MEETING OF THE PARLIAMENT

Wednesday 18 June 2003
(*Afternoon*)

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CONTENTS

Wednesday 18 June 2003

Debates

Scottish Parliament

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[THE PRESIDING OFFICER *opened the meeting at 14:30*]

Time for Reflection

The Presiding Officer (Mr George Reid): The first item of business this afternoon is time for reflection. Our time for reflection leader is Michael Burns, parish priest of St Ninian's Catholic Church in Edinburgh.

Michael Burns (Parish Priest, St Ninian's Catholic Church, Edinburgh): I feel that I have prepared all my life to say what I am about to say and it can be summarised in two words: people matter.

It was 1986, Waverley Street in Bathgate, and I arrived at the home of two elderly sisters, Margaret and Janet. Yes, I have changed their names. The door was open. I knocked on it and shouted, "Hello, hello, it's Michael Burns. I'm the new parish priest."

A reply came immediately, "Come away in, son."

I walked along the lobby and entered a simply furnished living-room. I saw Janet and Margaret sitting facing each other on either side of a coal fire.

"Hello ladies," I said. "I'm the new parish priest. Who are we going to talk about?"

"We'll talk about me," said Janet. She was noticeably blind.

"Okay," I said. I picked up the only other chair in the room and placed it beside Janet. I could see that Margaret was not too pleased that Janet was getting all the attention.

"So what are you going to tell me?" I asked.

She said, "I'm 43. No, I'm 45. No."

That was the beginning of a stream of partial consciousness that continued for a while until her sister, Margaret, could no longer stand her frustration and said, "She's 92."

That was the beginning of several hilarious yet homely chats with two Bathgate worthies, who unfortunately have since left us to continue the conversation with their maker.

As I continue to meet elderly people in houses, apartments and nursing homes near here in 2003, that first visit to Margaret and Janet stays with me. It informs each encounter and each meeting. Margaret and Janet invite me today to practise what I preach. The door was open. There was no obstacle between them and every other human being. They were undefended.

"Come away in, son." They invited a stranger to walk right into their hearth and home. They did not hide their vulnerability. Two people with few resources demonstrated a high level of trust.

Janet was blind. She sat on her side of the fire, with an open front door, without the capacity to see anything or anyone—as open as a book. I design my own blindness. From behind my closed door, I filter out the disturbing words of the other person and as they speak I reload for my next assault. Wid God the giftie gie me that I could assert and at the same time remain open to all different kinds of people.

God of all peoples, help us bring a sense of community, a capacity to be interdependent with one another and a level of deep trust into the most passionate debates held in this chamber, the European forum and the theatre of an emerging United Nations.

National Health Service (Patient Focus and Public Involvement)

The Presiding Officer (Mr George Reid): The next item of business is a debate on motion S2M-154, in the name of Malcolm Chisholm, on patient focus and public involvement in the national health service, and two amendments to the motion.

14:36

The Minister for Health and Community Care (Malcolm Chisholm): At the heart of our vision in the health white paper and the partnership agreement is a patient-focused culture of care, which is developed by a new partnership between patients, staff and Government. Our ambition is to develop systems of care that reflect the needs, concerns and experience of patients. For that to happen, we must engage with patients in a far more serious and systematic way than at any point in the past.

A key chapter of the white paper, which was deliberately put at the start of the various health service sections, is called "Listening to Patients". That is the central theme of my speech.

The agenda has several strands. It starts with involving and respecting individual patients. The white paper says:

> "People now expect to be involved in deciding about their own healthcare as responsible partners in care. They wish to be treated with dignity and respect, to be treated as individuals and not as cases, and to have the right care in the right place at the right time."

Those last words raise the issue of waiting, which is an important one for patients and therefore for us as well. No one can be in any doubt of our determination to make progress on that front. The radical out-patient action plan, which I launched last Friday, is all about making out-patient appointments quicker, more responsive and more convenient for patients.

However, patients are not concerned only about waiting. It would be wrong to judge the health service by that yardstick alone. The rest of the paragraph from which I quoted refers to wider attitudes towards individual patients. There is no doubt that treating them as partners in care involves a sharp break from the health service of the past. It is a major culture change, which will not be completed overnight but which is essential not only for increased satisfaction but for better health outcomes.

The aspect of patient focus was given particular attention in the recent NHS Quality Improvement Scotland report "Safe and Effective Patient Care: Generic Clinical Governance Standards". Although the report found that there had been progress in involving patients in all aspects of their care, it highlighted the need for significant improvement in many areas. That report and the other reports of NHS Quality Improvement Scotland are important drivers for change.

Better communication is an important part of the changes that are required. The Executive's action on staff training, patient information and advocacy will all help to bring about the necessary improvements. First, on staff training, together with the royal colleges, NHS Education for Scotland, the ethnic minority resource centre and staff and patients throughout Scotland, we are developing standards for communication training that will be embedded within pre-registration, post-qualification and continuing professional development of all national health service staff.

Phil Gallie (South of Scotland) (Con): Will the minister give way?

Malcolm Chisholm: I will take an intervention when I have finished this section.

In addition to the changes that I outlined on staff training, the centre for change and innovation has established a specific programme on doctors' communication.

My second point relates to patient information. Patients today have access through the internet to a huge range of health information, but they tell us that they lack quality-assured information from the NHS. Our patient information initiative is therefore under development. We will consult shortly on a framework for the production of quality-assured information across NHS Scotland.

Recently, I launched a guide to securing access to information for cancer patients, which is an important tool for NHS boards and cancer networks in their progress towards more patient-focused services. Such a service is already being applied in the Forth Valley NHS Board area—I am thinking of its highly commended patient-held guide to chemotherapy and colorectal cancer.

My third point relates to advocacy. Some patients need help and support to express their views and to ensure that health services offer them what they need. Advocacy is of key importance in that respect, as it ensures that people who cannot express themselves or who might have difficulty in communicating their views have the help that they need.

We have made a significant investment in advocacy and in the training and development that are needed to support it, with almost £500,000 being spent in the current year. We have also given a commitment in the partnership agreement to strengthen patient advocacy services through

the Advocacy Safeguards Agency and the Scottish Independent Advocacy Alliance.

Phil Gallie: I want to pick up on the point that the minister made about training and the problems that hospitals are facing as a result of changes to junior doctors' hours. I highlight the situation in Ayrshire where we are about to lose the services of one children's ward.

Malcolm Chisholm: Many members will want to raise issues about service reorganisation. I will address public involvement in service change in about five minutes.

It is important for us to achieve balance in the debate. To do that, we need to start with the patient agenda. The wider public involvement agenda is slightly different and I want to complete my remarks about patient focus before moving on to it. Patient focus does not mean only the involvement of individuals in their own care; it is the key part of the wider quality agenda—indeed, I see it as the very heart of the debate.

The starting point for improving quality must be the experience of every single patient who passes through the health care system. It is only by exploring the experiences of patients that we can develop services that are responsive to patients' needs. That is why we must and will invest in professional time and techniques to understand and analyse the wants and needs of different groups of patients.

There are many good examples of health care staff listening to and acting on what are sometimes called patient stories. I am pleased that that is an important part of the Royal College of Nursing leadership programmes that we are supporting. There are also good local examples such as Tayside NHS Board's study of cancer patients' perceptions of cancer and palliative care services, "Listening to Different Voices".

However, I believe that we must do that kind of work in a much more extensive and systematic way. We might be missing important aspects of patients' experiences because we are not asking them properly or not asking them at all. As a result, we might be failing to discover the problems that require to be addressed.

Those problems can range from patients' concerns about the symptoms that they are suffering to the range of issues that are referred to in chapter 3, section 4 of the white paper:

"fear of dying, loss of dignity and independence, cleanliness, privacy"

and so on. We know about some of those issues and we are taking action on them—clean hospitals are a good and important example. We might be missing other issues, so we need a systematic and comprehensive understanding of patients' experiences and programmes to ensure that that does not happen. I accept that we have some further work to do within the patient focus and public involvement agenda in order to achieve that objective.

Priorities for research should be responsive to the expressed needs of patients. I am pleased that that was emphasised in the recently launched nursing and midwifery research strategy.

Patient-focused research, which involves patients from the inception and engages with their experiences, is a key new frontier in which the patient agenda, the research agenda and the quality agenda come together. Patients are the fundamental source of the definition of quality and research is a key underpinning element of quality improvement. Patient experiences are also essential to the wider issues of service redesign as highlighted in the motion.

The fundamental principle of change is to see care and services through patients' eyes.

Dennis Canavan (Falkirk West): Will the minister give way?

Malcolm Chisholm: I will give way when I have finished this section.

That is beginning to happen, for example, in the development of managed clinical networks for coronary heart disease. The central involvement of patients was a key feature of the pioneering network in Dumfries and Galloway. It is beginning to happen in diabetes services. People with diabetes are involved in the work of diabetes service advisory groups throughout Scotland. We have also provided Diabetes UK with some £150,000 of funding to set up a diabetes patient and carer involvement project. It is also beginning to happen in cancer services, although in that area, as elsewhere, we seek to step up our efforts as part of our new redesign initiative. We will use techniques that allow the perceptions of patients to have a real influence so that their experience of the pathway of care can make tangible differences for other cancer patients.

Mr John Swinney (North Tayside) (SNP): Will the minister give way?

Bill Butler (Glasgow Anniesland) (Lab): Will the minister give way?

Malcolm Chisholm: I will in just a moment. I have a lot more to say on the patient agenda. I need to summarise that briefly and get on to public involvement. I will take one intervention on the way, because I have just heard that my speech is 15 minutes long, not 20.

I will summarise the other bits of the patient agenda. The first relates to patients' being involved in monitoring quality, which is, of course,

the work of NHS Quality Improvement Scotland. The second is the complaints procedure, which is about acting on patients' concerns. It is out to consultation and there will be a new complaints procedure that will be independent in a way that it has not been before. I also acknowledge the role of the voluntary health sector in the patient agenda, because it represents many patients groups. I refer to our "Fair for All" initiative in relation to the specific needs of ethnic minority patients. There is a very wide patient-focused agenda. I will take John Swinney.

Mr Swinney: In the lengthy section of his speech on patient involvement—which I do not question for a moment—the minister has made only passing reference to the role of carers. Many of us who are now confronting issues to do with the review of mental health services in the communities that we represent are concerned that the voice of carers, who are integral to the design of services for those who depend on mental health services, is not being taken adequately into account. Will he say a little more about the significance that he attaches to the carers' input, particularly in mental health services, in which the carer is invariably the person who articulates the patient's interest?

Malcolm Chisholm: John Swinney makes a fair point. Patients obviously come first in patient involvement, but carer involvement is a key part of that, and the "Listening to Different Voices" project, which took place in his part of the world, involved carers as well as patients. I commend and support that.

I must move on to the wider public involvement agenda. It is fair to say that all patients are citizens, but not all citizens are patients. Therefore, how we engage with citizens is not necessarily the same as how we engage with patients, but it is vital for the planning and development of services. I realise that some of the main controversies in the debate will be around that, but I am sure that we can at least all unite in agreeing with the motion's statement that it must be done more effectively than in the past.

Bill Butler: Will Malcolm Chisholm give way?

Malcolm Chisholm: I cannot take any more interventions, as I have only four minutes in which to cover public involvement.

The key point is that public consultation as done in the past was totally inadequate, because it was end-stage consultation. In the new guidance that we published some months ago, we made it absolutely clear that local communities must be engaged with and involved at an early stage before proposals are developed.

Dennis Canavan: Will the minister give way?

Malcolm Chisholm: I cannot take any more interventions.

Tricia Marwick (Mid Scotland and Fife) (SNP): Will the minister give way?

Malcolm Chisholm: I have only three minutes left, so I cannot possibly give way.

The partnership agreement commits us to ensuring public involvement in health service reorganisation plans by obliging NHS boards to consult stakeholders more effectively. We intend to ensure that those principles are reflected in our planned health bill, which will, for the first time, place a duty on NHS boards to promote public involvement.

I wanted to give some examples of good public involvement. Once again, I will have to skip that, although I will mention that I talked to the people in Tayside recently about the public partnership group that I launched there, which is a good example of the NHS board and the local authorities working together on this important agenda. Others may want to consider it.

Sticking with that part of the world, I think that it is good to see the way in which some of the historic issues to do with Stracathro hospital, which I dealt with when I was on the Health and Community Care Committee, have been dealt with through proper public involvement and engagement. There is a lesson in that for all of us. If we do public involvement better, the public will understand some of the dilemmas and issues a lot more. That is the key issue that we have to confront.

There will be much comment today on service change. I will make one general comment about the principles of service change. I believe—and contrary to the nonsense in the Conservative amendment, the white paper states—that more services should be delivered in local communities and that more power should be devolved to lower levels of the health service. However, the key issue is that, as far as clinical safety is concerned, it is often better to provide some in-patient and specialist services in more specialised settings. We and various boards are trying to deal with that balance across Scotland, and we need a much more mature public debate on the issue.

To support a strengthening public involvement, we plan to establish—as the motion mentions—a Scottish health council, one of whose key functions will be to monitor and quality assure what health boards are doing to involve the public. It will have a structure of local advisory councils to ensure that the voices of patients, carers and communities are heard. The consultation on that issue came to an end only a few days ago and I will read people's comments with interest. Although I have set out the plan for the moment,

bits of that can obviously change as we discuss the matter over the next few months.

I have only a minute left, so I will deal with the amendments. I have mentioned the Conservative amendment already. Sometimes I almost despair of having a sensible debate about health with the Conservatives, because they engage not with what we say about the issue but with some fantasy of their own creation. The whole message of the health white paper is about the devolution of power. It is the complete opposite of the centralisation of the health service which, if I may say so, was at its height under the previous Conservative Government. It is quite unbelievable for that party to talk about increasing bureaucracy when it created the most bureaucratic system in the history of the health service. We are not putting political priorities over clinical ones; no one is keener than I am about that. As the white paper makes clear, we are working and taking action to ensure that clinicians have a stronger role. However, we also want a strong patient agenda, which is my main theme this afternoon. If David Davidson is talking about the issue of waiting in his amendment, I point out that what he calls "political priorities" are actually patients' priorities. As politicians, we have a duty to speak for the patients whom we represent.

My time is up. We will have an interesting discussion about elected boards over the next few months, although I do not think that that in itself will solve the wider issues of patient focus and public involvement that I have highlighted today. As members know, we have secured wider representation on NHS boards in various ways. However, I accept that we need to discuss that matter. The key issue that people must think about is accountability, and I see some members in this chamber who would be the first to object if we had more local variation and postcode care. That would indeed be a consequence if primary accountability were local rather than national.

I have many more things that I would like to say, but I have no more time. Instead, I move,

That the Parliament welcomes the measures in *Partnership For Care: Scotland's Health White Paper* and the Partnership Agreement to step up progress to ensure that greater patient engagement and wider public involvement are at the heart of a modernised NHS and supports the Scottish Executive's commitment to placing the patient at the heart of the design of services, implementing a patient information initiative, ensuring public involvement in health service reorganisation plans by obliging NHS boards to consult stakeholders more effectively and setting up a Scottish health council as a national body with a local presence across Scotland.

Mike Pringle (Edinburgh South) (LD): On a point of order, Presiding Officer. As far as I am aware, this is the second time that a minister has been told—I am not sure by whom—the wrong length of time for his speech. I believe that it happened last week to Nicol Stephen, the Minister for Transport. As a result, neither minister has been able to take many interventions. I do not know whether this is a point of order, but it seems to me unacceptable for the same thing to happen twice in one week.

Malcolm Chisholm: On a point of order, Presiding Officer. I just want to clarify for the record that I knew about the timings earlier today. I should have been a bit more precise in my remarks. When I conceived this speech, I thought that I had 20 minutes but, as I have just said, I knew about the timings earlier today.

The Presiding Officer: In that case, we will just move on.

14:53

Shona Robison (Dundee East) (SNP): I do not know about other members, but I feel cheated by not hearing the other five minutes of the minister's speech.

I hope that today's debate will amount to more than motherhood-and-apple-pie talk about the need to involve patients and the public in decisions about the running of our health service. Since the document "Designed to Care—Renewing the National Health Service in Scotland" was published in 1997, Labour has had six years to consult on improving public involvement. Only now has it finished its consultation on how the public should be consulted. It has taken rather too long for that to happen.

Since the publication of "Designed to Care", there have been numerous glossy documents that have all said broadly the same thing. Although the document "Patient Focus and Public Involvement" was published in December 2001, it has taken until now for the consultation process to be completed. Furthermore, we have had consultation on reforming the NHS complaints procedure and patients' rights and responsibilities. Indeed, the only issue on which there seems to have been no consultation has been Labour's election manifesto commitment to consult on introducing a directly elected element to all NHS boards. I will return to that issue later.

Bill Butler: Shona Robison will know that my proposal for a bill on partially directly elected NHS boards was lodged for the first time on 19 December, and latterly on 8 May. She will know that because that proposal is the subject of the SNP's amendment. It is a serious proposal, and I wonder why she has tied it on as an amendment when the matter is about to go out to consultation. Surely we need a coherent consultation rather than a tagged-on amendment. I wonder why no member of the SNP supported it the first time it

was lodged, in December, and why only four members of the SNP have supported it in the past two days by signing it after it was lodged for the second time.

Shona Robison: I assure Bill Butler that his proposal has the full support of the SNP. He would find it difficult to argue that anyone should not support the amendment in my name, as it aims to create exactly what he aims to create. Spinning on the head of a pin is what comes to mind.

I turn to the patient information initiative to which the minister referred. We would all agree that the current patients charter is outdated and needs to be improved, but I am a little concerned about whether what is being proposed goes far enough. As I understand it, the Scottish Consumer Council has been given a budget of £450,000 over two years to develop leaflets on issues that patients have a right to know about, including issues relating to confidentiality, consent and complaints.

As the minister said, quality-assured information is important. Information is power, as they say, but I am not convinced that that initiative alone, however well intentioned, will be enough to empower patients by improving their access to information. Surely what we need is the establishment of a statutory independent patient body at national level with the power and resources to increase public awareness of patient rights and to enforce communication with the public at both national and local level. What we need is a body with teeth that can act as the patient's champion. That is what we would like, and what the minister is proposing falls way short of that.

Health councils are, without a doubt, one of the main ways in which the patient and public voice has been heard. Our 15 local health councils have done a tremendous job, and I take this opportunity to pay tribute to the work that they have undertaken over the past 25 years. They have helped many people to find a voice in dealing with what can be described only as the might of NHS bureaucracy. The Executive's proposal is to abolish the local health councils and instead have a Scottish health council as part of NHS Quality Improvement Scotland, with local offices in each health board area. We are told that those local offices will still provide the services of the local health council, but my question and that of many others is how independent that service will be. Genuine concerns are being raised about that, particularly by local health councils, which question the independence of the proposed regime.

Age Concern Scotland has said that the proposed Scottish health council should be independent and, which is important, should be seen to be independent. There has been very limited consultation with existing health councils about the proposals, and the feedback that I am getting is that people are not happy with the proposals at all. Many local health councils are concerned that it appears that NHS boards will organise the public involvement, whereas they wish to ensure that the opinions expressed will be independent. Health councils fulfil the role of seeing the broad vision of the patient's journey, and it is essential that that role continue to be fulfilled by independent sources that can act as a conduit between the Executive, health boards and the public. I remain to be convinced that the Executive's proposals will advance that in any way.

Robin Harper (Lothians) (Green): Does Shona Robison agree that, if the proposals go ahead, the health councils will be reduced to a mere cipher, and that that should be put far more strongly to the Executive than she is putting it at present?

Shona Robison: I thought that I had put it rather strongly. I cannot say anything other than that the local health councils' role has been a good one and that we should be taking the opportunity presented by structural changes to make local health councils more independent, not less independent. I hope that that is strong enough for Robin Harper.

The current complaints procedure has three stages, which can be time consuming, stressful and lacking in impartiality. Importantly, the independent review stage lacks the power to make changes. All of us have constituents who have been very dissatisfied with the complaints procedure. Among those whose complaint was dealt with locally, only one in three believed that it was handled well. Only one in four felt the same when it was dealt with at an independent review.

It is proposed that there should be a complaints officer in each NHS organisation and a member of senior management responsible for patient feedback. The SNP broadly supports the proposed changes, as long as they result in an accessible, transparent system of mediation, redress and compensation. We also support the introduction of a code of practice—which NHS boards would have to follow—governing how boards inform patients when mistakes occur in the NHS. That might help to address the problem of the blame culture that is making the NHS a difficult working environment for staff.

I turn now to the substance of the debate, which is about the best way of engaging in public consultation. People are very sceptical when we talk about public consultation. That scepticism is born out of experience. The picture throughout Scotland of acute services reviews is not good. The public has the sense that local managers embark on the consultation process with a fixed

outcome in mind and—lo and behold—end up exactly where they started. I am afraid that my recollection of the acute services review in Tayside is somewhat different from the minister's. I could also cite the reviews in Glasgow, Argyll and Clyde and Fife as examples of how not to consult on major changes to NHS services. The fact that one member of Parliament was elected on the basis of public dissatisfaction with the way in which the NHS operates is clear evidence that all is not well. It is unfortunate that that member has not turned up for today's debate.

The Health and Community Care Committee dealt with a number of public petitions concerning changes to local health services. The common factor in those cases was the failure of managers locally to consult in a way and at a stage that was meaningful and up front. For those reasons, I am sympathetic to Paul Martin's proposed member's bill. My views on medium-secure units differ from Mr Martin's, but the principle of making health boards consult when changes to services are being proposed and of giving the public the right of appeal has merit and is worth exploring further.

One issue that we must address is the problem of consultant shortages, which are driving many of the decisions that are being made. If consultant shortages are the driving force, public consultation is a sham as, at the end of the day, the same decisions will be made. The minister must try harder to address that issue.

The substance of my amendment relates to the issue of directly elected places on NHS boards. If we are serious about involving the public, surely members of the public should have a direct say on health boards. The proposal would send a clear, unambiguous message. I cannot understand the Executive's reluctance to take that step. Surely it is the logical conclusion of the wish to involve the public. The proposal would give the public a majority of places on NHS boards and, therefore, a key decision-making role.

Bill Butler: Will the member give way?

Shona Robison: No—I have already dealt with the member's point.

The introduction of direct elections to NHS boards would bring rights and responsibilities but, crucially, it would stop the public believing that decisions about our health service are made behind closed doors by unelected bureaucrats. It does not matter whether that judgment is fair—it is the public's perception of the way in which decisions are made.

I cannot understand why the proposal to consult on the issue of directly elected places does not appear in the partnership agreement, given that during the election campaign Labour thought that it was a good idea and included it in its manifesto.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Will the member take an intervention?

Shona Robison: No. I do not know whether the proposal was too much for the Lib Dems to handle or whether vested interests won the day and prevented its being advanced. We deserve to hear from the minister in his summing up why the idea was dropped.

We are still committed to providing directly elected places on NHS boards. I hope that all those who have supported the bill proposed by Mr Butler will be consistent and support the amendment in my name.

I move amendment S2M-154.1, after "effectively" to insert:

", requiring direct elections for the public to the majority of places on NHS boards,".

The Presiding Officer: The previous speech contained a reference to Dr Jean Turner. Members should know that Dr Turner is ill and has notified me accordingly. I am sure that Shona Robison would like that correction to be made.

Shona Robison: Indeed.

15:04

Mr David Davidson (North East Scotland) (Con): I am interested in the minister's response to our amendment. He seemed to focus on it in particular, so presumably—[*Interruption.*]

The Presiding Officer: Order.

Mr Davidson: Presumably, the minister is not paying too much attention to the minor amendment to his proposals that the SNP has lodged today. I say to Shona Robison in passing that we would like further detail, because I assume that she does not mean that members of the public, without any experience, qualifications or anything else, should be put up to run a health board.

Shona Robison: I would have thought that every member of the public has experience of the health service, given that they and their families use the health service. What better than to ask the people who use the health service?

Mr Davidson: In other words, Shona Robison is quite happy to let the bureaucrats whom she was talking about a few minutes ago help to run people who do not necessarily have experience or training. I am not objecting to whoever gets elected. The point that I make is simple: if we are going to run a huge, important national service, we have to ensure that the people who are charged with running the health boards have the full strength and support that they require to do that job on behalf of the patient.

Bill Butler: Will the member give way?

Mr Davidson: In a moment.

I turn to the minister's comments. He accused us of saying that the Government does not run the health service with political priorities, but—allegedly—there are a number of measures in the partnership agreement that encompass the interfering top-down approach from Government in Scotland. The Government might set targets and guarantees—today the minister mentioned eight initiatives and consultations that are under way—but people are in initiative and consultation overload.

We would like clarity as to what the minister wants to deliver. We heard admirable comments from him today about involving and respecting individual patients. Asking patients for an opinion is not providing patients with a real choice and that is where I see a difference between Labour and us. I am perfectly content to listen to the minister's proposals for quality-assured information—I do not think that anybody in the chamber would argue with that point. We believe that the NHS is there to serve the patient, not the other way round, but the minister has not quite expressed that view correctly.

Malcolm Chisholm: David Davidson has focused on an important point. Perhaps I did not clarify the issue of choice sufficiently. Of course I support patient choice, but the key issue for me is that I support a lot more as well. Ultimately, the difference between Labour and the Conservatives is that the Conservative Party has the reductionist view that it all boils down to choice and markets. Choice is part of the issue, but my view is that patients should not only be able to choose a service that somebody else provides but should be involved in creating that service. In theoretical terms, I am a co-productionist and David Davidson has a simple market model of the health service.

Mr Davidson: The very point that the minister makes is that patients should have a choice, but they cannot make it on their own. That is why we propose that the way in which the choice should be made and exercised is through the first port of call: the clinician. The clinician should advise and have freedom, in consultation with the patient, to obtain the treatment that is best suited to that patient, regardless of where it comes from. That premise could run right through the health service. If nothing else, it would put the patient in the driving seat.

The proposals that the minister has announced today are all very noble. Some health boards complaints procedures are very good, but in other areas, they are not perceived to be independent enough. In some areas, the procedure is such that people are terrified even to take it on. Advocacy services in particular have to be reinforced and expanded and must be in the ownership of the patients and the carers. As John Swinney rightly said earlier, carers did not feature in what the minister said today, but they are a vital part of how we are to deliver health services in this country over the next few years.

As far as choice is concerned, our proposals for general practitioner fund holding are nothing more than what the First Minister stated just before the election, in that GPs should be free to choose and obtain. All I asked in the chamber a couple of weeks ago—I have not had a response yet—was whether that means a return to commissioning and GP fund-holding. I would like to hear more from the minister on that.

I would also like to hear from the minister why he is so terrified of foundation hospitals when a Labour MP representing a Scottish seat is so happy to be promoting foundation hospitals for the people of England. Why is that not happening in Scotland?

Malcolm Chisholm: That is obviously another interesting point. As a decentraliser and as someone who wants more power for clinicians, I think that that is a good part of foundation hospitals. I want more power to be in the hands of front-line clinicians in practices—not just GPs, but the primary care teams—and doctors in hospitals.

However, in Scotland, we have a more integrated approach to health care, so we believe that foundation hospitals are a very conservative—with a small c—idea, because they will serve to fragment and accentuate the difference between the acute sector and primary care. That is why we object to foundation hospitals; we do not object to them because we do not want to devolve power to front-line staff.

Mr Davidson: Does "integrated" mean bureaucratic and centralised, because that is how it appears?

I agree with Shona Robison about local health councils. My wife served on the national body for a number of years, until about three years ago, and I know the work that it does nationally and locally. I am sure that Mr Rumbles would agree that Grampian Local Health Council has been excellent at representing patients and influencing what goes on on their behalf.

At the General Medical Council conference, I was staggered when a gentleman from NHS Quality Improvement Scotland put up a series of slides, each of which showed yet another organisation that was being added to his empire. That empire is directly accountable to the minister. How does having such a response system within the health service create patient involvement and choice?

I am sure that many other members would join me in agreeing with Shona Robison that we need to have an independent, impartial agency that is owned and run by and on behalf of the patients. Such an agency—we can call it what we like—should be funded through, but not run by, an NHS agency, as was the case previously. At a stroke, the minister has nationalised the patient organisation. That is not the message that he wants to convey.

On foundation hospitals, the minister seemed to be wriggling around a bit. He had great sympathy with them up to a point. Perhaps he could tell the Parliament exactly how much of the proposal he likes, which bit he does not like and why. I would like him to explain why the model down south is so alien to the Executive. Foundation hospitals are part of the minister's party's policy. I do not know what the Liberal Democrats' policy on the issue is but, as they have taken the Labour party's whip, I presume that the minister can speak for the Liberals on the issue. It would be interesting to develop that debate.

I do not want to knock the many good things that the minister has said about structures and so on, but we should look behind the bland words that the minister has given us and focus on patient-centred health care in Scotland. Why is the Executive ducking the options that seem to be available?

I am puzzled about why the minister came to the Parliament with a motion on the subject at such an early stage when, by his own admission, he has not received back all the consultation comments. I presume that we will have a rerun of the debate, during which he will tell us what the results of the consultation are. I warn him that the Conservative party will not let him tinker about and ride roughshod over the interests of patients. We will fight to obtain clarity. If the minister comes up with sensible, pragmatic proposals, we will be happy to support them, if they are in the interests of the patient.

I move amendment S2M-154.2, to leave out from "welcomes" to end and insert:

"regrets that the Scottish Executive's proposal in *Partnership for Care: Scotland's Health White Paper* and *A Partnership for a Better Scotland*, in an attempt to increase patient focus and public involvement, will only increase bureaucracy in an over-centralised NHS and considers measures such as GP fundholding and foundation hospitals would offer patients real choice regarding their own care and would focus on clinical priorities over political priorities, and would, therefore, start to solve the real problems facing the health service."

15:13

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I am delighted to be taking part in the debate as the new health and community care spokesperson for the Liberal Democrats. It is opportune, to say the least, that my first debate as health spokesperson should focus on ensuring that greater patient engagement and wider public involvement are at the very heart of the Executive's policies for our national health service.

Those measures form the centrepiece of the consistent approach that the Liberal Democrats have taken to improving health service provision throughout Scotland. The Liberal Democrats welcome the moves to place the patient

"at the heart of the design of services",

to implement "a patient information initiative", to oblige health boards

"to consult stakeholders more effectively"

and to set up

"a Scottish health council as a national body with a local presence across Scotland",

Malcolm Chisholm outlined those moves in the opening speech of the debate and which are contained in the motion.

In the recent negotiations on forming a new coalition Government for Scotland between the Labour party and the Liberal Democrats, we agreed that the needs of the patient must be put at the centre of our work on health. In the partnership document, we said:

"We will continue to develop our radical agenda to secure improvements in Scotland's health services, placing the patient at the heart of the design of services. We will make changes where needed to structures and boundaries. We will devolve power to the lowest level."

I turn for a moment to the opportunism shown by the SNP and by Shona Robison in her amendment. She asked why the Executive was not taking action on elections to NHS boards and attempted to embarrass Bill Butler into supporting her amendment. I say to Shona Robison that public elections to NHS boards are not in the partnership document and not part of the Executive's programme. She asked why the Labour party was not implementing such a policy. Malcolm Chisholm is here today as an Executive minister who is implementing a coalition agreement between the two parties.

Shona Robison: Will the member take an intervention?

Mike Rumbles: No, I will not. I would have given way had Shona Robison given way to me.

Bill Butler: The member does not have to— [*Interruption.*]

The Deputy Presiding Officer (Murray Tosh): Will you straighten your microphone, Mr Butler?

Bill Butler: What really annoys me—perhaps Mr Rumbles would like to comment on this—is that my bill is a serious proposal that is about, I hope, to go out to consultation, as happens with non-Executive bills. However, the SNP is not offering people a choice at this stage: its amendment is tagged on and its proposal does not appear anywhere in the SNP manifesto—

Shona Robison: Yes it does.

Bill Butler: Not in my reading of the SNP manifesto, which I admit was necessarily cursory.

The Deputy Presiding Officer: The member has made his point.

Bill Butler: Does the member agree that it is important to consult in a coherent way rather than just tag on consultation in an amendment?

Mike Rumbles: I certainly agree that the most appropriate way to consult on a bill is as Bill Butler is rightly attempting to do with his member's bill. However, his bill is not part of the Executive's programme.

The contents of the amendment are opportunistic because they do not appear in the SNP manifesto, which promised to

"bring greater democracy through a directly elected element".

The SNP amendment would require

"direct elections for the public to the majority of places on NHS boards",

which is quite a different matter.

We made several major commitments in the partnership agreement. We will continue to support community planning as the key framework in developing a shared plan for health improvement throughout local authority areas; we will legislate to reform the NHS by abolishing the wasteful duplication of NHS trusts; we will establish community health partnerships; we will review the boundaries of local health care co-operatives and health boards to facilitate joint working with local authorities; we will devolve management responsibilities to the front line, and so on. There are a huge number of issues that I will probably not have time to raise.

Those plans are built on the Executive's recent health white paper, "Partnership for Care", the key points of which have a direct bearing on the debate. In "Partnership for Care", the Executive said that there would be a new statement of patients' rights and responsibilities. Patients will be treated as full partners in their health care. I notice that Shona Robison also said that the white paper was full of motherhood and apple pie. Why cannot she be positive about most of those issues rather than constantly negative?

There will be better health information through patient information initiatives and a guarantee of service within national waiting times, with NHS Quality Improvement Scotland inspecting performance against standards. All that work will be underpinned by investment that will rise during the session from £6.7 billion to £9.3 billion, which is an annual increase of more than 5 per cent in real terms.

There is no doubt in my mind that the Scottish Executive is committed to increased public investment in our national health service. Indeed, the public consultation that has just ended on "A New Public Involvement Structure for NHSScotland" is concerned with achieving a service that is redesigned for and involves patients, with the specific structures that are needed to ensure that the NHS delivers effective patient and public involvement.

I turn to the rather negative Opposition amendment from the Conservatives. At first glance, the Conservatives seem to be on the right tracks, as their amendment also focuses on the needs of the patient. However, when one considers the Conservatives' proposals in detail, it soon becomes obvious that their hidden agenda is to derail our national health service. Their most recent innovation—the so-called patient passport scheme—looks superficially attractive. Patients would be able to use the passport to obtain treatment at the hospital of their choice. The allocations of funds would be driven by the choices made by individual patients. What could be more attractive than that?

Mr Davidson: Will the member take an intervention?

Mike Rumbles: In a moment. Since the treatment obtained in an NHS hospital would continue to be free of charge, the NHS would have to subsidise people who can afford to go private. In other words, the so-called passport is a passport out of the NHS and into the private sector for the fortunate few who can already afford to pay the extra. The new Tory health plans would mean less money for the national health service. Tory policies would benefit the most well-off at the expense of the old, the sick and the poor.

Mr Davidson: I am not sure that Mr Rumbles has read the details of the consultation document. No one is claiming that health service money will be used to take people out of the health service. If people want to top up and go beyond the requirements specified by their medical practitioner, that will be for them to negotiate. However, Mr Rumbles should remember that, just a few minutes ago, his colleague the minister agreed with me.

The Deputy Presiding Officer: This is a very long-winded intervention, Mr Davidson.

Mr Davidson: The minister agreed that general practitioners should have the right to obtain treatment wherever suited the best interests of the patient. The passport would facilitate that.

Mike Rumbles: Let me answer that point by considering the example of hip operations. Let us assume that the cost of a private hip operation is about £8,000, which would be subsidised by taking, let us say, £2,500 out of the NHS. However, only those who could afford the other £5,500 in the first place would benefit from the policy. The Conservatives cannot be trusted on the national health service.

The proposals that are outlined in the Executive's white paper and again in the partnership agreement between the Labour party and the Liberal Democrats are the way to proceed, focusing as they do on the needs of the patient and on ensuring real public involvement in our NHS. The siren calls of the Conservatives and the carping of the SNP need to be resisted. I have every confidence that patient focus and public involvement are key drivers of change in the NHS. The Executive's approach is absolutely correct and I urge members to support the motion.

15:21

Carolyn Leckie (Central Scotland) (SSP): The proposals in "Patient Focus and Public Involvement" on the new Scottish health council state that individuals and communities affected by changes should feel that their views have been

"listened to, understood and acted upon."

There is a claim of independence for the new council. The document also says that it is no longer acceptable

"to do things **to** people"

and that we must

"do things **with** the people".

Three tests can be applied to measure that: independence, accountability and democracy. Is the new council independent? Well, it is to be incorporated into NHS Quality Improvement Scotland, which is a quango that is appointed by, and accountable to, the Executive. There will be no elections from the public, patients or staff.

Is the council accountable and who is it accountable to? To the public? The patients? The staff? Can any of those people sack members of the council? No.

Is the council democratic? If a community—for example in East Kilbride, Hairmyres, Coatbridge, Dumbarton, Glasgow or Edinburgh—opposes the expensive borrowing mechanism of the private finance initiative, can it reverse the decisions of health boards or the Executive? Will that community be able to avoid scenarios in which proposals for cuts in service provision are presented as the only option on the ground of clinical safety, when such decisions are often symptomatic of a history of bad, unaccountable decision making and years of underinvestment in the buildings, infrastructure and staff of the NHS? Can the public overturn the decision of a health board? No.

Paragraph 25 of the document talks about requiring boards to carry out a consultation again. But will they still make the same decisions? Members should consider the sham of a second consultation in Glasgow. Glossy leaflets were produced and there were PowerPoint presentations—all in the face of the massive opposition that led to Jean Turner's being elected to this chamber. Will that consultation deliver more than two accident and emergency units in Glasgow? Will it maintain Stobhill hospital as a general hospital site? Is there democracy? Is what happened what we are to expect from second consultations that arise through the new Scottish health council? The third test is failed miserably. Is the use of the word "council" not a contradiction? It suggests democracy when, in fact, the council will not be democratic at all.

We demand fully elected health boards and a fully elected Scottish health council—organisations elected by the public, the patients and the staff. They should be supported by employed expertise and be completely separate from, and independent of, the Executive and the NHS. They should have their own statutory powers.

In February 2000, the Council of Ministers signed up to a statement that said that there should be

"Citizen and patient participation as a democratic process.

However, that is not what is in front of us today. The Executive's proposals fall way short of that statement and they are not supported by the Royal College of Nursing.

During this morning's Health Committee meeting, Mr Tom McCabe argued, with regard to health and the amnesic shellfish order, that he would always want to implement a European Commission directive. Amnesic shellfish poisoning has caused no deaths in Scotland, Britain or other European Union countries. However, decisions that affect the NHS are life-and-death decisions. If there is to be true democracy, true accountability and true independence, and if the Executive, given its willingness to implement the directive on amnesic shellfish poisoning, is to be consistent, why does it not implement the February 2000

decision of the Council of Ministers? What is more relevant and more important? What affects more lives? What affects the health of our patients and our citizens?

The Executive's white paper represents a smoke-and-mirrors approach to patient involvement, patient focus, democracy and accountability. The Executive's proposal has only a pretence of patient involvement and is not democratic, accountable or independent. The proposed new body will have no power—no teeth—which I believe exposes the Executive's arguments.

I support the idea of directly elected health boards, but the SNP amendment does not go far enough. I would have liked our amendment, which went further, to have been accepted. We will continue to campaign on the points to which I have referred.

It is a wee bit rich of Bill Butler to argue against something that he allegedly supports.

Bill Butler: On that point—

The Deputy Presiding Officer: No. The member is in her last minute.

Carolyn Leckie: Mr Butler should have tried to intervene earlier in my speech. What he said earlier is a bit rich and brings into question the consultation process on his own bill. By not supporting the SNP's amendment, he will seem to oppose the bill's proposals.

15:27

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The issue that we debated at this morning's Health Committee meeting might not have changed, but some of the faces have. However, Mr David Davidson, Mike Rumbles, Carolyn Leckie and I are again debating the issue. I see that Mr Tom McCabe is on the front bench for the debate. I hope that his involvement in ministerial duties does not restrict too much the active lifestyle that he has developed on Lanarkshire golf courses over the past six months.

I congratulate Shona Robison on her elevation to the SNP front bench. Why her party thought that her predecessor was not an ideal spokesperson on matters relating to the caring professions can be left to members' imaginations. However, justice's loss is Shona Robison's gain and I wish her well.

One thing that strikes me about the motion is how unremarkable it seems. At first reading, some might venture to complain that phrases such as "wider public involvement" being

"at the heart of a modernised NHS"

and

"ensuring public involvement in health service reorganisation"

are so non-controversial and bland as to be little more than platitudes. However, the idea that putting patients first is so obviously correct that it hardly merits a mention is the most interesting point in the debate.

Historically, the NHS has never been particularly good at bringing to the fore the needs of its core market—the paymasters—who are otherwise known as patients. We could all recount the story from the olden days about the neighbour up the stair who was taken into hospital for a kidney stone and came out with a wooden leg, but who never dreamed of pointing out the error because that would only bother the doctor. Besides, her leg might have needed that treatment in future so she would be grateful that she had it done anyway. Thankfully, we have moved on since then. Examples such as that seem to be ridiculous today.

However, not all in the garden is rosy.

Stewart Stevenson (Banff and Buchan) (SNP): Will the member give me the name of his doctor, so that I do not use him?

Mr McNeil: That was in the days of yore.

Members—including Stewart Stevenson—will hear constituents' accounts of their bad experiences in hospital. We have all felt ill informed about a treatment, been patronised by a GP's secretary, or intimidated by an overbearing surgeon. Many of us will have been frustrated and at times enraged by NHS bureaucracy. It seems that services can be put under threat by little more than the stroke of a bureaucrat's pen.

Maternity services in my constituency have been under threat for some years and have already been subjected to a supposed public consultation. That consultation was run so badly that its report had to be downgraded and the exercise started again from scratch. I therefore welcome many of the proposed measures outlined in the partnership agreement and elaborated upon by the minister today.

I am particularly interested in the new duty on NHS boards to co-operate with one another. I hope that that will reduce the impact on changes to service provision of external circumstances—the working time directive and junior doctors' hours—and the consequent pressure to centralise services.

I would argue that there is room to go further. First, the minister will be aware that our colleagues, Bill Butler and Paul Martin, have proposed member's bills to require direct elections by the public for the majority of places on health boards and to require boards to consult when

proposing to change the use of health service premises. Both those measures merit some serious consideration. I therefore ask the minister to consider closely in the coming months how the main provisions of those bills could be incorporated into the forthcoming NHS reform bill.

Secondly, if we are considering making health boards more efficient and responsive, why should we not also look at other unelected bodies that hold sway over the delivery of our health services? [*Interruption.*] I think that the next page of my notes has been put in upside down to trick me. For example, what about the royal colleges? Who decides their guidelines? How can the taxpayer challenge them? Who monitors their policies on supply and demand? Whom do they have to consult when they are making decisions? To whom are they accountable?

Let me return to the example of my local maternity unit. If it is deemed not to have reached a fixed level of births, the Royal College of Obstetricians and Gynaecologists could decide not to accredit that unit for training. That would have—and has had—an impact on the training of junior doctors and on their accreditation. It will result in the need to recruit junior doctors every six months and lead to a continued crisis in management, demoralisation and the ultimate doomsday scenario of closure. All of that will take place with no consultation and no real public involvement.

We are right to go after health board bureaucracy, but if we are to make today's warm words a reality, and if we are to effect a step change in the way in which the NHS is run, all areas of outmoded working protectionism and vested interests must be challenged.

15:33

Eleanor Scott (Highlands and Islands) (Green): I speak as the health spokesperson for the Green group in the Parliament and as a former health professional. I make no apologies for saying that. Although Mr Davidson might think that I am a complete amateur in the Parliament and that I do not know anything about the workings of the civil service or government and so should not have been elected, the richness of those bodies comes from the fact that people bring experience—even baggage—from their previous employment.

No one would argue against the greater involvement of patients in the health service, whether at the individual level, with patients being involved in their treatment plan and interacting with health professionals, or wider public involvement in health services.

I will return for a moment to my baggage from my previous job. Last week's *British Medical Journal* was entitled "The patient issue". It was an experiment, in which all the main editorials and many of the articles were written from the patient's point of view. A lot of the articles were written by doctors who had also been patients, who recounted how the experience felt to them—doctors are human too.

One article, written by a managing editor of a consumers website in Australia, was entitled "Just how demanding can we get before we blow it?" She made the point that there is a risk because of the lack of inclusiveness of patient power. She wrote:

> "It worries me that this trend is deepening inequalities in health care, as the better equipped patients corner more and more of their doctors' time."

She was talking about the middle-class patients who come with a list of questions, demands and so on. She continued:

> "Yet, they may be the very people who could get their questions answered in other ways, while the people who need to rely most on the doctor"

get pushed aside because they are not so articulate. We must ensure that our patient consultation is not just consultation of articulate individual patients or groups of patients but reaches everybody.

Mike Stone, the director of the Patients Association, raised another point. He listed the things that patients want from their doctor, some of which the minister has talked about, such as communication skills, eye contact, partnership communication and getting an appointment. He wrote:

> "However, if one wish could be granted for patients, it would be for more time with their doctor."

That is true. The one thing that patients want is more time with their doctor. Unfortunately, I do not think that the measures in the white paper will deliver that. In fact, I worry that staff—not just doctors, but all health professionals—who struggle to get the time off and the funding for study leave will have to undertake courses in communications and so on, meaning that we will be in a worse staffing situation that we are in now. People can engage with a doctor only if there is one there to engage with. In the Highlands and Islands, some areas are seriously under-doctored because of the recruitment problem. Frankly, someone would be quite happy to have an abrupt interaction with a doctor for three minutes now rather than wait a month to see somebody for eight minutes, if they are in pain or otherwise in need.

I hope that the idea of a culture of listening in the NHS is part of the idea of a culture of listening in government. Listening is meaningful only if what is heard during the listening exercise is acted on. If the Executive listens to communities but ignores

what they say and does what it was going to do anyway, listening is a fairly sterile exercise, as other members have pointed out. We also need to listen to communities about other factors that can determine health. NHS provision is only one small factor in the determination of the health of a population. Other issues are equally important and, in some cases, more important. Those include the quality of the food that people eat and the air that they breathe; the green spaces that children can play in; children being able to get outside to play and exercise; and people not having a motorway going past their door. When communities are consulted on such issues, or when they are not consulted but make their views known anyway, they must be listened to. Listening in the NHS is of no use unless the Executive is listening across the board.

I give qualified support to Shona Robison's amendment, but I am not going to talk about Mr Davidson's amendment, as I do not agree with a word of it. I agree that there is a major democratic deficit in the NHS that needs to be addressed. I respectfully suggest that a way forward for a somewhat election-weary Scottish public would be for the NHS board function to be transferred to local government, which is what happens in other countries. That would make health boards democratically accountable, put health and community care under the same umbrella and reunite public health and environmental health. It would be of overall benefit and is worth considering. I hope that that idea will be considered in the consultation as a possible solution. The NHS boards would hate it, but that is their problem.

I will support the original motion, with reservations. I will also support the amendment, with reservations, as I see it as a prompt to remove the democratic deficit in the NHS. However, we must be clear that there is no point in promising to listen if there are not enough staff in the NHS to be there to listen.

15:39

Christine Grahame (South of Scotland) (SNP): I will pick up on some phrases that have been used in the debate so far. The motion talks of "greater patient engagement"; the minister said that people should be "treated as individuals" and that there should be "better communication" with patients; and Duncan McNeil referred to "putting patients first". I will consider how those ideas are illustrated in relation to three issues and how the situation might be changed. The issues are the complaints procedure, access to medical records, and advocacy, which are basic issues for patients in the NHS at all levels.

The complaints procedure has been addressed in some detail by my colleague Shona Robison. The Executive's own findings are that the procedure is cumbersome and does not appear to offer independent advice, and that 75 per cent of those who go through the system are dissatisfied and believe that the current procedure is biased. Six years ago, there was a consultation on the complaints procedure—members of the previous Justice 1 Committee know the troubles that we had with complaints about professionals. I suggest that the area should be addressed urgently. Most members receive complaints of different natures in their constituency mailboxes that should never have come to an MSP as the court of last resort.

Rather than simply having a complaints officer in each NHS organisation, someone should be on the spot in hospitals to listen to people who want to complain. When people who are visiting their granny or mother find that the situation is not right and want to make a complaint, a named person to whom the complaint can be made should be available. People should not have to go through the labyrinths of the national health service structure.

I also suggest the early use of independent trained mediators to deal with patients, carers, families and professionals to try to find a resolution to problems. Complaints might be small—for example, a mother's buzzer alarm hangs on the wall and she cannot reach it when she needs help. If somebody complained about that, the situation might be dealt with without there being a full-blown problem that gives rise to a blame culture and a situation in which harassed staff feel that they are taking the buck for the problems in a system that is under stress.

I am also interested in the comment in "Partnership for Care" that a failure in the complaints procedure could trigger

"an investigation by NHS Quality Improvement Scotland and possible Executive intervention."

I presume that that relates to serious flaws in the complaints procedure or a serious complaint. The document continues:

"If these new arrangements do not lead to significant improvements in complaints performance, we will take all necessary steps including legislation."

I wonder how far that legislation has got on the drawing board. People often feel that, although they have been through the complaints procedure, nothing has changed. People should know that, at the end of the procedure, there is a statutory resort.

The second matter that I will touch on is access to medical records. It is astonishing that people do not know that they are entitled to see their medical records when they have been entitled to do so since 1990. If that is not common knowledge, what is wrong with the system? People are also entitled

to see medical reports that are written about them, although such reports are sometimes withheld. Constituents often tell members that they have not seen a medical report because it was produced for another body. However, the Access to Medical Reports Act 1988 gives patients the right to see any medical report that a doctor has written, whether it is for an insurance company or an employer. People do not know that, but informing them would be a simple matter. Such matters do not require fancy research and words—they are practical issues that could be resolved easily.

The third matter that I will touch on is advocacy. Paragraph 45 of the paper "A New Public Involvement Structure for NHSScotland", which deals with advocacy, states:

"Some patients and carers may need help of a more intensive kind or over an extended period of time. In these circumstances it may be appropriate to enlist more specialist advocacy support".

The paper continues:

"NHS Boards are already required to commission independent advocacy arrangements".

Who knows about that? There are many elderly people languishing in hospital who do not understand what is being said to them and who have simple problems such as having nobody to open the top of their drinking bottle to allow them to drink. Some people are left sitting in a chair for two or three hours because they have been parked there by harassed staff. Who speaks up and acts as an advocate for such people if they have no family?

One of the many briefing papers that members receive from Age Concern Scotland states:

"older people's advocacy only receives around 8% of the total advocacy budget",

although, as the paper points out, people older than 65 consume

"around 40% of total health care and social care costs".

That needs redressed.

The issues are simple, and we could start by setting up a one-stop shop. I endorse my colleague Shona Robison's move for a statutory independent patient body, to which people would be directed if they ask where to find out about something. The body would be separate from the system itself and would inform them in a way that they understand about advocacy, access to their medical records and all the other things they need to know, including the person to complain to.

15:45

Mary Scanlon (Highlands and Islands) (Con): I noticed that, when he responded to Phil Gallie's intervention, the Minister for Health and Community Care said that this was the start of the patient agenda. The Conservatives introduced a patients charter in 1991. If that had been continued by Labour, instead of being ignored for the past six years, patient involvement and empowerment would be far more embedded in the system than they are.

Malcolm Chisholm: I dealt with the patient focus agenda at the start of my speech, before moving on to public involvement. As other members have acknowledged, the issue has been growing over a period of time.

Mary Scanlon: I have had it confirmed by the minister before that he has, in fact, ignored that agenda. Nonetheless, I am pleased that he is addressing patients' rights and empowerment.

I had thought that a large percentage of the minister's speech might address NHS Quality Improvement Scotland's national overview, particularly as it was published last month.

I will give a number of quotes from the overview. First, it states:

"Communications, nationally and locally, are not always effective."

Secondly, it says that much information "is not readily available." Thirdly, it states:

"NHSScotland organisations still do not manage effectively potential risks to patients."

Fourthly, it says:

"Healthcare staff do not always have ready access to information to help them treat patients effectively, particularly across healthcare sectors."

As Christine Grahame said, it is all very well saying that patients are empowered, but they need the right information and knowledge, and the NHS must be joined up. Different parts of the health service need to communicate with each other and with the voluntary sector and other sectors. Those quotes from the national overview really do make poor reading, and they do not inspire one bit of confidence.

I wondered whether another document was the one that we were to consider today, entitled "A New Public Involvement Structure for NHSScotland". A health council member from the Highlands e-mailed me today and asked, "How can you be discussing that document if it's a consultation document? The consultation responses had to be in on 9 June."

Malcolm Chisholm: Will Mary Scanlon give way?

Mary Scanlon: Och, just let me get on.

Malcolm Chisholm: I would just like to clarify that point. That consultation formed one part of a much larger debate. If Mary Scanlon were to consider the balance of my speech, she would find

that the patient focus agenda was at the centre of it.

Mary Scanlon: The health council member's point was that the deadline for responses to the consultation was six working days ago. If we want to have a meaningful debate, I would have thought that the minister should be moving a more meaningful motion.

Having said that, I welcome the involvement with communities and voluntary organisations. I take the opportunity to commend the Scottish Commission for the Regulation of Care, in the light of responses that it has given out. I am aware of how complaints from several people, about care for the elderly, nursery school provision and so on, have been dealt with, and I cannot speak highly enough of care commission staff and their professionalism, at least in Inverness. However, I wonder how many people know about the care commission. If more people knew about it, that would help to empower patients. I also welcome the commitment to advocacy.

Health councils have done an excellent job, but members are appointed by the local NHS board, so it is difficult for them to be critical of the body that appointed them. That point has been raised in the Parliament many times over the past few years.

Paragraph 16 of "A New Public Involvement Structure for NHSScotland" states:

"NHS accountability must be open and transparent, involve independent assessment and include evidence-based clinical and service standards".

The document goes on to discuss the new health council being part of NHS Quality Improvement Scotland. Does that mean that the new health council will help to highlight and monitor the incidence of postcode prescribing? Where should patients go? Where should the patient in Inverness whose mother phoned me go? She told me, "Mary, I think my son is dying of leukaemia." After a year on interferon without responding, he has been told by a consultant that Glivec will give him the best chance in life. The consultant has to put a case to Highland NHS Board to see whether it can afford Glivec.

Last week, I spoke to Anna Gregor, the cancer tsar, and she said that he should have had Glivec from the start. I understand that Glivec for leukaemia is available in Fife, but is not available in Lothian. Many members have mentioned the bureaucracy. We need a simple path on which patients and MSPs can go forward to end postcode prescribing.

Carolyn Leckie *rose—*

Mary Scanlon: Just a second, Carolyn.

The minister might have made the point about postcode prescribing for four years and the Executive might have made it in the partnership document, but, as a question I put to the minister stated,

"Highland NHS Board has set up a task group to manage implementation of … new drugs 'within a cash limited envelope of resource'".

The minister replied that NHS Highland manages new drugs carefully, which

"includes assessing the cost implications and budgeting for them accordingly. But it does not alter the fact that clinical need, not finance, should determine whether or not a patient receives the drugs".—[*Official Report*, *Written Answers*, 12 June 2003; p 144.]

Finance is determining whether patients receive a drug. In fact, it is determining whether or not they live.

Carolyn Leckie *rose—*

Mary Scanlon: I am sorry, Carolyn. I have taken too long. I am in my last 20 seconds.

Having spent so much time working on the Mental Health (Care and Treatment) (Scotland) Bill, and knowing the shortages of staff, psychiatrists, mental health officers, social workers and medium-secure units, I ask who will monitor the implementation of the legislation? Will it be QIS? Ten beds are blocked because of delayed discharge in New Craigs in Inverness, simply because the patients cannot get out because there is nothing in the community. In the bureaucratic structure that the minister is organising, where will they go to get the care that we passed for them in the Parliament?

15:52

Michael McMahon (Hamilton North and Bellshill) (Lab): As a Parliament, we must recognise that Scottish society is forever evolving, and that the needs and aspirations of Scots in relation to the national health service are changing in line with our aspirations for every other aspect of life in our country. To remain in tune with that attitudinal development, we must reform the methods of delivery within our public services, especially the NHS. That is essential to ensure that the needs of patients are paramount in the progressive process. Partnerships in the community and effective co-operation and planning will strengthen public involvement, and will help to purge health promotion and other health services in Scotland of the bureaucratic formalities that hinder the fundamental needs of patients.

The ethos of the Scottish Parliament is that it is inclusive, and that the public are involved in discussions and have a direct hand in the policy-

making process. Scottish health care should be no different. With the changing pattern of health care services, decisions need to be taken in an open, honest and informed way, to ensure that patients are able to have their say on health care strategies that affect them, and to deliver high-quality services that address inequalities and inefficiencies in the right way. Working together is the key, as that will empower patients, communities and professionals, involve them in the decision-making process, and assist in addressing what individuals need and want.

Throughout Scottish health care services, new duties and roles have been adapted to address the ever-transforming nature of health care. By emphasising the patient, individuals are given a voice and are respected and involved in their own care.

Transparency with a flexible approach is crucial, but we need radical thinking now for a radical change tomorrow. We must combat the conservatism that is often exhibited by professionals in the NHS. No longer must we assume that the doctor always knows best. If power is to be devolved into the hands of the people, we must challenge the position of the British Medical Association and those within it who oppose change. For public requirements to be met, doctors and health care professionals should remember that they are, first and foremost, public servants who meet the requirements of the people whom they serve.

Patients should have an active role in their own care, by contributing to things that affect them and their families and by being involved more widely in developing and improving communication and partnerships throughout the population, developing new partnerships and strengthening existing ones.

Reform of the current system will ensure participation by patients, families, stakeholder groups and communities. They will be listened to and their suggestions will be taken forward. The empowerment of communities will increase control over, and improve, individuals' health, while clinicians, professionals, patients and carers work in partnership to understand a person's full needs and make an informed decision about the right treatment and care that should be received.

I was disappointed to hear the minister say that clinicians must be at the forefront. I think that the patient should be at the forefront. The clinician should listen to the patient's needs.

I am pleased that NHS trusts will be abolished to bring about the changes. That will cut bureaucracy and inefficiency. I welcome the extension of powers to intervene if protocol and best practice are not being carried out. I also welcome the establishment of community health partnerships, which will devolve responsibility to the front line so that local health services meet the needs of individuals and communities, and the placing of a duty on health boards to involve patients.

I am sure that such restructuring will effectively improve the quality and consistency of care for all. We must ensure that the efforts that are made are responsive to patient needs. Direct contact must be made with individual service users, community groups and voluntary organisations to inform—with mediation and advisory services if appropriate—and support those who need help through appropriately disseminated practical information and training.

Others want to pander to the vested interests in the NHS. They show a lack of enthusiasm for and a lack of interest in patient focus. I believe that we are on the right track to improve the voice and the health of the Scottish people.

Robin Harper: Mr Rumbles did not respond to the challenge. There is a view that the health councils provide a valuable and independent criticism of the strategies and actions of the health service. How does Michael McMahon view the virtual abolition of the local health councils under the strategy that the minister proposes?

Michael McMahon: There is a place for the voice of the people to be heard in the system, but it has to be an informed voice. I would rather concentrate on the information that comes from patients than on the structures through which the information comes.

That is what I mean by listening to the public. We must act on people's suggestions. We can define patient concerns and investigate ways of implementing appropriate and much-needed radical approaches. We can examine best practice for a socially inclusive, patient-oriented, contemporary health service in Scotland.

I commend the Executive for its plans, as far as they go, but I urge ministers to take on the consultants and doctors who stand in the way of the radical change that patients demand from our NHS.

15:57

Mr Rob Gibson (Highlands and Islands) (SNP): The national health service is correctly identified as a key indicator of how a civilised society is working. It is the most cherished service of most of the people of the nation as it gives all citizens a right to access treatment at the point of need.

In European and world terms, countries with such integrated health services show stronger social mobility and fewer extremes of wealth and

poverty. However, welfare provision must be participative; it is not a sales counter where the approach is to take it or leave it. That is why we in the SNP are so frustrated with new Labour and its Lib Dem partners for the six-year delay in setting up patient consultation and involvement in a workable framework. It has taken 50 years since the start of the NHS for us to get to this stage—thank goodness that we are beginning to address the issue now.

It is no accident that citizens advice bureaux had to evolve after world war two to give people help and advice about the services to which they have rights. As the Government machine became all-powerful in order to win the war, the right of people to information and redress—independent of the service that was being investigated—developed its own momentum in response.

Holding bureaucracies to account yet keeping trust in—in this case—the medics who serve us is a delicate balance. That is why more rights of involvement for patients are long overdue. People correctly welcomed the NHS as a milestone in state welfare services, but better quality service has been sought from early in its existence. That is why the health council element has to be independent of the NHS system and why health councils must not be bean counters in the annual accountability review process of another NHS department.

The SNP's long-held policy is to democratise health boards by having a directly elected element, and we have identified that as a key aspect in our amendment. Health boards could include members from local authorities or directly elected members of the public and elections could follow the four-year council election cycle. There is also a need for community councillors to sit in on the management decisions of local health care co-operatives. That measure could go a long way towards opening up lines of communication with health professionals.

Statistics show that the decreasing satisfaction rates in recent times come at the same time as communication problems form the core of complaints between health service staff and patients. NHS staff must be given clear guidelines for action in handling and recording errors and explaining mistakes to patients at the earliest possible instance. All of the statistics point to the fact that the longer the process lasts, the less satisfaction patients feel.

I turn to an example of how tortuously slow improvement in consultation can be, even at present. It stems from the experiences of dental patients in Caithness, who are deprived of NHS dentists because of retirements and recruitment problems in Highland Primary Care NHS Trust.

Over the past year, outrage has built up over the lack of NHS dentists and that led to calls through the independent Caithness local health council for a meeting with the trust. It took seven or eight months for such a meeting to be called, which is a long time considering that people in Caithness are said to be pulling their own teeth or having to make a 100-mile round trip to get an emergency appointment.

The fact that a meeting had to be held with health care professionals and management shows that the matter is of major concern to people in Caithness. The volume of complaints eventually led to a helpline being installed, but it was deemed to be worse than useless, as the information was out of date, inadequate and inappropriate.

Further expressions of public outrage led to Thurso community council inviting the trust to an open meeting during the election campaign in April. No trust personnel were available to appear, but two political parties—not the Conservatives or the Labour party—answered the invitation to hear 100 people letting off steam.

By 2 June, the trust finally held a consultation meeting on the way ahead, which was attended by MSPs, councillors and local community representatives. However, the meeting was held in Inverness, which is 100 miles away from the problem. If that is the timetable when a whole community is up in arms, what does that say about the treatment of individual patients?

The SNP does not wish to fuel the blame culture. We do not believe that a complaints department is the answer. In saying that, we are thinking about the least pushy patients, such as the elderly who have so often suffered in silence.

The tardy and bureaucratic proposals that are included in the Executive motion suggest neither urgency nor that the Executive has learned lessons such that far-flung board areas, including Highland, will receive rapid lessons in communication skills. The "Partnership for Care" proposals that are the subject of today's debate put local people first, but they pretend that a new national health council for Scotland with a local presence is the answer. I beg to differ, as does the SNP amendment.

16:03

Mike Pringle (Edinburgh South) (LD): The motion that we are debating is about a move towards decentralisation of power along with greater public involvement and accountability in the decision making of the national health service in Scotland. What is a patient-focused national health service? I think that it is a service that exists for the patient, and one that is designed to meet

the needs and wishes of the individual who receives care and treatment.

One aspect of today's debate is the proposal to reform the NHS complaints procedure. Clearly, many members are concerned about that issue; Christine Grahame and other members have referred to it. It is accepted that many people who make complaints at present express a high level of dissatisfaction with the system. Only about 20 to 30 per cent of those people said that they were satisfied with the time that it took to deal with their complaint—indeed, the majority were not at all happy with the outcome.

The consultation document lists some of the main causes of dissatisfaction among complainants as

"operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support."

The current NHS complaints procedure was introduced in April 1996 following the report of a review committee—the Wilson report of 1994—and the Government's response "Acting on Complaints" in 1995. The objective of the study was to provide an evaluation of how the new complaints procedures were operating throughout the NHS and to meet the information needs of the policy makers and managers who were concerned with the future development of the system.

Reform of the present system is very much needed. The advisory group was to be made up of NHS staff, the public and patients. However, I have looked at the list of 11 people who are on the advisory group and, although there is certainly one patient representative, I am not sure who the genuine members of the public were or are. I am sure that there is a good answer to this question—why were there no lay chairs, panel members or conciliators on the working party? Those people have been involved with the present complaints procedure since its inception and, because of their considerable experience, could have contributed a great deal to the review. With the exception of conciliators, they have done their work entirely voluntarily.

The strength of the system lies in the neutrality and independence that it offers to the complainant members, who are representatives of the community. There seems to be a determination to create a completely new system without any rationale for the change or any certainty that matters will improve. Would not it have been better for the emphasis to have been on improving the present system with much better training, more monitoring and much better guidelines for the staff involved?

A number of proposals have been made by the advisory group, but they do not include nearly enough detailed information on how the new system will work or how it will improve the situation. No substance is included, and much more detail will be needed about how the new proposals will work on the ground. How will the complaints procedure be better and more responsive? Will it serve the patients better and will they have more confidence in it? I am not sure that it will.

Greater efforts need to be made to improve the proposed new system. If that system is to be effective and to ensure consistency, perceived independence and timeous responses to complaints, senior NHS staff must endorse the procedures and recommendations. A culture of openness is needed among staff at hospital and primary care level so that complaints handling is considered a strength, not a weakness, of the NHS system. Doctors and other health professionals should not feel threatened, and whatever system is put in place must treat them, as well as patients, sympathetically.

I hope that the minister will take on board my comments and others that have been made today about the new complaints procedure. I hope that some different proposals will be made or that the present proposals will be reconsidered.

16:08

Marilyn Livingstone (Kirkcaldy) (Lab): Everyone who has spoken in the debate believes in the devolution of power and thinks that it leads to more effective decision making and stronger public services. We heard from the minister that he is determined to devolve power to communities, to strengthen public involvement and to promote health improvement. I welcome that, because it will benefit all the people of Scotland. As a socialist, it is my long-held belief that we gain power to give it away. The further empowerment of others to deliver better public services is stated in the white paper and the partnership agreement is designed to meet those aspirations.

However, the NHS in Scotland seems to be dogged by red tape despite determined efforts by many in our communities to improve that situation. The abolition of NHS trusts and the establishment of community health partnerships will help to bring together professionals and others at local level and at local stages, but there is still a democratic deficit within the health authorities. As Duncan McNeil said, there are also those with vested interests. I hope that the minister will consider those points.

As the summary white paper outlines,

"people today expect more".

Quite rightly,

"They want the right care at the right time and in the right place."

That represents the changing face of health services in Scotland today. The white paper also points out that patients

"want to be involved in decisions about what is best for them".

That aim is surely something that crosses all political divides and should find unanimous support in the Parliament.

Other MSPs have mentioned that they have received numerous complaints on this matter from their constituents; I am no different in that respect. People want to know at first hand that they are being listened to and about what the future might hold for them. Although many constituents do not feel that such information has been forthcoming, things have moved on. At this point, we must congratulate the doctors and nursing staff who have gone out of their way to ensure that the needs of patients are met. I have heard at first hand of big improvements in the NHS in that regard, and we should mention that fact in the chamber this afternoon.

The white paper is founded on the creation of a new culture of patient care and individual focus in the NHS, which I hope will allay some worries about whether such care is an entitlement or is, as Mary Scanlon mentioned, a postcode lottery.

I particularly welcome the proposals for a new statement of patients' rights and responsibilities as set out in the chapter in the white paper entitled "Listening to patients". As many members have pointed out, better NHS complaint handling—with legal rights if necessary—is also a welcome step.

We want a health service in which communities, patients and, most important, carers can participate to ensure that their views are sought, listened to and acted on. As for public involvement, I agree with the minister that people must be involved at the formative stage of any new proposals. Consultation after the development of a preferred option cannot and will not be acceptable.

I welcome the establishment of the Scottish health council as part of NHS Quality Improvement Scotland, as it will reflect the close links that must exist between quality and participation. NHS boards have been asked to develop sustainable frameworks for public involvement, and all members in the chamber should take an active interest in the frameworks that they come up with.

Although the Executive is taking the right line in bringing about the changes that are proposed in "Partnership for Care", it must have support from MSPs. We must cut bureaucracy and inefficiency by establishing single local health systems. The proposed NHS reform bill will seek to establish a new duty for health boards and special health boards to ensure public involvement in the health service. Just as important, there will also be a new duty on NHS boards to co-operate with other agencies within communities to enable more effective regional planning. Improving quality and consistency is of paramount importance, and I hope that the minister will stress that fact when he winds up.

The proposed bill will extend ministerial powers to allow ministers to intervene whenever necessary. That is very important, because ministers will have specific powers to act in areas such as the promotion of health improvements Scotland-wide. We have seen much about that issue recently in the news. It is not enough for us simply to talk about those issues in the Parliament; instead, it is incumbent on us all to pursue implementation rigorously.

In my final minute, I want to be slightly parochial and mention the consultation process on the acute services review that took place in Fife. As the minister is aware, the process is now complete and I believe that the board's preferred option to locate trauma services at Victoria hospital will benefit everyone—patients and staff alike—in Fife. I ask the minister to give us an update on the parliamentary answers that he gave last week about an imminent announcement on the "Right for Fife" review, as we urgently need that decision.

Secondly, I know that the minister is aware of speculation about the financial position in Fife. Today I have called on the health board and the chairs of the health trust to hold a press conference to respond openly and accountably to that speculation in order to allay public fears. Indeed, the measures in the proposed bill will be really successful once we see public participation on the ground and the public's questions being answered openly and accountably.

16:14

Mr Brian Monteith (Mid Scotland and Fife) (Con): I listened intently to the minister's opening speech today and was sadly but predictably unimpressed by his attempt to reinvent the wheel. When the minister launched "Partnership for Care", he said:

"Patients must be at the centre".

He also said:

"we are signalling a step change so that looking at services from a patient's point of view becomes the key driver of change".—[*Official Report*, 27 February 2003; c 18786.]

He went on to say that we need a "culture change".

Today, the minister was at it again, telling us that his changes to our NHS are justified because they put patients first. That leads me to three observations. First, the drive to put patients first started in 1991 with the patients charter, a concept that was developed by the Adam Smith Institute, run by two Scots, Madsen Pirie and Eamonn Butler. If Labour had listened to back benchers such as Duncan McNeil—who made a sound contribution to today's debate, on the difficulties of focusing on patient care and empowerment and avoiding producer capture—and if it had carried on and developed the patients charter that it inherited, we would probably not have needed today's debate. The minister's soundbites on putting patients first have a hollow ring.

Secondly, the very reason that public services required a culture change back in 1991, and need it even more now, is the congenital propensity for public services, as they mature and become more centralised, to ignore the customer. What we actually need for greater patient influence is decentralisation, providing greater diversity, greater specialisation and therefore greater patient choice. What we are being offered is not diversification or decentralisation.

Thirdly, as we remember the 50th anniversary of Eric Blair's death, we should note that we have a minister who deliberately uses Newspeak. In "1984", George Orwell said, "War is Peace." The minister says, "Centralisation is Empowerment." No doubt he also believes that ignorance is strength.

The Conservative amendment is about reality, not Newspeak. Providing choice empowers patients. Our amendment understands that choice comes from decentralisation. Foundation hospitals and a patient passport are the route to patient power, but the minister is travelling in the opposite direction.

Mike Rumbles *rose—*

Carolyn Leckie *rose—*

Mr Monteith: I shall take Mr Rumbles first and then Carolyn Leckie.

Mike Rumbles: Will Brian Monteith address the point that I raised earlier? Is not a patient passport a passport out of the NHS, because it will only subsidise those who are well enough off to afford private care?

Mr Monteith: Mike Rumbles is so predictable. He should know, as the minister certainly knows from my questions on the provision of private care for hip and knee replacement surgery at hospitals such as Abbey King's Park hospital in Stirling, that the NHS is already accessing private care. With regard to patient passports, we are asking why people should have to wait six months. Why should patients have to wait on the growing waiting lists?

Carolyn Leckie: Could Brian Monteith explain the mechanism by which foundation hospitals would end postcode prescribing—a subject that Mary Scanlon is rightly agitated and annoyed about?

Mr Monteith: That is an entirely valid point to raise, and I suspect that Carolyn Leckie is already thinking that foundation hospitals will clearly not end postcode care in England. However, the foundation hospitals have to be accompanied by the patient passport system so that patients are empowered to move to the hospitals of their choice, and the foundation hospitals can then supply that diversity and choice.

The minister said, arrogantly, that "no one is keener" than he is—those were the very words that he used today—to improve the health service. I can tell the minister that there are tens of thousands on the waiting lists who would disagree with him. I back the Conservative amendment.

16:19

Mr Bruce McFee (West of Scotland) (SNP): The SNP is very much in favour of real patient consultation and the greater involvement of the public in the planning and delivery of their health service. For six years, Labour has talked about greater patient involvement in decisions about patient care and proper community consultation in the provision of services. For six years, little has been delivered that has made a positive impact in those areas. Such has been the paucity of action that Labour MSPs are now raiding SNP policy documents—searching for ideas to fill the void created by this coalition Executive. The members' bills of Paul Martin and Bill Butler are but two examples of that process.

In many areas, the price of the Executive's inaction has been the breakdown of trust between communities and health authorities. Last night I attended a meeting in Dumbarton, organised by Argyll and Clyde NHS Board, on the withdrawal of all emergency surgery and major complex surgery from the Vale of Leven hospital to the Royal Alexandra hospital in Paisley. The previous evening, I was invited to a meeting that was organised by concerned members of the public, again in Dumbarton, on the same subject. The venue at the meeting organised by the health authority was two thirds empty, but at the meeting the previous evening there was standing room only in the hall—and little wonder.

Over the years, the level of service that is provided locally at the Vale of Leven hospital has been vastly reduced. Last year the maternity unit was closed and expectant mothers must now

travel to Glasgow. Earlier this month, on grounds of clinical safety, the authority announced the imminent withdrawal of accident and emergency surgery and of major complex surgery. Those changes are scheduled to take place in October. In effect, the present accident and emergency department is closing, to be replaced by an emergency treatment unit.

That unit will operate—but not literally—between the hours of 9 am and 9 pm. Even during daytime hours, all emergency surgery will be transferred to Paisley. After 9 o'clock at night, referrals for emergency treatment can be made only through a doctor or via the ambulance service. In addition, if someone turns up now at the door of the Vale of Leven hospital with a broken arm or leg, they cannot receive treatment locally. Instead, they will be transferred to Paisley to have their stookie put on.

It is not difficult to see why people in Dunbartonshire and beyond believe that they are being treated like second-class citizens. Decision after decision has been taken above their heads, with no consultation whatever. However, it is not just the people of the area who have not been consulted. Anyone who attended the two meetings in Dumbarton or who reads *The Herald* will be aware that GPs—the doctors who are expected to handle the extra work of referring patients after 9 o'clock at night for emergency treatment—have not been consulted either.

There is also some doubt about whether the ambulance service has been consulted properly. The authority's assessment is that one ambulance, complete with paramedic crew, is all that is needed to bridge the gap—one additional ambulance to cover the additional distances and to make the additional trips that will now be required. The health authority has already confirmed that it will not spend any additional money on ambulance provision for the area, but will simply "put pressure" on the ambulance service if provision needs to be increased.

I am sorry that the minister is not here, but from a previous intervention by me he will know that for some time there have been problems of bad management in Argyll and Clyde. Although dramatic changes have been made to local management, I ask the minister to respond to a few points. Will he take this opportunity to investigate the events leading up to the health authority's most recent decision and to the withdrawal of locally based services from the Vale of Leven hospital? As the present crisis at the Vale of Leven has been occasioned by an inability to retain and recruit consultants—especially consultant surgeons—will the minister take the opportunity to inform Parliament what action the Scottish Executive has taken to attract consultants into the Scottish NHS from other parts of the United Kingdom and from abroad, and how successful those actions have been? Further, what progress has been made on implementing the new contract for consultants, which was agreed by the majority of Scots consultants last year?

If the public are to believe that they have a genuine role to play in the development and delivery of health services, they must be properly represented. In my view—and in the view of the SNP—a real sense of public participation and public ownership of the process would be best achieved by direct election to the majority of places on NHS boards. That is why I am pleased to support the amendment in the name of Shona Robison.

16:25

Paul Martin (Glasgow Springburn) (Lab): I confirm for Bruce McFee's benefit that my member's bill was not raided from Scottish nationalist policy; it arose from the streets of Springburn, as a result of the injustice of a proposed secure unit and a closure. The people of Springburn were not interested in any of the SNP's policies and they confirmed that in the elections on 1 May, as did people throughout Scotland.

Shona Robison: Will the member give way?

Paul Martin: If Shona Robison gives me some time, I will confirm a number of points for her benefit.

I welcome the document that the Scottish Executive has launched today. We have seen a large number of documents like it, but we have to ensure that their proposals are enforced and that the aspirations and energy of civil servants are brought in to ensure that we deliver what the documents offer.

I am afraid to say that our unelected quango health boards have failed in the past to ensure that patient focus is the primary concern in our communities. I put it to the minister that that was the case in the acute services review in the Greater Glasgow Health Board area. I believe that the review and the process were cosmetic and did not investigate effectively many of the issues that people in the communities raised.

I am mature and experienced enough to know that different points of view will not always be accommodated. However, health boards have to present evidence to show that they are ensuring that local views are informed by debate and that they are not simply informing communities of decisions that have been made.

Shona Robison: Is not the member pleased that SNP members support his bill? It is important

that local people have the power to enforce consultation; the right of appeal is also important. I would have thought that the member would welcome SNP support for that.

Paul Martin: I welcome that support, but clarity is required as to where the proposal originated. As I said, the people of Springburn invented the proposal for my member's bill. I also welcome the fact that a number of cross-party groups support the proposal.

I welcome Bill Butler's proposed member's bill and I disagree with the SNP amendment that was lodged today. For the first time, I find myself agreeing with Carolyn Leckie. Boards should be 100 per cent directly elected. Before the business managers contact me on my pager to ask why I am supporting Carolyn Leckie, I must say that I will allow the three stages for Bill Butler's bill to inform the issue. Bill Butler advises me that I will be convinced not to support the 100 per cent election of board members.

Bill Butler: Does the member agree that there must be a real consultation process, rather than just an amendment tagged on to a motion? There might be support for the 100 per cent election of board members and I am enough of a democrat to accept that.

Paul Martin: I agree with that point of view. We should allow the three stages of the bill to provide effective scrutiny. We should listen to the wide range of views that will be aired during that process. I might change my mind and move from agreeing with Carolyn Leckie to agreeing with Bill Butler.

Carolyn Leckie: Will the member give way?

Paul Martin: I am sorry, but I have taken a number of interventions and I still have a number of points to make.

I am less concerned about the structure of health councils, although I take the point about health boards appointing health councils. I am more concerned about what health councils deliver in our hospital facilities. The Executive faces the challenge of ensuring that health councils are effective in dealing with the many issues that patients raise in our local hospitals. Rather than being concerned about the structure, we should ensure that our patients are aware of the presence of health councils in our hospitals and of their effectiveness in acting as facilitators for dealing with patients' complaints and the other issues that they raise.

Although I welcome the launch of the white paper, I ask that the issues that it raises be acted on.

16:30

Mike Rumbles: Today's debate has been very interesting and has included some excellent speeches, a few of which I want to highlight.

I was interested in Carolyn Leckie's proposal that health boards should be fully elected. I had just written down that, at that rate, we might as well just transfer them to local authorities when Eleanor Scott made that very proposal. To go down that route would be a nonsense. That suggestion is not on in any practical sense.

It is a pity that Eleanor Scott is no longer in the chamber. We should be very careful about what we say in the Parliament. She said that patients want more time with their doctors. Although I agree with that sentiment—no member would disagree with it—she went on to say that someone would rather have an abrupt three minutes with a doctor than have to wait for a month to see them. It might just have been a turn of phrase, but it gives the wrong impression to people listening to the debate. No such time problem exists. In the partnership agreement, we have guaranteed access to the NHS team within 48 hours. That will take effect—ah, I am glad to see that Eleanor Scott has returned to the chamber.

Eleanor Scott: Hospital specialists are doctors, too. If a person can get to see a specialist within a month, they are doing very well.

Mike Rumbles: We should be a little more precise in the language that we use.

Christine Grahame made some excellent practical points about the complaints procedure. We should have a named person to deal with complaints at every hospital. If that is not the case already, it certainly should be the case. It is also true that people should be entitled to see their records.

I was surprised by Mary Scanlon's emphasis on ending postcode prescribing. The partnership agreement between the Labour party and the Liberal Democrats states:

"We will end postcode prescribing by ensuring drugs approved by NHS QIS are made available in each health board area."

The only decision to make is whether those drugs are clinically appropriate and that is a doctor's decision.

As Mike Pringle mentioned, the complaints procedure must be examined, as there is much concern about it.

I am always entertained by Brian Monteith's speeches, which are well delivered. If the 1991 patients charter had worked, we would not be where we are today. That is the point, as Mr Monteith would discover if he tracked through the

logic of what he said. The fact that Malcolm Chisholm said something in a previous debate or a previous publication does not take away its validity. We are talking about a process. Brian Monteith said that the process started in 1991; in my opinion, it started long before then. We must try to ensure that we do not make such party points just for effect.

Brian Monteith did not deal properly with patient passports, which are a fundamental issue. He glossed over the subject and failed to address the points that I made in my opening speech about the effects that the patient passport would have on the NHS. I noticed that the Conservatives in the Scottish Parliament were most reluctant to advocate the patient passport, unlike Conservatives down south. Brian Monteith is shaking his head. He is confirming that Conservatives north of the border, as well as Conservatives south of the border, support patient passports. The example that I used was clear; patient passports would involve subsidising private health care.

There is nothing wrong with private health care and there are some very good private hospitals and treatments. If people want to use private health care, that is all well and good. However, the taxpayer should not be undermined by subsidising private health care through the national health service. That is quite different from a patient guarantee that if we cannot treat them on the national health service, we will use the private sector. That is a different argument that Brian Monteith should accept.

Mr Monteith: I must respond to two of Mike Rumbles's points. Our health spokesman, David Davidson, made it clear that the patient passport is a policy that is out for consultation. We support its being out for consultation. How can we come to any conclusion before it is consulted on?

Mike Rumbles: Well, I—

Mr Monteith: I said that I had two points.

The Deputy Presiding Officer (Trish Godman): He is in his last minute.

Mr Monteith: Is he? I will let him off, then.

Mike Rumbles: That was a very good backtrack from Brian Monteith.

In my last minute I will deal with the issue that Paul Martin raised. I ask whether his proposed bill is necessary. His proposal is that health boards should be required to consult

"where any changes of use of health service premises are proposed".

I can understand his concern about that. However, the Executive proposes to extend ministerial powers to intervene as a last resort to direct health boards to take specified action to secure the quality of health care required. I would have thought that the Executive is proposing those powers for the very reason why Paul Martin raises the issue. I will be interested to read the results of the consultation on his bill.

There have been some good contributions to the debate. None of the arguments proposed by the SNP, the Scottish Socialists, the Greens or the Conservatives have undermined in any way the proposals from the Scottish Executive. I urge members to support the motion.

16:36

Mrs Nanette Milne (North East Scotland) (Con): I am not quite as old as the other Nanette with whom Tom McCabe confused me during my maiden speech. However, I am old enough to remember the days when the medical superintendent and matron ran Aberdeen royal infirmary efficiently and effectively to ensure that their patients got the best care available at that time. Hospital wards and theatres were supervised by sisters who took pride in their work and their high standards had to be met by all members of the health team.

They were the patient's advocates and many gave a lifetime of service to the profession. That was in the heady days before promotion meant becoming an administrator.

Admittedly, in those days—

Carolyn Leckie: Does the member agree that the direct accountability to which she refers—nursing sisters, for example—was undermined and removed directly by the privatisation of cleaning services, a policy that was implemented by the Tories and is now supported by Labour?

Mrs Milne: No, I do not agree at all. The success of the cleaning services is the direct responsibility of the people who supervise the cleaners. The ward and theatre sisters used to supervise cleaning effectively. Some 70 per cent of the worst cases of dirty hospitals are in the public sector.

In the old days, patients were not consulted on every aspect of their condition and treatment. They did not expect to be; such was the ethos of the time. They felt, however, that they were important to the staff who looked after them and they trusted and respected them for it.

It was essential for us to move on from there. I absolutely agree that patients should be consulted and involved in decision-making about themselves and their loved ones and that there should be clear and well-publicised lines of communication in the NHS so that their voice is heard and listened to. It is right that patients and local communities

have an input into plans for developing the service and that complaints are dealt with swiftly and effectively, which is not always the case today—as we have heard.

However, that should happen locally. I agree with Shona Robison that local health councils have done a good job and together have a strong voice throughout Scotland. I fail to see why another layer of bureaucracy is needed to ensure that patients have an effective voice in the health service.

Malcolm Chisholm told us of a series of guides, strategies and initiatives—no doubt to be accompanied by glossy brochures, of which there has been a plethora from the Scottish Executive. I sometimes wonder whether that is to blind us to the continuing failures in services.

People are rightly sceptical about consultation processes; I picked that up clearly when I was a councillor. Again I have to agree with Shona Robison. Mike Rumbles stated that the Liberal Democrats will devolve power to the lowest level, and yet he is happy to support a centralised health council that will greatly dilute the influence of the excellent local health councils. I suspect that that, again, shows the two faces of liberal democracy. Eleanor Scott made very good points about the risks to inclusiveness and to the less articulate patient and about recruitment problems in the Highlands.

However, we have not dealt with the big, unsolved problems of today's NHS—the lack of staff to run the service and the time that it takes for patients to get the treatment that they need. Those problems will continue as long as the focus is on Government directives and centrally set targets. That spawns a bureaucracy that is driving NHS staff away in droves—especially GPs, consultants and nurses, who are fed up, disillusioned and unable to get on with the work that they are trained for because of paperwork and administration. That will not change until there is a radical overhaul of the NHS and until the focus is truly put back on patient care, with health professionals and not politicians making the decisions on health care priorities.

There is no point in coming up with complicated schemes for new national bodies such as the proposed Scottish health council when—

Mike Rumbles: Will the member take an intervention?

Mrs Milne: Not at the moment.

Mike Rumbles: Well when then?

Mrs Milne: I may not.

Such schemes will put further pressure on already overburdened health boards when the service is failing the many patients who are waiting far too long for treatment. As Carolyn Leckie pointed out, there are also serious concerns that the centralised health council will not be seen as independent of the NHS. It will risk duplicating the valuable work that is already being done by established organisations such as the Advocacy Safeguards Agency. There is doubt about who will monitor and scrutinise local charity and voluntary sector organisations to ensure that taxpayers' money is spent wisely and effectively on care and support and not on bureaucracy.

The NHS exists to serve patients. Patients must be put at the heart of the service and given real choice. That will not happen until power is devolved from ministers to GPs, who, as the first point of contact for most patients, are in the best position to interact with them and to determine priorities on the basis of clinical need and not political targets. That is why I support the Conservative amendment.

16:43

Stewart Stevenson (Banff and Buchan) (SNP): When Jack McConnell was elected as the new First Minister of the Parliament, he said that he would support good ideas from wherever they came. It is in that spirit that we move our amendment today to require the majority of places on NHS boards to be filled by election. It is in that spirit that we support Bill Butler's bill and in an equally friendly spirit that we support Paul Martin's bill. We would also have no difficulty if, as Carolyn Leckie wishes, 100 per cent of board members were elected. In that spirit of consensus, let us move on.

Malcolm Chisholm said that our culture must be patient-focused, that we must listen to patients and respect their views, and that we must deliver the right care in the right place and at the right time. In the spirit of consensus, I can hardly argue against any of that. We welcome any measures to shorten the period before people get the treatment or the appointment that they require. However, the minister should consider what constitutes failure in the health service. At the moment, there are many failures; and I believe that the minister also thinks that there are many failures. We are prepared to support him in fixing them. The failure of waiting times and waiting lists is undoubtedly the main one.

Another thing that concerns me is the apparent retreat from universality. For example, there is little mention in recent documents of dentistry or chiropody. We need national standards that are delivered locally. However, we must acknowledge that patients come in all shapes and sizes and that they are not an undifferentiated mass. For example, none of the Executive's recent

documents mentions the needs of young patients in any way, shape or form. Young patients are perfectly capable of making informed decisions about their medical treatment.

As a spotty 12-year-old—

Members: No!

Stewart Stevenson: Indeed, I was a spotty 12-year-old who had the most appalling acne, which required the assistance of a consultant. Being on an experimental programme to sort my acne left me with a condition that is with me to this day. I was not consulted about the treatment and discovered information about the potential side effects only a number of years later. As a 12-year-old, I should have been involved in the decision on my treatment. I hope that we will find that young people today are involved in such decisions.

I thoroughly agree with Christine Grahame's suggestion that we should have an independent patient body. Indeed, while sitting here I came up with a name for such a body. In line with such titles as Oftel and Ofgem, it should be called Of-ill. On that note, I hope that Dr Jean Turner is returned to good health shortly. Her contribution to the debate has been sadly missed.

I turn to the Conservative's contribution to the debate and in particular to Mr Davidson's bizarre suggestion that only the qualified should be entitled to be elected to contribute to decision-making in the health service. I think that he will probably be on his own on that, even among the Tory benches, unless Mr Monteith tells me otherwise, which would be a welcome relief to any who are listening in the chamber.

Mr Davidson: Will the member take a brief intervention?

Stewart Stevenson: Come on, then. Let us have it.

Mr Davidson: If Mr Stevenson had actually been listening, he would know that I asked his party's spokesman to give us the full details of how people would be put up and how they would qualify. I asked whether it would just be assumed that they would have the knowledge to take over the running of the health service.

Stewart Stevenson: It is simple. I would be perfectly happy if people nominated themselves and then got elected because they gained the confidence of the electorate that they were the appropriate people to do the job. That is the basis of democracy in our society, but it is clear that that practice is alien to Conservative members.

To my surprise, Carolyn Leckie referred to amnesic shellfish poisoning. I am delighted that she is becoming engaged with that subject, which I confess has been an obsession of mine and some of my colleagues for some time. Domoic acid from affected shellfish affects the memory. Therefore, if I do not remember Carolyn Leckie referring to amnesic shellfish previously, I must have been eating shellfish. Like her, I would like more EU initiatives to be introduced.

Mr Duncan McNeil made an interesting and rather jokey point about people getting the wrong treatment when they went into hospital. It is clear that there is a difficulty of patients receiving the wrong treatment in some parts of the health service. I have received information about three examples of that in recent weeks, all of which were based on difficulties in having patient notes delivered to where a patient was being treated. In one case, a patient ended up being severely constipated, which sounds trivial. However, if the patient notes had been available, the patient's particular health issue would have been recognised. That patient nearly died because the patient notes were not available, so getting the wrong treatment is not simply a joking matter.

Mr Monteith highlighted the 1991 patients charter. He seemed to think that that is a perfect instrument that should be implemented properly. The Tories were happy to support changes to the Agricultural Holdings (Scotland) Act 1991, which they introduced. In the same spirit, they should look at the 1991 patients charter as something on which we should move forward.

Patients' rights and responsibilities are referred to in the document that we have before us. We must consider the rights of older people. There does not appear to be adequate reference in the document to how people who are no longer in a position to speak for themselves will be treated. I am sure that that was not a deliberate omission by the Executive.

Waiting times will continue to haunt the Executive. Of course, they are a huge overhead for the health service. If the number of people on waiting lists remains static, the health service has the capacity to process them; we just need the resources to eliminate the waiting list.

I believe that the minister is sincere in wanting to improve the NHS. Whenever he makes proposals that will have the effect of doing so, he will have our support. Indeed, I believe that that is generally true across the chamber. Only the Tories have an agenda to slim down the NHS and perhaps to abolish it.

A developed society must not be judged solely by its economic performance and by its ability to impose its will on others. A developed and civilised society is judged by how it supports people in their hour of need. The health service is the support that we give to such people. I support the SNP amendment.

16:51

The Deputy Minister for Health and Community Care (Mr Tom McCabe): The Executive's commitment to patient focus and public involvement in the NHS is paramount. That means a firm commitment to changing and improving the way in which patients are involved in decisions about their care and how the public is involved in decisions about local health services.

It is a commitment based on the belief that NHS Scotland exists to serve the people of Scotland. It is a commitment based on listening to people across Scotland who tell us that they are concerned about the quality of local services. They want to know that their local NHS provides the best quality of care, at the right time and in the right place.

As members have heard today, it is a commitment that is already becoming a reality. Patients and the public are being placed at the heart of the modernisation agenda. NHS boards are being required to look at services from the patient's point of view.

Bill Butler: In the debate there has been a bit of talk about the non-Executive bill that I have proposed. The minister will remember that, last week, we started to arrange a formal meeting with his civil servants in order to consider the consultative process. Will the minister assure the chamber that he will consider that proposal and look seriously at what the Executive can do to assist in the necessary consultation process and in advancing the democratic principle at the heart of the proposals? I hope for a positive response, given that the minister signed the proposed member's bill.

Mr McCabe: I am happy to reassure Bill Butler and happy that he has indicated that the Executive has already shown its willingness to discuss his proposed bill with him. That proposal will go to consultation. That is how it should be treated. It is inappropriate for people to try to score political points and to jump the gun before people have been consulted on proposals. The Executive will seriously consider the proposal alongside its own radical agenda and we will explain our conclusions openly and with candour at the appropriate time.

I mentioned that patients are being placed at the heart of the modernisation agenda. I hear and take cognisance of Paul Martin's remarks and I acknowledge the concerns that he has made perfectly clear in the past.

I also hear the comments made by Bruce McFee. I am aware that there were elements of the recent consultation by Argyll and Clyde NHS Board that were not as good as they could have been with regard to GPs. I am aware of those shortcomings and it is because such things happen that we are pursuing such a radical modernising agenda.

Frances Curran (West of Scotland) (SSP): There was no consultation on the closure of accident and emergency facilities at the Vale of Leven hospital and lives will be lost. Will the minister intervene with the Argyll and Clyde NHS Board to reverse that decision?

Mr McCabe: The words "no consultation" might be a bit of an exaggeration, but there were shortcomings in the consultation in that area and I am happy to acknowledge those shortcomings.

I have spoken about the modernising agenda, but there is no room for complacency. Malcolm Chisholm said that we cannot change the culture of the NHS overnight. We are well aware that the health service will not be transformed just because we say it must be. A culture that has developed over 50 years will not be transformed easily or quickly. However, change is already happening and we are determined to drive that change forward.

An example of that is NHS Quality Improvement Scotland, the national health service's independent inspectorate. In response to comments that were made earlier, I inform members that the inspectorate is independent of the Executive and the local NHS. It is a key part of our drive for quality and patient focus. It recently involved more than 150 lay reviewers in its annual "MOT" of the national health service. They recorded many examples of good practice, but also highlighted a need for significant improvement in many areas. We expect all national health service organisations to implement effective policies to improve the patient focus of their services before next year's inspections take place.

Part of the new patient-focused culture must be a new willingness to address and respond quickly and flexibly to patients' concerns. That is why we have consulted on proposals for a simpler, more effective complaints process. Christine Grahame raised the point about the need to have someone on the spot. That is exactly what is suggested in our proposals. Trained mediators are already in place.

Christine Grahame: Will the minister give way?

Mr McCabe: Not at the moment. I have taken several interventions and I must make progress.

Concern has been raised about the wider range of voices that need to be heard, especially those of carers, to whom Mr Davidson and Mr Swinney referred. It is important to note that each NHS board is required to produce a carers strategy in partnership with carers and carers organisations. That is why we are placing great importance on

making independent advocacy available to all those who need it. It is why we are working to strengthen the Advocacy Safeguards Agency and the Scottish Independent Advocacy Alliance.

Patients, carers and the public want to be involved in decisions about the development of their local NHS, including those concerning what services it will provide and how and where they will be delivered. We have acknowledged the fact that the national health service has not always done enough to involve the public in key decisions about the future of health services. When difficult decisions have to be taken, local people need to be reassured that improving services, quality and patient safety always come first. That is why the forthcoming health bill will place a duty of public involvement on health boards.

Mary Scanlon: Given the fact that patient involvement is at the heart of the health service, how would the minister advise a patient who cannot receive a drug, despite its being passed and recommended on the basis of clinical need? I refer to the drug Glivec.

Mr McCabe: I am aware of the point that Mary Scanlon raised in the debate and know that Glivec is a very important component in fighting leukaemia. We have made it clear in the partnership agreement, which underpins the coalition, that if a drug is approved by NHS Quality Improvement Scotland, health boards must provide that drug in line with clinical need. We are determined—as are other members—to end postcode prescribing in the NHS.

We have acknowledged the fact that we have not always done well enough in involving the public in key decisions. We will underpin our determination with guidance on involvement and consultation in service change. The guidance will suggest a four-stage approach of informing, engaging, consulting and feeding back—informing the people and communities who are affected of the initial plans for a proposed service change or strategy and asking for their views; engaging them in developing potential options; consulting them on a number of options for the proposed change; and feeding back to the people who have taken part in some or all stages of the process of service change.

Mr Davidson mentioned choice. The process of involvement in decision making must start from the outset, with full involvement in developing options as well as in choosing between them. A full and honest explanation must be made of the final decision and of how views that were expressed during the consultation were taken into account.

The new Scottish health council will be a robust and powerful driver in quality assuring NHS boards' work to involve the public.

Mr Davidson: The minister's colleague in Westminster, Mr Lammy, has suggested that because of the issue of independence, local health councils in England might not be closed down. What is the minister's comment on that remark?

Mr McCabe: That is exactly the issue that I was about to discuss. Mr Davidson gave the impression that local health councils are independent bodies, whereas the reality is that they are appointed and staffed by local health boards. That does not give the type of independence that people seek.

The Scottish health council will ensure that the voices of local patients, carers and communities are heard and that NHS boards are aware of and in touch with local issues and concerns. It is important that the council's reports, which will be based on the experience of local people, will inform the NHS's accountability review process. The council will work in support of the public partnership forums, which each community health partnership must establish, and in so doing will ensure real local involvement in decision making in primary care service planning and delivery.

The agenda that we have set is challenging and will not be delivered overnight. It requires a major change in attitudes and culture throughout the NHS in Scotland. Our patient focus and public-involvement approach acknowledges that the NHS is accountable to the Scottish people for providing the best and most effective clinical care. The approach recognises that people want to have confidence in their NHS as a service that has their best interests at its heart. Therefore, our approach will commit the NHS to listening to the evidence of local people about what will work to improve their health, what will be effective and what is the best way in which to involve them in improving the quality of the care they receive.

Our approach will require the NHS to hear, understand and act upon what local people say and to show local people that their views have been taken into account and how they have influenced decisions. That must become the way in which the NHS does business in the future. Most of all, the patient focus and public involvement approach is about doing things with—not to—people. It is about the NHS supporting its front-line staff to build a truly patient-focused NHS that is modern, effective and efficient and harnesses the knowledge and skills of the people it serves in order to provide the highest quality health care at the right time and in the right place. Our approach is about harnessing the support of managers, clinicians and health professionals, and of patients, carers and the public jointly to build a real partnership for care to drive through the change that is needed.

The patient focus and public involvement approach is fundamental to the future delivery of

health care in Scotland. We do not underestimate the challenge that lies ahead in ensuring that the approach becomes part of day-to-day culture in the NHS. The journey has begun, progress is being made and we are committed to pursuing the approach with the utmost vigour. I commend the motion to the Parliament.

Decision Time

17:03

The Presiding Officer (Mr George Reid): There are three questions to be put as a result of today's business. The first question is, that amendment S2M-154.1, in the name of Shona Robison, which seeks to amendment motion S2M-154, in the name of Malcolm Chisholm, on patient focus and public involvement in the NHS, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (Aberdeen North) (SNP)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Mr Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Ingram, Mr Adam (South of Scotland) (SNP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Martin, Campbell (West of Scotland) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Mr Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Morgan, Alasdair (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (North Tayside) (SNP)
Welsh, Mr Andrew (Angus) (SNP)

AGAINST

Aitken, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Mr Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ferguson, Patricia (Glasgow Maryhill) (Lab)

Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McLetchie, David (Edinburgh Pentlands) (Con)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Mundell, David (South of Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Mr Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Mrs Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinburne, John (Central Scotland) (SSCUP)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

The Presiding Officer: The result of the division is: For 34, Against 80, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The second question is, that amendment S2M-154.2, in the name of David Davidson, which seeks to amend motion S2M-154, in the name of Malcolm Chisholm, on patient focus and public involvement in the NHS, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division

FOR

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Tosh, Murray (West of Scotland) (Con)

AGAINST

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Mr Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fox, Colin (Lothians) (SSP)
Gibson, Mr Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)

Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Mr Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Mr Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Mrs Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

The Presiding Officer: The result of the division is: For 17, Against 97, Abstentions 0.

Amendment disagreed to.

The Presiding Officer: The third question is, that motion S2M-154, in the name of Malcolm Chisholm, on patient focus and public involvement in the NHS, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division

FOR

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Mr Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Gibson, Mr Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Mr Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)

Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Mr Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Mrs Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Curran, Frances (West of Scotland) (SSP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fox, Colin (Lothians) (SSP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Harper, Robin (Lothians) (Green)
Johnstone, Alex (North East Scotland) (Con)
Leckie, Carolyn (Central Scotland) (SSP)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Tosh, Murray (West of Scotland) (Con)

ABSTENTIONS

Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Canavan, Dennis (Falkirk West)
Glen, Marlyn (North East Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)

The Presiding Officer: The result of the division is: For 85, Against 22, Abstentions 7.

Motion agreed to.

That the Parliament welcomes the measures in *Partnership For Care: Scotland's Health White Paper* and the Partnership Agreement to step up progress to ensure that greater patient engagement and wider public involvement are at the heart of a modernised NHS and supports the Scottish Executive's commitment to placing the patient at the heart of the design of services, implementing a patient information initiative, ensuring public involvement in health service reorganisation plans by obliging NHS boards to consult stakeholders more effectively and setting up a Scottish health council as a national body with a local presence across Scotland.

Concorde (Museum of Flight)

The Deputy Presiding Officer (Murray Tosh): The final item of business today is a members' business debate on motion S2M-59, in the name of John Home Robertson, on Concorde and the Museum of Flight. I invite those members who wish to speak in the debate to press their request-to-speak buttons now, and those members who are leaving to take flight at once.

Members: Shame!

The Deputy Presiding Officer: That shows that someone out there is listening.

Motion debated,

That the Parliament notes that British Airways will be withdrawing Concorde aircraft from service and welcomes the approach from the Chairman of the Trustees of the National Museums of Scotland to the Chief Executive of British Airways requesting that one of these aeroplanes is donated to the Museum of Flight at East Fortune; recognises the interests of education and tourism and the important role that museums play in both of these areas; takes into account the associations of Concorde with Scotland, namely that the design of the wings was undertaken by a Scot from Penicuik, Sir James Arnot Hamilton, that the early test flights were carried out at Prestwick in the early 1970s and that it was Concorde that flew over Edinburgh to celebrate the opening of the Scottish Parliament in July 1999; further recognises the wealth of experience of staff at the Museum of Flight in the preservation of aircraft and their years of experience in welcoming visitors to the museum; further notes that staff at the Museum of Flight are confident that the practicalities of landing a Concorde aircraft and of providing enclosed space for display have been investigated and that no difficulties are anticipated following a brief period of minor works; notes that the National Museums of Scotland has recently appointed a new General Manager at the Museum of Flight and that a major programme of development is planned to position the museum as a world class attraction, and recommends strongly that support be given to the National Museums of Scotland in its bid for Concorde for display at the Museum of Flight.

17:08

Mr John Home Robertson (East Lothian) (Lab): Having spent the morning giving evidence to the Finance Committee about another high-profile, high-tech, high-cost project, I am grateful for this opportunity to raise the subject of the Concorde supersonic airliner. Concorde is about to be grounded after 30 years, but I am confident that Scotland's new democracy will keep flying in the Holyrood building for at least 10 times that long.

I think that both of us, Presiding Officer, are old enough to remember the heady days of Harold Wilson's white-hot technological revolution. I seem to recall that Tony Benn was a pillar of the political establishment in 1968, when Concorde was rolled out at Bristol. The Concorde project was expensive and controversial at the time, but most of us were enthusiastic about what was an exciting and new European civil aircraft, which expressed the optimism and innovation of the 1960s. In those days, people were keen on new scientific ideas, and they were excited about technology and engineering.

However, the development of a potentially valuable, world-beating airliner in Europe was viewed with deep suspicion in the United States of America, where the authorities developed a rather uncharacteristic objection to aircraft noise. Who knows? If supersonic airliners had been invented in the United States, the skies might be full of them—but I am sure that the land of the free market would never indulge in protectionism.

It is one of my many disappointments that I have never flown in Concorde but, like many French and British citizens, I have always taken great pride in Concorde as the ultimate development in civil aviation. We have come to expect military aircraft to do astonishing things, but Concorde enables civilians to travel faster than the speed of sound. It is a beautiful aircraft and I can only marvel at the joy of an airliner that gets one to one's destination before it takes off.

Since Concorde, the civil aerospace industry has been able to produce only bigger and uglier jumbo jets—vast airborne torture chambers for prolonged endurance by passengers who have the misfortune to be taller than 5ft. I just had to make that point. I apologise.

The seven British Airways Concordes have been flying for 27 years. Those of us who can remember the excitement of Brian Trubshaw's test flights are 30 years older than we were then, and so are the airframes. Sadly, those fabulous airliners cannot go on flying for ever, whatever Richard Branson might say, but it would be a sin to scrap such an important part of our technological heritage. We must stake a claim to get one of BA's Concordes for the National Museums of Scotland's Museum of Flight at East Fortune. I am delighted that Dr Gordon Rintoul, the director of the NMS, and his board have already made a formal request to British Airways as part of their ambitious plan to develop the East Fortune Museum of Flight.

I visited East Fortune yesterday to discuss with Bob Layden, the manager of the museum, the plan to house Concorde in one of the hangars there. Concorde could and should take its place beside the museum's Comet 4, which was one of the world's first passenger jet airliners—another British first in aviation.

I am indebted to my constituent Lord James Douglas-Hamilton for reminding me that Concorde has strong Scottish connections. The wings were designed by James Arnot Hamilton of Penicuik,

and some of the test flights were made from Prestwick. Of course, all of us will remember the fly-past by Concorde and the Royal Air Force Red Arrows at the opening of the new Scottish Parliament in July 1999. That formation was assembled over East Lothian, so my constituents had a preview.

That brings me back to the specific point of the debate. The East Fortune Museum of Flight stands on a site that is steeped in aviation history. It was the take-off point for the first transatlantic airship flight back in 1919, it was an important RAF base in two world wars and the East Fortune museum now houses a spectacular collection of civil and military aircraft. Let me put in a plug for the East Fortune centenary of flight air show on 12 July. I am sure that many members will want to come along and join in the fun.

I also say in passing that the proposal by Transco to build a massive gas compressor station beside the historic site, dangerously close to a runway that may be needed for incoming aircraft in future, is an idiotic idea. Yes, there is a need for a compressor facility on the pipeline somewhere in East Lothian, but Transco is making a serious mistake if it thinks that it will be allowed to locate it at East Fortune. It would be well advised to start looking for a less unsuitable site. I ask the minister to convey that point to his colleague who deals with planning matters.

British Airways has stated that it is willing to give its Concorde aircraft to suitable museums for preservation and presentation as part of the national heritage. I whole-heartedly welcome the fact that the minister has already expressed the support of the Scottish Executive for the bid that has been made by the National Museums of Scotland to secure a Concorde airliner for the East Fortune collection. Scotland has a legitimate claim to one of those aircraft. Concorde at East Fortune would be a tremendous asset for the museum, for its visitors and for the development of tourism in East Lothian.

I am grateful for the support of 49 colleagues from all parties who signed the motion. In particular, I am grateful to James Douglas-Hamilton, who takes a special interest in East Fortune Museum of Flight.

I hope that the minister will be able to help us to ensure that Concorde comes to the museum at East Fortune, in my constituency, to form an extra attraction at the National Museums of Scotland's Museum of Flight.

The Deputy Presiding Officer: Before I call the next member to speak, I invite Donald Gorrie to remove his card and reinsert it, because he is currently shown as being Kenneth Macintosh—that may be a new whipping arrangement.

Donald Gorrie (Central Scotland) (LD): It is an improvement. I am rising in the world.

The Deputy Presiding Officer: Indeed.

You are now Donald Gorrie.

17:15

Lord James Douglas-Hamilton (Lothians) (Con): I warmly congratulate John Home Robertson on his success in bringing this extremely important subject before the Scottish Parliament and also on the enlightened wording of his motion.

The proposal to bring Concorde to the Museum of Flight at East Fortune is strongly supported by the National Museums of Scotland, the Scottish Executive, Edinburgh and Lothians Tourist Board, East Lothian Council, an enormous number of parliamentarians of all parties and all those in Scotland who are proud of Scotland's massive contribution to science, industry and aviation.

The Scots have been responsible for nearly a quarter of all Britain's most significant scientific inventions and in the case of Concorde there is, as John Home Robertson stated, a powerful Scottish connection. First, the wings were designed by Sir James Arnot Hamilton from Penicuik. Secondly, the early test flights of Concorde took place at Prestwick and, thirdly, just as the airship flew from East Fortune to North America in 1919 on the first ever transatlantic flight from east to west, so Concorde achieved the same at supersonic speed. Those were all historic events and it was no coincidence that Concorde made its welcoming appearance with the Red Arrows on the day on which the Scottish Parliament was formally opened.

Not only would the presence of this mighty aircraft provide many jobs at East Fortune, it would provide a terrific boost to tourism in Scotland, on much the same scale that Britannia did when it came to Leith. It would confirm the reality that the Museum of Flight is steadily but surely becoming a world-class attraction that is of tremendous interest to visitors from abroad as well as to countless schoolchildren. Already, about half of those who go to the museum come from outside Scotland. I strongly support John Home Robertson's comments about Transco.

The educational aspects of Concorde coming to the Museum of Flight are of enormous importance. It is natural that young people should feel an immense sense of pride in the inspiration shown by those who believe that the air is no more than a great navigable ocean that comes to every person's door.

In pressing our case today, it is as well that we should recall with respect those who put their lives

on the line in their determination to drive back the frontiers and perils of the unknown and remember that many of the greatest advances that have gone to make up our aviation history have sadly been at the price of human life.

John Home Robertson described Concorde as a beautiful aircraft. I am certain that the Museum of Flight can and will, if given the opportunity to do so, do justice to this great aircraft and to the countless memories that are associated with it. I give strong support to the motion in the conviction that we can do more to help our countrymen and countrywomen in the future if we understand correctly their magnificent and courageous contributions in the past.

17:18

Donald Gorrie (Central Scotland) (LD): I speak mainly to indicate that there is multiparty—I suspect all-party—support for John Home Robertson's motion. He and Lord James Douglas-Hamilton have covered many of the issues.

I stress that I think that Scotland deserves a fair share of goodies, such as old Concordes, which are being distributed around museums and such like. It is helpful to build up the Museum of Flight. In the past in Scotland and the rest of Britain we have been at fault in not safeguarding our heritage. I do not think that any Clyde-built warship or large liner is still preserved and visited on the Clyde; that would certainly have happened in other countries. As far as possible, we should preserve our aerial interests, of which Concorde is a prize example.

It is good that the Parliament puts its weight behind this official request, which has been made not by a fly-by-night outfit but by the National Museums of Scotland. The request thoroughly deserves our support and I am happy to give my party's support to the motion.

17:20

Stewart Stevenson (Banff and Buchan) (SNP): It is a matter of some considerable pride that Concorde was made in these islands. Indeed, it reflects the heady days when co-operation across the channel was still possible. The "e" in Concorde came about as a result of an unusual alliance between Francophone and Anglophone interests—before that point was reached, the aircraft's name was spelt differently on either side of the channel.

BOAC, which was the first airline to put Concorde into service, booked the registration sequence BOAA to BOAG, thus ensuring that one of the Concordes had the registration BOAC—such was the pride that BOAC took in the aircraft.

The Museum of Flight at East Fortune is a cornucopia of aviation history. As a youngster yae high, I got the "*Eagle*".

Mike Pringle (Edinburgh South) (LD): Mr Stevenson is showing his age.

Stewart Stevenson: Some members are old enough to remember the "*Eagle*".

Each week, the "*Eagle*" had aviation break-down diagrams. I remember the Comet being tested to destruction in one of them.

Examples of our space industry are on show at East Fortune—I am thinking of Blue Streak and Black Knight. John Home Robertson referred to the Comet 4C. I am not sure whether I have flown in that aircraft, but I have certainly flown in one of the Comet aircraft.

I have two personal attachments to East Fortune and the first is as a private pilot. I should declare that my entry in the register of interests shows that I am a member of two flying clubs. I have flown into East Fortune on a number of occasions to visit the museum and hope that nothing prevents the runway being accessible for future visits.

It is worth noting that there are 100,000 private pilots in the United States, many of whom would be delighted to come to Scotland and to include a visit to the museum at East Fortune during their time here. They are precisely the kind of wealthy visitors that we could attract to the museum.

My main plea is that Concorde be put into hanger four when it comes to East Fortune, which I am sure it will with the support of the Scottish Parliament. My reason for saying that is that another important aircraft, which was donated by the Scottish airline Loganair, is in hanger four. It is a Beech 18 and it was designed in 1935. It took one particularly important flight, which departed Aberdeen for Stavangar at 14:35 on 4 August 1969. The flight number was LN2501 and the registration of the plane was golf, alpha, sierra, uniform, golf—see how boring flying people can be.

The important thing about the flight was that my wife and I were on the plane, it was the first time we had flown and we were flying off on our honeymoon.

Mr Home Robertson: Was it turbulent?

Stewart Stevenson: No, it was a piston engine—a Pratt and Whitney rotary engine, if John Home Robertson really wants to know.

The Scottish aviation industry is practically at an end. In April, I flew in a Jetstream 31, which is one of the last aircraft to be built at Prestwick. We are down to the last fragments of the Scottish aviation industry with the Montgomery gyrocopter

continuing to be built in very small numbers in Ayrshire.

Flying is not only a pleasure thing for me; it has also been a business thing. I had a pal who was in an electronics company. He got up one morning, flew on a 757 to London, got on to Concorde, went to New York, met someone at the airport, showed him a piece of electronic equipment, signed a £12 million order, got back on to the same Concorde, returned to London and was back in Edinburgh for his tea. He was able to do that £12 million-worth of business because of the unique capabilities of Concorde.

We would be proud to have Concorde at East Fortune. For once, I am happy to support colleagues of other political viewpoints in this particular venture and I wish John Home Robertson well in it.

17:24

Colin Fox (Lothians) (SSP): I congratulate John Home Robertson on securing the debate and am happy to add my support to the motion, along with, as I hear, 49 of my colleagues.

I will declare an interest. I am not a pilot, but I take my kids to the museum at East Fortune regularly. It is my favourite museum in the country. It is a fantastic place to be. It has wide open spaces where the kids can run around and it is a fitting place for Concorde to enjoy its retirement. I am happy to support the motion in that respect.

Other members have highlighted the connection that the aircraft has with Scotland. Should we be successful in attracting Concorde to the East Lothian site, it may also be a fitting tribute to invite another of our national treasures—Tony Benn, the remarkable former Labour Minister of Technology, who, along with Stewart Stevenson, deserves the accolade of being the pilot of much of the project. I am not sure that John Home Robertson would regard Tony Benn as the same national treasure that I regard him to be, but the marketing slogan could perhaps be, "Bring Concorde to East Fortune and you get Tony Benn thrown in for good measure." Tony Benn who, as Lord James Douglas-Hamilton probably knows, was the minister responsible for the Concorde project, has strong connections with Scotland: his mother was from Paisley and his father was an MP for Leith. His presence would be fitting if we were to bring Concorde to Scotland.

Bringing Concorde to Scotland is a superb idea for the Parliament to be associated with. I can only congratulate John Home Robertson on that. As an avid supporter of the Museum of Flight, I suggest that Mr Layden, the new general manager, consider a constructive idea that I offer for encouraging as many visitors as possible to the site at East Fortune, which is a fantastic place to enjoy a day. He should consider waiving the admission charges. The museum is free for kids, but I was there a couple of weeks ago and there are either admission charges for me alone or there are admission charges for adults. They are not huge, but waiving them would help accessibility for the whole country.

Given where East Fortune is, the minister should consider examining the bus service to the site from Dunbar and Haddington. There is a genuine problem. For those who do not have a car, getting to an airfield in the middle of East Lothian has its difficulties.

I am happy to support the bid. I hope that the minister conveys the suggestions that I have made in the spirit in which they were offered. I suggest that, if we are successful, the minister persuade the pilot—or maybe Stewart Stevenson—to land the plane at Edinburgh airport on its penultimate journey. We could invite nominations from the Parliament, or the Parliament could invite nominations, for people to take Concorde's last flight—to the East Lothian airfield.

17:28

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): John Home Robertson looks slightly amazed at the prospect of my speaking. I was not going to speak but, as is often the case, one gets involved in the subject. I warmly congratulate John Home Robertson on securing the debate. I have greatly enjoyed the speeches that we have heard already.

As Colin Fox suggested, there is huge interest in the project. The only time I have been on Concorde was when I was on the one that is at the museum at Duxford in England. I assure all members present that it is a hugely successful visitor attraction. People of all ages flock to see it. It is probably the most popular aircraft at Duxford. Something about flight and beating the law of gravity continues to fascinate young and old. I warmly endorse the sentiments that we have heard so far and wish John Home Robertson all good luck in securing Concorde for East Fortune.

The point that I want to deal with arises from what Donald Gorrie said. He made an interesting remark. He said that we are very bad at looking after and preserving our heritage. He mentioned warships on the Clyde. It is a fact that only one warship from the first world war is still afloat. That is HMS Caroline, which is in Belfast. It is a light cruiser from 1916. It is the only ship from that era that is left.

Much more could be done in areas such as my constituency. We have an airfield and a bombing range at Tain. We have Invergordon, which, after

all, was the home of Beattie's battlecruisers in the first world war. When the RAF next decommissions a Tornado, why cannot it be restored to its 1941 or 1942 form with all its buttons and counters and returned to somewhere like Tain bombing range or even Tain aerodrome, with its old control tower that is still standing? Such planes are enormously interesting to people and, more important, they teach us history. After all, only a fool does not take regard of history, because it helps us to learn and prepare for a better future. A great deal could be done on the naval and aircraft fronts.

We should also remember that although an aircraft such as Concorde, or a Tornado, or even a first world war light cruiser, cost an unimaginable amount of money when they were built, they are worth practically nothing when they are scrapped. Very often, the blowtorch is taken to them and they are just chopped up. Instead of scrapping them, it would be so much easier to take them out and put them into areas of Scotland or England where they would prove to be significant visitor attractions and would help to teach our own very special history to generations to come.

17:31

Chris Ballance (South of Scotland) (Green): I too support John Home Robertson's motion, which all parties in the chamber agree with. The proposal to bring Concorde to East Fortune is no flight of fancy. It is eminently reasonable; it will bring real economic benefits to East Lothian and be a major boost to tourism in the region.

Concorde's withdrawal from service represents the end of an era. Although the aircraft was a triumph of engineering, the financial and environmental costs were very high. As members have pointed out, the name was chosen to reflect a spirit of co-operation and sharing; however, even its spelling was a matter of international argument.

Concorde's history extends back to the time of unbounded confidence in the white heat of technology but of limited awareness of that technology's repercussions. It is appropriate that the Museum of Flight should be the resting place for one of those craft. Our National Museums of Scotland are a byword for excellence and should house one of the world's most famous and prestigious aircraft as part of our industrial and aeronautical heritage. Concorde will be a major must-see attraction for one of the few major national collections sited outwith Edinburgh.

Concorde travel was the ultimate symbol of travel for the rich. It meant speed and power at the expense of daily noise interference to residents below and excessive climate-damaging emissions of pollutants. However, everyone can admire the static Concorde for its grace and style, which is why I completely support the motion.

17:33

Rhona Brankin (Midlothian) (Lab): I had not intended to speak in the debate, but I just want to make a couple of points. First, like other speakers, I congratulate John Home Robertson on bringing the motion before the Scottish Parliament and wish to put on record my belief that the National Museums of Scotland and the organisation's outlying museums are a tremendously valuable resource to the people of Scotland. Like other colleagues, I visited the Museum of Flight and very much enjoyed myself there.

I will raise a couple of issues, the first of which is the matter of transport to the Museum of Flight. If the museum were fortunate enough to get Concorde, that would increase visitor numbers. However, I agree that we need to examine major transport issues such as how people can reach the museum. Indeed, similar issues face people who want to visit the Scottish Mining Museum at Newtongrange in my constituency.

In that context, I draw attention to a project in my Midlothian constituency in which the council uses the money for school culture co-ordinators to take all Midlothian schoolchildren to the Scottish Mining Museum. Such an initiative might make it possible to increase visitor numbers to the Museum of Flight if Concorde were to go there and would be a way of getting all schoolchildren to visit the museum.

I support the proposal, which would greatly increase visitor numbers and put the museum more on the map than it already is, and I urge both John Home Robertson and the minister to think of innovative ways of increasing visitor numbers at the Museum of Flight and the Scottish Mining Museum.

17:35

The Minister for Tourism, Culture and Sport (Mr Frank McAveety): I congratulate John Home Robertson on securing the debate on his motion. As I looked at some of the names invoked in support of the Concorde bid, I noted that one requires a triple-barrelled name to be justifiable. James Douglas-Hamilton, my good friend John Home Robertson and Anthony Wedgwood Benn comprise an interesting trinity of triple-barrelled names. I do not know whether that says something about the elegance and income levels of those who are pilots, but Stewart Stevenson's contribution to the debate made me realise that this evening is the first time that I have ever seen a poor pilot.

Stewart Stevenson: Although it is expensive to learn to be a pilot, most private pilots spend less on their hobby than it would cost to buy a single packet of cigarettes per day.

Mr McAveety: The recommended policy of the SNP might well be for everyone to have access to being a pilot for the week. I thank Stewart Stevenson for his contribution.

This has been a broad and positive debate about what we can do in Scotland to maximise the opportunity to utilise something that is an important part of our past. That is true irrespective of our different interpretations of Concorde's significance in terms of the society and economy of the late 1960s and early 1970s. For some much younger citizens, understanding of the project comes from Airfix models rather than from being on Concorde itself, while others look back to a golden age when British-French relationships were reasonable enough to justify partnership.

We are delighted to try to help in the process of bringing Concorde to East Fortune. An MSP and a constituent are working together in partnership to identify ways of acquiring Concorde for the museum. I was interested in the suggestion made by three or four members that the aircraft should be used as an opportunity to explain our history in developing aviation technology. As Rhona Brankin and other members said, we should ensure that future generations have access to that history. I will certainly take back to the Executive the comments that have been made about partnerships at local authority level to ensure that young people have access to the museum.

It is part of our broader strategy for the National Museums of Scotland to ensure that we have a range and quality of museum provision that will reflect not just our ancient past but also our modern and immediate past. As each decade goes by, the more recent past becomes an important element of our history and who we are as a nation. For the likes of Benn in the 1960s, Concorde was one of the big symbols of Britishness, as much as it was a symbol of technological progress, and I am sure that there will be many other and different interpretations.

Lord Wilson of Tillyorn, chair of the National Museums of Scotland, wrote to the chief executive of BA on 18 April expressing an interest in acquiring one of the Concordes. Scottish ministers followed that up with a letter to BA to ensure that National Museums of Scotland has our support. BA is now determining the bid and considering all the other issues that have been identified and the other parties who may be interested. Interest in the acquisition of the Concordes that are no longer in use has been shown not only in the UK but also internationally.

We recognise that discussions have taken place between National Museums of Scotland and British Airways, and BA has replied saying that there has been a large amount of interest in acquiring the aircraft and that it hopes to make a decision soon. National Museums of Scotland has also had subsequent discussions with BA about the possibility of a permanent Concorde exhibition at the museum, including the practicalities of landing a plane at East Fortune. We expect the chief pilot to be in touch within the next few weeks, but we also expect that BA is making similar contacts with all applicants. If we need to demonstrate that we have pilot experience in the Scottish Parliament, I shall volunteer Stewart Stevenson for that journey and hope that it is a safe one for Scotland's sake.

Mr Home Robertson: Think about my constituents.

Mr McAveety: At least three members have touched on the point that Colin Fox made about the welcome nature of the museum itself and how we can develop that with National Museums of Scotland over the next five-year investment plan.

The investment plan is to find a way of turning the Museum of Flight into a world-class museum. Other tourist attractions are central to that task. Concorde exemplifies the kind of product that has been created in Scotland and illustrates the contribution that our engineers and designers have made to such developments. We have supported the appointment of a new general manager at East Fortune to assist with the development of the museum.

A number of members raised the issue of broader educational support. Through NMS, we are examining ways of improving access for educational groups. In partnership, we can also pursue the issue of transport access. I encourage members to write directly to the Minister for Transport and to me to facilitate dialogue on that matter.

As Colin Fox indicated, the Museum of Flight has a charging policy. Some time ago we removed charges from our national museums. Over the next year or so, a review of charges will take place as part of our museum strategy. Although adults pay charges, there are concessions for some adults to minimise the impact of charging. I stress that all the money raised from charging is invested in the development of the museum. It is not easy for the museum to move away from charges, because they generate significant income. However, over the next few years there will be opportunities for some debate on charging.

It has been extremely valuable to hear members speak not just of the importance of having historic artefacts at the museum but of its significance for

the economic regeneration of parts of East Lothian and of the wider Lothian and Scottish economy. One of the key challenges that I face is to maximise the opportunity that has been created by growth in world tourism. We in Scotland must seek a share of that growth. One of our key ambitions is to grow our share of the world tourism market, which is increasing by 4 per cent annually, to ensure that Scotland and Scots benefit from it. A key element in any tourism strategy is the quality of attractions that exist and that we can develop further. We are talking not about investing in a brand-new development in East Lothian, but about enhancing what already exists there. If we are able to secure Concorde from BA, it will make an incredible contribution to the future development of East Lothian.

We acknowledge the contributions that many folk have made and the use of the site for other purposes in Scottish history. We also recognise that we must make a coherent application to British Airways. We hope that before the company makes a final decision, it will take into account the fact that we can put together a broader strategy that enhances Concorde. We are not talking simply about providing a final location for Concorde when it is no longer in operation, but about using Concorde to amplify other debates about the importance of design and technology to communities and economic development.

I hope that we can progress this issue effectively for Scotland and nose ahead of our competitors. Hopefully, the Executive can make a genuine difference. If members would like to inform me of insights that could usefully be passed on to British Airways, I will be happy to assist. I commend John Home Robertson and all the other members who have spoken this evening about an aircraft that is worth acquiring for Scotland and our museum collections.

Meeting closed at 17:43.

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