part in the debate to press their request-to-speak buttons or we will not have any speakers.

16:05

Miles Briggs (Lothian) (Con): I thank the Labour Party for bringing this debate to the chamber today. It is right that we are debating the 12-week treatment time guarantee for patients who are due to receive planned in-patient and day-case treatment as this subject does not often come under the same focus as Government accident and emergency targets, for example.

Planned in-patient and day-case treatment is another area in which, sadly, the Scottish National Party Government's rhetoric on our NHS fails to match the reality for too many patients across Scotland. Ministers, including the First Minister, who steered the legislation through Parliament, must be embarrassed that the number of patients waiting more than the target treatment time has increased tenfold since the guarantee was introduced in October 2012. That means that one fifth of all eligible patients are having to wait for more than 12 weeks to receive the vital treatment that they require.

We will all be aware of extreme cases when some patients have faced waits of up to 22 months for out-patient appointments or day-case treatments. The impact on individual patients and their families can be severe, as Anas Sarwar has

outlined. In my region, Lothian, between the end of 2012 and the end of 2017, no fewer than 25,288 patients had to wait for longer than 12 weeks, which is the worst performance by far of any NHS board in Scotland. That is yet another indication of the particular pressures affecting capacity in NHS Lothian as our population continues to grow and the demand for services rises year on year.

Although I acknowledge that some individual cases might be complex and the specific needs and requirements of a patient, based on clinical advice, might prevent a 12-week treatment time, the majority of the missed targets are down to capacity and staffing pressures within our local health services. The failure to put in place a proper national workforce plan is the thread that runs through all of this SNP Government's NHS failings.

The motion rightly talks about transparency and the need for NHS boards to communicate honestly and accurately about expected waiting times. I whole-heartedly agree. As Anas Sarwar stated, nothing is more disheartening for a patient than to be expecting treatment within a set period only to be told towards the end of that period that they will have to wait for longer—often for weeks or months more. Rather, NHS boards need to be open and honest with patients about the likely waits that they will experience before they can be confident of receiving in-patient or day-case treatment, and they should be up front about that from the very beginning of the process. Procedures vary across health board areas and there is vast room for improvement here, but we need best practice to be spread right across Scotland.

The treatment time guarantee has failed many patients in Scotland. One constituent recently said to me that they felt as though they had simply been given false hope. We need to see action to help drive improvements in waiting times for planned in-patient and day-case treatment so that we can reduce excessive waits.

Clinicians across Scotland want to see a focus on best outcomes and, crucially, to ensure that all patients are communicated with about their treatment on a transparent, open and realistic basis.

Almost six years on, it is welcome that the SNP Government has realised that the treatment time guarantee has failed too many patients in Scotland and has now committed to amend the charter of patient rights and responsibilities to ensure that patients get an accurate waiting time estimate.

Under the SNP's stewardship, the NHS saw more than seven out of 10 waiting time targets missed last year. What we need now is improvement and renewed focus on patients receiving the treatment that they need and a driving down of unacceptable waiting lists. I hope that today's debate will help achieve that and start a real debate about how we can give patients realistic wait times for their treatment. I support Anas Sarwar and the Labour Party's motion.

16:09

Ross Greer (West Scotland) (Green): I imagine that very few MSPs have not been contacted by a constituent about NHS waiting times. Although the majority of people receive treatment within 12 weeks, that is far from the reality for everyone. As has been mentioned by others, severe delays sometimes have a big impact on those who have to wait.

I have recently been helping a constituent to get some clarity on how long they will have to wait for a hip operation. They were told that it would be 12 weeks and that NHS Greater Glasgow and Clyde was meeting the target. They were even specifically reassured that the recent severe weather would not impact on that 12-week waiting time. The problem was that, having been put on the list in December, they had still heard nothing by late April. They were checking their mail every day. It is fair to say that they were—and still are—quite desperate for that much-needed operation.

When my office got involved we found out that, not only was the person assigned to a hospital other than the one that they expected to go to—which they found understandable, although they wished that someone had told them—but the queue for their operation was nine months. We can all understand how frustrated and angry that person was to find out that an operation that they had expected to be imminent would take place around September—hopefully. They said that, if they had just been told that from the start, it might have been frustrating, but it would have dramatically reduced their anxiety and the stress that they felt every single morning when the post was coming through their door. In this case, it was clearly inappropriate for a member of staff to go as far as to reassure them that the 12-week target would be met, despite the weather, at a point when it was about to be missed and when the real nine-month waiting time was clearly well known and had been for some time. It should not have taken the intervention of an MSP to get that information for a patient.

We know that that is not an isolated incident. Members have cited other examples. Only about 70 per cent of patients receive treatment within 12 weeks of being referred, and the situation is getting worse. Audit Scotland reports that demand for healthcare services is increasing, and that more people are waiting longer to be seen.

We need to understand why waiting times are increasing. I understand that funding for the NHS has increased under the present Government, but we need to ensure that money is well spent and matches demand.

At this point I should wear my usual European affairs hat and point out the harm that is already been done to our health service by the UK Government's irrational and hostile immigration policy, including the minimum income threshold, which in many cases even prevents the nurses we so desperately need from coming and staying here—and that is before we deal with the coming disaster for our healthcare and other public services that European freedom of movement ceasing to apply after Brexit will bring.

Given how dependent our NHS is on citizens of other European nations and how dependent our care service is—a service that should be preventing avoidable hospital admissions and extended stays—it is clear that, although the current waiting time situation may be very far from ideal, the cack-handed anti-evidence approach of the UK Government is about to make it much worse. We have learned over the past few weeks that Theresa May overruled her own ministers to veto a plan to allow more overseas doctors to come and work in the UK. Last year we found out that the number of European Union nurses registering to work in the UK dropped by 96 per cent in a year, thanks to Brexit. With the UK Government's chaotic infighting and the uncertainty that that imposes on EU citizens, it is little wonder that nurses are not coming to work here.

We also face the impact of sanctions, universal credit and social security cuts, which are driving more people into avoidable health problems and, in turn, increasing demand.

Today's Labour motion is one that the Greens are more than happy to support. It is a reasonable proposal, which will be welcomed by patients across the country, including constituents who have got in touch with me—and, as I have said, with every other member in the chamber, I am sure.

Beyond that, we need to examine the wider preventive measures that will reduce demand on the NHS. Our healthcare challenges cannot be solved in a silo. A holistic, whole-system approach is needed, and the Greens would be more than happy to support one, were the Government to put it on the table.

16:13

Alex Cole-Hamilton (Edinburgh Western) (LD): I thank Anas Sarwar and the Labour Party for securing time for this important debate this afternoon. The motion that we are debating is very elegant. It is easy for us as Opposition parliamentarians to throw rocks at the Government about waiting times, sometimes unfairly and sometimes for reasons beyond its control, but that is not what the motion does. The motion looks in granular detail at a profound failure of expectation management, which our constituents are experiencing every single day.

We all have examples of constituents who have been failed in this manner. It starts with that profound mismanagement of expectations. It is often then characterised by pain and anxiety as the delay becomes manifest. Then, almost universally, that leads to deep frustration and anger.

That is typified in one example. At the turn of the year, I was visited by an elderly woman in my constituency. She had been referred to the dental hospital for investigative surgery regarding signs that could be linked to an early stage of mouth cancer. That was a very worrying prognosis. She got her automatic letter, which we have heard about this afternoon, telling her about her 12-week waiting time guarantee. A few months later, she got another letter, saying that her wait would actually be nine months rather than 12 weeks. That was troubling for her as she had to cancel a holiday that she had booked, because it was going to fall in or around that timeframe. However, what added insult to injury for her was an astonishing admission at the top of the piece of paper on which the letter was written: somebody had thought to write that the date that the message had been dictated was 15 October and that the date that it was typed was 17 December. For two months, that letter had lain in a dictaphone somewhere, waiting to be typed up. This is 2018 and we are relying on 1970s technology in the cogwheels of our NHS. For all that time, she had to wait with a troubling anxiety about what was causing the pain in her mouth. I am sure that every member in the chamber has a story like that.

This issue is not about the waiting times themselves; it is about the profound mismanagement of expectation that we are subjecting our constituents to through the current misapplication of the waiting time guarantee.

I used to think that the problem was all to do with delayed discharge. That is a huge part of it, because delayed discharge causes an interruption in the flow at every level of our health service. I will take a moment to put on record my thanks to the cabinet secretary for intervening in the case of William Valentine, which I raised with her last week. I am happy to say that he got home before the weekend.

Although I used to think that addressing the problem of bedblocking and ensuring that we do

not have 1,000 people who are fit to go home but cannot do so because they do not have a social care package in place would be the solution, but that issue is just part of the problem. Yesterday, we learned in the Health and Sport Committee that, although NHS Greater Glasgow and Clyde has the lowest level of delayed discharge of any health board in the country, it has some of the worst failures of that 12-week waiting time guarantee—the figure doubled last year, going up to something like 30,000 in-patient waits. The issue, therefore, is not just to do with delayed discharge; it involves care pathways, bureaucracy—people leaving letters lying around in dictaphones waiting to be typed up—demand and workforce planning. All those aspects are key to solving the problem of waiting times.

However, it is the issue of expectation management that the Labour Party is rightly bringing to the attention of Parliament today. If people are given the facts in a brass-tacks way about the delay that they will have to endure—if people are open and honest with patients at the start of the process—we should expect our patients to accept and tolerate that. However, what we cannot expect them to tolerate is the dangling of the false hope of a 12-week treatment time guarantee that their health board has absolutely no way of meeting.

16:17

Jackie Baillie (Dumbarton) (Lab): Four minutes is not a long time, so I will cut to the chase. Waiting times are far too long, and they are growing longer with each day that passes. It is a problem in NHS Greater Glasgow and Clyde, and it is a problem across Scotland. Almost 120,000 people in Scotland have had their waiting time guarantee breached. In effect, that represents the Scottish Government breaking the law—its own law—120,000 times. Almost 16,000 people have been affected in the NHS Greater Glasgow and Clyde area alone. Behind those statistics lie patients who are desperately in need of treatment and who are waiting in pain for months and, in far too many cases, more than a year.

In my constituency, the waiting list for ophthalmology is too long. I have cases in which patients who require cataract surgery are being told that it will be 13 weeks before they see the consultant, never mind receive treatment. That means that there are delays that do not even count against the treatment time guarantee. The NHS is front-loading the wait in order to massage its figures, which is nothing short of gaming the system.

The waiting list for orthopaedics is, frankly, shocking. People are waiting in excruciating pain and are now housebound because they have not received treatment. One constituent has crushed discs and can barely walk—she screams with pain—but she had to wait seven months for the results of a scan. One year on, she has been told to go back to her GP for a further assessment even though everyone acknowledges that what she needs is surgery. That is another example of gaming the system.

Another constituent required a hip replacement. They got their treatment time guarantee letter—oh yes, they did—but, when they phoned, they were told that the wait would be at least 50 weeks, although that would not be put in writing.

I raised numerous cases directly with the cabinet secretary in the chamber, months ago, and I have written to her on several occasions on behalf of individual constituents. In fact, I could paper my walls with all those letters and her formulaic responses. Every letter tells me how concerned the cabinet secretary is to read some of the information contained in my correspondence about the delays in the wait for treatment. Every letter tells me how grateful the cabinet secretary is for my bringing the matter to her attention and how it is vital that she hears about patients' direct experiences. However, despite all of that—

Shona Robison: Will the member take an intervention?

Jackie Baillie: No.

Despite all of that, nothing changes. The health boards are simply not listening to her. The cabinet secretary tells us that an extra £50 million was made available last year—£11 million for Glasgow alone—but I have to tell her that I do not see evidence of that in my constituency. Waiting times are not improving; the same problem remains.

For people in my constituency, the Golden Jubilee hospital—

Shona Robison: Will the member give way?

Jackie Baillie: No—put it in writing.

The Golden Jubilee hospital—the national waiting times hospital—is just down the road. The staff there can carry out the orthopaedic surgery and cataract surgery that my constituents are in desperate need of, but NHS Greater Glasgow and Clyde rations access. It does not want to pay for patients to go to the Golden Jubilee hospital, although, the last time that I looked, it is all one NHS. It would be quicker and more convenient for patients from my constituency to go straight to the Golden Jubilee hospital without NHS Greater Glasgow and Clyde's interference.

Audit Scotland has reported on waiting times on many occasions, and it does not make pleasant reading. It has also suggested that strengthening patients' rights and giving them more choice about

where they are treated will reduce waiting times. When she was in opposition, the cabinet secretary—perhaps she should listen to this—agreed that she wanted patients to have greater involvement in and choice about where and when they were treated. She believed that patients should be given a clearer indication of what their waiting time was likely to be.

The Presiding Officer (Ken Macintosh): That is your time, Ms Baillie.

Jackie Baillie: That, Presiding Officer, was in 2006. It has taken 12 years, but I am glad that it is now going to happen. I welcome the commitment today that all my constituents who are waiting beyond their guaranteed treatment time will actually be told how long they will have to wait.

The Presiding Officer: Conclude, please, Ms Baillie.

Jackie Baillie: I invite the cabinet secretary to make one other commitment, which is that my constituents can have their operations quickly, in the Golden Jubilee hospital, without any more gaming of the system.

16:22

Ivan McKee (Glasgow Provan) (SNP): The motion before us aims to tackle the lack of predictability around waiting times by requiring health boards to

"communicate an accurate expected waiting time range to patients."

That is a fine objective, and it is one that we all share. We recognise the human impact of poor waiting time predictability, including the economic cost to individuals and to society as a whole. However, as is often the case with instant solutions to complex problems, the devil is in the detail, and many questions arise about how such predicted waiting times are to be calculated, communicated and verified. In my brief remarks, I will consider some of the many issues that we need to address in order to implement that process improvement.

The motion introduces the concept of output predictability. It calls for health boards not only to achieve targets for the 12-week waiting time requirement but to predict the degree by which they will miss those targets and to do so at the level of individual patients. Although that is superficially attractive, it raises some interesting questions. If health boards are to communicate anticipated waiting time ranges to patients, what steps will be in place to ensure the accuracy of those predictions?

Neil Findlay: Mr McKee does business analysis of the health service all the time. Does he not understand that the health service is about people who are waiting in agony on waiting lists? When he tries to apply a business principle to everything, he takes away that human element.

Ivan McKee: Does Mr Findlay not understand that his standing up and ranting for 30 seconds does absolutely nothing to solve the problem? The problem will be solved by people understanding it and implementing solutions to make the situation better for the people of Scotland, not by Mr Findlay standing there and ranting. Let us go back to the real world, where we solve real problems.

Neil Findlay: What a clever man.

Ivan McKee: Thank you very much. [*Interruption*.] I hope that I will get some extra time for that, Presiding Officer.

The Presiding Officer: Please continue the debate.

Ivan McKee: Supply and demand variation—I am sorry, but where were we? The process would require us to measure whether a health board's expected waiting times were realised or not. I know that Mr Findlay does not care about that, but this is important if Labour members are serious about implementing what they have in their motion. Supply and demand variation and unforecast events mean that waiting times today, at the point when an operation is scheduled, may well be very different from the waiting times that are realised several months down the line. Once indicators are in place, it is but a small step to setting targets against those indicators.

Further questions exist around the terminology. What is meant by "range"? A wide range could be specified by the health board, which would meet the requirement but would, of course, be of limited value to patients. Work needs to be done to delineate the parameters of the anticipated allowable ranges. Similarly, the term "accurate" requires some clarification. What level of accuracy is acceptable and how would it be measured?

To track performance, health boards would need to collect data not only on the number of procedures that failed to meet the statutory targets, as they do at present, but on the variance between the predicted and actual outcome for each individual procedure. Verification would require information technology systems to be in place to collect that data, and what would the costs of that data collection be?

The question then arises as to the definition of the indicator. The simplest solution may be to track the percentage of operations that were completed within the predicted time range. That then raises the question of which is more important—predictability or speed. [*Interruption*.]

The Presiding Officer: Mr Johnson, either intervene or keep your comments to yourself, please.

Ivan McKee: The member might want to listen; he might learn something.

If a waiting time of 16 weeks is initially communicated to the patient and the operation is then completed in 13 weeks, meaning that the initial prediction was inaccurate, is that a good thing or a bad thing? That may depend on the individual circumstances of the patient. As always with target setting, there is the issue of unintended consequences. Any indicator to track predictability performance will need to be aligned with Harry Burns's review of indicators and targets and with the Scottish Government's national framework indicators review.

I welcome the intent of the motion. I have gone through it in a bit of detail—clearly unlike the members who proposed it. Predictability is a virtue, and I look forward to the many hours that we can spend on the Health and Sport Committee discussing how best to implement this process improvement.

16:27

Edward Mountain (Highlands and Islands) (Con): It was only last week that I stood up in the chamber and discussed with the Scottish Government its mismanagement of the national health service. It is of little surprise to me that I am back here again to discuss the same issues as I discussed last week.

When I thought about which waiting time issues to talk about, I was spoilt for choice. I could have gone with issues based on NHS Highland figures, such as the fact that Highland patients have to wait 26 weeks for routine orthopaedic surgery and 47 weeks for routine ophthalmic surgery. Those figures mean that, from receiving a referral from their GP for treatment, they are waiting for more than a year in many cases.

Local consultants who deliver care in the Highlands know and state that highlanders are resilient and uncomplaining. However, there are times when those strengths—which I perceive them to be—become weaknesses. When they first become ill, many people decide not to make a fuss about their poor health too soon. The result is that GPs and consultants in the Highlands are alerted to health problems much later than they should be, and symptoms are often more advanced when they are diagnosed. That is why the issue of waiting times in the Highlands is critical.

What ties diagnosis and treatment together is radiology—that is a simple fact, to my mind. Last year, I spoke about the poor state of radiology in the Highlands following the publication of a letter signed by more than 50 members of the department of medicine and general surgery at Raigmore hospital that expressed their deep concerns about the current state of the radiology department there. Why were they concerned? Staffing shortages had led to serious delays in elective and emergency reporting, with more than 8,000 films being unreported. Eight months on, there are still far too many unreported films. Yet, in many cases, neither medical diagnosis nor surgical operations can take place until radiologists have interpreted scans and X-rays.

The radiology department at Raigmore hospital is now lacking a clinical director, a head of service and a radiology services manager. The Scottish radiology transformation programme was meant to link up all departments across Scotland to cover short-term staffing issues and allow the reporting of images to be undertaken by any radiology unit. That was an admirable idea, but the NHS IT system is so clunky that it does not assist the speedy sharing of patient data between health authorities. I am therefore unclear about whether that is a realistic solution without huge technological advancement.

The cabinet secretary's recruiting plans seem not to be working, and it seems that new thinking is desperately needed. I will make a suggestion. One solution would be for her to consider starting a radiology training scheme based in Inverness, to encourage more consultants to live and work in the Highlands. I am sure that, once they were there, we could encourage them to see the benefits of staying there. Similar schemes have been developed in remote areas of Australia, Canada and Alaska and have proven hugely successful. I know that that is not a short-term solution, but let us not forget that the problem has been 10 years in the making and we need time to sort it out. That much I will give the cabinet secretary.

We should all be really proud of our NHS, and I think that, in many ways, we are. The staff who deliver healthcare have risen to the challenge that has been created by a lack of leadership and innovation. Across Scotland, the shortcomings in our NHS emanate from the top. It is time for the cabinet secretary to step up and provide the leadership that has been severely lacking but that our NHS desperately needs and truly deserves.

16:31

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): It is probably appropriate for me to follow Edward Mountain because I, too, want to focus on some things that are going on in the Highlands.

The Scottish National Party Government introduced the Patient Rights (Scotland) Act 2011, which Anas Sarwar mentioned, to ensure that patients are supported properly, that their voices are heard, and that they are seen as quickly as possible. Since then, more than 1.5 million in-patients—although not all patients—and day cases have benefited from the 12 weeks to treatment target.

The Government's amendment recognises that there is still room for improvement. Like Ross Greer, I am contacted by constituents who have been affected by systems or processes not working perfectly and things falling through the cracks. Long waits have serious implications, as Jackie Baillie outlined. Patients experience pain and discomfort that none of us can properly understand. For improvement, there needs to be targeted investment in services and reform of services.

Although we are often faced with challenges and difficulties, we had a breakthrough yesterday on the Isle of Skye in the NHS Highland area. I want to share some lessons from that experience, which demonstrates that proper engagement with patients, a focus on community services and money being targeted well all make a difference. As Alex Cole-Hamilton said, it is very easy to throw rocks—in fact, that must be the easiest politics going—but it is far harder to build consensus, to seek solutions, to deliver results and to be honest along the way.

After months—if not years—of severe challenges in the north end of Skye about the future of Portree hospital, the tide has started to turn in the past three months. I am sure that my fellow Highlands MSPs in all parties would agree that light was seen at the end of the tunnel yesterday, when Professor Sir Lewis Ritchie shared his findings of the review of Portree hospital in Skye and unequivocally stated that it would remain open. The review was announced last October after meetings with campaigners early in the year to discuss their legitimate fears and concerns about the future of Portree hospital, where out-of-hours services and new admissions were fairly regularly suspended. Campaigners were deeply concerned about local services, but the issue is a lot bigger than that. The example demonstrates that when services are cut in one area, that adds pressure in another.

Edward Mountain: Will the member take an intervention?

Kate Forbes: Yes—after my next comment.

Last summer, I spoke to a healthcare professional at Raigmore hospital—that person shall remain nameless—about local residents' fears about Portree hospital. She said to me in frustration that the problem with closing Portree hospital is that it would put greater pressure on the big hospitals, including Raigmore, and would make it even more difficult for such hospitals to meet waiting time targets. The Government's amendment states that we need to get more services into the community. In so doing, we will reduce pressure on hospitals such as Raigmore—which, incidentally, requires a minimum two-hour drive for most patients' journeys for basic services. I will take an intervention from Edward Mountain.

The Presiding Officer: It will have to be very brief, Mr Mountain.

Edward Mountain: It will be, Presiding Officer.

I join Kate Forbes in welcoming the report from Sir Lewis Ritchie, which I think shows a novel and innovative thought process, which has not been shown by NHS Highland. Does she agree with that?

Kate Forbes: I absolutely agree. The point that I have been making strongly is that it is easy to identify where the challenges are, but this entire process has demonstrated that where a clinician or independent reviewer can come in and build trust and faith between healthcare providers and the public, and find novel solutions, we can indirectly reduce waiting times by ensuring that investment is targeted well and services are reformed. In the case that I am talking about, that was all done with the very welcome backing of the cabinet secretary, which demonstrates that leadership right from the top is working in Scotland and is having a direct impact on patients' concerns in the north end of Skye.

16:36

Neil Bibby (West Scotland) (Lab): I support the motion in Anas Sarwar's name and I am pleased that other parties in the chamber intend to do so, too.

Patients should get the treatment that they need on time, but if they do not, health boards need to be open and up front about how long patients will be expected to wait and why. It is important to tell people why, because all too often breaches of the treatment time guarantee and other waiting times standards are symptoms of the wider problems in the NHS. We always hear lots of rhetoric from the SNP on staffing levels and resources, but the reality is that health boards have already had to make what Audit Scotland described as "unprecedented savings."

We also know from Audit Scotland that operating costs are up, demand for services is up, improvements in life expectancy have stalled, health inequalities persist, recruitment is in crisis and the NHS remains underfunded. Those

challenges are significant, but none of them is new.

The Scottish Government put in place the Patient Rights (Scotland) Act 2011, but the problem is that it has not put in place a proper plan or adequate resources to deliver it. For years, the SNP Government has been warned about mounting pressures on the NHS. For years, it has been told that it needs to deal with the NHS workforce crisis, but we see the NHS being overstretched and underfunded and NHS workers being overworked.

The Government's failure to rise to foreseeable challenges has prevented patients from getting the care that they need when they are entitled to get it. It is time that the Government admitted that and addressed it.

Across the country, patients are waiting too long for the care that they need. In my region, a constituent recently phoned the hospital about an appointment only to be told to go to accident and emergency to complain of heart pains because, otherwise, she would be waiting months to see a specialist about her heart complaint.

A number of families who once had open access to the Royal Alexandra hospital children's ward—which the minister closed—have told me that they now have to wait longer to see a doctor in Glasgow. As Jackie Baillie said, official statistics show that there are thousands of cases of patients in the NHS Greater Glasgow and Clyde area and throughout Scotland for whom the treatment time guarantee has been breached.

Of course, the SNP's waiting time guarantee is a legal one—it has been written into law. To put it simply, if the guarantee has been broken, that means that the law has been broken. The First Minister tells us that we are to judge the SNP on its record. We can do so—when it comes to health, its record is criminal. We have already heard this afternoon that the SNP Government and the health secretary have broken their own waiting times law more than 118,000 times.

Breaking that law can hardly make Shona Robison Scotland's Al Capone, but she is certainly guilty of failing Scotland's NHS and, in the next reshuffle, she might find out that she is not untouchable. The health secretary is running out of excuses. Shona Robison told us last week that adequate funding is being given to the NHS. Scottish Labour disagrees. If sufficient resources are going to the NHS, why are 3,000 operations being cancelled this year, why are A and E waiting times up, why are children's wards being closed, and why are 118,000 people waiting longer than the SNP's treatment times guarantee? That is 118,000 people who are waiting for hip replacements, knee replacements, stents, cataract treatment and heart surgery—real people with real needs who are being let down by the Government.

It is welcome that patients should start to get open and honest information on how long they will be expected to wait for treatment and why, but that is the very least that they deserve. We now need urgent action, so that far more of Scotland's patients get their treatment on time. That is why I urge members to support the Labour motion.

16:40

Michelle Ballantyne (South Scotland) (Con): Waiting times is not a new issue for debate. Back in 2006, Audit Scotland reported that the NHS in Scotland had made significant progress in reducing waiting times. However, some of that had been achieved by using the Golden Jubilee national hospital, private providers and waiting times initiatives, all of which came at relatively high cost. Evidence suggested then that short-term increases in activity at particular points in the system did not lead to sustained reductions in waiting times. Despite that knowledge, the Government promoted the Patient Rights (Scotland) Act 2011, which enshrined 12-week waiting time guarantees in law. For many of us, it is not surprising that we are here today listening to statistics about breached waiting times and stories about the distress and suffering behind those statistics.

Why do we have waiting time targets and what do they mean for us as decision makers? For Government, and indeed for our communities, waiting time targets signal that healthcare is being monitored, governance is in place and patients' rights are being protected. As a nurse and an operational and strategic manager in the NHS for more than 25 years, I witnessed the impact that Government targets and guarantees have on our care systems, and how the operational imperative of not breaching a target can drive decision making, which has led to some of the scandals that we have seen over the years.

Waiting times targets are not clinically led. If someone is in pain or suffering with acute mental health problems, the 12 weeks that they are told they will be treated within feels like a lifetime, but then to discover that the information that they have received is not accurate and that their expectations will not be met can be devastating to their physical and mental wellbeing. Patients want accurate and timely information.

Health and community care is a complex system, the efficiency of which is dependent on all its interrelated parts. Waiting lists and waiting times are affected by each part of the system and by the links between them. There is, of course, a place for short-term approaches to tackle delays,

but they need to be part of a wider strategy that looks at the whole system for achieving a sustainable reduction in waiting times.

At about £12.9 billion, our NHS spending accounts for 43 per cent of the overall Scottish Government budget, while rising operating costs have meant that health boards have had to make unprecedented savings of almost £390 million just to break even. In October 2017, Audit Scotland concluded that simply adding more funding was "no longer sufficient" to achieve

"the step change that's needed across the system."

Members in the chamber can trade insults, cast aspersions of blame and try to outdo one another on who is most virtuous, but that will not address the very real problems that our NHS faces.

In conclusion, I will say this. Do I blame the SNP and its Government for the failure to meet waiting times? No, I do not. The SNP does not control patient demand or many of the bottlenecks and realities in individual areas that impact on waiting times. Do I, however, hold the SNP and its Government responsible for the failure to meet waiting times? Absolutely, I do. The SNP introduced the Patient Rights (Scotland) Act 2011, established the measures and took responsibility, and it would want to take the credit if the targets had been achieved, so yes—of course the SNP is responsible when the promises are broken. That is the bottom line in this debate.

16:44

Fulton MacGregor (Coatbridge and Chryston) (SNP): I remind the chamber that I am the parliamentary liaison officer to the health secretary.

The Patient Rights (Scotland) Act 2011 created a statutory treatment time guarantee of 12 weeks and more than 1.5 million in-patients and day cases have already benefited from the 12-week treatment target since it was introduced, as other members have mentioned. We can see a programme of record investment and reform taking place in our NHS that is resulting in care being removed from hospitals, where appropriate, and integrated into the community. That is the right thing to do.

Our budget for health has seen significant increases under the SNP Government, and we will continue to increase that spending by £2 billion. We must accept that such changes will not happen overnight, but we are taking the correct steps towards real change and reform in our NHS and we will have the best possible treatments readily available in future.

Of course, it is the responsibility of health boards to ensure that eligible patients receive their treatment within 12 weeks. That may mean that, with the patient's consent, the health board makes arrangements for them to be treated in another health board area to ensure that the 12-week guarantee is met. In today's debate, no one is saying that all waiting times are met. We know that that is not the case, and the cabinet secretary herself has never said so. As a constituency member of the Scottish Parliament, I often have exasperated patients coming to me, who have waited over their time. As other members have said, such cases often relate to orthopaedic operations. I work with the NHS board to try to resolve the situation and, many times, we have been able to do so to the constituent's satisfaction.

The vast majority of waiting time targets are met, but staffing is of course an important issue when they are not. That is why, last week, I was in the local press, defending agency staff against what I perceived to be attacks from both Labour and Tory politicians. That is not because I want us to have agency staff per se, but because I realise that, with health staff leaving in the face of Brexit and other factors, such as the UK Government's austerity policy, there is a reality about how we meet the needs of the service and I recognise that when agency staff are there, they do a good and very valuable job.

Miles Briggs: Will the member take an intervention?

Fulton MacGregor: I will not have time, Mr Briggs—I am sorry.

The Scottish Government has always made it clear to boards that patients with the greatest clinical need, such as cancer patients, should continue to be seen quickly. NHS boards are asked to deliver against the two national cancer standards, which are that 95 per cent of all patients who meet the criteria should wait no longer than 62 days or 31 days, as set out by the Scottish Government. I am pleased to say that, according to my briefing from NHS Lanarkshire this morning, it has consistently delivered on both cancer standards. The most recently published figures show that NHS Lanarkshire had 96.1 per cent of patients starting treatment within 62 days of urgent referral with a suspicion of cancer, and 98 per cent of cancer patients starting treatment within 31 days of decision to treat. The targets were met in other health board areas too, but those figures are evidence of NHS Lanarkshire's continued excellent performance in that area, and of the dedication and hard work of its staff. I know that they will continue to work to maintain and improve performance to ensure that patients continue to receive the highest standards of care while also avoiding delays where possible.

In the short time that I have left, I would like to end on a positive story, because in the chamber

we often hear of situations in which things have gone wrong. For some months now, I have had the pleasure of assisting my constituent—who, sadly has been diagnosed with stage 4 colorectal cancer—in accessing various treatment programmes for his terminal cancer diagnosis. Although he was faced with aggressive treatment for an aggressive cancer, my constituent, who is an otherwise healthy father to a young adoptive family, was keen to explore all available treatment options, including those available through clinical trials. Unfortunately, my constituent was placed in the placebo group for the trial that he joined and, seeing no benefit in continuing with the treatment that was offered, as it was essentially no different to standard-line chemotherapy, he sought to access a course of treatment that was not routinely funded by the NHS or by any other means. Without going into any great detail, my constituent was devastated to be informed by his multidisciplinary team that that treatment was not considered to be appropriate at that point in time. However, the UK lead clinician for the treatment in question found him to be the optimal patient for that course of treatment and, feeling that he should be offered it, agreed to support him in his appeal to be treated in Scotland with NHS funding. I am delighted to say that that funding has been agreed, and my constituent's treatment is due to start later this month. At the start of this year, my constituent expected to have a short number of months left to live, but can now look forward to having possibly many more years with his young family.

I will end my contribution on that note, Presiding Officer.

The Presiding Officer: We move to closing speeches.

16:49

Brian Whittle (South Scotland) (Con): I start by referring members to my entry in the register of members' interests, in that I have a close family member who is a healthcare professional in the Scottish NHS.

We are debating the patients' charter, which states that there is a guaranteed 12-week maximum waiting time for treatment, which was set in stone by the SNP. Conservatives say that, in the interests of patient care and the principles of honesty and transparency, NHS boards should communicate an accurate expected waiting time range to patients.

I am sure that we all agree that it is the Opposition's responsibility to scrutinise Government policy and to hold the SNP to account wherever it has failed to deliver for Scotland. That scrutiny is being exercised in the Labour motion, which the Conservatives will support.

The fact that we are debating such an obvious point is one that should concern us all. It should not take an Opposition debate to raise such a fundamental principle and to get the SNP to take action, as Anas Sarwar pointed out in his opening address.

It is important that, when we debate health policy, we do so in a manner that does not undermine the work that is being done on the front line every day, as Michelle Ballantyne was at pains to highlight. She emphasised—she has 25 years of nursing experience—how important it is that, when we debate, we try to improve the health outcomes for patients and the outcomes for healthcare professionals.

The debate has given all the speakers in it—including Miles Briggs, Anas Sarwar, Ross Greer and Jackie Baillie—the opportunity to raise local issues. Edward Mountain used his speaking time to talk about healthcare in the Highlands and radiology services at Raigmore hospital. To his credit, he came up with positive solutions for the cabinet secretary to consider.

As I have said, this is not a typical health debate. It was obvious from the tone that was set in the opening speeches that this would be a non-debate. We need to address waiting times in the round. We need to look at acute waiting times, including waiting times for mental health treatment, given that people's conditions deteriorate over time, with increasing financial and personal cost, as we heard all too clearly in the previous debate on NHS Tayside. The physiotherapy waiting time of one year for musculoskeletal conditions that in essence require immediate treatment turns an acute issue into a long-term and costly matter, with a potential impact on physical and mental health.

Alex Cole-Hamilton highlighted the anxiety that his constituent has experienced when waiting for treatment for what could have been a very serious issue. The delay and the false hope of treatment that she has experienced impacts in all areas of her life, and we wish her well.

As I said, this is a non-debate. The net result is that Labour's debating time has been taken up with what the Scottish Government has already agreed to do in law. We could have been debating how we deal with waiting times, what they mean and the language that we use when we discuss them. If you were cynical, Presiding Officer, you might consider that the Scottish Government has agreed to the obvious in order to take the heat out of an issue that it should have dealt with already. Perhaps it has become so paralysed for fear of

doing anything wrong that it is reticent to do anything of note at all.

There is so much more to do if we are to tackle the issues that we face in the health service. We have to talk about education, nutrition, physical activity, planning, the environment and the rural economy, because they all have a footprint in improving the health of our nation.

If waiting times are the barometer for the health of our NHS, it reads "Change is required." I welcome the change that will take place as a result of this debate, but I struggle to see how the debate will impact on the real issues facing our NHS staff and their patients. It is important that waiting times are addressed, so I thank Labour for bringing the motion to the chamber. Given that what it says is so obvious, it needs no amendment from the Scottish Conservatives. However, the fact that the issue had to be raised should concern us all.

16:53

The Minister for Public Health and Sport (Aileen Campbell): I, too, take the opportunity to thank all our NHS staff and to recognise the phenomenal work that our NHS does day in, day out. The NHS, which is 70 years old this year, was founded on the principles of being free at the point of delivery, universal and not based on wealth, equitable and high quality. Those core principles are as relevant now as they have ever been. They remain constant but, undoubtedly, the context, the demand and the challenges that the NHS and that we as a society face have changed.

Meeting the challenges requires mature debate, and we have heard some of that this afternoon. This Government seeks to meet the challenges with a twin approach of investment and reform, and we will drive improvements in acute performance and

"shift the balance of care from acute to primary and social care",

as our amendment to the motion makes clear.

As we—rightly—celebrate all that is good and positive about the NHS, we all recognise that, sometimes, things fall below the standards that we expect. We have heard about some of those situations today. It is important that we not only hear about them, but learn from that direct experience. Such situations are real for individuals, who require and deserve clear information and reassurance. Ross Greer's contribution captured the essence of that.

As the cabinet secretary said, that is why we are committed to revising the charter and to working with boards to communicate the revised guidance. The experience of people and patients motivates our determination to make the improvements that we know are needed.

Anas Sarwar: Will the minister commit to bringing to the Parliament for discussion the suggested amendments to the charter? Will she also bring forward her guidance to health boards, so that we can see what language they will use when writing to patients?

Aileen Campbell: We will discuss the process with health boards and, in due course, we will publish the guidance. Perhaps there is a lesson that members who seek to discuss such things in the chamber should bring constructive ideas about and solutions to the challenges that we face. However, the cabinet secretary will of course publish the revised guidance in due course.

The dedication to making improvements is why £50 million was allocated to support the reduction in hospital waiting times. It is why the cabinet secretary launched the new access collaborative, which is backed with £4 million and seeks to improve how elective care services are managed and to reduce waits. It is why £200 million will be invested over the parliamentary session in expanding the capacity for routine elective operations at the Golden Jubilee hospital and in the new treatment centres across Scotland. That will help to reduce waiting times and take the pressure off. It is also why Scotland has been the first nation in the UK to publish a national health and care workforce plan and why it is the only nation that is committed to safe staffing legislation, which will build on the record high levels of NHS staffing that have been delivered under the Government.

That is a list of actions from the Government, which is relentless in its pursuit of enabling our NHS to meet the needs of the people it serves. However, the Government is not blind to the challenges that we face or the experiences of people in the here and now. We will listen to constructive contributions that seek to solve the challenges. We will respond to Edward Mountain's ideas about radiology and attracting professionals to the Highlands. We will not necessarily agree with everything that he or his colleague Michelle Ballantyne said, but we appreciate the attempt to be constructive and Michelle Ballantyne's professional experience.

We will absolutely consider the example that Kate Forbes gave, in which engagement and consultation with people and communities enabled a better decision to be made in the Isle of Skye. We will think about what that means for future engagement between NHS boards and the communities that they serve.

We will heed the words of Ross Greer, who urged people to examine the issues more broadly

and to understand, for instance, the impact of the hostile immigration environment that has been established and the impact of the freedom of movement restrictions under Brexit.

Presiding Officer, you will note that I have not mentioned the Labour members who come to the chamber and do well at criticising but do not do as well at bringing ideas to remedy the concerns that they have aired.

We will get on with the job of supporting our NHS, building on the high satisfaction rates across Scotland and improving on the targets. Nine out of 10 patients—1.5 million people—have been treated within the 12-week treatment time since the guarantee was introduced in 2012. We will continue to build on the strengths of our NHS to ensure that it is in a position of strength for the next 70 years.

16:58

David Stewart (Highlands and Islands) (Lab): This has been an excellent debate on a vital issue, and I thank members across the chamber for their insightful and knowledgeable speeches and their strongly felt views.

Waiting times are always difficult. When a patient is suffering from an illness or an injury, any time between cause, diagnosis and treatment is unwanted, because it prolongs the pain as well as putting additional stress on the patient's mental and physical wellbeing. Members such as Jackie Baillie, Anas Sarwar, Ross Greer, Alex Cole-Hamilton, Edward Mountain, Kate Forbes, Neil Bibby and Michelle Ballantyne have illustrated that perfectly by citing dissatisfied constituents who felt let down by the system—a system that put in place the Patient Rights (Scotland) Act 2011 to guarantee a 12-week treatment time. The treatment time guarantee allowed hospitals and boards to manage expectations and gave patients a known timeframe.

We must not forget that waiting times are not just simple facts and figures. Behind every delay in an operation or a consultant's appointment, there is often an individual who is experiencing anxiety, pain and stress. I remember when 80-year-old Inverness writer Bette McArdle came to see me because she was told that she had to wait 11 months for a relatively simple cataract operation. She said:

"It is vital that we octogenarians are able to lead independent lives and still contribute to society. And it has to be remembered that many are still caring for a partner or family member. Without the basic support of maintaining adequate eyesight we can rapidly become even more dependent on the NHS and care services and cost the state."

Every statistic holds similar stories.

Although I cannot fault NHS Highland for trying to clear the backlog and reduce waiting times, it is concerning that procedures are having to be outsourced to private companies and other boards at great cost. For the second year in a row, NHS Scotland failed to meet seven out of eight key performance targets, according to Audit Scotland's report. One of the key problems identified is the widespread difficulty in meeting demand and the impact that that is having on waiting times. Front-line NHS staff work tirelessly to try to ensure that staffing issues, lack of resources and underfunding do not compromise patient care, but they do so in the face of growing pressure. No one has to take just my word for that, because Audit Scotland said in its 2017 report:

"People are waiting longer to be seen with waiting lists for first outpatient appointment and inpatient treatment increasing by 15 per cent and 12 per cent respectively in the past year."

The other big issue is that the life expectancy gap is increasing, with men from the most deprived areas now living on average 12.2 years less than their more affluent counterparts, and women from those areas living 8.6 years less than their more affluent counterparts. Those from deprived areas are increasingly likely to spend more years in ill health: nine more years for men and 11.5 more years for women. On top of that, in one key area where waiting times were missed, there are higher cancer rates among disadvantaged communities but the lowest detection rates. Those from deprived communities are most likely to be diagnosed with breast and lung cancer at stage 4, whereas those from the least deprived areas are most likely to be diagnosed with cancer at stages 1 or 2. With those from the most deprived areas being diagnosed later, early access to treatment is key to improving outcomes and reducing the life expectancy gap. That disparity must be addressed as a matter of urgency.

The NHS turns 70 on 5 July and we are still having to fight to protect it. Its founder, Nye Bevan, said that

"discontent arises from a knowledge of the possible, as contrasted with the actual."

Debates such as this one are frustrating because we know that we can do better for the NHS, the front-line staff, the patients and the families of patients. I ask all members to support our motion at decision time.

Point of Order

17:02

Emma Harper (South Scotland) (SNP): On a point of order, Presiding Officer. What is the process for amending the *Official Report* when information that is shared in the chamber is incorrect or inaccurate? I am asking because during yesterday's members' business debate on dog attacks, when referring to the take the lead campaign, Finlay Carson made an incorrect statement when referring to me. He said:

> "It is somewhat disappointing but not surprising that Emma Harper, the parliamentary liaison officer to Fergus Ewing, who originally backed the campaign, has now backed off and supports the far from satisfactory postcode lottery option of additional local authority byelaw powers".—[*Official Report*, 8 May 2018; c 85.]

I was not in the chamber for the debate and could not respond, so I would like to note that I have never made any personal comment or statement about amending byelaws. I am therefore seeking your advice on how Mr Carson can amend his mistake in the *Official Report*.

The Presiding Officer (Ken Macintosh): I thank Ms Harper for advance notice of her point of order. She will know that the *Official Report* of that debate yesterday cannot be amended and that it is a correct record of what was stated in the chamber. However, Ms Harper has drawn the matter to the attention of Mr Carson and has put her comments on the record for all to see.

Business Motion

17:04

The Presiding Officer (Ken Macintosh): The next item of business is consideration of business motion S5M-12137, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees—

(a) the following programme of business—

Tuesday 15 May 2018	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Legislative Consent Motion: European Union (Withdrawal) Bill – UK Legislation
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 16 May 2018	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Communities, Social Security and Equalities
followed by	Culture, Tourism, Europe and External Relations Committee Debate: Erasmus+
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 17 May 2018	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.30 pm	Parliamentary Bureau Motions
2.30pm	Ministerial Statement: Scottish Veterans Commissioner's report on Veterans Health and Wellbeing
followed by	Stage 3 Proceedings: Land and Buildings Transaction Tax (Relief from Additional Amount) (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
Tuesday 22 May 2018	

2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 23 May 2018	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions: Economy, Jobs and Fair Work; Finance and the Constitution
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 24 May 2018	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
followed by	Members' Business
2.30 pm	Parliamentary Bureau Motions
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time

and (b) that, in relation to First Minister's Questions on 17 May 2018, in rule 13.6.2, insert at end "and may provide an opportunity for Party Leaders or their representatives to question the First Minister".—[*Joe FitzPatrick*]

Motion agreed to.

Decision Time

17:04

The Presiding Officer (Ken Macintosh): The first question is, that amendment S5M-12107.3, in the name of Shona Robison, which seeks to amend motion S5M-12107, in the name of Anas Sarwar, on an NHS Tayside public inquiry, be agreed to.

Amendment agreed to.

The Presiding Officer: The second question is, that amendment S5M-12107.2, in the name of Miles Briggs, which seeks to amend motion S5M-12107, in the name of Anas Sarwar, on an NHS Tayside public inquiry, be agreed to.

Amendment agreed to.

The Presiding Officer: The third question is, that motion S5M-12107, in the name of Anas Sarwar, on an NHS Tayside public inquiry, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament notes the concerns expressed by families regarding the treatment of their loved ones within mental health services in NHS Tayside, access to facilities and the limited scope of the inquiry announced by the board; believes that a wider independent inquiry across the region would allow for these concerns to be investigated comprehensively in order to restore faith in these services among patients and their relatives and friends; further believes that it is important that families seeking answers are included in the establishment and remit of a wider inquiry; notes the catalogue of concerns regarding mental health services in NHS Tayside raised by campaigners and families of people who have died by suicide in the region; welcomes the decision of the new chair of NHS Tayside to commission an independent inquiry into mental health and suicide prevention services across the region; believes that this inquiry must be an opportunity to capture the concerns of the patients and families who have felt let down by services; considers that the inquiry should also help ensure that recommendations from recent Health Improvement Scotland and Mental Welfare Commission inspection reports are fully implemented; believes that, if the NHS Tayside-commissioned inquiry is hindered in its undertaking by either non-cooperation by providers or by lacking appropriate independence, the Scottish Government should subsequently convert it to an inquiry under the auspices of the Inquiries Act 2005; supports calls for the forthcoming Suicide Prevention Strategy to help deliver more constant crisis support for people who have lost a loved one to suicide; approves of the creation of a national suicide prevention leadership group to help support the creation and delivery of local prevention action plans, and endorses the inclusion of the development of reviews, where necessary multi-agency, into all deaths from suicide as part of the new Suicide Prevention Strategy."

The Presiding Officer: The fourth question is, that amendment S5M-12108.1, in the name of Shona Robison, which seeks to amend motion

S5M-12108, in the name of Anas Sarwar, on waiting times, be agreed to.

Amendment agreed to.

The Presiding Officer: The final question is, that motion S5M-12108, in the name of Anas Sarwar, on waiting times, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament notes that the Patient Rights (Scotland) Act 2011 establishes a legal 12-week treatment time guarantee for eligible patients who are due to receive planned inpatient or day case treatment; further notes that Audit Scotland has shown that this has not been delivered for all patients; acknowledges the impact that long and unknown waits can have on an individual's work, family life and mental and physical wellbeing, and believes that, in the interest of patient care and the principles of honesty and transparency, NHS boards should communicate an accurate expected waiting time range to patients; supports the Scottish Government making any necessary changes to the Charter of Patient Rights and Responsibilities and guidance to NHS boards to ensure that this is delivered, and believes that, to meet the evolving needs of the people of Scotland, NHS and care services must be supported to shift the balance of care from acute to primary and social care where possible, and that effective engagement with the public will be key to this being achieved.

Roads

The Deputy Presiding Officer (Christine Grahame): The final item of business is a members' business debate on motion S5M-11185, in the name of Rachael Hamilton, on the condition of Scotland's roads. The debate will be concluded without any question being put.

Motion debated,

That the Parliament recognises what it sees as serious issues with Scotland's roads; believes that they have considerably deteriorated following the recent extreme weather, with new potholes being created and existing ones becoming worse; understands that recent statistics suggest that more than a quarter of the country's roads are in an unsatisfactory state and that, between 2015 and 2017, almost 12,000 miles of these were either earmarked for inspection or required maintenance; notes reports that, since 2010, spending on maintenance has been reduced by 20%; understands that a recent report by confused.com claimed that the potholes on Scotland's roads were the worst in the UK; believes that the report suggests that these potholes are four miles deep in total, cost £104 million in repairs in 2016, with requests for payments for repairs due to the damage inflicted by them rising by 130% between 2013 and 2017, and that over £2 million has been paid out in pothole-related compensation, and further believes that, despite efforts by local authorities, including the Scottish Borders Council's commitment to spend £22 million on roads and bridges, the recent severe weather has now made repair almost impossible, meaning that Scotland's roads are now facing a crisis.

17:07

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): Scotland's roads have suffered from chronic underfunding, which has allowed for the situation that many of us endure daily. Potholes are described as craters and our roads as resembling the surface of the moon.

Scotland's roads are in crisis. The anecdotal evidence has been proven by experts. Confused.com found that Scotland has the worst potholes in the United Kingdom, and recent statistics suggest that more than a quarter of the country's roads are in an unsatisfactory state. Between 2015 and 2017, almost 12,000 miles of those roads were either earmarked for inspection or required maintenance, with 423 potholes reported each day.

Millions are spent by local authorities to repair potholes, and £2 million has been paid out in compensation over the past 10 years. Indeed, compensation claims by motorists for damage that is caused by potholes alone have risen by 130 per cent between 2013 and 2017. This morning, I spoke to Sustrans Scotland, which told me that, in Edinburgh over the past 5 years, £111,000 has been paid out to road users, a staggering £66,000 of which was paid in compensation to cyclists.

Over the past seven years, funding to maintain Scotland's roads has been cut by a fifth. A report from the Convention of Scottish Local Authorities found that funding fell from £691 million in 2010-11 to £554 million last year. TRL—the transport research laboratory—found that every £1 reduction in spend on local roads maintenance could result in a cost of between £1.67 and £1.76 to the wider Scottish economy.

Potholes are our nemesis: they cause misery to our constituents and cost our local authorities millions. Undoubtedly, the beast from the east made things worse. The extreme weather has worsened the conditions of our roads, so much so that budgets for repairs will barely make an impact. We must acknowledge that, although local authorities try to combat the problem, it is now out of control.

The Scottish Borders region has some of the worst roads in Scotland and in the UK. My constituents agree with the Federation of Small Businesses when it says that run-down local roads hurt small businesses. A community group from Newcastleton said of the potholes:

"This is having a debilitating impact on our community with many now not attempting travel in the dark or even confident about leaving the village. There is real fear of risk, serious accident or injury being caused by driving".

Having inherited a backlog of repairs, our current administration at Scottish Borders Council has set aside £22 million for roads and bridges over the next three years. With the recent additional £1.8 million of investment, a total of 32 Borders roads will be improved as part of a £2.6 million resurfacing programme this year. Despite that encouraging news, the fact remains that the Borders has a roads network of 3,000km and, with more than 900 potholes recorded last year alone, the increased investment will not go far enough.

That is true for all. Scotland's local authorities have more than 150,000 potholes, and the Society of Chief Officers of Transportation in Scotland has warned that funding cuts mean that it is not possible to repair each one, so the problem is very much real and impacts on us all. Despite efforts from local authorities, they alone simply cannot do enough to fix the roads.

However, the Scottish Conservatives have a plan—a means to support local authorities and help repair our roads. A pothole fund of £100 million over the next parliamentary session—£20 million a year—would support local authorities to fix our roads. That funding would mean that 2 million potholes would be repaired over the next session, which would be enough to fix current and future potholes. Local authorities would bid for the fund to support their own efforts on road repairs. That is action that Scottish people deserve. They want a road network that is fit for purpose.

Scotland needs action now to stop this troubling situation from becoming further exacerbated. A good road network will benefit us all. It will benefit motorists, because with pothole-free roads, motorists can drive in comfort and safety. It will help cyclists, because they will be able to ride in safety and not be at risk of puncture or of falling off due to unexpected terrain under their wheels. It will help local transport, because bus journeys will be made safer and smoother, and there will be less chance of something going wrong.

In a recent promotional video for the National Trust for Scotland, Sir Chris Hoy talked about how he hates potholes, but loves that Scots can be the best in the world. We can be the best in the world. For example, the Scot, John Loudon McAdam, was the inventor of the macadam road surface.

We could encourage more visitors to the area. Instead of looking out for potholes, visitors could look at the beautiful countryside. We want to make a good impression in Scotland, and one way to do that is by making our roads pothole free and safe.

I have people in my constituency who are in such despair that they have started to fill in their own potholes. Roads are so bad that they cannot drive to their own front door. It is not right that the situation is now so bad that members of the public have taken action into their own hands. The fund would give my constituents, and each member's constituents, the roads and repair services that they deserve.

I reiterate that the Scottish Conservatives are offering real solutions, with a plan to introduce a pothole fund. It is a solution to fix our roads and fill in our 153,000-plus potholes. Scotland's roads are in crisis. The roads in the Scottish Borders are in crisis. The Scottish National Party must focus on the day job and resolve the national shame that are Scotland's roads.

17:13

Tom Arthur (Renfrewshire South) (SNP): I am very grateful to Rachael Hamilton for securing the debate. The issue is very important; it is one on which we get a tremendous amount of casework and one in which our constituents are very interested. I gently suggest to the Conservative Party that, if it wants £100 million to put into a pothole, it might want to first address the £500 million black hole that the Conservative Party's tax plans would create. However, I do not want to become too partisan in this debate.

I am very grateful for the opportunity to speak in the debate, because it allows me to highlight some of the fantastic work that my colleagues in SNP-led Renfrewshire Council are undertaking. Only today, on the front page of Johnstone's *The Gazette*, it was reported that—

The Deputy Presiding Officer: I am sorry—I know that you are very friendly with *The Gazette*, but I am not. No props, please.

Tom Arthur: I apologise, Presiding Officer, but I will read from the front page:

"7m to fix roads in ruin".

Indeed, SNP-led Renfrewshire Council is actually putting more than £7 million into the roads—it is a £7.2 million programme. That means that 86 roads across the region will be resurfaced; 33 roads will be surfaced, dressed or patched; and 46 footways will be resurfaced. It represents the biggest single investment in roads ever made by Renfrewshire Council, and there will be an on-going programme of pothole repairs. That has been complemented by the money invested by Derek Mackay and the Scottish Government, which was £312,000 for Renfrewshire Council and £136,000 for East Renfrewshire Council. Those councils cover my Renfrewshire South constituency.

I want constituents who are watching this debate—I am sure that many are watching, because potholes are an important issue—to have an idea of some of the work that will be undertaken. Therefore, I am delighted to share that the roads in my constituency that are to be resurfaced include the A761 Bridge of Weir Road; Beith Road, Kilbarchan Road, Barrochan Road, the Barrochan Road interchange, Linn Park Gardens, MacDowall Street and Spateston Road in Johnstone; Braehead, Bridesmill Road and part of the High Street in Lochwinnoch; Bridge Street in Linwood; Easwaldbank, Kilbarchan Road, Locher Road and Kibbleston Road in Kilbarchan; and Newton Avenue in Elderslie. That makes up a grand total of 41,000m^2, which, members might be keen to know, is 10,000m^2 more than the total floor space of the Scottish Parliament.

It is not just roads that we will be repaving in Renfrewshire South. We will repave footways, too, including Bridge of Weir Road; Clippens Road in Linwood; Park Gardens and Easwaldbank in Kilbarchan; Miller Street, Quarrelton Road, Beith Road and the High Street, where my constituency office is located, in Johnstone; Old Road in Elderslie, so Elderslie is not left out; Victoria Road in Brookfield; McConnell Road; and Falcon Road.

There is a bonanza of resurfacing about to happen in Renfrewshire South, and across Renfrewshire and East Renfrewshire, which I welcome. It demonstrates that, at local council and national levels, SNP administrations and the SNP Government invest in Scotland's roads. I know that all my constituents will be delighted about that.

17:17

Jamie Greene (West Scotland) (Con): I would have been absolutely delighted if the people of Renfrewshire were 100 per cent happy with the state of their roads, but judging from the scale and volume of the casework that I get in my inbox from Renfrewshire, I can assure Tom Arthur that that is not the case. However, it is great to see that Rachael Hamilton's debate has spurred Renfrewshire Council into action on the issue, at long last.

The truth is that all around Scotland—not just in Renfrewshire, North Ayrshire or the other constituencies that we will hear about this afternoon—roads are deteriorating. They are flooding and are full of cracks and potholes. Every week, all members must surely in their inboxes see complaints not just from drivers who have had to replace tyres, bumpers and suspension, but from cyclists and motorcyclists who are struggling to use our roads, and from pedestrians, wheelchair users and people who use mobility scooters. The issue touches anybody who uses our roads.

To give the matter scale, I point out that drivers lodged complaints about a road in Scotland every three minutes last winter. Depending on whom one asks, it is estimated that up to one third of our roads are in need of some form of repair. That is more than 4,771 miles of road that need to be fixed.

As Rachael Hamilton said, there are more than 154,000 potholes in Scotland. Councils have been struggling with that. Rather than spending money on fixing the roads, they are paying out compensation. It seems that they are stuck in a rotational situation that is hard to get out of. Repayments for damage have increased by 130 per cent since 2013. It is a chronic issue and it is caused not just by the weather, but by the roads being left to get worse year after year.

The problem is not only in one part of Scotland, but how bad the roads are varies depending where one lives. For example, in West Lothian, it is estimated that about 20 per cent of roads are in need of repair, but the figure could be up to 45 per cent in Argyll and Bute. As is so often the case, rural roads are the last to be addressed.

I recently ran—perhaps to my regret—a social media campaign asking people to post pictures of, or comments about, potholes in North Ayrshire. The Facebook post attracted 500 comments in a week—the most I have ever had on any post, even constitutional posts—and it reached more than 50,000 people, which struck me. Many people from across my area posted pictures and comments on specific roads that they wanted me to go and have a look at.

Road-maintenance funding has been reduced by approximately 20 per cent. According to the Society of Chief Officers of Transportation in Scotland, the cost for fixing it all is estimated to be up to £1.6 billion, and I do not think for a minute that the minister has that sort of money kicking around or up his sleeve. The reality is, however, that many councils simply do not have enough cash to resurface roads.

The problem is not limited to council roads. We know that trunk roads and motorways are also suffering, and more than a tenth of Scotland's trunk roads are showing damage. I am keen to hear what the minister will do to address that.

There are ways of fixing the situation. We could use technology better. Self-healing asphalt has been talked about and has been used in some countries for more than a decade. However, the piecemeal approach of just filling in holes rather than looking at long-term funding solutions and structures is not the way forward.

Drivers are sick of listening to politicians from all levels of government saying, "That road isn't my responsibility; it's someone else's." Drivers say enough is enough, and so do I.

17:21

Colin Smyth (South Scotland) (Lab): I thank Rachael Hamilton for lodging her motion, which has allowed us to have today's debate on the condition of Scotland's roads.

Having been a councillor for more than a decade and now as an MSP, when I say that few issues are raised as often and with as much passion by the public than the state of our roads, it is a sentiment that many other members will recognise. The number of those complaints is on the rise, and we can see why.

As the motion notes, Confused.com found that the potholes on Scotland's roads are now the worst in the UK. Figures from the most recent local government benchmarking report reveal that approximately a third of all roads are in need of maintenance work. Research by the Society of Chief Officers of Transportation in Scotland found that the cost of the backlog of repairs that are needed on Scotland's roads is valued at £1.6 billion.

That would be an onerous challenge at the best of times, but when it comes to council budgets, we live in the worst of times. We have seen a £1.5 billion cut in council budgets since 2011. UK Government austerity has been passed on, with interest, to local councils by the Scottish Government. The impact of those political, not economic, choices is there for all to see in the plague of potholes on Scotland's roads.

Those funding cuts mean that council roads budgets have been slashed by 20 per cent during the past seven years, and the number of road-maintenance workers has also fallen, as councils haemorrhage jobs by the tens of thousands. The workers who remain face an ever-growing workload with fewer resources and pay that has been falling in real terms.

Unison Scotland's "Road to nowhere" report highlights low morale among road-repair staff, with almost one in 10 survey respondents stating that morale in their team was low or very low. The same report found that the majority of workers reported skipping breaks or working late just to get through their growing workload. Until we have a fair funding deal for our councils, we will not begin to tackle the crisis on our roads.

The problems on our roads are not confined to those that are maintained by local authorities. The number of complaints that I receive about the lack of basic maintenance on some of our trunk roads is also on the increase. For example, the so-called temporary traffics lights on the Enterkinfoot stretch of the A76 that reduce the road to a single lane have been in place since 2014, as we await urgent repairs on Scotland's forgotten road. The A77 and A75, the crucial arteries for the south-west that lead to our ferry terminals at Cairnryan, have been starved of investment for far too long, with an economic impact for all to see.

We all know that we cannot build our way out of all the issues that affect our roads—for example, congestion. We need better investment and proper regulation of our buses and a railway system in which passengers, not profits, are the priority. However, that does not excuse the lack of basic maintenance on our roads that impacts on our drivers and other people including bus users. For people who travel by foot or bike, poorly maintained pavements or potholes can mean serious injury.

We also need to consider just how we repair many of our roads and how we guarantee the standard and longevity of such work. Technological innovations could reduce the time and cost of road works, so we should be supporting the development of new techniques such as the use of waste plastic, which is being pioneered by Dumfriesshire firm MacRebur. Such techniques have real potential to repair many of our roads in an environmentally friendly way.

If we do not begin to address the funding crisis that faces our local councils, we will never address the crisis of outstanding repairs to Scotland's roads.

17:24

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): Last year I apparently drove 19,000 miles around my constituency. Although I am not an expert on potholes, I am certainly very experienced when it comes to them. Highland Council represents a huge road network, with 6,754km of road in its area. Like other members in the chamber—with the exception, apparently, of Tom Arthur—we have problems with potholes, too.

At the beginning of the year—I say this to pay credit where credit is due—Transport Scotland moved very quickly on the A82 and A87 trunk roads on the west coast by releasing an additional £4 million to BEAR Scotland to deal with resurfacing works on those roads. It brought forward its programme of works to get started sooner.

On local authority roads, which is where the real problem is, just a few weeks ago Derek Mackay announced an additional £10 million for local authorities. Highland Council got the largest share of that, which is appropriate, considering the mileage of the road network that it needs to deal with. For me, the priority is that, with that additional funding, with council tax having gone up and with an increase, albeit a small one, to Highland Council's budget, it is right and fair that Highland Council move as quickly as possible to fill in potholes and resurface roads, which in some areas of my constituency are exceedingly bad.

The problem is not just bad weather. I was being contacted by constituents prior to the bad weather about certain stretches of road in the Highland Council region that desperately need attention. I am very concerned when I see urban roads in the Highland Council area getting quicker treatment than some of the worst rural roads in villages on the west coast of Skye, for example. I would like there to be a clear schedule of works, like the one that Transport Scotland has produced, for improvements to be made quickly, so that there is light at the end of the tunnel.

Constituents have contacted me about helping, and Rachael Hamilton mentioned how constituents are choosing to help. We now have tourists starting to arrive. One pair of constituents in particular, Annie and Neil Ferguson, have told me stories about how they have had to help visitors whose hire cars have been damaged by the potholes in the surface of roads on the west coast of Skye, which are Highland Council's responsibility. Annie wrote to me saying that, last Saturday, the breakdown truck attended her very small village 12 times, and that the Fergusons had personally been involved with seven lots of visitors in the space of a week—feeding them, providing lifts, making phone calls and even changing tyres. They have had German, French, Italian, Slovakian, American and Chinese visitors all coming to ask for help because of difficulties caused by the state of the road. I could cite other stories.

I would love it if Tom Arthur could put his council colleagues in touch with the Labour-Lib Dem-independent administration at Highland Council and perhaps share some ideas as to how the council can make better progress in filling the potholes and ensuring that my constituents can get to work and go about their business without fear of punctures or damaging their cars. There is money there, with £4 million having gone to Transport Scotland, the biggest share of the £10 million going to Highland Council and a decent share of budget this year. The council needs to publish a schedule of works and to get moving as quickly as possible.

17:29

Brian Whittle (South Scotland) (Con): I thank Rachael Whittle—Whittle? No, not yet.

Rachael Hamilton: Never!

Brian Whittle: I thank Rachael Hamilton for bringing the debate to the chamber and giving me the opportunity once again to highlight the issues that we have in the south-west of Scotland. The Minister for Transport and Islands is well aware of the campaigns that are under way to upgrade the A77 and A75. For his information, I recently took a trip in a heavy goods vehicle down the A77 all the way to Cairnryan. It was interesting to be in a 44-tonne lorry whose driver had to swerve to avoid potholes. I leave to members' imagination how big potholes must be to have an impact on a 44-tonne lorry.

I thank Bullet Express for allowing that to happen. Going on that journey was quite enlightening, as it went through a lot of small villages such as Maybole and Girvan at around 9.30 at night, and it was striking to see how close the lorry goes to the cars and the houses on either side. It was quite interesting to come out of the other side of Ballantrae and go up that hill as the ferry was being unloaded at the other end, with other 44-tonne lorries coming the other way, which meant that the lorries in both directions were crawling along at 4mph or 5mph, with their wing mirrors missing each other by a few inches. That was quite something to see.

What is happening on the A77 between Monkton and Kilmarnock is interesting, as temporary road surface signs have appeared. How bad do the trunk roads have to become before action is taken? They are inspected weekly and are becoming extremely dangerous, especially to motorcyclists. Given the condition of the A77 and the apparent inability of the transport secretary to

effectively address the issue, I am considering going elsewhere for a solution. Instead of treating this as an infrastructure issue, I have decided to treat it as an issue of culture. The A77 is no longer a road; it is a kinetic sculpture that aims to reflect the Scottish Government's approaches to dealing with health, education and the economy—it is crumbling under pressure and is full of holes. For the next part of that art installation, I will apply to Creative Scotland for a grant to repair the roads. My working title is "Competence, or How I Learned to Stop Making Excuses and Get on with the Job".

The second strategic transport projects review effectively means that the transport secretary will not be announcing any new major capital projects until shortly before the next election. Surely, that means that he has more time to dedicate to maintaining the existing roads network. However, even when the transport secretary has the funds, they do not seem to be spent, as there is currently a £50 million underspend. If I asked around the chamber, I am sure that we could all say how that money could be grabbed and spent. The Scottish Government is prepared to ignore south-west Scotland and allow the roads there to crumble while it crows over expensive vanity projects such as the electrification of the A9.

Kate Forbes: Did the member just say that the electrification of the A9 is a vanity project? I assure him that better infrastructure works on the road to the Highlands are not vanity projects.

The Deputy Presiding Officer: I think that you touched a raw nerve, Mr Whittle.

Brian Whittle: The thing is, Scottish Power says that there is a huge capacity issue that that project has not addressed. While the Government spends money on that, the infrastructure in the south of Scotland is crumbling and is left unattended.

We should not underestimate the economic impact that is made by the condition of Scotland's roads. Although I am not ruling out the possibility that the condition of the roads is part of a new economic strategy to boost the wheel and tyre repair sector, I suspect that that is not the case. There is a cost to the economy, whether it involves hauliers and other businesses dealing with the expense of repairs to their vehicles or commuters being caught up in traffic when someone bursts a tyre on a narrow section of road.

I say to Tom Arthur that, when we talk about investing in the economy, addressing the roads network is one of the issues that we are talking about.

17:33

Liam Kerr (North East Scotland) (Con): I thank Rachael Hamilton for securing this important debate. It is particularly pertinent to me, because I wrote to the minister a fortnight ago about the issue. I was on the A90, coming back from Forfar one evening in April, and I went through the 3 miles between the A935 and B966 turnoffs—locals will know that section of road as the section of pinkish tarmac that passes Stracathro services. I was absolutely incensed as I slalomed past the large, deep potholes, dodging other motorists who were doing the same thing, and grimacing every time I crunched into one. That day, I was in a 15-year-old sports car that reacts somewhat negatively to dropping into a hole at 70mph. I have also frequently ridden that road on a motorbike, and I can say that hitting one of those holes on two wheels or executing a last-minute swerve to avoid one could easily end in tragedy.

I immediately composed a letter to the minister, asking for urgent action. *The Courier* picked up on the matter and reported a study showing that, last year, around 22 per cent of A roads in Angus were categorised as red or amber. That figure was up from 17 per cent when the SNP took over. It also reported that, in Perth and Kinross, 40 per cent—that is nearly half—of A roads were categorised as red or amber, which is up from 36 per cent when the SNP took over. Kate Forbes may wish to note that that statistic has improved since a Conservative council took over and made tackling potholes a priority. I am sure that the councillors will be pleased to help her.

That is 324km of road in need of repair in *The Courier* country. It is more than a cosmetic issue; it is an economic issue as well as a public safety one. It is not straightforward to get to Brechin and Forfar from Aberdeen by public transport, and many people who do not need to make the journey could be put off by the risks of driving, which is not good for the local economy.

There are also public health risks. The minister will be well aware of "Potzilla", which opened up in March on the A90 outside Laurencekirk. More a sinkhole than a pothole, it put an estimated 21 cars on the verge in one evening alone with burst tyres and buckled alloys. That was financially crippling, but just imagine if one of those vehicles had been a motorbike. What will really have riled motorists on the A90 is that, when *The Courier* asked for comment, a Scottish Government spokesman said:

"The budget for maintenance... has increased and a recent Audit Scotland report found 87% of roads are acceptable. The recent severe weather caused more damage ... our trunk road operating companies make carriageway defects safe",

etcetera, etcetera, etcetera. That does not say anything about the A90 or acknowledge that there was a particular issue, and it does not say anything about when—indeed, whether—that moonscape will be repaired.

I have a good deal of time for Mr Yousaf, both as an individual and as a minister. I believe that he appreciates an opportunity to tell it straight. Therefore, I am not convinced that that generalised metaphorical pat on the head for the people of the north-east was given in his words. I am sure that he would not have wanted to disappoint the people of the north-east with that apparent lack of urgency or focus on the actual problem, so I am very pleased to have this opportunity—afforded by Rachael Hamilton—to ask the minister, in closing, to address that specific point. I ask him to give a cast-iron reassurance, on the record, to people in the north-east that the A90, especially that particular 3-mile stretch, will be sorted once and for all and to give a timescale for that. I am sure that he will do that today for the people of the north-east, because I know they will be watching with great interest.

The state of the A90 is hugely concerning. It is damaging to the local economy and to the vehicles that use it, and I pray that no damage to health or safety will arise from it. Although it may not yet be time for heads to roll over the A90, it is time that it got fixed so that our cars and motorbikes can.

17:37

John Scott (Ayr) (Con): I congratulate Rachael Hamilton on securing the debate, and I put on record how much I share her concerns about the deterioration of Scotland's roads. Nowhere is that more of a problem than in Ayrshire, as Brian Whittle and Jamie Greene have highlighted.

I will start with the M77. The deterioration of that road, which is much used by my constituents, has been very significant over the past winter. Cars travelling at 70mph, hitting potholes and swerving to avoid them in heavy traffic, have once again made that road a less safe place to drive than it should be. Until Liam Kerr spoke, I had not even thought about the danger to motorbikes. That the standard of the road's carriageway and surface has fallen below acceptable safety standards is, I believe, beyond doubt. The minister is aware of my constituents' concerns, and I await responses to many of the concerns that they have raised, knowing as I do what a significant mailbag he will have on the subject.

Brian Whittle has drawn the chamber's attention to the deterioration of the A77 from Kilmarnock to Portpatrick. Again, that affects my constituents, as it is part of the main arterial road between Glasgow and Wigtownshire. That road has also dramatically deteriorated over the winter. I understand that Transport Scotland's first duty over the winter was to keep the road properly clear of snow and ice, and I salute its efforts in that regard. However, the immediate priority of Scotland TranServ and Transport Scotland must now be to make our trunk roads safe to drive on again. Just today, I have been contacted by yet another constituent whose vehicle has suffered £500-worth of damage, and I know from bitter experience how difficult it will be for him to gain compensation for that damage.

Turning to the roads that are maintained by our local authorities, I know and understand the pressure that the Ayrshire roads alliance is under to repair winter damage. However, having spent part of the bank holiday weekend travelling the roads of Ayrshire—many of them in Jeane Freeman's constituency—I ask the minister and the Ayrshire roads alliance to note the poor state of the A714 south of Barrhill and before the Cree bridge and the A70 from Ayr to Muirkirk.

I will close at this point—no: I will turn to the potholes in my Ayr constituency, which are of enormous concern to my constituents. The difference between urban potholes and trunk road and rural potholes is the speed limits that are in force. Car damage is much less in built-up areas than in areas where the speed limit is 60mph or 70mph, and the potholes on our major trunk roads represent a real threat to life, as Liam Kerr has noted, which is why massive efforts must now be made to repair them.

I will close this time, Presiding Officer, although I could go on. I am certain that the minister will by now have got the picture of the state of the roads in Ayrshire without my detailing every last pothole on every road.

The Deputy Presiding Officer: That is the first time I have heard a member close a speech twice, but there we go. I call Humza Yousaf to close for the Government.

17:41

The Minister for Transport and the Islands (Humza Yousaf): I thank Rachael Hamilton for bringing this debate to the Parliament, which she is absolutely right to do, as all members will have had complaints from our constituents about potholes. I have seen potholes in my constituency, sometimes in the trunk road network and sometimes in the local road network. There have been some very good speeches, with some notable exceptions—without naming any names.

I will start with the Government's responsibilities and then move on to local authority roads. The Government's responsibility—and of course mine—is to maintain the 3,500km of our

trunk road network, which stretches from south to north of the country and east to west. Many of those roads have been mentioned in the debate.

Our investment has been about £8.2 billion since 2007 and the 2018-19 budget for maintenance of the network has increased by £65 million to £433 million. The increase was for a number of reasons. Members will remember the Audit Scotland report in 2016 on the condition of Scotland's roads. Local roads were in a less acceptable condition but, at that point, 87 per cent of our trunk road network was in an acceptable condition. Since then, we have had extreme weather challenges. Almost every speaker has recognised that this winter has had a detrimental effect on our road surfaces. We have therefore had to invest more and we are putting our money where our mouth is with regard to the trunk road network. That is worth putting on the record.

With regard to resurfacing, despite our postbags and inboxes being full of complaints, from 2016 to 2017 there was a 10 per cent increase in the satisfaction of the users of our trunk road network. The 2018 figures may be different, because I am the first to accept that the weather challenges have had a deteriorating effect on our road surfaces and the trunk road network.

I hope that most members have a relationship of sorts, even if it is not a good one, with the operating companies that work on the trunk road network in their constituencies. If they do not, I will be more than happy to facilitate introductions, as a number of members have asked about particular potholes in the trunk road network. Liam Kerr spoke about the A90 and if there are category 1 defects that could cause harm in the way that he describes—which I do not doubt at all—the operating companies have a duty in their contracts to repair them as soon as possible. If he does not have a good relationship with the operating company, I am happy to introduce him. I will take away the information on the potholes that he has mentioned; I do not have an answer for him right now in the debate, but I will see whether they have been repaired.

John Scott: When I or other MSPs write to the minister with a concern about a particular stretch of road or a particular pothole in a trunk road, is that concern passed as a matter of course from his office to the operating company?

Humza Yousaf: I would be surprised if we did not have a conversation. Essentially, we would have a conversation with the operating company to ask it about a pothole that has been raised by an MSP to allow us to draft a response. Sometimes, of course, I will ask my officials to communicate directly with the operating company and then write a response. If any member wishes to raise concerns about particular potholes—I know that many members have said that there is a long list of them—there is an open offer to speak to my road maintenance team in Transport Scotland for any member across the chamber to take up.

Since the winter, we have realised that there was a need to increase our investment. Towards the end of the financial year, an additional amount of money was redirected towards carriageway repairs. Many members have mentioned that. A further £6.5 million has been invested in delivering maintenance schemes.

Kate Forbes: Notwithstanding the pressures that members have indicated, does the minister recognise that Highland Council, which has a huge road network, faces particular pressures and that is why it got the largest share of the money?

Humza Yousaf: Yes, I recognise that. I have a good relationship with the leader of Highland Council, Margaret Davidson. However, Highland Council is not alone. Argyll and Bute Council's geographic scope is huge, and it therefore has a number of issues. I am meeting the leader of—

Brian Whittle: And the south-west.

Humza Yousaf: And the south-west. Dumfries and Galloway Council and other councils cover a large area. However, Kate Forbes was right to mention Highland Council.

My point about the trunk road network is that we are putting our money where our mouth is.

Before I turn to local authorities, there is another thing to say about the A90 in the north-east. We are investing heavily in that. Members will be aware—and, I am sure, very supportive—of the work that we are doing in taking forward the Laurencekirk junction, the Aberdeen western peripheral route, the dualling of the A96, the Haudagain roundabout and, indeed, the average speed cameras between Dundee and Stonehaven, which will help to improve road safety.

On local roads, many members have mentioned SCOTS, which, as members would imagine, I have a good relationship with. I will not take away from the fact that there have been challenging times for local authorities in the past few years, but it is clear that where they choose to spend their budget is a question of priorities. No party at the local authority level necessarily has clean hands on that; all of them have to reflect hard on where they have chosen to spend their money over the years. The £22 million over three years from Scottish Borders Council that Rachael Hamilton mentioned might go a good way to repairing local roads, but it is worth mentioning that the SNP opposition wanted an extra £2 million and that was voted down. Nonetheless, how does that £22

million over three years compare with the Borders budget over the next three years? Perhaps it compares positively; I am just asking the question. In previous years—SCOTS would be the first to say this—the amount that needed to be spent on road maintenance probably fell short of what it should have been.

Rachael Hamilton: Just for the record, the previous administration was an SNP one, and we are maintaining all the roads that it did not maintain and did not provide the budget for.

IAM RoadSmart, for example, considers that, rather than looking at our backlog, we should invest in future road maintenance and provide for that within the budget, as the Scottish Conservatives suggest with the pothole action fund. Does the minister believe that that is a long-term solution?

Humza Yousaf: I will not go back and forth on the Borders issue. As I said, I do not think that any political party can claim to have given the issue the priority that it should have been given at the local level. The Scottish Government has increased our trunk road spending, which I am pleased about.

I will turn to the proposal for a pothole fund—I am not sure what it is called. I think that Rachael Hamilton referred to £100 million over the parliamentary session. It is clear that the Conservatives can take that forward with Derek Mackay in the next budget negotiations. I am sure that he will give the challenge back that people cannot ask for a tax cut and then ask for £100 million unless they say where the £100 million would come from. The Conservative finance spokesperson has, of course, every right to take that issue forward with Derek Mackay during the budget negotiations. From our perspective, we will continue to invest additional moneys where we can. The £10 million additional money that Derek Mackay announced on the back of the beast from the east is one example of that.

I will work hand in hand with local authorities to see how I can be helpful in relation to my role in the trunk road network. Where we can be helpful to local authorities in this regard, we absolutely will be.

I make an open offer to members. If they want to raise particular potholes with me, my Transport Scotland officials will make themselves available for that. We will continue to liaise with other political parties on any ideas that they have about improving our local roads. From a Scottish Government perspective, we will continue to do the job that we are paid to do, which is of course to invest in and maintain our trunk road network.

Meeting closed at 17:50.

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