MEETING OF THE PARLIAMENT

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

Time for Reflection

The Presiding Officer (Alex Fergusson): Good afternoon. As always, the first item of business this afternoon is time for reflection. Our time for reflection leader today is the Rev Tony Stephen, of Banchory Church of Scotland youth ministry.

Rev Tony Stephen (Banchory Church of Scotland Youth Ministry): At school, I was forced to do something called Scottish country dancing. I hated it. I had to learn embarrassing things like pas de Basque and, even worse, I had to dance with girls. I could not get any of it right, so every week, at exactly the same time, I became prone to a mysterious tummy bug, which meant that I could sit at the side, in fear, and learn nothing about Scottish country dancing.

I then avoided all kinds of dancing until I came to Banchory. At my first ceilidh, I learned a wonderful secret. You see, the young people in Banchory could not give a hoot about the rules of Scottish country dancing. You are as likely to see them bouncing around like kangaroos or pulling shapes like John Travolta as you are to see a formal set or a pas de Basque. They know that the secret is not in getting the steps right: they are there to dance themselves dizzy, to laugh themselves hoarse and to squeeze every drop of flavour from the occasion. They are able to let go, which I find hard to do. I have therefore savoured every moment of every ceilidh with those young people in Banchory.

In Mark's gospel, some people confronted Jesus. They asked, "Why do the followers of John the baptizer and the Pharisees take on the discipline of fasting, but your followers don't?" Jesus said, "When you're celebrating a wedding, you don't skimp on the cake and wine, you feast. As long as the groom is with you, you have a good time. There's a time for dancing and a time for fasting."

Someone once told me that he would be more interested in Christianity if Christians looked a bit more like they had been saved. Not a week goes by when I do not hear a bad news story about our young people today. People who make such comments have not met the 50 or 60 young people whom I spend my time with each working week. They remind me daily that they know exactly what Jesus was talking about. After all, Jesus came to start a movement, not an institution; to invite us to a dance, not to a funeral.

Perhaps you signed up for a movement but sometimes feel that you are propping up an institution. Perhaps you feel that you spend too much time sitting at the side in fear. I pray that the words of Jesus and the example of our young people can inspire you, like me, again. Whether we know the right steps, when the band strikes up, I want to be one of the first out of my seat.

Grace and peace to you all today. Amen.

Points of Order

14:34

Robert Brown (Glasgow) (LD): On a point of order, Presiding Officer. I raise a point of order, under rule 13.2 of the Parliament's standing orders, on the Scottish Government's announcement yesterday on the Scottish futures trust, which is probably the most important issue in a very sparse Government policy and legislative landscape, and affects directly whether local authorities will be able to fund hundreds of much-needed modern schools and hospitals throughout Scotland.

It is outrageous that the announcement should bypass the Parliament and be made by the First Minister at an industry conference and media briefing. I go further and say that it is a direct snub by the Government to the authority of this Parliament. Instead of a ministerial statement or a debate—instead of this Parliament and the elected representatives of the people cross-examining ministers on the biggest U-turn yet by this Government—the Scottish Government ran up the white flag and bottled its plain duty to this Parliament. The excuse was that the announcement was made to Parliament by way of an inspired parliamentary question, a method that was designed for far less significant announcements.

Presiding Officer, I seek your advice on whether that was appropriate. As you are aware, there is specific guidance from the Presiding Officers, which was approved fairly recently, on when ministerial statements are appropriate. The guidance states that statements are appropriate on

"matters of significant and … on-going public … importance … issues where there is Parliamentary and public expectation that the Executive will want to explain its … position"—

the Scottish futures trust is manifestly such an issue—and "set-piece occasions". The announcement of the Scottish futures trust qualifies under all those headings.

It is manifest that the Scottish National Party Government could and should have programmed a ministerial statement, as the guidance encourages it to do. We are inundated with ministerial statements by the Administration on matters of modest parliamentary significance. Ministers will be telling us next that the legislative programme or the budget can be announced by means of an inspired PQ.

It is true that after I made a fuss in the Parliamentary Bureau, the Minister for Parliamentary Business—realising, no doubt, that the game was up—offered a ministerial statement on the matter in the business motion that he will move tonight. That is totally inadequate. A statement next week is about as useful as swimming trunks to an Eskimo.

Presiding Officer, I seek your guidance. The procedure that has been used on this occasion manifestly breaches both the spirit and the letter of your guidance on ministerial statements. Are you able to assist the Parliament on this matter?

The Presiding Officer (Alex Fergusson): I thank the member for giving me advance notice of his point of order.

The minister has indicated that he would like to respond, so I will give him an opportunity to do so. I refer members to the good-practice guidance on announcements by the Scottish Executive or Government, which sets out a number of methods by which the Government can make statements to the Parliament. It is for the Government to decide which of those methods is most appropriate in the circumstances, but this is clearly a matter of some importance. I am sure that the minister heard what the member had to say.

The Minister for Parliamentary Business (Bruce Crawford): Presiding Officer, thank you for giving me the opportunity to respond. I thank Robert Brown for giving me notice that he intended to raise this point of order.

I do not want to get involved in the invective that Robert included in his point of order, but I point out that many of the ministerial statements that we have made in the Parliament were requested by members of the bureau. On many occasions, such statements have been made at the request of the Opposition, so it is not accurate for the member to suggest that all ministerial statements are Government contrived. I can prove that case.

I put on record that the Scottish Government has followed to the letter the Presiding Officers' good-practice guidance on announcements by the Scottish Government. The guidance, which was agreed by all business managers, outlines five steps that may be taken when major policy or spending announcements are to be made. I emphasise the word "major". We have taken not one but three of those five steps. First, we agreed that John Swinney should appear before the Finance Committee next week to make a ministerial statement, as the committee requested. Secondly, we wrote to the convener of the Finance Committee to inform him of the business plan for the Scottish futures trust that the Cabinet Secretary for Finance and Sustainable Growth has outlined. Thirdly, as Robert indicated, yesterday the bureau agreed unanimously that the Government should make a statement on the

matter, although perhaps not exactly when Robert would like it to be made.

The Presiding Officer: I caution the minister against the use of first names only.

Bruce Crawford: I apologise.

We have taken three of the major steps that are set out in the Presiding Officers' guidance.

I am aware that concerns have been expressed about an announcement that Richard Lochhead is making this afternoon and I am looking into whether good-practice guidance has been followed in that case.

George Foulkes (Lothians) (Lab): On a point of order, Presiding Officer. The minister's response is entirely inadequate. It does not deal with the issues that Robert Brown was right to raise and it makes a mockery of you and the Parliament. We are talking about a major statement that ought to have been made to Parliament, but which was made in a press conference outside this Parliament. Precisely the same thing happened with the ScotRail franchise extension statement—

The Presiding Officer: I am not entirely clear what your point of order is.

George Foulkes: I suggest that because the minister's statement was inadequate, you should take back to the bureau the whole question of ministerial statements. You will remember that last week I raised my concern about what was a party-political broadcast by the First Minister—a statement with no substance whatsoever. Now we have some real substance, there ought to be a statement to Parliament. You and the bureau should take that on board—

The Presiding Officer: I do not accept that this is a genuine point of order. What is right or wrong is for me to determine in this chamber. I said in response to Mr Brown's point of order that the matter is of some importance and it is for the Government to decide how to go about making statements. I respectfully suggest that both members have had the opportunity to make their points and that they are now on the record.

Des McNulty (Clydebank and Milngavie) (Lab): On a point of order, Presiding Officer. In that context, there is a precedent in this Parliament. When the content of a statement was released to the press in advance of the material being discussed in the chamber, the minister concerned was obliged by the Presiding Officer at the time to come to the chamber and was not given the opportunity to make the statement that he intended to make. We cannot simply ignore such precedents, Presiding Officer. It has to be the case that if ministers do something that is clearly outwith the requirements for a major statement that should come to Parliament first, they are held to account by the bureau and yourself. The precedent has to be addressed.

Bruce Crawford: On a point of order, Presiding Officer. I ask you to confirm that information about the Scottish futures trust and the inspired PQ was sent to the convener of the Finance Committee before—[*Interruption.*]

The Presiding Officer: Order.

Bruce Crawford: That happened before anything appeared in the media. The situation is completely different from the one referred to by Des McNulty.

The Presiding Officer: I point out that the matter should be addressed by the good-practice guidance on announcements. Given the points raised in the chamber today, I will be amazed if the matter is not raised in the Parliamentary Bureau, which is the right place for such discussions to take place, rather than in the chamber. Members have had their opportunity to put their points on the record and I suggest that we move to the next item of business.

Iain Smith (North East Fife) (LD): On a point of order, Presiding Officer. It is on a related but different topic, which the Minister for Parliamentary Business mentioned it in his comments. Members will have noticed that the Cabinet Secretary for Rural Affairs and the Environment is not in the chamber at the moment. According to the BBC, that is because he is currently in Pittenweem in my constituency, where he is unveiling

"proposals aimed at strengthening Scotland's coastal fishing communities for 'generations to come'."

Although I welcome Mr Lochhead's recognition of the importance of the village-based fishing industry, particularly in Pittenweem, I am deeply concerned by yet another example of discourtesy to this Parliament and its members by a Government minister. It is surely not acceptable that a constituency member should learn of a visit to his constituency through the BBC. It is surely a serious discourtesy to the Parliament and the many members who represent fishing communities that Mr Lochhead is in Pittenweem making an important announcement on Government fishing policies to the press and not to Parliament.

Will you look into this matter in order to protect the right of all members of the Scottish Parliament to represent their constituents by questioning ministers on their policies? Will you raise with the First Minister the need to ensure that his ministers follow the protocols on visits to constituencies and that the ministerial code is followed, which states clearly that important Government policy announcements are to be made to the Parliament

in the first instance? Just for information, Presiding Officer, there has not yet been an inspired PQ and no information has been given to Parliament about this important fishing announcement.

The Presiding Officer: I thank the member for advance notice of his point of order. He raises two issues. With regard to the minister not informing the member of the visit to his constituency, I ask the member to raise the matter with me in writing under the code of conduct and I will look into it.

Secondly, I am unaware of the content of the announcement to which the member refers, but I take the opportunity to remind the Government that major policy announcements should not enter the public domain before or without being communicated to the Parliament. That principle is covered, as we have just discussed, in the good-practice guidance on announcements by the Scottish Executive and in the ministerial code.

I suggest that we are eating greatly into time for a very important subject.

Elaine Murray (Dumfries) (Lab): On a point of order, Presiding Officer. With regard to the Minister for Parliamentary Business's point of order, the e-mail in question was not circulated to Finance Committee members until a quarter to 11 yesterday, by which time the matter had been covered on "Good Morning Scotland" and the Scottish Government's website.

The Presiding Officer: Again, if the member raises the issue in writing with me, I will consider it.

We really should move to the next—and very important—item of business. We have already eaten severely into the time allowed for questions.

Smoking Prevention Action Plan

The Presiding Officer (Alex Fergusson): The next item of business is a statement by Shona Robison—[*Interruption.*] Could we please have some order in the chamber? The next item of business is a statement by Shona Robison on the smoking prevention action plan. As the minister will take questions at the end of her 15-minute statement, there should be no interventions.

14:46

The Minister for Public Health (Shona Robison): I am pleased to announce the publication today of our new action plan, which sets out a longer-term strategic approach to smoking prevention activity in Scotland. Although we will continue to do all that we can to help smokers to quit, the plan contains an ambitious programme of specific measures to discourage children and young people from starting to smoke and becoming regular smokers.

A generation after the health risks associated with smoking were demonstrated beyond dispute, smoking remains one of the principal causes of illness and premature death in Scotland. It is still linked to 13,000 deaths—and many more hospital admissions—each year. Apart from the human tragedy that those statistics represent, there is also a considerable resultant economic burden. The annual cost of hospital care alone is estimated at more than £200 million and of lost productivity at £450 million. Smoking also disproportionately affects those who are already disadvantaged by poverty and is a major contributor to health and premature mortality inequalities. As a result, tackling smoking-related harm lies at the heart of our health improvement and health inequalities drive.

In recent years, of course, significant progress has been made in reducing the cultural acceptability of smoking, including the bold and decisive legislative action taken by this Parliament in introducing the smoking ban and increasing the age of sale for tobacco from 16 to 18.

While the decline in population smoking in recent years is welcome, we must continue with firm action to reduce smoking's prevalence even further. Although we have already committed to continued investment in smoking cessation services, we also want to focus on preventing smoking uptake by children and young people.

Let me, if I may, remind members why a focus on children and young people is so vital. Smoking is dangerous at any age, but in this case the statistics are stark. Eighty per cent of smokers start in their teens. Moreover, the younger that people start, the more likely they are to smoke for

longer and to die early as a result. Worst of all, someone who starts smoking at 15 is three times more likely to die of cancer than someone who starts in their mid-20s.

I am sure that members will agree that those are compelling reasons for shifting the focus more clearly towards smoking prevention. In a nutshell, we want to do everything we can to denormalise smoking within society in Scotland to help our young people in particular to choose not to smoke. Our proposals are in line with the Scottish Government's desire, as set out in its economic strategy, to create a more successful country with opportunities for all to flourish.

The proposals that are set out in "Scotland's Future is Smoke-free: A Smoking Prevention Action Plan", which is published today, were developed in consultation with the ministerial working group on tobacco control. I chair that group, and I am grateful for its members' advice and support.

I am grateful also to Dr Laurence Gruer and other members of the expert smoking prevention working group, whose recommendations form the basis of the measures in the action plan. The group thoroughly investigated the issues and, importantly, has provided a strong evidence base for our proposed action. Of course, its recommendations were subject to widespread consultation. I am grateful to all of those who took part in the consultation, including young people who fed in views through focus groups and a Young Scot online survey.

The crucial point is that, although individuals and organisations might take issue with particular recommendations, the consultation results were overwhelmingly positive on the need for a longer-term strategic approach to smoking prevention. They also gave the Scottish Government a strong mandate to act decisively to stop a new generation of young Scots from becoming addicted to tobacco.

The challenge is to make cigarettes and other tobacco products less affordable, less accessible and less attractive to children and young people. Of course, that cannot be achieved by the Scottish Government alone: ownership and action are required from a wide range of individuals and organisations, including national health service boards, local authorities, third sector bodies and the business sector.

What do we propose? We propose to deliver a co-ordinated programme of measures that respond to all the factors that influence behaviour. The plan sets out action in five broad areas. First, we propose to educate and to promote healthy lifestyles through measures that make clear to children and young people the risks that are associated with smoking and which do everything possible to counter the idea that there is any link between smoking and glamour, celebrity, maturity and independence. Actions that we will take in that regard include the promotion of an all-encompassing approach to health and wellbeing in Scottish schools, which will be fostered through health-promoting schools, the curriculum for excellence and improvements in substance misuse education in schools; more effective engagement with young people in non-school settings, such as in universities and further education colleges; and engagement with members of harder-to-reach groups, such as people who are not in employment, education or training, or those who are in occupations or settings in which smoking levels are higher than average. We will also ensure that tobacco issues are addressed fully in the new health improvement social marketing strategy to discourage smoking uptake and promote healthy, smoke-free lifestyles.

Secondly, we propose to reduce the attractiveness of cigarettes through measures that will counter positive images of cigarettes in the media and at points of sale, which will reduce the opportunities for children and young people to be exposed to smoking. All such measures are important, but the one that I expect to have the greatest impact is our proposal to introduce legislative controls to further restrict the display of tobacco products at points of sale. Even though tobacco advertising was banned in 2002, there are growing concerns that prominent and public displays of cigarettes and other tobacco products in shops and at other points of sale are undermining our wider tobacco control efforts to denormalise smoking by shifting cultural perceptions of smoking and discouraging young people from starting to smoke in the first place.

Children and young people have been found to be far more receptive to tobacco advertising than are adults. The evidence is clear: young people who are exposed to tobacco advertising and promotion are more likely to take up smoking. There is also evidence that displays stimulate impulse purchases among people who did not intend to buy cigarettes and, importantly, among smokers who are trying to give up. Giving cigarettes pride of place in shops—a position that is much sought after in product placement terms—sits uncomfortably with our ambition to create a climate in which everything possible is done to dissuade people, particularly children and young people, from smoking.

I know that sections of the retail sector will be concerned about restrictions on displays, which it fears will impact adversely on businesses. However, it is clear that point-of-sale display is being used as a promotional tool. Protecting children and young people from the impact of

tobacco must be paramount. There are occasions when benefiting the public health of the nation must take precedence, and this is such an occasion.

As we move forward with the legislative process, I will engage fully with retailers on the proposal. International experience has shown that the implementation of tobacco display bans has not had a dramatic impact on local businesses. For example, following a ban on displays in one of the Canadian provinces, no shops were forced to close. Moreover, experience suggests that the cost of refit is largely borne by the tobacco wholesalers that supply tobacco products to the retail chains. The important point is that the removal of displays changes public perceptions of smoking.

Thirdly, we propose to reduce the availability of cigarettes by stepping up enforcement of tobacco sales law to ensure that cigarettes are not sold to minors and to prevent access to smuggled or counterfeit cigarettes. It is clear that, despite what the law says, underage young people have little difficulty accessing cigarettes if they want them. We will therefore pursue a two-pronged approach that involves more effective enforcement of the law by local authorities, which will be secured by introducing an enhanced tobacco sales enforcement programme coupled with increased emphasis on proof of age, and a review and update of tobacco sales law to introduce tobacco licensing and new sanctions, such as cautions and fixed-penalty notices for breaches of the law. We will also examine minimum pack sizes and sales from vending machines as part of the legislative review. This update of tobacco sales law is long overdue. Currently, the provisions governing tobacco sales are contained in the Children and Young Persons (Scotland) Act 1937, which was last subject to a major review in 1991.

There are, of course, a number of possible licensing options, and in developing detailed legislative proposals we will examine them closely in consultation with key stakeholders, including the Convention of Scottish Local Authorities, local authorities and retailers. My preference is for an approach that falls somewhere between the positive scheme favoured by Christine Grahame in her member's bill proposals and a negative licensing system that would bite only if retailers were found to be selling to underage young people. We are attracted to an approach that allows tobacco retailers to be clearly identified—which will enable trading standards officers and others to offer advice and support to them to avoid illegal sales—offers a proportionate response to the problem, is administratively simple and places the minimum burden on business.

The fourth area involves measures to reduce the affordability of cigarettes, which means ensuring that cigarette prices are sufficiently high to discourage children and young people from smoking. The price of tobacco products is one of the most important factors in determining consumption, so taxation policy is one of the main tools for preventing tobacco consumption. Of course, the availability of cheaper smuggled tobacco products—both cigarettes and loose tobacco—sold from vans at open-air markets and by other means in communities across Scotland undermines fiscal policies that are aimed at reducing tobacco consumption.

In addition to keeping pressure on the United Kingdom Government to ensure that tobacco duty remains sufficiently high, a protocol is being developed between Scottish trading standards services and HM Revenue and Customs on a collaborative approach to reduce the impact of those illicit products on Scottish communities. Such partnership working is important. Smuggled tobacco is more likely to be sold in deprived areas and it is increasingly targeted at children, so smuggling appears to have a disproportionate impact on young people in those areas and to be a factor in perpetuating health inequalities.

It is vital, too, that the action that we propose to tighten up illegal sales from legitimate business is matched by firm action on illicit tobacco sales. As part of the review and update of tobacco sales law, we will examine the question of minimum pack sizes. We know, for example, that young people are three to four times more price sensitive than adults, so as part of the legislative review we will consider the relationship between packs of 10 cigarettes and tobacco consumption, which I mentioned earlier.

The final area of the action plan describes how we will deliver, resource and measure progress. Much of the action in the plan will be delivered using existing resources, but in some cases there may be a requirement to refocus or prioritise efforts, for example in social marketing and communications activity.

We will continue to make substantial specific funding available for tobacco control. An additional £9 million will be made available over the next three years to boost delivery of actions in the plan and bring the total specific funding for tobacco control to £42 million from 2008-09 to 2010-11. That is in addition to the £2 million of annual funding that is allocated to tobacco control in national health service boards' unified budgets. The new £9 million is intended to support local delivery of the action plan, and £4.5 million will be allocated to NHS boards to enable then to co-ordinate action locally to underpin the proposed measures and to ensure that they are embedded in local tobacco control programmes. A similar

amount will be allocated to local authorities to enable them to step up enforcement activity. We have also pledged to continue to support the activities of the voluntary sector—ASH Scotland's partnership action on tobacco and health, and the Scottish tobacco control alliance—to allow it to contribute fully to the plan's delivery.

In recognition of the actions proposed in the plan and to drive delivery, we have set new targets for 13 and 15-year-olds and introduced a new target for 16 to 24-year-olds. We will also establish a research and evaluation framework to assess impact.

In my statement I have provided a brief overview of our proposals. Our proposed programme is ambitious. Although I am sure that it will be welcomed as a whole, I am conscious that members might take issue with some elements of it. In particular, some members might question the need for further legislative action on tobacco. Nevertheless, given the devastation—I use the word advisedly—that tobacco has wreaked on the Scottish people, causing nearly 700,000 premature deaths during the past 50 years, we owe it to Scotland and to the Scottish people to take firm and decisive action to prevent damage to future generations. There are times when the public health benefits of a policy must be Government's overriding concern, and this is just such a time. The perceived benefits to society of preventing young people from taking up smoking supersede any minimal costs that might be imposed on Scottish tobacco retailers.

I am sure that no one in the Parliament takes issue with our desire to denormalise smoking in Scotland and to save our young people from the misery and distress of wholly preventable cancer and heart disease. By passing historic laws to ban smoking in public places in 2005, the Parliament showed that it was prepared to act collectively and courageously in the interests of public health. I call upon the Parliament to do so again by supporting the Scottish Government in our further endeavours to secure a healthier, smoke-free future for Scotland.

The Presiding Officer: Members will realise that we are under considerable time pressure. I am keen to call all members who want to ask questions, so I ask all members, including front-bench members, to avoid unnecessary dialogue and to keep questions short and succinct.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I will try to assist you in that, Presiding Officer.

I welcome the minister's statement and thank her for providing an advance copy. I join her in commending the action plan, which is excellent. We entirely agree with many of the measures that are proposed, which follow the advances that have been achieved through the national ban on tobacco advertising and the ban on smoking in public places, which was a landmark for the UK.

There are worrying signs of a growing gap between the genders in relation to smoking habits. Some 12 per cent of 15-year-old boys smoke, whereas around 18 per cent of 15-year-old girls smoke. That needs to be addressed. I welcome the new targets for 16 to 24-year-olds, which will focus minds usefully.

The Royal Environmental Health Institute of Scotland and ASH Scotland have both expressed concern to me about the new system of funding through local authorities. According to REHIS, there is evidence that

"the funding may not even reach Environmental Health Departments, let alone be used specifically in support of smoke-free legislation."

In the context of proposed legislation and the emphasis on test purchasing, will the minister say how she will secure with local authorities clear agreements on delivery?

My second and final question relates to budgets. According to Scottish Government replies to parliamentary questions, the smoking cessation budget has been reduced from £601,000 to £500,000 and will flatline, the voluntary sector budget is being reduced from £770,000 to £737,000 and will flatline, and the communications budget is being reduced from £601,000 to £500,000 and will flatline. How will that approach support the Government's proper emphasis on the problem of smoking through smoking cessation measures, through support for the voluntary sector—which delivers for young people in particular—and through focused communication?

Shona Robison: I thank Richard Simpson for his supportive comments.

The disparity between boys' and girls' smoking levels is a reason for the new more specific targets, which will help us to monitor progress on that front.

On funding for enforcement, an additional £4.5 million for local authorities will be allocated under the terms of the concordat between the Scottish Government and local government. We are in the process of agreeing a set of outcomes with the Convention of Scottish Local Authorities, local authorities and the Society of Chief Officers of Trading Standards in Scotland, which will ensure a consistent approach to enforcement. Test purchasing programmes will be part of that.

I will tell Dr Simpson about outcome measures that we are considering. We are, for example, considering an increased target for enforcement activity at retail level under which 10 per cent of

tobacco retailers would be subject to test purchasing, with that figure increasing to 15 per cent by 2011. The targets that we expect local authorities to deliver under the terms of the concordat are specific and, of course, authorities are very keen to deliver. In putting together the proposals, we had a close working relationship with COSLA, whose member authorities are very much signed up to the process.

On the smoking cessation budget, I say again to Richard Simpson, for the sake of clarity, that the Government is investing £33 million over the next three years. That compares to £27 million over the previous comprehensive spending review period, so the budget increase is £6 million. We want to use the resource to target people better, including young people. Thus far, the experience of delivering smoking cessation activity to groups, particularly young people in more deprived communities, has not been good. We want to get that right.

I also say to Richard Simpson that, as part of our agreements with the community pharmacy sector, we are looking to extend access to smoking cessation support and to complement the wider range of smoking cessation services that health boards provide to help smokers to successfully stop smoking. We are working with community pharmacists across Scotland to provide a national smoking cessation service as part of the public health service element of the new contract. All that adds up to good input into smoking cessation.

Jackson Carlaw (West of Scotland) (Con): I am still trying to get my head around what Robert Brown imagines Eskimos wear when they go swimming.

I add my customary thanks to the minister for advanced sight of what is, undeniably, a busy statement. The minister rightly states that she intends to focus on actions to deter young people from smoking, noting that smoking commences in the teenage years. Does she share my view that education to curtail that trend needs to start earlier than that? In addition to the bodies that she mentioned in her statement, parents too must be made aware—whatever their practice—of their responsibility to discourage yet another generation from becoming smokers.

We welcome the action regarding proof of age and more rigorous enforcement. However, in terms of drawing up her strategy on retail premises, will the minister take into account the concerns of small retailers? Typically, only one person is on duty in such outlets and all the stock on sale is on view and to hand. If the retailer is required to take their attention from the store in order to retrieve items from a concealed area, such retail premises may be made open to increased incidence of theft.

We share the minister's view that the more administratively simple a licensing scheme is, the better. However, anyone of any age can access products from vending machines. The minister's committing merely to look at sales from vending machines is possibly the weakest component of her statement. Why is that component so weak?

Shona Robison: I confirm our belief that parents have a critical role—of course we want to involve them. As part of our emphasis on denormalisation of smoking, we need to involve parents. They need to set themselves up as role models for their children and to not smoke in front of them. We must try to put across messages such as that, which we will do as part of our social marketing campaign.

I turn to the concerns of small retailers in respect of the safety and potential theft of stock. We will discuss the detail of implementation with retailers, including the procedures that should be put in place, such as storing stock below the counter or installation of screens. There are international examples of that, including in Ireland where retailers are required to store tobacco products below the counter. In Nova Scotia, it has been done, but slightly differently. There are international examples on the best way forward.

As a point of principle, we will do this. We will of course involve retailers in discussion about the details of measures that are to be introduced and we will take on board the issues that small retailers have raised.

On vending machines, we want to look at the evidence base on what is best. Should we remove vending machines entirely or have token-operated machines? A number of options are available to us. We will take action: we are simply deciding on the type of action that we should take. We want to look at the evidence in more detail before we decide on the most appropriate route.

Ross Finnie (West of Scotland) (LD): I thank the minister for the advance notice of her statement. Clearly, in common with all members, the Liberal Democrats support the continuation of measures to make Scotland a smoke-free zone—if that is the current language.

We welcome much that is in the statement. The only matter that we wish to probe further is the legislative review, to which the minister referred in the latter part of her answer to Jackson Carlaw. Given that almost everything in the statement and the action plan is based on the recommendations from the smoking prevention working group, you therefore have available a considerable body of evidence on many of the matters. Will you tell members whether you intend to inject some

urgency into the legislative review? You said that you will consider introducing minimum pack sizes, and page 14 of your statement mentions the compelling evidence that children are more susceptible to the influence of price. Therefore, what other evidence do you need before you proceed to tackle those issues?

Jackson Carlaw rightly asked about vending machines. We know from the British Medical Association that the Scottish data say that one in 10 regular smokers aged 13 to 15 reported buying cigarettes from vending machines. In common with Jackson Carlaw, I am unclear as to what further evidence you require before taking more urgent action.

Finally—

The Presiding Officer: Very briefly, please.

Ross Finnie: Sorry—I will be quick. Christine Grahame's consultation on her proposed member's bill on the issue sets out the case for a positive licensing scheme while acknowledging that a negative scheme could be used. However, I am intrigued to know what a hybrid scheme is. Something is either a negative licence or it is not. Can you help us on that? I hope that the issue will not delay the introduction of legislation.

The Presiding Officer: I am not sure that Mr Finnie's definition of "briefly" and mine are exactly in tune.

I caution members please not to use the second person singular. I do not know how long I am going to have to go on about that, but I will go on as long as it takes.

Shona Robison: I say to Ross Finnie that there will be no delay. We will legislate at the earliest legislative opportunity, which is likely to be in 2009-10. There is no question of our having to gather evidence on the principle of our proposals. However, various options exist in respect of the details of how we progress with implementation.

The licensing system to which I pointed would in essence be a system that would require people who sell tobacco products to register. Trading standards officers would thereby have a system and a list to work with to ensure that retailers were complying. If, for example, a retailer was found to be selling tobacco products to underage people, the retailer would be removed from the register and would no longer be able to sell those products. That goes some way beyond a traditional negative licensing system, but it does not go as far as a positive system. I believe that that strikes the right balance, although the proposal will be subject to more discussion as the legislative process continues.

The Presiding Officer: We come to questions from back-bench members. Ten members wish to ask questions and I have 10 minutes to fit them in, so that is fairly simple.

Christine Grahame (South of Scotland) (SNP): My question will be brief because Ross Finnie has asked part of it. I turn to the comments on the proposed legislative scheme. Minister, now that you have said that—

The Presiding Officer: Second person singular, Ms Grahame.

Christine Grahame: Minister, can you tell me—

The Presiding Officer: No—you should say, "Can the minister tell me", not, "Can you tell me". I am the only "you".

Christine Grahame: I beg your pardon—I must learn. I will start again.

First, can the minister tell me the difference between registration and licensing? I feel so inhibited now. Secondly, I believe that the scheme is to be mandatory. Will you confirm that and, if it is to be mandatory, what would be the penalties? [*Laughter.*] Have I done it again?

The Presiding Officer: Please continue.

Christine Grahame: This is taking ages.

Will the minister keep an open mind in relation to my proposals? I intend to publish the responses to the consultation on my proposed member's bill next week. Of the respondents, 58 per cent are in favour of positive licensing and an additional 7 per cent are in favour of any form of licensing, so that makes 65 per cent in favour.

The Presiding Officer: Briefly, please.

Christine Grahame: My proposals are much more radical and would deal with vending machines. Will the minister give due consideration to the responses to my consultation?

Shona Robison: The debate on Christine Grahame's member's bill proposal has been useful and has helped to bring to the surface many of the licensing issues. It will certainly help us in developing our legislative proposals. I reiterate that my concern is to come up with a system that meets our need to know who the retailers are and to ensure that the law is adhered to.

Of course, a registration system requires people to register, although it does not require them to receive or apply for a licence, as Christine Grahame has been advocating. The proposal goes some way towards creating a system in which we would know who the retailers are. The list can then be monitored and worked with by trading standards officers.

On the new penalty system that we wish to introduce, we would want to give trading standards officers a bigger toolbox of sanctions, including the

power to issue cautions and fixed-penalty notices, which could be used against those who would flout the law. Retailers could, under a registration system, lose the right to sell if they were to breach the law by selling to underage people, for example. That would be a good package of measures to ensure that swift action could be taken against those who flout the law.

Margaret Curran (Glasgow Baillieston) (Lab): Will the Scottish Government introduce a debate on this subject, given that we have had a curtailed time in which to discuss it this afternoon?

In the drive to target resources at those who are most in need of intervention, will health boards be directed to spend more in deprived communities and on deprived individuals?

What specific actions is the Government introducing to tackle the gender gap in smoking behaviours?

Shona Robison: I will take the last question first. The new targets focus very much on smoking rates among girls and boys so that we can monitor the success of targeting in smoking cessation plans for girls and whether the message is getting across to girls in the same way as it is to boys. We know that the rate of smoking among boys is falling more quickly than it is among girls, which is the reason for the new targets.

On the question about deprived areas, the answer is, of course, yes. Under the new smoking cessation targets for young people, we want to get to the people who are harder to reach. We will test new smoking cessation measures in harder-to-reach communities, and we will particularly target young people. We will ensure that measures for communities in which there is greatest need in terms of reducing smoking levels are adequately resourced, so that those needs can be met.

On the debate that Margaret Curran calls for, it is not my fault that the discussion this afternoon has been curtailed. I am happy, however, to bring forward the terms of a debate after the summer recess. There will, throughout the legislative process, be plenty of opportunity to discuss the matter, for ample scrutiny and to debate many of the issues.

The Presiding Officer: I ask for strictly one question per member from now on, please.

Kenneth Gibson (Cunninghame North) (SNP): I warmly welcome the minister's comprehensive statement and the publication of the smoking action plan. Astonishingly, a minority of people, particularly young people, believe that smoking's adverse impacts come more in later life. Some young women and girls wrongly perceive that smoking might even have benefits.

The Presiding Officer: A question, please.

Kenneth Gibson: That might contribute to the gender gap. Can the minister clarify what specific steps will be taken to tackle myths among young people such as the those that say that smoking helps slimming, that it reduces stress and that it is not highly addictive?

Shona Robison: I absolutely agree that those are crucial elements. The overarching aim is to change the image of smoking and to denormalise smoking. Improvements in substance misuse education will be very important. A lot of work is going on to make such education more relevant to young people and to ensure that we target young people who are not in employment, education or training, who are the hardest to reach. We will be considering more imaginative ways of doing that in order to achieve a better reach through the policy.

James Kelly (Glasgow Rutherglen) (Lab): The minister has suggested that she will introduce legislation in 2009-10. Given the concerns about vending machines and minimum pack sizes, will she commit to returning to Parliament at the earliest opportunity to let us know what her thinking is on those matters, and on how it will inform whether those measures will be included in the eventual legislation?

Shona Robison: I am happy to do that. We can explore some of those matters in the debate that I am happy to bring forward after the summer recess. I am clear that the debate will not be on the principle of whether we should introduce the measures that I have set out: the question is about how we will do it.

There are options on vending machines: we could ban them outright or we could restrict their use through use of tokens. Those are legitimate areas for debate on implementation of what we want to achieve, and I am happy to have that debate.

Mary Scanlon (Highlands and Islands) (Con): Will the restrictions on displays at the point of sale apply equally to supermarkets and small shops? Will there be a consequential increase in the number of trading standards officers and school nurses?

Shona Robison: The restrictions will absolutely apply in the same way to supermarkets as they will to other retailers.

As I said, £4.5 million in additional resources is going to local authorities over the next three years. That equates to a minimum of one new trading standards officer per local authority. Obviously, given the breakdown of the resources, the larger local authorities will have many more than that, but there will be a minimum of one additional officer per local authority. The work that they will carry out with the health boards will be important. The input from community nurses and work with

parents and children will all be joined up as part of the way in which we will implement our proposals.

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): The minister said that, in making legislative progress, there will be full engagement with retailers. Given that there are already examples of good and bad practice, what engagement has she had with retailers before making her statement today?

Shona Robison: We have been engaging with retailers and getting their views. Retailers also sit on the working group that came up with the proposals. There has been a vigorous debate on some of the proposals, and the retail sector supports a lot of the stuff in the plan, although perhaps not every item. For example, it is keen on the action that we want to take on tobacco smuggling, which undermines legitimate tobacco sales. Although retailers support elements of the plan, it is important that we engage them further on the detail of implementation, but not on the principle, which has been agreed.

Michael Matheson (Falkirk West) (SNP): The minister referred in her statement to restricting advertising displays for the sale of cigarettes in shops, including supermarkets. Will she also consider the physical location of cigarette counters in many of our large supermarkets? They are designed to be the last port of call, where customers can get their cigarettes and lottery tickets on their way out the door. Even once the displays are taken away, those cigarette counters will continue to have highly prominent locations within large supermarkets. Will she consider how we can ensure that they are not in such prominent locations in such premises?

Shona Robison: I am certainly willing to give that point further consideration as we implement the detail in legislative proposals.

Des McNulty (Clydebank and Milngavie) (Lab): Research suggests that under-16s are much more likely than other tobacco consumers are to use newsagents, tobacconists and local shops to buy cigarettes. To ensure that that is acted on, will targets be set—as part of the single outcome agreements—for test purchasing and prosecutions of shopkeepers who sell tobacco to underage smokers?

Shona Robison: We are considering the outcomes at the moment. One of the outcomes that we are working on is to reduce the percentage of retailers who sell cigarettes to persons under 18, and the target that is being discussed is to reduce it to 10 per cent by 2011. The issue features strongly in the outcomes that are being discussed with COSLA at the moment.

The Deputy Presiding Officer (Alasdair Morgan): I am afraid that we now have to move on to the next item of business, so I express my regrets to members whom I was unable to call.

Hepatitis C

The Deputy Presiding Officer (Alasdair Morgan): The next item of business is a debate on motion S3M-1943, in the name of Shona Robison, on hepatitis C.

15:25

The Minister for Public Health (Shona Robison): I am grateful to be here to open this debate on our plans to tackle hepatitis C over the next three years with the second phase of the hepatitis C action plan. No one here would argue with the first part of the motion: the fact that hepatitis C is a significant public health issue for Scotland. Health Protection Scotland recently estimated that almost 50,000 people in Scotland have been infected with the hepatitis C virus—around 1 per cent of the population. That is about twice the level of estimates in the other United Kingdom countries, suggesting that the disease is a particular problem for us in Scotland. Although that may seem a relatively small number of people, hepatitis C is a serious and long-lasting condition that can often go undiagnosed. It has been referred to as the silent epidemic because those who are infected can live for years without knowing that they are infected, even if they are showing symptoms.

Hepatitis C places a heavy burden on the national health service and is a significant blight on the lives of those who are affected. With the second phase of the action plan, we are not only acting to address the serious needs of those who are currently suffering from the infection, but putting in place a set of services and a strategic approach to prevention to limit and, we hope, halt the spread of the condition to others. In that way, our investment in the action plan is an investment for the future—one that, in the longer term, will deliver benefits to individuals throughout the country and significant savings to the NHS.

Hepatitis C is a disease that is commonly associated with injecting drug use and it is true that the vast majority of those who are infected are current or former injecting drug users. However, a significant proportion of individuals with the disease—particularly those who are beginning to seek treatment—have long since moved away from chaotic lifestyles and have reintegrated into society as productive members of the community. The disease can be a destabilising and debilitating presence and it is our duty to ensure that such individuals receive the support and treatment that they require to continue their recovery and maintain their role in society.

There are also a small number of people who have been infected with the virus through infected blood products or other medical interventions. It is our duty to ensure that those individuals receive the best possible care, treatment and support to enable them to clear or to manage their condition.

In 2006, the previous Administration published the phase I "Hepatitis C Action Plan for Scotland". In addition to seeking to improve practices and services throughout the country, much of the work of that action plan was to gather evidence to inform the development of the second, much more substantial phase of action. The product of that work—the phase II action plan—was launched on 19 May in Dundee and I was pleased to be there.

Most members will have had a chance to consider the plan and I hope that there is broad agreement around the chamber that it is a bold one. It is certainly not short of either vision or ambition. It sets out 34 challenging but achievable actions for NHS boards and others in an attempt to deliver what could perhaps best be described as an industrial-scale intervention to tackle hepatitis C. A plan of such vision and ambition needs our support, which is why the Scottish Government has made more than £43 million of funding available over three years. We are investing funds now to reduce the longer-term burden on the NHS and on the people of Scotland from hepatitis C.

A significant strand of the activity within the plan, which is supported by £28 million, is about improving the testing, treatment, care and support services for those who are infected with the disease. We are setting ourselves the target of quadrupling within three years the number of people treated annually for the disease. Instead of treating 500 people every year, we will treat 2,000 or more people every year. We estimate that, if we can maintain that level of service over the next two decades, 5,200 cases of hepatitis C-related cirrhosis, including 2,700 cases with liver failure, will be prevented over the next two decades. That will not only change the lives of the people who are affected and their families, but create a significant saving in NHS resources.

It is worth considering the costs to the NHS of some hepatitis C-related conditions. It costs approximately £10,000 a year to manage someone with hepatitis C-related liver failure; approximately £8,500 a year to manage someone with hepatitis C-related cancer; and approximately £40,000 to give a person who is infected with hepatitis C a liver transplant. If we can successfully diagnose and treat a greater number of hepatitis C-infected people, we can reduce those significant costs to the health service. That is why quadrupling the number of people in treatment is such an important element of the plan.

To treat effectively those who are infected, however, we need to be able to identify them, and we are not yet good enough at testing for or diagnosing hepatitis C. It is an insidious condition, the symptoms of which are common to a wide range of other conditions. It can be difficult to spot, by doctors as well as by those who are affected.

Health Protection Scotland estimated that 38,000 people are chronically infected with hepatitis C. Of those, only 38 per cent have been diagnosed, only 20 per cent have ever attended specialist clinical services for chronic hepatitis C and only 5 per cent have received the antiviral therapy that has the potential to cure them. That is why we need to invest in testing and diagnosis, in awareness raising for health professionals and the public, and in professional training for those who are most able to spot and diagnose the condition. The phase II action plan seeks to do all those things.

The plan also acknowledges the social care needs of those who are suffering from hepatitis C, through actions that are aimed at improving links between clinical, addiction and mental health services, and through improvements to the range of support services that are provided by voluntary and non-governmental organisations. I am sure that members will agree that social care and support are just as important as medical treatment. We all know that the success of any treatment—particularly in the case of a difficult treatment such as antiviral therapy for hepatitis C—depends on the motivation of the patient, the support available to them and their ability to deal with other underlying conditions such as addiction and mental health problems.

The action plan does not, however, seek simply to improve the way in which we identify and deal with those who are infected with the disease. It also recognises the importance of activity to prevent people, as far as possible, from becoming infected in the first place. We will develop guidelines on needle exchanges and seek to improve access to exchange services throughout Scotland to ensure that, as far as possible, drug misusers have access to clean and sterile injecting equipment.

With Learning and Teaching Scotland, we will produce educational materials on hepatitis C that can be used in schools and other educational establishments as part of broader educational activity around blood-borne viruses. We will also develop educational materials that are aimed specifically at injecting drug users, who are the group that is most likely to be exposed to blood-borne viruses. All that activity will be supported by £8 million of the money that is available for the hepatitis C action plan. That money will be provided to NHS boards and will be in addition to the existing blood-borne virus prevention funding of around £9 million a year.

Underpinning all the good work on testing, treatment, care and support, and prevention, the action plan will introduce more robust monitoring and surveillance systems to allow us to better understand the scale of the hepatitis C problem in Scotland, to monitor progress in tackling the disease and changes in epidemiology, and to measure our progress in taking the plan forward. That will give us good-quality data so that in three years' time we will have a clear idea of how the landscape has changed, what impact the action plan has had and where further action is required. As I said, this is an ambitious and testing agenda, but I believe that the NHS in Scotland, in its 60th anniversary year, is capable of delivering it. This is the NHS at its very best.

I will say a word about the way in which the plan has been developed. A wide range of people, led by Health Protection Scotland, have been involved in developing the proposals. There has been a stakeholder event at which everyone had a vote on the proposed actions and a group of stakeholders has been discussing the pros and cons of the different proposed actions.

In its ambition and scope, it is a plan to be proud of. In the way in which it was developed by the NHS and others, the plan is an example of best practice in public policy development. On that theme, I will take this opportunity to thank publicly the key people who have steered the process and worked so hard to get us here today.

I thank Professor David Goldberg from Health Protection Scotland, who deserves much of the credit for steering the process; Dr John Dillon from NHS Tayside, who deserves credit for leading the testing, treatment, care and support working group; Professor Avril Taylor, who led the prevention working group; George Howie of NHS Health Scotland who led the education, training and awareness raising working group; and Dr Syed Ahmed of NHS Greater Glasgow and Clyde, who led the executive leads working group.

I also thank Brian Adam, who is convener of the parliamentary working group on hepatitis C, and the various members of the working group over the years. The group played a key role in shining a light on the issue of hepatitis C some years ago and leading us to where we are today. The group has continued to take an interest in the progress that has been made and I hope that the action plan has its support.

I am happy to accept both amendments. They are constructive and they add to the Government's motion. The action plan is a watermark document in tackling hepatitis C in Scotland. With the plan, we are leading the way in the UK—if not in

Europe—in tackling hepatitis C. I hope that all members support the plan and that, like me, they look forward to the great strides that we will make in treatment, testing, care and prevention in the next three years.

I move,

That the Parliament recognises the leading role that Scotland is taking in tackling hepatitis C as a significant public health issue; acknowledges the launch of the Scottish Government Hepatitis C Phase II Action Plan, backed by funding of £43 million, on 19 May 2008 as a significant step forward in seeking to prevent hepatitis C and in delivering testing, treatment, support and care services to those affected by the disease, and considers that this will enable NHS boards and others identified in the plan to deliver on the actions set out to improve hepatitis C services for patients and others in Scotland.

15:36

Dr Richard Simpson (Mid Scotland and Fife) (Lab): First, I draw members' attention to my declaration of interests. I still do some work in the drugs field, on single shared assessment.

Unusually, we lodged an amendment that changes the wording of the Government's motion from "acknowledges" to "commends". I do not know whether that is unique in the Parliament, but it is a measure of the fact that we welcome the phase II action plan, which undoubtedly takes forward the previous Executive's phase I plan in a way that should transform the management of hepatitis C and maintain our leading role in the area.

Following the Labour and Liberal Executive's statement of intent in 2004 and the consultation on the draft action plan in June 2005, the phase I report set out in detail the challenges that we face in tackling the problem. I pay tribute to Keith Raffan, who is no longer a member. He was forceful in drawing our attention to the matter in the first session of Parliament. He constantly railed against the Scottish centre for infection and environmental health's estimates, which the centre itself admitted grossly underestimated the problem. At the time, we were told that the number might be 30,000. Now, we know that it is probably nearer 50,000.

As the Minister for Public Health said, the main route of transmission by a huge margin—some 45,000 of 50,000—is current or previous intravenous drug users. It is worrying that hepatitis C is not diminishing. Indeed, the report is correct to estimate that 1,000 to 1,500 new intravenous drug users are infected annually.

In the phase I plan, we endeavoured to collect information and detail the existing services. The plan contained no fewer than 41 action points, including the delivery of a comprehensive national examination of the problem; work to build on the efforts of existing services; the examination of co-ordination, prevention, testing, treatment, care, support, education, training, awareness raising, surveillance, and monitoring; and the piloting of a number of concepts.

One of the most important things is that we now have two managed clinical networks and it is clear that, as a result of the action plan, the work will be rolled out. Traditionally, managed clinical networks are horizontally integrated but, as the minister said, they also need to be vertically integrated and to include voluntary organisations and NGOs as well as user groups. I have been unable to find out from the action plan how many user groups were involved in the stakeholder group and it would be helpful if the minister could put that on the record when she sums up.

I want to take us through a hepatitis C patient's journey. As the action plan shows, the problems that we face begin with diagnosis. Many substance misusers are treated in general practice. The involvement of primary care is vital to the delivery of an effective diagnostic service, yet the action plan states that approximately 95 per cent of GPs did not diagnose a single case of hep C in the previous year.

There are also problems with needle exchange services. They were set up in response to HIV and were successful in that regard, but they have been unable to test for hepatitis C because most are based in pharmacies and they do not have the necessary facilities. Such services need to be developed. Many of them are open from 9 to 5 on Mondays to Fridays, which is not satisfactory for the group. A further problem is that hepatitis C is significantly more infective than HIV, so the challenge that we face with the spread of infection by needles is even greater than it was with HIV. We must not let up on tackling that. I know that there has been a separate report on that, which is important.

Another point is that numerous drugs services are offered by voluntary organisations and social workers, neither of which groups is easily positioned to offer testing. It is also disappointing that prisons, which should be in the best position to test, are yet patchy in their response. Even when a patient is counselled and gets to the point of being shown to have the hepatitis C virus on the basis of the test, that test is not standardised throughout the country. Again, the report indicates that that needs to be tackled.

If someone tests positive and requires specialist assessment and treatment, they are usually managed as if they were a typical patient: stable, with a clear or at least some understanding of their illness, and possibly symptomatic. However, we know that the illness is asymptomatic. As the minister has said, it is silent. The patient often

does not understand why they need to be treated as they do not really have any problems, apart perhaps from being a little tired.

The result is that between 20 and 70 per cent of patients fail to attend the specialist clinics. Even when they attend, the clinics may judge that they are not suitable for treatment on the basis of their continued drug use or their social circumstances. Again, such decisions are not based on a standardised, common assessment tool. It will depend on the clinic that someone goes to and the attitude of their clinician as much as the circumstances in which they find themselves.

Once someone gets to the clinic, they may still be somewhat chaotic and there may be many other things with which they are still dealing, such as benefits meetings or appointments with drug clinics or general practitioners. If they fail to attend the clinic for whatever reason, they may be subject to the new ways waiting times. As Dr McKee and I have said, the patients in question will find that difficult to follow. As the report advised, there needs to be a careful look at non-attendees. I suggest that the new waiting times will damage further the attendances at such clinics, so there needs to be a sensitive application. If patients attend and are treated, some will relapse and require further courses, some will fail to complete the course and a number will not be treated because their type of hepatitis does not respond. Some estimates suggest that 20 per cent of those untreated may require a liver transplant, and it is clear that the increased treatment programme must deal with that.

We need to improve that difficult journey; the managed care networks will do that.

Of the 41 action points in the first phase of the plan, 40 were found to have been completed. One, in relation to prisons, was not completed, and my colleague David Whitton will deal with that. It is an area that requires particular attention. I want to use my final few minutes to offer some constructive criticisms of the report, which, as I have said, we warmly welcome.

First, other routes of transmission appear to be rather neglected in the second phase. There is a brief reference to pregnancy but almost no reference to the acquisition of hepatitis C from abroad. We know that such acquisition of HIV is increasing and it will almost certainly be increasing with hepatitis C.

Secondly, I suggest that the deadline of 2010 for the standardisation guidelines to be produced by NHS Quality Improvement Scotland seems far away, given the urgency and the good targets of increasing treatment set by the minister.

Thirdly, the managed clinical networks are important but, unless they involve primary care and community services, there will be problems. However, there is only one reference to community health partnerships in the report.

There is no indication of whether the national enhanced service contract for those practices participating in substance misuse services will be examined to incorporate testing and dealing with hepatitis C. There is no indication of whether the quality points for either preventive or testing work for other GPs will be examined. There is little mention of pharmacists, who play an important role in connectivity to the group. Will the minister examine that?

We are talking about a difficult service for often difficult people who can be homeless, previous offenders, unemployed, living on benefits and struggling to manage even day-to-day living. Therefore, we have to be sensitive to their challenges.

I want to make one point on the question of records. Hepatitis C patients may have up to nine separate clinical records: GP, voluntary sector drug services, social work, the health service, the blood-borne virus clinic, the needle exchange, the specialist drug service, the mental health service and the hepatitis clinic itself. That is not satisfactory. We need a patient-focused service.

I do not have time to deal with training, but STRADA—Scottish training in alcohol and drug abuse—is not mentioned in the report as the prime provider of services to tackle substance misuse. I hope that, rather than there being a fight over which board will lead, STRADA might be involved in that delivery.

I conclude by saying that we warmly welcome the report. The funding is excellent and I hope that the Government will be able to deliver, along with the health services, which are undoubtedly committed to making Scotland a leading player in tackling hepatitis C.

I move amendment S3M-1943.1, to leave out "acknowledges" and insert:

"commends the hard work undertaken by those staff involved in delivering 40 out of 41 action points in Phase I of the Scottish Government's Hepatitis C Action Plan and welcomes".

15:45

Ross Finnie (West of Scotland) (LD): I do not think that anyone in the chamber disagrees with the progress that has been made and which is embodied in phase II of the action plan. We continue to recognise, as the minister made clear, that hepatitis is potentially one of the most significant public health issues to confront Scotland. We must bear that in mind. After Parliament starts to address an issue, the danger

is always that people elsewhere think that a box has been ticked and that something has been sorted. However, that is not the image that the Government presents and I hope that Parliament will not present it. The problem remains serious.

We welcome the 34 actions in the plan. We particularly like the proposal to tackle the variations in the approach to the management and social care of people with hep C. Only two NHS boards have managed care networks for hep C and I welcome the extension of that. I also welcome the focus on increasing the number of individuals, and particularly prisoners, who receive antiviral therapy. Mr Whitton might expand on that, as presaged by Dr Simpson. That is linked to the recommendation to create in-prison needle exchange programmes to reduce the transmission of hep C. The link between social care, addiction services and hep C treatment is vital, because many hep C individuals have drug and alcohol problems or social needs. All those thrusts are warmly welcomed.

Our amendment raises the issue of continuing education, training and awareness raising. I am well aware that that was given much attention in phase I, but having read the substantial phase II action plan and looked back at phase I, I think that we must renew and in some ways reconfigure the important aspect of education, training and awareness raising, which was very much part of the phase I process. However, in so far as that developed satisfactorily into information gathering that improved awareness, we have a body of knowledge, which is a consequence of achieving 40 of the 41 actions in phase I.

We have now to look again to use that raised awareness and increased understanding to enhance the substantial part of the action plan and make it easier to implement. Different professions and different people will move into different stages, so education and awareness raising will continue, which might be through educating, informing and raising awareness among existing health professionals, notwithstanding the work that was done as part of phase I. That must link into the different challenges that are presented to the criminal justice professions as a consequence of our new information.

Our knowledge and understanding of how to support people who live with hepatitis C have increased. If we genuinely want to support people who live with hepatitis C—and it is equally important to reach the large percentage of that substantial body, which is estimated to be as much as 50,000 people, who might be undiagnosed—we must pay more attention to the programme of training and awareness raising. Otherwise, we run the risk that we will not capture those people as part of the all-important phase II development. As I have said, we must consider the knowledge of professionals, the potential scale and implications of hep C and exactly what is available to us at all levels.

It is also interesting to observe some of the work that has been done. We assume that those who deal in specialist non-pharmacy needle exchange work will have a high level of knowledge, but we continue to get evidence that there is a lack of standardised training and education of needle exchange staff, in particular on safer injecting techniques. We cannot lose sight of that issue, although it was a major element of the phase I action plan.

We warmly support the recommendations in the phase II action plan. Our amendment asks the Government to look again at the substantive section contained in the phase I action plan and perhaps bring it up to date so that by continuing—in combination with all the measures contained in phase II—to increase education, training and awareness raising, the overall impact will be greatly to help us tackle the potential problem of a hepatitis C outbreak.

I move amendment S3M-1943.2, to insert after "prevent hepatitis C":

"and working to raise awareness among professionals, the public and those at risk of infection".

15:51

Mary Scanlon (Highlands and Islands) (Con): We, too, will support the motion and the amendments.

Concerns about hepatitis C have been raised in the Parliament since 1999, by Brian Adam and by many others. Although the previous Administration is to be commended for its commitment to the phase I action plan and the achievement of 40 out of 41 of the plan's action points, there is no doubt that much remains to be done, particularly in the light of the statistic that 50,000 persons in Scotland are estimated to be infected with the hep C virus and that 38,000 are chronic carriers.

When I read the hep C action plan, I noted in particular the evidence base, the actions to be taken and the outcomes as well as the reviews, audits and monitoring systems, which we agree are essential to ensure that there is a targeted and focused approach. The evidence base that underpins the action plan is shocking and it aptly illustrates the fact that co-ordinated action is needed for diagnosis, treatment and support.

Other members have raised some of the points that are made in the phase II action plan, which states:

"The training of the Hepatitis workforce is substandard."

It also states:

"There is a lack of integration among primary care, specialist, addiction, prison and social care services".

How often have we heard that?

As the minister said, the plan points out that

"Insufficient numbers of infected persons"

are given antiviral treatment. As Richard Simpson and others have said, the plan refers to variations

"among laboratories in the way they test for Hepatitis C and report results to clinicians".

In addition it states

"More than half of Scotland's main Hepatitis C treatment centres have no outward referral links with mental health and addiction services and only one-quarter have outward referral links with social care services."

Furthermore it notes that

"Approximately 95% of GPs in Scotland did not diagnose a single case of Hepatitis C during 2006."

I have mentioned but a few of the evidence-based issues. That is all against the background that approximately 50 per cent of newly diagnosed infected persons who are referred to a specialist clinic fail to attend their appointments.

We have no doubt that action is needed. How does today's hep C action plan fit in with the drugs strategy that will be announced next week by Fergus Ewing? In the Health and Sport Committee's short scrutiny of the budget, we raised many concerns about drug and alcohol detoxification and rehabilitation interventions and treatments. The picture that was painted is similar to much of the background information in the hep C evidence base. There is a lack of co-ordination; lack of knowledge about which interventions are most effective; lack of knowledge about investment in relation to outcomes; and a distinct lack of a joined-up service throughout Scotland, although there were undoubtedly areas of good practice.

In respect of integration, I am pleased to note that the action plan includes mental health services. I appreciate that there are many answers to the question why people take illegal drugs, but there is no doubt that for some people drug taking is a form of self-medication for issues that should ideally be addressed in a mental health setting in which they can be given the appropriate support and treatment. If we expect people to stop injecting and spreading the virus, we need to provide them with the appropriate mental health support, at the appropriate time, in the appropriate place.

My other concern relates to the NHS QIS standards for hep C testing and treatment, care and social support for persons with hep C infection. The standards are welcome, but I was surprised to learn that they are not due to be developed until 2010, one year before the end of the phase II action plan period. I am concerned that the integrated and co-ordinated approach for which all of us hope may not be achieved until the NHS QIS standards and guidelines are set out. I hope that the next two years will not see more of the muddled and ad hoc approach of the past and that actions will not be delayed until standards have been published.

Given the crucial need for an integrated approach between the NHS, social services, primary care, the voluntary sector, mental health services and secondary care, it is interesting to note that each local authority will identify a strategic and operational lead for hep C infection and that each health board will have a hep C prevention lead person. I accept that the monitoring that will be put in place will produce robust data, as the minister said, but I am not sure what will be the lead organisation or authority with responsibility for co-ordinating all services, to ensure that the user does not fall through the net, as happened in the past.

Scottish Conservatives welcome the publication of the action plan, but we have concerns about the inclusion and integration of all stakeholders, in order to put the patient first. It is fair to say that injecting drug users are not the most compliant patient group. For the action plan to be effective, it must, first and foremost, be tightly co-ordinated with the patient's needs.

15:57

Brian Adam (Aberdeen North) (SNP): It is a great pleasure for me to speak in support of the motion and amendments that are before us. A number of members have taken a keen interest in hepatitis and the various challenges that it has posed over the past nine years. Some of those have related to difficulties with blood-borne viruses that have arisen as a result of transfusions for haemophiliacs, but a much greater number of people have hepatitis C infections and the morbidity and mortality problems that are associated with hepatitis C as a result of other means of transmission. Although there may be some anxieties about the pace at which we are moving forward, there is no doubt that we are moving forward. It is sensible that we are doing so using an evidence-based approach.

Phase I was about identifying challenges and how to go about tackling them. It involved an awareness-raising programme that focused not on the natural target group—the 50,000 people who are infected—but on professionals, people working in NGOs and people offering support services. If we cannot prepare the professionals to make the change, it is unlikely that we will succeed

immediately with the folk with whom they work, many of whom have fairly chaotic lifestyles. Even those who have put chaotic lifestyles behind them may wish to put all the potential harm that they are carrying around with them out of mind.

In a tight spending situation, a very significant amount of money has been devoted to the problem. Funding will increase stepwise, to the point at which £20 million a year will be delivered to treat 2,000-plus patients a year. If that many patients are to be treated—and the number could go up to 50,000—not everybody will be able to be treated immediately. There is also no guarantee that everybody will be cured. Some people have a natural mechanism to clear the virus from their system; they are able to get the harm to themselves—and potentially to others—out of their system. However, the proportion of people who are able to do that is modest.

We have moved on from the time when antiviral treatments had a success rate of only 10, 15 or 20 per cent. In the early days, we worked with interferon. I can remember when, as a young biochemist, I was really excited about this marvellous molecule that would be the saviour of mankind. It was a naturally occurring substance that would be terribly important. It is still important, but there is no silver bullet for some conditions.

Progress has been made with combinations of antiviral treatments. For example, HIV is no longer a death sentence, and the same goes for hepatitis C. The treatments will lead to much higher success rates, perhaps of 50 to 70 per cent. However, that will not eliminate hepatitis C from society; we will have to take other measures, too. Harm reduction methods and messages will be part of that. Uniformity of approach to training and services—which previous speakers have spoken about eloquently—will also be important. A coherent, step-by-step plan will eventually take us to a point at which hepatitis C is less important, in that the level of harm that is done to individuals and to society will at least have levelled out, if not been reduced.

I do not wish to take up any more of your time, Presiding Officer. It is a great privilege and pleasure to be associated with the group that has presented the action plan. I commend the Government ministers on their work.

16:03

Helen Eadie (Dunfermline East) (Lab): I welcome yesterday's announcement that the Scottish Government will dedicate £43 million to combating the spread of hepatitis C, ushering in phase II of its action plan. As I understand it, the money will be distributed to health boards across Scotland and will be used in treatment, testing and care for those who are suffering with the disease.

The action plan has been announced against the background of world hepatitis day, which was held on 19 May. We have learned that, in order to oversee world hepatitis day, and to ensure that it is a patient-led initiative, the World Hepatitis Alliance was established in Geneva with a governing board of patient representatives—one from each of six world regions—and a president, representing the totality of hepatitis patients. During the summer of 2007, the alliance asked 12 worldwide communications agencies to pitch to run the world hepatitis day campaign. It chose Fleishman-Hillard. I wish the World Hepatitis Alliance every best wish for success in its mission.

I note from *The Scotsman* of 19 May that Charles Gore, the chief executive of the Hepatitis C Trust, was talking about the importance of preventing further infections. He said:

"These diseases are as widespread and as deadly as HIV/Aids, TB and malaria, but there is nowhere near the level of awareness nor the political will to tackle them. This must change because this huge death toll is largely preventable."

I hope that the World Hepatitis Alliance, whose study has estimated that 500 million people are infected with this dreadful disease, notes the introduction of this and the previous action plan and acknowledges the dedication and commitment shown by many of my MSP colleagues, who have done a massive amount of work on the issue in previous parliamentary sessions, as testament to the Parliament's political will.

I note the Hepatitis C Trust's statement that it—and 200 patient groups—pledges support for world hepatitis day, which is the first truly globally aware event for chronic viral hepatitis B and C. As I said, I hope that the alliance will judge that the action plans reflect strong political will in Scotland; however, as Mary Scanlon has said, much remains to be done.

Like other members, I congratulate the team that worked so hard to achieve all but one of the 41 action points in the first action plan, which was produced by the previous Labour-led Administration. The action plan that is now under consideration is a product of the first action plan, and I know that MSPs of every political party will wish all the very best to all those who are involved in taking forward this work. As members have acknowledged in previous debates, this is, first and foremost, a human issue, not a party-political matter. I feel for anyone who has been diagnosed with hepatitis C and worry for the others who do not know that they are suffering from what has been described as a sleeping giant of a killer.

The £43 million funding will be vital in progressing the action plan, which, as the minister and other members did, singles out for praise Professor Goldberg and his colleagues at Health Protection Scotland. I echo that praise, because their critical expertise will help us to tackle this dreadful disease. I am certainly pleased to learn that Scotland is at the forefront of this work in Europe, and all political parties should congratulate one another on their determination in tackling these issues. The many hundreds of others who have contributed to the action plan should also be thanked for their input.

Other members have covered the issues that I wanted to raise, so I will spare the chamber any repetition and move quickly to my other points. Suffice it to say that I agree with those who have mentioned substandard training, clinical management and the QIS standards.

I hope that the minister will reassure me that a thorough screening programme is being implemented. After all, if we do not introduce such a programme now, we will have to be prepared to put up our hands and accept our part of the blame when, in 15 to 20 years' time, the extent of the problem becomes apparent and can no longer be ignored. The US and France, for example, are already taking effective action. It is estimated that the costs of treating those who have been diagnosed might be as high as £200 million.

I note from the action plan that

"by 2011, actions will have led to considerable increases in the numbers of persons diagnosed with Hepatitis C and the numbers of infected persons having cleared their virus through antiviral therapy, and early signs"

that the prevalence of the disease might start to decline. However, I suspect that the Scottish Parliament will want to monitor that statement carefully with a view to having further deliberations, if necessary. After all, outcomes are not always what we expect them to be.

The action plan also says:

"A Project Management approach to co-ordinate the effective, efficient and timely delivery of the Action Plan, will be employed. This will involve establishing a Project Management Team … and appointing Project Managers at … Board level".

I hope and pray that they will ensure a consistent and integrated approach to action plan co-ordination.

On research, not much has been said about the interventions that are used in other countries to reduce the transmission of hepatitis C. I believe that that comment was made by respondents in the analysis of the 2004 action plan.

16:09

Michael Matheson (Falkirk West) (SNP): Like a number of members, I am conscious that significant progress has been made since 2006. As Richard Simpson said, phase I of the action plan has resulted in the transformation of services over the past two years.

Richard Simpson correctly pointed out that Keith Raffan played a significant role in highlighting hepatitis C issues during sessions 1 and 2. Brian Adam also played an important part, and I suspect that their dogged determination to ensure that hepatitis C was a recurring subject of debate in Parliament led to the development of phase I of the action plan. Their role in ensuring that the issue was addressed effectively must receive appropriate recognition. I congratulate them on the work that they have done over the past eight or nine years.

I agree strongly with Ross Finnie that hepatitis C remains one of the most significant public health problems that our nation faces. It is also a significant health problem internationally—it is estimated that some 500 million people worldwide are infected with hepatitis B or hepatitis C. The fact that that is 10 times the number of people who are infected with HIV/AIDS puts into context the extent of the problem across the world.

Brian Adam said that there might be concerns about the pace at which some aspects of the phase II action plan are being progressed. I do not necessarily share those concerns. From what I have heard, that is not a matter of great concern. However, given the significance of the problem that we face in Scotland alone, it is legitimate to ask why it took us so long to introduce an effective action plan for tackling hepatitis C. I do not know whether that was reflective of the difficulties of the patient group concerned, many of whom acquired the condition through drugs misuse, which leads to a chaotic lifestyle and many accompanying problems.

Another factor might have been the asymptomatic nature of hepatitis C, which has led to its being described as a silent killer. Perhaps that is why effective progress was not made sooner. It is worth considering why that was the case, given that hepatitis C was a significant public health problem long before 2006. In saying that, I do not seek to lay blame on the previous Executive; I think that the reason goes wider than that.

I welcome phase II of the action plan and the additional financial resources that will be provided to ensure that it is delivered effectively. Two of the main objectives must be to prevent further transmission of hepatitis C and to ensure that those people who are infected with it have access to the best quality of treatment services.

In my view, how hepatitis C can be contracted continues to be surrounded by a large body of ignorance. One of the most important aspects of the phase II action plan is the continuing education work to ensure greater understanding of contraction of the condition and higher rates of testing. We understand that a large number of people could have hepatitis C without being aware of it. The importance of education in phase II cannot be underestimated.

The Scottish hepatitis support network has highlighted a number of important issues. There are notable gaps in services for hepatitis C sufferers and their families. The link between mental health services and hepatitis C services is often poor. It is commonly acknowledged that depression and mood changes can be significant side effects of treatment for hepatitis C. As phase II develops, mental health issues will be given greater prominence, and it is important that provision for those who have hepatitis C and treatment for mental health problems are linked more effectively. Additionally, there is a need to consider providing more effective support for those who are not suitable for antiviral treatment, or for whom that treatment may have been unsuccessful.

Another important area is the wider support that must be provided to the families of those who suffer from hepatitis C. The requirement for that area to be addressed more effectively has been highlighted, but I am not convinced that phase II will address it as it should. The illness can affect the whole family unit, children and adults, so there is a need to ensure the provision of more effective support for the family unit, particularly for the primary carer whose direct role is to support the individual who has hepatitis C.

There is a clear need for greater linkage between alcohol services and services for those with hepatitis C. The role of alcohol in accelerating liver disease is an important factor that must be recognised. I hope that, during phase II, there will be more effective linkage between those two service areas.

16:15

David Whitton (Strathkelvin and Bearsden) (Lab): I speak in support of the amendment in the name of my colleague Richard Simpson, which I am pleased that the minister has accepted. As Richard Simpson indicated, I will focus on what is happening in Scotland's prison estate with regard to hepatitis C.

In the introduction to the phase I action plan, Dr Harry Burns, the chief medical officer for Scotland, said:

"Prevention is as important and necessary as treatment and care … existing services may need to change the way they do things."

I will return to that point.

The phase I document went on to say, under its action points, that the Scottish Prison Service would pilot an in-prison needle exchange scheme at Craiginches jail in Aberdeen, and that a report on the pilot would be available in 2009. It was also reported that the Scottish Prison Service would provide access to training on hepatitis C to all prison staff as part of a larger training programme on harm reduction. The intention was that staff in Aberdeen would be given special training on safe injection techniques, as part of an intended pilot needle exchange in that prison. Why was it felt that that work was so important in Scotland's jails?

In April, as was reported, the prison population in Scotland reached an all-time high of around 7,700. There is widespread overcrowding; cells that are meant for one prisoner are sometimes used by not two but three inmates, and prisoners are locked up for longer. I do not think that anyone in the chamber believes that no drugs are available in our prisons; indeed, drugs have, in many cases, replaced tobacco as the currency of the prison. The reports before us make it clear that the vast majority of those with hepatitis C are, or have been, intravenous drug users. There are many drug users in our jails; in many cases, that is why they are in jail. Those who are locked up and taking drugs often share needles, and ultimately spread infection.

One of the most shocking statistics in the phase I report comes from a study of Shotts prison inmates a few years ago, which found that a quarter were infected with hepatitis C. I venture to suggest that a similar study that was done across Scotland's prison estate today might come up with the same figure or one that was even higher, which could be up to 2,000 prisoners. If that is the case, it is a cause for concern that the only one of the 41 recommendations in the phase I action plan not to have been implemented was the pilot of the needle and syringe exchange scheme at Aberdeen.

The Aberdeen scheme has been rescheduled as action 17 for phase II, but under "Outcome" the plan states:

"This action will demonstrate the acceptability, to users and prison officers … of an in-prison service providing injection equipment."

Will it? My understanding is that the main reason for the Aberdeen pilot not going ahead was resistance from the Scottish Prison Officers Association, which regarded the scheme as a health and safety matter for its members. Action 17 says that if the pilot gets the go ahead, it will be evaluated in 2011. I urge the cabinet secretary and her minister to consider that matter further. I hope that they would sit down with the Scottish Prison Service and the SPOA to ascertain whether

the pilot can be introduced more quickly and whether the findings can be accelerated.

I remind the cabinet secretary that the phase I plan said that

"existing services may need to change the way they do things."

On page 19 of the phase II plan, it is made clear that intravenous drug users who continue to inject in prison

"do not have access to injection equipment in that setting."

It is estimated that as many as 300 prison inmates inject at least once a month, using home-made, unsterile equipment. Needle exchange schemes have been introduced in some European countries, including Spain, Germany and Switzerland, but that has yet to happen in the United Kingdom. Will the cabinet secretary consider making Scotland lead the way on the matter?

Under action 23, a

"survey of Hepatitis C prevalence and incidence among prisoners in Scotland"

will be undertaken and the results published in 2011. Given that we have a captive audience in Scotland's jails, it should not take three years to garner the information. If hepatitis C tests can be organised in the Parliament, as I think happened last week, it should not be difficult to organise tests in a prison.

In section 4.5 of the analysis of consultation responses to the proposed action plan, under the heading "Prevention issues", it is noted that respondents

"acknowledged that significant action was already underway in SPS in the area of harm reduction and immunisation for Hepatitis B."

However, section 4.5 continues:

"Respondents called for further efforts to:

Educate and raise awareness among prison staff about Hepatitis C.

Stabilise chaotic drug use through effective substitute prescribing …

Develop needle exchange programmes or make available vending machines for distributing sterile needles/syringes and other paraphernalia.

Discourage tattooing, and inform inmates of the risks involved in using make-shift and non-sterile equipment for this purpose."

There is much to be commended in the phase II action plan. The minister mentioned the foreword to the document, which says:

"the Hepatitis C Phase II Action Plan amounts to intervention on an industrial scale; an investment in the public health of Scotland that should, over the longer term, significantly reduce the problem of Hepatitis C in Scotland."

If around a quarter of our prison population is suffering from the disease, intervention on an industrial scale is needed in prisons now.

16:21

Ian McKee (Lothians) (SNP): I congratulate the minister and everyone who was involved in the production of this hepatitis C action plan and the predecessor report. I also welcome the significant investment of £43 million to support the implementation of the plan during the next three years.

I have had first-hand experience of looking after people who have been infected with hepatitis C and I know how devastating the condition can be. My first such patient became infected as a result of a blood transfusion, but fortunately has not developed liver cirrhosis. However, her fear and anger, her irrational shame and the fact that she and her husband must use a condom when they have sex, to prevent him from becoming infected, have affected her in such a way that her life will never be the same as it was before she contracted the disease.

That woman did nothing to bring the disease on herself, and it is tempting to feel sympathy for such people while feeling no sympathy for the majority of people who have the disease, who became infected as a result of a drug habit. However, people turn to drugs for many and varied reasons and behind nearly every case is a victim who is equally deserving of our support. The difference between the two groups of patients is that people who have drug habits are exceedingly difficult to help. There are inevitably setbacks and moments when the professional and the patient or client wonder whether anything is being achieved. Patience and perseverance are needed.

If I have a criticism of the action plan, it is that some sections are almost too focused on hepatitis C. We must always remember that we are treating a person and not a condition. Hepatitis C is only one of a series of health risks that drug users face. I am sure that the minister is well aware that such people need to be screened for HIV and hepatitis B, for example, and that she is confident that that is happening, but I looked in vain for a mention of that in the document. I know that only a small proportion of hepatitis C cases are transmitted sexually, but given that the infection can be deadly, there would be merit in making a strong recommendation in management plans on regular use of condoms, especially if the drug user is also a prostitute.

On page 16, under the heading "Prevention", the plan says that the provision of injection equipment is, unlike methadone maintenance programmes, designed to prevent the transmission of blood-

borne viruses among intravenous drug users. However, in Lothian, the methadone maintenance programme and its precursors were introduced specifically for that purpose and had some degree of success.

The sad fact is that the efficient use of any sterile injection equipment is beyond the ability of many drug users, involving as it does the regular collection of clean needles from a central source, returning or safely disposing of used needles, and never, ever sharing. As the plan says, although we distribute 3.5 million syringes and needles a year, no one knows how many are being safely disposed of after use—or how many are casually discarded, making them a risk to others.

No member has mentioned what goes into those syringes. Although I am not surprised that there is no plan to provide intravenous drugs of an acceptable standard, every year intravenous drug users inject all sorts of rubbish into their flesh and veins. They inject dangerous drugs of uncertain strength and provenance that are mixed with anything from talcum powder to rat poison. They risk abscesses, blood clots, loss of limbs, and even loss of life. If a person is truly to be helped, pathways into oral maintenance should form a major part of any strategy.

In exploring further the issue of compliance, the plan tells us that 50 per cent of newly diagnosed infected persons fail to keep their specialist appointments. I am surprised that the percentage is not higher, given the chaotic lives that many of those people lead. How does the Government suggest that compliance will be improved? We are told that plans will be developed and that "innovative" strategies will employed, but what plans, and what innovations? Until we know and can assess what is proposed, such statements are nothing more than benign sentiments.

I do not want members to think that those few criticisms mean that I believe that the plan is critically flawed. On the contrary, for the first time, we have a national plan that is evidence based and which demands high standards of knowledge and service delivery from all practitioners. That approach should be emulated for many other conditions. I repeat my plea that we should remember that we are treating people, not conditions, and that holistic care plans should always form the basis of treatment.

The Deputy Presiding Officer (Trish Godman): We move to the wind-up speeches. I call Jamie Stone.

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): I thought that Jackson Carlaw was to speak before me, Presiding Officer. Is that not the case?

The Deputy Presiding Officer: You are correct, Mr Stone. [*Interruption.*] Please excuse me; I have the cold. I call Jackson Carlaw.

16:27

Jackson Carlaw (West of Scotland) (Con): Once again, on a matter that enjoys support across the parties, the subject of debate has brought out the qualities of a concerned, informed and collective chamber by way of members' contributions.

The Government's announcement of £43 million of additional funding is welcome. It is to be widely congratulated on doing so in seeking to meet the challenge presented by the scale of the hepatitis C problem. Many members detailed that during the debate—Dr Simpson and Dr McKee did so with considerable expertise. The action plan follows the first phase of the strategy that the previous Administration implemented—which we also supported—which, in turn, followed Brian Adam's sustained focus over many years and the subsequent members' business debate in 2004, at which the Conservatives joined others in recognising hepatitis C as one of our most serious public health risks.

Perhaps we should measure the Government's announcement today in terms of our ability to say to Charles Gore of the Hepatitis C Trust that we have responded directly to the comment attributed to him, which was that the condition is

"as deadly as HIV/Aids, TB and malaria but there is nowhere near the level of awareness nor political will to tackle"

it. The quotation continues:

"This must change because this huge death toll is largely preventable".

Helen Eadie also quoted him in her speech.

The incidence of hepatitis C in Scotland is chilling. It is estimated that 1 per cent of the Scots population—twice the percentage of elsewhere in the United Kingdom—is infected by this blood-borne virus. We are told that too few are aware of their infection and that thus far we have treated far fewer of those who are infected than is the case in Germany, Italy or Spain. We are also told that, in France, people who are infected are five times more likely to have been treated than is the case in this country.

We welcome the fact that phase II has followed on from a phase I. We do so not only because that is the rather obvious and natural order of things, but because we can see that phase I has been implemented almost in its entirety—all but one of 41 actions have been implemented. During phase II, the Government will endeavour to tackle directly the enduring ignorance that, if corrected, could be

so influential in the success of the preventive campaign.

We therefore applaud the Hepatitis C Trust's assessment of phase II that it is comprehensive and evidence based, that it involved wide stakeholder consultation, that it addresses health inequalities and that it takes account of Scotland's geography.

That said, perhaps we should be concerned at the sheer volume of public health information that we find ourselves having to, or planning to, communicate. We have vital messages on sexual health, such as those on the need for chlamydia screening among young girls and especially young men; the message on drugs generally; the effort to tackle obesity; the forthcoming strategy to address the ever-worsening scourge of alcohol abuse; and the statement on smoking prevention earlier this afternoon. The list goes on. To an extent, every new message and campaign competes for public awareness, often among the same demographic groups. We must be concerned about and alert to the possibility that that may begin to dilute the effectiveness of individual messages, however vital they are, and could lead to a need for even higher expenditure to break into the consciousness of any target group. We must therefore learn to be increasingly imaginative and versatile in our approach. Using the same medium every time may produce diminishing returns. At some point, we need to pause and dwell on the array of public health initiatives that are under way and planned. We do not want to stand accused in years to come of having been willing to spend money, but in a manner that became contradictory and confused.

The Government is to be applauded for being prepared to tackle the public health agenda head on and with fresh urgency, building—I say without hesitation—on what went before, which was also bold. However, the agenda is becoming wider and more ambitious in its reach every week. It is in all our interests that it succeeds, so I repeat that, at some point, we should find time to draw an understanding of the breadth of the competing and complementary strands. My colleague Mary Scanlon gave an immediate and worthwhile practical example of that when she referred to the forthcoming strategy on drugs. It is important that the immediate initiatives work effectively and concurrently. Richard Simpson identified a parallel issue about records.

As others have done today, we welcome the aims and objectives of phase II of the hepatitis C plan over the next three years and measures such as the direct support to health boards as they seek to meet the challenge. Taken together, the announcement of the inquiry and the phase II funding represent a significant and undeniable effort by the Administration to do justice to the historical hepatitis C issue, coupled with a striking commitment to mitigate future incidence. Surely none of us has any ambition to carp or complain. We must ensure that the money that is allocated is spent effectively and that the various strands of the strategy are monitored closely, as they all need to succeed so that, on hepatitis C, Scotland achieves a clear strike, even if it is in isolation. Lives will be saved if we do so.

I conclude by answering Charles Gore's challenge, which I mentioned earlier, by quoting from him today. He welcomed the Scottish Government's approach and concluded by saying that it will mean that

"thousands more patients are diagnosed and treated and this will save lives".

We must see that it does.

The Deputy Presiding Officer: I apologise to Mr Carlaw for not calling him earlier.

16:32

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): The trouble with Jackson Carlaw's excellent speech is that he has taken away just about everything that I was going to say. The trouble with the winding-up speeches in a consensual debate is that members end up saying exactly the same things. However, in my usual manner, I shall try to digress into some interesting sidelines.

The minister put us right on the ball by setting out the exact nature of the problem. We have heard it said many times in the Parliament that 50,000 people in Scotland are infected and that the rate of infection here is twice that in other parts of the United Kingdom. We should dwell on that and consider why it is the case. Let us hope that, as phase II proceeds, we will come to conclusions on that. The funding is welcome. There is to be £43 million over three years, and £28 million for improved testing. The number of people to be treated each and every year will quadruple from 500 to 2,000.

Richard Simpson joked that we should commend and not just acknowledge the work that has been done, but that is true. There is a consensus that excellent work was done in phase I and that phase II will build on that. Dr Simpson flagged up an interesting point about the role of pharmacists and connectivity. Pharmacists have a wide knowledge that may be of great assistance in tackling the disease. We should remember that and build on it. Another important point that Dr Simpson made was that people who suffer from hepatitis C can have up to nine separate records. I had not realised that the situation was so bad. To use his words, that is not good enough. That could

be an easy issue for the Scottish Government to tackle, and co-ordinating the records may assist the Government in its endeavours.

My colleague Ross Finnie moved my party's amendment, which is entirely about raising awareness among sufferers of the disease, the general public and health professionals. Mary Scanlon and other members asked why the rate of GP diagnosis is so low. That question must be answered. We are missing something and the answer may be to do with raising awareness, as mentioned in our amendment. Perhaps that applies to GPs as much as it applies to other people.

Ross Finnie suggested that because we have had the debate, it might seem easy simply to tick the box—to say that the matter is sorted and that we do not need to think about it any more. In that case, does not raising awareness apply just as much to us, as members of the parties in the Parliament, as it does to ministers? We need to remember that.

I have mentioned what Mary Scanlon said about GP diagnoses. She spoke about training, the lack of integration and variation in testing methods. She made an interesting point about drugs strategy. Fergus Ewing will shortly be introducing the drugs strategy, and the connectivity between the different areas involved is there to be seen. Ross Finnie and I have discussed in the past the lack of joined-upness—perhaps it exists as much in my party as it does in the governing party—between announcements by justice ministers on the licensing regime for drink, for example, with responsibility lying with Fergus Ewing's portfolio, and the medical aspects of the issue. Perhaps all parties should think more carefully about how to marry those two things. We shall be probing that matter in the future.

The speeches from back benchers were of a very high quality. Brian Adam knows the subject inside out, and he has pursued it doggedly—both with and after Keith Raffan. I can only salute him on his first-class speech. Michael Matheson brought an international context to the debate. Shame on anyone who did not listen to what David Whitton said about what has been happening in prisons—although I am sure that everyone listened. His was a very thought-provoking speech indeed, and all of us found it instructive in relation to what might be at the heart of the problem in prisons. [*Interruption.*] I will give way. I am sorry—I heard a sedentary remark behind me, and I thought that someone wanted to intervene. I am saddened.

Dr Ian McKee talked powerfully about the idea of treating the person, not just the disease. There is huge mileage in that.

In getting the message out, we might mention the hepatitis C support network, medical professionals and the role of the general public, but there is a difference, to my mind, between such organisations as the hepatitis C support network and drug users themselves. Whether drug users are in prison or out on the street, a lot of them know one another and they know where to get the drugs from. There is a network there. When we try to do work in the area of prostitution, for example, although it is a wickedness and a terrible thing in society, we find that the people involved talk to one another. If we can plug into those networks, in a non-threatening, non-I'm-gonna-tell-the-cops way, we can perhaps get the message out. Perhaps the hepatitis C support network and other organisations are indeed doing that, but perhaps not. Word of mouth, as the drugs are bought and sold on the street, could be one way forward. I would be interested to hear the minister's thoughts on that—if not today, then in the future. There might be something that we could do on that front to take a new approach.

Anyone who is suffering from hepatitis C should take comfort from what has been said today. We speak with one voice. We have heard about what the antiviral medicines can do, and Brian Adam has given us great cause for hope. We have a strong message, and it is unique when this Parliament, on one of its better days, speaks with one voice. I am happy to support the amendment in the name of my boss, Ross Finnie, the Labour amendment and the motion.

16:38

Dr Simpson: This has been a consensual debate, which reflects the continuing desire of the Parliament to tackle the problem effectively. Brian Adam, to whom people have paid tribute for the work that he has done, referred to the fact that phase I of the action plan gathered the evidence and assessed what things are like. He made the important point that we are going to proceed on the basis of that evidence.

Many members have commended the phase II action plan. It is a model of clarity in setting out the objectives and how they might be achieved. I will not go over all the figures regarding our situation, but members referred to them and to the fact that the situation is worse here than in some other parts of the UK. However, as Helen Eadie, Michael Matheson and others said—referring to both the outcomes and the numbers involved—it pales into insignificance in world terms.

The most striking thing in the action plan is the target figure and the funding for treatment that is associated with it. Members also referred to that. Increasing the number of treatments from 450 in 2006 to 2,000 annually after 2011 is quite a tough

target. I commend the Government for setting it, and I wish it and the health service well in delivering it. If we treat 2,000 people in 2011, we will treat as many as we have treated in total so far. That indicates the scale of the target that we have set.

Mary Scanlon said that integration is crucial, and it is. Her view is supported by speakers such as Ian McKee and Michael Matheson, who referred to the family and the patient, who must be the focus.

I have concerns about some of the systems that we are setting up, in particular the substantial bureaucracy that is being created. Mary Scanlon alluded to that by asking who is in charge. According to the action plan, there will be 14 health board leads, a Scottish Prison Service lead, 32 local authority leads, a lead for each managed clinical network, a co-ordinator for each network—which might mean up to another 14 people—and leads for prevention, national information, education, training and awareness. That is a lot of people, and the action plan lays out how many times they will meet and discuss issues. I suggest that that aspect needs to be examined closely to ensure that we do not end up with an overly top-heavy bureaucracy. We need to ensure that the focus is at the level of the individual.

Ian McKee said that the fact that there are so many non-attendees is important. Both he and I know from experience that we are dealing with a highly damaged group who, in relation to attending clinics, are not as responsive or as responsible as others are.

We are dealing with what many speakers have referred to as a silent killer—an asymptomatic disease—facing individuals who have many other problems to face. The disease may not be a priority for them, and that makes it difficult to deal with. I reiterate the point that it must be dealt with sensitively. Ian McKee rightly indicated that it would be dealt with sensitively under new plans and that there would be innovative ways of tackling it. However, we need to understand what they might be. I used text messaging for many such patients when I worked with drug addicts before I re-entered the Parliament, and they responded well to that.

Jackson Carlaw and others referred to primary care and the fact that 90 per cent of GPs did not identify a single case of hepatitis C last year. It is perhaps worse that 80 per cent of GPs do not ask about risk factors. GPs are on the front line of prevention and early identification, so we need to ensure that primary care is engaged. CHPs get only a brief mention in the action plan, but they are central to integrated delivery across local authorities and the voluntary sector. I would like the managed clinical networks to consider closely how the CHPs will deliver on those issues.

David Whitton was the main speaker on prisons and addressed the fact that the only one of the 41 actions in the first plan that was not fulfilled was the needle exchange pilot that was to be carried out in Aberdeen prison. That is regrettable but perhaps understandable. The issue is difficult for prisons to tackle—the culture in this country is different from that in Switzerland, Spain and Germany. Nevertheless, I reiterate and reinforce his call for the Government to seek early discussions to identify what the barriers were, tell us what they were and try to introduce the pilot as rapidly as possible.

Prisons have addressed a number of issues. For example, they are giving back needles that were confiscated on admission if they were supplied in police custody. That practice has been rolled out across the Prison Service, which is also training staff in hepatitis C, so the picture is not totally negative. There are 25,000 admissions annually to Scottish prisons but only around 7,000 residents at any given time, as David Whitton indicated, and a quarter of them might be infected. Many of the 25,000 will have a drug problem, and up to 40 per cent of those will have been intravenous drug users. That is a captive population that could be educated, tested and offered treatment.

It is startling to note from the action plan that, out of 450 patients who were treated, only 30 were prisoners. Given that the prison population has an overabundance of people who are infected with hepatitis C, that figure of 30—only 12 were treated inside prison—does not reflect the real proportions. I hope that, as we increase the number of treatments, the number of people who are treated in prison will increase.

I know, because I have asked, that the Government will reach a decision shortly about restoring the provision of medical services in prisons to the NHS. That is fundamental to the delivery of the plan. It is another reason for ensuring that the discussions between the NHS and the Prison Service address the relatively small disparity in funding, in order to deliver an English-style system in which the NHS is responsible for medical services in prisons.

Several members have highlighted the importance of pharmacists. They deliver much of the needle exchange programme and therefore have a huge educational role to play.

My colleague Margaret Curran, who was going to sum up the debate, intended to raise the issue of the hepatitis C inquiry budget line, which we are not totally clear about. It has been suggested that we need to make a freedom of information inquiry about that. It would be good if we could get a little clarity around that budget line, so that we can understand the overall budgets.

The debate has been highly consensual, with little criticism. The calls for speedy action from many of us are perhaps a good thing, as they keep the pressure on the Government. It is not easy to deliver on expansive plans such as this action plan, and I wish the ministers well. We will certainly keep them up to speed on the targets that they have set for themselves.

16:46

Shona Robison: I am grateful to members of all parties for their engagement with this important area. I sense that there is consensus around the chamber that what we are doing is a positive step forward. I will respond to a number of issues that have been raised.

In his opening speech, Richard Simpson asked how many users were involved in the development of the plan. I can tell him that around 20 users were actively involved in the stakeholder group that fed into the plan's development.

Richard Simpson and Mary Scanlon asked about the timescale for the Scottish intercollegiate guidelines network guideline. The SIGN guideline is already in place; it is the standards that are to be developed by 2010. That is the earliest point by which that can be done, as QIS has a heavy workload. Nevertheless, the standards are one of QIS's priorities and it is factoring that work in as quickly as it can. We will keep that under scrutiny.

Richard Simpson also talked about the roles of the MCNs, which will include representatives from primary care, pharmacy and social care. He was keen to hear how the co-ordination will happen. He also mentioned the role of STRADA, which I confirm will be involved in the education and training elements of the plan.

Richard Simpson asked about transmission of hepatitis C from overseas. I am sure that he has noted that one of the actions is to determine the prevalence of hep C among people in the Pakistani community in Scotland, who will have acquired their infection, in the main, in Pakistan. Pakistan is one of the countries with the highest prevalence of hepatitis C in the world. There are various reasons for that, one of which involves the previous childhood immunisation procedures, which, unfortunately, led to the spread of the condition. People have not found out that they have the disease until later in life—if at all—so it is important that we target the Pakistani community with testing, treatment and support.

Mary Scanlon asked how the action plan relates to the drugs strategy. As she will know, the strategy has not yet been published, but I assure her that the approach that is taken in the strategy will be fully dovetailed with, and complementary to, the action plan. When the strategy is published, she will see that the action plan is fully referenced in it.

David Whitton asked whether we can speed up the work in prisons. Given that that was one of the actions that were not achieved under the first phase, I understand his concern. I recognise the seriousness of the situation in prisons. His point was well made and we will certainly consider the scope for injecting more urgency into those actions as we take them forward with the Scottish Prison Service.

Ian McKee talked about methadone treatment. We acknowledge the importance of methadone in reducing injecting and therefore in potentially reducing hepatitis C transmission.

Our ambition is that, with the action plan, things will be better in the future. People with hepatitis C will be diagnosed quickly through a trained and knowledgeable NHS that is supported by effective and efficient diagnostic services. Those who have the disease will be quickly referred to specialist services that will be able to provide all the information that is required and to assess suitability for treatment. Where treatment is recommended, it will commence quickly and be supported throughout, and the service will link into other services such as addictions, mental health and local authority services.

There will be care and support services throughout the country to provide non-medical support to those with the condition. All that will be supported by a national awareness-raising campaign for both the public and professionals to ensure that people know what hepatitis C is, what the risks are, what the symptoms are and where to go for help. In short, the hepatitis C phase II action plan will fundamentally improve the services in Scotland for those with the disease.

As the Minister for Public Health, I made it clear at the outset that this is an important public health issue for Scotland. I sense that there is broad support from members around the chamber for what is proposed in the phase II action plan, and I am sure that those who are suffering from the disease or working in the field will be grateful for that. A number of issues on which we will be able to keep members informed about our progress have been raised during the debate. I am happy to undertake to ensure that members are kept informed of progress. I look forward to sharing that progress with them over the coming months and years.

Business Motion

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-1956, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a business programme.

There is an amendment to the business motion today, as amendment S3M-1956.1, in the name of Robert Brown, has gathered the appropriate support. The amendment is set out in the *Business Bulletin*, as revised at 4 pm today, which is available at the back of the chamber and which has been e-mailed to all members.

As it is somewhat unusual to have an amendment to a business motion, I will explain briefly how the procedure will work. Standing orders state that there can be only one speaker for and one speaker against a business motion and any amendment to that motion. Each speaker, in accordance with rule 8.11.3 of standing orders, is permitted to speak for a maximum of five minutes. That being clearly understood, I call on Bruce Crawford to move motion S3M-1956.

16:54

The Minister for Parliamentary Business (Bruce Crawford): As you are aware, Presiding Officer, there was a discussion at the Parliamentary Bureau yesterday about the request from business managers for the inclusion of a statement and a debate on the Scottish futures trust and a debate on moving Scotland forward. In response to those requests, with Parliamentary Bureau approval, next week's business programme was amended to include a ministerial statement on Wednesday afternoon on the Scottish futures trust and a debate on Thursday afternoon on moving Scotland forward, both of which are included in the business motion that is before Parliament today.

At the Parliamentary Bureau yesterday, I also agreed that there would be a requirement for a debate on the Scottish futures trust and that the timing of such a debate would be discussed at the bureau next week. That position was accepted by the majority of bureau members.

I remind members that the business motion that the Parliament is asked to approve today is not a Government motion but a Parliamentary Bureau motion that was agreed to by business managers yesterday. Robert Brown's second attempt to amend the business motion today asks the Parliament to include a debate on the Scottish futures trust next week, even though he is aware that the decision was arrived at by the majority of bureau members.

As members are aware, the Finance Committee is concluding a detailed inquiry into the funding of capital investment projects. The committee will conclude the oral evidence stage of its inquiry next week, when the Cabinet Secretary for Finance and Sustainable Growth will give evidence on the Scottish futures trust's contribution to infrastructure investment. To give the committee early notice of the Government's intent on the Scottish futures trust, we answered an inspired parliamentary question at 9 am yesterday. We also made available to the Finance Committee 10 hard copies of the Scottish futures trust business plan at 8.45 am, embargoed until 9 am, and not at 11.44 am as Elaine Murray suggested earlier.

I try to take a reasonable and pragmatic approach to all requests that business managers make to me. In this instance, again, I managed to satisfy the majority of the bureau. To date, the Government has received from the Opposition 17 requests for parliamentary statements, all but two of which have been accommodated, and seven requests for debates, all of which have been timetabled. The Government intends to be as helpful as possible on such matters and will continue to be so. I therefore ask the Parliament to agree to the business motion, which was lodged not on behalf of the Government but on behalf of the Parliamentary Bureau.

I move,

That the Parliament agrees the following programme of business—

Wednesday 28 May 2008

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Ministerial Statement: Scottish Futures Trust
followed by	Scottish Government Debate: Climate Change
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 29 May 2008

9.15 am	Parliamentary Bureau Motions
followed by	Ministerial Statement: Drugs Strategy
followed by	Scottish Government Debate: Common Agricultural Policy Health Check
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Health and Wellbeing
2.55 pm	Scottish Government Debate: Moving Scotland Forward

followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 4 June 2008	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Scottish Government Business
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 5 June 2008	
9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Justice and Law Officers; Rural Affairs and the Environment
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

16:57

Robert Brown (Glasgow) (LD): Presiding Officer, I am grateful for the Parliament's indulgence on the matter. I say immediately that the issue is not about whether the Government party's business manager responds to requests. The Government party should have proposed a debate on the Scottish futures trust from the beginning.

Earlier today, I raised a point of order about the Scottish National Party Government's failure to bring to the Parliament a ministerial statement on the Scottish futures trust. Tonight, I want to deal primarily with the consequences of that failure. I oppose the business motion on the basis that it contains no provision for a debate on the Scottish futures trust. I am subject to correction, but my recollection of what went on at the bureau's meeting is that there was an offer to consider the question of a debate rather than a promise of a debate. That is a matter of some distinct difference.

I pressed the issue to a vote. Indeed, it was the first time that that had happened in the current session. It was deeply disappointing not to receive support in the vote from the Labour and Conservative parties. Indeed, it is disappointing that the Conservatives once again support the Government on a matter in relation to which they and others should be rather more scrupulous about the rights of the Parliament.

The Scottish futures trust proposal is central to the SNP Government's programme. It purports to be the way forward for much capital spend by public bodies in Scotland, but there remains huge scepticism about it and, on any view, it should be subjected to detailed, effective and vigorous parliamentary debate. The first duty of a Parliament is to be satisfied about—and to give or withhold support for—the financial proposals of the Government. That was at the heart of parliamentary disputes with the Crown in days gone by. It is not ministerial statements, debates, points of order or even legislation that is at the core of the activities of any Parliament that is worthy of the name. It is finance—[*Interruption.*]

The Presiding Officer: Order. Could I bring the chamber to order, please? These are serious issues. We are in unprecedented, uncharted waters and I would like to hear Mr Brown in silence, please.

Robert Brown: It is finance that makes a Parliament. If the Scottish Parliament lets this overweening Government get away with making announcements on core financial issues without debate in the chamber at an early point, it is not a true Parliament. Amidst the anger and strong words with which I castigate the SNP Government tonight, I make a point that I hope will resonate—despite the cheap sneers from behind me—with the whole Parliament and with civic Scotland beyond. [*Interruption.*]

The Presiding Officer: Order.

Robert Brown: I urge colleagues to consider the matter not as party politicians but as parliamentarians.

For two weeks running, we have seen the SNP Government abuse the procedures of the Scottish Parliament to a degree that I find truly shocking. Last week, the First Minister came to Holyrood and delivered his proposals for the year ahead. Elected members were given 30 minutes to ask questions on the First Minister's statement, which was dismissed by commentators as vacuous. SNP business managers have now been forced to concede a debate to be scheduled for next week, but they appear to have learned no lessons.

This week, the Government bypassed Parliament entirely and launched the Scottish futures trust with a conference speech by the First Minister and a media briefing. Instead of a debate in the Parliament at the time on a matter of such importance to schools, hospitals and other public infrastructure contracts throughout the nation, the First Minister and his Government chose to tell Parliament about it by way of an inspired

parliamentary question from a tame SNP back bencher—indeed, is there any other kind of back bencher in the SNP group? [*Interruption.*]

The Presiding Officer: Order.

Robert Brown: There was no opportunity to question or challenge, no exchange with elected members and no debate. Only now has the SNP conceded a belated and pointless statement which, if anything, adds insult to injury.

The SNP Government, for which Mr Crawford is the apologist and public face in the chamber, is now a serial offender. The First Minister's statement last Wednesday made no mention of the Scottish futures trust announcement, which his team must have had at an advanced stage of planning. There is still no scheduled debate on the Scottish futures trust. We know from press reports that the SNP has finally admitted that its main manifesto promise is impossible to fulfil. Planning for new schools is stalling across Scotland.

The SNP Government is running feart. It will try every trick in the book to avoid exposing key policies to parliamentary scrutiny. We saw that on the budget, we saw it in the way it twisted and turned over police numbers, class sizes and university funding, and we have seen it again today.

No Government, let alone a minority Government, should be allowed to treat Parliament in such a fashion. The Government's proposals on the Scottish futures trust should be debated in the Parliament forthwith. That is why I both oppose the business motion and, unusually, move the amendment in my name to insert such a debate next Thursday morning. The common agricultural policy debate is not time sensitive and can easily be rescheduled for another suitable slot.

I move amendment 1956.1, to leave out

"*followed by*	Scottish Government Debate: Common Agricultural Policy Health Check"

and insert:

"*followed by*	Scottish Government Debate: Scottish Futures Trust".

17:02

Bruce Crawford: I will respond only to put right inaccuracies in Robert Brown's speech.

First, as I have already made plain, we made hard copies of the SFT document available to the Finance Committee at 8.45, embargoed until 9, with the intention that the Cabinet Secretary for Finance and Sustainable Growth would go before the committee the following week—

Elaine Murray (Dumfries) (Lab): On a point of order, Presiding Officer. It is not the case that hard copies were made available to Finance Committee members at 8.45. The committee clerk sent an e-mail to Finance Committee members at quarter to 11 advising that they would be available the following week.

The Presiding Officer: With respect, Dr Murray, that is not a point of order.

Bruce Crawford: Let me repeat what I said. At 8.45, hard copies of the SFT document accompanying the letter were delivered by John Swinney's private secretary to the Finance Committee clerk. They were embargoed until 9 am. The clerk was told the night before that that material would be coming to the committee.

Hugh Henry (Paisley South) (Lab): He is changing his story as he goes along.

The Presiding Officer: Order.

Bruce Crawford: I hear the mutterings around me that things are moving on, but I am repeating exactly what I said earlier. It was always the Government's intention to allow the cabinet secretary to go before the Finance Committee next week so that detailed scrutiny of the Government's proposals can be undertaken. We outlined that process. I also made it plain earlier today that not only did we write to the committee but we submitted an IPQ and we have now agreed to come back with a ministerial statement.

Presiding Officer, your guidance makes it clear that there are five routes by which major policy or spending announcements can be made. We are now committed to following three of those five routes—I do not think that the Government could have done any more.

George Foulkes (Lothians) (Lab): On a point of order, Presiding Officer. Is the amendment to the business motion not debatable?

The Presiding Officer: I explained at the beginning—if anybody was listening—that there would be one speaker for and one against the motion, if anyone requested to speak against it, and one speaker for and one against the amendment. We have followed that process and I move now to the vote.

The question is, that amendment S3M-1956.1, in the name of Robert Brown, which seeks to amend business motion S3M-1956, in the name of Bruce Crawford, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Baker, Claire (Mid Scotland and Fife) (Lab)
Brown, Robert (Glasgow) (LD)

Finnie, Ross (West of Scotland) (LD)
Hume, Jim (South of Scotland) (LD)
McInnes, Alison (North East Scotland) (LD)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
O'Donnell, Hugh (Central Scotland) (LD)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tolson, Jim (Dunfermline West) (LD)

AGAINST

Adam, Brian (Aberdeen North) (SNP)
Ahmad, Bashir (Glasgow) (SNP)
Aitken, Bill (Glasgow) (Con)
Allan, Alasdair (Western Isles) (SNP)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brown, Keith (Ochil) (SNP)
Brownlee, Derek (South of Scotland) (Con)
Campbell, Aileen (South of Scotland) (SNP)
Carlaw, Jackson (West of Scotland) (Con)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
FitzPatrick, Joe (Dundee West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kidd, Bill (Glasgow) (SNP)
Lamont, John (Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Marwick, Tricia (Central Fife) (SNP)
Mather, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLetchie, David (Edinburgh Pentlands) (Con)
McMillan, Stuart (West of Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Paterson, Gil (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Swinney, John (North Tayside) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Wilson, Bill (West of Scotland) (SNP)
Wilson, John (Central Scotland) (SNP)

ABSTENTIONS

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Foulkes, George (Lothians) (Lab)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Kerr, Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Mulligan, Mary (Linlithgow) (Lab)
Murray, Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)

The Presiding Officer: The result of the division is: For 15, Against 62, Abstentions 44.

Amendment disagreed to.

The Presiding Officer: The next question is, that motion S3M-1956, in the name of Bruce Crawford, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (Aberdeen North) (SNP)
Ahmad, Bashir (Glasgow) (SNP)
Aitken, Bill (Glasgow) (Con)
Allan, Alasdair (Western Isles) (SNP)

Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brown, Keith (Ochil) (SNP)
Brownlee, Derek (South of Scotland) (Con)
Campbell, Aileen (South of Scotland) (SNP)
Carlaw, Jackson (West of Scotland) (Con)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
FitzPatrick, Joe (Dundee West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kidd, Bill (Glasgow) (SNP)
Lamont, John (Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Marwick, Tricia (Central Fife) (SNP)
Mather, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLetchie, David (Edinburgh Pentlands) (Con)
McMillan, Stuart (West of Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Morgan, Alasdair (South of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Paterson, Gil (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Swinney, John (North Tayside) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Wilson, Bill (West of Scotland) (SNP)
Wilson, John (Central Scotland) (SNP)

AGAINST

Brown, Robert (Glasgow) (LD)
Finnie, Ross (West of Scotland) (LD)
Hume, Jim (South of Scotland) (LD)
McInnes, Alison (North East Scotland) (LD)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
O'Donnell, Hugh (Central Scotland) (LD)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tolson, Jim (Dunfermline West) (LD)

ABSTENTIONS

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Foulkes, George (Lothians) (Lab)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Kerr, Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Mulligan, Mary (Linlithgow) (Lab)
Murray, Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)

The Presiding Officer: The result of the division is: For 62, Against 14, Abstentions 45.

Motion agreed to.

That the Parliament agrees the following programme of business—

Wednesday 28 May 2008

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	*Ministerial Statement: Scottish Futures Trust*
followed by	Scottish Government Debate: Climate Change
followed by	Business Motion

followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 29 May 2008	
9.15 am	Parliamentary Bureau Motions
followed by	Ministerial Statement: Drugs Strategy
followed by	Scottish Government Debate: Common Agricultural Policy Health Check
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Health and Wellbeing
2.55 pm	Scottish Government Debate: Moving Scotland Forward
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 4 June 2008	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Scottish Government Business
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 5 June 2008	
9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Justice and Law Officers; Rural Affairs and the Environment
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Decision Time

17:07

The Presiding Officer (Alex Fergusson): There are three questions to be put as a result of today's business. The first question is, that amendment S3M-1943.1, in the name of Dr Richard Simpson, which seeks to amend motion S3M-1943, in the name of Shona Robison, on hepatitis C, be agreed to.

Amendment agreed to.

The Presiding Officer: The second question is, that amendment S3M-1943.2, in the name of Ross Finnie, which seeks to amend motion S3M-1943, in the name of Shona Robison, on hepatitis C, as amended, be agreed to.

Amendment agreed to.

The Presiding Officer: The third question is, that motion S3M-1943, in the name of Shona Robison, on hepatitis C, as amended, be agreed to.

Motion, as amended, agreed to.

Resolved,

That the Parliament recognises the leading role that Scotland is taking in tackling hepatitis C as a significant public health issue; commends the hard work undertaken by those staff involved in delivering 40 out of 41 action points in Phase I of the Scottish Government's Hepatitis C Action Plan and welcomes the launch of the Scottish Government Hepatitis C Phase II Action Plan, backed by funding of £43 million on 19 May 2008 as a significant step forward in seeking to prevent hepatitis C and working to raise awareness among professionals, the public and those at risk of infection and in delivering testing, treatment, support and care services to those affected by the disease, and considers that this will enable NHS boards and others identified in the plan to deliver on the actions set out to improve hepatitis C services for patients and others in Scotland.

Insulin Pumps

The Deputy Presiding Officer (Alasdair Morgan): The final item of business is a members' business debate on motion S3M-1888, in the name of David Stewart, on increasing access to insulin pumps. The debate will be concluded without any question being put.

Motion debated,

That the Parliament notes the considerable benefits that insulin pumps have for diabetics to help them to manage their condition; notes with concern the current restrictive criteria for eligibility for the use of insulin pumps which have contributed to insulin pump usage in Scotland being among the lowest in western Europe, with only around 0.75% of people with Type 1 diabetes using pumps in Scotland, compared with 15% to 20% in the United States of America and Germany; is concerned at the extreme regional disparity in uptake of insulin pumps across NHS boards, with only two patients receiving insulin pump therapy in NHS Ayrshire and Arran, compared with 42 in NHS Tayside in the most recent figures, despite all NHS boards having received funding for access to insulin pumps; supports the campaign of Diabetes UK to increase access to insulin pumps and welcomes the review being undertaken currently by the National Institute for Health and Clinical Excellence (NICE) of the eligibility for use of pumps in the NHS, and believes that further steps should be taken to ensure that new NICE guidance that seeks to relax access criteria is adopted swiftly in Scotland, to support all NHS boards to increase access to insulin pumps for patients with diabetes and to enable more training for health practitioners to support patients in moving to the use of pumps where it is clearly of benefit in the management of their diabetes.

17:09

David Stewart (Highlands and Islands) (Lab): I welcome the opportunity to debate increased access to insulin pumps specifically, but also the bigger picture of diabetes and its role in health care management. The motion has widespread support across the political spectrum and I thank members who supported it. As for those who have not, I always welcome sinners who repent.

First, I acknowledge the work of the cross-party group on diabetes, which Karen Whitefield convenes and of which I am a member. I warmly welcome the visitors in the public gallery, particularly the representatives of Diabetes UK Scotland.

Some may ask, why debate diabetes? I declare a personal interest, in that about 11 years ago I made a fascinating visit to Raigmore hospital in my constituency. I went to the diabetic specialist centre there, where I was encouraged by the staff to take a particular interest in the debate. I also had a family member, who is unfortunately no longer with us, who suffered from diabetes for more than 70 years, so I have first-hand experience of day-to-day family life with a diabetic. In my Westminster days, I was secretary of the all-party group on diabetes.

Members will be aware of the major causes of concern about diabetes. It is the main cause of blindness among people of working age; half of all non-traumatic lower limb amputations are due to diabetic complications; and diabetic care costs the national health service in Scotland the phenomenal sum of about £0.5 billion.

On type 2 diabetes, members will be aware that I have supported a campaign for high-risk screening for type 2, or mature onset, diabetes for people who are overweight, or who have a family history of diabetes or who are over 45. I hope to use the United Kingdom screening committee to give some support to that campaign.

What am I calling for? It is important that we have greater use of continuous subcutaneous insulin infusion—CSII—or, as it is also known, insulin pump therapy, which is slightly easier to pronounce, so I will use that term for the rest of the debate. As members will be aware, insulin pump therapy provides significant improvement in glycaemic control and quality of life for some people with type 1 diabetes—so-called early onset and insulin-dependent diabetes.

The pump is an external device that continually infuses insulin into the patient's body and thus controls their glycaemic levels, which many patients otherwise struggle to achieve. That alternative way of maintaining insulin levels can contribute to more stable wellbeing by reducing the risk of hypoglycaemia and replacing several daily injections with only two to three a week. With the pump, insulin levels can be increased by simply pressing a button on the pump instead of using a pen needle, which can be embarrassing for patients, particularly when they inject in public.

Insulin pumps empower patients to have greater control over their condition as they give them a more flexible and reliable means of managing glycaemic levels. Improved control over one's own health means improvement in the quality of life of many patients: it means fewer hospital visits, a more productive work life and less stress at home. Fewer hospital admissions and a reduction in primary care contacts also mean that there is less strain on the NHS.

Diabetes UK Scotland has argued that there is a saving of more than £23,000 over two years, which would comfortably offset the cost of pump therapy. Let us look at the big picture and compare the cost with the costs of poorly controlled diabetes: a one-night stay in hospital following admission to accident and emergency for a diabetes emergency costs £350; one course of laser treatment for retinopathy costs £850; one procedure of dialysis treatment for kidney disease costs £500; and renal dialysis for one year costs £15,000.

Despite the outlined benefits of insulin pump therapy, it is still rare in Scotland. That is particularly problematic considering Scotland's prevalence of type 1 diabetes, which is well above the European average. Less than 1 per cent of sufferers of type 1 diabetes receive insulin pump treatment. That is in stark contrast to other parts of the world, where rates of pump use are much higher. For example, in Germany and the United States 15 per cent to 20 per cent of patients enjoy the benefits of insulin pumps. What would it mean if we had the same rate as the USA and Germany? it would mean that another 4,000 to 5,000 people in Scotland would benefit. In my region—the Highlands—that would mean a jump from six users, which is very low, to 450. In the Western Isles, it would mean a jump from only one user to 33.

What is obstructing patients from accessing the treatment, which could potentially change fundamentally the lives of so many of them? Part of the explanation is that the criteria for qualification for insulin pump therapy are currently restrictive and exclude many patients who could otherwise benefit. If a patient does not fall into the set category, they have to fund the treatment themselves, which can run into thousands of pounds. Diabetes UK Scotland has criticised the criteria, which, as members are aware, are currently under review by the National Institute for Health and Clinical Excellence. It appears likely that the criteria will change and be relaxed, but that does not mean that our work is over—we must ensure that health boards have the funds to finance treatment for the additional patients.

A further concern is that only limited specialist centres in Scotland are able to deliver pump therapy, which means that some patients have to travel extensively. The answer to a recent parliamentary question from Christine Grahame showed that since February 2007 there has been an increase in the number of users of about 127. I give praise where praise is due: Lothian NHS Board and Tayside NHS Board should pat themselves on the back, because their levels of pump usage are well above those in England and the rest of Europe. I do not, however, have such a positive message to put out for Greater Glasgow and Clyde NHS Board and Ayrshire and Arran NHS Board, which are in the corner with dunce's caps for their low level of pump usage.

As with most things in life, we never really appreciate the devastating extent of a disease until we suffer it ourselves. That is why I will end my speech by telling members a story about a diabetic who can tell members first hand how life-changing the effects of insulin pump therapy can be. Her name is Dorothy, she is in the gallery today and she has had type 1 diabetes for 37 years. She has struggled to control her blood sugar level, which has affected her health and deprived her of sleep. She states:

"Within 4 weeks of starting the pump, my blood glucose levels came down to 7.5. I suddenly got my life back. My appetite returned and at last I could see the light at the end of the tunnel.

Despite feeling 100% better, I still have problems with my control and it's my belief that had I got the 'pump' earlier, I would never have experienced these problems.

For this reason and many others, I strongly believe that continuous subcutaneous insulin infusion (CSII) should be available to everyone who would benefit from it and especially to young people who have their whole life in front of them.

It is my dearest wish that they may live their life free of all diabetic complications."

I call on the Cabinet Secretary for Health and Wellbeing to follow NICE guidelines and to encourage increased use of pump therapy, to provide a new era of hope for type 1 diabetics.

17:17

Nanette Milne (North East Scotland) (Con): I am pleased to take part in the debate and I commend David Stewart on lodging the motion. Since I entered Parliament five years ago, my focus and that of many others has been on the frightening increase in the incidence of type 2 diabetes in our population, following what is almost an epidemic of obesity that affects younger and younger age groups. Because type 2 diabetes is such a great public health concern, it is easy to forget that the incidence of type 1 diabetes in Scotland is among the highest in the world.

As we know, diabetics depend on a successful insulin regime to keep their blood glucose under control. The better and more consistent the control is, the less likely it is that they will suffer the long-term complications of type 1 diabetes, such as retinopathy, arterial disease and renal failure. Many people adapt to their changed lifestyles after diagnosis without too many problems, but others find it hard to achieve a normal blood glucose level and fluctuate widely between hyperglycaemia and hypoglycaemia, both of which are dangerous for the patient in different ways.

There appears to be no doubt that better control of blood sugar, with fewer fluctuations and complications, can be achieved by many people who use insulin pumps, and that the quality of life of patients and their families is improved as a result. As David Stewart said, children in particular have been shown to adapt well to the use of insulin pump technology.

Clearly, any device that can improve blood-glucose control in diabetes will lead to long-term benefit, not only to the patient's health and wellbeing but also to the NHS, which will be faced

with fewer complications to treat, and will experience reduced hospital admissions and less medical staff time being used in primary, secondary and tertiary health care settings.

Not every type 1 diabetic is considered suitable for, or wants, an insulin pump, but even under the fairly stringent eligibility criteria that have been recommended by NICE, which are currently under review, there are significantly fewer pump users in Scotland than in the rest of the UK, and many fewer than in the diabetic populations of the rest of the European Union and in the United States. Now that all health boards in Scotland have strategies in place for prescribing insulin pumps, their use is on the increase, but there is still significant regional disparity in the provision of pumps. Many more people could benefit from them.

The pumps do not come without cost, and their effectiveness depends on a sufficient number of health practitioners having been trained to support patients in their use. However, the long-term savings could be very significant. It is indeed a spend-to-save provision that concurrently leads to improved quality of life for successful users of the technology.

Several recent members' debates have illustrated the patchy provision of life-enhancing equipment in Scotland. There was Trish Godman's debate on wheelchair provision, mine on alternative and augmentative communication aids, Alison McInnes's on school book provision for visually impaired pupils, and now David Stewart's on the availability of insulin pumps. All those debates have concerned people for whom improved provision would make a huge difference to the quality of their lives. I am sure that there are many other long-term conditions for which treatment could be improved by technology or by more specialist nurses or other staff within the community.

Taken together, the improved quality of life for many people, and the resultant decrease in use of highly specialist secondary and tertiary NHS facilities and other public services, could only be of long-term benefit to our society, both physically and financially.

In supporting David Stewart's plea for greater provision of insulin pumps, I suggest to the cabinet secretary that a good deal of work needs to be done by, and with, the Long-term Conditions Alliance Scotland, to consider how provision could be improved across the board, with the ultimate goal of eliminating postcode lotteries in Scotland and improving the quality of life for all patients with chronic conditions who currently receive less than optimum care—including type 1 diabetics. [*Interruption.*]

The Deputy Presiding Officer: I am sorry—I do not want to be a spoilsport, and I should have said this earlier—but applause from the public gallery is not permitted.

17:21

Karen Whitefield (Airdrie and Shotts) (Lab): I welcome the opportunity to speak in this evening's debate and congratulate David Stewart on securing a members' business debate on this important topic.

Some members may recall that I, too, secured a members' business debate on diabetes a few years ago. That debate was the first time—and, I think, the last time—that the then Lord Advocate spoke in a debate in this chamber on a topic that was outwith the justice field. Colin Boyd wanted to participate to highlight the effect that diabetes had had on his life. His speech clearly demonstrated the wide-ranging impact of diabetes in our society. There cannot be a family that has not been touched by diabetes in some way.

I know only too well the difficulties and challenges that diabetes can cause within a family. Those difficulties are why it is vital that our NHS provides support, care and clinical treatment to those who suffer from the illness. Previous initiatives such as the launch of the Scottish diabetes framework and the associated action plan, as well as the ban on smoking in public places, have all been positive but, as others have said, we can still do much more to improve diabetes services in Scotland. Today's debate highlights just one way in which we can do that.

Insulin pumps will not be suitable for all diabetes sufferers. The treatment requires commitment on the part of the patient, as well as proper support from clinicians. It is also true to say that substantial costs are associated with this form of treatment. However, as the briefings from Diabetes UK and Roche Diagnostics clearly demonstrate, considerable savings to the NHS can accrue as a result of people using an insulin pump. The savings come from a reduction in the need for on-going clinical interventions for problems such as severe recurrent hypoglycaemic episodes and hyperglycaemia. Diabetes UK estimates that such a reduction could result in savings of up to £23,500 per patient over two years. That can be offset against the cost of maintaining a patient on an insulin pump.

Not only are we not delivering on that potential saving and improved service, we are not even achieving the number of people that NICE estimates should be accessing the service in Scotland. That point has already been made, and I am sure that it will be made again.

Unfortunately, Lanarkshire, where I live and part of which I represent as an MSP, has some of the worst health statistics in Scotland. That is certainly true with regard to type 1 diabetes; the number of people in Lanarkshire who suffer from the condition is 18 per cent above the Scottish average. However, the percentage of those people with an insulin pump is only a quarter of the figure for the rest of Scotland and a tenth of the UK figure. In short, Lanarkshire has one of the worst problems with diabetes and one of the poorest records in supplying insulin pumps. That situation must be addressed and I urge the Cabinet Secretary for Health and Wellbeing to work in partnership with NHS Lanarkshire to ensure that the people of Lanarkshire are not disadvantaged in comparison with other parts of Scotland or the UK.

I very much welcome the steps to improve the prevention, diagnosis and treatment of diabetes in Scotland, but in the provision of insulin pumps we are clearly lagging behind the rest of the UK and are far behind many other parts of the world. It is important that the cabinet secretary listens to Diabetes UK's concerns and provides funding and resources to ensure that the Scottish people get the very best possible care and treatment for their diabetes.

17:26

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I, too, congratulate David Stewart on securing this debate. I am slightly disappointed that there are not more members in the chamber—indeed, one party is not represented at all—because diabetes is very serious and important health issue, the complications of which, as Nanette Milne has made clear, have massive consequences for not only individual suffering but the cost to society.

Over the past 20 or 30 years, diabetic care has improved substantially, and the shift to primary care has been fundamental in ensuring a much more proactive and individualised approach. The creation of care plans, for example, has been important, but we are still some way from the establishment of key workers, which I think is also fundamental to the delivery of good care.

In the early 1990s, during the time of fund holding, I was among those who were invited to carry out a study on how fund holding and commissioning could be used to drive forward a retinal screening programme in my locality. In two years, the subsequent programme increased the level of screening from 60 per cent to 92 per cent. What levers are available nowadays to deliver on these matters? The information that we have received makes clear the extreme range of provision. For example, the figure for those with diabetes who have insulin pumps is 0.1 per cent in Ayrshire and Arran, but 2.7 per cent in Tayside. I am glad to say that two out of the three health boards in my region of Mid Scotland and Fife—NHS Tayside and NHS Fife—are doing quite well in that respect.

I should also point out that Tayside has the most highly developed diabetic programme in Scotland. In identifying diabetics and ensuring more integration of care, the diabetes audit and research in Tayside Scotland study, which involved the Tayside medicines monitoring unit, has helped to drive up care levels in that area in a way that perhaps has not happened elsewhere in Scotland. It is therefore no surprise to me that the figure in Tayside for those with insulin pumps is 2.7 per cent, a full 1 percentage point above any other area.

I suggest that the benchmark for Scotland should be in the region of 2.5 per cent and that we invite the Cabinet Secretary for Health and Wellbeing to use every available means to hold health boards, particularly the outliers, to account and to ask them to explain these massive discrepancies between one area and another—to her, to the Government and to the Parliament.

Pumps are not suitable for everyone, but for people for whom they are suitable, particularly those who are unstable and require a background delivery of insulin, savings can undoubtedly be delivered.

One of the problems for the health service is the demand that we place on it to achieve efficiency savings. That demand is entirely appropriate, but it is far too often recognised only in the short term. We need a system that allows health boards to invest the savings that they make and encourages them to invest for future savings. We need to raise people's sights and horizons to savings that could be made down the line, which will involve thinking beyond the spending cycle that, to a large extent, governs our actions. In the 1980s, I made proposals to eliminate a nine-month waiting list for vasectomy that I said would have a one-off cost that would be paid for in six years. The health board's response was that it did not think that far ahead. We need to think that far ahead.

17:30

James Kelly (Glasgow Rutherglen) (Lab): I welcome the opportunity to take part in this evening's debate on the provision of insulin pumps and congratulate David Stewart on bringing the issue to the Parliament. As other members have said, the subject is important, as it affects not just the treatment of type 1 diabetes but the whole NHS.

As Nanette Milne said, type 1 diabetes is an extremely serious issue in Scotland, given the high incidence of the condition here—the third highest in the world. We have about 197,000 sufferers of diabetes, more than 26,000, or 15 per cent, of whom have type 1 diabetes. That is an extremely large number.

As other members have said, the condition has a significant impact on young people, 35 per 100,000 of whom are affected by it. That has an impact not only on their lives, but on those of their families and on the support that the NHS provides through treatment of continuing illnesses.

It is clear that the use of insulin pumps can make the treatment of type 1 diabetes more effective, in that it can help people to manage their condition, make them more disciplined and contribute to an improved quality of life. The disparity between the use of insulin pumps in Scotland and in the rest of the UK and internationally is a concern. About 1 per cent of people in Scotland who have type 1 diabetes use insulin pumps, whereas the figure for the UK as a whole is 2 per cent. The disparity is even starker if we compare the situation in Scotland with that in other EU countries, where the figure ranges between 10 and 20 per cent. In the United States, too, the figure approaches the 20 per cent mark.

As other members have said, there are wide variances between the rates in different health board areas. There are more than 5,000 sufferers of type 1 diabetes in the Greater Glasgow and Clyde NHS Board area, but only 31 of them use insulin pumps, which equates to a rate of 0.6 per cent. The rate in Lanarkshire, too, where only 21 out of more than 3,000 sufferers use insulin pumps, is only 0.6 per cent, which is well below the Scottish average and even further below the UK average. It is clear that urgent action is required. It is important that we raise the standard. I endorse Richard Simpson's suggestion that we should try to raise the level of insulin pump usage to 2.5 per cent across Scotland.

The provision of an insulin pump costs about £1,600 a year, whereas injections cost about £500 a year, but as Karen Whitefield and David Stewart said, the use of pumps can result in the NHS recouping £23,000 over two years because type 1 diabetes sufferers can go on to suffer from heart disease, stroke, kidney problems and blindness, which has an impact throughout the service. The use of insulin pumps to tackle type 1 diabetes has two main advantages: it improves people's health and it reduces the long-term strain on the NHS.

I congratulate David Stewart on raising this issue. He has helped to raise its profile, which I hope will help diabetes sufferers and have long-term benefits for the nation's health.

17:35

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I thank David Stewart for bringing the issue to the chamber, and I thank those in the public gallery who have attended to hear the debate. Like other members, I pay tribute to the work of Diabetes UK Scotland.

Other members have highlighted effectively the scale of the diabetes challenge. More than 200,000 people in Scotland have a diagnosis of diabetes. Every one of them needs access to high-quality services and appropriate educational programmes to optimise self-management. People with type 1 diabetes, who need insulin to survive, make up about 13 per cent of the total. That means that more than 27,000 people need access to structured care, timely advice and local education programmes.

As we have heard in the debate, between 1 and 2 per cent of people with type 1 diabetes use an insulin pump to deliver insulin continuously. There is no doubt that, for suitable people with type 1 diabetes, getting access to continuous subcutaneous insulin infusion—I will refer to that as insulin pump therapy from now on—can be a life-changing event. We have heard examples of that during the debate. I assure David Stewart and others that the Government is committed to ensuring that people with type 1 diabetes who meet the criteria should have access to the insulin pumps that deliver therapy.

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): We heard during the debate of the poor figures for Ayrshire and Arran. Given that, does the cabinet secretary feel it appropriate to get in touch specifically with Ayrshire and Arran NHS Board to ascertain what it intends to do to progress matters?

Nicola Sturgeon: I am always happy to follow up issues individually with health boards, and I will return to the issue of variability across boards in a minute.

As members are aware, our national policy is set out in the diabetes action plan. Each NHS board area should have an insulin strategy covering the full range of insulin use, including, where appropriate, the use of pumps. Local implementation of that insulin strategy is the responsibility of each NHS board, working closely with its diabetes managed clinical network to ensure that it complements the other services for people with diabetes. That approach allows the diabetes MCNs to monitor regularly the availability of pumps, and to report their findings to the Scottish diabetes group. The group arranged for advice on the subject to go to all the diabetes MCNs in spring of last year. It also organised a

national meeting of MCN representatives to share best practice around insulin pump therapy. A working group then produced a national educational curriculum, which is available to all NHS boards. The diabetes lead clinician intends to ensure that progress is a standard item on the agenda for the regular meetings that he has with the networks' clinical leads.

There has been a growth in the use of pumps across Scotland. We should acknowledge that progress, but we must recognise that there are two main concerns about current performance, the first of which is the variation in provision across NHS boards. The motion, quite rightly, draws attention to the disparity in uptake of pumps across NHS boards. A number of members have touched on that in relation to specific boards: NHS Ayrshire and Arran, and NHS Lanarkshire. I assure members that I will continue to press boards on that issue.

Another concern that has been highlighted in the debate is that, on current criteria, as set out by NICE, our use of pumps is at the lower end of the spectrum. There are 263 people on an insulin pump, whereas applying the NICE criteria suggests that the number should be somewhere in the range of 260 to 530. As we have heard, NICE is reviewing its technology assessment, which might mean that around 15 per cent of people with type 1 diabetes could be considered eligible for an insulin pump.

I want to introduce an important factor that is not mentioned in the motion but which was touched on by, I think, Richard Simpson. For people with type 1 diabetes, it is a case of determining the insulin regime that is best suited to each person's circumstances. We also need to take into account the type of regime that commands the confidence of the team that provides diabetes services. As members know, the main options are insulin injections, which might need to be administered between two and four times a day, and insulin pumps, which are now technically much more reliable than they used to be. The choice of insulin regime should be agreed between the person who has type 1 diabetes and the team that supports their diabetes care.

The benefits to patients of insulin pumps were well described by David Stewart and other members, but it is important to put on record that insulin pump therapy is not always an easy option and requires determination and commitment on the part of the patient, coupled with a structured education course. Insulin pump therapy improves patient satisfaction in some cases, but it does not inevitably lead to better control of blood glucose levels. Children who are on insulin pump therapy need continuing care, especially during the transition to adolescence and adulthood. However, as many members said, insulin pump therapy can offer people with diabetes increased freedom and flexibility and a better quality of life. We would not want to reduce such an issue to a crude cost benefit analysis, but points about cost savings were well made by members.

We will encourage boards to continue to increase the number of people who use insulin pumps, but we need to acknowledge that that must be a managed process, in part because a key factor is the availability of staff to deliver the education programmes that are needed before pump therapy commences, to ensure that the regime is used optimally. Structured education is very important in maintaining and improving blood glucose control in all 27,000 people with type 1 diabetes and is an important adjunct to insulin pump therapy.

I repeat my thanks to everyone who took part in the debate. I acknowledge the importance of the issue and I support the thrust of the motion. I will ensure that I and the Scottish diabetes group continue to monitor closely insulin pump programme availability throughout Scotland and on a board-by-board basis, particularly when the new NICE criteria are available. I have no doubt that the Parliament will also want to monitor the issue closely.

Meeting closed at 17:42.

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