The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 9 November 2011

Session 4

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Scottish Parliament

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[The Presiding Officer *opened the meeting at 14:30*]

Time for Reflection

The Presiding Officer (Tricia Marwick): Good afternoon. I remind members to leave their voting cards firmly in place. The first item of business is time for reflection. Our time for reflection leader today is the Rev John Chalmers, principal clerk of the General Assembly of the Church of Scotland.

The Reverend John Chalmers (Principal Clerk of the General Assembly, Church of Scotland): "They shall not grow old, as we who are left grow old".

Those words that call us to remembrance will mean so much more to me this year, because on 27 May two Royal Marines from 42 Commando and their Afghan interpreter were killed by an improvised explosive device in Helmand province. Our youngest son and another young man from his troop were next in the line of the blast and were repatriated two days later-–just clinging on to life. That weekend, the phrase "the family has been informed" took on a very different meaning for us.

This year the poppy has a new depth of meaning. In fact I have learned new things about the poppy, which until now was always just associated with Flanders fields. In serving in Helmand province, our servicemen and women are facing an enemy whose economy depends on the poppy that supplies 75 per cent of the world's illegal opiate. The same opiate, however, saves the lives of those who are traumatically injured in the field. Months later, the young men and women who survive their injuries find themselves addicted to the drug—a drug that they would never otherwise have entertained as any part of their life. That is because they have needed so much morphine throughout their treatment that they have become dependent. Our injured service personnel then have to go through withdrawal symptoms.

I now know that the process of withdrawal goes deeper still as our young men and women remember the colleagues and the experiences that change their lives forever. A very high price is being paid on the battlefields of this world.

The real point of all this is to remember that the young women and men who go out to theatres of war do not choose their battles; they are servants of their Governments and they depend on folk like you making the wisest of decisions. And it is down to us—people who have power and people of good will—to find better ways than war to resolve some of the world's most intractable problems.

The poppy that I wear this year will remind me of three men who took the full force of a blast that changed our family's life. It will remind me of the families of those same men, because what has been a trial for us has been a tragedy for them.

I offer this prayer.

Remind us blessed God that even the smallest decisions that we make in places of power can have consequences beyond our wildest imagining. And endow us with the wisdom needed to govern with mercy, compassion and justice.

Amen.

Rehabilitation and Enablement

The Presiding Officer (Tricia Marwick): The next item of business is a debate on motion S4M-01262, in the name of Michael Matheson, on rehabilitation and enablement in Scotland. Mr Matheson, you have a generous 14 minutes to speak to and move the motion.

14:35

The Minister for Public Health (Michael Matheson): Thank you, Presiding Officer. That sounded like I might have 15 or 16 minutes!

I am pleased to open this debate on rehabilitation and enablement, particularly given their importance to and the role that they can play in the health and social wellbeing of the people of Scotland.

As the motion states, it is essential that we recognise the importance of rehabilitation and re-enablement in supporting the health and wellbeing of Scotland's population, the key role that rehabilitation and re-enablement services play in enabling individuals to live productive and meaningful lives and the importance of that approach in underpinning the future sustainability and affordability of Scotland's health and social care service provision.

I emphasise just how central the approach to enablement is to the Government's ambition of improving the health and wellbeing of the population of Scotland, and my belief that rehabilitation and re-enablement will be instrumental in achieving many of the key national outcomes agreed both with NHS Scotland and by our local authorities.

Scotland has a growing elderly population, which is testament to the many successful measures that have been taken over the years to improve public health overall and to the improvement in the standard of care that is available in the national health service.

The fact that more people are living longer is not new information, but the way in which the demographics of Scotland are changing demonstrates the extent of the challenge that we face in ensuring that the systems that we have in place are sustainable and provide the best quality of care for individuals.

We must recognise the full extent of the demographic shift in Scotland, the challenges that lie ahead and the financial pressures that will be experienced as a result.

Let me remind the chamber of some of the challenges. It is predicted that there will be a 62 per cent increase in the number of over-65s by 2031. It is also predicted that emergency admissions will rise by 84 per cent by 2031; that by the age of 65 nearly two thirds of people will have one or more long-term condition; and that people with a long-term condition will be twice as likely to be admitted to hospital and will account for 60 per cent of all hospital bed days used. By 2031, it is predicted that there will be an increase of 144 per cent in the number of over-85s in Scotland. I believe that those statistics show the context for the need to address how we provide services and to ensure that they are both focused on the needs of individuals and sustainable in the long term.

Our reshaping care for older people programme is focusing on improving services across health and social care for older people. All 32 partnerships agreed local change plans and received their allocations of the £70 million change fund available in this financial year. Following the 2012 spending review, we announced a further £80 million change fund for partnerships in 2012-13, with £80 million committed for 2013-14 and £70 million for 2014-15, to drive the development of services that optimise the independence and wellbeing of older people at home or in a homely setting. We will also continue to ensure that we address the challenges that arise even with the provision of funding through the change fund.

Too many older people and vulnerable individuals end up in hospital when they should not, and too many stay there much longer than need be the case. That is why the Cabinet Secretary for Health, Wellbeing and Cities Strategy recently announced new targets to reduce delayed discharges in our health settings: by April 2015 we want no one to be delayed in hospital for more than two weeks.

Now, more than ever before, we need to deliver health and social care in an integrated way and to ensure that primary healthcare and community care staff work efficiently together to prevent unnecessary hospital admissions and inappropriate referrals to secondary healthcare services. Moreover, we must enable our health professionals and support staff to meet the growing demand for their expertise and interventions. That will require a not insignificant shift from traditional models of care that have tended to focus on deficits and naming and fixing problems to a model that embraces the concept of assets and sees the patient's own experience and knowledge of their condition as a resource that can be built on to support resilience and self-management.

Of course, rehabilitation is not a new concept. In fact, it was established around the time of the first world war to support soldiers who were recuperating and adapting to life after injury in

service. Fundamentally, it is a partnership between patient and therapist as well as family and carers. It is not a passive process and relies heavily on the individual's motivation and participation to recover and adjust, achieve their full potential and, where possible, live a full and active life, whatever their age.

Improving community-based rehabilitation and re-enablement services is already integral to the prevention of dependency on healthcare and support services through the promotion of independent living, making better use of resources and improving outcomes for users. Although much has been done to develop rehabilitation and re-enablement services since the publication in 2007 of the delivery framework for adult rehabilitation, I recognise that we still have a significant way to go on this journey.

Rehabilitation co-ordinators, directors of allied health professionals in NHS boards and directors of social work have all played an important role in mapping out services across health and social care and supporting multi-agency working to address gaps and join up service provision, particularly at key transitions between care settings. We have expanded rehabilitation and re-enablement services in a range of speciality areas such as chronic obstructive airways disease, stroke and cardiac services and have also seen significant growth in local authorities' development of rehabilitation and re-enablement services, using occupational therapy expertise to transform the delivery of home care across Scotland. However, challenges remain in meeting the needs of those who require rapid access to advice and self-management support and in enabling the transition between services provided in hospital and community settings or for those with complex care needs and multiple long-term conditions who wish to remain in their own home.

The earlier that advice or intervention can be provided, the more likelihood there is of a positive outcome, be it a return to work, preventing a condition from becoming chronic or avoiding hospital referrals or admissions to care settings. Indeed, such an approach will be critical, given the demographic changes ahead and the financial pressures that public sector budgets are already under.

Mary Scanlon (Highlands and Islands) (Con): Given that physiotherapy will be one of the main focuses of the debate, I point out that, according to the response to a freedom of information request that I submitted two years ago, 20,000 people in Scotland were on the waiting list for that treatment. How many are on the waiting list now?

Michael Matheson: I am aware that people wait too long to access rehabilitation services, including physiotherapy. As I develop my speech, I will try to explain to the chamber how we intend to address the issue and improve our approach to ensuring that people get more timely access to services.

Current patterns of service provision are both unsustainable and undesirable. Without the implementation of rehabilitation and re-enablement strategies, the costs of health and social care for all ages are expected to rise over the next 20 years by about £2.5 billion.

Now, more than ever before, we need to deliver health and social care in an integrated way and ensure that primary healthcare and community care staff work efficiently together to prevent unnecessary hospital admissions and inappropriate referrals to secondary services.

To that end, we will soon be consulting on work that is already under way to strengthen intermediate care: entitled "Recovery, Re-enablement, Rehabilitation: a Framework for Intermediate Care", its aim is to ensure that there is intervention at the earliest point possible.

I take the opportunity to acknowledge the commitment, energy and enthusiasm that allied health professionals demonstrate in delivering the health agenda across Scotland. They are a key group of practitioners who support the delivery of rehabilitation and re-enablement care, and they are the only group of staff working across health and social care who are expert in rehabilitation practice at the point of qualification.

AHPs have enthusiastically embraced opportunities to strengthen their role as first-point-of-contact practitioners, to extend their scope of practice and to deliver improved patient pathways through innovative ways of working. Their interventions include supporting faster access to diagnostic services and providing early intervention, as well as rehabilitation, to enable individuals to be supported more effectively in their own communities; supporting children to get the best possible start developmentally and enabling them to participate in education; enabling people with learning disabilities to live fulfilling lives; and supporting individuals with mental health problems to focus on their strengths, their recovery and their ability to remain in, or return to, work. In addition, people can self-refer to AHPs on a range of conditions, such as communication difficulties and musculoskeletal problems, as well as for foot care support and advice.

Patients and carers consistently tell us that those services make a significant difference to their health and wellbeing and, importantly, to their quality of life. For individuals and families, particularly older people and those with dementia or complex needs, AHPs play a central role in helping them to live self-determined lives and to

avoid unnecessary admissions to hospital or other care settings.

In many areas, AHPs have taken the lead in ensuring that rehabilitation pathways for individuals are integrated across health and social care and, in doing so, have developed strong links with the voluntary and independent sectors. They have also actively facilitated partnerships and redesign initiatives that enhance the delivery of enabling services that can optimise an individual's independence and wellbeing, and which ensure that services work across boundaries.

AHPs' leadership will remain key to the rehabilitation and re-enablement agenda, and I would like their leadership role to be further recognised and strengthened going forward. In addition, it is critical that the many good examples of rehabilitation and re-enablement practice that AHPs deliver are consistently applied across NHS Scotland to secure the maximum benefit for people across the country.

There is no doubt that significant progress has been made, but there is certainly more to do. I am aware that we have improved overall access to rehabilitation services and that many people are seen by an AHP within 18 weeks, but I am equally aware that many have to wait too long to access those services, and that there continue to be gaps and inconsistencies in how services are provided. The chief health professions officer and AHP directors are now working collaboratively to address that situation and to help AHPs to manage demand and provide more flexible and responsive services across Scotland.

In order to make further progress in that area, I have asked my officials to work with service leads to develop a national delivery plan for allied health professionals in Scotland, which will provide the opportunity to explore waiting times and other aspects of efficiency and productivity in the delivery of safe, effective, person-centred care. The intention is for the plan to be used as a strategic platform for future activity, including service redesign. Such a plan will be a first for not only Scotland but the whole of the United Kingdom. I expect the consultation to be published later this year, and I expect us to have finalised the plan by spring or early summer of next year.

Obviously, as a former occupational therapist, I am biased, but I want to recognise the unique role that the allied health professions can play in the delivery of our health and social care agenda. We face many challenges in taking this matter forward, and demographic and financial issues will play their part in that. However, I have little doubt that AHPs have a significant role to play in the reshaping of our services. I hope that members will recognise that, in taking forward the work with a national delivery plan, the Government is committed to ensuring that we make more progress in this area.

Mary Scanlon: The minister talks about AHPs. Can I assume that he will not be looking at the waiting lists for mental health? Will that be included in his plan?

Michael Matheson: We will look at the role that AHPs have across the board, whether in general medical services or in mental health. It is important that we are clear about their role and about how we can take a more coherent approach to ensuring that we address some of the gaps that exist in the service in a way that they have never been addressed before in order to ensure greater consistency across the country in how services are delivered and in what patients can expect to receive in their locality.

I look forward to the debate. I am sure that members will express their views on the failings of the existing system and on how we should go forward. I look forward to listening to those constructive contributions. I assure members that, as we take forward the consultation around the national delivery plan, all constructive views will be openly considered.

I move,

That the Parliament recognises the importance of rehabilitation and re-ablement in supporting the health and social wellbeing of the growing older population, people with long-term conditions and those trying to remain in or return to work after illness or injury; further notes that rehabilitation and re-ablement are key to supporting self-management and enabling individuals to live productive and meaningful lives in their own homes and communities, and recognises the importance of this approach in underpinning the reshaping of community services as well as the future sustainability and affordability of health and social care provision.

The Presiding Officer: I ask members who wish to take part in the debate who have not yet pressed their request-to-speak button to please do so now.

Jackie Baillie, you have a generous 10 minutes.

14:52

Jackie Baillie (Dumbarton) (Lab): I start by apologising to members for the fact that I will be unable to be in the chamber for the closing speeches. I have, of course, sought your permission for that, Presiding Officer, and am grateful that you have graciously agreed. I will study the *Official Report* with considerable interest to read the speeches that I will miss when I am absent.

I welcome the opportunity to debate rehabilitation and reablement. I welcome the minister's comments about a national delivery plan, which I will touch on later. There is

considerable support on Labour benches for both approaches, which are, of course, complementary, with rehabilitation involving services that are designed to help with recovery after a hospital stay, getting the person better more quickly and enabling them to return to their own home sooner, and reablement involving services that restore independence to people and enable them to manage their own condition, which decreases hospital admissions and reliance on home care support—it is very much a case of doing it for oneself rather than having someone else do it.

The attraction of both approaches is self-evident. When money is tight, getting people out of acute beds by providing focused rehabilitation that continues in a community setting saves money. Enablement provides for more self-care, saving money on hospital admissions and lessening the need for home care. Much more importantly, it is also better for the individual. Studies tell us that enablement leads to better health and social care outcomes, improved physical functioning and the restoration of independence. There is no argument about the principle of or the direction of travel for approaches that are founded on rehabilitation and reablement; as ever, the test is how that is delivered on the ground.

There is a pressing need to get this right, as the minister says. We all know the statistics about the growing population and changing demographics. The number of people over 75 is set to increase by 23 per cent by 2018 and by a staggering 84 per cent by 2033. In my view, this is the biggest challenge that we face in public policy, and I am genuinely worried that we do not yet have in place all the elements that we need in order to meet that challenge.

We should of course be empowering our older people to live active and full lives and preventing them from coming into contact with the formal care system for as long as possible. When they need help, there needs to be access to home care, to reablement and to rehabilitation. There is no doubt that, for rehabilitation and reablement to work well, teams need to be integrated between health and social care. Nurses and allied health professionals such as occupational therapists, physiotherapists and speech and language therapists all have a critical role to play, working alongside social care staff.

I very much agree with the minister's positive comments about allied health professionals. Better integration is indeed required if we are to get the relationship with social care right. However, some seven months after the election, I am still waiting to hear the detail of the Scottish National Party's proposals on how integration will be achieved. Scotland's older people cannot afford to wait much longer. I urge on the minister a greater pace of change.

In recognising the importance of allied health professionals, how will the SNP deliver on a challenging agenda while it is presiding over a decline in workforce numbers? The numbers of occupational therapists, physiotherapists, speech and language therapists and podiatrists are down. Since the high point in 2009, the numbers have declined year on year.

In reality the position is worse, because the figures do not include vacancies in posts that have, in effect, been frozen or maternity leave. I know that the minister was an occupational therapist, but the workforce is predominantly female and maternity leave levels are higher.

The royal colleges have made the point that the workforce statistics mask a change in the skills mix, with the numbers in lower-paid grades increasing and less-qualified staff providing care. In some cases that might be appropriate, but it is not appropriate if it diminishes the quality of care. There are also huge problems for newly-qualified professionals in finding employment, but there remain long waiting times for services in many areas throughout Scotland.

I will give members a flavour of what is happening. In a 2011 survey, speech and language therapists said that health boards were widely operating a policy of natural wastage and downgrading and freezing posts. The therapists talked about reductions in service. They said that there is less speech and language therapy coverage on wards, that they are increasingly "firefighting", and that waiting lists and times are growing, particularly for people with communication disability.

Some 93 per cent of physiotherapists said that they are required to make savings from the budget, and 43 per cent expected the cuts to have a negative impact on services. Some 80 per cent of managers reported that vacancy management is preventing recruitment to most if not all posts and 87 per cent reported an increased workload in the past year. I think that all members would agree with the 100 per cent of respondents who said that they expect demand for physiotherapy to increase; almost 70 per cent thought that they do not have the resources to meet demand.

There is a difficult backdrop for allied health professionals who want to deliver on the agenda that the Government and the Labour Party want. What action will the minister take to ensure that he arrests the decline in numbers among the people who have such a central role to play in rehabilitation and reablement? What action will he take to tackle waiting times—which he acknowledged are sometimes considerable—for

essential services, which will be so important in shifting the balance of care?

The minister is a former occupational therapist and he will bring to the issue welcome understanding and insight. I also welcome the national delivery plan that he announced, but I wonder whether it will address all the concerns that have been expressed and I encourage him to make the scope as broad as possible.

The second issue that I want to raise is about the nature of reablement teams. Throughout the country, the teams that are being established and the staff recruited are—I think without exception—the preserve of the public sector. However, the independent and voluntary sector are the principal providers of care in most homes and communities throughout Scotland. In anticipation of the reablement agenda, many organisations in those sectors have been investing in training their staff to fulfil some of the reablement roles that the Government envisages. However, none of them has been involved in any way whatever. I do not want to think that that is deliberate; I think that it is perhaps an oversight. Whatever the reason, I will be grateful if the minister gives further consideration to the matter.

The third issue that I want to raise with the minister is the change fund for older people's services. I think that we would all acknowledge that £70 million is but a small fraction of the £4.5 billion spent on social care, and the test—again—will be the change that that pot of money generates. There is some disquiet about the operation of the change fund so far and concerns about substitution. John Downie of the Scottish Council for Voluntary Organisations has said:

"The funds must not simply be spent on the same or alternative means of providing existing services or be used by local authorities and NHS Boards to plug existing funding gaps."

There are concerns on the ground that that is, indeed, what is happening.

There are also concerns that the change fund is not focused on prevention, which I think we all acknowledge is the way forward in lowering public spending and improving outcomes. Only something like 18 per cent of the spend is currently identified for prevention. What is perhaps even more worrying is the discovery that the change fund is heading for a £12 million underspend, with real fears that it will end up being more than that.

It would appear that only £10 million—one seventh of the change fund—has been spent in the first half of the year and that local authorities are going to attempt, valiantly I am sure, to spend £60 million in the remaining six months. The difficulty with that is that it seems to be more about getting money out the door quickly than about considering what it is best spent on. I invite the minister to consider whether there is a better way of doing that and of enabling some of the money to be carried forward into the next financial year.

The minister will be aware of another challenge in helping people to stay in their own homes, which is the apparent reduction in budgets for aids and adaptations. Often, a small piece of equipment or an adjustment to a home is enough to give people the control and independence that they need to remain in their home and community. However, waiting times for them appear to be lengthening, people are facing charges that were not there before and local authority budgets are tightening.

Alison McInnes (North East Scotland) (LD): Does the member share my concerns about the 25 per cent cut in the budget available to registered social landlords for housing adaptations?

Jackie Baillie: I am about to share with members an example of something that happened in the context of registered social landlords. A family had to wait a year for vital assistance, which resulted in their child having to be readmitted to hospital because the registered social landlord and the local authority, working together, were unable to provide timely support in the way of aids and adaptations. The minister will have the support of Labour members if he can improve at all the situation in that regard.

Finally, I want to address the issue of delayed discharge. I am sure that we would all agree that this area requires further action. I know that the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced to the Scottish National Party conference that she wants to reduce delayed discharge to two weeks, and I support her in that aspiration. However, there is an immediate problem. Having reached zero through the successful delayed discharge plan that the previous Labour Administration implemented and that the SNP carried on, we are now starting to see delayed discharge figures going the wrong way.

Kevin Stewart (Aberdeen Central) (SNP): Will the member give way?

Jackie Baillie: In a minute.

Despite a promise made in the chamber by the minister's predecessor, Shona Robison, that the number of waits of more than six weeks would be zero, 95 patients were delayed for six weeks according to the July 2011 census, compared with just 12 in April 2011. The overall number of those awaiting discharge was 722. Again, that is up on the previous quarter's figure. In addition, we have received quite disturbing reports that consultants

are being encouraged to designate patients as having complex needs so that they do not appear on the quarterly statistics. I hope that that is not a case of an SNP hidden waiting list.

Kevin Stewart: Ms Baillie pointed out that there were 95 delayed discharges in July and 12 in April. Does the member acknowledge that in October 2001, when her Executive was in power, 2,162 were waiting for more than six weeks, when Iain Gray was the minister?

Jackie Baillie: Had the member cared to listen carefully, he would know that the plan and the resources were actually put in place by the previous Labour Administration and, to its credit, continued by the SNP. So, we took the action that was required to deliver on the zero target. Now, surely, this is something on which the Parliament can unite. To have an older person in a hospital bed for longer than they need to be is not something that we on the Labour benches want to see and I hope that Kevin Stewart joins me in that.

Integrating health and social care is the route to eradicating delayed discharge. Rehabilitation and reablement teams will help with that, too, but the challenge is great and the minister must get delivery right on the ground. There is clearly more work to do in that regard. I hope that the minister knows that we will help him on that journey as a critical friend, urging him to do more. The prize for us all is great indeed, because this is about providing dignity and security for our older people along with the right care, at the right time, so that we enable them to live full and active lives.

I move amendment S4M-01262.1, to insert at end:

"; believes that allied health professionals (AHP) perform a central role in rehabilitation and re-ablement as well as in delivering quality NHS services and the preventative health agenda more generally; therefore notes concerns expressed by the various Royal Colleges regarding reducing budgets and skills mix in the AHP sector as well as severe recruitment problems for newly qualified professionals in recent years, and calls on the Scottish Government to address these issues as a matter of urgency."

15:05

Nanette Milne (North East Scotland) (Con): I welcome this debate, which is timely given our rapidly increasing elderly population and the demands that the changing demographic will place on our health and community services. I pay tribute to the previous Administration for having had the foresight to launch the delivery framework for rehabilitation in 2007 and to the Government for its commitment to continuing the initial work for older people, people with long-term conditions and people who have been out of work and are seeking—

The Presiding Officer: One moment, Ms Milne. Will someone in broadcasting turn Ms Milne's microphone up just a touch, as it is very quiet?

Nanette Milne: Do you want me to go back, Presiding Officer?

The Presiding Officer: No, no—keep going.

Nanette Milne: The change fund arrangements are welcome, but they will need to be closely monitored to ensure their effectiveness. As Jackie Baillie has said, there are already problems with how change fund money is being spent.

At their core, rehabilitation and enablement are known to be effective not only in improving the independence of individuals but in reducing the cost to the taxpayer of care services. The 2007 framework expands the style of healthcare delivery outlined in the earlier document, "Delivering for Health", which I believe was the first real attempt to define rehabilitation. Similarly, its sister manifesto, "Changing Lives", highlighted the need for a greater emphasis on cross-agency co-operation, with a particular focus on delivering services close to where people live, offering services on a suitable and reasonable timescale and promoting a greater stress on anticipatory care as well as supporting individuals and carers in the self-management of long-term conditions. That is key to a successful future for the wellbeing of people in this country.

That revolutionary shift in how the NHS works, which has taken it from a hospital-driven service to one that is embedded in the community, is important as it represents a significant attempt to make services more patient focused. The framework was also the first to instruct NHS boards to appoint rehabilitation co-ordinators to measure existing services, implement the recommendations of the national implementation group, redesign services, where appropriate, and promote new treatment styles. As the minister has said, we are some way along the road to success in that regard, but there are many challenges ahead that must still be met.

Another extremely significant point is the emphasis on the greater use of e-health to increase service provision, for example when local authorities work to develop local transport for rehabilitation purposes. There is enormous untapped potential for telehealth in many spheres, including rehabilitation and enablement. My colleague, Mary Scanlon, will touch on that point in her speech.

There are areas of concern that were highlighted by the Parliament's Health and Sport Committee when it conducted an investigation into the rehabilitation framework three years ago. Among its findings was a call for better information and data on what services are available, greater

multi-agency working through joint management structures, better workforce planning and training, and greater co-operation between health and social care services.

As Jackie Baillie said—I totally agree—there is a key concern about allied health professionals. I totally agree with the minister that AHPs are vital to patients in their health journey, and he outlined the many areas where they play a leadership role in patient care. That is clearly very important. However, AHPs such as physiotherapists find that once they are qualified they are unable to get positions. Indeed, in 2007, unemployment among physios stood at 71 per cent, with the Chartered Society of Physiotherapy predicting a crisis in recruitment.

Derek Mackay (Renfrewshire North and West) (SNP): The point about vacancy management and the lack of new professionals coming into the system was raised earlier. Part of the reason for that is arguably the Government's no compulsory redundancies policy. Does Nanette Milne suggest that that policy should be abandoned?

Nanette Milne: My party has no specific policy on that, but I have an issue with workforce planning and the appointment of physiotherapists.

Occupational therapists, podiatrists and speech and language therapists fall into the same category as physiotherapists. I am therefore sympathetic to Jackie Baillie's amendment, and I agree that the Scottish Government urgently needs to give the issue some attention. I hope that the proposed national delivery plan will examine the serious problems in workforce planning that have been raised in today's debate.

However, Labour's amendment can unfortunately be read as implying that there is an overall reduction in the health budget, which has in fact been protected. That would make it difficult for us to support the amendment, so perhaps Ms Baillie will clarify the matter.

Jackie Baillie: Does Nanette Milne agree that if health service inflation is taken into account, there is in fact a real-terms reduction in the health budget of £319 million? That has been confirmed by the Scottish Parliament information centre.

Nanette Milne: The health budget has nevertheless continued to increase, although there are issues around the allocation of the budget to different sectors. That is perhaps more of a health board issue that must be sorted out.

The nursing profession has a major role in rehabilitation and enablement, from the acute phase in hospital through to resuming life at home, where the nursing team can work with patients' families and carers to ensure that the necessary support networks are in place for the most successful rehabilitation possible.

Figures show that the number of nurses currently in post in Scotland is at its lowest point since 2006, and this year there has been an accelerated loss of nursing posts. The Royal College of Nursing is naturally concerned that that may indicate the financial pressures—at which Jackie Baillie hinted—that health boards have been facing on the ground, despite the comparatively positive position of the NHS in the Scottish budget.

The ready availability of properly trained health personnel working together as teams—which is in itself important—is clearly essential if the Government is to realise its ambition to move away from reactive, unplanned and episodic care to a service that gives on-going co-ordinated and personalised support.

With an increasingly ageing population requiring support, particularly when the patient is moving from acute care into the community, staff availability is crucial. There must be proper co-ordination between health and social care, which is why all parties have come to realise that those services need to be integrated, however that may be done. As members will know, my party has suggested doing that by merging social care into the health service.

I have had recent personal experience of rehabilitation after hip replacement. I must say that I was extremely pleased with my treatment in the NHS and the teamwork of the various professionals who were involved in my care. Pre-operatively, the occupational therapist investigated my home circumstances and ensured that the necessary aids, such as raised toilets and a perch stool for the shower, were in place before I was discharged from hospital. Post-operatively, I was shown how to get in and out of bed without stressing the new hip joint, and the physiotherapists supervised the necessary exercises and provided the walking aids that I required for the first six weeks of recovery. I have to say that, even though I am a medic, I was a good patient and did all my exercises religiously every day.

Once the staff were satisfied that I could cope unaided, I was discharged without further support, which raised a few eyebrows. However, if necessary I would have had physiotherapy after discharge, and therefore I was not at all concerned that I was not immediately referred for physiotherapy.

My only concern was about the lack of nursing staff on the ward at night. Day staff were pleasant, efficient and plentiful, and those on night duty did a terrific job, but it was hard for one charge nurse

and one auxiliary to cope with a whole ward of post-operative patients, six of whom were on intravenous antibiotics and a few of whom needed significant help to get in and out of bed. They were wonderful staff, but they were a bit demoralised by the lack of numbers.

The Presiding Officer: Will the member wind up?

Nanette Milne: I am concluding, Presiding Officer.

I fully recognise the importance of rehabilitation and reablement in supporting the health and social wellbeing of people in Scotland, but the Government must pay heed to the concerns about workforce planning that are expressed in the debate.

The Presiding Officer: We now move to the open debate. I call Jim Eadie, to be followed by Malcolm Chisholm. We still have a bit of time in hand, particularly for members who want to take interventions.

15:15

Jim Eadie (Edinburgh Southern) (SNP): The motion sets out several key challenges that we face as a society. Foremost among those is ensuring the health and wellbeing of the older population, people with long-term conditions and those who are trying to remain in or return to work after illness or injury. The motion rightly highlights the crucial role that rehabilitation and enablement strategies and policies can play in translating those positive aspirations into concrete action and service delivery on the ground. I will touch on three areas: older people's services; the health of the workforce; and the needs of people with a learning disability.

Ensuring the long-term health and wellbeing of our growing older population is a serious challenge, with a third of the Scottish population projected to be over 60 by 2033. However, we should be in no doubt that the provision of care for older people that preserves their dignity and independence is one of the most important duties of any civilised society. Ensuring that older people can remain independent in their own homes is what we all want for our own care and that of our families. With the right support packages in place, we can ensure that optimal care is provided. As has been stated, the benefits of that arrangement extend beyond the person who is receiving care, as it allows NHS boards and local authorities to focus and work together to reduce the number of unnecessary hospital admissions and to speed up discharge from hospital after a crisis.

One of the key challenges is in unlocking the money that is currently tied up in the acute sector to bring about a shift in resources and services from acute hospitals to care that is delivered in the community. The change fund is a key route by which we can bring about that shift—a shift that is absolutely vital if we are to meet the demographic challenge of an ageing population. The change fund has the potential to leverage in additional resource to support services and to bring about the change that we want.

I turn to the health of the workforce. The Scottish centre for healthy working lives, which is funded by the Scottish Government, has undertaken important work in that area. Earlier this year, it published "Working Health Services Scotland", an evaluation of projects that were delivered in the Borders, Dundee and Lothian. Those projects involved 1,247 people who were referred to a programme that offered support to individuals working in small and medium-sized businesses who had a health condition that was affecting them at work. Eighty per cent of those people had a musculoskeletal disorder, while 11 per cent presented with mental health problems and 9 per cent had other conditions. The project used a biopsychosocial model utilising case management and provided access to physiotherapy, occupational therapy, psychological therapy and counselling services. That interdisciplinary model of working delivered significant benefits. Eighty-three per cent of the people who were absent from work when they entered the programme were at work when they left the programme, and 78 per cent of those who had been long-term absent from work—absent for 31 days or more—at entry were at work at discharge.

How we integrate those ways of working into mainstream health services is a key issue, but it is clear that allied health professionals are key to the delivery of rehabilitation and enablement services throughout Scotland. They work within multidisciplinary teams across health, social care and education, and they have particular expertise that is invaluable. Allied health professionals can promote independent living, and their input can lead to a better use of resources and improve health outcomes for patients.

The Chartered Society of Physiotherapy would like patients to have the ability to self-refer to a physiotherapist. Given that a person is able to self-refer to a podiatrist through their general practitioner practice—a service that is available within NHS Lothian—should they not also be able to self-refer to a physiotherapist, considering the health benefits that such a measure would bring? At the moment, the wait to see a physiotherapist can be up to 10 weeks, during which time a person's condition can worsen. Early intervention, diagnosis and appropriate referral and treatment are key to ensuring optimal care and can help

someone to remain in work rather than go on incapacity benefit. As we have heard from other members, that approach may also prevent admissions to accident and emergency departments. Avoiding those scenarios will of course save resources.

How we bring about the necessary culture change and embed it in clinical practice is one question that confronts us. How do we enhance the role of allied health professionals, such as physiotherapists and speech and language therapists? I welcome the Scottish Government's announcement today on the development of a national delivery plan for allied health professionals, which will be the first such initiative in the United Kingdom. The Royal College of Speech and Language Therapists has sought clarification on the plan's roll-out. It has asked whether a quality service standard for AHP services will be included and whether the quality strategy measurement framework and the health improvement, efficiency, access and treatment targets will be developed to include access to AHP services. I hope that the minister will address those points in summing up.

As the deputy convener of the proposed cross-party group on learning disability, I highlight the fact that people with learning disabilities face particular challenges in society as one of our most vulnerable groups. Those people depend on social care services or a carer's support to live fulfilling and meaningful lives.

Enable Scotland estimates that some 3,000 people over the age of 65 care for a family member. I welcome the fact that 20 per cent of the change fund for older people's services has been set aside for carers and I hope that older people who look after a younger relative with learning disabilities will be able to access those resources. The eligibility criteria for accessing services, the inconsistent levels of provision and the disparity in care charges among local authorities across the country are all issues that the Learning Disability Alliance Scotland has highlighted.

Action is needed on all those matters to change a culture of dependence into one of self-management, for the sake of the carer, the health professional and the user alike. We would do well to acknowledge the importance of rehabilitation and enablement for the future of a safe, effective and sustainable health and social care service.

15:22

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I am always fascinated by the continuity in health and community care policy from the Administration that governed until 2007 to the current Scottish Government. That is certainly true in the debate's themes. Members might have seen the Scottish Parliament information centre's material for debates document, which mentions the rehabilitation framework from 2007 and "Healthy Working Lives" from 2004, and which might well have mentioned the David Kerr report, whose central theme was shifting the balance of care into the community.

The current Scottish Government has produced "Health Works", which picks up on "Healthy Working Lives", "Improving the Health and Wellbeing of People with Long Term Conditions in Scotland" and "Reshaping Care for Older People". The themes and messages of those reports are consistent with the earlier reports that I mentioned.

I am sure that we were all struck by the demographic information that the minister gave. We are all familiar with it in general, but I was struck by the 144 per cent increase in over-85s by 2031 that he cited.

I was also struck by a statement by Dr Roger Gibbins at the Health and Sport Committee a couple of weeks ago, in which he tied demographics in with funding issues. Dr Gibbins, a former NHS Highland chief executive, said:

> "Broadly speaking, the number of older people in Highland was increasing at about 5 per cent a year. As older people consume about 50 per cent of the health budget, that meant an immediate pressure of 2.5 per cent on the health budget that had to be addressed just to stand still."—[*Official Report, Health and Sport Committee*, 25 October 2011; c 376.]

As the minister said, that is completely unsustainable.

Services must be redesigned for financial reasons, but that must be done in a desirable way, as the minister reminded us. That is always a challenge for us in looking at new models of care. We can perhaps see the benefits for the service, but can we see the benefits for individual service users? We must be able to see both if we are to approve redesigned services.

I took the word "reablement" to be a specific reference to a form of rehabilitation that has existed in England for a few years and which was pioneered in Scotland by the City of Edinburgh Council in 2008. When reablement started in Edinburgh, it was quite controversial and people had many concerns about it.

The theory of reablement is that work is done with people to make them as independent as possible, doing things with them rather than to them. Under the Edinburgh model, which follows the model that was used extensively in England, work is done with people for six weeks, either when they come out of hospital or when they are referred to the service from the community. Intensive work is done with them for six weeks.

They are then, the theory goes, able to look after themselves to a far greater extent.

Obviously, there were concerns that reablement would just be a cover for cuts, but the Scottish Government commissioned an evaluation in 2009 that indicated a 41 per cent reduction in hours of care resulting from the six weeks of reablement. It also said, perhaps reassuringly, that most of the reabled clients had a positive view of the service that they received. The evaluation was of a fairly small number of people, so there is perhaps more room for qualitative research. However, most people were reassured by what they learned from that report and from what they heard from people who had used the service.

Mark McDonald (North East Scotland) (SNP): The member might be aware of a pilot scheme that was undertaken in Dundee in which, at the end of the reablement process, some 60 per cent of users required no on-going social care services. That work is being done in other places as well, and it demonstrates that, in the past, we have been too quick to put people into care packages when that might not have been the best route for them to take.

Malcolm Chisholm: I accept that, and I realise that the scheme has been rolled out in many other parts of Scotland, but Edinburgh was the first when it started in 2008.

The reshaping care for older people programme has many interesting points that relate to reablement. The programme document tells us that current spend on health and social care for over-65s is £4.5 billion, 7 per cent of which is spent on home care. There is a commitment to double the proportion of the health and social care budget for older people that is spent on home care over the 10 years from the launch of the programme—that is, the decade that we are in. It would be interesting to have an update on that. There are wider concerns about the way in which low-level, preventative and anticipatory care at home is being squeezed as we have higher eligibility thresholds for home care to meet statutory duties. Is the balance of care being shifted significantly? The change fund is highly relevant to that issue. Everyone welcomes the fund, although I think that the minister ought to respond to some of the concerns that Jackie Baillie raised.

I have spent too long talking about older people so I do not have so long to spend talking about the more general management of long-term conditions. Most people accept the good model of a productive partnership between informed and empowered people with long-term conditions on the one hand and prepared and proactive health teams on the other. I am sure that we all recognise that it is right that the individual should take the lead in managing their own health. Clear information is important in that regard. However, some who are involved with people who have long-term conditions have expressed concern that self-management could become a replacement for services. I am sure that that is not happening in every case, but there are concerns about it.

Unless I am allowed a bit of extra time, I will not have time to say what I want to say about the healthy working lives strategy—I have already referred to it—which was launched in 2004 and which the Government has reviewed. The 2004 publication, "Healthy Working Lives: a plan for action", emphasised the need to establish a joined-up approach between business, health, local government and trade unions in the delivery of vocational rehabilitation pilot projects—I thank Jim Eadie for giving us an update on those.

The Scottish Executive also established the Scottish centre for healthy working lives within NHS Scotland to oversee the development and delivery of advice on workplace health and wellbeing as well as promoting a healthy working lives awards scheme.

The Government's 2009 review of the strategy said:

> "For many common health conditions, early intervention provides the best opportunity for a speedy and full return to work. We will establish minimum standards for access and support, defined in a 'Scottish Offer'".

Will the minister say something about that when he is winding up?

The Deputy Presiding Officer (John Scott): Will you wind up now please?

Malcolm Chisholm: I thought that I would be able to go on for ever—that was the mood music. All good things must come to an end.

The Deputy Presiding Officer: Many thanks. I appreciate that that was the mood music but our opening speakers appear to have used up the extra time that we had in hand. Members will all have to adhere pretty closely to their six minutes, please.

15:29

Clare Adamson (Central Scotland) (SNP): I declare an interest: I am an elected member of North Lanarkshire Council. As such, I have been a member of the living well officer-member working group in North Lanarkshire. We worked with partners that included the Voice of Experience Forum in Lanarkshire, North Lanarkshire Carers Together, Cumbernauld Action on Care of the Elderly, Alzheimer Scotland—Action on Dementia and NHS Lanarkshire in developing the quality of life strategy for older people in North Lanarkshire. I am sure that that is of interest to Jackie Baillie.

During the project, I was introduced to the concept of reablement, which is a different approach to home care services that provides short-term support to encourage people to be as independent as possible, and supports people to learn or relearn skills and regain confidence through a wide range of personal and practical support.

In conjunction with its partners, which include NHS Scotland, North Lanarkshire Council recently completed a number of road shows with staff rolling out their reablement strategy. The success of any reablement strategy is underpinned by delivering on key stages in the patient journey. Proactive care and support at home must include a responsible and flexible way of delivering home care. There must, of course, be integration of case and care management with all the partners involved, and carer support must be included where that is appropriate, including respite care where that is necessary. Timely access to equipment and the installation of aids and adaptations are important, and telecare support services and technology will form a vital part of reablement implementation.

We must ensure that effective care is delivered in times of transition. Reablement and rehabilitation services need to be available when they are required in the patient journey. We must ensure that special clinical advice for community-based reablement teams is available when it is required and that NHS teams are fully involved in the process, and we must look to alternatives to emergency care admissions for elderly patients who are already known in the system. Hospitals are not always the best places for them to be. Responsive palliative care where it is required is also important, of course.

In hospital care and in homes, we must ensure that triage training is given to identify the needs of frail and vulnerable elderly people at the earliest opportunity. Early assessments, timely referrals to rehabilitation services, and effective and timely discharges into homes or intermediate care services are important, and there must be no more bed blocking.

I am most concerned about the fourth area of the patient journey, and must declare another interest as the vice-chair of the Scottish Accident Prevention Council's home safety committee. In preventative and anticipatory care, we must ensure that we care for the mental health of elderly people in our communities, and we must support and build social networking opportunities and maximise opportunities for participation in communities. Early diagnosis of conditions such as dementia is needed.

On accident prevention, it is important that we consider preventing falls and fractures. Prevention is better than cure, and preventative spend is necessary to ensure that elderly people are informed of the risks that they face in their own homes. The Scottish Accident Prevention Council has been vocal in its support for statutory duties relating to home safety that are similar to those for road safety. In times of unprecedented budgetary cuts, it is unfortunate that home safety officers and home safety functions in councils have been cut, whereas road safety is protected by a statutory requirement. More people are injured or sustain fatal accidents in their homes than on the roads.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I agree entirely with the point that the member is making. The current Government continued the previous Government's falls initiative, and falls co-ordinators have been established, but that has tended to be in the health service. Are practices being properly spread out? Is that the member's experience?

Clare Adamson: I agree that the strategy was very successful, but it tended to pick people up after they had incurred an injury at home. We need preventative action and education before things happen.

Home safety officers provide vital training for elderly people to understand the risks that they face. For example, training is given on the appropriate use of safe steps, which are designed for people who have impaired balance and mobility and which can prevent falls from height. Simple advice about removal of rugs from rooms and positioning of furniture to reduce risk can literally be life saving if it prevents a hip fracture in an elderly person. Where necessary, access to information about Care and Repair Scotland's services can be vital, especially in tackling poverty issues such as loose or frayed carpeting or bad maintenance that could lead to a fall or injury.

I am most concerned about fire safety, particularly in relation to supporting people who have mobility issues in their homes. The Rosepark care home fire and the 12 tragic deaths there led the Parliament, under the steam of Michael Matheson, to introduce the mandatory use of sprinkler systems in residential care homes. I argue that, when we support an elderly person in their home, in some circumstances, the installation of a domestic sprinkler is just as imperative.

15:36

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I welcome the debate, but it is important to place it firmly in the context of the motion and the Labour amendment. I will turn first to the motion in the name of Michael Matheson and deal with what I understand is meant by the principles of rehabilitation and reablement to which it refers. As I hope we all agree, sustaining services for older

people is important, but there is a serious challenge. Nonetheless, providing quality compassionate care for older people that protects their dignity and independence is one of the most important duties of any civilised society. It is right to work to allow older people to lead independent lives.

The serious challenge that is before us and which we must rise to is, as the minister set out, the major demographic change that we face in the coming years. By 2033, the over-60s will make up one third of the population. There is an expectation that, in the next six years, there will be a 25 per cent increase in the number of older Scots who need some form of care. That will have a real impact, given that the Government estimates that, overall, about £4.5 billion is spent every year on older people's services across health and social care. That is in the current context, so the figure is likely to increase in the future.

About one third of that £4.5 billion—£1.4 billion—goes on unplanned emergency admissions to hospital. It is therefore vital that we do more to reduce unplanned admissions. One way in which to achieve that is by integrating health and social care through the lead commissioning model. The Government has established a lead commissioning integration group to consider that. Why is it important to reduce unplanned admissions? Clinicians, care managers and older people tell us that such admissions to hospital are often distressing and result in poorer outcomes than might have been achieved through a package of primary and social care in the community. Further, it costs the Government more in the long run. Therefore, changing how we work in the area is important and that fits very well with the preventative spend model to which we are increasingly moving.

There is broad consensus in the Parliament that we should move towards the integration of social care and health services, although there are different views on how that is best achieved. The Government has come to the view that lead commissioning is the way forward. I agree that that is the way in which we should move, because it will give people quicker access to care and will reduce delayed discharges. I am sure that we all share those aims.

Jackie Baillie raised issues about delayed discharges and asked whether we share those concerns. She mentioned that, recently, 95 patients were discharged late. I absolutely agree that that is 95 too many, although Kevin Stewart made the point rather well that we must consider that in the context of the past situation. About 10 years ago, more than 2,000 patients were delayed in leaving hospital by more than six weeks; of course, that was under the Labour-Liberal Executive.

Dr Simpson *rose—*

Jamie Hepburn: I will let Mr Simpson in in a minute, because I was just about to turn to him. I should say Dr Simpson—I apologise.

I do not know whether the *Official Report* will pick this up but, in response to my point that more than 2,000 patients were delayed in leaving hospital under Dr Simpson's party, he said from a sedentary position, "We didn't make promises." That was quite telling. The Labour Party made no promises—presumably, no promises to tackle the problem. We might come to the conclusion that coming to the chamber and raising those concerns is somewhat contrived. I do not think that that is the case. I got the impression that Jackie Baillie was genuinely concerned by delayed discharge, and those concerns are shared across the Parliament.

Dr Simpson: We are all genuinely concerned about it. We had a plan to reduce it to zero in 2008, and that is what happened—it was our plan and our resources—but in 2008, the ministers promised that the numbers would not rise above zero after March 2008. The problem is not only that that has not been fulfilled but that, according to the Audit Scotland report, the numbers of delayed discharges of under six weeks have doubled, so we have gone backwards. We welcome the new promises, but we have been going backwards since 2008.

Jamie Hepburn: I return to my earlier point: we must place the figures in the context of where we have been. Only 10 years ago, 2,000 patients were delayed in leaving hospital for more than six weeks. I accept absolutely that we want to get the figure to zero, but tremendous progress has been made over the past decade and we should recognise that.

I said that that position is shared throughout the Parliament. Only last month, the Cabinet Secretary for Health, Wellbeing and Cities Strategy said:

"the reality is that too many patients, many of them older people, are still waiting too long to be discharged."

The matter is important to the Government.

I have got caught in a cul-de-sac on that issue, so I must move on more quickly and return to lead commissioning. Lead commissioning is an important way forward. It is important to get health boards and local government working together and contracting services from one another with one taking the lead. That model can focus far better on a person's needs and on outcomes than can different parts of the public sector operating in silos. Lord Sutherland himself has said:

"Lead commissioning provides the best and quickest way of achieving an integrated care system, and I believe the Scottish Government's approach is the right one."

I am being told to wind up. Our latitude has obviously run out, although I could have said much more on the matter. I welcome the debate and look forward to supporting the motion this evening.

15:42

Mary Fee (West Scotland) (Lab): I welcome the Scottish Government's continuation of the change fund. That measure is extremely important in facing the challenge of a changing demographic. However, I have some concerns, which are shared by many in the care sector. My main worry is that some councils and health boards may use moneys from the fund to offset any budget cuts that the Administration imposes. Also, how will they evaluate any changes that are made?

Over the past few years, the SNP has continually underfunded local authorities and our health service. Those who suffer most are the elderly, the vulnerable, the disabled and the poorest people in society.

Derek Mackay: If those areas are underfunded, what are the overfunded areas from which the member suggests we should transfer funds?

Mary Fee: It is up to the member's party to make budget choices, as it is in government, not me.

If the Government really wishes to improve the rehabilitation of the elderly and ensure that they have dignity in their twilight years, it must fund local authorities and the NHS appropriately. As a result of its funding, many councils have been forced to increase or introduce charges for services on which elderly people rely to enable them and to help their rehabilitation after an illness or a time in hospital.

Jamie Hepburn: Will Mary Fee give way?

Mary Fee: I have already taken one intervention and I do not have time. I need to move on.

Does the minister agree that charges for elderly day care services, such as the £34.70 per day that Dundee City Council charges, contradict the statement that the Government makes in paragraph 3.4 of "Reshaping Care for Older People: A Programme for Change 2011-2021"? It states:

"Achieving this vision involves helping older people to have the best possible quality of life by: ... having opportunities to meet and support each other; ensuring no-one is socially isolated or lonely".

I hope that the minister can provide the Parliament with a response to that contradiction.

In the same programme, the Government points out that we all have a role to play, and I agree fully. Families, neighbours, friends, housing agencies and transport providers can all support and care for the elderly. However, I am a bit unsure of how shops and banks can play a similar role.

As I have said, the change fund is a very welcome initiative and I hope that we can build a bridge between health and social care and utilise the experience of the third and voluntary sectors. However, I hope that the Government will listen to the third sector and, in particular, the Scottish Council for Voluntary Organisations. In the SCVO briefing for this afternoon's debate, there is a focus on the difficulty that third sector organisations have in engaging with the decision-making process. The structural issues within the change fund, which result in a lack of drive for change, are also highlighted. The SCVO has suggested changes that I feel the Government should consider, such as reforming the partnership model overseeing the implementation of the change fund to ensure that the third sector is genuinely an equal partner from the earliest stage of the decision-making process.

The Government will look to bring the self-directed support bill to the Parliament in the new year. I hope that there will be considerable discussion with the third sector before the bill is brought to the chamber. The Government's plans in the programme for change indicate that SDS should be provided to as many people as possible, including the elderly, to provide them with the chance to input into their care packages. I have reservations about self-directed support. What level of involvement will the user have in choosing their care? What monitoring will take place? Who will regulate the care? How often will visits take place? What training will the carer be provided with? What safeguards will be put in place to protect the user from fraud and abuse of the system?

Carers have a vital role to play in the rehabilitation and enablement of the elderly. I hope that every measure of support can be offered to them, particularly if they are unpaid or elderly. Many of the elderly carers who provide 20 hours or more of care are unpaid. As I have said, everyone has a role to play in the care and support of our elderly, but none is more important than the carers themselves. Carers must be given more say in the creation of care packages, especially when the older person is being discharged from hospital.

I would like to hear from the Government—particularly when the self-directed support bill is introduced—whether carers will be guaranteed the national minimum wage or the living wage when

the user is creating the package of care that is best suited to them. We all know that one of the biggest problems that elderly people face when they are admitted to hospital is the unnecessary length of hospital stays, which leaves them with a serious lack of confidence, as well as confusion. Many emergency admissions will be the right course of action; however, we must focus more on how to reduce lengths of stay to less than two weeks, which is the Government's target. To reduce the length of stay, greater focus is needed on integrating health and social care, so that the right plans are in place for the older person to leave, go back to their home and be as comfortable and safe as possible.

There need to be better means of detecting problems with the older person's health, before hospital admissions are needed. One perfect example of doing that could be training all those who make visits, including those who deliver meals, to look out for symptoms and assess the patient in their home before it is too late.

We all know that social work departments and health boards require more integration. However, I have considerable apprehension that social work departments will struggle, due to budget cuts that they have forced upon them. Social work departments have a role to play in identifying the welfare needs of the elderly and detecting any health problems. However, that role is becoming highly restricted, due to the budget cuts. I believe strongly that that will cause further damage to our elderly and our health service.

Telehealth is another vital tool that can reduce emergency admissions to hospital. I have come to discover that there is no set budget for telehealth; that is a massive failure to improve the health of older persons and encourage the rehabilitation and enablement of the elderly, especially in rural areas, such as the Highlands and Islands and the Borders.

The Deputy Presiding Officer: I would be grateful if you could close, please.

Mary Fee: I hope that the minister will give a commitment to fund properly a telehealth service.

15:49

Dennis Robertson (Aberdeenshire West) (SNP): The minister said in his opening remarks that he had a bias towards occupational therapy. It will come as no surprise to him and perhaps other members in the chamber that I, too, have a bias towards part of the rehabilitation sector. I worked in the social care and rehabilitation sector for more than 30 years. I would probably like to change some of the terminology and use words such as "rehabilitation", "enabling", "empowering" and "positive adjustment".

Some weeks ago, we had a debate in the chamber about people's mental health and wellbeing. Quite often, we need to look positively at the health and wellbeing of people who have an impairment or are suffering from some chronic condition.

I worked with people with dual sensory impairment, and I was proud and privileged to work in that field. The North East Sensory Services in Aberdeen was the first organisation in Scotland to have a dual approach to sensory impairment for those who are blind, partially sighted, deaf, hard of hearing or deafblind. That was supported by the Government, which was supporting various other projects in Scotland on the one-stop-shop approach to rehabilitation and empowerment.

Sometimes the simplest things make the biggest difference. Many speakers have mentioned that already—and I applaud Nanette Milne for being an ideal patient. The simplest approach in giving a person an appropriate aid can mean so much to them. I remember that during my first months working in the field I had a signature guide. It was a simple piece of plastic with a window that enabled people to put their signature on a form. To the person who had recently lost their sight, that meant a lot, and it gave them the independence that they required to write cheques—not to me, I hasten to say.

It is important to remain positive. When we work with people in the field of rehabilitation, we cannot accept—to go into the Doric—the "I'm nae able" attitude. The individuals concerned are sometimes happy to sit down and say "No, I don't want to", "No, I can't" or "No, I'm too old and I can't do this". That is not the approach that we want to hear, and that is not the approach that the professionals and care staff take when they work with people.

We enable people to adjust to their new circumstances and we empower them to become independent in their community. We want to prevent people from going into hospital stays and from feeling isolated in their communities. That is why we have to look at a little investment through preventative spending. We should look at people's own homes, sheltered homes and residential care and carry out the appropriate audits to ensure that there is appropriate lighting, colour and contrast.

We want to ensure that people do not have trips and falls. I believe that a paper is due to come out shortly, if it is not already out, about trips and falls strategies, and I look forward to seeing it. We want to prevent people from going into hospital for long stays. That is about saving money, but it is also about ensuring that people have a quality of life and can stay within their own community.

The simplest of aids and apparatus are sometimes cheap, but self-help is also important. That depends on carers and the individuals themselves having the best information. That is why I support the one-stop-shop hub approach to integrated care. Integrated care in the community involves not just changing the plaque over the door but ensuring that the teams in the building are fully integrated—that they are supervised, trained and brought together to provide an integrated approach to the service. A multidisciplinary approach will ensure that people in the community are prevented, as much as possible, from having trips and falls and requiring long-term hospital stays.

I support the approach that is taken by the Government and the great work that is done by our community optometrists in ensuring that many more people go for free eye tests. Giving people up-to-date eye tests will prevent them from having some of the trips and falls that cause them to go into hospital.

In my own case, I have learned to live with sight loss for many years. Having one's own independence is invaluable to people, but they need support. I sincerely hope that my wife is not listening, as I admit that I could probably iron my own shirts—

Members: Ah!

Dennis Robertson: But I prefer to put the kettle on to make the coffee while she is doing it. [*Laughter*.]

The issue is about empowerment, enabling and positive adjustment.

15:54

Derek Mackay (Renfrewshire North and West) (SNP): Dennis Robertson has very helpfully outlined a human perspective on the issue, which is very welcome. We have spoken today, as we have before, about the pressure on budgets and services. Others—not in this chamber—have described the changing demography as a burden. Of course, it is not a burden. We are talking about human lives—about people who are reaching a different stage in their lives—and we must recognise that in the language that we use. Dennis Robertson may have satisfied his wife, but I know that his closest assistant is Mr Q, the dog, who makes sure that he gets where he wants to go.

This is a serious issue, of which I have experience, through my community health partnership and council roles. It is clear that the teamwork agenda is crucial here, that reablement and recovery are not just a catchphrase but a state of mind and that, whatever strategies are in place, they can be delivered only where public sector leaders are delivering them. Physiotherapy is a great example of where teams can work together. I was very conscious of the plethora of different physio teams in Renfrewshire—the acute sector physio team, the community health partnership physio team, project physio teams and council physio teams. Without necessarily having to spend more money, we could through greater integration achieve shorter waiting times, shorting waiting lists and a more effective and upskilled service. Within the immense resources that exist, we can ensure that there is greater and closer working, rather than the silo mentality that we experience.

The cost of unnecessary hospitalisation is not just financial but human, because we are well aware that there are cases where, if someone is hospitalised, they may not get back out; their life may be shortened because of that experience. Therefore, a presumption to support people in their own home is critical. When the paramedics attend someone who has had a fall, the presumption should not be, "Let us take them into hospital, where there is adequate support"; the presumption should be that there can be an adequate response from community infrastructure services to support them, even at the earliest stage, rather than an unnecessary hospitalisation. The huge investment that is required in community infrastructure will make a difference here.

I was involved in a Convention of Scottish Local Authorities negotiating team when the change fund was created, at £70 million. I remember advisers saying to us—if this is not a breach of confidence—"You will not get a penny more than £50 million, if you are lucky." I was delighted that the end agreement was £70 million, although I note that, in my absence from the COSLA negotiating team, the fund is now £80 million. Members can draw their own conclusions from that.

Jackie Baillie: I do not recall the figure of £50 million. I certainly recall a leaked document from COSLA anticipating £140 million. Perhaps the member's absence from COSLA has meant that it has been reduced by half.

Derek Mackay: I certainly could not comment on any leaked document but, if £140 million was the figure, it was very aspirational. That change fund went from zero pence under the Labour-Liberal Executives to £70 million under an SNP Administration, and has since increased to £80 million.

Duncan McNeil (Greenock and Inverclyde) (Lab): That is not new money at all.

Derek Mackay: I want to make more progress, as I am more than halfway through my time and I think that I have made my point.

Of course, that £80 million is captured within the total of £500 million for preventative spending. Some of the community infrastructure that should be developed is good practice, but it should be made core work, such as the programmes on reaching older adults and encouraging healthy lives within the community—I am sure that George Adam will cover that, shortly, from a local perspective. Fuel poverty is also an issue—the choices that many pensioners and older citizens have to make if they are to heat their homes. It is absurd that a country as rich in resources as Scotland still has fuel poverty. We would address that if we had access to all our own resources. Travel, telecare and winter preparedness are all issues worthy of consideration as well.

I welcome what the minister said about taking a holistic approach, because sometimes there will be financial issues too, to do with self-directed care and direct payments. Indeed, if someone is hospitalised, they should have an immediate benefit analysis to see what financial support they can have once they go back to the community—the sooner, the better in many cases.

I welcome some of the comments that have been made by the Opposition. I know that Jackie Baillie said that she may be absent from the end of the debate, but what has also been absent is any serious policy contribution from the Labour Party, particularly on its abandonment of its policy on a national care service. I welcome the abandonment of that policy.

Jackie Baillie: Will the member take an intervention?

The Deputy Presiding Officer: The member is in his final minute.

Derek Mackay: I am in my final minute. I have learned that, if you take an intervention, you get cut off very abruptly at six minutes. I will not make that mistake again.

It will cheer Jackie Baillie up to hear that I agree that the pace of change must be greater. An area that the Finance Committee is studying closely is the joint ownership agenda on issues such as delayed discharges, which social work may not see as being a core responsibility, but which health boards do. There is a HEAT target on that, which has to be delivered in partnership with social work. I hope that Jackie Baillie and her colleagues will support the new onus that we are putting on community planning partnerships to ensure that partners work more closely together.

16:00

Helen Eadie (Cowdenbeath) (Lab): I welcome the opportunity to contribute to the debate and, in the context of the minister's request for constructive input into the work that he is undertaking with a view to developing services, I would like to make some recommendations for action.

Before I do so, however, I would like to applaud the Government for the fit for work service in Scotland, which is called working health services Scotland. Funded by the Scottish Government and the Department for Work and Pensions, it is a Scotland-wide pilot that supports more than 3,500 employees of small and medium-sized organisations to continue in work or to return to work following a period of ill health or sickness absence.

I mention that service in the context of musculoskeletal disorders, which are one of the most common types of work-related illness in Scotland—48 per cent of work-related illness in this country is of MSD origin. Just two weeks ago, a cross-party group on musculoskeletal disorders was set up, thanks to the support of Nanette Milne and Jim Eadie, who is not in the chamber—I am sorry; he has moved seat. He has had two plaudits from me in two days, so he is doing okay. The cross-party group will allow us to take forward formally work that we have hitherto taken forward informally. I hope that the minister will give favourable consideration to being a guest speaker at one of our meetings, if the establishment of the group is approved by the Standards, Procedures and Public Appointments Committee.

I would like to thank the clinicians, the patients and the members of the Association of the British Pharmaceutical Industry such as Wyeth, Pfizer, Abbott and GlaxoSmithKline who have played a highly constructive part in all the work that we have done.

What recommendations would we like to see being taken forward? The Government could increase the delivery of integrated services at a local level to ensure early diagnosis and appropriate treatment. It could recognise the importance of retention in, or return to, work as an outcome of successful patient care throughout Scotland. That should be reflected in national policy and service delivery guidance and targets, such as the NHS Scotland quality strategy, the Scottish intercollegiate guidelines network guidelines and the HEAT targets.

The Scottish Government and the DWP should work together to continue to fund working health services Scotland, and the Government should appoint a clinical lead for MSDs, to provide enhanced strategic direction and oversight. In addition, it should be ensured that the NHS improves its collaboration with relevant patient representatives. That is an extremely important focus, and one that we have had in our working group.

In 2007, in response to the increasing prevalence of MSDs and the corresponding rise in sickness absence in the workplace, the industry group supported the Work Foundation Report entitled "Fit For Work? Musculoskeletal Disorders and Labour Market Participation". It looked in detail at the impact that MSDs have on the working lives of thousands of workers across Scotland and the UK as a whole, the adequacy of the treatment and support that they receive, their experiences at work and the human and financial costs involved, and it made a series of recommendations on supporting people with MSDs in the workplace.

A number of the report's recommendations have particular resonance in Scotland. The report recommended earlier intervention by general practitioners and employers in the active management of people with musculoskeletal disorders. It also recommended changing the remit of the National Institute for Health and Clinical Excellence to allow it to look at the broader costs to society when the cost effectiveness of treatments is assessed. In Scotland, the industry urges the Scottish Medicines Consortium's consideration of new medicines to be based on the broader costs to society, taking into account the economic and social impact, as well as the cost to NHS Scotland.

For Great Britain, the report recommended greater joined-up policy making between the Department of Health and the Department for Work and Pensions. In Scotland, that would mean closer working between the Scottish Government's health directorates, NHS Scotland and the DWP, to ensure that appropriate action is taken to allow people suffering from MSDs to return to health and move from a reliance on incapacity benefits, and thus contribute to the Scottish economy.

Early diagnosis and prevention are vital in the context of all musculoskeletal disorders. The value of that cannot be overestimated. It can significantly reduce the effects of musculoskeletal disorders on an individual's physical and mental health and help with labour market participation and productivity and with their personal life.

Members would not expect me to sit down today without mentioning Remploy and supported businesses across Scotland, which have great relevance to a discussion of enablement and disability. I hope that the minister will tell Fergus Ewing that I am still waiting for a copy of the letter that he sent to the Secretary of State for Work and Pensions in Westminster, which contained the Government's response to the proposal to close every factory and business in the UK that is related to people who are disabled. That proposal will affect 2,500 in factories and a total of nearly 6,000 people across the UK. Eight of the factories are in Scotland. I do not want them to close.

It is the week before remembrance Sunday, when we remember people. If we remember people in a way that disempowers them and takes away their ability and right to work, that is no good. We must honour the blood that is dropped across the world—and it is still being dropped—and the soldiers who come back after they have fought in military service.

16:07

George Adam (Paisley) (SNP): The debate concerns a subject that is quite close to my heart. I would like to talk about long-term conditions. My wife suffers from a long-term condition—apart from being married to me, that is. She suffers from multiple sclerosis. She walked down the aisle, but now, anywhere we go, I push her in a wheelchair. We have had to change our lifestyles as her disability has increased over time. It has got to the stage where, whenever we go, we have to plan carefully where we are going, what time we are going there and what we are going to do.

When I was elected as a councillor, I became the go-to guy for people who are living with long-term conditions. That becomes quite a difficult job, because anyone who is working in the community on these matters will hear some tragic cases. I have worked closely with the MS Society in Paisley and the surrounding district and together we have raised money to ensure that we can get extra help for people.

Much of the time, what people with long-term conditions want is simply the opportunity to talk to other people with the same condition. My wife loves going to the Revive centre in Maryhill. People with MS can go there and, as well as accessing medicine and so on, they can simply sit in the cafe with cups of tea and talk to each other. When I ask my wife what she gains from going there, she tells me that she likes to talk to people who are suffering from the same illness.

Mary Fee: Does the member agree that a local authority that imposes charges for buses to day care centres, increases elderly and adult day care charges and implements charges for blue badges does little to rehabilitate or enable elderly and disabled people?

George Adam: I find it quite funny that, one minute, Mary Fee says that she wants no responsibility and does not want to discuss any new ideas or look to the future, and the next minute, she is talking about negative issues. I am trying to be extremely positive about how we deal with the difficult situation facing us in these difficult times. It is particularly funny that Mary Fee should ask that question, given that, in Renfrewshire

Council, she voted for a Tory budget that would close a care home in Paisley.

Mary Fee *rose—*

George Adam: I want to move on and talk about the matter in hand. I am talking about people with long-term conditions.

The minister was right to say that there must be a shift from the traditional model of delivery of care. Given the severe financial cuts from Westminster, there is a need for strong leadership on health and social care, particularly in relation to the needs of older people and people with long-term conditions. In Renfrewshire, at the high flats at Rowan Court in my council ward in Paisley, work has been done to create a social area at the bottom of the flats, where the older people can meet. People look after one another, which means that older people can remain part of their community, rather than facing the expense of going into a care home.

We also dealt with delayed discharge. There is free bus travel for elderly people now, but there was a time when Renfrewshire Council used to send people doon the water for a summer trip. We used that money to help with delayed discharges.

We also have the groundbreaking reaching older adults in Renfrewshire—ROAR—partnership, which is ensuring that we can work with everyone and that people are not left alone.

Something that does not work is Strathclyde partnership for transport's dial-a-bus scheme. I have brought the issue up again and again. Renfrewshire Council spends £3 million a year on the system, and it annoys me when I hear of elderly people being abandoned at clubs and having to get taxis when no one came to pick them up. A report from the council says that it would be cheaper to provide a 24/7 taxi service. We are spending money that could be better used.

In 2007, when the SNP administration came in in Renfrewshire Council, the scrutiny board had a look at demographic change in Renfrewshire and how we could deliver services. It was important to do that at an early stage, because we could see that there were difficulties ahead—and that was before the financial problems that we currently face. At that time, an expert from the University of Paisley—as it will always be to me; I know that it is the University of the West of Scotland now—told us that the retirement age was the idea of the Prussian premier Bismarck. Bismarck learned that most of the people who worked for him died at the age of 64, so he decided to establish a retirement age of 65. We heard about the need to keep older people involved in society for longer.

It is important that we have the services that older people need. Some 20 per cent of the £70 million change fund, which is rising to £80 million in 2012-13, will support carers. That is extremely important. I have been dealing with a case in which a gentleman has Alzheimer's and terminal cancer and all his wife wants is to get him back home so that he can spend his final years with his life partner.

How we deal with the health and social wellbeing of our older population defines us as a nation. There is a need to consider different models of delivery, and such work must be led by health and social care professionals, who need the Parliament's support. We must move forward together. The Scotland of the future that I want is one that will work to ensure that all Scots have a life of fulfilment and, if possible, can stay with their families and in their communities.

16:13

Kevin Stewart (Aberdeen Central) (SNP): I refer members to my entry in the register of members' interests. I am a member of Aberdeen City Council, which I will mention.

There was a bit of a spat between Jackie Baillie and me earlier on delayed discharge. I think that 95 delayed discharges is too many delayed discharges and I would like the figure to be zero. I certainly do not want to go back to the dark days when 2,162 folk were waiting to get out of hospital.

Jackie Baillie: Does the member acknowledge that the plan to tackle delayed discharge and the resources to do so were put in place by the Labour Administration and were continued by the SNP, and that that is what has resulted in the improvements that we have seen?

Kevin Stewart: It was implemented by a minority SNP Government and will be continued by this SNP majority Government.

I was elected to Aberdeen City Council in 1999, and it used to perturb me greatly to see the number of folk whose discharge from hospital was delayed. I hated the term that was used at that time even more, so I am glad that we have got away from that horrid term "bedblocking", which was so often used.

To ensure the required changes, Aberdeen City Council in collaboration with NHS Grampian put a number of things in place, including Rosewell house and Smithfield court. I have had the benefit of a family member being in the latter. I will not say too much about those things, because another member of Aberdeen City Council will speak after me and I think that he will cover some of those points.

On enablement—I will use that word rather than re-enablement because my council colleague Jim Kiddie hates that term—there has been an

£800,000 investment in a new enablement service, ensuring that the occupational therapy teams are in place with the physiotherapists to keep folk at home whenever that is possible.

Nanette Milne referred to e-health and telecare in her speech. In Aberdeen, we have some of the leading lights in Scotland in that area. I agree with Nanette Milne that we are not rolling out some of the schemes quickly enough. We should look much more closely at the knowledge and skills that we have in order to roll that out a bit more. I hope that the minister will deal with that in his summing up.

A very important issue that no one has talked about in the debate is the impact of the Westminster Welfare Reform Bill and what we will try to do here in that regard. Evidence on the bill that was given at the Local Government and Regeneration Committee today showed that there will probably be impacts on aids and adaptations and there will certainly be impacts on transportation. There will also be impacts on home care budgets right across Scotland. All that will cause major difficulties if we hope to achieve what the motion lays out. It is up to all of us to scrutinise the Welfare Reform Bill to the nth degree because—let us be honest—we do not know very much about its detail. However, we do know that it will have a major effect on some of the poorest and most needy in our society.

Jim Eadie spoke earlier about learning disabilities. We still have very old-fashioned service delivery throughout the country to provide for the needs of people who have learning disabilities. There was a furore in Aberdeen a couple of years back when we closed a day centre, but it was the right thing to do, because the service that was provided there was extremely old-fashioned. We now have services that allow a level of independence for folk that was not there before.

I pay tribute to the charity Inspire, which has taken over some services and ensures that people are out and about, living life to the maximum. That is what we should aspire to do right across the country, whether for our older people, our folk with learning disabilities or our people with chronic ailments. I hope that we can learn the very good lessons that are taking place in some areas and ensure that best practice is rolled out throughout Scotland. I hope that the minister will comment on that in his summing up.

16:19

Rhoda Grant (Highlands and Islands) (Lab): I very much welcome the debate. We have spoken in Parliament many times about shifting the balance of care. Re-enablement and rehabilitation are crucial to that, through enabling people to get their lives back after they have been unwell.

We also need to ensure that we include self-management, independence at home and people's social wellbeing. We have an ageing population and we need to ensure that health and social care providers work together to deliver joined-up services that fit the person's needs. From my experience of trying to organise care for family members, when I not only had to go between the health service and council social care services but had to speak to different services within those organisations, I know that it becomes very clear that there is no joined-up care. As an MSP, I am used to working with those organisations when I represent constituents, and I have found the process to be hugely difficult, so elderly people who do not have families must find having to deal with those services and trying to get care packages in place nigh on impossible. We must do something about that if we are to consider the whole person.

John Finnie (Highlands and Islands) (SNP): Does Rhoda Grant accept that co-location of teams from different spheres of the care sector is a benefit in delivery of care? We have that in the Highland Council area and it happens in Orkney, too.

Rhoda Grant: Co-location is a benefit, but we also need better communication. We need to ensure that service providers speak to each other, so that when they have identified a need it does not remain with that provider but is passed through the system. Services should be geared to the person, not to the tickbox and to whoever is delivering the service.

We also have challenges with service delivery in rural areas. We need generalists and every service has grappled with how to provide services when the population is not large enough to have specialists in place. To train generalists and put them in place is challenging because they are not recognised professionally and they are certainly not recognised financially, because payment tends to attach to the level of qualification and the specialism. We need people who can treat the whole person and we need to recognise their skills.

We must also recognise that there is an added cost in delivering services in rural areas. I have been banging on for a number of years about the need for a health funding formula that acknowledges that added cost; we need to do something about it. It has been too long and there have been too many reviews. Something now needs to happen to ensure that funding is in place and that it is fairly distributed.

We must also involve communities in the services that they receive. My postbag is full at the moment as communities are complaining about how they are receiving services and about how changes to services are being managed. Communities in Ardnamurchan are considering their emergency out-of-hours services, as are communities in Glenelg and Arnisdale, and although that might not directly impact on today's debate, people living in those communities who want to be independent and to be reabled and rehabilitated might not have the confidence to move home if they feel that services are not there to back them up.

One service that could really impact on rural areas includes telehealth, telemedicine and telecare. We can use it to monitor conditions and information can be sent to the patient and the practitioners so that health conditions are recognised and deterioration is dealt with quickly. It can also be used to get information to patients about their conditions through CDs and DVDs so that when they need the information, it is available.

We could also consider videoconferencing. I have seen physiotherapy classes being delivered by videoconference, which is hugely enabling to people with long-term conditions who might not wish to travel. That has a real benefit for rural areas, but to deliver it properly we need connectivity. Broadband is not an infrastructure problem; it is a health and local government problem. We need good broadband to deliver that care to the people who require it because such care not only improves services but alleviates the cost of delivering them.

At a time of very tight budgets, there are huge savings to be reaped across all our public services, health and local government by investing in that type of infrastructure. The Government must look at the Audit Scotland report on how we deliver telecare and telehealth and then set a strategy and targets, which must join up with its targets on the roll-out of broadband to rural areas.

I will touch briefly on prevention, which several members have discussed already. Access to services such as physiotherapy could offer huge cost savings to the health service. For instance, if patients with issues were triaged by a physiotherapist, they would probably never have to see a consultant, which is a costly service, but they would be seen quickly before any complications occurred and they would be back to being independent and working without having had to wait.

The Presiding Officer is looking at me, so I must wind up. There are many other issues that I could speak about, but it is important that we deliver patient-centred services to ensure that people are independent and have good quality of life.

16:26

Mark McDonald (North East Scotland) (SNP): Sometimes I wonder what life would be like in the alternate reality that some members of the Labour Party seem to occupy: the one where there is no need to take responsibility for anything and one can increase a budget without the consequential need to reduce another budget.

Unfortunately, that view was epitomised in Mary Fee's speech, which essentially contained no ideas and was just moaning. It also sums up how Labour approached the 2011 election campaign, which is why the arithmetic in the chamber adds up the way it does—[*Interruption*.] I hear the convener of the Health and Sport Committee getting rather exercised as he leaves the chamber. Nonetheless, that is where we are.

With regard to what Jackie Baillie was saying, it is always interesting to see where Labour defines year zero. It usually tends to land somewhere after 2007: things only ever get bad after 2007, and all was rosy before that.

Jackie Baillie: Will the member take an intervention?

Mark McDonald: I will, in just a second. My colleague Kevin Stewart quite rightly highlighted the delayed discharge situation. I accept that some progress was made under the Labour Party, but in 2007, when this party came to power, there were still 233 people under delayed discharge. This Government has made significant progress in that regard. Yes—the numbers are too high at present, but we should never forget the situation that we inherited and the progress that has been made under this Government. It is very churlish to keep talking—as Dr Simpson did—about things going backward. We are nowhere near going backward to the situation that we inherited in 2007, and it is disingenuous to suggest as much.

I will, of course, give way to Jackie Baillie.

Jackie Baillie: I am grateful to Mark McDonald for taking an intervention, and for highlighting that at the point when the SNP took over, the number of delayed discharges was 233. That was 233 too many, and there are currently 95 too many. It would be better if we agreed on how we get to zero, as the Scottish Government has so far failed to be consistent in its approach.

I point Mark McDonald towards a statistic from 2009 that I used in order to give the SNP credit for achieving a high in the number of allied health professionals, while expressing my genuine disappointment that there has been a decline year on year in the number of the very people whom we want to deliver rehabilitation and reablement services.

Mark McDonald: I hope that the Presiding Officer might be a little bit lenient with my timing; Jackie Baillie, having used up almost all the extra time in the debate in her own speech, has now taken a huge chunk out of my time with her intervention.

We have a higher level of allied health professional full-time-equivalent employment now—by more than 500—than we did in September 2006. I say to Jackie Baillie that the issues of unemployment and difficulties in the job market for speech and language therapists and physiotherapists are not new phenomena. They very much existed when the Labour Executive was in power, and that Administration did not manage to solve the problem either. The minister has highlighted quite clearly that the issue is very much on his agenda, so we should back him in what he wants to do.

Being a positive individual like my colleague George Adam, I will focus on some positive examples of where work is being done, particularly on integration of health and social care. I am grateful to my colleague Kevin Stewart for allowing me to focus on the work that is done at Rosewell house and Smithfield court, if for no other reason than that my speech would otherwise have been very short.

Rosewell house, which I have mentioned before in the chamber, opened in Aberdeen in 2009. It is a purpose-built 60-bed care home that provides residential, respite and rehabilitation places in a partnership approach between the council and the NHS. When we talk about the need for the integration of health and social care services and the need for the NHS to work more closely with council services, Aberdeen has a good story to tell. I will come to that again when I talk about Smithfield court. Rosewell house has a large therapy suite and rehabilitation is delivered jointly by the council and NHS Grampian. Crucially, over time, the number of residential beds at Rosewell house will be reduced until it does not offer residential places, which ties in with the rehabilitation and reablement approach that is being taken. The facility is helping Aberdeen City Council to achieve extremely good delayed discharge figures.

Besides that, there is Smithfield court, with which my colleague, Kevin Stewart, is extremely familiar. Not only is it in the council ward that he represents, it is at the bottom of the street where he lives, so he has a good knowledge of the facility. It is a multistorey sheltered housing complex within which 22 flats have been adapted for rehabilitation and within which NHS physiotherapy and occupational therapy staff operate. The council housing service collaborates closely with NHS Grampian to deliver those services, which are another key component in the council's bid to reduce the number of delayed discharges.

Clare Adamson made an important point about trips and falls. Aberdeen City Council is looking at a downsizing scheme that tries to house people in more appropriate surroundings, which is something that other councils could do. Often, elderly people live in the three-bedroom or four-bedroom council properties that they lived in with their families. When the family have grown up and moved out, those elderly people continue to live alone in such properties. We must do what we can to facilitate their moving to more appropriate properties such as amenity bungalows, where there is less likelihood of a trip and fall occurring because they do not have to go up and down stairs to get to their bedroom or bathroom.

I would be grateful if the Presiding Officer would grant me a little leniency to speak briefly about the Dundee pilot scheme that I mentioned in my intervention on Malcolm Chisholm. The pilot scheme looked at a control group of 22 people who did not receive the enablement service and 22 people who received it. Over a six-week period, the number of hours of care that were required by the enablement sample group went from 314 to 154, whereas the number of hours of care required by the control group went from 275 to 204. Crucially, over a six-month period, the number of hours of care required went from 314 to 107 in the enablement group and from 275 to 279.5 in the control group. That shows that enablement services have a real role to play. There is a clear difference between savings in care hours and cuts in care hours. When savings in care hours are made, it is because people have been inappropriately placed in care packages—we have heard examples of that from around the chamber. We often put people into care packages because we think that it is the right thing to do, but it is not always the right thing to do, as those examples demonstrate. Thank you for your leniency, Presiding Officer.

16:33

Mary Scanlon (Highlands and Islands) (Con): I welcome the debate and the minister's commitment to do better and to listen to constructive points. The debate has been so wide ranging that I have found it difficult to know what to include in my summing up. It has been about the social wellbeing of the older population, people with long-term conditions, people who are trying to remain in or return to work after illness, and supporting self-management. I particularly enjoyed the speeches from Jim Eadie and Dennis Robertson, which were measured and made

highly constructive points. That is what we were all looking for.

Kevin Stewart was the only member to mention the Welfare Reform Bill, but he was right to mention it. It should be a catalyst for provision of better services, better rehabilitation and for giving people the confidence and dignity to get back into work or training when that is appropriate and possible. I can imagine people being placed in the impossible position of being asked to come in to have their benefits reviewed and then being told that they are on a waiting list for a year or 18 months to see a psychiatrist. We should be discussing that.

Much has been said about the change fund. Whether the amount is £80 million, £120 million, £50 million or whatever, I welcome the change fund. However, I am one of the starters in the Parliament from 1999, when we on the Health and Community Care Committee said, "Why don't social work services and the NHS talk to each other?" I am sorry to say that it is sad that, in the Parliament's 13th year, we are now dedicating millions to trying to get those services to work together. Nonetheless, I welcome the fund and I hope that the action will work this time.

I will mention another issue that I find sad, after listening to other members—Rhoda Grant, in particular. She and I represent the Highlands and Islands. In the past week, I have had about three phone calls from people who have constant battles to get the care packages for which they were assessed. They are exhausted and are phoning here and there. I feel embarrassed about that, because much of my time in Parliament has been spent on health issues. What we hear in Parliament often does not reflect people's experience, particularly in Orkney and Highland. Last week, I had a bad case that I could do nothing about, but I went to Social Care and Social Work Improvement Scotland, which I am pleased to say responded excellently.

John Finnie: Will the member take an intervention?

Mary Scanlon: I will not, just now.

Orkney and the Highlands are two areas where integration should be working. We are right to expect more.

I welcome the minister's national delivery plan. We constantly discuss health issues and strategies, but we need to do more to focus on the devastating impact on families of long-term illness, disability and inability to work. My colleague Nanette Milne gave a clear overview of her experience, which was most welcome.

As I said earlier, I made an FOI request in 2009 that revealed that more than 20,000 people were on waiting lists to see a physiotherapist. A person who is on a waiting list to see a physio for more than three months is much less likely ever to return to work. The figure that I received was an underestimate, because many health boards had incomplete figures. There is no doubt that physiotherapy input and advice at the right time keep people in work and help people to return to work.

We have spoken often about telehealth. I agree again with Kevin Stewart—telehealth has tremendous potential. When the issue was raised with the cabinet secretary at this week's Health and Sport Committee meeting, she gave us a positive response, but we need to move forward. We have undertaken many successful pilots, but somehow they have not been rolled out.

Telehealth can be used to deal with chronic obstructive pulmonary disease and diabetes, and for cardiac and stroke monitoring and managing depression. I commend NHS 24's cognitive behavioural therapy service. Many people in the Highlands do not want to go to meetings, give up work, travel to Inverness or be an in-patient in a psychiatric unit. CBT helps them to understand the triggers that cause their depression and to have the self-management and coping mechanisms that will keep them on an even keel, which is phenomenal. That initiative is welcome. I hope that it will be rolled out and that people will be given more opportunity to access it.

Tonight, I will have a reception in the garden lobby, which 76 chiropractors will attend. It is odd that, although chiropractic treatment should be available on the NHS, no GPs refer patients for it. It provides one of the easiest and quickest ways for many people to be without pain and get back to work. I hope that the minister will take that point in the constructive way in which it was made.

I do not have time to talk about chiropody or podiatry.

Whatever the delayed discharge figures are, I welcome the fact that the target will reduce from six weeks to two weeks. After six weeks in hospital, people can lose their confidence and their independence. Much damage is done in that time, so I welcome the reduction to two weeks.

16:39

Dr Richard Simpson (Mid Scotland and Fife) (Lab): This has been an important debate. Although it has been slightly acrimonious at times, on the whole it has been consensual.

Rehabilitation is important in relation to illness and reablement is important in relation to the maximisation of independence. Maintaining independence, especially in the elderly, is critical.

As Malcolm Chisholm said, it is also important that people can return to work or be maintained in work through the healthy working lives initiative, which was established by Labour.

The minister gave an excellent description of the problems that we face. Life expectancy has increased enormously, but healthy life expectancy has not increased to the same extent. Sixty per cent of hospital beds are occupied by people who have long-term conditions, which illustrates the challenge that we all agree is facing us.

Unlocking funds from the acute sector is critical, as Jim Eadie and Malcolm Chisholm reminded us, and making shifts within £4.3 billion must be a challenge, so we welcome the change fund. The funds that are being drawn together might not be new, but the concept is new and it might serve us well. It is critical for local authorities to be in partnership in that regard but, as Mary Fee and Jackie Baillie emphasised, the voluntary sector must also be fully engaged. I will illustrate that point a little later.

Like Jim Eadie, I welcome the change fund's emphasis on carers and I share his concern about those with learning disabilities who have complex needs but who will benefit most from the required integration.

The issue of delayed discharge led to some acrimony in the debate. We all agree that progress has been good. The critical point is to look at where we started from and where we finish, and the SNP's ambition is not in doubt. As Mary Scanlon said, the move to a two-week target is very welcome, not just because it will save costs but because it will reduce institutionalisation and loss of independence. We are one with the Government on that, but the fact remains that there has been a problem since 2008. Audit Scotland reported a doubling of the numbers whose discharge was delayed for more than six weeks. The figure has not stayed at zero because of the problems that some local authorities face.

Many members referred to the partnership between users and carers that is required. We are not talking about something passive but about something active. That partnership must involve a multidisciplinary team of occupational therapists, speech and language therapists, social workers, podiatrists, nurses, dieticians, mental health nurses, psychologists, pharmacists and doctors. They all have to be involved.

I welcome the proposal for a further national implementation plan for allied health professionals, against the background of a loss of posts since 2009. That was when the SNP achieved an excellent high point, but 230 posts have gone and others are frozen—although those posts are not included in the posts that have been lost. Band 8 posts are being reduced at the very time when we will need leadership to fulfil the SNP's ambitions.

Jamie Hepburn: Does the member recognise that more people are employed in the allied health professions than during the final year of the Labour Administration?

Dr Simpson: I accept that there are more than there were in 2006-07, but we shall see whether that will be the case in a year's time. The fact remains that numbers are reducing at the very time when the Government's ambition is to increase the use of reablement and rehabilitation.

Malcolm Chisholm remarked on the continuity of policy. The framework that was started by Labour in 2007 was targeted at older people, people who have long-term conditions and people who are returning to or maintaining employment. Following consultation, that framework had six statements, five key actions, a national implementation group and rehabilitation improvement programmes, and local co-ordinator posts were set to be established. I was not able to find a single report from the national implementation group. Does it still exist? What progress has been made?

No significant movement has been made to integrate care across Scotland. Indeed, history shows that Mary Scanlon and I sat on the Health and Community Care Committee in the first session of Parliament and called for integration of services.

We actually made the joint future programme: we gave money to Perth and Kinross and Tayside health boards to integrate, and although it took them two years, they achieved it through establishing lead commissioning, which is now being proposed again. However, within three years, that integration had broken down.

Labour's ambition was to have national care standards and a national, statutory approach, but not one that created a global agency. Our ambition was to reinvigorate the community health partnerships, which have withered, and the local healthcare co-operatives, of which there were 85; there are now only 40. Primary care physicians and their primary care teams have become disengaged from the process. There has not been integration; rather, there has been disintegration. We need to have a far more vitalised approach.

It is not the case that there is not good practice; indeed, many members have given good examples of good practice. Clare Adamson referred to North Lanarkshire. A relative of mine works in the rapid discharge team there. It is highly effective in getting people out of hospital quickly and in providing ablement. She described other initiatives that provide continuity beyond that, preventing emergency admissions. She also mentioned the use of intermediate care units. We

stopped the reduction in community hospitals that occurred until 1997. They have a critical role to play.

Clare Adamson said important things about early work to prevent falls as opposed to work after falls. Such early work is critical. She also reminded us that domestic sprinklers may be critical in keeping people—and their neighbours—safely in their own homes.

Mark McDonald gave examples of collaborative rehabilitation using adapted flats in Aberdeen, and Malcolm Chisholm referred to a programme in Lothian under the leadership of Peter Gabbitas, whose appointment was made jointly by the City of Edinburgh Council and Lothian NHS Board. That has led to teams of nurses and social care workers providing six weeks of intensive support.

Mark McDonald reported on enablement in Tayside.

Derek Mackay: Will the member take an intervention?

Dr Simpson: I cannot, as my time is running out.

I want to add something about voluntary organisations. Physical activity is a critical part of reablement for some people. There are 160 therapeutic horticultural projects in Scotland, most of which are voluntary or social enterprise projects. The voluntary sector is critical. I refer to the example of Penumbra's involvement in the housing sector. Members have said that the work of Care and Repair is vital. The organisation is undoubtedly under attack. I attended its national conference this year, at which it indicated that it was being cut.

From his extensive experience, Dennis Robertson referred to the fact that small changes in lighting and décor, for example, are sometimes needed. Rhoda Grant and other members referred to the need for more e-health and telecare services.

I pay tribute to Helen Eadie for her work in the important field of musculoskeletal disorders. Jim Eadie talked about a programme in the Borders. Some 38,000 people in Scotland have musculoskeletal disorders, which are critical in respect of returning to work.

I pay tribute to Kevin Stewart. He was absolutely right that the Welfare Reform Bill is very important, although otherwise I pretty well disagreed with what he said. We need to consider the effects that the Welfare Reform Bill will have on all our shared ambitions.

We agree on the route map, and we pay tribute to the Government for its ambition and hope that it is successful. However, we need to see effective leadership at all levels. The centre needs to spread good practice and manage integrated care, backed by integrated resource framework budgeting, which no member has mentioned. That demonstrates where areas are succeeding and where others are not.

I welcome the opportunity that I have had to speak in the debate.

16:48

Michael Matheson: Mary Scanlon and Richard Simpson mentioned that the debate has been wide ranging, but it has also been useful and good. Members have raised a range of issues—some were helpful, but some were not so helpful. We will be able to consider some of the issues that have been raised in our national delivery planning.

From the outset, I was keen to set the context of the debate. Malcolm Chisholm picked up on that in his speech. The demographics that we face in Scotland mean that we have to change, and not only because of the financial environment in which we find ourselves. Even if we were in the land of milk and honey and had much more public resource, we would still have to change how we do things and how we deliver certain services because of the significant demographic shift that is taking place. That is making it more difficult to create such change in the current economic climate, and it makes the environment more challenging for professionals and others to work in to achieve the necessary change. A large part of the problem is the demographic shift; it is not a purely financial problem.

Several members referred to the change fund. Broadly speaking, members throughout the chamber feel that the fund is positive and can have a real benefit in changing the way in which services are delivered. Jackie Baillie, who unfortunately had to leave early, was concerned about a potential underspend in the budget and a rush to get money out the door. The fund is new and some organisations are still working together—in some cases for the first time—to get programmes together. The Government intends to ensure that the money is used as effectively as possible.

The fund is not there simply to backfill services that have been drawn back; it is about transforming the way in which services are delivered. It could almost be interpreted as a form of bridging finance to try to achieve the transformation that we need in the community to allow resources to transfer from the secondary care setting. It is extremely important that we support both aspects of the service to allow that transition to take place. That is the intention behind the change fund.

Kevin Stewart: The Local Government and Regeneration Committee has heard in evidence that the reason why there might have been a delay in delivering the change fund is because local government budget cycles do not necessarily tie in with those in the health service. Will the minister consider that issue to try to make the process easier in future?

Michael Matheson: That is a valid point. As I said, this is the first year of the change fund, so clearly there will be lessons to learn about how we can improve things as we progress.

We have given an indication that we will continue the funding until 2014-15. Next year, 20 per cent of the fund will be for carer services. It is right that we do that because, given that part of the transformation that the change fund is intended to bring about is to provide more support to people in the community and encourage more self-management, one thing that will occur as a result will be a greater direct and indirect burden on carers. Therefore, it is extremely important that, as services are redesigned, we recognise the role and value of carers. That is why, in the next financial year, part of the fund will be dedicated to addressing carers' needs.

I have no doubt that we will be able to find some really good measures that have been introduced in some areas in Scotland through the change fund, but it is extremely important that we do not get into a cycle of reinventing the wheel. Every time a good initiative is identified in one part of the country, we must extend that practice and experience to other parts of the country. As the change fund progresses, we will be keen to encourage that to ensure that it happens.

There will be considerable scrutiny of the fund to ensure that it is used as intended and that it is transforming services.

Dr Simpson: In 2001, the Labour Government, in trying to do what the SNP is now trying to do, set up the joint future group. Does it still exist and, if so, will it deal with the spreading of good practice that the minister rightly talks about?

Michael Matheson: The joint future group is doing some of the work on the change fund, in relation to the local plans. We have 32 local plans in place. I am conscious of concerns about local authorities that I have heard from the third sector. One thing that we have included in the change fund is the need to ensure that measures are signed off by the local authority, the health board and the third sector, so that the third sector is at the table from the outset. However, I have heard concerns about Glasgow City Council and the way in which it is working with the third sector in relation to the change fund. We must consider how to address that.

Mary Fee expressed concerns about the change fund and other aspects of the agenda such as self-directed support. Her speech largely involved her saying that we need more money for a range of measures. She is right that Governments must choose where to put their money. As a back bencher and a member of the Health and Sport Committee she has an opportunity to bring forward amendments to the budget bill to take money from one part of the health and sport budget and to reallocate it to another area if she is so minded. Given that she is nodding, I suspect that she will do that. In doing so, she will have to explain where the money will come from before she puts it anywhere else. If we are to have a serious debate about that, all members must recognise the financial environment in which we operate. It is entirely unrealistic and misleading to give people the impression that there is a pot of money that we can simply throw around.

I turn to the integration of health and social care, which a number of members mentioned. Mary Scanlon says that she is frustrated about that because, since 1999, when she joined the Parliament, she has been expecting to see greater integration of health and social care. I am sorry to tell her that, when I started out as a new occupational therapist back in 1991, we were also going to have greater integration of health and social care. Therefore, I feel as though I have been treading that route even longer than she has, despite the fact that I am younger. [*Laughter*.] I say that in the nicest possible way.

I reassure Mary Scanlon that the Government is determined to take forward that agenda in a way that has not been done before. We need to ensure that patients and others who require services receive services that work collectively to meet individuals' needs rather than operating within their own silos—to use a term that I think Derek Mackay used—and for their own purposes.

I know that Jackie Baillie is a bit frustrated that we have not made an announcement on that in the past seven months. Given the length of time that the agenda has been on the table under successive Governments, the seven or eight months that we have taken to try to ensure that we take it forward in the right way—so that we get it right and do not have any of the false starts that we have had over recent years—is time well used. The Government will present its considered view on how we drive forward greater integration of health and social care in a way that ensures real change on the ground.

Derek Mackay made a good point about delayed discharge. I do not want to get into throwing brickbats about which party has done more than the other on delayed discharge. The reality is that delayed discharge is about human

beings being somewhere they should not be when there is a more appropriate setting for them to go to. Our focus must be to ensure that services work together in a co-ordinated way, with a shared agenda and a shared priority of ensuring that the resource is provided timeously to allow someone who is presently in a hospital bed but can be moved out into a social care setting to move out into that setting. We will continue to work towards ensuring that that happens.

A range of other issues have been raised. The number of allied health professionals has risen by 5.2 per cent since 2007. The Government continues to value the important role that AHPs play.

Prevention is an important part of our spending programme. We have said that clearly. Dennis Robertson and Clare Adamson both raised that issue.

Clare Adamson spoke about how we can prevent falls. During the summer, I launched a national falls prevention programme. It has a particular focus on the care home environment, which has been identified as one of the riskiest environments. That is not because the care in care homes is inappropriate but because they care for people who are much more frail than was the case in the past. About 1 per cent of falls translate into a fractured neck or femur. That costs our NHS some £73 million each year to address. If we can at least halve the number of falls, we can make a significant saving as a result. We have introduced the national falls prevention programme to try to do that more effectively.

We intend to consult on a national allied health professional delivery plan for Scotland, which will be the first of its type for any part of the United Kingdom. We will publish the consultation document in December this year, and we expect to take forward the detail of the plan in April next year. I encourage members and all the organisations that have an interest in the delivery plan to make their views known during the consultation to ensure that we can continue to deliver the health and social care services that the people of Scotland deserve.

Business Motions

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of business motion S4M-01276, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 16 November 2011

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Scottish Government Debate: Regeneration Strategy
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 17 November 2011

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Conservative and Unionist Party Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Justice and the Law Officers; Rural Affairs and the Environment
2.55 pm	Scottish Government Debate: Oil and Gas Framework
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 23 November 2011

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 24 November 2011

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time

	Health, Wellbeing and Cities Strategy
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business—[*Bruce Crawford.*]

Motion agreed to.

The Presiding Officer: The next item of business is consideration of three business motions. I ask Bruce Crawford, on behalf of the Parliamentary Bureau, to move motions S4M-01277 to S4M-01279, setting out stage 1 timetables on various bills, en bloc.

Motions moved,

That the Parliament agrees that consideration of the Agricultural Holdings (Amendment) (Scotland) Bill at Stage 1 be completed by 30 March 2012.

That the Parliament agrees that consideration of the Alcohol (Minimum Pricing) (Scotland) Bill at Stage 1 be completed by 9 March 2012.

That the Parliament agrees that consideration of the National Library of Scotland Bill at Stage 1 be completed by 16 March 2012.—[*Bruce Crawford.*]

Motions agreed to.

Parliamentary Bureau Motions

17:01

The Presiding Officer (Tricia Marwick): The next item of business is consideration of three Parliamentary Bureau motions. I ask Bruce Crawford to move motion S4M-01280, on the designation of a lead committee, and motion S4M-01281 and motion S4M-01282, on approval of Scottish statutory instruments.

Motions moved,

That the Parliament agrees that the Health and Sport Committee be designated as the lead committee in consideration of the Alcohol (Minimum Pricing) (Scotland) Bill at Stage 1.

That the Parliament agrees that the Interpretation and Legislative Reform (Scotland) Act 2010 (Consequential, Savings and Transitional Provisions) Order 2011 [draft] be approved.

That the Parliament agrees that the Scottish Local Government Elections Order 2011 [draft] be approved.—[*Bruce Crawford.*]

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

Decision Time

17:02

The Presiding Officer (Tricia Marwick): We come to decision time. There are five questions to be put as a result of today's business.

The first question is, that amendment S4M-01262.1, in the name of Jackie Baillie, which seeks to amend motion S4M-01262, in the name of Michael Matheson, on rehabilitation and enablement in Scotland, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Dugdale, Kezia (Lothian) (Lab)
Eadie, Helen (Cowdenbeath) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Findlay, Neil (Lothian) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Harvie, Patrick (Glasgow) (Green)
Johnstone, Alison (Lothian) (Green)
Kelly, James (Rutherglen) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McArthur, Liam (Orkney Islands) (LD)
McCulloch, Margaret (Central Scotland) (Lab)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Murray, Elaine (Dumfriesshire) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Rennie, Willie (Mid Scotland and Fife) (LD)
Scott, Tavish (Shetland Islands) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, Brian (Aberdeen Donside) (SNP)
Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (SNP)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
Mackenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (SNP)
Walker, Bill (Dunfermline) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

Abstentions

Brown, Gavin (Lothian) (Con)
Davidson, Ruth (Glasgow) (Con)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
McGrigor, Jamie (Highlands and Islands) (Con)
McLetchie, David (Lothian) (Con)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)

Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Liz (Mid Scotland and Fife) (Con)

The Presiding Officer: The result of the division is: For 39, Against 64, Abstentions 14.

Amendment disagreed to.

The Presiding Officer: The second question is, that motion S4M-01262, in the name of Michael Matheson, on rehabilitation and enablement in Scotland, be agreed to.

Motion agreed to,

That the Parliament recognises the importance of rehabilitation and re-ablement in supporting the health and social wellbeing of the growing older population, people with long-term conditions and those trying to remain in or return to work after illness or injury; further notes that rehabilitation and re-ablement are key to supporting self-management and enabling individuals to live productive and meaningful lives in their own homes and communities, and recognises the importance of this approach in underpinning the reshaping of community services as well as the future sustainability and affordability of health and social care provision.

The Presiding Officer: The next question is, that motion S4M-01280, in the name of Bruce Crawford, on the designation of a lead committee, be agreed to.

Motion agreed to,

That the Parliament agrees that the Health and Sport Committee be designated as the lead committee in consideration of the Alcohol (Minimum Pricing) (Scotland) Bill at Stage 1.

The Presiding Officer: The next question is, that motion S4M-01281, in the name of Bruce Crawford, on approval of a Scottish statutory instrument, be agreed to.

Motion agreed to,

That the Parliament agrees that the Interpretation and Legislative Reform (Scotland) Act 2010 (Consequential, Savings and Transitional Provisions) Order 2011 [draft] be approved.

The Presiding Officer: The next question is, that motion S4M-01282, in the name of Bruce Crawford, on approval of an SSI, be agreed to.

Motion agreed to,

That the Parliament agrees that the Scottish Local Government Elections Order 2011 [draft] be approved.

Prescription Medicine Waste

The Deputy Presiding Officer (Elaine Smith): The final item of business is a members' business debate on motion S4M-00941, in the name of Margaret Mitchell, on prescription medicine waste. The debate will conclude without any question being put.

Motion moved,

That the Parliament notes with concern the amount of prescription medicine wastage in Scotland; commends the NHS Forth Valley eWard scheme, which allows hospitals and community pharmacies to share information electronically, thereby helping to improve patient safety and reduce medicine waste; notes the report published in 2010 by the University of York that shows that better medicines management around the time of hospital admission and discharge will result in more optimal use of medicines; believes that the role of pharmacists in helping people understand their medicines will be enhanced by the Chronic Medication Service; recognises that, in order to minimise medicine waste, the electronic recording and sharing of information between hospitals, GPs and pharmacies is essential, and considers that this issue is worthy of further debate.

17:05

Margaret Mitchell (Central Scotland) (Con): According to the Royal Pharmaceutical Society, the cost of providing medicines is rising every year. Given that fact, and with the advent of free prescription charges, it is a matter of concern that, at a time when finances in the public sector are under pressure, there appears to have been no attempt to date to quantify the cost of wastage in Scotland.

My recent freedom of information request to Scottish national health service boards about prescription medicine wastage revealed that boards are largely unaware of how much that wastage costs, but NHS Lanarkshire estimated it to be a staggering £2 million each year and NHS Tayside subsequently estimated the cost to be £3.5 million a year. To put the figures in perspective, that is equivalent to the cost of 180 bypass operations and 137 community nurses respectively. In other words, there are substantial sums of money that could be used for the delivery of essential and front-line services and/or the provision of staff.

Prescription medicine wastage is clearly an issue that needs to be tackled. I am therefore pleased to see that, since I lodged the motion, the Scottish Government has announced that the role of pharmacists is to be reviewed. That is to be welcomed, as I believe that pharmacists are potentially key in our attempts to address the issue.

It is worth while to stress that some prescription wastage is unavoidable—for example, if a patient

recovers before the prescribed course of medicine is completed, if a treatment is changed by a doctor because it is not working or has an adverse side effect, or if a patient builds up an immunity to the medicine prescribed to treat their condition.

The good news is that there are various ways that wastage can be reduced or even eliminated. For instance, NHS Lanarkshire and NHS Tayside have both taken steps to tackle wastage by raising awareness of repeat prescription usage through initiatives to encourage people to think about their repeat prescriptions, to stop ordering items on a just-in-case basis, and to make them aware of the costs, especially as most people do not realise that even if they return unused medicines to their pharmacy those medicines cannot be reused and are destroyed.

Other methods to reduce wastage include doing something as straightforward as ensuring that patients know how to take their medicines correctly and recognising that vulnerable groups may be unsure about how often to take their medicine or which medicine to take. If people are uncertain of their supply, they repeat order all of their prescription, which in turn leads to medicine going to waste or being stockpiled at home.

If pharmacists were given access to relevant parts of patients' health records, they could dispense repeat prescriptions with more accuracy and at the same time help to manage patients' care as they move between different parts of the NHS. Ultimately, there must be better communication between healthcare professionals, general practitioners, pharmacists and patients, thereby providing improved patient treatment and reducing waste.

It is evident that providing pharmacies with time-saving technology and enabling them to have access to accurate, up-to-date records will allow them to spend more time with patients, helping to address any problems with medication and ensuring that medicines are dispensed only in the quantities required and when they are needed.

To that end, the chronic medication service has not only the potential to improve significantly the care of those with long-term conditions but the ability, through its electronic sharing of information and the establishment of a relationship between the patient and a particular community pharmacist, to reduce prescription medicine wastage.

Furthermore, last year's University of York "Evaluation of the Scale, Causes and Costs of Waste Medicines" concluded that

"enhancing hospital and primary care liaison in contexts such as improving the quality of care at around the time of hospital discharge"

was a positive opportunity for the reduction of medicines waste.

That is borne out by the experience in the new Forth Valley royal hospital, which has Scotland's first fully robotic pharmacy, where NHS Forth Valley uses an innovative eWARD system. The system has substantially improved electronic communications between the hospital and the primary care sector and has resulted in a 20 per cent reduction in stockholding. The use of both electronic medicine records in the hospital and the innovative eWARD discharge system has already resulted in positive changes, not only in the ward but also at home.

Finally, as I said, regulations mean that returned unused medicines cannot currently be reused and are destroyed. However, I understand that some European countries, including France, have waste medicine recycling schemes, whereby unused packs of medicines, with suitable expiry dates, are collected and later supplied to populations in need in countries around the world.

Given that counterfeit medicines are being distributed to so many third world countries, I request that the minister looks at the possibility of adopting a recycling scheme, similar to the French one, to help people in Africa and other parts of the world where medicines are desperately needed and could make a massive difference.

17:12

Gordon MacDonald (Edinburgh Pentlands) (SNP): I think that Margaret Mitchell and I must have written our speeches together, because I will duplicate much of what she said.

There is no doubt that drug wastage is a major problem throughout the United Kingdom. A report that the York health economics consortium published in 2010 found that unused prescription medicines cost the United Kingdom more than £400 million per annum.

The Royal College of Nursing report published in 2011, entitled "Taking the Pulse of NHS Scotland", identified that

"GP prescribing has been noted as a significant cost pressure by all NHS boards".

It estimated that, in 2009,

"GP prescribing budgets were overspent by around £22 million."

Researchers found that most medicine wastage is caused by a combination of patients not taking their drugs as prescribed, or by illness progression leading to changes in patient treatment regimes.

My recent visit to a pharmacy in my constituency confirmed those findings. Following discussions with the pharmacist, representatives of Community Pharmacy Scotland and, later, with a retired general practitioner, I was made aware of

the issues that can cause prescription medicine wastage.

As Margaret Mitchell said, the reasons why patients stop taking their medications include: experiencing side effects and discarding their drugs; recovering before they have completed their course of medicine; issues with fitting medication into their daily routines; and medication becoming out-of-date. Other reasons for drug waste include: medicines from repeat prescriptions being stockpiled as a result of patients requesting everything instead of just the item that they need; wrong repeat medication being requested; and hospitals retaining medication on admission and not returning it to the patient on discharge.

There is no official mechanism for measuring medicine waste in primary or secondary care. However, the 2010 study found that in England it was estimated that £110 million of unused prescription medicines are returned to community pharmacies each year and that care homes annually dispose of medicines worth another £50 million. That represents half of the estimated total value of drug wastage in England of £300 million per annum.

A number of measures need to be put in place to tackle the problem effectively. More effective and co-ordinated partnership between GPs and pharmacists is needed, such as the sharing of online patient records. The chronic medication service is a move in that direction, but it is still in the early stages of development.

It would be simpler to share existing electronic patient records with community pharmacies so that all NHS professionals have access to the same level of information. Patient records are already shared with NHS 24 and hospital pharmacies, so why could they not be shared with community pharmacies?

We must encourage patients to discuss their repeat prescriptions with their pharmacist and their general practitioner so that any issues with their drugs can be highlighted. Giving patients the opportunity to discuss the use of their medicines will help them to take their medication properly, which, in turn, could reduce waste, as they would know what each item on the prescription was for and how to use their medicines appropriately. In addition, we must start thinking the unthinkable and allowing the recycling of unused, unexpired and unopened medicines that have been returned to community pharmacies.

Prescription charges have been touched on. I would like to quote what a retired GP said on the subject in a message to me:

"Prescription charges are illogical and do not stop waste ... If a prescription has been issued, a qualified doctor has come to the opinion that it is needed. If you think that prescription was unnecessary then it is the doctor you should get at, not the patient ... If someone does not get a script dispensed because they do not want or cannot afford to pay for it, their condition may well get worse, requiring even more expensive treatment. The lay person isn't qualified to decide that not getting a prescription dispensed is in their best interests. The fact is that before we abolished charges, in poorer areas patients often asked pharmacists only to dispense some of the items. This is harmful to them and to others."

Only through a more co-ordinated approach, better education on the use of drugs, and the recycling of unused medicines will we make major inroads into drug wastage in the NHS.

The Deputy Presiding Officer: I should have said that speeches should be of four minutes.

17:17

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I congratulate Margaret Mitchell on securing an important debate, and I commend the NHS Forth Valley eWARD scheme, to which she referred.

It is quite disappointing that the majority of NHS boards have not collected and held information on prescription medicine waste, or evaluated its cost to them. The findings of Margaret Mitchell's freedom of information request offer the Scottish Parliament an opportunity to be innovative in implementing effective national policies for collecting information, minimising waste and improving medicine management.

The NHS Forth Valley eWARD scheme serves as a model for all health boards. Its capital costs have been recouped already, as a result of the destocking that it has allowed. The improvement in patient safety because of the data flow and tracking system, which means that pharmacists are not constantly interrupted by phone calls from the ward, has been an important element of the scheme. It has also allowed for the integration of medicines that are brought in by a patient, which can then be used or not used. If they are used, they are simply topped up so that, when the patient goes out, all their medicines are at the same level and there is not a discrepancy. That co-ordination with what happens in the community is the third element of an extremely important scheme, which I know that the Cabinet Secretary for Health, Wellbeing and Cities Strategy has seen. I expect that the minister has seen it, too, as it is in his constituency.

Community Pharmacy Scotland supports the innovative practice of transferring discharge information to pharmacists, to which Gordon MacDonald referred. That is important, because the sharing of electronic information fosters the practising of safe medicine. Community Pharmacy Scotland credits the reductions in waste that have

been made to the sharing of information between hospitals and community pharmacies. Pharmacists will not supply medicines that have changed if they are made aware that a prescription was stopped or altered during a hospital admittance. There may be outstanding prescriptions that may be dispensed if the issue is not dealt with properly, so electronic sharing of information is critical.

Mention has been made of the University of York study, which quantified prescription medicine waste in England as amounting to about £300 million a year. Medicine waste Scotland estimates that, in Scotland, prescription medicine waste costs about £44 million each year. We can all suggest what that could be used for. I suggest that some of it could be used to provide some of the newer drugs that we need for patients, which are expensive. With cuts in Government spending and the provision of free prescriptions in Scotland, it has never been more crucial for the Scottish Government to recognise the cost of medicine waste and seek a solution. I hope that we will hear something from the minister on that.

The Welsh Government has recently implemented a discharge medicine review that is similar to the NHS Forth Valley eWARD scheme and has also implemented a policy that is designed to ensure that medicine information is transferred between the secondary and primary care services. The role of pharmacists and their access to patient records is pivotal in that regard. They should have access to electronic records, but at the moment they do not. However, I suggest that that happens only with the explicit permission of the patient.

Another possibility for Scotland is not the French scheme but the Inter Care scheme, which was referred to by Margaret Mitchell. Inter Care is a UK-registered charity that collects selected prescription medicines from registered GP practices and reallocates them to more than 100 health centres in six sub-Saharan African countries. I suggest that the Government considers the possibility of taking a much more active role in that regard. A pilot that has been run in a number of practices in Lothian—the minister might speak about it later—has demonstrated the capacity of the system to achieve savings at all levels.

In 1980, I began my life in committee work in the health service as the chairman of the pharmaceutical liaison committee in Forth Valley Health Board, collecting unused medicine. That amounted to tonnes, which were then incinerated. I welcome the motion and I acknowledge that we need to do more to solve this major problem.

17:21

Nanette Milne (North East Scotland) (Con): My colleague, Margaret Mitchell, has brought an important issue to the Parliament this evening, and I join others in congratulating her on securing the debate.

At a time when public sector finance is under severe pressure, it is important that savings are made wherever possible in the NHS to allow optimum funding for front-line services, and it is encouraging that determined efforts are finally being made to reduce the annual waste of prescription medicines. It is self-evident that the money that is saved could be put to a variety of clinical uses, such as more drug courses for breast cancer or Alzheimer's. However, the statistic that struck me most forcefully was that, if the £44 million that is currently wasted on prescription drugs was saved, nearly 11,900 patients could potentially be relieved of the severe pain that I endured earlier this year, prior to hip replacement surgery, and could return to a normal, productive lifestyle—I accept that that might be labouring a point, as I mentioned that earlier this afternoon.

As we have heard today, recent research has shown that, although not all prescribed medicine waste is avoidable, it can certainly be reduced, and often to the clinical benefit of patients.

When my husband was in general practice, he regularly found unused prescribed medicines in patients' homes. That is not only wasteful but is also a potential hazard to any youngsters who come across them. They included antibiotics that were unused because patients felt better before their treatment was completed, pills not taken because of side effects and repeat prescriptions that had been ordered unnecessarily, resulting in stockpiles of them building up in medicine cupboards while the recipients were selective with regard to which pills they swallowed, resulting in less than optimal treatment of whatever long-term condition they were meant to treat.

I am sure that my husband's experience was not unique—Richard Simpson's experience clearly agrees with it. If that experience is multiplied across households in Scotland and the many care homes in which patients are on multiple and often changing drugs for long-term conditions, it is not difficult to see where savings can be made.

It is therefore encouraging that health boards are at last seriously trying to take action in that regard. We have already heard about NHS Forth Valley's effective eWARD scheme and the awareness-raising campaigns that are being undertaken by other health boards in Scotland.

In February this year, GPs and pharmacists in NHS Grampian joined with those in Orkney,

Shetland and the Western Isles in a bid to educate patients about their treatment and to help them understand more about the medicines that they are taking and why they are taking them. The campaign was supported by television advertising and the colourful campaign materials were displayed in pharmacies and GP surgeries to raise awareness of medicine waste among patients and, importantly, carers, with more information to be found on a new national website. Patients were encouraged to have regular reviews of their prescribed medicines with their pharmacist or prescribing doctor, to iron out any issues that they might have with taking their medication.

A senior pharmacy representative said at the launch of the campaign:

"The least cost effective medicine is one that is sub-optimally or not used at all once supplied. It is estimated that up to half of all medicines are not taken as the prescriber intended"—

I am sure that members agree that that is a frightening statistic. She went on to say:

"Real value for money can only be achieved if the NHS supports patients to get more benefit from their medicines."

I commend the recent and on-going campaigns by health boards and I encourage the minister to take up the Royal Pharmaceutical Society's suggestion and organise a higher-profile national campaign, which involves community pharmacists alongside GPs and hospital practitioners. Community pharmacists undoubtedly have enormous untapped potential to help patients to understand and optimise their use of prescribed medication. Like Margaret Mitchell, I look forward to the outcome of the pharmacy review.

17:25

Jim Eadie (Edinburgh Southern) (SNP): I congratulate Margaret Mitchell on securing the debate. She and Gordon MacDonald set out the extent of the problem and the challenge that we face if we are to reduce the cost of prescription medicine waste to the NHS in Scotland. Nanette Milne made a valuable speech from her professional perspective.

Richard Simpson talked about the approach that NHS Lothian, in my area, has taken. NHS Lothian estimates that, in 2008, the cost of prescription medicine waste was £3 million. That is the equivalent cost of 75 nurses, or 460 hip replacements, or 260 heart bypass operations. We are right to be concerned about the financial cost to the NHS of prescription medicine waste and the need to secure best value for the taxpayer, as the Royal Pharmaceutical Society and the Royal College of Nursing highlighted in advance of the debate. I note that the Royal Pharmaceutical Society said in its briefing:

"There is no conclusive evidence on whether the decision of the Scottish Government to set prescription charges to zero has had any impact on levels of medicines waste."

In addressing the issue, we need to consider the factors that give rise to medicine waste. We also need to acknowledge that not all such waste is avoidable. Let us take the case of a patient who stops taking their medicine because their condition improves, or a patient who discontinues their medicine because of an adverse drug reaction, which in the UK is subject to the yellow-card reporting system, or indeed a patient who stops taking a particular medicine so that they can progress to a different and more effective treatment. In each case, we can see that what matters most is not the cost to the NHS but the safety and appropriateness of the patient's care.

We must surely minimise waste where we can and I have no doubt that much more can be done in that regard. We must also provide the care and treatment that are most appropriate and effective for the patient. In their report, "Evaluation of the Scale, Causes and Costs of Waste Medicines", researchers from the York Health Economics Consortium at the University of York and the University of London school of pharmacy said:

"in welfare terms significantly greater returns could be generated by better medicines use, as opposed to waste reduction per se. Improving adherence in medicine taking can improve health outcomes."

If we consider the wider policy context in which this debate is being held, we can reflect that there have been significant and positive developments in Scotland since the publication of "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland" in 2002. One successful initiative was the establishment of a national medicines utilisation unit, to provide the NHS in Scotland with valuable information on how medicines are used, for example through the development of a hospital medicines utilisation database, which identifies how medicines are used in hospitals and allows linkage between information sources. Perhaps we can explore the role that the medicines utilisation unit might have in addressing the important issue of waste.

There is also an enhanced role for pharmacists and nurses as supplementary and independent prescribers, who provide more timely access to appropriate treatment for patients. There is growing confidence on the part of community pharmacists throughout the country.

Members might ask what all that has to do with prescription medicine waste; I think that medicines utilisation, pharmacy prescribing and dispensing and community pharmacy all have a role to play if we are to address and tackle the issue better in future.

The Scottish Government said that work is being progressed through the national prescribing workstream of the NHS Scotland efficiency and productivity programme.

I hope that we can tackle waste by addressing the issues of the role of annual patient medication reviews and repeat prescribing; reducing the length of supply from 84 days to 56 days, and perhaps in time to 28 days, could make a difference. We also need to ensure that the effective therapeutic partnerships—GPs, pharmacists and others working together—can help to improve quality and reduce inefficiency in the system.

The Deputy Presiding Officer: Mr Eadie, can you come to a conclusion?

Jim Eadie: It is apparent that more can be done to address prescription medicine waste. The key to doing that is to empower our healthcare professionals to undertake new ways of working and for them to redesign services. If we do that, we will not only reduce waste but enhance patient care.

17:30

Alison Johnstone (Lothian) (Green): I thank Margaret Mitchell for bringing the motion for debate. There is no doubt that this is an extremely important issue in terms of both reducing avoidable waste and saving the NHS money. Indeed, it could simply be described as a no-brainer to make progress on an issue that avoids unnecessary waste and saves money at the same time, especially money that can be used in the NHS at a time of such great need.

I read in advance of the debate that the Scottish Executive raised the very same issue in a strategy in 2002. The Scottish Government has now raised the issue in a strategy in 2011. That is recognition that medicines and money are still being wasted and welcome recognition that we need to do more to address that.

What are the solutions? The lack of progress could be down to the fact that, although it is a no-brainer to tackle the problem, only a combined and concerted effort will resolve it. Recent research means that we now have a better understanding of the causes of waste medicine, so we are best placed to act. General practitioners and pharmacies must combine forces to tackle the problem and they must be supported by backing from Government. I agree with Nanette Milne that community pharmacies have a vital role to play in reducing the amount of waste medicine.

We must also improve the quality of medicine management and make better use of medicine reviews, as well as make prescribers fully aware of the consequences of overprescribing. Responsibility lies with the patients receiving medicines, too. We must encourage a greater take-up of medicine use check-ups. Of course, that does not apply to all patients. For example, for care homes in particular, we must ensure that the necessary action is taken to reduce and avoid medicine waste.

Even with the best information technology, under present arrangements we cannot prevent the waste of all medicines, as we have heard. There are prescribed medicines that are never used. Even medicines in pristine, untouched packaging that, for whatever reason, have not been collected from pharmacies must be destroyed, as must pristine medicines that have never left professional care. We must explore alternatives to disposing of or incinerating that so-called waste medicine.

Currently, prescribed medicine can be used only by the person who is named on the medicine. As we have heard in the debate, there are many circumstances in which prescribed medicine can no longer be used by the named person but could be perfectly safe for another person to use. I ask the minister what action has been taken to consider how prescribed medicines in such circumstances could be recycled or reused rather than be incinerated and whether the current system could be changed so that, in a safe and regulated environment, the medicines could be used by another patient.

I agree whole-heartedly with colleagues that we should study practices around the globe where medicine waste has been reduced. I hope that the minister will be open to addressing this issue with the UK Government, where required. I also ask that he follow the example of Sweden, where clear labelling ensures that, to better ensure safe disposal, people are aware of the medicines that are most toxic to the environment.

17:34

The Minister for Public Health (Michael Matheson): I congratulate Margaret Mitchell on securing time for the debate, in which a number of very interesting points have been raised. Reducing prescription medicine waste across the NHS in Scotland is everyone's business. From NHS clinicians and managers and the Scottish Government, to the behaviour of patients themselves, we should do everything we can to reduce unnecessary waste. It is important that we do not lose sight of the challenge of improving the quality of care as a whole within the resources that are available to us.

We should seek to reduce waste wherever possible as we strive to improve overall service

quality through the ambitions that are set out in the healthcare quality strategy for Scotland, which are that care should be person-centred, safe and effective and should happen where the most appropriate treatment can take place and appropriate intervention and support services are provided.

A number of members, including Margaret Mitchell, referred to the research by the University of York and the University of London on evaluation of the scale and cause of waste of medicines in England. The Government has given that some consideration and members should be aware that the study did not find systemic problems with drug waste in the NHS or, in particular, in primary care. Although medicine waste deserves to be addressed, members will acknowledge that there are occasions on which it is unavoidable, although the study estimated that under 50 per cent of waste could be cost-effectively prevented in some fashion.

As Margaret Mitchell rightly pointed out, there is more to be gained from helping people to take their medicines more effectively, even though that might increase the overall volume of drugs that are paid for. The most expensive drug, as Nanette Milne said, is the one that is prescribed but not taken. That is why we need to ensure that there is more education to support patients in taking their medication.

In Scotland, more patients are registering with the chronic medication service, which is delivered through our community pharmacists and is designed to support people with long-term conditions and, in particular, to provide support in and advice on taking medication. It formalises the contribution of community pharmacists to improving the quality, safety and effectiveness of pharmaceutical care to patients with long-term conditions. Some 81,000 patients across Scotland are now registered with the chronic medication service, which offers each patient a comprehensive assessment of their pharmaceutical care needs in order to identify any problems that they might be experiencing with their medicines. The pharmacist and the patient agree the actions that are required to address the problems and they are recorded in an individual pharmacy care record that is regularly monitored and reviewed by the pharmacist.

Later this year, we will further enhance that service in two additional areas. The first aim is to address early engagement with patients on newly prescribed medicines in order to increase patients' compliance and to reduce waste. The other aim is to support patients who are on specific forms of medication, when greater support might be appropriate. That is all helping to pave the way to ensuring that pharmacists take a much more proactive role in working with patients and general practitioners in order to optimise the benefit to patients of their medication.

That is also helping the Scottish Government to achieve its manifesto commitment

"to further enhance the role of pharmacists ... and encourage even closer joint working between GPs, pharmacists and other community services"

by capitalising on the investments that can be made through the chronic medication service. I am disappointed to have to inform Margaret Mitchell that the review is the result of our manifesto commitment to continue to improve community pharmacy, rather than the result of the motion that she has put before the Scottish Parliament.

In addition, the research by the University of York and the University of London identified that systems that support closer professional management of medicine supply at the point of dispensing, such as the development of the pharmacy-managed repeat-dispensing process, might have a significant future role to play in reducing waste. We are piloting several prescribing and dispensing programmes within the chronic medication service with a view to rolling them out in 2012-13. That will allow community pharmacists to check that each medicine is required at each dispensing interval, thereby reducing the unnecessary waste that occurs through repeat prescriptions being taken when they are not required, as members have mentioned.

We have already seen some promising results from the pilots, and we will continue to monitor them. The research has identified that further enhanced hospital and primary care liaison could, by improving the quality of care around the time of hospital discharge, help to reduce waste.

Margaret Mitchell highlighted the benefits of electronic recording and sharing of information among hospitals, GPs and pharmacists. In particular, she mentioned the initiative that is taking place in the new Forth Valley royal hospital in my constituency. That system allows accurate recording of the medicines-reconciliation process and patients' drugs history, prescribing by electronic transmission to pharmacies, and information sharing between acute care and community pharmacists. The pharmacy department at Forth Valley royal hospital is working on a Scottish Government sponsored project to assess the benefits of sending electronic discharge information, including any associated pharmaceutical care plan, to the patient's community pharmacy when the patient is discharged from hospital. It is expected that the results of that project will be made available to the Government by the end of this year. We will then take an informed view of its benefits in terms of

improving information sharing between hospitals and community pharmacists, and we will consider the potential benefits for patients.

In addition, our e-health team has recently undertaken a pilot to allow hospital pharmacists and other hospital clinicians to access the emergency care summary to assist medicines-reconciliation activities. The pilot was considered to be successful, so following the current consultation we intend to roll it out across all health boards.

The Scottish Government recognises the public concern that the NHS should not waste in any way the important money that it has, and that it should ensure that money is directed towards patient care wherever possible.

The Deputy Presiding Officer: I would be grateful if the minister could come to a conclusion.

Michael Matheson: I am just about to draw my remarks to a conclusion.

Waste by its nature cannot always be easily measured. Most health boards offer a service through community pharmacists whereby medicines can be returned for disposal. I hear what members have said about considering alternative measures for disposal, and I am happy to go away and consider whether we can put in place further measures.

A number of members have raised concerns around waste of medicines. It is important that we put in place mechanisms that are effective in reducing such waste where it is reasonably possible. I hope that some of the measures that I have outlined this evening will reassure members that the Government is taking the issue seriously, and that we will consider further how we can make better use of medicines that are returned by patients.

Meeting closed at 17:42.

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