The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 7 March 2012

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): The first item of business this afternoon is time for reflection. Our time for reflection leader today is Sheila McKay, chair of Grampian Family Support Forum.

Sheila McKay (Chair, Grampian Family Support Forum): My son was a heroin addict for seven years. Exactly five years ago today, he entered a Christian rehabilitation centre in Derby and the Lord delivered him from his addiction.

When my son came home from rehab, I could not believe the change in him. He was healthy, strong and drug free, and seemed to have an extra dimension in his life. I decided that I wanted what he had, so I opened my eyes and I saw; I opened my ears and I heard.

My calling is a direct outcome of my son's bad choices. How do you know what your God-given assignment is? Whose tears affect you? Whose pain do you feel? Who do you want to protect? Whose enemies do you want to confront? Your assignment is geographical: there is a place where you will flourish.

I am chair of a voluntary organisation called Grampian Family Support Forum. Our members have been affected by drug addiction within their families. Knowing that a family member has a drug problem is a painful and lonely experience. The majority of our members are part of family support groups, kinship care groups and, sadly, bereavement groups. Our core aim is to encourage the formation of new peer-support groups and increase the membership of those that already exist.

We have been community partners with the Scottish Parliament during the past year. Since the project started, our numbers have increased from three to 21 throughout the north-east of Scotland. Our profile has been raised, our opinions have been valued and our voice has been heard. We have had the privilege of working with MSPs from several parties on various issues. With the help and encouragement of those people's champions, we are making an impact and planting the seeds of change.

We want to use our lived expedience to make positive changes within our communities. Why? Because, when you are qualified to speak, people listen. Otherwise, they would just tune out. Built into every trial that we go through in life—every trial that forces us to grow—are the answers that other people need.

In the words of the great statesman Edmund Burke:

"All that is necessary for evil to triumph is for enough good men to do nothing."

The fact that I am standing here today on the fifth anniversary of my son's restoration is by no means a coincidence, it is a God incidence!

Regulation of Care for Older People

The Presiding Officer (Tricia Marwick): The next item of business is a debate on motion S4M-02175, in the name of Duncan McNeil, on the Health and Sport Committee's report "Report on Inquiry into the Regulation of Care for Older People".

14:33

Duncan McNeil (Greenock and Inverclyde) (Lab): Today we are to debate—not for the first time, nor, I suspect, the last—the age-old question of how we care for the elderly.

With the death of an elderly resident at the Elsie Inglis nursing home in Edinburgh under investigation by the police and following the collapse of Southern Cross Healthcare Group, the Health and Sport Committee decided to launch its inquiry into the regulation of care for older people. We wanted to ensure that the system was fit for purpose and that it was delivering the appropriate scrutiny of and improvement in all our care for the elderly.

The inquiry was the committee's first of the parliamentary session. I thank the 51 organisations that submitted evidence to the inquiry, the clerks, the Scottish Parliament information centre and, in particular, the service users and carers whom we met on our fact-finding visits.

The committee's report is a consensual one, and it is all the stronger for that. It enables us to provide the Government with a clear steer on areas for improvement in the regulatory system, because although we found the system to be sufficiently rigorous to identify care services for older people that are failing to deliver high-quality care, there are some areas that the Government needs to address. I will cover those that relate to inspections of care services by Social Care and Social Work Improvement Scotland—the care inspectorate—complaints, the national care standards, the workforce, and commissioning and procurement practices. I am sure that other members of the committee will pick up other subjects.

A key issue that was raised right at the start of the inquiry was the proposed reduction in the frequency of inspections of care homes conducted by the care inspectorate. That was criticised, and we were pleased that the committee's inquiry prompted the Government to address that concern by increasing the frequency of inspections.

Inspections are conducted against four grade themes, but not all the themes are covered in each inspection. That approach was criticised by Age Scotland, which felt that each theme should be assessed as part of a "whole care service review" whenever an inspection was conducted.

There seems to be some contradiction between the Scottish Government and the care inspectorate on the issue of inspecting against the four themes. The Government states that the care inspectorate is assessing whether efficiency savings can be made and resources redirected to inspecting all four themes in all inspections. However, in its response, the care inspectorate states that that will not happen and that although all four themes will be inspected in medium to high-risk assessments, only a sample of 10 per cent of better-performing services will be inspected against all four quality themes. Therefore, the care inspectorate will not provide a blanket approach involving inspection against all the themes in all inspections.

Does the cabinet secretary believe that, to provide maximum assurance of the quality of care, all four themes should be covered in every inspection? The committee calls on the Scottish Government to ensure that the care inspectorate has all the necessary support to fulfil its role.

We heard evidence that the complaints system should be bolstered by greater support for whistleblowers. Our recommendation is that the care inspectorate should publish guidance for all care staff who wish to raise concerns confidentially. The Government's response refers to the Scottish Social Services Council guidance on whistleblowing, but that guidance does not make specific reference to the whistleblower's confidentiality being protected. I therefore seek the cabinet secretary's views on confidentiality as it relates to whistleblowing.

Another key recommendation of our report called on the Government to conduct a review of the national care standards. I am pleased that the Government has accepted our recommendation by announcing that it will conduct a review of those standards, but I ask it to tell us when that review will get under way.

The committee felt that, as well as being in need of an update, the national care standards should have equality and human rights issues at their very heart. The Scottish Human Rights Commission has told me that it believes that the care inspectorate should be encouraged to develop its understanding of human rights standards as they apply in care settings.

Those are not simply dry words. They include, for instance, the right to be free from unintended or careless neglect; the right to be protected from pharmaceutical or medical abuse; the right to live as independently as possible; respect for privacy;

and the right to modesty when dressing and bathing.

The Government's response to our report made no explicit reference to human rights, and I am keen to hear an assurance from the cabinet secretary that human rights will be embedded in the national care standards. That can only help to improve people's understanding of how those rights can be delivered in practice.

Another area that the committee considered was the care workforce. Its members are vital to ensuring that our care services are of the highest quality, but for many years, the social care workforce has been undervalued and often poorly paid, poorly treated and poorly trained. Its members must be registered, invested in and paid at least the living wage.

We heard from Lord Sutherland during our evidence sessions that there were instances in Edinburgh in which care home staff had left their jobs during the summer to take on casual jobs at the Edinburgh festival because those jobs were better paid. What does that say about the value that we place on the social care workforce?

Good commissioning and procurement practices go hand in hand in determining the quality of care that is delivered by a care service. The committee supports the view of the Coalition of Care and Support Providers in Scotland—CCPS—that the care inspectorate has "far fewer teeth" to challenge commissioning practice in comparison with its powers of intervention in service delivery.

The Government's response is at odds with that view. The CCPS has reiterated its position on the issue, and it points to a number of issues to support its view. First, there are no national standards for commissioning and procurement against which to assess an authority's performance. Secondly, there is no minimum frequency of inspection of those functions. Thirdly, there are no provisions under which the care inspectorate can issue improvement or condition notices for poor practice in commissioning.

In addition to the CCPS's comments, "Commissioning social care", which Audit Scotland published last week, states:

"Councils ... have been slow to develop strategic commissioning. Only 11 of the 32 council areas had commissioning strategies covering all social care services."

It also notes that

"there is a risk that councils focus too much on reducing costs when procuring services and give insufficient regard to the range and quality of services and their impact on individuals."

Given the CCPS's position and the Audit Scotland report, will the Government explore further the merit in extending the care inspectorate's powers in that area?

I am sure that I speak for all my colleagues on the committee when I say that I do not view this debate as the end of our work on the issue. Our current inquiry into the integration of health and social care services will doubtless raise issues about the assessment and monitoring of different services. We will also explore in further detail the provision of care-at-home services during our forthcoming scrutiny of the Social Care (Self-directed Support) (Scotland) Bill.

I believe that we all recognise that the commitment to elderly care has been promoted across Governments, across parties and across the Parliament. We must maintain that commitment and never lose sight of the fact that dignity, compassion and kindness should always be at the heart of care for the elderly. I believe that our inquiry has been about doing just that.

I move,

That the Parliament notes the conclusions and recommendations contained in the Health and Sport Committee's 3rd Report, 2011 (Session 4): *Report on Inquiry into the Regulation of Care for Older People* (SP Paper 40).

14:44

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): I welcome the debate on the regulation of care for older people that the Health and Sport Committee has brought to the chamber following its inquiry into and report on what I consider to be a matter of fundamental importance. I compliment Duncan McNeil on a very good and passionate speech.

I believe that the way in which any society cares for its most vulnerable citizens is a mark of that society. Therefore, after the election last year and in response to some understandable concerns, I made clear my personal commitment, and that of the Government, to improving care for older people in Scotland. We have continued to reaffirm that commitment, both in our words and in our actions. I said then, and I say again today, that the care we provide for our older people is generally good, but being generally good is not good enough. Incidents such as those at the Elsie Inglis care home remind us of the need to be constantly vigilant and to constantly ask ourselves: how can we do things better?

In my evidence to the committee on 4 October, I confirmed the importance that the Government attaches to the inquiry, and gave an assurance that the committee's analysis of the issues, and any recommendations it came up with, would form a key part of our commitment to continue to review

the regulation of care. I thank the committee for its work, and for its recommendations, the majority of which the Government has accepted in full.

Over the past year, we have seen a new regulatory landscape for older people's care taking shape. On 1 April 2011, the care inspectorate was established as the new single regulator for care services, and Healthcare Improvement Scotland as that for healthcare. The establishment of those bodies has contributed significantly to the simplification of the scrutiny landscape and the regulation of care in particular. As part of the reforms, we introduced a new duty of user focus on those bodies, building on the existing systems for involving service users. I was pleased to see that the committee's report welcomed the steps taken to date by the care inspectorate in engaging service users in its inspection process and in its use of lay inspectors.

It is also important to put on record some of the other initiatives that the care inspectorate has been taking forward to improve involvement, including service users and carers themselves working with the inspectorate to develop a new approach to how people get involved in inspections. That comes as part of a wider programme of improvements, including changes to the inspection reports and consideration of how inspection findings are publicised. All of that, along with the recommendations and action that will flow from the committee's report, is important in maintaining and improving public confidence in our regulation regime and in ensuring continuous improvements in care, highlighting high-performing as well as poor-performing care services.

As Duncan McNeil has said, in the autumn I announced a number of other steps that I would take to strengthen the regulatory regime and improve public confidence in regulation. That followed the tragic incidents at the Elsie Inglis nursing home and was, in part, in response to public concern arising from the BBC's "Panorama" investigation at the Winterbourne View care home in England. Those steps included introducing regulations on an increased minimum frequency for certain older people's services. To honour that commitment, regulations were laid in December and came into force on 8 February 2012, meeting the committee's correct call for the increased inspection frequency to commence before April this year.

The regulations make it a statutory requirement that all care home services, including those for the elderly, be inspected at a minimum frequency of least once every 12 months. They stipulate that inspections should be carried out on an unannounced basis. The same regime will apply to care-at-home services for the elderly, which are an important aspect of care for the elderly generally.

We will continue to work with the Convention of Scottish Local Authorities and others, including the United Kingdom Government, to introduce recommendations on how greater financial robustness in the sector can be assured. Duncan McNeil mentioned procurement and commissioning, and we will also work with COSLA in response to Audit Scotland's recent report on commissioning.

In response to the committee's concerns about the care inspectorate having sufficient resources, we have made it clear that we will continue to ensure that appropriate funding is in place to support the inspectorate's current and additional activity, and that efforts and resources are targeted at the areas where they are most needed. In particular, the costs of the new inspection arrangements that we have introduced will be contained in the care inspectorate's proposed budget settlement for the next financial year.

The inspectorate is, of course, funded not only by the Government, but by the fees it charges, and I intend to launch a review of its fees regime shortly, by means of a public consultation. I intend to have a new system in place for 2013-14, meeting the committee's request that the Government clarify its intentions regarding fees charged by the care inspectorate.

Looking ahead, as Duncan McNeil mentioned, I intend to commence a review of the national care standards through public consultation. In response to one of his direct questions, I can tell him that we intend the consultation to be under way by June. As I have previously indicated to Parliament, it is important that we consider such a review in the context of work on the integration of health and social care services, new models of care and the implementation of the dementia standards.

I also give Duncan McNeil and the Parliament an assurance that human rights will be at the centre of that review and of the national care standards, just as they are already at the centre of our dementia standards.

Finally, in addition to its work on older people's care, the care inspectorate is currently developing a new approach to inspecting how services work together to support the most vulnerable in society. It will be testing that new approach in the coming months and implementing it for services that support vulnerable children and young people before applying it to services for adults. That demonstrates the importance that we all place on driving improvement in person-centred, accountable services in a genuinely joined-up way.

I repeat today what I said in my statement to Parliament on 15 September 2011: I fully intend to continue to listen to concerns and debate on the

regulatory regime. I have not had the chance in the time available to me today to respond to all Duncan McNeil's specific points, but I am happy to do so in writing.

I have no doubt that we will come back to debate the issue in Parliament on many occasions. It is vital—and I take the responsibility squarely—that we take whatever steps are required to ensure that there is confidence in the care system and in the regulation of that system.

I thank the Health and Sport Committee for its work. I look forward to working with the committee and other members to continue to provide the services that our older people have a right to expect.

14:51

Jackie Baillie (Dumbarton) (Lab): I welcome the opportunity to debate the Health and Sport Committee's report on its inquiry into the regulation of care for older people. Like others, I commend the members of the committee for their work.

As Duncan McNeil rightly reminded us, it was less than a year ago that we debated in the chamber the disturbing events at the Elsie Inglis nursing home, which is not a stone's throw from the Parliament. The poor standards of care there resulted in two residents dying and six being admitted to hospital. There were distressing reports of residents sleeping on stained and ripped mattresses, of residents being forced to eat food with their hands and of open wounds and sores being evident. In 2010 alone, there were 20 separate recorded outbreaks of infection affecting 72 residents, yet, just a year earlier, the care inspectorate inspected the home and gave it a good report. Families had confidence in and relied on such good reports when they made decisions about which care home to place their loved ones in.

It is clear that the change that happened at the home was dramatic and very quick, and was picked up only because the City of Edinburgh Council acted on a complaint and subsequently brought it to the attention of the care inspectorate. I understand from the cabinet secretary that the police investigation is still on-going.

Although it is important to acknowledge that the majority of care homes provide first-class care, there are still too many where the quality of care leaves a lot to be desired. It is incumbent on the Government to ensure that people have confidence in the quality of care for older people across Scotland.

A robust inspection regime is key to that, and the Scottish National Party has finally discovered that that cannot be done on the cheap. Members may recall that the care inspectorate was to start life with a 25 per cent budget cut and a 20 per cent reduction in staff, the majority of whom were to be inspectors. The regime was to move from twice yearly inspections to risk-based assessments, with some homes not being inspected for as much as two years. Given what we know about the speed at which the problems at Elsie Inglis mushroomed, that hands-off approach seems wholly misplaced.

I therefore welcome the SNP's conversion to more frequent inspections and the partial restoration of the care inspectorate's budget. However, it is disappointing that the cabinet secretary, and even the First Minister, were in denial about the budget cut in the first place. Their ostrich-like behaviour meant that a number of staff who took voluntary redundancy or early retirement this financial year have now had to be rehired at an additional cost, over and above their redundancy packages, of approximately £400,000. That money could have been spent on ensuring the best care for our older people.

Inspections are important in ensuring quality, but I think that all members agree that the quality of care staff is also key. We are talking about an area in which we know that wages are low and investment in training and upskilling the workforce is not generally a priority. The committee recommended that care staff be paid the living wage. If homes value their staff, they will be repaid in staff commitment and in the quality of the service.

The Government's response in that regard was disappointingly timid. If it had the political will to do so, it could use procurement and commissioning of services to drive up standards and thereby drive up quality. In many cases it is the local authority and ultimately the Scottish Government that provide funding for adult residential care, so we can do more.

I will touch on the qualification standards that are expected of the workforce and on the committee's recommendation that the Government accelerate the timetable for registration of care workers. It might be instructive for members if I outline the timetable for registration of workers in adult care homes: managers had to be registered by November 2009; workers with supervisory responsibilities have to be registered by March 2012; practitioners have to be registered by March 2013; and support workers, who make up the bulk of the workforce, have to be registered by September 2015. Support workers are expected to attain a Scottish vocational qualification at level 2, but they do not have to do that by 2015; they can take another three years, so we are really talking about 2018.

The Scottish National Party's response to the committee's call to accelerate the timetable was non-committal, at best. If we want to drive up standards and if we care about the quality of care for our older people, where are the urgency, the drive and the ambition? The Government cannot afford to stroll along on the issue. Progress is slow in relation to a number of recommendations—for example, on commissioning, enhanced powers for the care inspectorate and changes to the national care standards.

The Royal College of Nursing said that, given the increasingly complex care needs of older people, we require an increased number of qualified nurses in the care home sector, and called for a national approach to guaranteeing staffing levels.

On the national care standards, we have been promised a review by the First Minister and by the cabinet secretary. The question is, when? The cabinet secretary said that the review would be under way by June, but that is too long a timescale for embedding human rights in our care system.

The cabinet secretary has often talked about our sacred duty to older people, and rightly so, but she has a sacred duty to do more than just talk about the problem. Scotland's older people want and deserve action, and that action must go at a faster pace than the SNP Government's current glacial pace of change.

14:57

Mary Scanlon (Highlands and Islands) (Con): It is worth highlighting that the social services staff workforce is around 200,000 strong. There are 943 care homes for the elderly, with more than 39,000 beds, and they account for 90 per cent of care home residents. Therefore, our debate affects thousands of vulnerable people and their families, friends and carers.

I enjoyed being a member of the Health and Sport Committee while it was carrying out post-legislative scrutiny on implementation of policy on care for the elderly—to be honest, I enjoyed most of that. I enjoyed working with the new members, Richard Lyle and Mary Fee, who have a background in local government and are both enormously committed to improving care for the elderly.

I am pleased that the health secretary has accepted the committee's main recommendations. For me, the main issues are the 70 per cent of elderly people in care homes who are being given psychoactive medication; training and support of care home and care-at-home staff; and the general feeling that the care inspectorate would bring confidence and reassurance to the sector after the dreadful events that members mentioned.

In its response to the committee's recommendations on psychoactive medication, the Government gave a commitment to

"complete a baseline assessment on current prescribing levels in January 2012 ahead of an initial commitment on reducing such prescribing."

The Government went on to say that the care inspectorate has confirmed that it will have discussions with the Mental Welfare Commission for Scotland on creating new guidance and improving awareness on the important area of psychoactive medication. It also said that the Royal Pharmaceutical Society is about to publish a report on pharmaceutical care in care homes, and that a review is under way, the report of which is due in the autumn.

Of course I welcome the "baseline assessment", the discussion, the guidance and the improvement of awareness as a result of the review, but am I reassured that there will be improvements in the use of what is often described as the chemical cosh? The truth is that I do not know. If I were being generous, I might say that, if all this works, it might improve the situation and things might get better.

It is hardly surprising that I sound a bit impatient. All the same issues and more were highlighted—tragically—in "Remember, I'm still me".

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I understand that the Mental Welfare Commission is to issue new guidance. Does the member think that that should be a matter of some urgency? Secondly, I simply point out that the one recommendation that the Government has rejected is that the long-term conditions registration process be open to care home residents.

Mary Scanlon: I have so many concerns about this issue; it should be the subject of a debate in its own right. If I may say so, Presiding Officer, I feel that an hour and a half is not sufficient for this topic. However, I hope that we will be able to debate it another day.

"Remember, I'm still me", which was a joint report by the care commission and the MWC, was published in 2009. Has anything improved since then? The truth is that I am not sure—I simply do not know. On the evidence that was available to the committee and from all the reports and reviews, it seems that not much has changed in the past three years. For example, "Remember, I'm still me" said:

"very few people had a planned health check every year by their GP and there was little evidence that medication was regularly reviewed."

Three years later, the committee heard exactly the same thing. There is still little or no evidence of

annual health checks by GPs and still little, if any, evidence that medication is regularly reviewed. "Remember, I'm still me" also pointed to

"evidence of inappropriate and multiple prescribing"

and the fact that

"Very few care homes had the right information or legal safeguards ... to give covert medication"

and said that, despite specific warnings, certain drugs were being used.

My second concern—as I am summing up, I will finish it in my closing speech—relates to the training and support of care home and care-at-home staff. Hugh Henry, Richard Simpson and I were members of the committee that considered the Regulation of Care (Scotland) Bill, but we were never told—and indeed would never have expected—that it would take 20 years to train and register all existing staff. However, much of the training that is required for care home and care-at-home staff could be carried out through assessments in the workplace and distance learning.

I will finish there, Presiding Officer.

The Presiding Officer: Thank you very much. We move to the open debate. I point out that, as time is tight, back-bench speakers will be entitled to four minutes. I will be most grateful if members can keep to that; if they do not, those who wish to contribute will have to fall off the end of the list.

15:03

Jim Eadie (Edinburgh Southern) (SNP): As a member of Health and Sport Committee, I welcome the opportunity to speak in this debate on its report on the regulation of the care of older people. As a result of the demographic shift facing Scotland, the number of people aged 60 and over will increase by 50 per cent by 2033. Although more and more of us will enjoy healthy life expectancy and can expect to live longer, each of us is likely to have one or more long-term or life-limiting conditions by the time we retire.

In ensuring that older people receive high-quality care in a setting most appropriate to their needs, society will have to deal with a number of challenges. We must ensure that the system of registration, regulation and inspection is not only fit for purpose but fully funded. Care services will have to adapt and to accommodate the move towards increasing provision of care in a person's home rather than in a hospital, institution or care home.

Given that the regulatory system was established by legislation passed in 2001, it was felt appropriate for the committee to undertake this inquiry and carry out valuable post-legislative scrutiny 10 years later. We have already heard about the issue of funding, and I was interested to note in the report that

"The Committee welcomes the assurance given by the Care Inspectorate that it will be able to find £400,000 of efficiencies which can be reinvested to supplement the current complement of inspection staff in order to meet the increased demands required of it."

I think that we will all welcome that.

The committee asked a number of specific questions, the first of which was:

"Can we be confident that the regulatory system is picking up on care services where the quality of care is poor?"

The committee concluded that

"the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care."

The committee also asked,

"Are there any particular weaknesses in the current system?"

and agreed that there are areas in which the care inspectorate and the Scottish Government must continue to take action.

The committee recommended that care services should receive at least one unannounced inspection each year and expressed the view that such an increase in the number of inspections should be implemented before the expected statutory commencement date of April this year. The cabinet secretary has recognised that the previously planned rate of inspections was not sufficiently frequent to provide reassurance that standards of service were being maintained and improved. That shows exactly what the role of the committee system and the Health and Sport Committee is in Parliament. The committees bring issues before the Government that can then be addressed by the Government in a way that we all want to see.

Resources are critical. There must be sufficient resources in the system to ensure that the care inspectorate can fulfil its role and discharge the functions that the Government has given it. The care inspectorate and the cabinet secretary assured the committee that the available budget would be sufficient to allow that to happen. The care inspectorate also made it clear that, if circumstances were to change such that it no longer felt that it was sufficiently resourced, it would make the Government aware of the need for additional resources.

The report covered several other issues, such as whistleblowing so that staff can speak out on behalf of patients. That must be linked to ensuring that all healthcare professionals have a clear duty of care to report all concerns when they arise. The

committee felt that that duty should be given far greater prominence in the training of all healthcare professionals.

This is an important report that can herald much-needed improvements in the regulatory system, but there must be a willingness to take action when it is required, and proper evaluation of progress over time must be done—

The Presiding Officer: I am sorry, but the member needs to finish now.

15:07

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): There is no room for complacency when it comes to improving the care of older people, but I believe that certain people should be commended. First, the Health and Sport Committee is to be commended because the report is impressive and comprehensive. When I started on Twitter at the end of September, one of my earliest tweets was from the Health and Sport Committee and was about how the committee showed Parliament at its best. The Opposition, too, should be commended for raising various issues during the past few months. Last, but by no means least, the cabinet secretary has shown herself to be very willing to respond to the concerns that the committee and Parliament were expressing.

This subject was one of the first to be debated after the election. I spoke in that debate on 9 June, partly because I had grown very interested in what was happening at the Elsie Inglis nursing home in Edinburgh. It is frustrating that neither the Health and Sport Committee nor anyone else can get any insight into that situation because of the police inquiry. I know that because I have submitted a freedom of information request yet still have not been able to get information because of the police inquiry. We might eventually know more about what happened there, but it threw up many of the issues that have been the subject of debate and inquiry since.

One of those issues is the frequency of inspections and, again, the cabinet secretary is to be commended for—I have to say this gently—going back to the original 2001 system of one unannounced inspection a year. She deserves credit for making that decision. The other issue that was raised by the case of the Elsie Inglis home was the consistency of inspections. It seemed odd to everyone that a home that had had a good grade became totally unacceptable; we still do not know all the reasons for that. We are told that there were management changes at the nursing home. That might explain it, but people are still concerned about consistency of inspection. The committee, rightly, made a recommendation about that.

Another interesting issue is the number of themes that should be inspected. The committee gave a measured recommendation on that and talked about taking a risk-based approach. The cabinet secretary is going further and saying that we need to deal with all four quality themes, so that issue is still to be resolved.

The main theme that I emphasised during the debate on 9 June 2011 was the need to involve residents in the inspections. We need to look at their emotional care and the stimulation that they receive as well as their physical condition. Although the committee highlighted that issue, it is the one area that the committee might have emphasised more in its report.

We are asking the care inspectorates to inspect more often, to deal with more quality themes and to have more user focus, so this is a difficult issue. We have to trust our front-line staff to have some discretion, which is why, on balance, I probably agree with the committee's approach to thematic inspections and with the need for flexibility in relation to the number of themes to be explored.

We need to reduce the bureaucracy of care inspectorate staff to a minimum, so that they have as much time as possible to spend in care homes and, in particular, to engage with care users. That kind of user focus was embodied in the original 2001 care standards, of which every member at the time was proud, but the committee's recommendation that they should be reviewed and the Government's acceptance of that recommendation are important. We have to move forwards, particularly in relation to the dementia standards.

Finally, commissioning is the one area on which I am not entirely clear. The committee made a good recommendation about a greater role for the care inspectorate in commissioning, but the Government says that it is already possible for the inspectorate to do a lot of that work. I am a little unclear about what can and cannot be done, but it is certainly an important area. I hope that the commissioning practices of councils will be increasingly challenged, where necessary, by the care inspectorate.

15:11

Richard Lyle (Central Scotland) (SNP): As a member of the Health and Sport Committee, I welcome this debate, and I thank and congratulate all involved in securing it. I am especially grateful for the excellent contributions to the report by my good friends Mary Scanlon and Mary Fee, both of whom are, sadly, no longer on the committee.

With an ageing population, it is increasingly salient that we ensure that older people are provided with the correct care. It is important not only that the correct care is provided but that we can deal with the increased demand for care as a result of demographic change. Sadly, as the report makes clear, healthy life expectancy has not increased at the same rate as life expectancy, and men and women can expect to spend about seven and nine years respectively in poor health. That suggests not only that the demography and demands are changing but that those changes will have a detrimental effect on the health of all Scottish citizens.

The type of care that is required is changing and must adapt to accommodate the move towards provisions for care in a person's home as well as for care in a care home. The motivation to produce the report stemmed from the increasingly high-profile cases of the past year, including the announcement in July 2011 that the Southern Cross Healthcare Group would cease to be a care home operator, a decision affecting more than 90 care homes in Scotland. Our aim was to scrutinise and investigate the relevant legislation in order to reveal any weak areas in the regulatory regime and to examine whether the safeguards were robust enough to protect the elderly.

Although the report shows that the current regulatory system is sufficiently rigorous to identify those care services for older people that are failing to deliver high-quality care, that does not mean that there are no weaknesses. I will highlight a few. There must be improved accessibility to and better dissemination of inspection reports, as well as enhanced engagement of healthcare professionals in the inspection process. There must also be research into the appropriate staffing mix for care homes and other services for older people, and all staff should be paid the living wage and trained to the highest standards.

The committee's inquiry has received widespread support, including from the Scottish Human Rights Commission, which has welcomed this debate, because it has a number of recommendations for areas of improvement. The responses that the report has induced from bodies such as the commission on how we might further regulate our system are extremely valuable for the growth of better regulation for the care of older people.

In addition to that outside support, I welcome the cabinet secretary's previous announcement that care homes for older people would receive at least one unannounced inspection each year, and that it was hoped that that provision would be implemented before the expected statutory commencement date of April 2012. In fact, that provision came into effect on 8 February, which is great news.

Feedback from inspections and from relatives and friends of care home residents should not be deemed as negative. We would like to encourage the process of regulation from within the care homes themselves. The report has already highlighted important areas that lacked integrity previously. It also works as a tool for knowledge for those who are unaware of the changing demographic situation, which must be addressed right away.

Quality of care for the elderly is a key priority for the SNP Government. The SNP is bringing forward inspired plans on the integration of health and social care through the Social Care (Self-directed Support) (Scotland) Bill. We aim to make the transition as quickly as possible so that we avoid any more tragic incidents. The Government has taken on board the committee's recommendations. I welcome the debate and compliment Duncan McNeil for bringing the report to the Parliament.

15:15

Gil Paterson (Clydebank and Milngavie) (SNP): It is worth noting that, when the inquiry was first proposed, the intention was to hold a one-day evidence session. Because of the serious nature of the incidents that led to the inquiry, I felt strongly that a one-day inquiry would not be adequate to investigate fully the issues surrounding care for the elderly or to do justice to those who were affected by the tragic events at the Elsie Inglis nursing home last year. The decision not to hold a one-day inquiry was criticised in the press. I leave it to the readers of our report to draw their own conclusions as to whether one day would have been enough.

I will highlight a number of issues that relate to the report. First, the prospect of having oversight of the financial viability of the multimillion pound corporations that are involved in the care home sector presents us with serious challenges. It is certainly simple that, before a licence is issued, a full and in-depth financial disclosure should be provided. However, in the world of private business—big or small—difficulties can and do arise in a short space of time. For obvious reasons, that is normally kept top secret by private companies, whether in the care home sector or in other sectors, at least in the short term. Nevertheless, the fact that the issue presents us with challenges is not a good reason not to explore how we can be better informed so that intervention can be orderly rather than alarming.

Secondly, it is clear from the evidence that we require not only a dedicated staff for the care

sector but a well-trained and well-rewarded professional workforce. However, training and higher wages come at a price. It is difficult for me to imagine how both aims can be achieved without additional new moneys. In my view, those goals can be realised only by reducing the profits that the companies that own care homes enjoy, or by raising the charges to those who use the services, which means individuals or local authorities.

An indication of the urgency that is needed can be seen from all the predictions from informed commentators, including the Scottish Government, that the number of people who will be in need of such care will continue to grow, if not explode, in the next few years. The issues that are raised in the report highlight significant challenges for us to tackle in the not-too-distant future. I can say without overstating the situation that, given the cuts to our budget from Westminster, we will need to be inventive to make the difference. Not to put too fine a point on it, sooner or later, some of us will be in need of such care. Our decisions will affect the whole lot of us. Given the Parliament's record on these matters, I am confident that we can get it right. I commend the report to the Parliament.

15:18

Mary Fee (West Scotland) (Lab): I am pleased to speak in the debate, as the report on the regulation of care for the elderly is the culmination of months of work by the Health and Sport Committee, which I was a member of before I moved to the Equal Opportunities Committee. I fully welcome the report. The regulation of care for the elderly has had a lot of attention in the past year. Improvements in care for the elderly need to be made quickly.

The importance of inspections and a robust and thorough inspection process has been highlighted. Another thing that can contribute to better regulation and care is a robust complaints procedure. Every care home and care service must have a fit complaints system at its heart so that service users, relatives and carers can feel confident that any issue that they raise, internally or externally, will be considered seriously and resolved. That is a must for driving improvements in our care service across Scotland and will benefit the service users as well as giving comfort to families that their loved ones are being looked after well.

Many people do not feel confident about complaining to a care provider directly, partly because of the lack of profile of the complaints process. I therefore welcome the cabinet secretary's response, during the evidence sessions, that the Scottish Government will continue to support the care inspectorate in raising the profile of the complaints process. I was also happy to find, in the Government's response, that it accepts the committee's finding that there is a need for a single point of entry for integrated services. I hope that that is given full attention as the Government focuses more on the integration of health and social care services up and down Scotland.

I take the opportunity to discuss regulation of the workforce—in particular, those who provide care services to the elderly through self-directed support. Will those care providers be regulated? The registration of workers is vital to ensure the highest standard of care. What assurances can the cabinet secretary give the chamber that the Social Care (Self-directed Support) (Scotland) Bill, which will come before Parliament in the near future, will ensure that all staff who are taken on by service users are fully trained and registered, as those in care homes and the care sector are?

Members will know that, last year, I raised many concerns about cuts in the third sector, the impact of which was felt acutely by staff in organisations such as Quarriers, whose level of care is of the highest standard. In its report, the committee shares those concerns that the social care workforce has long been undervalued. The Quarriers case was a perfect example of that. Those at the bottom, who provide essential care to our elderly, bear the brunt of cost cutting at every level of government. A worker's pay should reflect their output, and no one can doubt the excellence of the care that many care workers in Scotland provide, yet they do not receive what they should, nor do they have relevant terms and conditions or a chance of training and development.

In addressing the regulation of care for our elderly, it is essential that we assess the procurement process to guarantee that staff and service users do not suffer due to a race to the bottom in tendering services. Regulation and procurement are very much entwined in how services are run.

I welcome the cabinet secretary's response on the living wage and hope that the Government can do more than support it in principle. I hope that it will introduce legislation to bring a living wage to everyone in Scotland, not only in the care sector. The living wage is essential to bringing people out of in-work poverty, which is the position of many workers in the care sector, particularly women who work part-time. I, too, await the outcome of the inquiry into the living wage in Scotland by the Local Government and Regeneration Committee.

Although we all welcome the report, I hope that every member will continue to work to improve the lives of our elderly, our vulnerable and our disabled, no matter what constitution is in place. We all know—

The Presiding Officer: I am sorry, but the member must finish.

15:23

Sandra White (Glasgow Kelvin) (SNP): As someone who is not a member of the Health and Sport Committee, I thank the members of that committee for the report. I am also grateful to be able to speak in the debate. As the cabinet secretary said, how we care for our elderly and vulnerable people is a reflection of the society in which we live. If we cannot care for our older people, that says something about our society.

The speeches that we heard from Duncan McNeil and others were excellent and raised some very good points. Malcolm Chisholm raised issues from his constituency and talked about the Elsie Inglis nursing home. However, I was disappointed in Jackie Baillie's speech, as she seemed to use the committee debate as a political stage instead of trying to get to the nub of the committee's report, which I understand was supported by all the parties that are represented on the committee—I commend them for that. Committee debates are important, and I look forward to the next one, in which I will also speak. It would be great if committee debates in the chamber were a regular feature so that committees had the opportunity to put forward what they have been looking at and the inquiries that they have been pursuing.

I am the convener of the cross-party group on older people, age and ageing, and the issue of care homes—their treatment of people, their staffing and the frequency of inspections—is raised often in that group, not just by members of the group but by individuals. I go out into my constituency and try to visit care homes, not just as most MSPs do, but as the convener of the cross-party group.

I am pleased that the Scottish Government has taken on board most of the recommendations in the committee's report, particularly the recommendation on the frequency of inspections of care homes, which is an issue that individuals have raised on many occasions. It is important that visits are unannounced and that people know exactly what to expect.

Duncan McNeil mentioned whistleblowing, and that is something that we have to look at. Many staff desperately want to tell people what is happening in some care homes and the nastier aspects of it, but they are terrified to say anything. That is an important point and we need to look into it.

The training of staff is an important issue, and Mary Fee mentioned the need for fair wages. If we want decent staff, we have to give them a decent wage. We have to look at that also.

As we all know, the percentage of older people is growing, unfortunately. Perhaps we will get more younger people in, particularly with immigration, but we know that the propensity exists for older people to form the biggest population group in Scotland, so it is incumbent on us to ensure that our older people are looked after and cared for properly. After all, we will all be old one day. That is why it is important that the care of elderly people is properly regulated, that care homes are properly inspected, and that the legislation is in place to provide what older people want. After all, they are the ones who have to live with the consequences.

It gives me no pleasure to say that members would not want to live in, or even visit, some of the care homes that I have visited. We need to ensure that the regulations are watertight so that our older people can live in dignity. That is where the human rights issues come into the debate.

I am grateful for the opportunity to speak in this debate. I look forward to the future and I thank the Scottish Government for taking on board most of the recommendations in the committee's report.

15:26

Anne McTaggart (Glasgow) (Lab): I rise to speak as the next member on the conveyor belt.

Although I am not a member of the Health and Sport Committee, I welcome the opportunity to speak in the debate. After all, at the heart of the inquiry was the need to ensure that our older people have systems and structures that provide a safe and dignified life.

I put on record my appreciation for the hard-working, compassionate people who care for our older people. The role that they play in the lives of many of our senior members of society should not be taken for granted.

Recently, we saw the financial collapse of Southern Cross, and we all worried about the ramifications for residents and staff alike. We must ask why that situation came about. Was profit pursued ahead of care? Were residents merely customers? We must accept that the reason why our demography is changing, with people living longer lives, is massively influenced by the NHS being a public service and not a private one. We must look at ethical finance models for care services, such as mutuals and worker co-operatives, which have as their priority the care of service users, not shareholder profits. When we have an ageing population but people are not necessarily living healthy lives for longer, we need to have services for older people that we can trust.

That is why it is concerning to read in the committee's report—

The Presiding Officer: One moment, Ms McTaggart. Could Joan McAlpine please sit down and not turn her back on me?

Anne McTaggart: That is why it is concerning to read in the committee's report that, in some cases, residents and service users do not feel confident about contacting service providers directly to make complaints. How can we allow our older people to be cared for by businesses that they do not feel confident in speaking to?

There have been worryingly similar accounts from staff about whistleblowing in the sector. We need to see a commitment to work with trade unions and employers to ensure that staff feel supported in the event that they need to report poor practice. I was pleased to see the Royal College of Nursing call for independent care providers to keep formal registers of all concerns that are raised by staff in order to increase accountability and improve practice. However, I know from my background in social work that having better whistleblowing support and complaints procedures is not enough, because concerns about complaints and whistleblowing do not usually arise without reason. If there are issues that are being complained about, we need to tackle them and not just the complaints process.

Is it too much to expect staff to be properly trained and qualified in best practice in caring for our older people? Staff deserve that as much as service users do. Such training is vital as we try to reduce the high turnover of demotivated staff. On that point, I am glad that the committee supported Labour's call for a living wage for care employees.

We need to ensure that a qualified and properly remunerated workforce is properly monitored and appraised through inspections and follow-ups. With such support, it can deliver and maintain the high standards of care and support that our old people deserve.

15:30

Nanette Milne (North East Scotland) (Con): As more and more people live into extreme old age thanks to the support of modern medicines and an excellent health service, pressure is undoubtedly growing on the organisations and the people who care for the frailer members of our elderly community, many of whom have very complex physical and mental conditions. Those people increasingly depend on the staff who look after them for good-quality care.

In recent years, there have been disturbing reports of people who have been let down by the care services that were available to them. The Health and Sport Committee's report on the regulation of care for older people is timely and makes interesting reading, even for those of us who were not directly involved in hearing the evidence or producing the report.

I was pleased to learn that guidance will be published for care staff who wish to raise concerns about a care service confidentially. I am sure that we all know just how vulnerable older people feel who depend wholly for their health and wellbeing on the care that others provide. Many are frightened to complain, or even just to speak out, in case they get picked on—I am sure that we have all heard anecdotally of examples of that.

Government support to raise the profile of the complaints process is welcome, as is the national inquiry line, which was set up in April last year. The line deals with more than 2,000 calls per month on care issues and signposts people to other relevant bodies, but I wonder whether families, carers and users of care services, as well as care staff, are all fully aware of the service. I would like it to be publicised more widely.

I welcome the commitment and the work that has been done to reduce the time between inspections and the publication of inspection reports. It is important for those who commission care—whether that is a council, the NHS or families and carers—to have access to the most recent information as soon as possible before making any decisions about placement in care homes. I would also like a system to alert councils to a very poor inspection report, so that they may consider suspending placements until they are satisfied that significant changes have been made to bring the service up to the quality standards that are expected of it.

Paragraphs 42 and 43 of the report relate to enforcement powers, which have concerned me for some time. I think that most people in Scotland would like to be sure that, following a poor report, the service will be improved to the extent that it meets quality standards, but that will happen only if rigorous enforcement procedures are implemented.

Training is another important issue that the report deals with. I have no doubt that better training will lead to higher quality standards, higher morale and, I hope, a higher rating by the care inspectorate. That win-win situation should also lead to a better wage and career structure for many care workers, as many of them are underpaid. That should result in reduced staff turnover—turnover is another significant problem that faces people who receive care, in particular care at home.

I welcome the Government's commitment to reduce the prescribing of psychoactive drugs.

Concerns about psychoactive and covert medication have been around for some time and were raised in the "Remember, I'm still me" report three years ago, which Mary Scanlon mentioned. A number of members will have met my constituent Hunter Watson, who has been a dogged campaigner on the issue for many years and still has the concerns that Mary Scanlon highlighted.

Some older people—particularly those with dementia—can be extremely difficult to handle when they become severely confused and agitated. Psychoactive and sedative medicines are the easy way to deal with them, but that is wrong and stops a number of people functioning at their best. Proper and adequate training is essential to equip staff with the skills to deal appropriately and sensitively with such people, so I welcome the recognition of the need for better training in dementia for care workers.

15:34

Annabelle Ewing (Mid Scotland and Fife) (SNP): I would like to make four brief points. First, I thank the Health and Sport Committee for the power of work that it has done and I commend the hard work of all its members.

In addition, I welcome the cabinet secretary's speedy response to the key issue of the frequency and nature of inspections.

I have a general point to make about the language not of this debate but that is frequently adopted in the press with respect to the issue of our population demographics. My colleague John Mason lodged motion S4M-02189 last week on that very subject, following a press report that used language such as "demographic time bomb" and "increased burden". The motion stated that

"older people are inherently a good thing for Scotland ... Scots of all ages have much to contribute to society and ... in particular, older people can be a source of wisdom and support for their immediate families and the wider community".

I absolutely endorse what my colleague said in his motion.

My last point is about one of the committee's specific recommendations, which is on the important issue of monitoring financial viability. My colleague Gil Paterson alluded to the issue earlier. The committee was very concerned about the issue and it recommended that

"the Care Inspectorate should require registered service providers to submit copies of their annual accounts."

It recommended that they should do so year on year. The committee pointed out that the information is already provided at the outset of the registration process as a set of annual accounts.

The committee's idea is interesting, but I have questions about the efficacy of using that approach to secure on-going monitoring of financial viability, because annual accounts show the position for historical periods of time. I hope that the minister can indicate in his winding-up speech how that very important issue could be dealt with.

I welcome the fact that the cabinet secretary is undertaking work with the care inspectorate, COSLA and other relevant bodies to bring forward recommendations on how financial robustness in the sector can be assured. The aim of course would be to ensure that there was on-going risk assessment.

Within the continuing work, I wonder whether it would be helpful for the Scottish Government to consider requiring additional on-going financial reporting by service providers, which could be justified in light of the vital public interest that is involved. Of course, it may be too early to say what the direction of travel is in the discussions, which involve more than simply the Scottish Government, but it would be interesting to hear the minister's response.

I put on record my thanks for the outstanding job that care home staff and other staff do throughout Scotland for so many individuals and, of course, their families.

15:38

Mary Scanlon: I put on record my support for the points that my colleague Nanette Milne made.

I was probably the most vocal member of the committee on the issue of training and support for staff. Again, I am sorry to say that I found the response disappointing. The best that I could find was that the Scottish Social Services Council

"will continue to work with employers on the development of qualifications and products that support and delivers a competent, confident and qualified workforce."

I am not entirely sure what the SSSC is continuing and whether it means that more care workers will be trained, supported and valued, but I hope that it does.

The fact is that care workers with little or no training are going into the homes of vulnerable elderly people. Investment in our colleges and the Scottish Social Services Council could secure training, would value and support the workforce and, most of all, could provide better-quality care to thousands of older people.

Jackie Baillie gave us earlier the timetable for registration of workers in adult care homes, but I will add one date to that. Registration for workers for care-at-home services will not start until 2017, with achievement of registration by 2020.

After reading the report again and reading the Government's response, my conclusion is that there suddenly seem to be dozens of new plans and reviews. I totally agree with Malcolm Chisholm's point about reducing bureaucracy and allowing the care inspectorate to focus on the job that we want it to do. He also raised the issue of the two paragraphs in the report on involving service users, friends and relatives, which is important, too.

The care inspectorate's response to those two short paragraphs is that it has already started to build on the issue; it has another recently completed review; a care inspectorate involvement strategy is being developed; it is working on developing new methodologies; it has held a series of focus groups; further work is now required to underpin the new scrutiny model findings; it is preparing a full public reporting strategy; there will be a new proactive approach; it is undertaking an evaluation of its risk tools; it is holding a series of scrutiny, intelligence and risk events; a new assessment tool is on its way; and it is currently developing its involvement and intelligence strategies. There are 11 initiatives in response to two short paragraphs.

That is why I find things difficult. I hope that that is what is required, that this is not about building bureaucracy, and that what is being done will lead to improved standards, but the approach seems incredible. There are new plans, reviews, strategies and action plans, but the truth is that we really do not know whether things will be better. The response is typical of the Government's response, although it is more the care inspectorate's response.

I hope that the committee's report will improve the health, welfare and wellbeing of older people who receive care at home or in care homes, but I am not convinced of that on the basis of what I have heard today. I hope that we will visit the issue again soon, given that much work is being done in the background. An update on the improved inspection process and regulation would be helpful.

15:41

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I begin by making a declaration. A relative of mine recently went into a care home, and I am a director of Nursing Home Management Ltd, which runs a single nursing home in England.

As we have heard, the inquiry arose from a combination of serious events at the Elsie Inglis home, which recently had good assessments, and the collapse of the Southern Cross group of homes. As Malcolm Chisholm said, the report illustrates the Parliament working at its best in partnership with the Government and the Opposition. The Government responded as evidence came in. In particular, it reversed in part the cuts in the new care inspectorate budget, although that came too late to prevent significant redundancies among qualified inspectors, and it has modified the lighter-touch inspection regime to which Parliament had signed up. As Jim Eadie said, we will need to scrutinise the care inspectorate's capacity to perform adequately.

One of the core concerns arose because of the rapidity with which the level of care declined at Elsie Inglis. Jackie Baillie and Malcolm Chisholm described that. Risk assessment that underpins the announced and unannounced inspection system is critical if public confidence is to be maintained. In England, the recent resignation of the chief executive of the Care Quality Commission demonstrated the importance of public confidence. Therefore, I welcome the continuing efforts to ensure that the risk assessment tool is subject to further iterative development, as are the triggers for additional unannounced scrutiny. Will the Government place the new tool and strategies in the Scottish Parliament information centre as soon as they become available? I hope that that will be soon.

The inspectorate's national inquiry line and dedicated national complaints team are welcome, but independent evaluation of its credibility with residents, staff and carers is needed. As the cabinet secretary knows, I have been pressing for an independent and confidential whistleblowers telephone line for NHS staff, which should be for all care staff given the pending integration of health and social care. I hope that that will be part of the cabinet secretary's welcome commitment to raising the profile of the complaints system generally. The complaints system should be aligned and integrated with the new complaints process for the NHS. As Mary Fee reminded us, the landscape is far too cluttered. It needs to be focused on the individual, not on service silos.

On the engagement of health professionals, the development of shared protocols between the inspectorate, the General Medical Council and the Nursing and Midwifery Council is welcome. Visiting health staff are being invited to comment as part of the pre-assessment. However, the Government's rejection of the involvement of community pharmacists beyond their current role is a mistake, and it deprives residents of the same rights to registration for long-term conditions that others will enjoy. That really must be extended to other groups, such as optometrists and audiologists, as part of a falls prevention strategy.

I welcome the greater fulfilment of the key performance indicator on timing of publication but, as Richard Lyle and Nanette Milne said, local

authorities must be alerted to that and we need to ensure that the process continues.

I also welcome, but seek some urgency on the implementation of, the powers to refuse further registration of services and, as Anne McTaggart and Annabelle Ewing said, powers to examine the financial health of care homes.

Many members mentioned the need to value the workforce, the absolute need to establish a minimum wage, the need to ensure that there is good training and the issue of registration. The length of the registration process is now more crucial than ever. We are moving to self-directed care and much more home support, so we need care workers to be registered early. I hope that discussions on that will continue.

We need the national care standards urgently, not in the future. We also need all local authorities, not just 11 out of 32, to have commissioning strategies if we are to prevent further scandals like the one that was exposed by the BBC's "Panorama".

15:46

The Minister for Public Health (Michael Matheson): The committee has published a useful report and we have had a useful debate that shows our shared concern to ensure that the regulation of care services in Scotland is proportionate and right to meet the needs of the individuals who use them.

In his opening speech, Duncan McNeil helpfully set out the catalyst for the committee's decision to undertake the inquiry—the incident at the Elsie Inglis care home and the financial collapse of Southern Cross. From the way in which the matter played out in the media, it was clear that there was public concern about the operation of care establishments in Scotland—if not, to some extent, throughout the UK.

It is essential that there is public confidence in the regulatory regime for Scotland's care services. That is why the Government has been prepared to consider where changes can be made to ensure that the regime is sufficiently robust and proportionate. We are open to making such changes and, to a large extent, the committee's report recognises that.

Mary Scanlon helpfully pointed out the overall scale of social care provision in Scotland, the number of people who receive such services and the number of people who work in them. We should not underestimate the scale of that business or the need to ensure that the system is correctly balanced.

We have accepted the majority of the recommendations that the committee made. I note that some people think that we have not moved as fast as we could have on particular matters. However, when we have been able to take early action—such as on the regulations on the inspection regime—we have done so at the committee's request.

It should be noted that the national care standards have been in place for almost 10 years. They have stood the test of time but there is no doubt that, given the changes in demographics and some of the challenges in social care, we must review them in order to get them right. However, it is not a simple case of refreshing the existing care standards; it is also about ensuring that they work in tandem with the standards on dementia care and the review of the social care contract that COSLA is undertaking. We need to ensure that that collection of standards works in partnership. It is better to take appropriate time to get that right to ensure that, if the standards are in place for another 10 years, they stand the test of time.

Duncan McNeil also mentioned whistleblowing, as did Richard Simpson and several other members. We and the care inspectorate recognise that it can be a valuable way of highlighting concerns about care standards. The care inspectorate and the Scottish Social Services Council have been working in partnership on a campaign with care providers in the health and social care sectors to ensure that they get the message out about having codes of practice for whistleblowing. We are more than happy to consider further whether there are ways in which we can continue to build on what is already happening in the workplace to assure people that the whistleblowing mechanism is robust and will activate the appropriate mechanisms should concerns be raised.

Mary Fee and Richard Simpson raised issues to do with the complaints process. They may be aware that the care inspectorate has already held a consultation on that process, which ended at the end of last year. We expect the findings of the review of the complaints process to be published this month. As a Government, we are open to looking at whether, when it comes to lodging a complaint, there should be a single point of call, so that there are no questions about where someone should go if they want to make a complaint. We should allow the care inspectorate to analyse the results of the consultation that it has undertaken.

The timeframe for training and qualifications has been mentioned. We are looking at that area to see whether we can address some of the issues, but we should not underestimate the scale of what is required, given that 95,000 members of staff might have to receive some form of training provision. We need to ensure that the staffing and

training arrangements that are put in place are robust enough to allow that to happen in an effective way, while sustaining services.

Mary Scanlon mentioned the concerns that the committee raised about the use of psychoactive medication. We do not believe that the chronic medication service is the appropriate way of addressing the issue, because that service has been designed to improve the concordance of patients with a long-term condition with their medication, which is self-administered, often in the setting of their own home. Even the pharmacists' professional body recognises that the chronic medication service is not the appropriate mechanism for dealing with the issue, which is being looked at as part of the review of the pharmaceutical care of patients in the community. It will consider what is the most effective way of ensuring that there is sufficient pharmaceutical care provision in our care homes. Once we have the findings from that review, in the autumn, we will be in a position to look at how to proceed.

The debate has been extremely useful. There is no doubt that the committee's report will assist us in continuing to improve the care regime for care services in Scotland.

15:52

Bob Doris (Glasgow) (SNP): It is a privilege to sum up for the Health and Sport Committee in what, in general, has been a positive, informative and constructive debate. Indeed, that was the approach that our committee took to the inquiry into the regulation of care of older people. I thank the members of our committee for that approach. In my thanks, I would like to include the former members of the committee Mary Fee and Mary Scanlon, who served the committee well during their time on it. I also thank the clerking team, SPICe, all those who gave evidence, whether in written form or in person, and all those members who have made positive contributions to the debate, a number of which I will touch on.

However, I will start with a more general point. Our committee system can make a powerful contribution to driving positive change. That is exactly what I believe the Health and Sport Committee has achieved in relation to improving the system of regulation of care of older people.

When the committee embarked on its inquiry, we were determined to scrutinise the regulatory framework for some of our most vulnerable citizens in a rigorous, non-partisan and mature way, and that is what we did. Of course, our interest in the subject was raised by the tragedy at the Elsie Inglis home and the debacle surrounding Southern Cross, but it is worth stressing that our inquiry had at its core a significant degree of post-legislative scrutiny. There had been no rigorous review of legislation in the area since the implementation of the Regulation of Care (Scotland) Act 2001, since when it should be noted that the tragedy at the Elsie Inglis home and the Southern Cross debacle occurred.

I am sure that fellow committee members will agree that increased post-legislative scrutiny by our committees would be beneficial to the Parliament. While admitting that our inquiry was prompted by public concerns about high-profile incidents, as opposed to being a pre-planned effort on the committee's part, I believe that the regulation of care of older people is all the better for it.

We should put on record the committee's unanimous belief that the current system was sufficiently rigorous, but that that does not mean that there are not always various areas in which the system of regulation must be improved.

It is also worth noting that there remains cross-party support for the use of a risk-based assessment process in the regulation of care of older people, that risk assessment should be robustly evidence driven and that the frequency and type of inspection should be proportionate to that risk. Indeed, the Health and Sport Committee made several recommendations specifically on those points.

In his opening speech, Duncan McNeil rightly pointed out that there seemed to be a lack of clarity around whether inspections should judge care against two or four quality themes. It is a minimum of two and a maximum of four, based on a risk assessment. I draw to members' attention the fact that the regulatory assessment tool—the tool by which one assesses the risk in the first place—has been reviewed by the care inspectorate and improved for the current year.

I listened with interest to Jackie Baillie's contribution, in which she rightly identified a dramatic drop in the quality of care at the Elsie Inglis nursing home. The committee accepted in taking evidence that that could happen under any regulatory system, no matter how robust it was. What is important is how effectively we pick up on those dramatic falls in care standards. We are all working on the same agenda, which is to improve the system. I mentioned the regulatory assessment tool because that is the way in which we collect the evidence to allow us to pick up on those situations in which the quality of the care service has dramatically fallen.

Jackie Baillie also mentioned issues around procurement and the living wage. The committee was concerned about those matters, and I note that the Government has had further discussions with COSLA in that regard. It is only right that the

committee will want to see where those discussions arrive at.

The complaints process has been a common theme in the debate: it was discussed by members such as Malcolm Chisholm, Sandra White, Richard Lyle, Nanette Milne and Mary Fee, to mention just a few. The committee believes that the complaints process is vital but the process should be positive. An open complaints process drives positive improvement in care homes, and those that are up for the challenge should have nothing to fear.

I note that Nanette Milne welcomed the guidance on confidential complaints that we are hoping to see in the near future, which links in with the concerns that we have heard about whistleblowing.

It is important to mention Mary Scanlon's comments on the use of psychoactive drugs, which were a passionate display on an issue that she has been following for a number of years. The Scottish Government has said that it is in discussions with the care inspectorate and the Mental Welfare Commission for Scotland to improve those standards and link them to dementia standards. I sense Mary Scanlon's frustration. Although that is the right thing to do, she wants tangible outcomes to show whether things have improved. I am sure that our committee will want to monitor that in future.

Jim Eadie mentioned the duty of care for the wider health professional groups. I know that undergraduate training for doctors and nurses will be bolstered to remind students of that. Perhaps we should extend it to training for other health professionals.

I will highlight one of the committee's recommendations, which will, I hope, become common practice in a few years' time. We identified that the inspection process for health and social care is not integrated. Ron Culley of COSLA told the committee that the current system of regulation was centred on general service provision and that we should move to a system that is more focused on individual outcomes. Geraldine Doherty of the Scottish Social Services Council agreed with that.

As we progress further down the road of closer health and social care integration, it is particularly important that the care pathway for individuals is assessed in a meaningful way. I do not want to overplay the importance of that but, given the current legislative context in respect of closer integration, it is vital that we get it right.

Joint inspections and closer working are vital if we are to make progress. When the care inspectorate—or whoever—enters a care home, it is reasonable to hope that the inspectors will examine the care journey for some of the residents and families who use the care home and how an individual came to be in that care home, whether they or their family believe that they could have been supported in their own home for longer and, if they had a stay in hospital before they arrived at the care home, what the quality of care in the hospital was like. The care pathway—the human journey—is where we must take the care system in future. Joint inspection work is one way to do that, and it is important.

The Deputy Presiding Officer (Elaine Smith): I would be grateful if the member could come to a conclusion.

Bob Doris: I just want to mention some of the achievements that we have already made in relation to the regulation of care of the elderly.

Every care establishment will now have one unannounced visit a year, and some will have more depending on the risk. At least two quality themes will now be inspected. The system of engaging with health professionals such as GPs and pharmacists has been beefed up. The training of doctors and nurses will be beefed up. The complaints process will be made more accessible and streamlined, with a single point of contact, and we will soon be reviewing the national care standards. All of that has come from our committee's recommendations. We are driving change. This is what the committee and the Parliament should push forward.

Pernicious Anaemia and Vitamin B12 Deficiency (Understanding and Treatment)

The Deputy Presiding Officer (Elaine Smith): The next item of business is a debate on motion S4M-02185, in the name of David Stewart, on petition PE1408, which is on the understanding and treatment of pernicious anaemia and vitamin B12 deficiency. This, too, is an extremely tight debate. I call David Stewart to speak to and move the motion on behalf of the Public Petitions Committee. Mr Stewart, you have 10 minutes, but if you are able to take less time, I might fit in back benchers.

16:01

David Stewart (Highlands and Islands) (Lab): I am pleased to speak on behalf of the Public Petitions Committee in its first chamber debate of this session of Parliament. I welcome the opportunity that has been given to the committee today to highlight the issues that are raised by Mrs Andrea MacArthur in her petition on pernicious anaemia and vitamin B12 deficiency, especially as I understand from the Scottish Parliament information centre that this is the first-ever debate of its kind in the chamber.

PE1408 calls on the Scottish Government to review and overhaul the current outdated and ineffective method of diagnosing and treating pernicious anaemia and vitamin B12 deficiency. The committee initially considered the petition at its meeting on 15 November last year, and we heard evidence from the petitioner, Mrs MacArthur, and from Martyn Hooper, the executive chair of the Pernicious Anaemia Society. The committee agreed to seek time in the chamber for a committee debate on the issues that were raised, so I appreciate the opportunity to have the debate this afternoon.

Vitamin B12, which we normally obtain from food, is important for production of red blood cells and maintenance of the nervous system. B12 deficiency can result in anaemia, with symptoms including fatigue, lethargy, breathlessness, headaches, disturbed vision and mouth ulcers. Some of my committee colleagues will be able to talk in more detail later in the debate about the symptoms and effects of the condition. The most common cause of vitamin B12 deficiency is pernicious anaemia. It is an autoimmune disease in which the body attacks the stomach cells that produce intrinsic factor, which is a binding protein that is needed for absorption of vitamin B12. That leads to vitamin B12 deficiency because the body can no longer absorb it from food.

Diagnosis of vitamin B12 deficiency, or pernicious anaemia, is usually done by way of blood tests. A blood sample is examined for several things, including the amount of vitamin B12 in the blood and the antibodies against stomach cells that might appear in pernicious anaemia. I understand that an alternative test has become available in England—the active B12 test—which measures the amount of vitamin B12 that is present in the form that can be taken up and used by the body. The test appears to address the problem of blood levels of vitamin B12 appearing to be normal when the amount that is available for use by the body is actually very low.

It appears that there are no exact figures available for the number of patients who have been diagnosed. However, in answer to a parliamentary question by Mary Scanlon in August 2011, the minister who is here today—Michael Matheson—advised that an estimated 12,200 people had face-to-face consultations on pernicious anaemia in 2009-2010 in Scotland. In the petition, Mrs MacArthur quotes the Scottish Government's prescribing data for 2011, and states that about 109,000 patients were identified as having pernicious anaemia. That gives us an indication of the numbers of people involved.

Treatment of non-diet-related vitamin B12 deficiency is normally done through injections of the vitamin. The injections are given every other day for two weeks or, if there are neurological symptoms, until there is further improvement. They are usually then given every two to three months. However, Mrs MacArthur points out in her petition that the prescribing data show that the cost to the national health service of treating those 109,000 people was just over £800,000, half of which was spent on treating just 9 per cent of patients with the least effective form of treatment available, which, according to the petition, is oral tablets. In Mrs MacArthur's words, it is ineffective because the body is unable to absorb the vitamin B12 in tablet form while the serum levels are elevated, making it appear to the doctor that everything is well.

I understand that vitamin B12 injections are direct and cost around 50p. We heard from Mrs MacArthur that she lodged the petition as a result of her own experiences of being unable to get effective diagnosis and treatment for her own suspected vitamin B12 deficiency. The petition therefore calls for the current diagnosis and treatment procedures that are in place to be reviewed and updated. Mrs MacArthur made the point in evidence that

"Doctors have very little knowledge of the condition, so they stick rigidly to the little guidance on treatment that they are given. The guidance itself is incomplete."—[*Official Report, Public Petitions Committee*, 15 November 2011; c 229.]

Mrs MacArthur contends that there are major failings in the treatment and diagnosis of the condition and that many patients are dismissed or treated as being hypochondriac, neurotic or depressed and that failure to get proper diagnosis and treatment only allows the condition to worsen.

The Pernicious Anaemia Society told us that it hears frequently of patients who struggle to get the diagnosis and treatment that they require. Mr Hooper, the chairman of the society, told us that

"Treatment of the condition is so consistently bad that to hear of someone who has managed to get their doctor's co-operation to treat them more effectively is a most surprising and rare event."—[*Official Report, Public Petitions Committee*, 15 November 2011; c 228.]

After considering the petition and hearing the oral evidence from the petitioner, the committee agreed to write to stakeholders to seek their views. We received evidence from a range of organisations, including Highland NHS Board, Lanarkshire NHS Board, Greater Glasgow and Clyde NHS Board, the Royal College of General Practitioners in Scotland and, of course, the Scottish Government. The written evidence that we received was very interesting. The responses are on the petition's web page and are available to all members, should they wish to consult them for more detail.

In the brief time that is available, I will highlight points from the written submissions that the petitioner feels support the points about inconsistency that she makes in her petition. First, in relation to the tests for diagnosis, NHS Highland writes:

"We accept that the diagnosis of B12 deficiency is not foolproof at the present time."

Likewise, NHS Lanarkshire states:

"It is well recognised within the Haematology Service that the vitamin B12 assay does not completely reflect the tissue availability of vitamin B12. More complex and detailed assays are available which will more accurately reflect the body's vitamin B12 state but these assays are beyond the scope of the general Hospital Laboratory at this time."

Incidentally, Wikipedia tells me that an "assay" is a

"procedure in molecular biology for testing ... the activity of a drug or biochemical in an ... organic sample."

In contradiction to the first two quotes, NHS Greater Glasgow and Clyde states:

"The current diagnostic tests and treatment are considered by the medical profession to be up to date, accurate and evidence based. There is no question that the current diagnostic methods are 'outdated or unreliable'."

I will again quote NHS Highland. It states:

"Whilst we cannot support an 'automatic trial' of B12 injections in patients with no laboratory evidence of B12 deficiency, better diagnostic techniques would allow treatment to be targeted appropriately."

Those points in themselves lead one to believe that there are, indeed, inconsistencies of approach throughout Scotland. They also seem to indicate that there is no consensus across the NHS boards.

However, I was pleased to note that the Scottish Government, in its response, indicates that it takes the issue very seriously and that it is committed to improving awareness, diagnosis and treatment for people, irrespective of their condition. I would like to ask the minister to address in his winding-up speech whether that commitment could be demonstrated by the Government's reviewing the research that the petitioner refers to as having been undertaken and available for review; by its finding out exactly what is happening to patients in advance of the British committee for standards in haematology's guidelines on the diagnosis of B12 and folate deficiency, which I understand from the Scottish Government is due to be published in March; and by its working with health boards to raise among health professionals awareness of diagnosis and treatment of the condition.

I welcome the opportunity to debate the issues that have been raised in the petition and I look forward to hearing the views of colleagues from across the chamber this afternoon.

I move,

That the Parliament notes petition PE1408 in the name of Andrea MacArthur on the issue of vitamin B12 deficiency and pernicious anaemia; congratulates the petitioner on her efforts to highlight what it considers to be a concerning issue, and commends the issues raised in the petition to the Scottish Government for further consideration.

The Deputy Presiding Officer: I am much obliged to you for coming in before your time, Mr Stewart.

16:09

The Minister for Public Health (Michael Matheson): I congratulate the Public Petitions Committee on securing its first debate—but not its last, I am sure—in this parliamentary session. I have no doubt that it will bring other important topics to the chamber, including matters that relate to my portfolio.

David Stewart was right to say that the Government takes pernicious anaemia and vitamin B12 deficiency seriously. I am committed to ensuring that people are treated with care and compassion and that they are given the support that they need in order to be able to lead more independent and fulfilling lives.

Estimates of the number of people who have pernicious anaemia vary considerably. David Stewart mentioned parliamentary questions to which I have responded. It is clear, however, that pernicious anaemia and vitamin B12 deficiency

affect a great many people and that we need healthcare services that can meet all their needs.

We have clearly set out our aim to be recognised as being world-leading in respect of the quality of healthcare services that we provide: the healthcare quality strategy is an important part of our commitment to making Scotland healthier and it is about putting people at the heart of our NHS. We have set ourselves three bold and ambitious shared ambitions for our healthcare services: to deliver care that is truly person centred, safe and effective. The ambitions are based on what people have told us they want from their NHS. Therefore, we want to be able to detect and diagnose pernicious anaemia and vitamin B12 deficiency as early as possible and to ensure that people who have the condition get the right treatment, when they need it. We aim to offer clinicians and people with the condition the tools, guidance and support to make that happen.

I am sure that many members acknowledge that primary care is often the first point of contact for people who are living with pernicious anaemia or vitamin B12 deficiency. General practitioners enjoy a high level of trust and confidence among their patients.

Scotland's population is getting older, and there is a projected rise in that proportion of the population from some 19.7 per cent to 24 per cent by 2033. The number of people who live with long-term conditions, such as pernicious anaemia and vitamin B12 deficiency, is also set to increase. Through our healthcare quality strategy, we aim to build a healthcare system that recognises and responds flexibly to each person as a unique individual, by building trust and empathy and engaging people in decisions that affect their healthcare and wellbeing. Implementation of the strategy means that there are already on-going improvements in services for people who have a variety of long-term conditions.

In her evidence to the Public Petitions Committee, Andrea MacArthur spoke of her hope that we could

"start a process that leads to the treatment of the condition being overhauled and tailored to the individual patient's need, rather than the one-size-fits-all policy".—[*Official Report*, *Public Petitions Committee*, 15 November 2011; c 228.]

The "Delivering Quality in Primary Care National Action Plan" aims to do precisely that. In it, we set out the strategic direction for primary care. We say that we want care that is

"increasingly integrated, provided in a joined up way to meet the needs of the whole person",

and that people should have more power over how decisions are made about the treatment that they receive in the health service. We go on to say that care should be clinically effective and delivered to the individual in the most appropriate way. However, the scale of the challenges that we face and require to address in general practice is stark, given the demographic shift.

An important initiative, which is being taken forward with support from the Scottish Government, is the access to local information to support self-management project—ALISS, as it is commonly known. The project is beginning to draw together valuable information from a variety of local sources, GP practices and voluntary organisations, and to make the information easily accessible, in order to support people who are self-managing their condition.

The Pernicious Anaemia Society will undoubtedly have a valuable role in sharing its knowledge and expertise, and I encourage it to work with Long Term Conditions Alliance Scotland, to ensure that the ALISS project properly supports people who suffer from conditions such as pernicious anaemia and vitamin B12 deficiency.

Presiding Officer, I will finish on that point, to assist with the rest of the debate, but in my closing speech I will try to address specific points that members raise during the debate.

16:14

Dr Richard Simpson (Mid Scotland and Fife) (Lab): This is a most interesting debate, which I very much welcome. It is a good innovation, and for petitioners who want an open debate rather simply a report or an acknowledgement it is the right way forward. I hope that this is the first of many such debates, because it enhances the role of Parliament. That is important.

Pernicious anaemia is a suitable topic for the first debate on a petition because the issue is not clear. We do not know the epidemiology of the illness nor its prevalence and incidence. There are wide discrepancies in the figures. That is an important starting point.

The second most important starting point is the survey that was conducted by the Pernicious Anaemia Society. Even though its sample may have been skewed, the fact that 47 per cent of respondents had waited two years or more for diagnoses indicates that all is not well. This is not a situation with which we should be happy.

The Pernicious Anaemia Society has listed on its website the symptoms that people might experience. That list is long and the symptoms are scored: 12 of them score 5; three score 2; and no fewer than 20 score 1. That illustrates the problem for the general practitioner: when one is

confronted with such a variety of symptoms, it is difficult to decide on a diagnosis.

The public now expect us to have a medical system in which there is a simple test that defines the condition and allows clear treatment to be given, but of course that is not the case. Doctors need to be aware of the most common symptoms and they need to be able to think of B12 deficiency as being one of the possible diagnoses. To do that, they require the support of good information technology systems so that they can interrogate the symptoms—B12 deficiency may come up on the list of symptoms that are presented.

On the diagnostic tests, I found the Schilling test on the Royal College of Practitioners website, yet the test has been abandoned. If our respected college does not have the most up-to-date information, there is a problem.

The petitioners have suggested that we should adopt the new active B12 test. I find that fascinating because, as a GP, I used to be presented with patients who were being given B12 and were testing adequately for it, but who still had symptoms that they should not have had. From the information that we now have, we know that there is active and inactive B12. It is important that we move forward on tests such as the active B12 test. I hope that the Government can give us a response on that.

There are other tests, such as the anti-intrinsic factor antibody test and the antiparietal cell antibody test, but they display the common difficulties that are faced by medicine in that they have different levels of sensitivity and specificity, which means that they are not like simple dip tests that would allow us to say, "This is pernicious anaemia."

The inconsistencies, which were recognised in the evidence that was given to the Public Petitions Committee, are sufficient for us to ask a number of questions of the Scottish Government. First, why is there no Scottish intercollegiate guidelines network guideline for pernicious anaemia? It should be placed on the SIGN work table, unless the National Institute for Health and Clinical Excellence guidelines embody the new ones from the British Society for Haematology. We need greater clarity.

We need not just to look at the fact that 47 per cent of diagnoses were delayed, but to ask why there were delays. What caused them? We need to know what review the Government is undertaking of diagnostic testing for pernicious anaemia. In the light of continuing concerns about the validity of thresholds for B12, we need to know whether the active B12 test should be introduced as a priority, not only because the condition itself is unpleasant, but because the neurological consequences—dementia is an increasing problem—can be serious if the condition is left untreated.

What steps has the Government taken to examine the practice team information data to ensure that everyone on B12 injections is—first—adequately monitored and, secondly, treated with folate? That combined treatment is necessary.

16:19

Nanette Milne (North East Scotland) (Con): As many members do, I welcome today's debate—which is the first Public Petitions Committee debate and the first time that this serious matter has been discussed in this session of Parliament. I also congratulate Andrea MacArthur on the tremendous work that she has done in pursuing awareness of vitamin B12 deficiency and pernicious anaemia. I am grateful to the PA Society for highlighting the current serious problems with the way in which PA is diagnosed and treated.

Members will be aware that it is thought that pernicious anaemia affects around one in 8,000 people over the age of 60, with the likelihood of developing it increasing towards the age of 80. It also sometimes affects children and may result in educational problems. It is more prevalent in women than it is in men. Symptoms include tiredness, headaches, breathlessness and heart palpitations as well as mouth ulcers, weight loss and blurred vision. Everyday tasks can become difficult for sufferers, and they often feel isolated.

Pernicious anaemia is caused by a lack of vitamin B12, which is vital for manufacture of new red blood cells. When B12 is in short supply, fewer red blood cells are produced, they are abnormally large in size, and they do not last as long as they should, so anaemia develops.

PA develops when the body becomes unable to absorb vitamin B12 properly from foods such as meat, eggs, dairy products and green vegetables. Normally a protein that is known as intrinsic factor, which is made in the stomach, attaches to vitamin B12 and carries it through the intestinal wall into the blood stream, but in pernicious anaemia, the stomach cells that produce intrinsic factor become damaged, so vitamin B12 is no longer absorbed and a deficiency develops.

The petition that is before us today rightly calls on Parliament to urge the Scottish Government to review the diagnosis and treatment of pernicious anaemia. Reading Mrs MacArthur's testimony, one cannot fail to be moved by the her account of what she describes as a "forgotten illness". In evidence to the committee, Mrs MacArthur said—incredibly humbly, in my view—

"solely due to the doctors that I have, I fared well."—[*Official Report, Public Petitions Committee*, 15 November 2011; c 238.]

However, it is unacceptable that despite demonstrating the signs of pernicious anaemia for 13 years, Mrs MacArthur was never tested. Indeed the Pernicious Anaemia Society has evidence to prove that today's doctors do not, in the main, view many of the symptoms that are experienced by patients as being indicative of pernicious anaemia.

The lack of testing that is available to GPs and common misdiagnosis are at the heart of the petition that has led to today's debate. Coming from a medical background, I fully accept that the symptoms of pernicious anaemia can often be mistaken for those of other conditions, but it is extremely important that GPs become better trained in diagnosis, because prolonged vitamin B12 deficiency can lead to irreversible nerve damage.

Diagnosis of B12 deficiency is difficult for two reasons. First, the lower threshold for determining deficiency is too low, so that patients who have all the symptoms of deficiency are not picked up because they are one or two points above the test's threshold. Secondly, the test that is available in Scotland does not distinguish between active and inactive B12. The active form plays a part in forming red blood cells, while the inactive form is just that, and the available test does not take into account that the inactive form could be as high as 90 per cent of the patient's vitamin B12 content.

Also, unfortunately, the classic test that was used to diagnose vitamin B12 absorption—the Schilling test—is no longer available; I was surprised by what Richard Simpson said about the website to which he referred. The test that doctors currently use to look for intrinsic factor antibody is only 30 per cent to 40 per cent reliable and it does not identify those who do not produce any intrinsic factor. That leads to patients who still have a lack of B12 producing a negative test. It is "a mess", as one professor of general practice is quoted as saying.

The Scottish Government's response to the committee's request for its comments on the petition was not entirely substantive. It said that all GPs should be able to manage any patient who presents with pernicious anaemia, but that is clearly not the case. Mrs MacArthur also made the valuable point that PA is often dismissed as being something that only the elderly suffer from or as being merely a vitamin deficiency. That clearly fails to acknowledge what a serious condition pernicious anaemia is, which is why we need the medical profession to acknowledge that.

I will deal with the approach to the treatment of PA and vitamin B12 deficiency in my closing remarks, but for the moment I end by saying that I am glad that my colleagues and I on the Public Petitions Committee pressed for the matter to be brought before members this afternoon.

The Deputy Presiding Officer: I thank the opening speakers for their time discipline. If the speakers in the open debate limit their speeches to four minutes, I hope to be able to fit everyone in. I call John Wilson.

16:24

John Wilson (Central Scotland) (SNP): I welcome this debate, which has been secured by the Public Petitions Committee, on pernicious anaemia and vitamin B12 deficiency. I declare an interest, because my wife, who has lived with multiple sclerosis for more than 25 years, was finally diagnosed with pernicious anaemia seven years ago.

The petition is a result of what the petitioner perceived to be major failings in relation to both the diagnosis and treatment of pernicious anaemia and vitamin B12 deficiency. Based on the experiences of my wife and others, I completely agree with the petitioner Andrea MacArthur's argument that inconsistent treatment, ambiguous testing and inaccurate diagnosis currently stand in the way of effectively managing the condition, which has a huge impact on those associated with it.

As I said during the committee's meeting on 15 November, which is when the petition first appeared before us, I have had the opportunity over the past few years to speak to members of the MS Society in Lanarkshire. I have been surprised to hear that those who suffer from both MS and pernicious anaemia are subject to a variety of medical treatments by their GPs and other medical practitioners. Indeed, variations in treatment occur not only between, but also within GP practices, with some GPs or practice nurses following the SIGN guidelines and others treating patients on an individual basis, according to need.

It is clear that, while three-monthly treatments, as outlined in the SIGN guidelines, may work for some, they definitely do not work for everybody. That raises serious questions about whether the SIGN guidelines are fit for purpose.

The focus must be on the individual. We must put the individual at the centre of managing symptoms that can have a huge impact on their lives. Every person is different and requires treatment to manage the symptoms associated with their condition, and they can react differently to the medication they receive and the efficacy of the benefit derived.

In written evidence to the committee, NHS Lanarkshire noted that only in exceptional situations would vitamin B12 be administered more frequently than on a three-monthly basis. Based on evidence heard by the committee and on my experience, I suggest that many patients require treatment on a much more frequent basis, depending on the nature of their condition. It is therefore crucial that all relevant best practice guidelines are reassessed to guarantee that patients' needs are best met.

I look forward with interest to the results of the Pernicious Anaemia Society's survey of the experience of its members—I understand that it is due to be published this spring. Such research will be critical in moving the debate forward and will go some way to improving our collective understanding of not only the condition as it affects sufferers, but the problems faced by carers in seeking assistance from medical professionals.

In his evidence to the committee, Martyn Hooper, the executive chair of the Pernicious Anaemia Society, stated:

"The test for pernicious anaemia is about 50 per cent accurate, but vitamin B12 deficiency is current in about one in 10 of the population."—[*Official Report, Public Petitions Committee,* 15 November 2011; c 232.]

That is extremely worrying.

I realise that pernicious anaemia is a complex condition and that the symptoms can easily be mistaken for other neurological conditions, such as MS. However, problems with testing have resulted in patients having to wait for years to be correctly diagnosed, which can consequently lead to devastating health and social problems.

I thank the Pernicious Anaemia Society for and congratulate it on its production of the film "Living with the Fog". It is clear that more work must be done to raise awareness of pernicious anaemia and vitamin B12 deficiency. I look forward to continuing to address this debate in committee and to hearing the Scottish Government's response.

16:29

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): This is an important subject in itself, but it also raises interesting general questions about the role of the Public Petitions Committee, of the Parliament and of Government in relation to clinical issues.

Politicians certainly have a role to play in representing and championing the concerns of patients, and I congratulate the committee on doing so. We also believe strongly now in a partnership with patients and in the increasing ability of individual patients to have power over the decisions that affect them. That is a feature of the 21st century health service unlike any other in any previous health service. I still believe, however, that we must tread rather carefully when it comes to clinical matters. I am not entirely sure that it is the Scottish Government's role

"to review and overhaul the current out-dated and ineffective method of diagnosing and treating Pernicious Anaemia",

to use the words of the petition. At the end of the day, although it is the Government's role to drive forward improvements in quality—the minister mentioned improving quality in primary care—diagnosis and treatment are matters for clinicians. Guidelines are properly a matter for the royal colleges, NICE and NHS Quality Improvement Scotland.

The correct thing to do is to ask those bodies to consider the issues that have been presented in the debate, while taking full account of patients' views and in partnership with patients. John Wilson referred to a SIGN guideline but, in fact, SIGN has never produced a guideline on pernicious anaemia. All that exists are criteria in the Scottish programme for improving clinical effectiveness in primary care. Perhaps one thing that the Government should do is to ask SIGN or NHS Quality Improvement Scotland, over which the Government has more direct influence, to consider that matter urgently in the light of the concerns that have been expressed.

It was interesting to read the submissions on the issue, particularly the submission from NHS Lanarkshire. One issue that I homed in on as a matter of primary concern was that of how frequently people with pernicious anaemia should receive injections. There was a lot of debate and controversy about that in the submissions and in the oral evidence session. NHS Lanarkshire's submission said:

"Most patients who are on 3 monthly vitamin B12 will run with higher than population norms of vitamin B12 levels and these can easily be assayed. Were we to see a patient who ran with lower than normal levels despite 'a standard vitamin B12 supplementation' and particularly were they symptomatic, it would certainly be our guidance to consider increasing the frequency of B12 administration."

That perhaps explains some of the seeming inconsistencies. It certainly suggests that, at least in NHS Lanarkshire, clinicians are willing to look at the specific individual circumstances of a particular patient.

At the end of the day, we in the Parliament cannot give a definitive medical view and nor can the minister or his civil servants. It is up to the clinicians and the bodies to which I have referred to consider the issue. I hope that one outcome of the debate is that they will do so.

16:32

Kenneth Gibson (Cunninghame North) (SNP): The word "pernicious" originates from the Latin term "perniciosus", which means destructive and ruinous. Pernicious anaemia is insidious in nature and, if left untreated, can cause severe neurological deterioration, which affects the patient in everyday tasks and leaves them feeling helpless. The disease can be successfully managed and controlled, and even halted or reversed, with effective treatment and early diagnosis. However, many patients find treatment unreachable and inaccessible, especially if the diagnostic tests that are used are inadequate in identifying the condition. That is a major issue that we face.

The unreliable and restricted nature of the test often leads to misdiagnosis and uncertainty among patients. A negative result might not necessarily exclude pernicious anaemia, as the patient might not produce antibodies, because of the absence of the intrinsic factor, and so give a false negative result. That occurs in up to 40 per cent of patients who suffer from PA, which means that too great a proportion of patients are left battling the deteriorative condition without appropriate medical intervention.

New alternative diagnostic methods that offer a more reliable diagnosis are being developed and used. The parietal cell antibody method tests for antibodies that are produced by parietal cells, which manufacture the intrinsic factor. As we have heard, the test is positive in 90 per cent of PA cases. It directly examines the cells that are responsible for the absorbency of vitamin B12 in the small intestine. The new active B12 test provides a specific spectrum of results that directly co-relate with the action of vitamin B12 and which are impossible to obtain with the current test. The new test distinguishes between active B12, which plays a pivotal role in forming healthy red blood cells, and inactive B12.

In response to the petition, NHS Highland described the active B12 test as "an interesting diagnostic test" that

"ideally should be the subject of a Health Technology Appraisal."

The current test requires an overhaul, and more reliable and adequate techniques must be evaluated and considered by health boards and doctors. The unwillingness of some doctors to test for PA often causes delay and complications in detecting the disease.

Last year, there was an increase of 13 per cent in the number of patients who were diagnosed with the condition. As we have heard, patients may present with a series of common symptoms associated with PA, which are often misdiagnosed. The Pernicious Anaemia Society's survey showed that some 18 per cent of patients were misdiagnosed with depression and that 11 per cent were misdiagnosed with irritable bowel syndrome. John Wilson has revealed that his wife was also misdiagnosed. Delayed diagnosis damages patient-doctor relationships, undermining confidence in health professionals.

The recommended regime is 1mg of hydroxocobalamin administered every three months by intramuscular injections performed by a nurse. Health professionals are advised to adhere to that guideline; however, treatment varies from patient to patient, and general guidelines often do not meet individual needs. Many patients require more frequent injections, but some doctors are reluctant to vary the regime and, as a result, patients are resorting to other measures to obtain alternative treatment. Those include buying injections from the internet and purchasing online other sources of the medication, including sublingual lozenges, nasal sprays and ointments. Individually designed treatment courses would help to discourage patients from making harmful online purchases and would restore confidence in health professionals where it is lacking.

One of my constituents was recently diagnosed with PA and is concerned about his prognosis. After caring for his sick wife, who had the condition, he was unexpectedly struck down. It is our responsibility and duty to offer him, his wife and all other PA sufferers appropriate care and treatment that will be continually available.

I welcome this very important debate being brought to the chamber and congratulate the Public Petitions Committee on doing so.

16:36

Nanette Milne: This has been a useful and thoughtful debate in which pernicious anaemia and vitamin B12 deficiency have, at last, been highlighted and championed in the chamber. I mean no disrespect to the Parliament when I say that it is significant that the issue has not been relegated to a members' business debate, which is sometimes a twilight zone, but has been brought by the Public Petitions Committee to a full meeting of the Parliament.

I welcome the Government's acceptance of PA as a serious condition and its commitment to early diagnosis. I also welcome Malcolm Chisholm's emphasis on the partnership approach to the management of long-term conditions. In the few minutes at my disposal, I will concentrate on the treatment of PA.

In her petition, Mrs MacArthur speaks of how her doctor allowed her to try vitamin B12 injections, as she presented with all the symptoms

of PA. Sadly, that is not the experience of all patients. Members will have read on the website of the Pernicious Anaemia Society—an organisation that, like others, does tremendous work—of the concerns of many patients who have been told that B12 injections are not justified because they are not deficient enough. Other members have spoken of how testing does not lead to effective treatment. The petition makes it clear that adopting the new active vitamin B12 test would achieve early diagnosis.

Although pernicious anaemia is still treated by vitamin B12 injection, the frequency of administration has changed significantly over the years. When I was in clinical practice, the injections were given monthly. I had not realised that the situation had changed until the committee was told that, in 1974, the frequency was changed to every two months and that, in the 1980s, the frequency became every three months. Apparently, the medicine did not change in any way, and no explanation was given for the change to the frequency of administration. In France, where vitamin B12 can be bought at the same strength from any pharmacy—I do not know whether it is to be taken orally or by injection—the literature that comes with it states that it should be taken monthly. It appears that people in France are getting three times as much treatment as people in the United Kingdom and we do not understand why.

A number of important questions need to be asked and, despite what Malcolm Chisholm said, it is a matter for the Government as well as for medical bodies north and south of the border. Having heard the debate this afternoon, and given the disparities in treatment throughout the UK, does the minister accept that it would be at least useful to learn more about the serious issues surrounding PA and its future diagnosis and treatment from all stakeholders? Will he commit to setting up discussions between his civil servants and those in other parts of the UK to establish some clarity and commonality for patients throughout the country?

I close by adding my thanks and gratitude to Andrea MacArthur for bringing the issue to the Parliament's attention. While coping with pernicious anaemia, she has dedicated a considerable amount of her time to helping others by achieving the recognition that this serious and important condition deserves.

16:40

Jackie Baillie (Dumbarton) (Lab): Like others, I welcome the debate. I congratulate the Public Petitions Committee and David Stewart on bringing the petition to the chamber for debate, and I join others in congratulating Andrea MacArthur, the principal petitioner.

The problem with following all my esteemed colleagues, including members of the committee, is that they have covered it all. However, I will do my best to fill the four minutes that I have been given.

At the heart of the petition is the call for the Government to review and overhaul the method of diagnosing and treating pernicious anaemia, or vitamin B12 deficiency. I understand that, in the western world, the frequency of pernicious anaemia is estimated at 127 cases per 100,000 of population and that prevalence increases with advancing age. As we heard, diagnosis is usually made using a blood test but, as Nanette Milne outlined, it is only about 30 per cent reliable. The alternative test that has been developed—the active B12 test—is much more accurate, but it does not appear to be routinely used in Scotland, and GPs are not issued with specific guidance in that regard.

The Government's response to the Public Petitions Committee was that GPs should be able to diagnose and manage any patient with pernicious anaemia as a matter of course and that

"Healthcare professionals are expected to follow agreed local and national guidelines which are complemented by the agreed pathways in NHS Boards".

Although I welcome much of what the minister said, John Wilson was right to suggest that people's experience highlights the fact that treatment is inconsistent and that there are delays in diagnosis.

I was struck by Richard Simpson's comment about the survey by the Pernicious Anaemia Society. If 47 per cent of those who were surveyed said that they waited at least two years for a diagnosis, it surely tells us that there is a problem.

It appears to me that the nub of the problem is that there are no adequate guidelines and that there are major failures in diagnosis, so treatment is delayed. Kenneth Gibson touched on the consequence of the lack of adequate guidance. Of course, the condition worsens, but in addition the neurological problems increase, which affects people in doing their everyday tasks. It would be so much better to prevent that from happening in the first place.

It seems that, on our journey of discovery about the condition, many of us visited the Royal College of General Practitioners website. It mentions management of the condition and asks whether practices maintain a database of patients with a diagnosis. It gives advice on testing, some of which is outdated, as Richard Simpson pointed out. It mentions an annual review including a full blood count and thyroid function and blood

glucose tests, and it even mentions a system of identifying when injections are overdue. That information was provided in November 2003. It even mentions data collection and benchmarking, but if that is done, I am not sure whether the Government collects the information or whether any information that is collected supports the contention of this position.

I always listen carefully to Richard Simpson. He called for SIGN guidelines because we know that they drive better diagnosis and treatment. I respectfully ask the minister to review the research and to ask the clinicians to bring forward SIGN guidelines so that we have clarity. That will ensure that patients' experience of the diagnosis and treatment of pernicious anaemia is improved.

The Deputy Presiding Officer: Thank you. I had every confidence that you would use your four minutes.

16:44

Michael Matheson: This has been a useful debate and I welcome the contributions that members have made.

As I mentioned in my opening speech, we are committed to ensuring that people with pernicious anaemia and vitamin B12 deficiency are detected as quickly as possible to ensure that any risk of complications is minimised. However, the evidence that the Public Petitions Committee gathered suggests that there is still uncertainty about the optimal means of detecting and diagnosing pernicious anaemia. That issue was also raised by Richard Simpson.

As Jackie Baillie said, we expect general practitioners to be able to identify pernicious anaemia. It is not for me to defend what is on the Royal College of General Practitioners website but, as Richard Simpson highlighted, the royal college has noted that B12 deficiency could cause a wide range of symptoms, which can make diagnosis challenging for a GP.

I reassure members that we are committed to ensuring that NHS Scotland provides the latest and most effective diagnostic tools and treatment once their clinical effectiveness has been demonstrated. However, perfect diagnostic tools are not always available in medicine.

Kenny Gibson highlighted some of the progress on new tests that are being developed. Our chief scientist office would be pleased to consider innovative research proposals that are of a sufficiently high standard on investigating further diagnostics and treatments for vitamin B12 deficiency and pernicious anaemia. As for further research, I understand that the Pernicious Anaemia Society is leading research at Cranfield University to identify the ideal dosage and frequency of vitamin B12 therapy.

Once a diagnosis has been confirmed, the care arrangements—which will in many cases involve input from the person's GP, possibly a specialist and other healthcare professionals—will usually be agreed with input from the patient. We would expect the patient to be at the centre of that process.

The vast majority of people who are diagnosed with pernicious anaemia are getting the treatment that they require, but I understand that some members of the Pernicious Anaemia Society have expressed concern about the frequency of their treatment regimes and report on-going symptoms prior to their next injection. In such circumstances, we would expect patients to be referred to a specialist.

I am sure that all members recognise that clinical decisions about an individual's treatment are a matter for clinicians to decide, in partnership with their patients. However, I was concerned to hear that some members of the Pernicious Anaemia Society were resorting to B12 treatment outwith the NHS in order to obtain additional injections. I am sure that all members of the Parliament agree that that should not happen. A treatment regime should be determined by the patient in close consultation with their clinician. If patients find themselves in the situation that has been described, clear processes are in place in the NHS to revisit and reconsider matters, and I encourage patients to use those processes.

Several members referred to guidance. I understand that the British committee for standards in haematology will publish a guideline on the diagnosis of B12 and folate deficiency later this summer. That comprehensive document will look at optimal diagnosis, management and frequency of treatment of pernicious anaemia. Comments from the Royal College of General Practitioners in Scotland indicate that it would welcome access to such updated guidance. I am happy to undertake to draw the new guidance to the attention of relevant clinicians in the NHS in Scotland, which will—importantly—include our general practitioners. Following the publication of the guidance, I will be more than happy to ask Healthcare Improvement Scotland to look at further measures whereby it can assist in taking forward programmes to help staff to understand more about the issues that relate to the condition.

We believe that the vast majority of people who are diagnosed with pernicious anaemia receive the care that they require, but we are committed to supporting on-going improvements. Therefore, in addition to highlighting the latest guidance, we will continue to engage with general practitioners on accessing education and information on the

symptoms and management of pernicious anaemia.

I invite the Pernicious Anaemia Society to work with NHS inform to help it to ensure that the information on its website for patients with the condition is as up to date and appropriate as possible.

Several members have referred to SIGN guidelines. It is my understanding that SIGN has no plans in its present work programme to consider guidelines in this area. I say respectfully to Jackie Baillie that it is not for ministers to tell SIGN which guidelines it should issue. I have no doubt that Jackie Baillie is aware of that. However, I am more than happy to ensure that the content of this debate is brought to the attention of SIGN so that it can reflect on the views that members across the chamber have expressed.

I am grateful to the Public Petitions Committee for bringing forward the debate, and I hope that I have given some reassurance that the Scottish Government is committed to continue trying to improve services for patients with pernicious anaemia and vitamin B12 deficiency.

The Deputy Presiding Officer: I call Sandra White to wind up the debate. You have eight minutes, Ms White.

16:51

Sandra White (Glasgow Kelvin) (SNP): Thank you, Presiding Officer. I think that the time has gone from seven minutes to eight minutes, but I have made a couple of additions to my speech, so I hope that I can look forward to taking eight minutes.

It has been an excellent debate. Like the previous debate this afternoon, it illustrates the breadth of issues and experiences with which parliamentary committees are involved. I congratulate the petitioner, Andrea MacArthur, on her tenacity in pursuing the issue and I thank the members of the Public Petitions Committee and the committee staff, as well as members of other committees, for their help and contributions.

Vitamin B12 deficiency has become a serious issue that deserves our attention and action by all agencies. Like Nanette Milne, Dr Richard Simpson spoke on the issue, and I bow to his knowledge of it; his speech was excellent. Vitamin B12 deficiency is closely related to pernicious anaemia and is an illness that has confused many GPs, largely because its signs and symptoms are often linked to a number of other illnesses, such as multiple sclerosis.

I commend John Wilson for raising in his speech the connection between MS and pernicious anaemia, the inconsistency of treatment and the fact that one size does not fit all patients. We need to consider that issue. Some health boards might produce a plan for a patient, but that does not necessarily mean that it will fit or suit all patients.

We must highlight the fact that the testing for vitamin B12 deficiency has not been as accurate or effective as it should be. A number of members made that point in their speeches. As I indicated, the testing frequently results in misdiagnosis. The minister said that the Scottish Government wants diagnoses of pernicious anaemia to be made as quickly as possible. I welcome that view and I will return to the minister's closing speech later.

As the committee's report indicated, the rates of vitamin B12 deficiency are far too high throughout Scotland. As the minister and Nanette Milne outlined, a number of groups are particularly at risk of vitamin B12 deficiency, including those over the age of 60, people with an auto-immune condition and those with a family history of pernicious anaemia. Such people may be in need of medical treatment for the condition. In Northern Europe in total, one in 10,000 people is at risk of suffering from vitamin B12 deficiency. Such an incidence is far too high, so we must strive to promote awareness of the illness and work towards a credible solution for dealing with it.

As has been mentioned, a first step was taken in that regard by the debate in the Public Petitions Committee in November 2011, when Andrea MacArthur presented her petition on the issue of vitamin B12 deficiency and its treatment. Mrs MacArthur alerted me and a number of my colleagues to the issues regarding the identification and prevention of the disease. She has been a champion in the fight against vitamin B12 deficiency.

In the committee, we touched on many topics to do with vitamin B12 deficiency. The convener of the committee has already mentioned the lack of attention that is paid to the issue. Mrs MacArthur stated:

"Treatment of the condition is ... consistently bad".—[*Official Report, Public Petitions Committee*, 15 November 2011; c 228.]

The convener of the committee also raised that issue. Such a statement brings to light the fact that there really is a problem that demands our immediate, utmost attention.

Members have said that the committee received mixed responses from various health services. The response from NHS Highland—I think that Kenny Gibson mentioned it—was basically entirely different. It agreed that the issue deserved attention and that reform was needed, but Greater Glasgow and Clyde NHS Board did not seem to sense the need to change the testing or medicine for vitamin B12 deficiency. It is rather strange that

two NHS boards reached two different conclusions on a very important issue.

I want to touch on something that Kenny Gibson and Nanette Milne mentioned—I think that another member mentioned it, too. The lack of testing and misdiagnosis are important. People can have multiple illnesses, but they can be misdiagnosed. In his closing speech, the minister mentioned people who suffer from vitamin B12 deficiency and pernicious anaemia and have to go outwith their doctor's surgery and access vitamin B12 injections from another source. That is worrying and telling.

The lack of acknowledgement from national sources prevents information from getting into the public domain and slows the spread of awareness about B12 deficiency. That is one of the key problems. As I mentioned to the committee—John Wilson raised a similar issue—one of my friends suffers from B12 deficiency. I do not think that she was aware of what was happening to her body and to other people. This debate is a fantastic first step in raising the issue of B12 deficiency and pernicious anaemia.

I have much more to say, but perhaps only a minute and a half in which to say it. I will therefore touch on the Schilling test, which Dr Richard Simpson mentioned. He said that the test was mentioned on the website of the Royal College of General Practitioners, but that it should have been taken off because it is no longer used. No accurate test has been used as a replacement. I think that Dr Simpson also mentioned the active B12 test. We could use that, and it is much cheaper. NHS Highland said that that would be a better way of going forward and acknowledging the problem with the current testing process. It accepts that

"the diagnosis of B12 deficiency is not foolproof",

but that we should use the active B12 test. It said:

"The Active-B12 Test ... is clearly an interesting diagnostic test".

I want to pick up on some of the issues that the minister raised in his closing speech. I welcome his comments, the fact that the chief scientist office would look forward to having input into more research—the petition proposes that—and his comments on the Pernicious Anaemia Society taking part in that. Patients should be at the centre of treatment—I have mentioned that before—although some patients have worries about that. The minister raised that issue.

I look forward to the updated guidelines. The minister mentioned that he would produce updated guidelines and speak to the Pernicious Anaemia Society. There is also the involvement of Healthcare Improvement Scotland.

The petition urges the undertaking of a review of the current situation. The minister has answered some of the questions. On behalf of the committee, I ask him to consider the petition further, and I look forward to the review of the current situation.

Business Motions

16:59

The Presiding Officer (Tricia Marwick): The next item of business is consideration of business motion S4M-02234, 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 14 March 2012

1.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Stage 1 Debate: Land Registration etc. (Scotland) Bill
followed by	Stage 1 Debate: Alcohol (Minimum Pricing) (Scotland) Bill
followed by	Financial Resolution: Alcohol (Minimum Pricing) (Scotland) Bill
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.30 pm	Decision Time
followed by	Members' Business

Thursday 15 March 2012

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Liberal Democrats Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Finance, Employment and Sustainable Growth
2.55 pm	Stage 1 Debate: National Library of Scotland Bill
followed by	Scottish Government Debate: Local Government Finance (Scotland) Amendment Order 2012 [draft]
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 21 March 2012

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 22 March 2012

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 Rural Affairs and the Environment; Justice and the Law Officers
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 business motion S4M-02238, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out an extension to the timetable for stage 1 of the Alcohol (Minimum Pricing) (Scotland) Bill.

Motion moved,

That the Parliament agrees that the deadline for consideration of the Alcohol (Minimum Pricing) (Scotland) Bill at Stage 1 be extended to 16 March 2012.—[*Bruce Crawford.*]

Motion agreed to.

Parliamentary Bureau Motions

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of two Parliamentary Bureau motions. I ask Bruce Crawford to move motion S4M-02239, on the referral of a Scottish statutory instrument to the Parliament, and motion S4M-02240, on committee membership and substitutions.

Motions moved,

That the Parliament agrees that the Local Government Finance (Scotland) Amendment Order 2012 [draft] be considered by the Parliament.

That the Parliament agrees that—

James Dornan be appointed to replace Bill Walker as a member of the Local Government and Regeneration Committee;

Angus MacDonald be appointed to replace Bill Walker as a member of the Public Petitions Committee; and

Dave Thompson be appointed to replace James Dornan as the Scottish National Party substitute on the Finance Committee.—[*Bruce Crawford.*]

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

Decision Time

17:01

The Presiding Officer (Tricia Marwick): There are four questions to be put as a result of today's business. The first question is, that motion S4M-02175, in the name of Duncan McNeil, on the Health and Sport Committee's report on its inquiry into the regulation of care for older people, be agreed to.

Motion agreed to,

That the Parliament notes the conclusions and recommendations contained in the Health and Sport Committee's 3rd Report, 2011 (Session 4): *Report on Inquiry into the Regulation of Care for Older People* (SP Paper 40).

The Presiding Officer: The next question is, that motion S4M-02185, in the name of David Stewart, on petition PE1408 on the understanding and treatment of pernicious anaemia and vitamin B12 deficiency, be agreed to.

Motion agreed to,

That the Parliament notes petition PE1408 in the name of Andrea MacArthur on the issue of vitamin B12 deficiency and pernicious anaemia; congratulates the petitioner on her efforts to highlight what it considers to be a concerning issue, and commends the issues raised in the petition to the Scottish Government for further consideration.

The Presiding Officer: The next question is, that motion S4M-02239, in the name of Bruce Crawford, on the referral of a Scottish statutory instrument, be agreed to.

Motion agreed to,

That the Parliament agrees that the Local Government Finance (Scotland) Amendment Order 2012 [draft] be considered by the Parliament.

The Presiding Officer: The next question is, that motion S4M-02240, in the name of Bruce Crawford, on committee membership and substitutions, be agreed to.

Motion agreed to,

That the Parliament agrees that—

James Dornan be appointed to replace Bill Walker as a member of the Local Government and Regeneration Committee;

Angus MacDonald be appointed to replace Bill Walker as a member of the Public Petitions Committee; and

Dave Thompson be appointed to replace James Dornan as the Scottish National Party substitute on the Finance Committee.

Gadburn School

The Deputy Presiding Officer (Elaine Smith): The final item of business is a members' business debate on motion number S4M-01982, in the name of Humza Yousaf, on saving Gadburn school. The debate will be concluded without any question being put.

Motion debated,

That the Parliament notes with concern the decision by Glasgow City Council to close Gadburn School, which teaches children in the north east of Glasgow who have additional support needs; understands the importance of additional support schools with regard to the wellbeing and education of many of Scotland's young people and believes that the parents and teachers of these young people are best placed to understand the children's educational needs; commends the parents of the Gadburn pupils for what it considers to be their tireless campaign in trying to keep the school open and secure adequate educational facilities for children with additional support needs, and believes that the decision-making process for the future of Gadburn has been flawed.

17:03

Humza Yousaf (Glasgow) (SNP): It is a pleasure to hold my first members' business debate since being elected to the Scottish Parliament on such an important issue.

I have just come from a meeting where I had the honour of hosting Nobel peace prize winner Muhammed Yunus, who has earned accolades throughout the world for tackling poverty. A key theme of that meeting centred on the famous saying that a nation's greatness is measured not by the strength of its economy or military might but by how it treats the most vulnerable in its society. All members will sign up to such a sentiment and many of us will agree that children with disabilities or learning difficulties certainly fall into that category.

Gadburn school is located in the north-east of Glasgow. It does an excellent job of educating some of the most vulnerable young people in our city. However, the parents and—more important—the children of Gadburn now face an uncertain future due to a process that has, largely, treated them as an afterthought.

I thank members from across the Parliament for their support for the motion. The fact that it has received support from members of the Labour Party, whose colleagues in Glasgow City Council took the decision to close Gadburn school, shows that there is a common desire to secure the best outcome for the children of Gadburn and to meet their educational needs. For that, I give them thanks.

From the outset, it is important to note that the parents of children at Gadburn are not opposed to integration or mainstreaming as such, but they believe that the children must be placed at the centre of any such decision. The fear that is continually expressed by the parents is that Glasgow City Council's decision to relocate Gadburn has been taken for financial reasons and is not in the best educational interests of the children.

A survey of the parents of children at Gadburn showed some very worrying statistics. It found that more than a third of the children reported having being bullied—that included being spat or urinated on—more than 45 per cent of them had been removed from mainstream school because the system could not cope, and almost 10 per cent had been assaulted, some physically and some sexually. The additional support and educational facilities that Gadburn provides are essential for those young people. Parents of Gadburn pupils say that the education that is provided at the school is working and is producing positive results for their children, and they are undoubtedly best placed to understand their children's educational needs.

The process of consultation and the way in which the council has dealt with Gadburn school have been mired in controversy and full of sleights of hand and rushed agenda items that have suddenly appeared on or disappeared off committee minutes. It is for that reason that I join local councillors in asking the cabinet secretary, unequivocally, to call in the council's decision and save Gadburn school.

It is a telling sign that, months before what will be a hotly contested local election in Scotland's largest authority, local councillors of all parties, led by the Scottish National Party's Grant Thoms, have joined together to oppose the ruling administration's decision to shut Gadburn school.

The executive committee of Glasgow City Council first considered the closure of Gadburn school at its meeting on 9 December 2010. That triggered a statutory consultation on the closure of the school in January 2011, which ended on 4 March of last year. In the intervening period, parents of pupils at Gadburn, along with parents of pupils at Barmulloch primary—where the council hoped to relocate the special needs pupils—local councillors and council officials had a number of discussions on the way ahead.

The original plan was that the consultation responses and the recommendation to close Gadburn were to be presented to the executive committee on 23 June, but the agenda item was removed at short notice—no explanation was given, even to elected members.

From October to late November, local councillors gained the confidence of the Gadburn

parent council on agreeing a compromise solution to prevent the closure of Gadburn school and, instead, to relocate it within Barmulloch primary as a stand-alone school. The intention was to work towards the integration of the two schools over a longer period—three to four years, say. In addition, parents were told time and again by council officials that there was no rush to make a decision on Gadburn.

Therefore, it came as a shock to everyone when a report recommending the closure of Gadburn was presented at the council's executive committee in December last year. The administration rejected calls for local councillors to be able to complete discussions and reach a consensus whereby Gadburn school could be relocated within the buildings of Barmulloch primary but remain a separate school. At the time, the administration stated that some of the councillors in the ward did not agree with the continuation of discussions, but after consultation with all the councillors for the ward, it was clear that no such indication had been given, and the decision to close Gadburn school was called in to the council.

When the call-in was heard on 12 January of this year, it was decided that if, and only if, discussions could not resolve the matter, consideration would be given to having Gadburn as a separate school within Barmulloch primary. However, when the executive committee reconsidered the matter a few days later, it inexplicably reaffirmed its decision to close Gadburn school. Even now, the parents of pupils at Gadburn do not know where their children will be—whether in a separate classroom, a Portakabin or elsewhere—when the new term starts. So much uncertainty is clearly the last thing that they need.

I put on record my admiration for the parents of children at Gadburn school for their tireless campaign. It has been a tough and constant slog having to fight against the machinery of Glasgow City Council—at times, getting answers from the Kremlin would be more likely.

I would not want to get on the wrong side of two of the parents, Isabel Kelly and Sandra Martin—I am told that she is no relation of Paul Martin MSP. They have been passionate and driven—as any parent would be—in trying to secure the best future for their children.

Members who are in the chamber agree that the process has been flawed. It seems that parents and children have been an afterthought in Glasgow City Council's rush to cut the finances and balance the books. I urge the cabinet secretary to call in the decision and give hope to those who are fighting for the most vulnerable in our community.

17:10

Paul Martin (Glasgow Provan) (Lab): I congratulate Humza Yousaf on bringing this important debate to the chamber. Like him, I welcome the parents who have joined us this afternoon.

It is important that we recognise that, for more than a year now, the parents at Gadburn school have sought to play a major part in shaping the future of their children's education. I would not fault them for being—on many occasions—robust, outspoken or difficult in order to ensure that their children's complex needs are met. In my dealings with Isabel Kelly and Sandra Martin—she is not a relative of mine—I have found their arguments to be cohesive, intelligent and robust.

I am afraid that the same cannot be said of the education officials in Glasgow City Council. They have failed on a number of occasions to recognise the scale of the parents' concerns, and they are unwilling to negotiate with the parents on an equal basis. It is another David and Goliath story—one that has highlighted a number of poor practices that exist throughout Scotland with regard to how education authorities consult parents.

We need to be clear that the decision is one for Glasgow City Council, regardless of the minister's decision on whether to call it in. I welcome the fact that—as Humza Yousaf said—we have taken a cross-party approach in representing the parents at Gadburn.

Councillor Leonard and Councillor Davidson, who are Labour councillors, have been working closely with Councillor Thoms, who is a local SNP councillor. The councillors have met with education officials on numerous occasions to try to resolve the various differences that exist.

For many of the parents, the main issue—as Humza Yousaf highlighted—is that they no longer have confidence in mainstream education. Their children been poorly supported during the whole process, leading to some of the issues that have been raised, such as children being bullied and parents finding it difficult to feel sure that their children will be able to continue in mainstream education.

I have met the parents on a number of occasions and advised them that I am an advocate of ensuring that children are given a fair chance to access mainstream education—an ethos with which I think many members in the chamber would agree.

I have learned from the Gadburn parents that, as Humza Yousaf suggested, the issue is not as straightforward as it seems. Given the parents' preference for special needs provision, the proposed move to Barmulloch primary school is

perhaps the way forward. Of course, the parents' first preference is for Gadburn school to remain open. However, if possible, they want a separate educational establishment at Barmulloch, given the possibility that the establishments could consider integrating in future.

The parents' requests are not unreasonable, given the circumstances in which the parents find themselves. We must consider their requests alongside the request from members today for the minister to call in the decision.

We in this Parliament should show leadership. We should call on the education officials to work closely with the local elected members to ensure that the interests of the parents—and, more important, the interests of the children—are paramount in making progress on the issue. [*Applause*.]

The Deputy Presiding Officer: I remind visitors to the Parliament that they should not applaud. I respectfully ask them to desist.

17:15

Annabel Goldie (West Scotland) (Con): I am pleased to speak in the debate, and I thank Humza Yousaf for bringing the issue before the Parliament. Gadburn school is outwith my region of West Scotland, but I am speaking on behalf of my colleague, Ruth Davidson, who is unable to attend.

Ruth Davidson gave her support to Humza Yousaf's motion after receiving correspondence from constituents who are concerned parents of children at Gadburn, and my colleague, Councillor David Meikle of Glasgow City Council, has written to the Scottish Government expressing his concerns.

Gadburn is a non-denominational primary school, catering for children aged four to 12 years. It has a roll of 33, and meets the needs of children with additional learning needs, including some with autism spectrum disorder. I understand that the council proposes to close the school by August 2013, and to offer, as we have heard, additional support for learning provision in Barmulloch primary. There is clearly an apprehension that Glasgow City Council education department's plans to shut Gadburn have been too hasty, and most parents are naturally fearful about the impact that integration with a mainstream primary will have on their children.

In early 2011, the city council launched an official consultation into the future of the two schools, in which it outlined its plan to move the children at Gadburn to the new unit in Barmulloch primary. According to the consultation paper, measures would be taken to ease the transition, but it is instructive to note that of the 67 responses, only 15 supported the plan, while 45 were against and seven unclear. It is disappointing that the council then took the decision on 27 January of this year to close Gadburn school.

The early years are an important time for children's physical, emotional, educational and social development, Parents naturally want the very best for their children, including a schooling environment that supports their needs. Schools such as Gadburn aim to educate pupils who require additional support in a way that addresses those pupils' individual differences and needs. That might include adapted equipment and materials, accessible settings and other interventions designed to help children who require additional support to achieve a higher level of self-sufficiency and success than if they were given access only to a typical classroom environment and education. Humza Yousaf's description of some of the young people's experiences is disturbing.

"Gadburn School Handbook" states:

> "The pupils learn in a highly structured, ordered environment designed to reduce anxiety and prevent distraction. A clearly defined, predictable routine is followed throughout the day."

I can see, therefore, why Gadburn parents have genuine fears that a change in the school setting will be a seriously disruptive upheaval for their children. Ruth Davidson and I understand that the closure of a school, particularly one that provides additional support to students, is a sensitive subject. I know that the parents at the school have campaigned tirelessly to try to prevent the closure, and I sympathise with their concern about Glasgow City Council's decision. There are significant concerns about the council's decision-making process, and I urge the minister to listen to the parents' legitimate concerns, heed these children's very particular needs, and call in the decision. I support the motion.

17:19

James Dornan (Glasgow Cathcart) (SNP): Like other members, I am delighted to congratulate Humza Yousaf on securing the debate. I had a similar situation with a school in my constituency but, unfortunately, it did not have the time and ammunition that Gadburn has to ask the minister to call in the decision. If there is a lesson to be learned from that situation, it is for Glasgow City Council. If it wants to close down an additional support for learning school without getting into the current process, it should do so by making the decision on the last day of term—for both the school and the council—so that the parents are not allowed the opportunity to get together and campaign as the parents have done

in the case of Gadburn school. Those parents should be congratulated. There is nobody in Glasgow who does not know about the parents and pupils of Gadburn school and the work that elected representatives such as Grant Thoms have done to defend the school.

Humza Yousaf talked about some of the conditions that the kids have had to put up with in Gadburn. When I was dealing with St Raymond's school, parents told us that one child had had to up his dose of antidepressants by three times since the threat of closure was made at the school. Parents at St Raymond's told me that—as Humza Yousaf said about children at Gadburn—their kids were taken out of mainstream schooling because it would not work for them and it was a danger to their own health and that of others.

There is clearly a process at play. I have been concerned for some time about the way in which Glasgow City Council education department has looked at ASL schools in Glasgow. It came home to me when St Raymond's was affected, but I have known about Gadburn for some time and, in addition, nobody seemed to be very happy about a restructuring of schools that took place a couple of years ago.

In the case of St Raymond's, Glasgow City Council education department made the final decision to close the school just prior to Christmas and kept the parents in the dark at all times. The only time that the parents heard anything was when somebody from the *Evening Times* informed them or I managed to get information from a letter or whatever. The parents were not kept informed at all. The method of communication was to put a letter in a school bag of a child with special needs. How can that possibly be the right way to communicate with parents who must know what is going on at all times for the benefit of their children?

I agree with Paul Martin that there must be a look at the way in which Glasgow City Council education department deals with such situations. It has a duty of care not only to its staff but to every child who goes through the doors of its schools and, in particular, to children who go to schools such as Gadburn or went to schools such as St Raymond's.

To some extent, the situation at St Raymond's had a wee bit of a happy ending for some of the parents involved, because the ones who made the most noise got preferential treatment. Glasgow City Council education department went out of its way to ensure that their children got to go to the school of their choosing. However, what about the other parents who were not as voluble and determined? What about those who thought that such closures are just what happens and did not believe in fighting authority?

Glasgow City Council education department has a crucial role in such situations, which should be to first and foremost look after the welfare of the children. I do not think that it is a coincidence that the Gadburn children are being moved to Barmulloch primary school when Barmulloch is only one third full; surely if it is only one third full, there is scope for a stand-alone Gadburn in that school. Like Humza Yousaf, I urge the cabinet secretary to call in the decision.

17:23

The Cabinet Secretary for Education and Lifelong Learning (Michael Russell): I congratulate my good friend Humza Yousaf on securing the debate.

As members would expect, how we ensure that all our children and young people are given the support that they need to realise their potential is a subject with which I am very engaged.

I welcome the parents and representatives of Gadburn school. I have been involved in the issue of school closures for all of my political life. The Presiding Officer is right to say that people in the gallery should not applaud, but she will allow me to applaud those who are fighting for their school.

Last year, we published a refreshed Government economic strategy. It reaffirmed our central purpose of making Scotland a more successful country, with opportunities for all to flourish through increasing sustainable economic growth. I make that point because key to the delivery of that purpose is an education system that unlocks the true potential of every child. A child's education is affected by a wide range of issues: social, emotional, environmental and even genetic. However, it is also affected, axiomatically, by his or her school.

Legislation such as the Education Scotland Act 1980, the Standards in Scotland's Schools etc Act 2000, the Education (Additional Support for Learning) (Scotland) Act 2004 and the Equality Act 2010 have enshrined the right of every child to receive the support that they need to access learning. The curriculum for excellence is providing a framework for all our young people to gain the knowledge and skills for learning, so we know that prospects are bright for our young people. The most important principle is to meet the needs of the individual pupil in the most appropriate setting for them. That is true for all children; it is particularly true for children who have additional support needs.

Today we are debating the future of Gadburn school, which provides for children with such needs. As we heard, members are passionate about the positive impact that the school is having on young people. Glasgow City Council has taken

the decision to close Gadburn and transfer the children to new specialist provision at the neighbouring Barmulloch primary school. I understand the widespread concern that the decision has caused, particularly given the questions that have been asked about the process.

As I have said many times in the Parliament, sometimes schools have to close. Communities change, populations move and sometimes buildings become unsuitable. However, I am entirely clear that common decency as well as good practice demands that a closure must attempt to command public confidence. At the very least, the process of decision making must be inclusive and transparent.

All proposed school closures result in worry, anger and resentment for the pupils, parents and staff who are affected. I have been through school closures—I have seen and suffered them at close quarters. The effect is made much worse when schools are closed without proper and full consultation with the communities that they serve.

That is why this Government introduced the Schools (Consultation) (Scotland) Bill, which was agreed to unanimously by the Parliament in November 2009—the bill united the Parliament. The Schools (Consultation) (Scotland) Act 2010 is intended to make the consultation process for the proposed closure of any school open, transparent and fair. The Government sought to increase local participation, ensure that there is genuine dialogue and foster a sense of trust between local authorities and the people whom they serve.

The 2010 act established a more formal role, by means of a safeguard whereby ministers are able to call in decisions in relation to which they perceive serious flaws in the consultation or decision-making process. The call-in can be triggered by community or parental request, but such requests have to outline a flaw in process. The key word is “process”. The 2010 act is not about prejudging or second-guessing a local authority’s decision; it is about ensuring that the process, as enshrined by statute, has been carried through properly and correctly.

Since the 2010 act was passed, it is fair to say that a number of school closures, particularly of rural schools, have given me great cause for concern. That is why, in June, I established the commission on the delivery of rural education, to consider and make recommendations on the 2010 act. I am grateful to the Convention of Scottish Local Authorities for agreeing to a moratorium on rural school closures while the commission undertakes its work—although we should note that a presumption against the closure of rural schools is written into the 2010 act. Since the establishment of the commission, no contested closure of a rural school has taken place.

The commission is currently taking evidence and I was encouraged to hear the constructive and active participation of the local community at the commission’s evidence session at Lochgilphead last night. The commission has arranged several more meetings, so that it can take evidence from rural communities across Scotland. I encourage parents and other interested stakeholders to attend whenever they can. I look forward to receiving the findings of the commission in August. I think that its work will greatly improve the process of consultation on all closures and I hope that it will restore confidence in the 2010 act throughout Scotland’s communities.

Gadburn is not a rural school. Indeed, Glasgow is the one local authority in Scotland that has no rural schools, by the definition that we operate. However, the school is vital to the community and the young people whom it serves, and I take every proposed school closure seriously.

Glasgow City Council notified me formally of its decision to close Gadburn school on 27 January. The 2010 act allows a three-week period for representations to be made to the Scottish ministers and a further three weeks to enable me to consider representations and reach a decision on whether to call in the council’s school closure decision.

I have received 19 representations from parents of children at Gadburn school, setting out their concerns about Glasgow City Council’s proposals and asking that I call in the decision. I have also received letters from the local councillor, Grant Thoms, from Glasgow MSPs Paul Martin, Patricia Ferguson and, of course, Mr Yousaf, and from the Westminster MP, Margaret Curran. I have carefully considered the representations that I received and I can announce that I have decided to call in Glasgow City Council’s decision to close Gadburn school, for further investigation. The council was informed this afternoon of my decision. A copy of the letter will be published on the Scottish Government website tomorrow.

Given that it is now for Scottish ministers to determine the matter of process, I am sure that members will understand that I cannot comment further on the case. To do so could be seen as prejudicing the decision that I now have to make. However, I can assure all members, stakeholders, Glasgow City Council and the school community that, in reaching my decision, I will consider very carefully all the information that has been put to me.

Meeting closed at 17:30.

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