The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 29 May 2013

Session 4

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Scottish Parliament

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[The Deputy Presiding Officer *opened the meeting at 14:00*]

Portfolio Question Time

Finance, Employment and Sustainable Growth

"Managing early departures from the Scottish public sector"

1. Mary Scanlon (Highlands and Islands) (Con): To ask the Scottish Government what action it is taking in the light of the findings of the Audit Scotland report "Managing early departures from the Scottish public sector". (S4O-02165)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): As that Audit Scotland report highlights, many public bodies have decided to run voluntary exit schemes as one way of reducing costs at a time when the United Kingdom Government has made significant reductions to the Scottish budget.

Voluntary exit schemes deliver significant year-on-year savings to the public purse, while providing public sector staff with security of employment at an economically challenging time. Under the civil service compensation scheme, costs are recouped in two years, with recurring annual savings thereafter. As an example, estimated savings from the Scottish Government's voluntary exit schemes between 2009-10 and 2011-12 amount to around £73 million a year.

The report provides a useful reminder of the principles of good practice in managing early departures, and it confirms that bodies across the public sector are applying those principles. I encourage all bodies to reflect on Audit Scotland's advice to ensure that we continue to demonstrate best practice in the area.

Mary Scanlon: I thank the cabinet secretary for emphasising in his response the principles of good practice, with which, I am sure, we all agree.

Why did the Scottish Government approve the Scottish Enterprise early departures scheme when that scheme did not meet the guidance in the Scottish public finance manual, and resulted in the average cost of early departure for Scottish Enterprise employees being almost £100,000 more than the average for Scottish Ambulance Service employees?

John Swinney: I will make two points in response to Mary Scanlon's question. First, Scottish Enterprise has made it clear that it has concerns about the presentation of elements of the information that has been supplied by Audit Scotland, which it considers could confuse the reader about the facts and the substance behind the points. I make that point for the record.

Secondly, a factor that is material to Scottish Enterprise's position being different from the positions of other parts of the public sector is that all the voluntary severance schemes must respect the terms and conditions on which members of staff have been employed. It is inevitable that circumstances differ between one public sector organisation and another, so terms and conditions are not uniform. That explains why there are differences in the settlements that are arrived at. They are driven by the requirements of contractual terms that all public sector bodies must respect—which, I am certain, Mary Scanlon will understand.

Ken Macintosh (Eastwood) (Lab): The Audit Scotland figures appear to be even worse than those in Labour's freedom of information investigation. It seems that the Scottish Government is spending more than 10 times as much putting people out of work than it is on getting them into work.

The Audit Scotland report specifically criticises early departure schemes that are driven by short-term budget cuts. What are the finance secretary's long-term plans for the public sector workforce?

John Swinney: I have not—in all Ken Macintosh's contributions on the subject—been able to understand what he would like us to do. We face reductions in public expenditure—nobody can dispute that—but we have an obligation to make public finances sustainable. Unfortunately, that has required us to engage voluntary redundancy measures across various parts of the public sector. That has been done where a business case has proven that such a scheme will deliver long-term savings to the public purse.

The Audit Scotland report states:

> "Early retirements and voluntary redundancies … can be a useful way of avoiding the delays and costs of compulsory redundancies and quickly reducing staff numbers and costs. Once the initial outlay has been recouped, they can provide significant savings for organisations."

That is about making public finances sustainable.

Mr Macintosh has never made a representation to me during the budget to ask that money be put in place to avoid voluntary redundancy schemes and people would still have to be paid if they are still employed in the public sector. I am at a bit of a loss to understand what the Labour Party's position is.

The Government has given clear and consistent reassurance to public sector workers that we do not support and will not implement compulsory redundancy programmes. That is a strength that is acknowledged by the Audit Scotland report.

Sandra White (Glasgow Kelvin) (SNP): The cabinet secretary and others have mentioned the Audit Scotland report and voluntary redundancies. Does he agree that the Scottish National Party Government's policy of no compulsory redundancies is providing staff with employment security at a time when unprecedented cuts to the Scottish budget are coming from Westminster?

John Swinney: I went through some of the issues in Sandra White's question just a moment ago. The Government has given the public sector workers whom it employs an assurance that there will be no compulsory redundancies, recognising the fact that that provides a better employment climate. As the Audit Scotland report suggests, that policy is also actually more efficient than undertaking compulsory redundancies, for which some people in the debate have argued.

The manner in which we have gone about trying to sustain workforce engagement in a difficult time of economic and financial pressure has resulted in the public sector workforce remaining strong and resilient in difficult economic times.

Tavish Scott (Shetland Islands) (LD): Is the cabinet secretary familiar with paragraph 57 of the Audit Scotland report, which comments on the use of compromise agreements to silence whistleblowers? Is he aware that, at the Public Audit Committee meeting this morning, the Auditor General for Scotland could not tell Parliament how many compromise agreements have been used among the 14,000 members of staff who have left the public sector over the past two years? Is he able to enlighten Parliament as to what that figure is?

John Swinney: I do not have the precise number in front of me, but I am happy to write to Mr Scott with any available information. If my memory serves me right, we have responded to information requests on that point. My memory may be letting me down on that, but I will confirm the answer to him.

Compromise agreements can be used only where there is overwhelming justification for that approach. They are undertaken with the interests of the public purse in mind, and the Government embarks on them only when the conditions merit it. The number of such cases will be a small minority of the individuals who have left the employment of the public sector.

The Deputy Presiding Officer (Elaine Smith): Before I call the next question, I make a plea for shorter questions and answers. Otherwise, we will not make much progress.

Planning System (Economic Impact)

2. Annabelle Ewing (Mid Scotland and Fife) (SNP): To ask the Scottish Government how economic impact can be considered more fully in the planning system. (S4O-02166)

The Minister for Local Government and Planning (Derek Mackay): The planning system plays a key role in supporting sustainable economic growth through the provision of up-to-date development plans and a supportive business environment for investment. Economic benefit, in particular job creation, should feature as a significant material consideration when determinations on individual applications are made.

The public consultation on the draft Scottish planning policy, which is open until 23 July, invites views on appropriate measures to support sustainable economic growth and economic recovery. Responses will help to inform the finalised policy, which is due for publication and implementation by the end of the year.

Annabelle Ewing: I hear what the minister says, but he will be aware that some investors query how much weight is given to economic impact in any given planning application. Therefore, I ask him to clarify what difference the Scottish Government's proposed planning policy will make in that key respect.

Derek Mackay: The SPP review will draw that out as an important issue. I have some sympathy with what Annabelle Ewing says. Economic impact must be taken more seriously and given more clarity in consideration and determination of planning applications. It is important, at this time of economic recovery, that the planning system supports sustainable economic growth and considers fully economic growth and displacement to ensure that it supports the competitive business environment that we all seek to create.

It is about leadership, culture and policy clarity, and those are what the draft of the planning policy will provide. I am supported in that by the Confederation of British Industry, the Scottish Chambers of Commerce and the Federation of Small Businesses, no less.

Local Authorities (Funding)

3. Graeme Dey (Angus South) (SNP): To ask the Scottish Government what the impact has been of the 85 per cent funding floor for local authorities. (S4O-02167)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John

Swinney): The introduction of the 85 per cent funding floor will provide Aberdeen City Council and the City of Edinburgh Council with additional resources over the three-year period 2012 to 2015. That delivers on the Scottish Government's commitment to introducing a new funding floor to ensure that, as part of the outcome of spending review 2011, no local authority will receive less than 85 per cent of the Scottish average in revenue support.

Graeme Dey: Does the cabinet secretary agree that, given the financial pressures that the Scottish Government faces—not the least of which is the unprecedented budget cuts from Westminster—any reasonable person would recognise that it has provided a fair settlement to local government?

John Swinney: It is best to consider the issue in terms of the statistics. In the period between 2007-08 and 2012-13, the resources that were at the Scottish Government's disposal increased by 6.4 per cent and the resources that were made available through Scottish Government funding to local government increased by 8.9 per cent. I think that that demonstrates that local government in Scotland has been given a very fair settlement by the Scottish Government.

The Deputy Presiding Officer: I call Jenny Marra. Please be brief.

Jenny Marra (North East Scotland) (Lab): The cabinet secretary says that the minimum is 85 per cent, but does he recognise the figures that have been provided by the Scottish Parliament information centre, which show that Aberdeen City Council's funding settlement for the current year, instead of being 85 per cent of the average, is not even 80 per cent of the Scottish average? Will he confirm that the difference between the funding that Aberdeen was promised and what it gets is £20 million for the current year?

John Swinney: Let me refute what Jenny Marra has said. The Scottish Government has explained repeatedly to Parliament that the calculation around local government settlements was made at the time of the spending review. At the time of the spending review, the 85 per cent funding floor was applied and presented throughout the three years of the spending review, and will be delivered and guaranteed for Aberdeen City Council.

I have to say that Jenny Marra, who raised the issue with me from the Labour benches, has a heck of a brass neck. Let me quote Gordon Matheson, the leader of Glasgow City Council:

"As quickly as we work to protect schools, jobs and the vulnerable of this city"—

Glasgow—

"the SNP Government bleed money away to other parts of the country for political gain. They have given up on Glasgow and decided to concentrate the nation's resources on winning Edinburgh and Aberdeen for the SNP."

There we are. The Labour Party is pointing in two directions, and it represents a Government that, for eight years, did absolutely nothing—not a thing—to address the funding challenges of Aberdeen City Council.

Glasgow Council for the Voluntary Sector

4. Anne McTaggart (Glasgow) (Lab): To ask the Scottish Government what recent work it has carried out in partnership with the Glasgow Council for the Voluntary Sector. (S4O-02168)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): Glasgow Council for the Voluntary Sector is part of Glasgow's third sector interface, which provides a single point of access and support to the third sector in Glasgow. In 2012-13, we have allocated more than £460,000 to help the Glasgow interface to develop volunteering and social enterprises, to grow a strong local third sector and to build the third sector's relationship with community planning. GCVS has supported the distribution of Glasgow's £700,000 reshaping care for older people transformation fund, and it successfully applied for funding in year 1 of the reducing reoffending change fund.

Anne McTaggart: In June last year, the Government published "Action for Jobs—Supporting Young Scots into Work: Scotland's Youth Employment Strategy", which highlighted the importance of the third sector in the Government's plan to address growing unemployment. Given that the youth unemployment rate is now estimated to be more than 16 per cent, is the cabinet secretary satisfied that the objectives in the strategy are being met?

John Swinney: There is clearly a significant issue in relation to youth employment in Scotland today, which is why the Government took the action that it took to establish the specific ministerial responsibilities that Angela Constance is taking forward in tackling the issue. The statistics demonstrate that we are making significant progress in reducing the levels of youth unemployment, and that we are boosting youth employment in Scotland.

However, I say to Anne McTaggart that we are only part of the way through that exercise. There needs to be an intensified focus—to which I am certain the third sector in Glasgow is contributing—to ensure that we complete the tasks that are involved in creating the necessary opportunities for young people in our society, and in tackling the level of youth unemployment as effectively as possible.

Barnett Consequentials (Police Funding)

5. Graeme Pearson (South Scotland) (Lab): To ask the Scottish Government what discussions the Cabinet Secretary for Finance, Employment and Sustainable Growth has had with the Cabinet Secretary for Justice regarding the allocation of Barnett consequentials to Police Scotland. (S4O-02169)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): The Barnett consequentials accrue to the Scottish block as a whole and ministers take collective decisions about their allocation.

Graeme Pearson: In that context, did the cabinet secretary and his colleagues give any consideration to the allocation of a portion of the accumulated police reserves to the Scottish Police Authority to support the organisation in managing its initial budgetary challenges, in particular in implementing the national information technology systems that are so necessary to enable a single police service to operate in Scotland?

John Swinney: That consideration would not have been necessary because the Government, as part of the process of establishing Police Scotland, has given full consideration to the funding requirements of Police Scotland in taking forward the necessary work to establish the single police force. That whole initiative is being taken forward by the Scottish Police Authority and Police Scotland. The Government will of course continue to engage in dialogue with the essential partners in that process as the implementation of Police Scotland is taken forward.

Single Outcome Agreements

6. Richard Lyle (Central Scotland) (SNP): To ask the Scottish Government what action it is taking to strengthen single outcome agreements as part of its response to the commission on the future delivery of public services. (S4O-02170)

The Minister for Local Government and Planning (Derek Mackay): Community planning and the single outcome agreements are at the core of the Scottish Government's approach to public service reform. Following the Christie report, the Government and the Convention of Scottish Local Authorities agreed a statement of ambition that sets out our shared aims for community planning and provides the basis for action to achieve those aims. That action includes requiring single outcome agreements to set out a clear vision of what each community planning partnership wants to achieve for its area, to include a sharp focus on key policy priorities and to show how each CPP will deliver prevention and the other pillars of public sector reform.

All 32 CPPs have now submitted new draft SOAs and a process of assurance involving senior managers from across the public sector will commence shortly. The process will identify specific development and improvement actions for each CPP that will form part of the agreement of the SOA.

Richard Lyle: The recent "Weathering the storm?" report from the Carnegie UK Trust praised Scotland's adoption of an outcomes-based approach across the public sector. What is the minister's assessment of that report?

Derek Mackay: We have had a range of reassurances that the Scottish Government has been leading the way on tackling inequality in our preventative spend agenda and on focusing on community planning. As regards new developments such as the proposed extension of the legal duty, working closely with the Accounts Commission, the national group will deliver a focus on place, partnership and performance. Perhaps that is why the advisers to the United Kingdom Government who advise on issues such as early years have commended the Scottish Government as leading the way on prevention and early years work.

Mary Scanlon (Highlands and Islands) (Con): Will the new draft single outcome agreements include a measure for wellbeing?

Derek Mackay: On the national measurements and the outcomes, a range of indicators are taken into account—not just gross domestic product or economic value—in order to consider what progress we are making both nationally and locally. The local SOAs will have indicators that cut across a range of areas and focus very specifically on quality of life as part of the consideration around a sense of place. There is a range of indicators and I am happy to share them with the member to give her further reassurance.

2 Sisters Food Group (Cambuslang)

7. James Kelly (Rutherglen) (Lab): To ask the Scottish Government what discussions it has had since March 2013 with the 2 Sisters Food Group regarding the future of Vion Cambuslang. (S4O-02171)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): Since March 2013, Scottish ministers and officials have had regular discussions with the 2 Sisters Food Group regarding the future of Vion Cambuslang.

James Kelly: I am glad that the cabinet secretary has been able to have regular discussions with the 2 Sisters Food Group, because I and my parliamentary colleague Tom Greatrex have had difficulty in establishing that.

Two months down the line, we still lack clarity about the 2 Sisters Food Group's plans for Vion in Cambuslang. In the cabinet secretary's discussions with the group, has there been any commitment of practical and financial support from the Scottish Government so that the 2 Sisters Food Group can continue to support operations at Vion Cambuslang?

John Swinney: I will certainly do what I can to encourage dialogue with the group. It is important that local members are able to have that dialogue.

The Government has made an offer of financial assistance to the 2 Sisters Food Group, but it is conditional on its sustaining the current level of employment at the operations that the group has acquired. Issues in connection with that are still under negotiation with the company and, once those discussions are concluded, I will be quite happy to brief Mr Kelly on the details. The Government continues to take a close interest in the steps that are being taken to implement the transaction.

Maureen Watt (Aberdeen South and North Kincardine) (SNP): Will the cabinet secretary join me in congratulating what is now the latest 2 Sisters Food Group meat processing plant in Portlethen in my constituency because Tesco, which already takes most of its meat products, has agreed to market premium, high-value beef products in its leading stores, thus acknowledging the increasing demand for Scotland's top-quality beef, which is good news for retailers, processors and producers alike?

John Swinney: I welcome that. Part of the Government's objective has been to ensure that at the various plants that have been affected by the 2 Sisters Food Group's acquisitions—at Cambuslang, in Mr Kelly's constituency, at Portlethen, in Maureen Watt's constituency, and at Coupar Angus, in my constituency—employment is sustained to provide clear outlets for quality Scottish agricultural produce. Not only is significant employment vested in those three plants, it is also connected to the agricultural workforce around the country. It is therefore good to see what has been achieved at the McIntosh Donald plant in Portlethen. As part of the Government's discussions with the 2 Sisters Food Group, we will continue to promote the strength and quality of Scottish produce, which are evidenced by the agreement that has been reached with McIntosh Donald.

The Deputy Presiding Officer: Unfortunately, if you turn away from your microphone, it becomes difficult for our official report to pick up what you are saying, cabinet secretary.

Oil and Gas Industry (West Scotland)

8. Stuart McMillan (West Scotland) (SNP): To ask the Scottish Government what the West Scotland region's economic input is to the oil and gas sector. (S4O-02172)

The Minister for Energy, Enterprise and Tourism (Fergus Ewing): Scottish Enterprise estimates that 15.5 per cent of Scotland's high-growth oil and gas companies have operations in the west of Scotland; that is one in six. Those companies range in size from the Wood Group to small and medium-sized enterprises. Scotland's oil and gas strategy, which the First Minister announced last year and which has been developed in conjunction with the industry, lays out a plan to help the industry to go from strength to strength. Through the strategy, we aim to secure investment and maximise jobs.

Stuart McMillan: The minister will be aware of the numerous companies in the west of Scotland that participate successfully in the oil and gas sector, such as James Walker Devol and Jenda Energy, to name just two in Inverclyde. What support can Scottish Enterprise and Scottish Development International provide to manufacturing businesses from the west of Scotland to encourage more of them to take their first steps into the oil and gas sector, especially bearing in mind the huge economic success and future potential of the sector in Scotland?

Fergus Ewing: I know that Stuart McMillan lobbies very hard for and has close engagement with the companies in his area, and that he wants even more companies to join the successful ones in his part of Scotland. He is quite right, because a huge number of oil and gas companies operate in the west of Scotland and we would like to see even more join them. I was happy to visit James Walker Devol in Greenock to see the excellent work that it does. Members from all sides of the chamber will want to see this work progressing.

Scottish Enterprise and SDI can help companies in a great many ways, particularly in those areas in the west of Scotland where regional selective assistance is available to encourage employment creation. That is a good tool. It has been used very well in the past, and I fully intend that it should be maximised in future.

Hydrogen Energy Storage

9. Clare Adamson (Central Scotland) (SNP): To ask the Scottish Government what steps it is taking to promote hydrogen as a means of storing and distributing energy. (S4O-02173)

The Minister for Energy, Enterprise and Tourism (Fergus Ewing): The Scottish Government has helped to establish leading centres of excellence, such as the Pure Energy

Centre in Unst and the Hydrogen Office in Methil. Scottish universities are at the cutting edge of research and development in hydrogen and fuel cells. We are also supporting the Aberdeen hydrogen project, which will deepen our understanding of the role that hydrogen could play and enhance our reputation for energy innovation.

Clare Adamson: As far back as 2006, the hydrogen energy group produced the report "Hydrogen and Fuel Cell Opportunities for Scotland", which concluded that hydrogen and fuel cell technology has the potential for

"10,000 jobs and GVA to Scotland's economy of £500 million per annum ... In order for Scotland to achieve its ... renewable target ... it will almost certainly require hydrogen and fuel cell systems to balance and integrate many diverse ... sources of energy."

How far have we gone in maximising the potential of that technology?

The Deputy Presiding Officer: Before the minister responds, I advise members that I have had a number of requests for supplementaries on the previous few questions. I am afraid that time is running away with us and, unfortunately, it will be difficult to take further supplementaries from members.

Fergus Ewing: We are making progress, and we want to make more progress. To take one example that I mentioned, the Aberdeen hydrogen project will help to deliver a fleet of 10 hydrogen buses for the city. Those will be very welcome, not least when this Scottish National Party Government delivers the new Aberdeen peripheral road, which will tackle a long-standing problem that—as I know from my frequent visits to Aberdeen—has caused serious problems for the people in that city. I am pleased to say that we are making progress, but more remains to be done.

Barnett Consequentials

10. Elaine Murray (Dumfriesshire) (Lab): To ask the Scottish Government what discussions the Cabinet Secretary for Finance, Employment and Sustainable Growth had with his ministerial colleagues prior to allocating the most recent round of Barnett consequentials. (S4O-02174)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): Barnett consequentials accrue to the Scottish block as a whole, and ministers take collective decisions about their allocation.

Elaine Murray: In answer to parliamentary question S4W-14615, the cabinet secretary stated that financial transactions totalling £290.8 million were available to the Scottish Government to support loans and equity investment but would have to be paid back to the Treasury in future years. Has the Scottish Government considered using part of that funding to support loans to housing associations for the construction of homes for social rent, given that many are experiencing problems securing loans from conventional sources such as banks?

John Swinney: From the nature of her question, I can see that Dr Murray understands the difference between financial transactions and the capital departmental expenditure limit that is available.

The Government has set out a commitment to allocate the £290.8 million in financial transactions to the housing sector. I am certain that some of that financial transaction capability will be utilised to support housing associations, but the Government continues to work with Her Majesty's Treasury to identify the terms of and rules on the utilisation of financial transactions.

We are required to ensure that none of the financial transaction facility can in any circumstance lead to anything that could be construed as public expenditure, because that would defeat the nature of the classification of financial transactions. If it is helpful, I am happy to explain that to Dr Murray in more detail in writing as we acquire the detailed understanding of what is involved.

Council Tax Freeze

11. Bruce Crawford (Stirling) (SNP): To ask the Scottish Government how much the average household has saved since the introduction of the council tax freeze. (S4O-02175)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): Over the six-year period during which the council tax freeze will have been in place—from 2008 to 2014—the average band D household in Scotland will have benefited from cumulative savings of almost £690.

Bruce Crawford: Is the cabinet secretary aware that, during Labour's last period in government in Scotland, the council tax in Aberdeen rose by 72 per cent, leaving residents with the highest average bills in Scotland? Does he agree that that makes the call by the Labour Party candidate in the Aberdeen Donside by-election for a hike in council tax bills particularly incomprehensible, considering that people there are already living with household budgets that are under huge pressure?

John Swinney: The numbers speak for themselves. The Scottish National Party Government has delivered assistance to hard-pressed families at a time of need and economic difficulties, while the Labour Party is talking about increasing their council tax bills. Mr Crawford summed it up very well—I do not think that the

Labour Party's position on the subject is in any way comprehensible.

Banking (Small Businesses)

12. Neil Findlay (Lothian) (Lab): To ask the Scottish Government what recent discussions it has had with the banking sector regarding help for small businesses. (S4O-02176)

The Minister for Energy, Enterprise and Tourism (Fergus Ewing): The Scottish Government has regular discussions with banking sector representatives on a range of issues, including access to finance for small and medium-sized enterprises.

We actively encourage the banks to return to acceptable levels of lending and to improve the supply of finance for viable small and growing businesses. The recently published banking strategy sets a framework to work closely with the banks and others to restore the traditional principles of Scottish banking, which are based on probity, prudence and stewardship. It also encourages the banks to work with public agencies to enhance the quality of business loan proposals and so maximise the potential number of successful applications for finance.

Neil Findlay: I have been approached by businessmen in my region who face the real prospect of going out of business because of the outrageous costs that the Clydesdale Bank is imposing on them for breaking a commercial fixed-rate tailored business loan. My understanding is that that is a growing problem for many small and medium-sized businesses. What discussions have the minister and the finance secretary had with the banking sector in Scotland about that developing mis-selling scandal that is threatening many small businesses?

Fergus Ewing: I make it clear that I do not adopt the terminology that the member uses but, nonetheless, there is a serious point about the alteration of terms of business for existing customers. That is a serious matter that my colleagues and I have raised regularly and repeatedly with banks, as all members will be aware. The issue arises for a number of reasons, including the revaluation of assets on a conservative basis, which causes banks to review their lending policies.

I will say a couple of things. First, we are absolutely clear that we want banks to treat their customers fairly and decently. Secondly, if a decision is made with which a customer disagrees, there is a right of appeal. From having seen the statistics, I am aware that those who appeal against decisions of banks, whether to decline lending or to change the terms, enjoy a pretty high success rate in their appeals. Therefore, the right of appeal is not a paper, nominal or negligible one—it is serious. I am happy to write to Mr Findlay with the details and precise statistics, so that the constituents who have raised those matters with him can be sure that they have access to appeal if so advised.

Stewart Maxwell (West Scotland) (SNP): I welcome the recent announcement by the Deputy First Minister on the trialling of project bank accounts to speed up payments to contractors that are involved in public sector projects. Will the minister outline how that measure and other work that the Scottish Government is doing will help to support small businesses?

Fergus Ewing: That is an extremely important measure. As Mr Maxwell will know, particularly in the construction sector, subcontractors—or subcontractors to subcontractors—often find that it takes far too long for them to receive payment. In too many cases, that has led or contributed to insolvency situations. Project bank accounts are a way in which trusts can be used to administer payments so that small businesses are paid on time for the work that they do and a larger business does not just sit with their money in its bank account.

That is why I am delighted that the Deputy First Minister has, on the recommendation of banking experts, taken forward a trial of project bank accounts, which are a very good measure. I pay tribute to the small businesses that lobbied us hard and whose views we have listened to by introducing the trialling of project bank accounts.

Public Health Supplement (Preventative Spending)

13. Jim Hume (South Scotland) (LD): To ask the Scottish Government how much funding raised by the public health supplement has been allocated to preventative spend initiatives. (S4O-02177)

The Cabinet Secretary for Finance, Employment and Sustainable Growth (John Swinney): The additional income raised by the public health supplement—which is estimated to be £25 million in 2013-14, rising to £35 million in 2014-15—will help local government contribute to the decisive shift to preventative spend measures outlined in the spending review 2011.

Jim Hume: The cabinet secretary will recall the controversy that surrounded the supplement's introduction. It is important that every penny is spent. Two months into the new financial year, we have learned today that the money is yet to be allocated. Given that this Government is looking for more powers, why is it so slow to act on the powers on funding that it actually has?

John Swinney: I am not sure that I follow at all the point that Mr Hume is making. If he wants to write to me to explain it, I will happily consider it.

Yesterday I had the enormous pleasure of attending a huge gathering of public sector staff at the early years collaborative in Glasgow. It involved discussion and the exchange of information and guidance about the achievements that have been made in various preventative spending interventions across the country. It was a most encouraging and inspiring event.

If that is not work happening on the ground, I am not quite sure what is and I am not quite sure what point Mr Hume was making. That work is being supported by the preventative spend expenditure that is being made available by the Scottish Government. If there is something that I missed in Mr Hume's question, he can drop me a note and I will happily consider it.

North Lanarkshire Council (Meetings)

14. Siobhan McMahon (Central Scotland) (Lab): To ask the Scottish Government when it last met North Lanarkshire Council and what issues were discussed. (S4O-02178)

The Minister for Local Government and Planning (Derek Mackay): The Scottish Government meets Scottish councils regularly and discusses a range of issues with them.

Siobhan McMahon: I recently met representatives of Airvolution Energy, which has submitted a planning application to North Lanarkshire Council for nine wind turbines on land between Harthill, Eastfield and Shotts. I was pleased to learn of its commitment to use local expertise and resources to carry out the work associated with construction on the proposed wind farm. It is also keen to help increase local employment by promoting skills training and apprenticeships.

The Deputy Presiding Officer: I must ask you to hurry.

Siobhan McMahon: What assurances can the minister give that any future wind farm planning applications will have a guaranteed provision for local employment opportunities, skills training and apprenticeships, which will help increase local employment and provide real community benefits?

Derek Mackay: Without prejudicing any planning application—the member referred to one—I would say that the point I was making earlier was about considering economic impact in the determination of any planning application. The issues that she mentioned would therefore have a weighting within the system.

Separately, the Government is pursuing a procurement bill that looks at social, environmental and local economic benefits as part of procurement. As part of the renewables strategy, we would want to ensure that Scotland benefits from every aspect of the technology and every part of the supply chain so that we maximise the benefits of the industry for communities across Scotland.

Business Support (Western Isles)

15. Rhoda Grant (Highlands and Islands) (Lab): To ask the Scottish Government what action it is taking to support businesses in the Western Isles. (S4O-02179)

The Minister for Energy, Enterprise and Tourism (Fergus Ewing): The Scottish Government is working closely with a wide range of organisations, including Western Isles Council and Highlands and Islands Enterprise, to support businesses and promote sustainable economic growth in the Western Isles.

HIE's investment of £1.4 million to create a site in Tarbert on Harris has attracted a multimillion pound private sector investment by Isle of Harris Distillers Ltd. The construction of the distillery is being supported by the Scottish Government through a £1.9 million grant under the food processing, marketing and co-operation grant scheme. The development of the creative industries and media centre in Stornoway has been supported by more than £1 million of European regional development funding and £750,000 from HIE, in recognition of the employment opportunities offered by the creative sector in the Western Isles.

Rhoda Grant: The Scottish Government has now had the impact report on the removal of the road equivalent tariff for commercial vehicles in the Western Isles, Coll and Tiree for some weeks. It shows that the policy has had a devastating effect on the islands' businesses and economies. What action is the Scottish Government taking to mitigate those catastrophic effects?

Fergus Ewing: Due to cuts imposed on the Scottish Government's budget by the United Kingdom Government, it is correct to say that we have had to take difficult decisions to ensure that existing ferry routes and services are maintained. We therefore took the difficult decision to remove RET for large commercial vehicles from spring 2012.

The results of the RET pilot showed that the major impact of RET was in fact on the tourism industry, as perhaps one might expect. I understand, however, that concessions have been introduced so that lorries carrying hay, livestock and live shellfish make the return empty journey for free, other than the charges to cover pier duties.

The member will know that those matters are primarily dealt with by my colleague Keith Brown. I am perfectly sure that if she wishes to make any specific proposal about additional expenditure—where it would be made and how it would be funded—he will be happy to give it full consideration.

The Deputy Presiding Officer: That ends portfolio questions. Apologies to the many members whom I could not call for supplementaries and to those whose questions we did not reach.

Chronic Pain Services

The Deputy Presiding Officer (Elaine Smith): The next item of business is a debate on motion S4M-06746, in the name of Alex Neil, on ensuring access to high-quality sustainable services for people living with chronic pain. I invite members who wish to speak in the debate to press their request-to-speak button now.

I call Alex Neil to speak to and move the motion. Cabinet secretary, you have 14 minutes.

14:41

The Cabinet Secretary for Health and Wellbeing (Alex Neil): I have great pleasure in speaking to my motion on chronic pain. In doing so, however, I want to pay tribute to those who have campaigned long and hard on the matter, some of whom are in the public gallery today. I hope that they will be cheered by what I have to say about the substantial progress that I believe we will make on chronic pain. I particularly mention Jacquie Forde, Susan Archibald—who led the petition to the Public Petitions Committee on the issue—and Dorothy-Grace Elder. All have campaigned very vigorously on behalf of the 800,000 or so people in Scotland who suffer from chronic pain.

I think that I am right in saying that the only other debate that we have had on the subject since the Parliament was established in 1999 was a members' business debate that Dorothy-Grace Elder secured when we were in the other place up the road—I remember that the public galleries were full to the gunwales for that debate. I am delighted that we are having another debate not just because it means that we are talking about the subject but because we are acting in a number of ways to address it.

As I said, we estimate that about 800,000 people in Scotland suffer from chronic pain, of whom a quarter suffer from possibly life-long chronic pain syndrome. Also among that number are 70,000 children who suffer from what is by any standard a debilitating illness. Today, I will spell out the progress that has been made and, more important, look to the future with regard to our plans for taking matters forward.

Early on—indeed, about five or six years ago—we recognised chronic pain as an illness in its own right that required a dedicated solution, dedicated care and dedicated services, and the budgets to go with them.

I start by making absolutely clear the situation with regard to residential facilities. As we know, an average of 20 people every year have to go down to Bath to receive the specialist treatment that is

available for sufferers of the most severe chronic pain. We intend to end that situation by ensuring that those facilities are available in Scotland.

We will consult on that because there are different ways of delivering such a service. First, we could establish a centre to serve the entire country; secondly, we could have a mobile service; and, thirdly, we could have a range of services in different parts of the country. However, as with all such services, we will consult patients and other stakeholders before we make a final decision on the most appropriate model. I give the guarantee that, once we take that decision and the facilities are in place, there should be no need for anyone to travel to Bath to get the support and services that they need.

Jackson Carlaw (West Scotland) (Con): May I potentially short-circuit the cabinet secretary's consultation by saying that I think that we would welcome all three approaches?

Alex Neil: If the member got his Government to reverse its cuts, I might be able to afford all three.

As there are at least three possible scenarios, I cannot accept Labour's amendment, which would commit us to only one scenario, with one centre. I am absolutely sure—I hope that Jackie Baillie will confirm this—that we are all in the same place in the debate, and that we all want to end up in the same place in respect of the quality and range of services available. However, it would be rather foolish of me to accept an amendment that committed us to only one centre when we will consult on whether there is a better model.

Bruce Crawford (Stirling) (SNP): The cabinet secretary will be aware that chronic pain is often unseen and that, as such, it often goes unrecognised. Constituents have told me of their experience in accessing support services, which are limited and patchy. Will the cabinet secretary say how my constituents might go about contributing to the consultation process that is obviously about to begin?

Alex Neil: Absolutely. We will publish a document fairly soon on the pros and cons of each model. We will then go out to consultation, and everybody will be free to have an input. Once we have evaluated the findings from the consultation, we will reach a decision. I encourage as many people in Scotland as possible to participate and to tell us their preference, because I want the process to be driven as much as possible by the needs of the people who require the services. Clearly, we will take into account the views of patients and other stakeholders before we make any final decision. I am determined that we will make a decision on the model around September this year; I do not want the process to drag on. We will have a period of consultation, listen to what people say, and then make a decision and deliver on the promise to have an alternative to Bath in Scotland as soon as possible.

Margo MacDonald (Lothian) (Ind): I thank the cabinet secretary for giving way, particularly when he was in full flow.

I welcome the cabinet secretary's remark about stakeholders, because folk who have chronic pain know that they have it, but many doctors who treat them do not know what like it is or how to treat it. Patients learn how to cope with pain, and I suggest that some medical staff should do a course of instruction, too.

Alex Neil: Margo MacDonald makes a very fair point. One of our clear objectives is to raise awareness in the medical profession of not only chronic pain but what can and should be done to help people who suffer from it.

The second major point that I want to make is that we have already substantially reduced waiting times for psychological services from more than 80 weeks to just over 60 weeks. In the immediate period ahead, we will continue the drive to reduce waiting times significantly, particularly for services that are crucial to sufferers of chronic pain. I do not believe that it is right that people have to wait that length of time for essential services that they need fairly urgently.

The third point that I want to make concerns the petition that was submitted by Susan Archibald, which was supported by many people. It made the key point that, in delivering services for sufferers of chronic pain, we should think about not just a medical health model but a social model. We are very committed to that principle; indeed, the bill that was published today on the integration of adult health and social care should help us to deliver integrated health and social care services for sufferers of chronic pain. If there was ever an example of where the integration of services is important, it is in dealing with chronic pain.

I will set out some of the work that is already going on and the approaches that are being taken. I recognise that there is still a wide variation in access to certain services in Scotland. One of our key policy objectives is to ensure that there is no postcode lottery in the delivery of services; we want consistent delivery of high-quality services in both the primary care and acute sectors for the sufferers of chronic pain.

Clearly, a tiered approach is required, because most services will be delivered not in the acute sector but, inevitably, in the primary care sector. We have long advocated the role of managed clinical networks in co-ordinating a multidisciplinary approach to service provision. We need to ensure that they give a strong voice to patients in shaping local service delivery. As I will

outline, we will place an obligation on the territorial health boards to provide a minimum level of good-quality services and, in doing so, we will require them to discuss the shape of their local services with local populations and stakeholder groups representing chronic pain sufferers.

Some areas have made more progress than others. For example, the MCN in NHS Greater Glasgow and Clyde, which has been operating for five years, has demonstrated real improvements, including developing a pain management programme, setting standards for chronic pain services, developing primary care guidelines and, more recently, setting up specialist nurse clinics to provide patients with more local care. That is a very good example of the ambition that we have for the delivery of the service.

The figures that were published yesterday on workforce development across the board show an increase in the appropriate skills and occupations in the health service that service chronic pain sufferers and others. For example, compared with last year, there has been a 5 per cent increase in the number of clinical and other applied psychologists working in the health service.

In the mental health strategy for Scotland for the next three years, there is a commitment to continue our work to deliver faster access to psychological therapies. The programme is delivered locally but supported nationally and includes support for local service redesign, which is aimed at achieving service improvement within existing resources. Obviously, the territorial boards are receiving a real-terms budget increase this year and next, so the resources should be in place to allow them all to deliver the quality of services that we demand.

We are supporting the development of MCNs and service improvement groups with pump-priming funding of up to £50,000 per year over two years for each group, with the purpose of each putting together a local improvement plan in their area. So far, the following health boards have participated in the programme: Ayrshire and Arran, Dumfries and Galloway, Forth valley, Lanarkshire, Lothian and Tayside. Between them, they cover 73 per cent of the population. Our aim is for the programme to have 100 per cent coverage to ensure that local service delivery plans are in place from next year at the very latest.

The main priority of those groups is to focus on and accelerate the implementation of the Scottish service model for chronic pain. In particular, as they develop, the groups will look to improve links with primary care services, paediatric services and the voluntary sector. Patient participation will be an essential feature of their work.

Some work is obviously in the early stages. For example, NHS Ayrshire and Arran's work to improve chronic pain services has been closely aligned with the redesign of musculoskeletal services, which will allow for early identification and rapid triage and assessment, with timely onward referral to appropriate services, including chronic pain management, self-management support and working health services Scotland.

NHS Fife and NHS Borders are currently working on draft proposals for their groups. NHS Fife already has a fully integrated chronic pain management service—Rivers—which has been established for more three years and fulfils a number of aspects of the MCN approach. We will work with that group and others to take the programmes forward to ensure coverage throughout Scotland.

I have told boards to accelerate progress and I have set an expectation that improvement plans will be in place for every board by the end of this month. In addition, I have advised chairs of boards that I will be calling on them to update me on progress when I meet them in June. I will be looking to them to identify and seek solutions to barriers to delivery.

I have commissioned work to consider how most efficiently to include chronic pain in boards' local delivery plans from 2014-15 and ensure that clear reporting mechanisms are in place to monitor progress through the annual national health service board review process.

I could mention many other initiatives, but no doubt other members will do so. The Minister for Public Health, Michael Matheson, will cover initiatives that I have not been able to get to. On behalf of the Scottish Government, I spell out our commitment to improving the chronic pain service throughout Scotland and to ensuring that we have the indigenous services in Scotland that our patients need, to deal with this very debilitating condition.

I move,

That the Parliament welcomes the Scottish Government's plans for the implementation of the Scottish Service Model for Chronic Pain, which will ensure the best outcomes for the care and support of people living with chronic pain; further welcomes that the Scottish Government has committed to providing a highly specialist intensive pain management service in Scotland; notes that, prior to consultation, the NHS is working with partners, including patients and clinicians, to assess appropriate options for a Scottish intensive pain management service; also welcomes the decision of the Scottish Government to provide appropriate residential accommodation in the options for the new Scottish intensive pain management service, and further notes that each territorial NHS board in Scotland will be required to prepare and implement a service delivery plan for covering all aspects of chronic pain services, from April 2014.

14:55

Jackie Baillie (Dumbarton) (Lab): I welcome the opportunity to participate in the debate, not just on behalf of my party but as one of three co-conveners of the cross-party group on chronic pain—the other co-conveners are Jackson Carlaw and John Wilson. I echo what the cabinet secretary said and welcome to the public gallery the many people from across Scotland who are part of the cross-party group. Some members might spot Dorothy-Grace Elder, a former parliamentary colleague, whose championing of the cause of chronic pain in the first session of the Parliament led to the cross-party group's formation.

The campaign is not new. Indeed, some of us think that it has been rather a long haul. Many of the campaigners who have been seeking change for more than a decade are impatient to see a difference on the ground. Over the years, there have been numerous helpful reports, commissioned by different Governments. Professor McEwen's report, for example, was followed by the report, "Getting to GRIPS with Chronic Pain in Scotland—Getting Relevant Information on Pain Services: Benchmarking Chronic Pain Services in Partnership with NHS Boards, Patients and Service Providers". All the reports highlighted gaps in provision.

There has been frustration about the lack of action. We have a postcode lottery of care—whether someone receives a service depends on where they live. Much of what the cabinet secretary said is therefore most welcome.

I think that Scottish Labour was the only party to pledge in its manifesto that it would create a residential pain centre in Scotland and end the ordeal of pain patients from Scotland being sent as far away as Bath, in Somerset.

Alex Neil: Does the member accept that I am delivering on her manifesto commitment?

Jackie Baillie: I encourage the cabinet secretary to read the rest of our manifesto. If he delivered on all our manifesto commitments, I might have more praise for him.

The cabinet secretary and I share the objective of setting up a residential service, because we often think about people who have to make a return journey of 800 to 1,000 miles to get a service. The distances can be even longer; I understand that one sufferer from Shetland was sent on a marathon return journey of more than 1,600 miles. The number of patients might be small, but the people who are subjected to such gruelling travel are perhaps at the most acute end of suffering. I therefore welcome the cabinet secretary's promise to create a Scottish in-patient service.

I sound a note of caution. Specialist provision, by its very nature, cannot be scattered across Scotland, especially when there are gaps in the most basic services, as we acknowledge to be the case.

There has been a lack of action on the matter in the past, so I applaud the cabinet secretary's determination to set up an in-patient service, which is in stark contrast with what went before. In the past few years, more than £1.1 million of Scottish taxpayers' money has been used to send just 119 patients on long journeys, rather than spent on creating a Scottish in-patient service. Wales has long had an in-patient centre at Powys, and I commend that model to the cabinet secretary. Our amendment is about not bricks and mortar but recreating specialist provision in Scotland, which, because of its nature, I fear needs to be centralised.

Members might know that Susan Archibald brought a petition to the Parliament on behalf of the cross-party group. She asked for residential services to be provided in Scotland, not Bath. She asked for improved and consistent access to pain services for patients throughout Scotland. As a severe pain sufferer, her evidence to the Public Petitions Committee was courageous and profoundly affecting. I do not think that anybody remained unmoved by her story. I am extremely proud of the campaigning by the cross-party group's volunteers over the years because, despite obstacles, they have persevered to keep their focus on improving services.

I turn to local services. The Scottish service model for chronic pain, to which the health secretary referred, was outlined by the late Dr Peter Mackenzie, our first lead clinician in chronic pain, in 2009. However, so far only six of the 14 health boards have the model in place. I accept that more are in the pipeline but how long do patients have to wait? I share the cabinet secretary's desire to accelerate the rate of change.

We now hear from the Scottish Government that it will hold health boards accountable for implementing the model. That is welcome, but real improvement cannot be implemented without funding. We know that 10 of the 14 health boards do not record a budget for chronic pain treatment. That is not me saying that; it is the campaigners who the cabinet secretary rightly praised a few moments ago. The previous health secretary declined to give any direct funding to stimulate the provision of chronic pain services beyond initial funding of some £50,000 for a managed clinical network in Glasgow. For the past few years, it appears that the Scottish Government has put chronic pain—which affects some 780,000 people in Scotland—in the slow lane. Now, at least, in complete contrast to his predecessor, we have a

health secretary prepared to inject some momentum.

Accelerating the pace of change is essential if we are to see a difference on the ground, but we also need transparency. Information on the true state of chronic pain services has not always been evident. I doubt that even the cabinet secretary has been told about some of the issues that have arisen. For example, was he told that NHS Lanarkshire, which has one of Scotland's worst chronic pain rates, has only two part-time consultants working with pain? That is one whole-time equivalent for a population of 562,000, with an estimated 26 per cent of the population suffering from chronic pain. We know that Lanarkshire has had some small seed money for an improvement group, but the need is clearly far greater than that. We have consultants who are part time—they are also, in the main, anaesthetists. That also applies to people in multidisciplinary teams—the nurses, physiotherapists and clinical psychologists. In many areas, disciplines such as occupational therapy and physiotherapy are just not represented.

I know that money is tight but the cabinet secretary needs to be aware that more than 50 patients were suddenly removed from NHS Lanarkshire's waiting list last year, apparently without the knowledge of the doctors or the staff. They were sent to a private hospital for pain treatment but were not seen by a pain specialist. Making a waiting list look better is not confined just to a few areas. That money could have been better spent on securing more time for chronic pain treatment in the NHS.

Margo MacDonald: Is there an agreed standard for the severity of chronic pain among the health boards? Is it staged and so on? How do the health boards judge the requirement for clinical services?

Jackie Baillie: There will indeed be standards, and the health boards will have a system that they operate. However, those are matters for clinical judgment rather than the judgment of politicians or bureaucrats. The health boards will have protocols that refer people to the right level of pain treatment. The cabinet secretary may be more knowledgeable than me on the issue. He might well place something in the Scottish Parliament information centre to advise us about that—I am getting the nod, so there is agreement there.

I take members from NHS Lanarkshire to NHS Greater Glasgow and Clyde, which has had plans in place for years and staff who have worked incredibly hard to provide a service. I know that that service is widely appreciated by patients. However, just last year, the health board reported that the waiting time for patients for appointments to see a pain psychologist to help them to cope was

"between 72 and 82 weeks."

I ask members to imagine someone in severe pain being informed in the winter that their next appointment would not happen in the current year or in the next year but that they would be seen the following year. That is quite shocking. I think that the cabinet secretary said that at present people are waiting 60 weeks, but that is still well over a year.

I hope that the cabinet secretary agrees that there is a need to be transparent about the scale of the challenge that we face, so that we can accurately measure progress.

In discussing transparency, I have to turn to Healthcare Improvement Scotland's update report, which was widely attacked for whitewashing the bad news about chronic pain. The report omitted staff numbers, whole-time equivalent numbers and patient numbers; it also omitted to mention the fact that only four out of 14 health boards had a budget for chronic pain treatment. The information had been sent by health boards to Healthcare Improvement Scotland, so one can only presume that it chose to leave it out so that the picture would look better.

We were told by HIS that the average waiting time for a first appointment at a pain clinic was 11 weeks. The report did not mention that six boards had not supplied information about waiting times, so it was not possible to give us the Scottish average. The answer to a freedom of information request that I sent to health boards last year showed that around 3,000 pain patients were on waiting lists: 1,866 were waiting for a first appointment and 1,082 were in the queue for a second appointment. Despite the hard work and innovation of staff to stretch services, the wait between first and second appointments was frankly appalling in some areas.

We hear much about the need to transfer more chronic pain services to primary care. Many of us agree with that, as that approach brings services much closer to patients and allows patients increasingly to self-manage their conditions. However, we need to be wary. The British Medical Association has said:

"Primary care already deals with the great majority of chronic pain cases. However, there needs to be the option to refer to a specialist pain service for particularly difficult cases. Any further transfer of work ... would have to be evidence based"

and

"be accompanied by appropriate resources".

There is a need to involve those with chronic pain in the design of services. I know that the

cabinet secretary has already added one patient to the chronic pain steering group, which is welcome, and he has outlined a process of more systematic engagement. I support the cabinet secretary's new approach.

If we get this right, we are much more likely to design services that actually deliver for people. That surely is an objective that we all share across the Parliament.

I move amendment S4M-06746.1, to leave out from "also welcomes" to end and insert:

"calls on the Scottish Government to establish a dedicated NHS chronic pain residential treatment centre as a matter of urgency, and believes that NHS boards should be required to prepare a service delivery plan for all aspects of chronic pain as soon as possible and that regular monitoring of each plan's implementation should be required."

15:07

Jackson Carlaw (West Scotland) (Con): I, too, welcome the many volunteers to the Parliament. I will not add to the flattery, because they have had 10 years of that and have found that it does not butter many parsnips. I think that they will have whole-heartedly welcomed the cabinet secretary's speech.

I am a co-convener of the cross-party group on chronic pain and a member of the Public Petitions Committee, which heard the Susan Archibald petition. Margo MacDonald asked, "What is chronic pain?" She knew the answer, but she legitimately asked how people who do not suffer from chronic pain can define its severity.

Some might have thought that you were the definition of chronic pain, Presiding Officer, when you said that we had a 14-minute speech from the cabinet secretary ahead of us. Some of us in the cross-party group have found new ways to define pain that I am sure that some members present today will recognise.

Chronic pain is sterilely described as

"continuous, long-term pain lasting more than 12 weeks, or pain persisting after the time that healing would have been expected to occur after trauma or injury."

I cannot pretend to know what chronic pain that lasts longer than 12 weeks is. I am a chronic migraine sufferer, and have been all my life. My migraines last for 72 hours. I can only describe what that is like for me.

Imagine a plain red brick, which is central to the entire construction of a four-storey building. It suddenly shatters. You can see that if you pulled it back into alignment, all would be well, but you cannot.

Imagine now that brick inside a human being. Imagine the grating noise of that brick and your every function starting to become debilitated and unable to operate normally. Your neck cannot support your head. There is pain and a feeling of nausea that exudes not from your stomach but from every pore in your body.

Other people laugh at a joke. You laugh, too—you still can—but at the end of it, that pain, nausea and discomfort are still there. You go on holiday, as other people do. They enjoy the view; you sit there absorbing the view while absorbing the continuous pressure and pain. Other people eat a meal and enjoy it; you eat a meal because you have to—no enjoyment comes from it at all. The pain is continuous.

Last week I had for the first time in years what I call a chronic migraine. It lasted three days, during parliamentary business. In the time that I was not in the chamber, I was flat on my back, unable to sleep or get any relief.

I participated in a debate, but I wrote the speech out because I was not sure that I could recall any of it or have the ability to construct sentences were the speech not in front of me. Afterwards, I was told by some people who wrote to me that it was one of my better speeches—I am not sure what the moral of that story is. Migraine also affects your vision, which becomes blurred, and you cannot concentrate. Even Paul Wheelhouse looked young and Tory again from where I was standing. Migraine is completely debilitating.

If, when suffering a chronic migraine, I had an electric drill, I could put it to my head and drill into the source of the pain to relieve the pressure. So, I understood Susan Archibald when she told the Public Petitions Committee that she has considered suicide because of the pain that she has endured. It becomes a mental health condition and leads to people having alcohol problems—they try to dull the pain that they endure—or to problems with drugs. People with chronic pain take medication at the prescribed dose but it makes no difference, so they take more than the prescribed dose and it still makes no difference. It is a fundamentally debilitating condition, but they look perfectly normal to everybody else around them and no one has any sense of what they are suffering or enduring.

For the past 10 years, despite people knowing that we have been talking about chronic pain in Parliament, there has been no significant or material progress towards any kind of long-term relief or hope for sufferers. I therefore welcome whole-heartedly everything that the cabinet secretary has said. I was not being flippant when I said that we would like all three ways of delivering the service to be implemented, because I think that those who suffer from chronic pain would like that approach.

I suspect that having one centre has appeal because of the cynicism that has grown up among sufferers about the lip service that is paid by health boards and the variable delivery of treatment across health boards in Scotland. A physical centre would exist and would have to be resourced, but I think that many people would also like the option of a local facility to which they would have access.

Jackie Baillie talked about sending people to Bath. Has anybody been to Bath of late? From Scotland, that is a monumental journey for anybody. I do not suppose that taking one's family there is the equivalent of trying to get there while suffering from chronic pain—although with my family it would feel very similar—but it takes a long time to get there. I ask members to imagine doing the 1,600-mile round trip while suffering that degree of pain. Having a facility in Scotland is therefore a major step forward and I welcome that.

Some 780,000 people suffer not as I do, periodically for a 72-hour period, but for weeks on end or permanently—for the whole of their lives. Chronic pain is not a sexy condition in the sense of lots of nurses standing in front of a brand new, shiny building that we can point to while saying, "There we are. We've now addressed it." It is a condition that it takes will, courage and a sense of purpose to deliver progress on. I think that the cabinet secretary is up to that task. I will not say that he is Prince Charming to the Ice Queen of old, although Jackie Baillie tried to turn it into that metaphor, but I think that he is genuinely committed to our making that progress.

In a fraternal way, I lend my support to Ms Baillie's amendment. More important than anything else, this must be the watershed debate after which chronic pain sufferers will be able to say that parliamentarians finally rose to the challenge and made a commitment to deliver real relief to those who suffer from the condition.

15:13

Aileen McLeod (South Scotland) (SNP): I welcome the opportunity to speak in this debate on the important issue of chronic pain. I am pleased to see so many people in the public gallery to listen to the debate.

Significant pain is reported to be experienced by 14 per cent of our population, with 6 per cent suffering severe chronic pain that has a major impact on their quality of life, employment, daily activities, mood, sleep and all aspects of their general health and wellbeing. Chronic pain is a sensitive and deeply personal subject for those who suffer it and for their loved ones, who often suffer with them and can feel powerless to help. I am therefore genuinely pleased to see the commitment that the Government has outlined to deliver high-quality chronic pain services at every level of care.

The Scottish service model for chronic pain, for example, will greatly assist patients' understanding of what support is available and will give clinicians and healthcare professionals the knowledge and structure to direct patients and allow consistent care pathways to be followed. I further welcome the Government's commitment to provide a highly specialised pain management service and today's announcement of a public consultation on the options for the future delivery of the service.

The new service for Scotland will be a strong addition to the services that are necessary to meet the many and complex needs of those with a debilitating chronic condition that can devastate the lives of patients if appropriate support is not available.

I will highlight the progressive initiatives that are taking place in Dumfries and Galloway, which show how the Scottish service model for chronic pain is being implemented based on specific local needs and circumstances. Since its formation in April 2012, NHS Dumfries and Galloway's chronic pain improvement group has worked well. Each of its five sub-groups has developed a range of projects to improve the chronic pain care pathway. An important element of the improvement work is the upskilling of local staff. Twenty physiotherapy staff have recently undergone a two-day cognitive behaviour training course and community pharmacies have participated in training sessions on chronic pain. Pharmacies have also circulated patient questionnaires to people who are prescribed medication for chronic pain, and the responses will be fed into the patient involvement sub-group.

NHS Dumfries and Galloway has agreed to create an additional health psychologist post, with two sessions a week for chronic pain. In addition to working with patients, the postholder will, crucially, cover the education of general practitioners and other clinicians. Arrangements are also in place for GPs and community physiotherapists to use the much-praised electronic referral system to refer patients directly to Pain Association Scotland, which has a funded service agreement with the health board.

It is key to assist people to manage chronic pain themselves not only by making sure that the necessary support and advice are there but by giving them the tools to do it themselves, when appropriate. That is as much about empowerment as it is about prescribing.

Such examples are being replicated across the country. Some boards are further forward than others in developing their local service delivery

plans for implementing the model, but it is important to emphasise that progress is being made and that that is a significant step towards ensuring equity of access to chronic pain services and support across all levels of primary, secondary and tertiary care.

Prior to consultation, the NHS is working with partners, including patients and clinicians, to assess appropriate options. Addressing the needs of patients at the pinnacle of the Kaiser Permanente pyramid can be challenging. Consultation, especially with the small number of patients who have the most severe needs, is vital to ensure the most appropriate targeted use of resources and to deliver equity of service for that highly specialised group of patients.

Therefore, I especially welcome the Government's decision to include appropriate residential accommodation in the options for the intensive pain management service. That is fundamental in ensuring that patients get the support that they need from the intensive service. It is vital that the service offers as non-medicalised a routine as possible and that any accommodation reflects normal aspects of daily living, because that helps patients to maintain progress when they return home.

Services need to be person centred. All the measures in the Government motion add focus and positive direction to chronic pain services, not only at the highly specialised intensive end of the spectrum but in prevention and secondary care. With the publication today of the Public Bodies (Joint Working) (Scotland) Bill, which is to integrate adult health and social care, that approach will help to reduce health inequalities and empower patients with chronic pain to have as full a life as possible.

I think that everyone in the chamber recognises the importance of delivering high-quality services for chronic pain sufferers—there can be nothing more personal than pain. Although improvements have been made in service provision since 2007, it is equally clear that the Government is resolute on the need to accelerate the delivery of further improvement throughout the spectrum of treatment. That is a work in progress, but I am confident that we are heading in the right direction.

I support the Government's motion.

15:19

Jayne Baxter (Mid Scotland and Fife) (Lab): As we know, chronic pain has been the subject of parliamentary discussion for more than 10 years. The number of reports that have been produced on chronic pain is startling—the cross-party group on chronic pain has highlighted that there were five reports before devolution and there have been four in the years since. Despite that, chronic pain appears to be one of the ignored issues in the debate about Scotland's health services, so it is welcome that it has finally been given the debate time and attention that it deserves.

As recently as 2012, the then Cabinet Secretary for Health, Wellbeing and Cities Strategy answered a parliamentary question by stating that there was

"insufficient evidence for an economic case to support the development of a Residential Pain Management Programme."—[*Official Report*, *Written Answers*, 7 February 2012; S4W-05186.]

Although a commitment was made to a review by the chronic pain steering group in the summer of last year, that was just the latest of the varying responses to the recommendations that have been made over the years for pain services in Scotland.

I was surprised to learn of the Scottish Government's response that there is a lack of evidence for an economic case and I hope that that attitude is shifting, because the Chartered Society of Physiotherapy Scotland has highlighted the fact that the direct healthcare cost of chronic pain in Scotland is about £160 million. That figure pales in comparison with the associated costs of chronic pain to the economy. For example, when we consider the number of working days or workers lost to the economy in the United Kingdom due to chronic pain, the figure leaps to £1.7 billion. Despite the huge opportunity and economic costs associated with a condition that can be long term, the level of care available throughout Scotland is extremely patchy.

Unfortunately, adults are not the only ones who suffer. It has been estimated that up to 80,000 children in Scotland have chronic pain. It is worrying that, in many places, those children face the same difficulties in accessing appropriate treatment and support. Healthcare Improvement Scotland's "Update Report on Scottish Pain Management Services" noted:

"The development of children's pain services in Scotland is at a relatively early stage".

Given the numbers of children who are affected, that is a disappointing statement.

Equally disappointing is the postcode lottery of multidisciplinary care, which varies as much throughout the country for children's pain services as it does for adult services. Few health boards offer primary care provision of multidisciplinary pain management for children or adults.

NHS Fife is one of those few. The Fife integrated pain management service for patients with chronic pain has a single referral system, clear referral criteria and a triage process.

Through that approach, the health board can refer one patient in 10 with chronic pain to a pain management programme. That might not seem like a high figure, but it compares well with the shocking experiences of patients in some other health board areas who, as we have heard, have been referred to a pain management programme hundreds of miles away in Bath.

The combination of primary and secondary care that NHS Fife uses is based on self-management and physiotherapy and uses community venues. It was developed from work done in west Fife. When the initiative was established some years ago as the Rivers pain service, the aim of the physiotherapists and pharmacists involved was to provide services for people who were coping with chronic pain in local settings, such as community and leisure centres.

I am grateful to the Chartered Society of Physiotherapy for highlighting the service to me before the debate. I share its view that such community-based treatments are essential to providing pain care programmes that enable those who suffer chronic pain to gain greater control of their condition.

I encourage the Scottish Government to look into the Fife example when it begins to implement the Scottish service model for chronic pain. Sadly, not all examples are as positive as the one that I just outlined.

One of my constituents, Linda Penn, who is a patient under another health board in the Mid Scotland and Fife region, has raised with me her experiences of the long waiting times that she has endured to see a specialist and the difficulties that she has encountered in accessing treatment. Having waited 12 weeks for an initial appointment with the pain specialist, she waited a further seven weeks for a 10-minute acupuncture session. As she is a resident of Alloa and unable to drive, she had to undertake a one hour and 20 minute bus journey each way to the pain clinic at Falkirk. Strangely enough, any benefits of the 10-minute treatment at the pain clinic are undone by the round trip of nearly three hours. After the debate, I will raise the detail of my constituent's case with the cabinet secretary and the health board.

Unfortunately, I am sure that Linda Penn's experiences are not unique. They serve to highlight the need for a chronic pain residential treatment centre like the one in Wales that has been mentioned. Scottish Labour's amendment, on the need to establish such a centre as a matter of urgency, is to be welcomed. I hope that improvements take place across the board for patients with chronic pain in Scotland as soon as possible.

15:24

John Wilson (Central Scotland) (SNP): I welcome the cabinet secretary's motion on chronic pain. I come to the debate with the background of being one of the three co-conveners of the cross-party group on chronic pain, along with Jackie Baillie and Jackson Carlaw, and as a member of the Public Petitions Committee, which considered the petition that Susan Archibald lodged on the cross-party group's behalf to take forward the issues that the group has highlighted in relation to chronic pain. That petition has clearly brought important issues into the wider public domain and partly helped to initiate today's debate.

It is estimated that 800,000 people, including 70,000 children, suffer from chronic pain at varying levels. Healthcare Improvement Scotland provides no definitive figures on the numbers of people who are affected by chronic pain but, according to the Scottish intercollegiate guidelines network, the problem might affect approximately 18 per cent of the population at some point during their lives.

I recognise that the Scottish Government considers that the best way in which to fully investigate the issues behind chronic pain is to adopt a Scottish service model. The Government accepted some four years ago that long-lasting pain is a condition in its own right but, that said, there has been criticism of health boards in relation to taking the necessary action in a wider Scottish context.

The Scottish Government has made a commitment to provide two-year funding to start up local service improvement groups. The requirement for better data collection has been recognised for benchmarking. In addition, the chief executive of NHS Scotland has proactively looked for feedback from all health boards on how progress towards the four key recommendations is being assessed. I touched on the first recommendation in mentioning the Scottish service model for chronic pain, and the cabinet secretary rightly identified that we also have to look at the social model of care for sufferers of chronic pain.

I will spend some of my time talking about the second recommendation, which is about working with patients and the voluntary sector. Although health boards need to develop a stronger level of participation by patients, some people could argue that patients can be moved around for treatment, so we need to look carefully at whether the treatment plan is patient centred. Some members of the cross-party group have made the criticism that there is little patient representation. The Scottish Government clearly has a role in developing solutions on that. The role can be successfully implemented only if organisations work jointly on a shared programme.

That is just one aspect of the approach that is needed if we are to ensure better service delivery for people with chronic pain. Another concerns what is happening on a practical, day-to-day basis. Although I recognise the good work that is taking place at the Buchanan centre in Coatbridge, which is a primary care facility, it is centralised, which leads to problems with patients accessing the facility, especially if they stay in outlying villages in Lanarkshire.

The most basic building block of the NHS is the general practitioner. GPs have a vital role in developing an holistic approach. I note that the need for their assistance in developing an approach that delivers local clinics run by GPs with a specialised interest is going to be answered by 10 GPs who have registered an interest in Lanarkshire.

I note and welcome the fact that the Scottish Government has placed a high priority on each health board delivering a plan that covers all areas of chronic pain. The Government is already committed to providing the appropriate residential accommodation, especially for patients whose chronic pain is severe, and that should limit the impact on people who are at risk now and in the future.

I welcome the opportunity to highlight chronic pain because, behind the talk of data collection, we must remember that we are talking about real people who, at many levels, are just trying to get through the day and through their lives. Chronic pain has an impact not just on individuals but on their families. It affects people's day-to-day activities and whether they can hold down a job. We must remember that, if people are to be active in their communities, they need services to be provided by the health board and others to enable them to do that and to continue leading fulfilling lives, rather than finding that their condition has a debilitating impact on them.

We look forward to a time when chronic pain is taken seriously not just by the people who suffer from it but by all those who are involved in delivering services, such as health boards and others. That will ensure that, when we move forward as a society, those individuals feel that they are part of that society.

I look forward to the initiatives that the cabinet secretary is taking and I look forward to a time when Scotland has a comprehensive chronic pain service that is provided in every part of Scotland, with health boards playing a vital role and with GPs being seen as front-line service providers for many patients. There should be a co-ordinated approach to ensure that all patients, no matter who they are, receive the treatment that they deserve and require.

15:31

Graeme Pearson (South Scotland) (Lab): The NHS faces many challenges, to which it often responds by delivering positive outcomes. However, chronic pain has been and still is the ghost in the machine. Affecting thousands of Scots, chronic pain—and sometimes also severe pain—results in long-term suffering for patients, apparently without meaningful support or treatment. The presence of campaigners in the chamber reflects the dire need for support that exists in the real world.

Chronic pain—pain that continues over an extended period—is a blight on the lives of thousands of Scots, and our debate must focus on how to support the individuals and families who are affected. As the cabinet secretary acknowledged, it ought to go without saying that Scots who suffer from chronic pain should have access to the full range of available treatments here in Scotland, yet too many patients are being forced to travel to other parts of the UK for support.

Scots not getting access to the treatment that they need has been a running theme in the chamber over the past few weeks and, unfortunately, the postcode lottery of chronic pain services means that that theme is likely to continue today. The cabinet secretary acknowledged that some 800,000 Scots, including 70,000 children, suffer from chronic pain. To obtain some relief a lucky few—if we can call them lucky—have to travel 400 miles or more for specialist treatment. The cost of sending some 20 people a year to Bath in Somerset for treatment at a specialist unit runs to some £250,000. Surely that money would be better spent on providing treatment here in Scotland, and I welcome the cabinet secretary's commitment to resolve that matter. I am concerned about how the Scottish Government plans to continue treatment arrangements such as those in Bath in an independent Scotland, but perhaps that is a debate for another day.

Healthcare Improvement Scotland's "Update Report on Scottish Pain Management Services" reported that 75 per cent of the population now have access to a pain management programme. However, the report has been widely discredited—as has been mentioned—with the true statistics showing that barely 64 per cent of Scots have access to a pain management programme. Waiting times are also significantly longer than those claimed.

Dealing with chronic pain is hard enough without the Government massaging the figures and hiding the scale of the problem from the public. However, the HIS report exposed the significant variations in treatment across Scotland and noted that the

majority of NHS boards provide community-based pain services, not clinician-led services.

At the moment, those who suffer from chronic pain face a postcode lottery for access to day clinics and, if they require specialist treatment, they face that 800-mile—or more—round trip to Bath. That seems ludicrous, with the travel causing additional grief and stress for the sufferers. Of course, we must not ignore the fact that chronic pain is generally not an ailment in itself; it is often an accompanying symptom of illness or injury.

The Government must ensure that root problems are catered for and dealt with by staff who understand the problems. We must achieve a balance between providing care and treatment for the underlying causes, such as arthritis, cancer and multiple sclerosis, while offering dedicated medical support to deal with the resulting chronic pain. It is important to acknowledge the Scottish Government's promises and give credit to Alex Neil for his pledge to improve the specialist care that is on offer to Scots who suffer from chronic pain.

I close by commending the work of the cross-party group on chronic pain, particularly that of the co-conveners Jackie Baillie, John Wilson and Jackson Carlaw. They have acknowledged that minor improvements have been made during the past decade, but the well-documented major issues still need to be addressed.

I hope that, in his consultation, the cabinet secretary and his colleagues will consider carefully the recommendations from all relevant organisations to ensure that those who suffer from chronic pain have access to much-needed support and treatment. I hope that he delivers action and real services in addition to his words today. The majority of feedback seems to indicate that little has changed in the 11 years since the previous parliamentary debate on chronic pain—a debate that prompted a record level of interest. I hope that today's debate will bring a focus on effective treatment so that we can now make it happen.

I support Jackie Baillie's amendment.

15:36

Bob Doris (Glasgow) (SNP): I note that Mr Pearson's speech seemed to be a speech of two halves, and that the tone of the first half was just a little bit wrong. I do not understand how he managed to bring independence into a consensual debate like this; that was a complete non sequitur and a bit insulting to the substance of the debate. It might be out of character, but there we are.

As other members have done, I pay tribute to Susan Archibald and her petition, and to all those who are involved in the wider campaign to improve the situation for those who live with chronic pain. I have not followed the issue particularly closely, so today's debate has given me the opportunity to find out more. Having said that, a number of individual constituents have made representations to me in the past on chronic pain issues. Indeed, I am sure that we all have, as I have, a family member who lives with chronic pain, so we can all see the social and emotional consequences of it as much as the medical consequences.

I welcome the progress that has been made with regard to chronic pain. In doing so, I note the concerns of the cross-party group in the Scottish Parliament on chronic pain, which supplied a briefing for this afternoon's debate, and those of the Health and Social Care Alliance Scotland. Those groups have raised concerns about the pace of implementation of recommendations that started as early as 2007 with "Getting to GRIPS with Chronic Pain in Scotland", and about the progress that has been made by each of the 14 health boards. I believe that progress has been made, but we must draw attention to the fact that concerns have been raised about that progress.

Of course, it is right for passionate and committed campaigners to be in a hurry for quick progress to be made on chronic pain management—that is the role of doughty campaigners, for which I pay tribute to them. Health boards and the Government must take a planned approach to developing new or improved services. The important date for many will be April 2014, by which time each health board will need to have in place a chronic pain service delivery plan.

Since 2009, we have had a national lead clinician whose job it is to spearhead and champion the development of pain management services. A national chronic pain steering group has been developed, as well as a Scottish service model for chronic pain. I would welcome information from the Scottish Government on the degree of preparedness for the April 2014 deadline. Many people see that date as an end point for having a comprehensive system in place to tackle chronic pain, rather than a starting point. More information on the preparedness of each health board would be welcome.

There is a new set of SIGN guidelines that should underpin any managed clinical network and how it will work. I note that NHS Greater Glasgow and Clyde now has a managed clinical network for the management of chronic pain.

I am interested to know how the care pathways will work for those who live with chronic pain. How will sufferers seek support? The documentation may be available on file and briefings may have been provided to MSPs, but what will be the reality for those who live with chronic pain?

I would welcome more information on how the Scottish Government will ensure a consistent approach in the quality of service that is provided across all health boards. However, although I mention the need for a consistent approach, I accept that there is a need for localised delivery models and that is what I want to concentrate much of my speech on.

One of the organisations that I work with in Maryhill is Revive MS Support—multiple sclerosis is a significant cause of chronic pain for many—which provides services such as physiotherapy, aromatherapy, reflexology, counselling, hyperbaric oxygen therapy and speech and language therapy, including swallowing and cognitive advice. I could cite many more examples of the services that Revive MS Support provides, but the important point is that the organisation provides an holistic approach to help those living with chronic pain, such as MS sufferers and their families, by supporting them in the community.

Revive MS Support is based in the north of Glasgow, but it also does outreach work in Paisley, Douglas, Hamilton, Glasgow's south side and beyond. Therefore, as others have said, in looking at the network of support that is available for those living with chronic pain, it is important that we consider the support that can be provided by the third sector or voluntary sector.

I want to put on record the words of a lady called Jenny Wilson Best, who is an ambassador for Revive MS Support. She said:

"REVIVE offer many different therapies but for me it was the 'Fatigue Management Group' that allowed me to find myself again. I renamed it 'Anger Management' then 'Sadness Management' and finally to 'Acceptance Management'. I cried a lot but I don't cry anymore. Now I get on with my life and live it to the full. I still suffer fatigue and chronic pain and have learnt how to use my wheelchair but thanks to REVIVE I have found a path upon which I can walk."

The reason for my using that quote is that people may not consider organisations such as Revive MS Support to be clinician led, but they provide a quality service that supports people living with chronic pain. When we look at the strategy in each health board area, we need to ensure that there is breathing space for organisations such as Revive MS Support. I should put on record that Revive MS Support recently got a £20,000 grant from the Scottish Government to provide an additional support worker for its outreach work.

The Deputy Presiding Officer: You should draw to a close, please.

Bob Doris: As we move towards health and social care integration, health boards and local authorities should be looking to disinvest some of their funds in favour of such organisations, which provide an holistic approach to tackling chronic pain in our communities.

15:42

Gil Paterson (Clydebank and Milngavie) (SNP): I welcome the opportunity to speak in the debate from both a personal and a general perspective. I speak from a personal perspective in that, having suffered from chronic pain, I can fully appreciate the background to, and experience of, the issue and the impact that the implementation of the Scottish service model on chronic pain will have on sufferers across Scotland. I speak from a general perspective in that, as a former member of the cross-party group on chronic pain—a group that does sterling work on the issue—and in my daily constituency duties as an MSP, I have met a large number of people from many different backgrounds who have been afflicted with chronic pain at some point in their lives and who have helped to shape policies that can support sufferers and their families.

For me, there are two aspects to chronic pain. The first is the debilitating effect that severe acute continuing pain has not only on the body but on the mind. The physical inability to function to do some simple tasks is difficult to explain to those who have not suffered the impacts and effects of chronic pain. The second aspect relates to what people think. In my own situation, I looked okay on the outside, but I suffered embarrassment when I had to ask a workmate—in my case, it was an employee—to lift a package that was no heavier than a pint of milk into my car. That left me with a deep feeling of guilt, and I think that my employee thought, "He's at it."

I put up with the situation for years until my good friend Alex Neil, who funnily enough is now the Cabinet Secretary for Health and Wellbeing, accidentally found out about my situation and advised me on how to seek a solution. That was a fair number of years ago, and it was his good advice that started my recovery. It is difficult to calculate how many people have been in a similar situation to mine but were not as fortunate as I was in receiving that valuable information.

Margo MacDonald: He never told me.

Gil Paterson: I believe that the stigma that is attached to chronic pain and the lack of understanding of it have been reduced drastically over the past years. However, I am pleased that the Scottish Government continues to attach such importance to the issue, because almost 18 per cent of the Scottish population might have been affected at some point in their lives. I am sure that members will agree that that amounts to a large proportion of our people and makes it more than likely that nearly every family in Scotland has a

member or friend who has at one time or another suffered from chronic pain.

In recent years, there has been a marked improvement in tackling pain—not only in attitude, but in action. The establishment of a national lead clinician in 2009 was an important step, as it acknowledged the impact that chronic pain has on the lives of so many people and led to today's debate. The Scottish Government should be praised for funding that position, as we are now seeing its hard work come to fruition. The national chronic pain steering group, which was established by the lead clinician, has played a fundamental role in developing a model that will help all sufferers.

Over a number of years, the steering group has developed the Scottish service model for chronic pain, which offers a valuable approach to dealing with the varying and complex levels of the condition. To ensure the best outcomes for the care and support of people living with chronic pain, there must be a complete understanding of what chronic pain is and how best to treat it. The challenge for the service model is to ensure that that is the case. I believe that we are on the right road to improving the understanding of chronic pain as well as its prevention and management.

A recent concern regarding care for those with chronic pain is the disparity in the range of services and resources in different health boards. I believe that, with the implementation of the service model across NHS Scotland, that variation will be addressed, which will have a positive impact on sufferers across Scotland. I am pleased that the Scottish Government is fully committed to implementing the service model, but that will happen only through close co-operation between the Government, the national lead clinician, the steering group, Healthcare Improvement Scotland and the health boards.

At present, a number of people have to travel outwith our country to the Bath centre for pain services. I make it clear that I would have travelled to the ends of the earth to relieve the pain that I suffered from, but it is good that the Government is taking action on that. I welcome the Government's commitment to consult interested parties to ensure that specialist facilities are available here in Scotland. To be honest, I am not sure what the best model is. I like the idea of consulting and talking to all interested parties, as we should engage with people, rather than do it ourselves.

Since 2007, there has been a huge improvement in the provision of chronic pain services, but we must never rest on our laurels. We must continue to build on that improvement and, if members support the motion, I believe that positive progress will be made.

15:49

Hanzala Malik (Glasgow) (Lab): I welcome the opportunity to talk about access to services for people living with chronic pain. I have personal experience of the issue. As I come from a family of four generations, with a great-grandmother, grandfather, father and son, it is fair to say that we are regular customers of the health service in one form or another.

The 2012 report, "Update Report on Scottish Pain Management Services" from Healthcare Improvement Scotland states that

"... pain is not consistently managed across the whole health and social care system at present".

I was shocked to read that, according to the report, the average waiting time in Scotland for the first referral appointment is 11 weeks. Even that is not the full picture.

Based on my personal experience of waiting for appropriate treatment for several months, it is extremely debilitating if that is the real fact of the matter, given that some patients are sent from pillar to post and are often confused about what to do and where to go for real help. Patients can feel that their problem is not being taken seriously. In my case, I felt uncomfortable being given higher and higher doses of medication, while a proper solution to my problems was not being addressed—as I felt—immediately.

At one stage, a doctor suggested that I consider going private. As a member of the Labour Party, I was astonished that an NHS doctor would make such a suggestion. The doctor to whom I was speaking knew that I am a socialist and would never consider that option. I put that point to him and added, "You do appreciate that I'm a Muslim; despite that, if the press got hold of this, they would crucify me." The doctor appreciated my dilemma and sought other ways in which he could help me.

I am glad that the Scottish Government has begun to deal with the issues around the inconsistency of chronic pain services. However, these are the early stages: the first steps. I genuinely wish the Government well, because a lot of people are suffering unnecessarily.

The postcode lottery in the provision of chronic pain services needs to be addressed. A lot of people use the phrase "postcode lottery" and assume that everybody understands. However, I think that the people who suffer really understand when they see the indifference that exists in communities, which can create a lot of ill-feeling. Not only is one suffering, but perhaps one also feels not as well looked after as other members of the community are.

Waiting times for access to chronic pain services need to improve. That has been demonstrated and we are aware of that.

I thank Jackson Carlaw for the description that he drew today of people who suffer from migraine. My wife suffered from migraine for years and until today I had not realised how badly I have treated her. I have never taken her ailment seriously. Today I will apologise to her, now that I realise how badly she suffers. When she moves around the house like somebody in outer space, I will now be able to understand why. I thank the member for that description, which I take on board.

I want to say to the cabinet secretary: sir, the Labour Party's amendment is very reasonable. Our suggestion is not one that will challenge the cabinet secretary in accepting it, so I genuinely hope and wish that he will take it on board before the end of business. The issue is not party based; it is about caring for communities. I am a sufferer, and many others in the chamber today have shared their experiences. We are not looking at reports, or at the fancy graphs that consultants produce; we are talking about real people with real issues. We are speaking from experience and from our hearts. We wish the cabinet secretary well in what he is trying to do, and hence I cannot emphasise enough how important the amendment really is. I hope and wish that members will take on board our amendment.

15:54

Joan McAlpine (South Scotland) (SNP): I, too, welcome the campaigners to the gallery, particularly the petitioner Susan Archibald. I had the great pleasure of hearing Susan speak at the recent demonstration against Trident in Glasgow and she was very eloquent about the scandal of paying for nuclear weapons on the one hand, while on the other hand vulnerable and disabled people, including those who suffer from chronic pain, are being punished by welfare cuts and the bedroom tax.

Before directly addressing the motion, I want to talk about priorities in much the same way that Susan Archibald talked about priorities in condemning at that demonstration the amount that is being spent on Trident. With regard to the availability on prescription of paracetamol and aspirin-based painkillers in the NHS, some have suggested recently that as prescriptions are now free in Scotland, prescribing such medicines is a waste of money. However, this debate might offer the opportunity to remind ourselves that chronic pain is a very serious condition that requires medication and painkillers and that it would be wrong to punish those who have such a serious condition by charging them for their care.

Of course, chronic pain is a long-term condition and the plight of those who suffer from such conditions was recently highlighted in a report called "Paying the Price: Prescription Charges and People with Long-Term Conditions", which examined the effects of prescription charges in England. The report was written by the prescription charges coalition, which comprises 20 organisations, including Arthritis Care, the National Rheumatoid Arthritis Society and Disability Rights UK, that represent patients, many of whom suffer from chronic pain. Of the 4,000 people who were surveyed, 73 per cent paid for their prescriptions and 35 per cent of those people had on occasion failed to pick up a prescription because of cost.

The same issue is reflected in other polls; for example, a MORI survey for Citizens Advice found that in 2007 800,000 people in England had failed to collect a prescription because of cost—and, as we know, the cost has risen considerably since then. Although we are looking at the work that needs to be done and indeed the work that has already been done to develop specialised services for those with chronic pain, we should not overlook the benefits that the introduction of free prescriptions has brought to such patients.

Drew Smith (Glasgow) (Lab): Will the member give way?

Joan McAlpine: No—I want to make progress.

I am fortunate in not having suffered serious illness in my life; indeed, I have experienced severe pain on only two or three occasions as a result of toothache and childbirth, both of which thankfully ended quickly. However, I know people who suffer from chronic pain and have seen how dreadful and debilitating it can be. In my experience, although it can be managed with good services, the individual can become completely housebound and isolated and I welcome the cabinet secretary's commitment to community-based services, primary care services and a social model of care. For some sufferers, that is the only method of delivery that they would be able to access.

I am very glad that the cabinet secretary intends to end the situation in which unwell people travel to Bath in Somerset. I am told that Bath is a very attractive city—indeed, it is still on my list of those that I wish to visit—but it should be visited voluntarily and for pleasure, not out of necessity.

Margo MacDonald: I appreciate that the member wants to make headway, but I note that two or three members have already referred to going to Bath as if it were like going to Mars. If I need specialist treatment, I will go wherever it is provided. It is simply unrealistic to imagine that either Scotland or England can contain all the centres of excellence.

Joan McAlpine: The member makes a reasonable point; indeed, I was just about to address the substance of her comment.

I welcome the fact that the cabinet secretary will consult on the type of residential treatment that will be delivered in Scotland. That seems eminently sensible because having only one centre in the central belt, no matter how specialised it might be, could mean long and uncomfortable journeys from the far north of Scotland and indeed from less accessible parts of the south of Scotland area that I represent. I am encouraged by what is happening across the country to deliver care to people where they live, and by Aileen McLeod's comments about the considerable progress that is being made in Dumfries and Galloway to establish a service improvement group.

I welcome the cabinet secretary's commitment to reducing waiting times and agree that the integration of health and social care, on which we will legislate, is particularly relevant to chronic pain sufferers. As the cabinet secretary said, it is important to give sufferers a real say in how their services are delivered.

It is important to remember the progress that has been made to date. In 2007, only one NHS board had a pain management programme; in 2013, five boards have a pain management programme. As has been said, from April 2014 every health board will be required to produce a chronic pain service delivery plan. Seventy-five per cent of the adult population of Scotland now have access to a pain management programme, and I welcome the cabinet secretary's commitment to raising that figure to 100 per cent.

It is clear from the cabinet secretary's comments that the Scottish Government is committed to enhancing the provision of chronic pain services and building on the improvements that have been made. I welcome Opposition members' acknowledgment of the sincerity of the cabinet secretary's commitment. That spirit of respect and co-operation will help us to build on the progress that has been made to date.

16:00

Jim Hume (South Scotland) (LD): As the Lib Dem spokesman on health, I, too, pay tribute to Susan Archibald, Dorothy-Grace Elder, Jacquie Forde and, of course, their colleagues on the cross-party group on chronic pain. That group can take huge credit for this debate. The way in which we deal with chronic pain in Scotland is being given the much-needed spotlight that it deserves because of its campaigning.

We know that Healthcare Improvement Scotland defines chronic pain as

"continuous, long-term pain lasting more than 12 weeks"

and we know from evidence from SIGN that as much as 18 per cent of our population—and 8 per cent of children—suffer from chronic pain. I want to focus briefly on what chronic pain means to its sufferers and their families. Some members have managed to articulate that. I hope that Susan Archibald will not mind if I refer to her particular circumstances to illustrate the point.

Like many at the worst end of suffering, Susan Archibald was driven to attempt suicide as a result of having to deal with constant, non-stop pain. She started to swallow pills while her husband and children were asleep, and she was saved by her baby's crying. That act of desperation at a very low point was possibly a sad reflection of the deficiencies of pain management services in the current provision. Although some improvements have been made, the pace of change has been slow, and gaps still remain. Thankfully, Susan has put her experiences of dealing with chronic pain to good use in her campaigning efforts, and I congratulate her and her colleagues on bringing their petition to the Scottish Parliament.

We know, sadly, that there are tragically high rates of suicide and attempted suicide among those with chronic pain. That can be linked to depression. People with chronic pain might not be able to hold down a job and that, of course, has all sorts of consequences for home and family life.

Not many may know that today is world MS day. Bob Doris mentioned multiple sclerosis. A couple of weeks ago, I visited the MS Therapy Centre Lothian in Edinburgh, which also covers Fife and the Borders, and I spoke at length to the manager there, Nancy Campbell, her team and some of the centre users. We discussed issues such as the practical challenges that MS sufferers face. It was clear from those discussions that the physical effects of the condition are wide ranging and that they cannot really be pinned down to one, two or three main symptoms. Each sufferer is different so, in creating a model for chronic pain, we need a system that can work for individual patients.

The problem of treating chronic pain is not new, and evidence tells us that it is not treated in the same way throughout our country. Throughout the country, patients and health groups tell us there is too much regional variation, and we cannot be assured that the best treatment is being provided to patients equally. We often talk about postcode lotteries in the health sector; in this case, the failure to address chronic pain management effectively across the board seems to represent a health inequality with a huge human cost.

The Liberal Democrats welcome the plans for a Scottish service model for chronic pain that would mean NHS boards implementing a service delivery

plan from next year. It is important to say that the forthcoming legislation to integrate social work and NHS services will be an opportunity to ensure that chronic pain management does not fall between the bailiwicks of those two services.

We support the aspiration for more management of chronic pain to be undertaken within the community. It is common sense that people should be treated and supported as close to home as possible, rather than have to travel to hospital or, in some cases, as far away as Bath in Somerset. That will of course require improved understanding among general practitioners, so we look forward to the publication of the SIGN guidelines next year.

It has been a day for welcoming, so we also welcome the commitment to consider options for a specialist residential facility in Scotland that we hope would ensure that patients who need that level of care would no longer have to travel to Bath for it. However, I believe that we need the consultation to run before we recommend what would be the best approach.

Alongside effective treatment, self-management techniques and support can be critical in helping people to take greater control over their condition and enjoy better lives. Better partnership working between the NHS, social care and the third sector is crucial in improving support for self-management. However, people should know where to get help, so we also welcome the community pharmacy campaign, which highlights where people can find reliable information on pain management.

Nobody doubts that there is still a long way to go in Scotland, particularly in children's pain services, which will have to be a major part of the health service's implementation of a Scottish model. Children are particularly vulnerable, with 8 per cent, as I said, estimated to be suffering from chronic pain, which can undoubtedly interfere with their quality of life and of course their education. We need to build on children's pain services as a matter of urgency, and I look forward to hearing from the minister and cabinet secretary in due course on that specific point.

We welcome the plans for a Scottish service model for chronic pain, which is long overdue. Chronic pain is perhaps a misunderstood part of our health service and it has not been afforded the focus that it deserves. I hope that today's debate is a marker for change.

16:06

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I am slightly surprised that we have got this far down the speaking order without exploring in a more structured way that there is a large variety of pains and chronic pains. Jackson Carlaw referred to his migraines, Graeme Pearson referred to arthritis and other members referred to particular kinds of pain. However, the minister's announcement of a consultation to look at three options—indeed, the consultation may throw up other options—is quite proper because there are so many different sources and effects of pain and chronic pain that there may not be as simple a solution as perhaps the Labour amendment suggests.

I will illustrate that point with a few examples, some of which are close to home and some of which are not quite so close. First, my mother, who as a youngster was an active tennis player, developed arthritis in her late 30s and early 40s. Eventually, she had to have her hips, where she was most affected, immobilised—it was before the days of hip replacement—and, ultimately, the muscles in her thighs cut to prevent movement. She suffered pain of an excruciating nature for the rest of her life. In our family we lived with that and with the reality in those days that relatively little could be done about it.

My mother was not miserable because of the pain: she lived with it and coped with it, as she had to. As a little lady of 4 feet 10 and a half, she ran around on elbow crutches for most of her adult life, but it was different when she got in her Mini Cooper S. I remember being with her on one occasion on the Baiglie straight up to Bridge of Earn doing 100mph—she was liberated by some technology—which was before Barbara Castle brought in the 70mph limit, just in case anyone thinks otherwise. We lived with that situation for my mother and there was no remedy.

When I started as a nurse in a psychiatric hospital as a fresh-faced, innocent 17-year-old in 1964, my first task was to go and see Jimmy in the corner. I was told, "He's got a problem with his legs." I asked Jimmy what his problem was and he said it was his legs. I said, "What's the problem, Jimmy?" He said, "My legs." Eventually, of course, I rolled back the sheets; there were no legs. Jimmy was suffering the substantial pain that amputees often suffer after the removal of the source of the pain. The treatment that someone in such a situation requires might be quite different from the treatment that someone else requires. In those days, it was simple: we simply gave Jimmy as much codeine as he wanted, as a result of which he was addicted to painkillers—that was very much the choice in those days.

For my part, I have had intermittent bouts of pain—perhaps rather fewer than some members, given what they described. In particular, I suffered pain in my neck for four or five months. That turned out to have been caused by a trapped nerve, and I was very fortunate in that a single

session of manipulation relieved the problem. The pain has not come back in 30 years, which is terrific.

More serious, as an adolescent I had to have my torso flayed, to remove the outer surface of the skin. It took six months and was extremely painful. That was because my acne was so severe—oh, the things that I tell members; you won't tell anyone outside the chamber, will you?

The reality is that there are many different sources of and treatments for pain. My father, who was a GP, used hypnosis to help his patients to deal with pain. Indeed, I was taught some hypnosis tricks to help me to deal with my asthma, and to this day I can deal with my asthma without using medication. I was lucky to get a top-up of my hypnosis skills and ability to control my pain from Yvonne Gilan—an actress who, incidentally, was once in "Fawlty Towers"—who specialises in treating people in the acting profession.

Jim Hume talked about young people and pain, which is another, quite different area. There is a huge variety of sources and types of pain, which need to be dealt with in different ways.

We should not talk down Bath too much. The city has 2,000 years of experience of dealing with pain. The Romans built a spa there, where both physical and mental pain were treated. Bath is probably a very good place to go; it is just a shame that we cannot move it a little closer to the patients who need help in Scotland.

We have not yet heard in the debate about pain at end of life. There have been great improvements in the management of pain at end of life through the hospice movement. Again, that is a very different issue to deal with.

We must remember that pain has a purpose: to prevent us from damaging ourselves further where damage already exists. Pain alerts us to that.

I welcome what the minister said and look forward to the outcome of the consultation.

16:13

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I will concentrate on the level 3 programmes for pain management and specifically the requirement for a residential facility. First, however, I pay tribute to Jackson Carlaw and Hanzala Malik for their speeches. I suffer from chronic pain, and both members summed up the importance of the debate. I had a dreadful episode with my sciatica at the weekend—I was not sure whether I wanted to murder other people or myself. Pain is an important and serious issue.

We heard about the residential centre in Bath, which is attended by about 27 patients from Scotland at a cost of about £251,000 per annum. I was delighted when, following the GRIPS report in 2003, we set up a short-life working group, which met for the first time on 1 March this year. I understand that it met again this morning to discuss producing an options paper by mid-June in relation to the need for a residential pain management service in Scotland. I was delighted when the cabinet secretary said that he will go out to consultation on three models of level 3 pain management. Looking at the Labour amendment, I think that if a short-life working group is set up in March and the cabinet secretary tells us today that he wants the results by September, six months later, that shows a degree of urgency.

Jackie Baillie: Will the member take an intervention?

Fiona McLeod: I am sorry, but I am very short of time and I want to concentrate on a suggestion that I want to make to the cabinet secretary.

First, though, what is a level 3 programme? Level 3 programmes are about therapeutic care for those with pain and about teaching us pain management skills. It is delivered by interdisciplinary teams. What we are hoping to achieve through that is not just the reduction of pain but the reduction of the impact of that pain. At the end of it, we want each individual who suffers from chronic pain to be able to live the fullest life they can.

At this point, I would like to make an entirely personal contribution to the consultation. I believe that we have a residential facility in Scotland that could become the residential pain management centre. I quote:

> "This purpose-built, fifteen bed hospital ... is a place of calm, light and healing. A superb project incorporating creativity within tight controls and a fine example for future healthcare buildings to emulate."

That is the description in Scottish Enterprise's dynamic place awards in 2002 of the Glasgow homoeopathic hospital, which had opened fairly recently, in 1999. As many will know, nowadays the Glasgow homoeopathic hospital is the NHS centre for integrative care. The hospital building, with its 15 beds, is capable of treating 10,000 out-patients and 500 in-patients a year. I worked there as the librarian from 2004 to 2008, so I have an interest. However, I also have an understanding of the services that are delivered in that NHS building.

In the years that I was there, the hospital set up the chronic fatigue syndrome/ME project and service delivery. After I left, it moved on to the wellness programme. Those are holistic, multidisciplinary, allopathic and complementary services. The hospital treats people with long-term chronic conditions. In fact, many of the patients at

the hospital at the moment were considered untreatable and incurable. The hospital has done so well in its work over the years that its physio, Stephanie Wilson, has won awards for the delivery of her programmes for ME and wellness. I should say that Stephanie Wilson is a close friend of mine, but she well deserves the accolade that she received a few years ago.

We have the building, the staff, the reputation and the beds. I hope that the cabinet secretary will consider that building as part of his consultation on looking for a centre for pain management in Scotland.

16:18

Siobhan McMahon (Central Scotland) (Lab): I am pleased to speak in the debate. It is an important debate and one that I know will be followed with interest by many throughout Scotland, not least those joining us in the public gallery.

I was surprised to learn that this is the first full debate on chronic pain that the Parliament has ever had, although a members' business debate has been held on the subject. I am concerned that a subject that affects so many lives throughout our country has never been given this level of attention before. One thing that is certain is that this will not be the last debate we hold on this subject.

I welcome the fact that the Scottish Government plans to implement the Scottish model for chronic pain and I am pleased that the NHS has already begun working with patients and clinicians to agree the most appropriate option for a Scottish intensive pain management service.

As others have mentioned, the cross-party group on chronic pain has labelled the debate a landmark one. I hope that members of the group feel that this afternoon's contributions have lived up to that status.

According to NHS Scotland, chronic pain is very common. Around one in five people have continuous pain. In 2008, the Lanarkshire health survey showed that 26 per cent of Lanarkshire's adult population was affected by chronic pain. That means that an estimated 120,000 people in Lanarkshire may live with pain. It is therefore pleasing to me that NHS Lanarkshire recognised that problem and was one of the first health boards in Scotland to offer primary care pain management services.

We all know that access to NHS pain clinics can be a postcode lottery, and that becomes even more apparent for a regional list member. I am lucky that in my area, Central Scotland, if a constituent lives in the NHS Lanarkshire or NHS Forth Valley areas, they can access a primary care multidisciplinary pain management service. However, that is not the case for people who live in other areas of Scotland, which is why it is essential that we move to a clinician-led service across Scotland. Where you live should not determine the level of healthcare that you receive. As Jackie Baillie said, we should also provide enough clinicians and support for people who live in those areas. It is not good enough to say that the services are there when, of course, people have to wait their turn and are not seen correctly. I hope that that will be addressed in the consultation and the recommendations that the Scottish Government will make to NHS Scotland.

In recent weeks, we have heard examples of people having to leave their home in Scotland and travel to England for the health treatment that they so vitally need and deserve. Those who suffer from chronic pain are no different. It is truly shocking that in 2013 someone who has a chronic pain illness such as ME, MS, arthritis or one of the many other conditions has to leave their home and travel to England for treatment—not just across the border, either, but to places such as Bath, in Somerset.

I can only imagine what travelling that distance will do to someone who already suffers ill health. That is one reason why I welcome the Scottish Government's intention to build our own dedicated service in Scotland. The other reason is financial. It does not seem reasonable to have spent more than £1 million in the past few years on sending people for treatment outwith Scotland, when other Scottish patients can and do get the help and assistance they require from their own health board. Of course, they will get that only as an out-patient, which is why the sooner residential accommodation is built, the better.

Having read the briefings for today's debate, I was concerned to note that, although Scotland has a good Scottish service model for chronic pain, that model is not implemented throughout Scotland. I would therefore be grateful to know what precise action the cabinet secretary will take to ensure that the model that the Government plans to implement will help everyone in Scotland. I have already welcomed the work that the Scottish Government is planning to do, but we all know that that will not happen overnight. It is therefore essential that the strategies, plans and clinics that are already in place give the much-needed help and assistance that is required by patients and their families today, and do not wait for the action that has still to come.

I am not a member of the cross-party group on chronic pain, unlike others who have spoken today, although I am a member of the cross-party group on disability. It is through that membership

that I met Susan Archibald. Susan has rightly been given credit by others in the chamber today for bringing this matter to the forefront of our minds as a result of the petition that she brought before the Public Petitions Committee.

It is never easy to speak about the personal aspects of your life, particularly if that involves speaking about being disabled. Susan, however, went one step further and shared with us how desperate she had been to end the pain that she had felt consistently for more than 13 years. I know that Susan would not have taken such a decision lightly and that the last thing on her mind would have been to get praise for doing so, but it is by her brave actions that this subject has finally got the recognition that it deserves. Susan's experience is all the more poignant because we know that she is not alone. Others will have contemplated ending their life and others will have done just that. We cannot allow another person to feel that way or indeed to take their life.

As the cabinet secretary mentioned, it is crucial that mental health services are integrated into the future plans and strategies. Those vital services cannot be left outside the multidisciplinary approach. I believe that those services will be relied on heavily in the months and years to come, not only as a result of the mental anguish that chronic pain patients go through but because the issue will be compounded by welfare reform. Those who already receive benefits are going through their medical assessments now and some are finding themselves either being put on a lower level of benefit or having their benefits removed entirely. I know that that is not of the Scottish Government's making, but I urge it to be mindful of chronic pain sufferers when looking at ways to mitigate that pernicious policy.

I urge the Scottish Government to take action today to implement the Scottish model for chronic pain across Scotland and establish the specialist intensive pain management centre without delay. We cannot afford to wait any longer.

16:24

Sandra White (Glasgow Kelvin) (SNP): Like other members, I pay tribute to the many campaigners who have worked tirelessly to ensure that chronic pain is at the top of the agenda. In particular, special thanks must go to Susan Archibald. Like Joan McAlpine, I met Susan on the march in Glasgow at George Square and was bowled over not only by her frustration at what was happening in the health service—for example, concerning prescription charges—but by her tenacity to push forward anything at all. She spoke eloquently on the bedroom tax and welfare changes. I also pay tribute to Jacquie Forde for her hard work in bringing the matter forward.

Like the cabinet secretary, I remember the early days of the Parliament when Dorothy-Grace Elder took up the cudgels—I think that "cudgels" was her word—on behalf of chronic pain sufferers, and I welcome her back to the Parliament today. She worked long and hard to ensure that chronic pain was at the top of the agenda, so I thank her along with all the others who have worked tirelessly to bring the matter forward.

I welcome the cabinet secretary's announcement of the provision of residential accommodation and look forward to other ideas coming forward. I was taken by Fiona McLeod's interesting suggestion of using the homoeopathic hospital. As one of quite a few MSPs who brought the plight of the homoeopathic hospital to the Parliament when it was under threat of closure and who worked with MSPs from all parties to debate the issue, I think that Fiona McLeod's idea is a good one. It is a fantastic building on a fantastic site that is very easy to reach. It is in a good setting and offers fantastic treatments. A number of members may have visited the homoeopathic hospital. It has a relaxing feel about it and, as Fiona McLeod said, it has won awards. I would be interested in exploring that idea, and the homoeopathic hospital may support it in the consultation.

The cabinet secretary talked about integration, clinical networks, health boards and the creation of action plans by the health boards to improve the services that are available locally. Every one of us would agree that it is imperative that we have not just joined-up thinking but joined-up working. All the services must have that in order to ensure that the services that people suffering from chronic pain get are the very best. We have heard from practically every member who has spoken in the debate, regardless of their party, that the service that is provided by health boards is patchy in the extreme. My health board, NHS Greater Glasgow and Clyde, seems to offer one of the best services, but in other areas people are not getting the service that they deserve. It is therefore important—as, I am sure, the cabinet secretary and the minister will take on board—to monitor the health boards to ensure that they produce plans. If they do not work together, the system will not work at all.

The service that local community pharmacies deliver has been mentioned on numerous occasions. In Glasgow Kelvin, they provide an invaluable outreach service. I ask the minister to say, in his summing up, exactly what role community pharmacies will play in the Government's plans. Will their role be enhanced? Will they be involved in the consultation that is going out to patients and so on? What exactly will they be doing? I am sure that community pharmacies would also like to know that.

Hanzala Malik: Will the member take an intervention?

Sandra White: I am sorry, but I do not have much time left.

Joan McAlpine touched on the important issue of prescription charges. Although the debate has been, on the whole, consensual, we cannot ignore the Labour Party's proposal to reintroduce prescription charges. I do not know whether it will be Jackie Baillie or Drew Smith summing up, but the Labour Party should come clean and tell the Parliament and the people in the public gallery and beyond—[*Interruption*.]

Jackie Baillie may be laughing, but people should be told about some of the issues that she and others have raised. Joan McAlpine made the valid point that people who are suffering from chronic pain do not need anything else to make them suffer even more. [*Interruption*.] It is an important point, Jackson Carlaw, and it is about time that the Labour Party came clean. Perhaps whoever is summing up for Labour will tell us exactly what it means by prescription charges. [*Interruption*.]

The Deputy Presiding Officer (John Scott): Order.

Sandra White: I seem to have touched a nerve. I am sorry for that pun.

The debate has, on the whole, been a good one. As others have said, congratulations must go to the people who introduced the topic to the Parliament.

The Deputy Presiding Officer: You must close.

Sandra White: I look forward to the introduction of the chronic pain centre.

16:30

Margo MacDonald (Lothian) (Ind): Presiding Officer, I hope that I did not affect your nerves by leaving the chamber just before my speech—I just went out for a couple of co-proxamol. I assure members that it was not the quality of the speeches; it was just that the tablets also suffered from their postcode origin.

If I earlier gave the impression of demeaning in any way the medical services in Scotland, particularly here in Lothian, I did not mean to. I am sometimes in a lot of pain and I receive wonderful support.

Too many doctors rely on too many drugs. I was once sent home from hospital with a bag of goodies that would have kept half a housing estate happy for a month or so. At the time, I thought that there was a carelessness in that approach. I was judged to be a trustworthy and sensible person—they should know better—so I was given the drugs to take home. I could have easily become addicted, and I realised how many other people must fall victim to such an addiction.

If I had the time, I would pursue two or three of the issues that Stewart Stevenson raised because the quality and types of pain are all important. I ask the minister to bear it in mind that not all pain is the same. That means that there will be postcode lotteries because some folk will live nearer to a centre of excellence, which might also be their drop-in centre.

Talking of drop-in centres, I commend to the minister the health flat arrangement that he and I once visited where local people provide complementary services, such as aromatherapy, massage and so on. Such services can be a great help to pain sufferers because they do not suffer pain on their own, and it is often the case that a group of people suffering from the same symptoms can be helped together. All those alternatives—the full breadth of treatments—should be considered, as should travelling abroad to England, if people need to do so. As far as I am concerned, people from England are also welcome to come here if they need to do so.

Some members talked about their own experience of chronic pain. Stewart Stevenson reminded us that chronic pain can be a near-death experience. One of the most awful things for someone is for their life to end in pain, suffering and distress. I will not commend my end-of-life assistance bill to members, but they will see where there is a crossover.

Presiding Officer, I thank you for giving me this extra time at the end of the debate. I am now trying to get my co-proxamol, but I cannot find them. [*Laughter*.]

16:34

Nanette Milne (North East Scotland) (Con): The debate has been worth while, although long overdue. As verified in the briefing from the cross-party group on chronic pain, and confirmed by the cabinet secretary, this is the first Government-led debate on chronic pain in the Parliament, although there have been two previous member's debates, the last of which was led by my colleague Mary Scanlon two years ago, as she reminded me this afternoon.

As we have heard, chronic pain is not uncommon: it affects nearly one in five adults and 8 per cent of children in Scotland. Whatever its cause—and there are many conditions that give rise to it—long-standing pain is a blight on the lives of those afflicted by it. A third of those affected are never free of it.

I have experienced the pain of an arthritic hip prior to replacement, with the other one following suit. Believe me, that was not funny, but at least I knew that in time the pain would be relieved—as do the increasing numbers of people who nowadays undergo hip replacement. I do not know how I would have coped 15 years ago, before such surgery was available. I can only imagine the agonies that my husband's grandmother must have gone through before the inflammatory process was spent, leaving her crippled and deformed.

Many people affected by a wide range of conditions that give rise to chronic pain cannot look forward to a cure. They ought to be able to access symptomatic relief and help to cope with the pain wherever in Scotland they live. Sadly, that is not yet the case.

Of course the ideal would be to prevent pain from becoming chronic. That is often achievable with back pain, in which early intervention by a physiotherapist may quickly allow patients to get back to a normal life.

My husband was a fundholding GP in the 1990s, and physiotherapy was one of the first services that he recruited with his budget. That allowed immediate referral for his patients with back pain, prevented chronicity from developing and usually got them back to work quickly. It was a winner all round with happy, pain-free patients and significant savings in sickness benefit. Sadly, fundholding became ideologically unacceptable and was stopped.

When pain cannot be dealt with in the three months before it becomes chronic, a proper pathway really should be in place for the effective and equitable management of such a serious long-term condition. Therefore, there must be an all-round welcome for the Government's plans to implement the well-designed Scottish service model for chronic pain to ensure the best possible outcomes for the care and support of those who live with pain.

To be fair and effective throughout Scotland, that model must be backed by a service delivery plan prepared with patient input and implemented by all of the territorial health boards. I agree with Labour's amendment that that is urgent and that each delivery plan's implementation should be monitored—although, unless I am being somewhat naive, I imagine that that is the Government's intention.

Although the management of patients with chronic pain has been on the radar since the mid-1990s, it is fair to say that progress really only began following the GRIPS report of 2007-08 and the Government's appointment of a lead clinician for chronic pain to co-ordinate and champion the development of pain management services.

Now, with further funding in place to drive forward the implementation of the Scottish service model, we will surely begin to see results, including the better understanding, prevention and management of chronic pain and better services giving patients the earliest and most appropriate treatment locally but with ready access to specialist services when needed.

The availability of proper advice, support and help at community and primary care level should allow many people to manage their pain effectively with appropriate medication. For people with more complex pain, the model should ensure the ready availability of specialist pain management programmes within secondary care delivered by allied health professionals and pharmacists skilled and knowledgeable in pain management.

I fully understand the demands for a residential centre in Scotland to cater for the needs of the small number of people with severe chronic pain who currently have to travel hundreds of miles to access the specialist services that they need. It would undoubtedly be better for patients if such care were available as near to home as possible, with friends and family reasonably close.

I still remember how isolated I felt as a relative when my son was seriously ill in Birmingham even though I was there with him. That sense of separation was all the worse for him—and that was without a travel ordeal, because he was totally unaware of his journey there.

I am glad that the Government is giving the possibility of an in-patient facility serious consideration during the continuing assessment of what is required within a Scottish intensive pain management service. A positive outcome, as called for in Jackie Baillie's amendment, would certainly be welcomed by the patients who cannot get appropriate specialist treatment in Scotland. I hope that, if the experts considering it recommend such a residential facility, it will be established without delay.

The debate has been, on the whole, consensual and constructive. It has also been important for the many people in Scotland who live with chronic pain. It has taken far too long for chronic pain to be recognised as a serious long-term condition and for the equitable development of pain management services throughout Scotland to take place. However, the Government deserves credit for moving things forward in the past few years.

I welcome the progress that has been made so far, but there is still a long way to go to ensure the availability of good pain management for all the thousands of people in Scotland who suffer from long-term pain now and those who will have

chronic pain in the future. I hope that the next debate that we have on the subject will be soon and will celebrate the achievement of a first-class system for all who need it.

16:39

Drew Smith (Glasgow) (Lab): This debate has taken us two hours or so this afternoon, but for the chronic pain sufferers in the public gallery and those in our constituencies and regions who are following our proceedings, the debate about the need for proper support for and treatment of chronic pain has taken more than 11 years.

It has been a good, consensual debate. Jackson Carlaw started well when he introduced a note of levity, but he still made serious and sincere points. Margo MacDonald—who, if I picked it up correctly, made a sedentary intervention that could probably win an award for heckle of the year—and Nanette Milne told us that such conditions are absolutely not a laughing matter, but we were still able to progress through the debate in a generous way.

We should remember that, for every hour and day of those 11 years, Scots have suffered in pain while politicians have failed to put in place all the services for which they have asked us. Despite that, members on all sides have approached the debate in a spirit of hope rather than recrimination. I listened to the radio on my way to the Parliament this morning, and it was clear that many people feel that they have been let down by the seemingly endless debate and investigation of the issue rather than action. Reports and recommendations have come and gone and the sun has set after a number of false dawns.

Throughout that time, there have also been the voices of those who have been helped by the services that exist, such as those who have benefited from a visit to Bath and those whose health boards provide more support than others. Members throughout the chamber sought to give voice to those people. Perhaps most memorably, we heard Stewart Stevenson's description of his hypnotic trip. I noticed that the minister paid close attention to that, so I will let him deal with some of the points that Mr Stevenson raised.

I think that it was Bob Doris who said that we all have examples of constituents who have been to see us and of partners or family members who have contacted us because a loved one is unable to make that contact themselves. People are often unable to live the life that they would choose to live because they are lying in pain at home.

In 2011, Scottish Labour included in our manifesto for the elections to this Parliament our commitment to a residential treatment centre for chronic pain. We therefore welcome the cabinet secretary's confirmation this afternoon that that will be adopted by the Scottish Government. We accept that it is sensible to examine the options and consult those who are most likely to benefit from such a service about the best model of delivery for a centre.

A residential centre is a vital component of what I think John Wilson described as a comprehensive service for chronic pain sufferers because of the respite that it could offer as well as the treatment that it could provide. We know that those who have travelled elsewhere in the UK have benefited significantly from their experience despite the distances involved, which in one case amounted to a return journey of 1,600 miles from Shetland, as Jackie Baillie mentioned. Up to now, only a very small number of people have been able to do that—the figure is 119 patients. The provision of in-patient facilities closer to home is likely to increase substantially the number of people who will wish to have access to them.

Graeme Pearson was right to highlight the cost of sending patients to Bath, which has amounted to just over £1 million in the past few years. It would be useful to lose much of the travel element of that expenditure, and we can do that if we have a service that suits the needs of pain sufferers across Scotland.

An in-patient resource would be an important step and an important statement in not just recognising chronic pain but resolving to help those who are affected. However, the pressures of the likely demand as well as the need to consider the best interests of patients mean that it can only ever be one component of the comprehensive package of support that must be provided.

Chronic pain is associated with long-term conditions, and long-term support that is proportionate to needs—and particularly to varying needs—is essential. When people are able to continue in work, services must be responsive to their lives rather than force them to give up or become isolated as a result of the pain that they suffer. Jim Hume was right to say that, like other long-term conditions, chronic pain can reduce people's resilience as well as inhibit their daily lives. Hanzala Malik, for Scottish Labour, argued that the most urgent reform that is required, beyond the provision of in-patient services for those who are most in need, is for the Scottish ministers to act to end the postcode lottery of care.

Services in different parts of the country should be responsive to local needs and opportunities. As a Glasgow MSP, I particularly recognise the innovation that has been possible in my health board area because of the championing of a managed clinical network by the Greater Glasgow and Clyde NHS board. However, when chronic pain conditions are so widespread and so debilitating to so many people in every part of

Scotland, it cannot be right that a wide divergence exists not only in what support is provided but—too often—in relation to whether any real support is offered at all.

Another related issue that Labour members have sought to highlight, and which is topical across nearly all NHS services at the moment, is the time that people are waiting to access the support that is available. Despite the good practice that exists in Glasgow, for example, last year my constituents who were waiting for an appointment with a pain psychologist could face waits of about 18 months—waiting times that many of us thought had been abolished since this Parliament was created and took control of our national health service.

At the end of last year, those waiting times were down, but they were still more than a year. We therefore believe that, following agreement and, I hope, some consensus about what pain sufferers across the country have a right to expect, the Scottish Government will also need to make some firm commitments about what should be considered reasonable waiting periods for people for whom every hour or day of living with pain can be a mental as well as a physical trial.

The current co-conveners of the cross-party group on chronic pain have been mentioned, as have a number of activists including Dorothy-Grace Elder, who championed the issue as a member of Parliament and has kept up the pressure outside Parliament as a journalist and campaigner, and Susan Archibald, who petitioned the Parliament on the issue and whose willingness to share her story has ensured that attention to her case might benefit others.

Those individuals and many others have kept up the pressure on an issue that was never going to go away, despite a lack of action from this place for too long. Those outside the Parliament who have persisted in their campaigning know that today is not the end of their wait; the actions that we have discussed and that will now be consulted on are not—as I think Siobhan McMahon said—the last words on the matter.

It is a cliché to say that actions speak louder than words, but it is true that budgets demonstrate commitment much more effectively than platitudes. Providing the required services will be good value for money, but they will need to be resourced. The clinical network in Glasgow, which has been mentioned a few times, was started with only modest initial funding, but 10 out of 14 health boards still have no budget at all for chronic pain treatment. It is therefore no surprise that the Scottish service model for chronic pain is being followed consistently by only six boards.

A number of members have mentioned the various reports that have been produced. The Healthcare Improvement Scotland report of last year was perhaps the document that caused the most consternation among people who follow the issue of chronic pain because it was perceived to underplay real experience in favour of painting the picture in the best possible light. Such practices from official inspection bodies are not helpful, but on the Labour side of the chamber we are pleased that the current cabinet secretary has decided to look beyond the official picture and attempt to see what support is needed to make a real difference to people's lives.

Joan McAlpine raised the cost of prescriptions, and there is a debate to be had about that. It was not necessarily appropriate to raise that issue in this debate, but perhaps when the minister closes he might say a word or two about some of the value-for-money issues. We want people who need painkillers to get them, but painkillers cost 19p from high street pharmacists while it costs the Scottish health service £3.10 to provide them through the current arrangements. There are questions to be asked about that.

Scottish Labour has reiterated its commitment to chronic pain sufferers. The amendment in the name of Jackie Baillie seeks not to criticise or to trip up ministers but simply to add a degree of urgency around the long-understood and long-awaited need for in-patient provision. Sandra White even appeared to have a venue in mind for that. I hope that members will support that urgency and the need to have consistent services across the country.

16:49

The Minister for Public Health (Michael Matheson): The debate has drawn considerable consensus across all parties on our shared desire to achieve a better way to provide services for patients who suffer from chronic pain, for whatever reason and however it may manifest itself.

It is also an issue that a number of members have acknowledged has a long history of campaigns both within and outwith Parliament seeking improvements. The first debate, as members have mentioned, was led by Dorothy-Grace Elder back in February 2002, and Mary Scanlon's debate was in March 2011. We now have the debate that the Government is leading today.

It is an issue that has drawn considerable parliamentary interest over the period, although not necessarily by absorbing debating time in the chamber. Through the cross-party group and other activities, a significant number of MSPs have been involved in and interested in it.

I also acknowledge that for campaigners who have been pressing for improvements to services, there is—despite improvements that have been made since 2007—a degree of frustration, a desire for things to move on apace, and for that pace to be stepped up. Today's debate demonstrates the Government's response to that, which is to push forward with further improvements.

The debate has been very much about looking forward to how we can continue to improve on the progress that has been made, and to build on it, rather than about looking back too much at what happened in the past, which report said what, when it was published or whatever. We have looked at how we can move forward and improve services overall.

Mary Scanlon (Highlands and Islands) (Con): I chaired the cross-party group on chronic pain for eight years as a result of a promise that I made to Dorothy-Grace Elder. I would not have dared not to keep it.

There is currently no clear referral policy for chronic pain, so how will the Government identify patients who would benefit from more specialised or residential treatment before moving to the new model of delivery?

Michael Matheson: I will try to address Mary Scanlon's point when I talk about and develop issues around the SIGN guidelines.

Jackson Carlaw made an excellent contribution about the difficulty in defining chronic pain. We could take the very sterile approach of using the clinical definition but, like Jackson Carlaw, I think that the real definition is about the effect of chronic pain on the individual. That is a definition by which we have to measure what we have to do to help support an individual and address their needs. That goes beyond the physical limitations that chronic pain causes, such as whether someone is able to tie their own shoelaces, to get out of their bed on their own, or to comb their own hair. Those are small practical things that a person who is suffering from chronic pain can find themselves unable to do. However, the definition should also cover the psychological impact and draining effect that chronic pain can have on individuals when they lose the ability to do those things themselves. That can demoralise them and have a negative impact on their mental wellbeing.

There is also the social impact to consider—people's potential to lose self-confidence or to desire to withdraw because they are concerned that they are not as independent as they would like to be. That can have a consequent effect on an individual.

I recognise the medical model that was very ably illustrated by Margo MacDonald in her description of the "bag of goodies" approach that is often taken to chronic pain. The social model has an important part to play in supporting individuals who suffer from chronic pain and, by raising that issue through her petition, Susan Archibald has made a valid point. It is more about enabling, helping to support and intervening where necessary than it is about just looking for a straightforward medical solution.

John Wilson talked about the holistic approach and Bob Doris referred to the work that is being done by Revive MS Support in Maryhill. The holistic approach that is used there looks at the whole person, including the medical, physical, and social aspects, when deciding how best to address the issues and support the individual most effectively.

Alongside that, it is important that we have the clinical standards that underpin some of the necessary progress on chronic pain. Margo MacDonald talked about clinical standards, and Mary Scanlon raised the issue during her intervention. In December last year, the draft SIGN guidelines covered a range of areas that go from assessment and planning of care, support and self-management, and pharmacological therapies right through to dietary, complementary and physical therapies. That will offer a holistic package of standards to support improvements and developments. The SIGN guidelines are due to be finalised by December this year. The guidelines will provide us with another building block in progress on clinical standards.

Several members referred to the Scottish service model for chronic pain, which the cabinet secretary in his opening remarks highlighted will include a three-tier approach. The reality is that the vast majority of individuals who suffer from chronic pain will receive services under tiers 1 and 2, which are about self-management and services within primary care settings that might be provided by general practitioners. However, where necessary, people will be referred to a tier-3 intervention, which will be a more specialised service that will be delivered within an acute setting.

An extremely important point to recognise is that, for the service model to work effectively, we need within primary care settings to ensure that we have the right clinical skills and understanding of how to support individuals with chronic pain. In Dumfries and Galloway, for example, 20 physiotherapists have been trained in cognitive behavioural therapy to help to support that approach. NHS Lanarkshire is currently providing training to GPs and is, I understand, looking to recruit a GP clinical lead on chronic pain who can continue to drive forward improvements in the primary care setting.

Using GPs and other clinicians who are based in primary care settings, working in partnership with the community pharmacists to which Sandra White referred—

The Deputy Presiding Officer: Forgive me, minister. There are too many conversations going on. Can we have a little bit of respect for the minister, please?

Michael Matheson: It will be extremely important that community pharmacists work in partnership with community physicians—GPs—to ensure that they provide the best type of medical intervention, with pharmacological input as and when necessary, to help to support patients.

Hanzala Malik: I have a local difficulty. A person wishes to open a chemist but some of the bigger boys—in particular, Boots the chemist—who sit on the NHS board continue to refuse the application. Can something be done to allow small independent chemists to open without harassment from the bigger players in the field?

Michael Matheson: There is a formal application process for a pharmacy licence. If Hanzala Malik wants to write to me with the details, I will respond to him in more detail.

Finally, on the residential facility, members should be in no doubt that the consultation that we intend to publish later this year will consult not on whether we should have a residential specialist facility, but on the model for it. Given the history of patients feeling that they have not been listened to and feeling that not enough action has been taken to address their concerns, it is important that we take the time to consult them on their views on what model the facility should follow. If we do that, we will ensure that we get the best outcome for patients. As a Government, we are very much committed to ensuring that we provide an appropriate facility. Whether three, four or five options—or a combination of those, as Jackson Carlaw suggested—are consulted on, it is extremely important that we take the necessary time to consult patients, who have the biggest interest in the issue, so that we get the right model. I regret that, on that basis, we are not able to accept the Labour Party amendment.

I urge members to unite in supporting the motion in the name of the cabinet secretary at 5 o'clock this evening.

Business Motions

16:59

The Deputy Presiding Officer (John Scott): The next item of business is consideration of business motion S4M-06758, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a programme of business.

Motion moved,

That the Parliament agrees the following programme of business—

Tuesday 4 June 2013	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Economy, Energy and Tourism Committee Debate: Underemployment in Scotland
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 5 June 2013	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions Justice and the Law Officers; Rural Affairs and the Environment
followed by	Scottish Labour Party Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 6 June 2013	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
12.30 pm	Members' Business
2.30 pm	Parliamentary Bureau Motions
2.30 pm	Scottish Parliamentary Corporate Body Questions
followed by	Stage 1 Debate: Crofting (Amendment) (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
Tuesday 11 June 2013	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)

followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 12 June 2013	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions Health and Wellbeing
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 13 June 2013	
11.40 am	Parliamentary Bureau Motions
11.40 am	General Questions
12.00 pm	First Minister's Questions
12.30 pm	Members' Business
2.30 pm	Parliamentary Bureau Motions
2.30 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time—[*Joe FitzPatrick*.]

Motion agreed to.

The Deputy Presiding Officer: The next item of business is consideration of business motion S4M-06759, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out the stage 1 timetable for the Crofting (Amendment) (Scotland) Bill.

Motion moved,

That the Parliament agrees that consideration of the Crofting (Amendment) (Scotland) Bill at stage 1 be completed by 7 June 2013.—[*Joe FitzPatrick*.]

Motion agreed to.

Parliamentary Bureau Motion

17:00

The Deputy Presiding Officer (John Scott): The next item of business is consideration of a Parliamentary Bureau motion on the establishment of the City of Edinburgh Council (Portobello Park) Bill committee. I ask Joe FitzPatrick to move motion S4M-06760.

Motion moved,

That the Parliament shall establish a committee of the Parliament as follows:

Name of Committee: City of Edinburgh Council (Portobello Park) Bill Committee.

Remit: To consider matters relating to the City of Edinburgh Council (Portobello Park) Bill.

Duration: Until the Bill is passed, falls or is withdrawn.

Number of members: 4.

Convenership: The Convener will be a member of the Scottish Labour Party and the Deputy Convener will be a member of the Scottish National Party.

Membership: James Dornan, Alison McInnes, Fiona McLeod, Siobhan McMahon.—[*Joe FitzPatrick*.]

The Deputy Presiding Officer: The question on the motion will be put at decision time.

Decision Time

17:01

The Deputy Presiding Officer (John Scott): There are three questions to be put as a result of today's business. The first question is, that amendment S4M-06746.1, in the name of Jackie Baillie, which seeks to amend motion S4M-06746, in the name of Alex Neil, on ensuring access to high-quality sustainable services for people living with chronic pain, be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baxter, Jayne (Mid Scotland and Fife) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Brown, Gavin (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Davidson, Ruth (Glasgow) (Con)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Findlay, Neil (Lothian) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kelly, James (Rutherglen) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
Macintosh, Ken (Eastwood) (Lab)
Malik, Hanzala (Glasgow) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McGrigor, Jamie (Highlands and Islands) (Con)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)

Against

Adam, George (Paisley) (SNP)
Adamson, Clare (Central Scotland) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Allard, Christian (North East Scotland) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Biagi, Marco (Edinburgh Central) (SNP)
Brodie, Chic (South Scotland) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Burgess, Margaret (Cunninghame South) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Campbell, Roderick (North East Fife) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)
Constance, Angela (Almond Valley) (SNP)
Crawford, Bruce (Stirling) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Ind)
FitzPatrick, Joe (Dundee City West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Caithness, Sutherland and Ross) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hume, Jim (South Scotland) (LD)
Johnstone, Alison (Lothian) (Green)
Keir, Colin (Edinburgh Western) (SNP)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Central Scotland) (SNP)
MacAskill, Kenny (Edinburgh Eastern) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
MacKenzie, Mike (Highlands and Islands) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West Scotland) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McInnes, Alison (North East Scotland) (LD)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McLeod, Fiona (Strathkelvin and Bearsden) (SNP)
McMillan, Stuart (West Scotland) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Rennie, Willie (Mid Scotland and Fife) (LD)
Robertson, Dennis (Aberdeenshire West) (SNP)
Robison, Shona (Dundee City East) (SNP)
Russell, Michael (Argyll and Bute) (SNP)
Salmond, Alex (Aberdeenshire East) (SNP)
Scott, Tavish (Shetland Islands) (LD)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Swinney, John (Perthshire North) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (Ind)
Walker, Bill (Dunfermline) (Ind)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Wilson, John (Central Scotland) (SNP)
Yousaf, Humza (Glasgow) (SNP)

Abstentions

MacDonald, Margo (Lothian) (Ind)

The Deputy Presiding Officer: The result of the division is: For 40, Against 70, Abstentions 1.

Amendment disagreed to.

The Deputy Presiding Officer: The second question is, that motion S4M-06746, in the name of Alex Neil, on ensuring access to high-quality sustainable services for people living with chronic pain, be agreed to.

Motion agreed to,

That the Parliament welcomes the Scottish Government's plans for the implementation of the Scottish Service Model for Chronic Pain, which will ensure the best outcomes for the care and support of people living with chronic pain; further welcomes that the Scottish Government has committed to providing a highly specialist intensive pain management service in Scotland; notes that, prior to consultation, the NHS is working with partners, including patients and clinicians, to assess appropriate options for a Scottish intensive pain management service; also welcomes the decision of the Scottish Government to provide appropriate residential accommodation in the options for the new Scottish intensive pain management service, and further notes that each territorial NHS board in Scotland will be required to prepare and implement a service delivery plan for covering all aspects of chronic pain services, from April 2014.

The Deputy Presiding Officer: The third question is, that motion S4M-06760, in the name of Joe FitzPatrick, on the establishment of the City of Edinburgh Council (Portobello Park) Bill committee be agreed to.

Motion agreed to,

That the Parliament shall establish a committee of the Parliament as follows:

Name of Committee: City of Edinburgh Council (Portobello Park) Bill Committee.

Remit: To consider matters relating to the City of Edinburgh Council (Portobello Park) Bill.

Duration: Until the Bill is passed, falls or is withdrawn.

Number of members: 4.

Convenership: The Convener will be a member of the Scottish Labour Party and the Deputy Convener will be a member of the Scottish National Party.

Membership: James Dornan, Alison McInnes, Fiona McLeod, Siobhan McMahon.

Automatic External Defibrillators

17:04

The Deputy Presiding Officer (Elaine Smith): The final item of business today is a members' business debate on motion S4M-06362, in the name of Margaret Mitchell, on automatic external defibrillators in Scotland. The debate will be concluded without any question being put.

Motion debated,

That the Parliament acknowledges the ongoing AEDs in Scotland campaign, which aims to have automatic external defibrillators (AEDs) placed in strategic locations, such as rural communities, where it is difficult for an ambulance to respond quickly, or areas where there is a high incidence of cardiac arrest and in public buildings such as cinemas and supermarkets; believes that sudden cardiac arrest is a treatable condition whereby the body "short circuits", interrupting the heart's regular rhythm and keeping it from pumping blood through the body; further believes that, for every minute that passes without defibrillation, the chances of survival decrease by 14% and that research shows that applying a controlled shock using an AED within five minutes of collapse provides the best possible chance of survival; understands that AEDs, which are of simple design and can therefore be used without specialist training, can help to stop the heart's arrhythmia, allowing the heart to re-establish an effective rhythm, but that CPR should also be administered; believes that 12 young people die in the UK each week as a result of a sudden changes in cardiac rhythm, but that only 10% of UK schools currently have AEDs; further understands that North Lanarkshire Council has recently purchased 25 defibrillators, one for each of its secondary schools, but that in March 2013 Samantha Clinton from Bellshill, North Lanarkshire, started a petition as part of Sudden Arrhythmic Death Syndrome (SADS) UK's Big Shock Campaign to have a defibrillator placed in every school in the local authority area; notes that, in order to raise awareness, Samantha has designed colouring sheets for primary school children to take home to their parents with information about sudden cardiac arrest and a copy of the petition; is of the view that AEDs save lives and triple the chances of surviving a sudden cardiac arrest, and notes calls for AEDs to be located in all schools across Scotland as well as in public places and remote locations.

17:04

Margaret Mitchell (Central Scotland) (Con): The campaign for AEDs, or automatic external defibrillators, in Scotland is run by first-aiders Laura and Paul Macadam-Slater, who briefed MSPs about the issue when they visited Parliament last month. AEDs are machines that deliver an electronic shock to the heart in cases of cardiac arrest, when the heart stops pumping blood. To realise the full significance of that, suffice it to say that the survival chances of people who are affected by cardiac arrest decrease—

The Deputy Presiding Officer: Excuse me, Mrs Mitchell. Could I stop you for a moment? People who are leaving the gallery should do so quietly. Parliament is in session.

Margaret Mitchell: The survival chances of people who are affected by cardiac arrest decrease by 14 per cent for every minute without defibrillation. Furthermore, 70 per cent of sudden cardiac arrests occur outside hospital. Of those, only one person in 20 currently survives and death from sudden cardiac arrest can occur within 10 minutes.

In the United Kingdom, an estimated 4,000 people a year die from SADS—sudden arrhythmic death syndrome—which is a genetic heart-rhythm abnormality. In Scotland, cardiovascular disease, or CVD, is the main cause of deaths. There were 17,000 deaths from CVD in 2010, which equates to almost a third of all deaths in Scotland that year. It is worrying that 50 per cent of the people who require defibrillation do not have a previously diagnosed heart condition, and that many of those individuals will be young and seemingly healthy.

The campaign therefore calls for AEDs to be placed in public places, in remote communities and in all fire and police vehicles in Scotland, and in other strategic locations, because cardiac arrests are, by nature, unexpected and sudden. One relatively recent high-profile case involved the collapse of Bolton Wanderers footballer Fabrice Muamba on the pitch during an FA cup match in 2012. Television footage that is now part of a British Heart Foundation advertising campaign shows the shock and distress that registered on the faces of the other players as they watch the previously fit and healthy 20-year-old lying motionless and face down on the pitch. Although he was technically dead for 78 minutes, Fabrice survived, partly thanks to the use of a defibrillator.

The Isle of Man already has a number of AEDs, and a local Manx charity, Craig's Heartstrong Foundation, aims to raise £60,000 in 2013 to equip all 34 primary schools on the island with lifesaving AEDs and training from St John Ambulance. Craig's Heartstrong Foundation was established by the Lunt family in memory of their 25-year-old son Craig, who was a popular young footballer who tragically died as a result of previously undiagnosed heart defects.

AEDs that are located in Scotland include one here in Parliament, and a number that have been donated by the British Heart Foundation which has, by working in partnership with the Scottish Ambulance Service and Scotmid, succeeded in placing 40 AEDs in Scotmid stores. In 2009, Strathclyde Partnership for Transport bought AEDs for six of its subway stations and plans to extend that provision to all 15 subway stations. SPT also intends to place AEDs in East Kilbride, Greenock and Hamilton bus stations.

It is not just the efforts of big organisations that have seen AEDs being placed. For evidence of that, we need look no further than the small village of Collieston, where the community raised nearly £3,000 to fund and install a defibrillator in the village. However, there are still far fewer AEDs in Scotland than there should be, hence the call from the AEDs in Scotland campaign and the Institution of Occupational Safety and Health for AEDs to be placed strategically in public and remote places.

According to a recent online discussion that was hosted by the Scottish Ambulance Service, which asked members of the public where they would like AEDs to be placed, the following locations were cited and suggested: public places, especially where large numbers of people gather; remote communities, where it can take an ambulance much precious time to arrive; village halls; old phone boxes; places that are accessible 24 hours a day; and schools.

Given that, alarmingly, each week 12—potentially more—young people die from SADS in the UK, the argument in favour of placing AEDs in schools is compelling. In March, as part of the SADS campaign, Samantha Clinton from Bellshill started a petition calling for all schools to have AEDs; in the light of that, the joint decision by North Lanarkshire Council and NHS Lanarkshire to provide an AED in each of its 24 secondary schools is very much to be welcomed and it is hoped that more local authorities and NHS boards throughout Scotland will follow their example.

However, as more AEDs are placed in our communities, they must be mapped to ensure that, should one be required, its location is known. All the AEDs on the Isle of Man have to be registered at the emergency services joint control room, which handles all 999 calls, to allow people to be directed to the nearest defibrillator. That is particularly useful as it helps to identify AEDs in private locations such as office buildings that can be accessed by the public in an emergency, as well as those that are provided in cabinets. To ensure that the locations of defibrillators are known, the AEDs in Scotland campaign has undertaken its own mapping scheme. So far, it has found 104 AEDs in Scotland, but only 29 that are accessible 24 hours a day. The Scottish Ambulance Service believes that there are 327 AEDs in total, but it does not know where they are all located.

Despite people's apprehension, defibrillators are, in fact, very easy to use; once it is switched on, the AED guides the operator through the procedure using a computer-generated voice. Once it is connected, the AED automatically analyses the victim's heart rhythm and delivers the shock only when it detects the presence of a rhythm that requires defibrillation. It also gives the operator guidance on when to begin and stop chest compression. As a result, anyone who is involved in an emergency can be confident that

they will be able to use the AED safely and correctly.

In conclusion, the fact that AEDs can save and have saved lives is the reason why campaigns such as the one that is being run by Laura and Paul Macadam-Slater are to be welcomed and supported in seeking to have more of these important machines located across Scotland, to raise awareness of sudden cardiac events and, crucially, to explain the action that is required.

I very much look forward to the minister's comments on this important issue.

The Deputy Presiding Officer: Thank you very much. I apologise for the earlier interruption.

I ask for four-minute speeches, as we are quite tight for time.

17:12

Aileen McLeod (South Scotland) (SNP): First, I congratulate Margaret Mitchell on securing the debate. I must also give my apologies, as I will have to leave the chamber before the minister responds to attend to an urgent constituency matter.

I attended Laura and Paul Macadam-Slater's recent presentation to MSPs, which made a very good case for making life-saving public AEDs more widely available across Scotland, and I very much support what they are trying to achieve. Members will have reflected on the statistics, but they are worth repeating. For the 70 per cent of sudden cardiac arrests that occur outside a hospital environment, there is about a one in 20 chance of survival. I was very struck by that statistic; I was not aware of it before and it has certainly made me think.

Although sudden cardiac arrests are clearly very dangerous, they are treatable, and defibrillation is the accepted method of treatment. Chances of survival dramatically increase if defibrillation is delivered quickly but decrease equally dramatically with every minute that treatment is delayed. Given that, as Margaret Mitchell pointed out, AEDs are easy to use—indeed, they can be used by someone with no medical training at all—the argument seems clear that the provision of AEDs in public places might very well make a significant difference.

As for international comparisons, some countries have had a comprehensive roll-out of publicly available AEDs, while others are at various stages of development. Hong Kong, for example, is rolling out 300 AEDs in public locations, but the lion's share of the plaudits must go to New Zealand, which, with a population similar to Scotland's, has 2,941 publicly available AEDs and a fantastic online interactive map that shows people exactly where they are.

For me, that is particularly instructive. Many AEDs are located in health centres, hospitals and fire stations, where we might expect them to be, but there are also many in private businesses, residential addresses, dental surgeries and even boats, all of which are registered online and visible on the map.

Margaret Mitchell's motion refers to rural areas in particular. In Dumfries and Galloway, some moves have already been made by individual communities towards the wider provision of AEDs. Some community councils have used community benefit money from wind farms to purchase defibrillators, which are available in public buildings such as village halls and shops.

Other communities are participating in the Scottish Ambulance Service's volunteer first responders scheme. As well as basic first aid and cardiopulmonary resuscitation—CPR—training, an AED is a crucial part of a first responder's equipment. Although such AEDs are not publicly available, they are ultra-local and can cut response times dramatically. First responders teams are established and running in a number of Galloway's remoter communities. It is by no means very remote, but Dalbeattie is setting up a group that will provide an out-of-hours first responders service to almost 5,000 people. All that activity is welcome, but it relies, of course, on individuals and groups recognising the importance of the issue and being prepared to act.

In closing, I will mention training and awareness. Conversations with the British Heart Foundation have established that a good number of Dumfries and Galloway's secondary schools and some of its primary schools have had heartstart training. To complete the equation, we need the equipment—that is for sure—but also public awareness.

I am very pleased that we are having the debate and highlighting the issue. I am particularly grateful to Margaret Mitchell for securing the debate. I wish Laura and Paul Macadam-Slater every success with their campaign, and I hope that, in time, we will see many more publicly available AEDs across Scotland. I also commend the efforts of North Lanarkshire Council.

17:17

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I congratulate Margaret Mitchell on lodging this important motion and I look forward to the rest of the debate, including the minister's speech, because the last statement of the Scottish Government's position on the matter that I can see is in the "Better Heart Disease and Stroke Care Action Plan" from 2009, which said that boards

have to follow the advice of cardiac managed clinical networks on defibrillators. I do not know what advice was given to different boards, so I look forward to an update.

The action plan was interesting in presenting the evidence that existed on the matter. It referred to an evaluation of the scheme in England, which was really ahead of us at that time. That evidence suggested that AEDs were very effective in busy public places, and it looked as if there were also promising results for community first responders. That was clearly very important for Scotland, because many areas of Scotland rely on community first responders. I hope that AEDs are available to them.

Another dimension to all this in Scotland is the rural issue, which the motion refers to. I was interested to read about the AEDs in Scotland campaign, which is based in Fort William. Other campaigns are mentioned in the motion, and I will refer to them in a moment, but that campaign has argued for AEDs to be readily available in public places in communities where ambulances cannot reach someone with a cardiac arrest within five minutes of the 999 call, and for AEDs to be carried in all police and fire service vehicles.

A map of availability, to which Margaret Mitchell referred in general terms, is shown on the AEDs in Scotland website and the online AED locator. It indicates that the majority of the devices are already kept in more remote locations. However, as members will realise, the reaction time of the emergency services might not be delayed simply as a result of geography; towns with a high population density or compromised road networks might also have slower responses. That is why further investment in urban areas is also essential.

The motion draws attention to the issue of young people who become victims of SADS—I say "SADS" for the sake of speed; everyone knows what it means because of Margaret Mitchell's speech. As the AEDs in Scotland campaign highlights, the majority of the people affected by the condition are between the ages of 12 and 35, but children as young as six years old have been victims of it.

We need to examine the case for having defibrillators for use in the education environment. The motion rightly points to the great work done by individuals such as Samantha Clinton and to her involvement with the big shock campaign in raising awareness of cardiac arrest in young people among young people and their parents.

The recent news that North Lanarkshire Council will install a defibrillator in every secondary school is indeed welcome. The initiative is part of the British Heart Foundation's heartstart schools programme, which aims to teach all students in Scotland basic life-saving skills by 2015. As we have heard, all 24 secondary schools in North Lanarkshire will be fitted with the machines before the end of March 2014, to ensure that any incident in which a schoolchild or employee suffers from cardiac failure will be met with a timely response until medical help is sought.

The heartstart programme is particularly useful as it allows young people to recognise the early signs of an oncoming cardiac arrest, such as dizziness and chest pains, and teaches them to respond in a calm and responsible manner or take appropriate action if they require help. It is important to widen the debate to that more general campaign, because clearly it is a matter of not just AEDs but emergency life support more generally, which the British Heart Foundation campaign highlights.

I believe that the Government has awarded £110,000 for a fund to develop sustainable models to create increased provision of emergency life-support training in secondary schools more generally by working with designated local authorities. I would welcome more information about that, because I have not read any more about it, apart from the generality.

The Deputy Presiding Officer: I must ask you to conclude.

Malcolm Chisholm: I ought to add that part of the training is about CPR, which might also be required. That wider education of young people is crucial, but having the devices in schools is clearly an important part of that.

17:21

Nanette Milne (North East Scotland) (Con): I, too, congratulate my colleague Margaret Mitchell on securing the debate so that we can acknowledge the work of the AEDs in Scotland campaign, which seeks to extend the availability of automatic external defibrillators in schools and public places and in remote areas, where it is difficult for an ambulance to respond quickly.

It is a sobering thought that 12 young people still die each week in the UK from sudden cardiac arrhythmia, usually ventricular fibrillation, which can kill within minutes in the absence of a defibrillator and effective CPR. Most of those victims are very fit young people and often skilled athletes.

Cardiac arrest can of course occur in all age groups or as the result of an accident. It is important that as many people as possible know how to deal appropriately with such a serious emergency. In the old days when I was a young doctor, defibrillators were scary pieces of equipment and quite difficult to use safely and

effectively. Now, however, the modern automatic external defibrillators are very user-friendly and quite easy for members of the public to operate.

Sudden death in young people from cardiac arrhythmia was brought to my attention very soon after I became an MSP 10 years ago by the redoubtable Wilma Gunn from Selkirk, who lost her son from that cause. She asked me and several other MSPs to be a patron of her charity, Scottish Heart at Risk Testing, for which she campaigned tirelessly. Scottish HART had the twin purposes of seeking cardiac screening for all young people taking part in strenuous sport and of raising funds to put defibrillators in strategic places such as football grounds and sports stadia. I do not know how many such machines Scottish HART funded, but there were many, not least in the Dons home ground of Pittodrie, in Aberdeen.

I remember facilitating a meeting in St Andrew's house with Malcolm Chisholm, when he was a health minister, civil servants, Wilma Gunn and Professor Hillis from Glasgow, an expert in sudden cardiac arrest, to discuss the feasibility of screening young people who might be at risk. The perceived wisdom at the time was that large-scale screening was not appropriate, but things moved on. I believe that such screening is now available for young athletes, but the minister might be able to correct me if I am wrong on that.

It is important to raise awareness of the possibility of sudden cardiac arrest and what can be done to save the lives of those who fall victim to it. Widespread distribution of AEDs is needed, together with, as has been pointed out, educating people from an early age in how to recognise cardiac arrest, how to do CPR and how to use an AED.

Samantha Clinton is to be congratulated on her efforts to have a defibrillator placed in every school in her local authority area and on designing colouring sheets for local primary school pupils that are aimed at teaching parents about sudden cardiac arrest. I am sure that her work could be used as a template for other council areas and would help to spread the word about how to recognise and cope with a potentially fatal cardiac collapse.

I thank Margaret Mitchell again for highlighting the excellent work in her region and other parts of Scotland, and I look forward to hearing the minister's response to the debate.

17:25

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I am sure that it is a great relief to members that the Minister for Public Health is here to respond to the debate. As I recall, he was a member of Scotland's emergency services when he was a member of a mountain rescue team. I am sure that he is more than adequately trained, should any of us require first responder intervention.

This is an excellent and opportune debate. The motion is comprehensive and covers many of the bases. The key underlying point is that early intervention dramatically improves the likelihood of a good outcome in the long term.

Nanette Milne and Malcolm Chisholm talked about the related intervention of cardiopulmonary resuscitation. We should say a little more about that, because as anyone will know who has been trained to do CPR, as I have—albeit that I must be incredibly rusty now—it is easy to watch and difficult to do. A person must have the confidence to put their full weight into CPR as they press on the chest of the person who is suffering a heart attack. They must be prepared to break ribs, if that is what it takes. In older people, that can be a consequence.

In light of that, we must consider the practical training that is given to people if they are to administer CPR. It is not a question of having a bit of paper that tells one how to do it; people need to realise that it needs a lot of physical effort. I hope that we tak tent of that. I am sure that Laura and Paul Macadam-Slater, who are trained first-aiders, are familiar with the issue, which is partly why CPR is mentioned in the motion.

There are other, simple things that people should be trained to do at school. For example, youngsters should know how to get someone into the recovery position. Such an intervention can be decisive in ensuring a person's survival, given that vomiting can be associated with a heart attack and someone who is in the wrong position can drown in their own vomit. People should be taught the recovery position.

I represent many of Scotland's fishermen. These days, a large proportion of fishing boats carry AEDs, which are vastly easier to use than the kind of equipment that Dr Milne used, which came in some time after my father graduated in medicine.

There is a small personal element to this debate. In 1930, long before I was born, my grandfather had a heart attack on what was then the lower station in Dunfermline, and that was the end of him. I would like to think that if that had happened today, CPR or intervention via an AED would have meant that he could have lived beyond his 68 years.

I hope that the debate stimulates wider interest and that we hear interesting things from the minister. I also hope that the minister will not have to make a personal intervention and use his previous training.

17:29

Siobhan McMahon (Central Scotland) (Lab): I congratulate Margaret Mitchell on bringing the debate to the Parliament.

I have spoken in the Parliament about the use of AEDs in Scotland, so I welcome the opportunity to make a small contribution to the debate. When I spoke in November 2011 in my members' business debate on the heartstart campaign that was being run by the British Heart Foundation and North Lanarkshire Council, I talked about the need to introduce emergency life-support training in schools throughout Scotland. I asked whether we could afford not to do such a thing. Since 2011, a number of schools have taken part in the training. However, it is still not a universal service throughout Scotland. The curriculum for excellence provides schools with the opportunity to add that training to the school day, but I would encourage the Scottish Government to do more in that regard so that, from now on, no pupil goes without ELS training.

During that debate, I spoke about the heartstart campaign that is run by North Lanarkshire Council and led by the healthy lifestyle co-ordinator, Charles Fawcett. I told the chamber that a pilot was being run at St Ambrose high school in Coatbridge to better educate staff and pupils in the use of defibrillators. At that time, defibrillators—or AEDs—were not an integral part of the school building. That is why I was delighted to learn that North Lanarkshire Council had installed AEDs in all its 24 secondary schools—the first local authority in Scotland to do so. The cost of that initiative is £70,000. As we have heard, it is partly funded by North Lanarkshire Council, NHS Lanarkshire and Amey. The cost is nothing in comparison to the value that we get from a generation of life-savers in our communities.

For every minute that passes without defibrillation in the aftermath of a cardiac arrest, the chances of survival decrease by 14 per cent. It is therefore essential that AEDs become more widely available. Ideally, they would be held in all public buildings, along transport routes, in private gyms and in all workplaces. I know that I am not alone in calling for those measures. Other members have mentioned that tonight and organisations such as the British Heart Foundation and AEDs in Scotland have also called for action. I hope that, in his closing speech, the minister will be able to commit to action on the matter.

I have recently had the opportunity to attend two heartstart ELS training sessions in Lanarkshire. Those sessions were carried out by a volunteer from St Andrew's First Aid. One session was given to young carers. I do not have to explain to members how vital that session was to those young people. The other session was given to teachers in order to train them in the use of the new AEDs. Those are essential sessions, which I have found invaluable. As members know, due to my disability, I have the use of only one hand. As a result, I have always shied away from going forward for a first aid course. However, from those sessions I now know some basic first aid. More important, I know that I can use AEDs very easily—far more easily than heart compressions. Without the education that programmes such as that offer, many of us would not be able to help if called on in an emergency. I therefore call on the minister to establish a programme of such training across Scotland.

I congratulate North Lanarkshire Council and Charles Fawcett on the initiatives that they have introduced. I congratulate the heartstart campaign on providing ELS training throughout schools in Scotland and I congratulate Margaret Mitchell again on bringing the debate to the Parliament. I hope that AEDs will be in all our schools the next time we debate this important issue.

17:33

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I, too, thank Margaret Mitchell for bringing the debate to the Parliament. In following Siobhan McMahon, I remember her members' business debate in November 2011, and I remember speaking about a charity that is very close to my heart, which I will speak about again today. That charity, Lucky2BHere, was established in Skye in 2007 by a friend of mine, Ross Cowie, when he had just suffered an almost fatal cardiac arrest. As a result of its fundraising, nearly 30 defibrillators have been put in since 2007, especially in the Highlands and Islands but also in the central belt. An important point is that Lucky2BHere not only raises funds and puts defibrillators in public spaces; it always gives training, too. When a community says that it wants a defibrillator, it joins up with heartstart and everybody is trained to use a defibrillator.

Siobhan McMahon talked about the British Heart Foundation's work on ELS in schools. I loved her description of "a generation of life-savers". That is very fitting, and it is what we should be working towards.

I was delighted last year at the Scottish National Party conference when not only Alex Neil, the Cabinet Secretary for Health and Wellbeing, but Alex Salmond, the First Minister, signed the British Heart Foundation's petition on ELS in schools. We have a Government that is committed to doing this and I am sure that it will happen.

To Margaret Mitchell, I say that Lucky2BHere's 30-odd defibrillators are all mapped on its website. When you click on it, you get the address and a

picture of the building in which the defibrillator is located. If you are panicking, at least you can see the picture of where you have to run towards.

This has been a short contribution to a really good and important debate. I always like to highlight the work that Ross Cowie and Lucky2BHere do on this issue.

17:35

The Minister for Public Health (Michael Matheson): As others have done, I congratulate Margaret Mitchell on securing time for this important debate.

The sudden and unexpected death of a young person that has been caused by an inherited cardiac condition may be rare, but it is always a tragedy. We have made great advances in recent years in reducing the number of people who die as a result of cardiac events, but there is much more that we need to do to reduce that number still further.

A number of members referred to SADS and the particularly devastating effect that it can have on a young person, who often has had no symptoms and no indication that they were at risk.

I acknowledge the work that is undertaken by the familial arrhythmia network for Scotland—or FANS, as it is known—which plays a vital role in helping to identify young people with an arrhythmia. The network brings together cardiologists, clinical geneticists and pathologists to help ensure that we reduce the risk of sudden cardiac death, and target the young people who may be at particular risk.

Nanette Milne referred to CAYA—the cardiac assessment for young athletes. We have provided that programme with a further £40,000 to allow it to continue, so that we can look at further measures that can be undertaken to develop the programme and provide protection to young people who are involved in athletics.

We have taken forward a range of work with the Scottish Ambulance Service, to which we have provided £7.5 million to allow it to purchase more than 500 state-of-the-art defibrillators for all Scottish Ambulance Service ambulances.

Members such as Stewart Stevenson referred to the fact that delay in performing defibrillation can reduce the chances of recovery and the important role that AEDs and PADs—publicly accessible defibrillators—can have in supporting someone who has arrested, prior to the arrival of the emergency services. AEDs and PADs must be looked at in the context of community resilience and what we can do to help the wider community make use of such pieces of equipment when they are available. There is no point in making them publicly available if individuals do not have the confidence and ability to use them.

The Scottish Ambulance Service has been working in remote and urban communities in which a publicly available defibrillator that could benefit those communities can be provided. Some of that work has been done by looking at remote areas, urban venues with high footfall, or areas in which clusters of cardiac arrests have occurred. The Scottish Ambulance Service is also looking to train community members in the use of the equipment.

To support that work, since 2011 the Scottish Ambulance Service has developed a partnership with Scotmid—which owns the Semichem network—and the British Heart Foundation, which has identified shops in which defibrillators could be located. Staff have been trained and supported in how to use defibrillators in the community. I have no doubt that that will help to make defibrillators more accessible and ensure that we have individuals who have received training and can make use of them.

To those who have had no training in the use of an AED, I can say—Stewart Stevenson gave away some of my background in his speech—that they are extremely simple. It is not possible to shock someone accidentally. If the person should not be shocked, the system does not allow a shock to be discharged. It also monitors whether there is any rhythm and, in some cases, it indicates that no shock should be provided because no support is necessary. The units are extremely safe, and although several models are available, they are extremely easy to use with a little training and understanding of them.

In providing the units in different parts of the country, we need to know where they are at any given time. Therefore, the Scottish Ambulance Service is undertaking work to map the publicly accessible defibrillators, and that information will be built into its command and control unit so that, when someone calls for an ambulance, that individual can be directed to where they can get a PAD. I understand that the defibrillators that are being provided in schools in Lanarkshire will form part of that information in the command and control unit, and I have no doubt that that will help to support the service.

I agree with Malcolm Chisholm that it is important that, although technology can help us to a considerable extent in supporting someone who is having a cardiac arrest, we must also ensure that people understand the basics of CPR. It is a bit like going up a mountain with a GPS device but not knowing how to use a compass if the device breaks down. People need to be able to go back to the basics, and part of that is CPR. We are working with the British Heart Foundation, as Malcolm Chisholm said, in providing funding

support to develop the heartstart programme, which will provide emergency life-support training for school pupils. That programme is being developed, and we hope to make an announcement later this year when we will take that further forward.

Fiona McLeod referred to Lucky2BHere, a charity based in Skye that is undertaking tremendous work not only around AEDs but around CPR training for school pupils. Work is also being done by Chest, Heart and Stroke Scotland with Education Scotland on developing a national emergency life-support education resource that can be used in classrooms as part of the health and wellbeing part of the curriculum for excellence.

Technology has a lot to give in support of addressing this issue, but we must keep it within the wider context of educating our young people in how to carry out CPR as and when it is appropriate. The work that the Scottish Government is doing with the British Heart Foundation will support the delivery of that in schools throughout the country.

I hope that that has given members some assurance about the work that we are undertaking to ensure that publicly available defibrillators are properly mapped and are more widely available in areas where they can be most appropriately used, alongside our support for the training of school pupils in the basics of CPR.

Meeting closed at 17:43.

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