The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Wednesday 5 March 2014

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

Rural Affairs and the Environment

The Deputy Presiding Officer (John Scott): The first item of business this afternoon is portfolio questions. I would prefer, in order to get in as many members as possible, succinct questions, with answers to match, please.

Environmental Legislation and Guidelines

1. John Finnie (Highlands and Islands) (Ind): To ask the Scottish Government what steps it will take to ensure that environmental legislation and guidelines do not have a disproportionately negative impact on the species Homo sapiens. (S4O-02957)

The Minister for Environment and Climate Change (Paul Wheelhouse): The principal purpose of our environmental regulations and supporting guidance is protection of the environment, given its importance to supporting the quality of life and wellbeing of current and future generations. As such, the impact of regulations on individuals and communities is an important driver of many of the regulations, and is an essential criterion that is considered in both the development of policy and its implementation.

Independence will give Scotland the opportunity to strengthen commitments on environmental protection even further by enshrining the principle in the proposed written constitution, which will further underscore the importance of safeguarding our natural heritage for future generations.

John Finnie: Bonawe common grazing committee provided response number 411 to Scottish Natural Heritage's consultation on core areas of wild land. It states:

"These days crofters view with great suspicion anything emanating from SNH, however innocent it may seem at first glance. This is especially true for something that could be used in future to impose a further layer of bureaucracy and restriction to land use. Further designations will erode the influence and local control which is essential if crofting communities are to thrive in the future."

The people of the Highlands and Islands appreciate their precious environment, and they appreciate jobs and houses. What specific steps can the minister take to ensure that the need for jobs and housing is not subsumed by what may be seen as externally imposed restrictions on land use?

Paul Wheelhouse: The first thing to say—while not showing any disrespect to those who wrote the comments that Mr Finnie read out—is that we are not proposing a designation of wild land. In fact, in so far as wild land is a factor in the national planning framework 3 and Scottish planning policy, it is really in relation to wind-farm development. We are mindful of the need to ensure that there exists the ability to develop local economies in regions such as the Highlands and Islands. We do not want to be prescriptive against developments, and there is a need for sustainable development principles to be applied in those areas.

I would be happy to write to John Finnie about what else we are doing. We think that we have strong support in place for the principles of sustainable economic growth with due regard to the environment. That is emphasised in the Regulatory Reform (Scotland) Act 2014. It is the approach that we take in respect of many sectors of the economy.

Scottish Dairy Review (Recommendations)

2. Mary Scanlon (Highlands and Islands) (Con): To ask the Scottish Government what progress it has made on implementing the recommendations of the Scottish dairy review: "Ambition 2025". (S4O-02958)

The Cabinet Secretary for Rural Affairs and the Environment (Richard Lochhead): The recommendations in the Scottish dairy review: "Ambition 2025" aim to transform our dairy sector. I have already implemented two of the recommendations. First, I am delighted that Paul Grant, who is the driving force behind the internationally successful jam and marmalade manufacturer Mackay's, has agreed to chair the Scottish dairy growth board, which will oversee "Ambition 2025". I have also provided start-up funding for the dairy hub, which will act as a one-stop shop for information, advice and training for Scottish dairy farmers.

Mary Scanlon: I welcome that response.

Given that several supermarkets are selling four pints of fresh milk for £1 as a loss leader, will the cabinet secretary reassure members that the price that farmers receive will not be affected? What is he doing to focus on non-liquid dairy products? Finally, what will he do to help to promote the nutritional and health benefits of milk?

The Deputy Presiding Officer: There were three questions there, cabinet secretary.

Richard Lochhead: On the first question, how much to charge consumers for milk is a matter for

the retailers. However, I think that all members agree that any reduction in cost should not simply be passed on to the primary producer. As long as the primary producers see a fair return for their milk, it is for supermarkets to use their commercial criteria to determine what to charge consumers.

I am thankful that the price of milk has become increasingly steady over the past year or so and I hope that that continues to deliver good news for primary producers. The dairy review will, I hope, add value to the primary product in the years ahead.

Secondly, on non-liquid milk products, the dairy review focused very much on adding value to the primary product, which is why there is a heavy emphasis on exploiting export opportunities. In the context of the increasing middle class around the world, we can add value to our product and sell it to overseas markets. We have neglected to do that in past decades in the dairy sector.

Thirdly, on the nutritional benefits of milk, I put on record the fact that milk is very nutritious, and we will always look for opportunities to highlight that to the consumer. I am sure that members will wish to encourage people to support our dairy sector by consuming dairy products, including healthy raw milk, in a moderate way.

The Deputy Presiding Officer: Question 3, in the name of Dennis Robertson, has been withdrawn, for understandable reasons.

National Marine Plan

4. Claudia Beamish (South Scotland) (Lab): To ask the Scottish Government what the implications for the marine environment and marine industries are of the delay to the national marine plan. (S4O-02960)

The Cabinet Secretary for Rural Affairs and the Environment (Richard Lochhead): As members may be aware, we received thousands of responses to the consultations on the national marine plan, marine protected areas and marine renewables. That illustrates the importance of all the issues involved. We are now in the process of considering all the responses and the important issues that have been raised at the consultation events around Scotland.

We are aiming to develop a national marine plan that will best achieve the balance of protecting and enhancing our marine environment while growing our existing and emerging marine industries. What matters is getting the outcomes right for Scotland's seas. We have always said that the timetable should reflect the need for proper consultation and engagement.

Claudia Beamish: I thank the cabinet secretary for that response—in particular regarding the balance between the industries and the marine environment. As I understand it, a range of stakeholders have expressed concern about the shortage in the draft plan of clear policy and guidance to resolve conflict between the many users of the sea. What mechanisms will the Scottish Government use to address conflicts between the marine sectors, and to ensure sustainable development?

Richard Lochhead: As Claudia Beamish rightly highlights, one of the crucial issues in the consultation is how we will strike the balance between competing sectors, and resolve potential conflicts. That is why we have to take a bit more time to listen carefully to the representations that we have received through the consultation, as referred to by Claudia Beamish.

We have always said that the timescale for publishing the marine plan in the summer would be subject to change, depending on the consultation. As was indicated in Claudia Beamish's question, there have been lots of representations. We have to get the plan right, because conflict resolution will be at the heart of the way forward in relation to all the competing industries. We must listen carefully to people's views.

Jamie McGrigor (Highlands and Islands) (Con): Does the cabinet secretary agree that a comprehensive approach to the fish farming sector must be adopted in order to ensure that the industry is well equipped for the future while also ensuring strict environmental protection and protection for wild migratory sea trout and salmon? Does he believe that that will be achieved under the national marine plan?

Richard Lochhead: Under the ministerial working group, there are various streams of activity and working groups below the main one. They are examining individual issues that aquaculture faces for the future. We want to take a comprehensive approach to making the most of the global opportunities for farmed salmon and other aquaculture products.

The purpose of the marine plan is to plan properly for Scotland's seas, just as we do on land. Aquaculture plays a central role in that. There will potentially be competition for space in some parts of Scotland, which is why we have both to get the decision-making framework right, and to develop a way to resolve potential conflicts.

We very much have the interests of aquaculture at heart as we move forward with the national marine plan.

Independence (Forestry)

5. Joan McAlpine (South Scotland) (SNP): To ask the Scottish Government what benefits

independence could bring to the forestry industry. (S4O-02961)

The Minister for Environment and Climate Change (Paul Wheelhouse): Joan McAlpine will know that this Scottish Government has always sought to put the best interests of the forestry industry at the very forefront of our decisions. It is committed to planting a further 100,000 hectares of new woodland over the period from 2012 to 2022. Our commitment is demonstrated by the fact that woodland expansion in Scotland in 2011-12 was nearly three times as much as it was in the rest of the United Kingdom.

As is highlighted in the white paper, with independence the Scottish Government will, in the next common agricultural policy negotiation, seek to correct the failings of the UK Government and to negotiate an uplift in pillar 2 funding for the Scotland rural development programme, thereby moving from our current position, in which the UK has negotiated Scotland to the bottom of the European Union league table for such funding. If we had a similar pillar 2 budget to Ireland, for example, we would have a budget that was more than four times the size of our current allocation, which would open up the possibility of increasing support for each area that is funded under the SRDP, including forestry.

Joan McAlpine: Over the past decade, the forestry industry has become more centralised. The minister is aware of the Scottish Woodlot Association in our region, South Scotland, which believes that decentralised local tenure brings resilience to the industry, encourages more young people to get involved and connects the industry to local people. Will the minister outline how we could encourage more initiatives such as woodlots and bring about a more decentralised forestry industry?

Paul Wheelhouse: I accept that, to a degree, the forestry industry has become more centralised over the past decade. In my closing address during the parliamentary debate on woodlots in October last year, I welcomed the pioneering initiative that the Scottish Woodlot Association has created, which aims to create a greater connection between people and Scotland's land and forests. Key elements of that are encouragement of wider forms of management and ownership, and ensuring that a range of opportunities exist, such as in the national forest land scheme, which offers an opportunity to promote woodland crofts and hutting.

I hope that Joan McAlpine will be pleased to hear that the Scottish Government is providing financial support to help the woodlots initiative to establish a network of demonstration sites throughout the country. It is also working to establish a hutting pilot on the national forest estate. Given the time constraints, I would be pleased to write to the member with further details of that work.

Alex Fergusson (Galloway and West Dumfries) (Con): Is not it wonderful that devolution allows the Scottish Government to deliver what the minister has just pointed out?

The main concern of people in the forestry sector to whom I speak is not independence or otherwise, but the lack of planting of the commercial timber crop that is required to keep the sector active in the future. Will the minister consider reviewing the percentage of commercial tree planting that must take place as part of any planting scheme?

Paul Wheelhouse: I recognise the point that has been made by many stakeholders in the forestry sector about the need to promote more productive forestry planting. That is why we have indicated that in the next SRDP we will try to promote an approximately 60:40 split in favour of productive planting. That is something that we have identified and will work hard to address. The consultation on the SRDP considers the intervention rates in terms of funding for planting projects.

On Mr Fergusson's opening remarks, pillar 2 is crucial to our aspirations in forestry. Although we may have our differences about Scotland's constitutional future, I hope that we both agree that if we had more pillar 2 funding, we could do a lot more with forestry. We might have different views of how we might achieve that, but I believe that independence is the route to a fairer allocation for Scotland.

Cara Hilton (Dunfermline) (Lab): The Forestry Commission throughout the UK benefits from cross-border co-operation. There are fears, particularly in Silvan house in Edinburgh, that separation will impact on that work. I therefore ask the minister what representation he has had from the United Kingdom Government regarding research that was carried out by the Forestry Commission, and whether that would continue to the same extent if in September Scotland were to vote for separation?

Paul Wheelhouse: I have huge respect for Forest Research and the work of the Forestry Commission in relation to the number of disease threats that Scotland faces. The commission is doing important work on developing its knowledge of ecosystem services as a concept, and on our national forest estate.

We have a good relationship with Forest Research. It is currently funded by the Department for Environment, Food and Rural Affairs—it is a reserved budget—but we look closely at what we would do in the future. If Scotland gains

independence—as we hope it will—we will work closely across these islands to ensure that we have research collaboration. Obviously, we would have discussions with the UK Government about how we would facilitate that. The people who work in Forest Research have nothing to fear from independence.

Flooding (Rivers)

6. Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): To ask the Scottish Government what actions it has taken to help protect householders living near rivers from flooding. (S4O-02962)

The Minister for Environment and Climate Change (Paul Wheelhouse): Flood risk management is a high priority for the Scottish Government and we work closely with the Scottish Environment Protection Agency and other resilience partners to prepare communities affected by flood risk. In the current spending review period, with the agreement of the Convention of Scottish Local Authorities, we have specifically identified £42 million a year within the capital settlement for flood protection projects that cost in excess of £2 million. In the eight years from 2007-08 to 2014-15, we will have provided £326.4 million of capital funding for flood protection, which is more than seven times as much as was paid out under the old flood prevention grant scheme in the eight years up to 2006-07.

We have invested significantly in improving Scotland's flood warning service, including funding to enable SEPA and the Met Office to establish a Scottish flood forecasting service, which is resulting in better flood forecasting and warning information being made available to the public throughout Scotland. We are also supporting the public and others to take practical actions through our additional funding for the Scottish Flood Forum.

Christina McKelvie: As I have previously brought it to his attention, the minister knows about the plight of the Hamilton family in Rosebank, a village in my constituency, who faced an unusual circumstance on 30 December, when the River Clyde burst its banks and flowed back the way, flooding their house. Can the minister suggest a course of action that can be taken, such as requesting that the Scottish Environment Protection Agency conduct a full investigation into the reasons why the Clyde flooded in that unusual manner?

Paul Wheelhouse: I have seen the evidence that Christina McKelvie has presented to me and I commend the Hamilton family for taking all the steps that they can to protect their property. I know that there are specific circumstances in relation to the location of the house, which is in close proximity to the river. I am happy to ask SEPA officials to go on a site visit to examine that location and see whether they can give any advice to the family with regard to how they may be able to better protect their property in the future.

Air Pollution (Glasgow)

7. Anne McTaggart (Glasgow) (Lab): To ask the Scottish Government what action it has taken to tackle air pollution in Glasgow. (S4O-02963)

The Minister for Environment and Climate Change (Paul Wheelhouse): Glasgow City Council has produced an air quality action plan containing a comprehensive range of measures to improve air quality in the city. The Scottish Government is working closely with the council as it implements the measures that are contained in the plan and is providing practical and financial assistance where appropriate. In the current financial year, the council has received £165,000 of funding from the Scottish Government to support action on air quality. The council's other partners, including Transport Scotland and the Scottish Environment Protection Agency, are also working closely with the council.

Examples of the measures that are being implemented include: a commitment to introduce and enforce low emission zones at the Commonwealth games venues this year; grant funding for the introduction of all-electric vehicles and bus quality partnerships; monitoring, local air quality management and enforcement of vehicle emissions regulations; and the provision and collation of advice and information through the Scottish air quality website, Scotland's environment web and the Scottish transport emissions partnership.

In addition, the Scottish Government is taking forward various national measures to improve air quality, as outlined in the air quality strategy for England, Scotland, Wales and Northern Ireland. Those measures are intended to reduce air pollution in towns and cities throughout Scotland.

Anne McTaggart: I thank the minister for that extremely detailed response, given that as many as 3,000 people die prematurely from air pollution in Scotland, and that the worst levels of air pollution have been recorded in Hope Street, in Glasgow. I think that the minister has clearly indicated what action the Government has taken.

The Deputy Presiding Officer: I take it that there is no question. Many thanks.

Flooding

8. Liz Smith (Mid Scotland and Fife) (Con): To ask the Scottish Government what discussions it has had with local authorities following the recent incidents of flooding. (S4O-02964)

The Minister for Environment and Climate Change (Paul Wheelhouse): When I visited Dumfries during the flooding on 30 December 2013, I met representatives of Dumfries and Galloway Council. I then hosted a local authority summit on 15 January to look at the work that is under way to produce the first-ever round of flood risk management plans. The summit was attended by 28 of Scotland's 32 local authorities.

My officials have been in touch with a number of local authorities regarding the operation of the Bellwin scheme in relation to the recent flooding. The Cabinet Secretary for Finance, Employment and Sustainable Growth triggered the Bellwin scheme on 31 December and, as a result, Scottish Borders Council, Orkney Islands Council and South Lanarkshire Council have notified the Scottish Government of possible claims for additional revenue funding under the scheme. In addition, Dumfries and Galloway Council is seeking additional financial support outwith the Bellwin scheme, and that request is currently being considered.

I met representatives of West Dunbartonshire Council last week, and will meet representatives of Argyll and Bute Council later today, to discuss its funding needs.

Liz Smith: The minister will be aware that, in England, two councils have temporarily suspended council tax for those families who have been badly affected by flooding, and he will know that he gave a commitment in this chamber last week that lessons will be learned from what is happening down south. Would the Scottish Government consider suspending the council tax of those families who are extremely badly affected in future?

Paul Wheelhouse: From correspondence with another member, I believe that we have had a look at this issue. Although local authorities have responsibility for collecting council tax, there is scope for them to take a position with regard to particular local exemptions or changes in collection policy. I am happy to get details of that consideration and write to Liz Smith on the matter. As I am sure that she appreciates, the matter is partly outwith my portfolio, and I will get her a response on that basis.

Elaine Murray (Dumfriesshire) (Lab): Can the minister advise on the likely timescale for a decision to be made on the request from Dumfries and Galloway Council for funding for flood prevention measures?

Paul Wheelhouse: I do not have a timescale to report to the member, but I am happy to write to her to update her on what I understand to be the situation. The discussions involve other ministers as well as me, and I will write to Elaine Murray on that basis.

The Deputy Presiding Officer: Question 9, in the name of Jim Hume, has not been lodged.

Tenement Housing (Recycling)

10. Marco Biagi (Edinburgh Central) (SNP): To ask the Scottish Government how it supports local authorities with a high proportion of tenement housing to improve recycling in those areas. (S4O-02966)

The Cabinet Secretary for Rural Affairs and the Environment (Richard Lochhead): Zero waste Scotland provides a range of support to local authorities and businesses to help them to improve recycling services and drive down waste. That includes working closely with councils to help them to develop and deliver innovative ways to improve the recycling services that are available to tenements and flats. To date, 14 councils have taken advantage of that support, with over £250,000 being channelled into service improvements across Scotland.

Marco Biagi: Clearly, the communal gathering of waste is difficult in tenement housing and there are particular problems in my constituency. What further help does the cabinet secretary envisage for the years to come and are there particular examples of good practice that he might single out in the policy area?

Richard Lochhead: We recognise that local authorities with a lot of tenements and flats face particular problems. Zero waste Scotland has carried out a lot of work with local authorities, including workshops, to try to develop innovative ways of collecting waste from tenements and flats. Indeed, the financial help to which I referred is still available should the City of Edinburgh Council or any other local authority wish to take up the offer. Various householder surveys are taking place to help to inform guidance that will be developed and made available to local authorities.

We recognise that many specific challenges face different tenements and flats in Scotland. We are doing our very best to develop the expertise that will enable us to improve the services.

Justice and the Law Officers

The Deputy Presiding Officer: Question 1, in the name of Jim Eadie, has not been lodged. An explanation has been provided.

Taxis and Private Hires (Regulation)

2. Colin Keir (Edinburgh Western) (SNP): To ask the Scottish Government whether it plans to bring forward proposals regarding the regulation of taxis and private hires. (S4O-02968)

The Cabinet Secretary for Justice (Kenny MacAskill): As we announced in the programme for Government 2013-14 in September 2013, we will shortly introduce legislation that will improve licensing in a range of areas to preserve public order and safety, reduce crime and advance public health. The planned bill will include provisions in relation to taxi and private hire car licensing.

Colin Keir: Given the difficulties that local authorities have had in the past in defending policies of restricting the numbers of taxis and PHCs, will the Scottish Government consider introducing guidelines or regulations that would help local authorities to withstand legal challenge to such policies?

Kenny MacAskill: I am aware of the member's travails on that in his previous role as a council convener.

In last year's public consultation, we specifically asked about convening a working group to provide updated, improved guidance on overprovision studies to support local authorities in conducting those studies in a timely and cost-effective way. In light of the responses to the proposal, we will work with local authorities to develop best-practice guidance so that they can share their experience in developing such policies.

I am aware of the issue that Mr Keir raises and the difficulties that he experienced when he dealt with such licences. We have consulted on the matter and are intent on acting upon it.

Police Scotland Facilities (Fife)

3. Annabelle Ewing (Mid Scotland and Fife) (SNP): To ask the Scottish Government what specialist Police Scotland facilities are based in Fife. (S4O-02969)

The Cabinet Secretary for Justice (Kenny MacAskill): Police Scotland's operational support division units for the dog section, firearms unit and divisional road policing unit are all based in Fife. Its corporate headquarters and the Scottish Police College are based at Tulliallan in Fife. A number of other specialist Police Scotland resources are based in Fife. I will provide a member with a full list.

Annabelle Ewing: I am pleased to hear of the range of specialist services that are based in Fife. I understand that they also include the domestic abuse and rape investigation units in Glenrothes. Although I understand that those units are working very well, will the cabinet secretary clarify what performance monitoring systems are in place for them?

Kenny MacAskill: Obviously, the good practice is being shared throughout Scotland. Fife had a good legacy from its legacy force, but we seek to share the benefits and address a problem that is significant in all areas of Scotland.

Key performance indicators are in place. They are monitored regularly at service and divisional level. Regular information is also reported to the local authority's scrutiny board. In conjunction with local policing colleagues, officers in the Glenrothes rape investigation unit and specialist officers who deal with domestic abuse make an important contribution to providing a supportive and consistent approach to victims while effectively pursuing offenders.

Fife is benefiting from the establishment of a national unit in that field. The expertise is used locally but can be garnered centrally to ensure that every area of Scotland that is afflicted by such difficulties benefits from the best possible advice and support.

Police Scotland (Public Counter Services)

4. Mark Griffin (Central Scotland) (Lab): To ask the Scottish Government whether Police Scotland has informed the Cabinet Secretary for Justice of the number of respondents to the consultation on public counter services. (S4O-02970)

The Cabinet Secretary for Justice (Kenny MacAskill): The police in Scotland operate independently of ministers, and the provision of public counter services is an operational matter for Police Scotland and the Scottish Police Authority. I advise Mark Griffin to contact Police Scotland directly to request the information that he seeks.

Police Scotland held a four-week consultation on the proposals during October 2013 and agreed to accept late submissions after the closing date so that all interested parties had an opportunity to contribute their views. Police Scotland have informed me of the changes in the provision of counter services that are taking place to ensure that officers and resources are deployed in the most effective way.

Mark Griffin: Kilsyth police station moved premises less than three years ago and its hours of operation were reduced from a 24-hours-a-day seven-day service on the basis that there would be no further reduction, as promised to the community by senior police management. Does the cabinet secretary think that it is appropriate that, less than three years on, services to the Kilsyth community are being cut again?

Kenny MacAskill: We have to ensure that the public get the best possible police service to which they are entitled. I was delighted to see yesterday that, yet again, the Government has met its commitment to 1,000 additional officers in our communities.

We are talking about operational matters, and the police have to balance the pressure of calls with the use of community bobbies, response calls and the need to man stations. I think that communities prefer the police to be interacting with them and responding to calls when they are needed, rather than stuck behind a counter.

Last night I attended a meeting of Meadowfield, Lady Nairne and Paisley residents association—we can see at least some parts of that housing estate from the back window of the chamber. The local police officer was there—a young Polish woman who has joined Police Scotland—and I was delighted to meet her. There was a significant turnout, and I think that the community was gratified that she was at the meeting rather than stuck behind a police counter.

Crime Figures (Offensive Weapons)

5. Mike MacKenzie (Highlands and Islands) (SNP): To ask the Scottish Government what the latest figures are for crimes involving the handling of offensive weapons. (S4O-02971)

The Cabinet Secretary for Justice (Kenny MacAskill): Crime in Scotland is at a 39-year low; a reduction that has been supported by the 1,000 extra officers. The latest recorded crime figures show that the number of offensive weapon crimes recorded by the police in Scotland decreased by 29 per cent between 2011-12 and 2012-13 and now stands at 4,015. Such crimes have decreased by 60 per cent since the Government came into power and are at their lowest since 1986.

In Mike MacKenzie's area of Highlands and Islands, the number of offensive weapon crimes recorded by the police decreased by 35 per cent between 2011-12 and 2012-13, and the figure now stands at 199. We recognise the importance of the issue, and our award-winning no knives, better lives programme will be extended to all local authorities from April 2014.

Mike MacKenzie: I thank the cabinet secretary for that answer and I welcome the reduction in such crimes. Does he agree that all parts of Scotland are benefiting from Police Scotland's resources in being able to draw on specialist expertise in matters such as gun crime, not least the Highlands and Islands, which previously lacked such specialist services, resources and expertise?

Kenny MacAskill: I believe that significant benefits have been provided as a result of the move to Police Scotland. The legacy Northern Constabulary had training facilities at Daviot, and the new service is ensuring continuity. For example, the armed response units, not just down the A9 but along other corridors, can share and pool resources across the north rather than simply in the legacy area of Northern Constabulary. Gun issues are as significant in rural areas as they are in urban areas, and the benefits that the new single service provides are there for all to see.

The opening of the new police and ambulance station in Fort William also shows the benefits that reform can bring. The reform ensures that we keep local police officers in our communities but that we share and get the benefit of national resources, whether that relates to firearms or rape and domestic abuse, as Annabelle Ewing mentioned earlier, or road traffic policing, which I think will make up much of the work of the new Fort William station.

The Deputy Presiding Officer: It appears that Gil Paterson is not in the chamber to ask question 6, so we will seek an apology and an explanation for why he is not here.

Rehabilitation of Offenders Act 1974

7. Alex Fergusson (Galloway and West Dumfries) (Con): To ask the Scottish Government what plans it has to reform the Rehabilitation of Offenders Act 1974. (S4O-02973)

The Cabinet Secretary for Justice (Kenny MacAskill): The Scottish Government published a discussion paper on the 1974 act on 27 August 2013. Although the initial closing date for comments was 19 November, the date was extended to the end of January 2014 to allow late submissions to be received. A series of discussion workshops was held with relevant organisations and individuals, including representatives of employers and ex-offenders. The analysis of the responses to the discussion paper and workshops is proceeding. The evidence that is gathered will inform our consideration of possible options to reform and improve the current legislation, taking account of the need to support the rehabilitation of offenders and to ensure continuing protection for the public, and in particular for vulnerable groups.

Alex Fergusson: In my capacity as convener of the cross-party group in the Scottish Parliament on armed forces veterans, I have had it brought to my attention that the changes that the United Kingdom Government has announced that will reduce the period during which certain convictions need to be disclosed to potential employers could be of considerable benefit to the disproportionately high percentage of armed forces veterans who, sadly, fall foul of the law following discharge. Given that that percentage is even more disproportionate here in Scotland, will the cabinet secretary keep the issue at the forefront of his mind when considering changes to the legislation in Scotland?

Kenny MacAskill: Absolutely. I welcome the point that Mr Fergusson makes and the spirit in

which he makes it. We recognise that England is ahead of us on the issue. Some of that is historical—it is because the changes in England commenced when we went into a purdah period for the elections in 2011. The democratic process caused disruption and delay on the issue. However, that has given us the opportunity to see what happens south of the border.

We all recognise that there has to be change. The points that Mr Fergusson makes are valid, especially for armed forces veterans, although they apply across society. However, we have to ensure that we get the balance right and that we protect others, including the young and the vulnerable. I can give an assurance that we will look seriously at what is happening south of the border. We recognise that there has to be change, but we have to ensure that that change is balanced by the appropriate protection. I am more than happy to continue the discussion, and I welcome input from Mr Fergusson and those who represent veterans organisations, because getting people into employment is fundamental for their health and welfare and for the wellbeing of society.

Unlawful Eviction

8. Alison Johnstone (Lothian) (Green): To ask the Scottish Government what its position is on the implications for the justice system of the introduction of a requirement for local authorities to investigate allegations of harassment or unlawful eviction. (S4O-02974)

The Cabinet Secretary for Justice (Kenny MacAskill): Under section 22 of the Rent (Scotland) Act 1984, it is a criminal offence to unlawfully evict the residential occupier of any premises or to harass them with the intent of causing them to give up their occupation of the premises. Tenants who experience harassment or unlawful eviction can report it to the police, who have a general responsibility to investigate and detect crime. The Scottish Government has no current plans to introduce a requirement for local authorities to investigate allegations of harassment or unlawful eviction.

Alison Johnstone: Figures from Citizens Advice Scotland show that it is dealing with 30 cases a week of illegal eviction or harassment by landlords in the private rented sector, which is up 20 per cent on last year's figures. The homelessness task force made the point that only 15 people were prosecuted for unlawful evictions between 1995 and 1999 . My question suggested a possible solution that would fit with councils' existing housing duties but, if the cabinet secretary is not supportive of it, what specific action will he take to reduce the incidence of these serious crimes?

Kenny MacAskill: The member raises a fair point, and such cases are on-going. When I was in private practice, I usually referred such matters to the Shelter housing aid centre. I am more than happy to engage with the member, who should perhaps also speak to my colleagues who deal specifically with housing.

We have to ensure that prosecutions are brought to the attention of the police and the Crown. I hope that CAS and the Shelter housing aid centre will make sure that such matters are reported, as they have done in the past, to their credit. We do have laws, such behaviour is unacceptable and we must protect people, whether through criminal sanctions or civil actions such as interdict and other aspects that can be brought in.

Our view, as an Administration, is that currently we have the laws, which we must ensure are properly enforced. We must ensure that those who are charged with enforcing the laws know about this offence and are aware of their obligations and duties. There was a time when police officers might not have understood that the 1984 act made it a criminal offence to harass a tenant, but those days have changed.

We need to recognise that we have the legislation in place. What can we do to raise awareness? We can inform tenants and those who advise them that such behaviour is unacceptable and ensure that those who have the authority, whether the Crown Office and Procurator Fiscal Service or the police, will act. I am more than happy to engage on this matter with Alison Johnstone and CAS, as I have no doubt my Cabinet colleague who deals with housing will be. Such behaviour is unacceptable. Let us use the legislative framework; it is there and it should be used better.

The Deputy Presiding Officer: Question 9, in the name of David Torrance, has not been lodged, although an explanation has been provided.

Honorary Sheriffs (Abolition)

10. Liam McArthur (Orkney Islands) (LD): Apologies for my slightly late arrival for justice questions.

To ask the Scottish Government what impact the proposed abolition of honorary sheriffs will have on access to justice in rural and island areas. (S4O-02976)

The Minister for Community Safety and Legal Affairs (Roseanna Cunningham): I recognise the contribution that honorary sheriffs make to the justice system in rural and island areas, particularly in view of the fact that the position is unpaid. The proposed reforms to the justice system, including the creation of new

summary sheriffs and increased use of technology alongside sheriffs, will reduce the need for honorary sheriffs and improve access to justice. I assure Liam McArthur that the position of honorary sheriff will be abolished only once alternative arrangements have been made.

Liam McArthur: The proposal in the Courts Reform (Scotland) Bill appears to lack thoroughness and I am told that many of those who will be most directly affected have not been properly consulted on it. In island areas such as the ones that I represent, the abolition of honorary sheriffs could create serious difficulties, for example when police require warrants to be signed. Is the intention for sheriffs to be on call 24 hours a day, seven days a week, or are scanned warrants to be admissible? If it is the latter, what will be the cost and timeframe of the delivery of the required technology?

If the minister's concern relates to the security of tenure and independence, is that not an argument for amending the appointments system? Will she not concede that even if the change is to be phased in, the chances are that the appointment of honorary sheriffs will cease in the meantime, which will create practical difficulties in many rural parts of the country, including Orkney?

Roseanna Cunningham: That was a long question of many parts, and I will ensure that each of them is dealt with separately. I said at the end of my initial comments that honorary sheriffs will not be abolished until we have ensured that alternatives are in place. Liam McArthur is wrong to say that consultees did not submit responses to the bill. They did, and the issue was raised in consultation responses.

Liam McArthur asked a specific question about warrants. I assure him that emergency applications will be dealt with by sheriffs or summary sheriffs and the increased use of technology. It is anticipated that in future custody courts and the issue of warrants and interim orders could be carried out by videolink and electronic authentication. We want to introduce those kinds of things to ensure that new practices are brought in. We use new technology over a wide range of professions and business and there is no reason why it cannot be introduced equally well in the court system.

I reiterate that until we are sure that there will not be difficulties the honorary sheriffs will not disappear.

NHS Scotland (2020 Vision)

The Deputy Presiding Officer (John Scott): The next item of business is a debate on motion S4M-09222, in the name of Alex Neil, on an update on delivering the 2020 vision in NHS Scotland.

14:39

The Cabinet Secretary for Health and Wellbeing (Alex Neil): The debate provides the Parliament with an opportunity to focus positively on the key role that innovation and technology will play in delivering the 2020 vision for health and social care.

Our vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. We need to enable the people of Scotland, their carers and their families to use digital technologies to access the best possible quality healthcare. That will be good for patient safety, it will promote health and social care integration and it will, I hope, reduce the amount of unnecessary hospitalisation. In addition, it will help us to proceed on seven-day working and to achieve a range of other qualitative objectives in the national health service.

David Stewart (Highlands and Islands) (Lab): The motion stresses the importance of innovation in technology. The cabinet secretary will be aware that funding from the European Union's horizon 2020 programme is designed to enhance innovation in health. Has the cabinet secretary had any direct involvement to see whether funding from that programme can benefit Scotland?

Alex Neil: Our director of finance, John Matheson, has been actively involved with the European Union in exploiting all financial opportunities for the national health service and the wider life sciences industrial sector to use European funds to promote research and development in a range of ways. We are making as much use of those programmes as we possibly can.

As I said in a previous debate, I am inviting the Opposition spokespeople to attend a presentation in St Andrew's house on the wider 2020 vision. I hope to arrange that for early April because I am very keen that the 2020 vision, as far as possible, is developed more consensually than perhaps has been the case with some other health debates in the Parliament, and that other parties have the opportunity to input their ideas and thoughts on where not only the national health service but social care needs to be by 2020.

Scotland is recognised internationally as a country that has advanced medical science and

leads in the field of information technology and informatics. We have 80 European leaders coming to Scotland next week to look at the use of innovation and technology in the national health service because we are recognised as a world leader in the application of much of that technology. We will also fairly soon have visitors from as far away as Peru coming with a view to learning lessons about what we do that are applicable in their country.

We need to grasp even further the opportunity that new technology gives us to deliver a step change in how healthcare services are accessed and delivered. I will update the chamber on where we are now. As I have said, the good news is that Scotland is well ahead of the game. Yesterday, I hosted a summit of digital health leaders from across Scotland. There was consensus that we had achieved much over the past seven years under our e-health strategy, when investment has totalled more than £770 million. Those digital health leaders agree that there is an opportunity to step up the pace and scale of change and to exploit significant investments made in our core infrastructure. Therefore, although we are ahead of the game, we must focus our energies and support digital technologies to step up the pace of delivery of our 2020 priorities of person-centred, effective and high-quality safe health and social care.

Many members will be familiar with the reviews of national health technology programmes south of the border and their astronomical cost with little to show from much of that investment. That unsuccessful centralised and big-bang approach has failed for many reasons, including a lack of collaboration with service providers and poor public consultation.

The Scottish Government recognised the risks and struck a different course. We have taken a consultative approach with patients; we have made improvements based on clinical leadership and local innovation; and we have recognised that the technology is an enabler to achieving our 2020 vision and not an end in its own right.

I want to highlight some examples of areas in which technology is already delivering for patients in Scotland and areas in which I think that we can do much more. In Renfrewshire, telecare support has meant that people with dementia have been able to stay in their own homes for two years longer than expected. It is also an effective use of resources. The Renfrewshire project has meant that £2.8 million has been ploughed back into front-line services.

Local authorities have led the way in their use of technology to support people at home. Around 115,000 of our most vulnerable people received telecare services last year. Early work in Dalmellington in East Ayrshire, Girvan in South Ayrshire and parts of North Ayrshire has shown that, for patients with chronic lung diseases, telehealth reduced emergency admissions by 70 per cent and general practitioner appointments by 26 per cent.

There is more to come. More than 8,000 people have been involved in the initial planning stage of living it up, our innovative £10 million partnership programme with the United Kingdom Technology Strategy Board. It uses familiar devices such as televisions and smartphones to help people manage their own health and wellbeing at home. I think that we would all agree that self-management has a big role to play in the future delivery of health and social care.

It is clear that there is a demand for all those areas of work, but we want to do much more. I want all that work to be done with greater pace and on a wider scale across the health and social care sector in Scotland. Therefore, I am pleased to confirm to Parliament that an additional £10 million of funding will be provided to national health service boards to support the expansion of home health monitoring solutions across Scotland as part of an integrated care package. That will help us to deliver real results in telehealth and telecare over the next two years.

We must not forget the emerging technologies that we are developing with partners to support future healthcare models. I was delighted when, thanks to a £10 million investment by the Scottish Further and Higher Education Funding Council, the digital health institute was launched in October last year. That innovative partnership between healthcare providers, industry and academia will create the next generation of technology.

I have outlined how patients in Scotland are already benefiting from digital technology but, quite rightly, they expect more. In a world in which technology allows us to access information at the touch of a button, we must support people to interact electronically with their healthcare services.

Today, I can confirm that I am setting the ambitious goal of creating a personalised electronic patient record for every citizen in Scotland by 2020 at the latest. That will allow people to digitally access and jointly manage the health and care information that is important to them and their wellbeing. Involving people in co-producing their records will ensure that complex clinical information is explained to the patient, which can bolster the relationship between patients and clinicians and promote patient empowerment.

That project will build on a series of building blocks that we already have in place. The award-

winning key information summary—KIS, for short—is an excellent example of clinicians and patients working together. It now supports more than 76,000 vulnerable people to live safe and secure lives.

We need to develop an approach to handling information that keeps everyone informed, engaged and aware. I have asked for clear and effective risk-based models to be developed to ensure that information flows through the system.

Of course, some of our patients already have direct access to online records and advice to support greater interaction with their clinicians. For example, the my diabetes, my way website, which supports nearly 5,000 people with diabetes, and renal patientview, which supports more than 4,000 people, were developed by clinicians to support patients to live fully active lives in their own homes.

In response to patient demands, technology systems in GP practices are starting to offer online transactional services, such as appointment bookings, repeat prescriptions and access to information, including test results. The service needs to be available to everyone in Scotland as soon as possible. We need individuals to participate in their own health and care and to design solutions that fit their needs.

I have highlighted how digital technology is delivering for patients. One element that might not be immediately visible to patients is how technology will allow the NHS in Scotland to work smarter and more flexibly in the delivery of services. We have to recognise that new ways of working will be required and that there must be a big shift in embedded cultures and practices. Although such challenges are tricky, we intend to meet them head-on through strong leadership and the commitment of a workforce that has always valued service improvement. Indeed, we have already seen how technology advances can support effective service redesign. Our telestroke service, for example, has led to a 151 per cent increase in treatment rates for stroke thrombolysis in boards.

I have mentioned our NHS staff's commitment to the issue of core e-health. We need to support our workforce with the right information, wherever they need it, at the right time. Our e-health strategy has moved the health service from its reliance on paper to a service with an efficient core infrastructure to support electronic records in place and, in order to support integrated health and social care, we need to look beyond traditional healthcare settings. In 2012-13, we made an additional £1 million investment in mobile devices to support the community healthcare workforce. In order to truly shift the balance of care, we need to focus more resources on that area to develop and support integrated working. One example of that is the use of apps in, for example, the musculoskeletal service in Ayrshire and Arran, which is making a material difference to the quality and cost effectiveness of service delivery in that area.

Our 2020 vision also sees a more effective and safer NHS Scotland. For example, all boards have adopted clinical portal technologies to ensure that relevant information can be assembled for the clinician from different information technology systems at the point at which the information is needed. They also provide the platform for future interactive online services and information.

NHS Scotland now has the means of collecting more and richer real-time clinical and performance information. In NHS Borders, I have seen for myself—and I think that Jim Hume saw this morning—the significant progress that has been achieved through the electronic whiteboard solution that has been installed in all its wards. That solution, which has been developed by a Scottish company, has contributed to reduced lengths of stay, improved patient safety and reduced referral levels, while ensuring operational consistency. This financial year alone, I have provided £2 million to NHS boards to ensure that every board has similar capabilities in place; indeed, my ambition is for those whiteboards to be in every ward in every hospital in Scotland.

Although Scotland benefits from good electronic communications between primary and secondary care, we still need to bring together information from across primary, secondary and community care in a consistent electronic patient record. A major patient safety and efficiency initiative that has been introduced as part of prescription for excellence is what is known as HEPMA—or hospital electronic prescribing and medicines administration—out of which will come the development of a shared virtual medications record. The move has received massive support from clinicians across Scotland, who see it as the last major piece of clinical technology that is absent in acute care. Without it, an electronic patient record is not fully achievable. It is an example of significant investment in business change delivering immense improvements in efficiency and patient safety.

Although building on such examples to deliver at pace and at scale will not be straightforward, the 2020 vision underpinned by the increased pace of innovation gives us the route map to delivery and success. The rewards for patients in Scotland are immense and I look forward to working with all the other parties in the Parliament to help deliver our vision for 2020 and beyond.

In that spirit, I move,

That the Parliament recognises that innovation through technology is vital in delivering Scotland's 2020 Vision for health and social care, whereby everyone is able to live longer, healthier lives at home or in a homely setting; considers that enhanced home-based monitoring services are instrumental in reducing levels of hospital readmission; acknowledges that digital healthcare should be a catalyst for people interacting with services and information online, building on examples such as the Key Information Summary and the internationally acclaimed Emergency Care Summary, and recognises that Scotland has a clear opportunity to be a leader in the growing global digital healthcare market, following the establishment of organisations such as the Digital Health Institute.

14:54

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I declare a family interest in the area of IT and e-health.

My recent experience of treatment makes me very proud of the NHS in Scotland and proud of the shared vision of Scottish Labour and the Scottish National Party and, indeed, other parties of an NHS that is based on co-operation and collaboration and is firmly embedded in its founding principles.

The 2020 vision, which we are debating, with its triple aims, 12 priorities and 24 key deliverables, is fine, and I very much welcome the cabinet secretary's offer to meet parties and to have a briefing and update on the other key deliverables. However, there are trenchant warnings from the King's Fund and Audit Scotland in its critical analysis, and we need quite a radical vision if we are to be able to deliver those shared objectives. As one commentator has said, it will not be possible to have business as usual. That is not possible with the current financial restraints and the growth in demand. Although the Government's motion and the cabinet secretary's speech are all about e-health, we cannot ignore the serious pressures on the NHS.

For many years, telehealth and telecare have held out the hope of a revolution in self-management, monitoring and preventive care, and there is no doubt, as the cabinet secretary said, that Scotland is at the forefront of development in that field. That has been recognised in Europe. However, the delivery has been overly dependent on the signing up of individual health boards. My speech will be critical, but it is really a reality check, although I share the cabinet secretary's aspirations.

The evidence of the benefits of telehealth and telecare is becoming clearer. First, there is the positive effect on the wellbeing and confidence of patients, their families and carers. Secondly, there is the possibility of reducing readmissions or unplanned emergency admissions for some disease-specific conditions—cardiac failure, for example. However, that is illustrative because, at the very time when we are getting in place good monitoring systems, cardiac specialist nurses have been reduced or redeployed to general wards. That means that the managed care network or clinical pathway is damaged.

The success of telehealth or telecare, like that in other areas, depends on all parts of the managed care network or clinical pathway being effective. The fact that chronic obstructive pulmonary disease support, for example, has not yet led to clear improvements in readmissions, except in small-scale projects such as the one that the cabinet secretary mentioned or the one in Argyll and Bute, may be due not to a failure of telecare but to a need for a redesign of the back-up services. That emphasises the point that I am trying to make about the managed care networks being critical.

The use of telecare in hypertension monitoring is a very good example of empowering patients. It has been proven to improve medicine compliance, which, in turn, improves outcomes.

The first message that I would like the Government to take on board is that it should ensure a continuing strong research element to the developments. No pilot should be undertaken without an effective and proper audit of what is happening and preferably some form of controlled or randomised controlled trial. Secondly, where telehealth and telecare are shown to be effective, health boards should be required to implement. That should be achieved through a rigorous inspection and monitoring system. The Audit Scotland review in 2013 showed a rather patchy response, except in implementing videoconferencing, which all 14 boards had adopted.

I very much welcome the launch of the digital health institute in September to October last year. That is indeed a very ambitious project, with its aim to establish 120 innovation collaborations and release 140 products and services. I wish it well.

As the cabinet secretary said, empowering patients is essential for self-management. That means access to things such as the key information summary across Scotland. I add my congratulations to Dr Libby Morris and her team on their success as winners in the excellence in major healthcare IT development category at the *E-Health Insider* awards in 2013. KIS and the emergency care records system in Scotland are indeed a success story. However, I will turn to IT generally now, on which I have to be more critical.

IT is an area that promises much, but it is extremely fragmented in the NHS in Scotland. We have avoided the massive implosion in the system that was so expensive in England, but we have

had our own problems. The cabinet secretary did not mention, for example, the failure of eCare after five years at a cost of £56 million. Then there is the IT software for the national needle exchange system, which was developed at a cost of £0.25 million but used by only one alcohol and drugs partnership in Scotland, as far as I am aware.

An area of personal interest to me as a former clinician is our failure to develop a single shared assessment system for drug and alcohol misuse, which I called for in 2003, after stepping down as the minister in charge of that area. We now have the Daisy Group to deliver that. I would like the cabinet secretary to give us an update in his summing up, if possible, on progress on that. However, it is 10 years since I called for something and, again, it is a national system. Glasgow has tried to develop a system that I hope will be built on. There are other measures around, which I will perhaps tell the cabinet secretary of later.

We have undertaken a series of freedom of information requests in the past six months that have demonstrated that there are a number of disturbing features. First, only one health board in Scotland—NHS Fife—has met the ISO standard for its IT. Another of our FOI requests has shown that there has been not just one—the Glasgow interruption of service—but 252 interruptions in IT services over three years. Three health boards—Highland, Dumfries and Galloway, and Forth Valley—could not even tell us whether there had been interruptions or not. That is not satisfactory.

The recent collapse of the Glasgow IT system, with its potential for damaging clinical consequences, produced a first report that could not find a cause, which was worrying. However, it went on to recommend expensive remedial measures. How can that be done if the cause of the failure was not known? All that is crying out for Healthcare Improvement Scotland to undertake a formal inspection of the resilience of our IT systems across all the health boards in Scotland.

In my view, devolving most of the IT budget to 14 different health boards following the report by the now chief executive of Glasgow health board was an abrogation of the necessary central leadership. It has allowed the growth of fragmented IT systems and has meant that there is no universal clinical access to data. For example, from my recent experience I know that Tayside consultants cannot access laboratory results for patients in Fife, of whom they see quite a number. In my case, my consultant in the Beatson could not access the laboratory results from a GP in Fife.

The clinical portals system started in 2009, but it is only just in place after five years and the portals are not accessible across managed care networks or are accessible only in a cumbersome way in which clinicians have to come out of one system and go back into another. They tell me that that is very cumbersome. Our only major success, which I would not criticise at all, has been the radiology system, which is absolutely world class.

Younger health professionals must be absolutely horrified, as I am, by our failure to adopt digital solutions. They use iPads and iPhones, or their equivalent, extensively, but they are back to pencil and paper on the wards. I saw vast paper records in the wards in which I was present. There is a lack of a prospective system for ensuring patient confidentiality in the hospital IT systems. I believe that that is in breach of the European Union legal case precedent of I v Finland, which is worrying.

We had another FOI request that looked at inappropriate access to electronic data. It showed that Lothian—the only board that has had a system in place since 2011, albeit a retrospective one—reported 794 breaches in two years. However, at least Lothian has a system and it is showing a reduction. The other boards either do not have systems or are reporting unbelievable results. For example, Glasgow has reported only 10 breaches. Fife reported a rising trend and Dumfries and Galloway, which only started its system in April, has recorded 23 breaches in six months. I have no confidence in the other boards' protection of patient data.

The previous Cabinet Secretary for Health and Wellbeing made a promise to me in the chamber that, by 2015, patients would have access to an audit trail of all those who were looking at their clinical data. Will the cabinet secretary update us on that promise? The Government must get a grip in this area or it could endanger the excellent Scottish primary care information resource—SPIRE—data sharing project, which is in a much better position than the data sharing project in England.

As our amendment states, the first step in delivering the 2020 vision will be

"to identify pressures on the service".

I will mention some of the concerns and my colleagues will expand on them. They include the workforce issues that we have discussed elsewhere—for example, there have been cuts in trainees and nurses, followed by their re-establishment. Many boards are finding it difficult to meet the challenge of the waiting times targets. The delayed discharge target has not been met in 16 of the past 20 quarters. Shifting the balance of care has not been evidenced, according to Audit Scotland, whose critique in its report "Reshaping care for older people" is devastating. The reality, which Audit Scotland has repeatedly evidenced, is

that the situation is not sustainable. We need to be proactive and not reactive.

I welcome the cabinet secretary's aspirations. There is a lot to do.

I move amendment S4M-09222.2, to insert at end:

"; believes that innovation and digital technology will play a significant role in delivering the 2020 vision; accepts that it is also essential to identify pressures on the service in order to secure successful and effective services for the future, and further believes that the Scottish Government should undertake an immediate and independent review of the NHS to identify pressure points and a long-term way forward for the future of health services".

15:06

Jim Hume (South Scotland) (LD): I recently had the privilege of experiencing the good work that our NHS does, although it was on Friday past and not, as the cabinet secretary said, this morning. During my visit to the Borders general hospital I spent some time in the stroke unit, the intensive care unit and the mental health facility at Huntlyburn, and I witnessed the innovative Wardview system that is in place and is being further developed.

The concept of the system is simple enough, but the potential is mind boggling. Wardview is more than a replacement for squiggles on a whiteboard. A huge touch-screen display gives an instant view of all the patients on the ward. Staff can instantly see who needs what medicine and when, they can see when patients will be discharged and they can ensure that the discharge letter is prepared in time. The system is a powerful tool for clinicians during their huddle, as it enables them to ensure that they are focusing their efforts where they are most needed.

Because Wardview is the same for all wards, the icons and the set-up are familiar to all NHS staff in the area, no matter which ward they are seconded to. The information is also portable, and it is likely that it will become more portable in the near future with the use of tablets and smart phones. As the cabinet secretary said, patient statuses can be updated live, so gone are the days of doctors and nurses having to find time to write their notes by hand, perhaps some time after the event. I was therefore pleased to hear the cabinet secretary say that Wardview will be spread out to all health board regions across Scotland. It is important to note that the system can be used not just in wards but, for example, by health visitors. I will come to that later in my speech.

That innovative system ensures that, when a patient is transferred, their details are all on the display straight away, so there is no need for staff to decipher doctors' notes or nurses' fine handwriting. The power of the system lies in its ability to work through cyberspace. In the Borders, the system is being implemented in community hospitals, so consultants can monitor and possibly diagnose from a distance, remotely and virtually.

The system can go further. For example, if it is implemented in pharmacies, that can help with patients leaving hospitals. If it is integrated with transport and ambulances, we can ensure that there is safe and timely discharge, and an incoming patient's information can be with the hospital before they are. The system can even be used for catering. When a patient is moved from one ward to another, their dinner can be guaranteed to follow them. Believe it or not, patients who move between wards often miss out on food or end up getting two servings, which means that there is waste in the system.

As I said, the system's potential is mind boggling. Will we see hospitals without walls—or virtual hospitals? I am sure that we will still need walled hospitals and community hospitals, but the innovation must lead to better care, with more people being cared for where they want to be cared for and staff able to manage their wards and hospitals better, to get an immediate picture of where they are in relation to targets and available beds and, most important, to ensure that patients are getting the person-centred care that they deserve and which we want them to get.

The position will evolve and we might not recognise it in years to come, but I am convinced that that is the future—a future of better care and integrated care, so that more and more people can stay in their homes and communities.

Technology is a valuable tool for integrating health and social care seamlessly, as the cabinet secretary hinted. I support him in looking to roll out the program across Scotland in some form but, as Richard Simpson was right to say, a uniform approach must be taken. As we all know, patients' health knows no boundaries and many patients have to move between health board areas.

I think that the matter is urgent, which is why I lodged my amendment. Having witnessed what innovation can do, I believe that we should establish a health improvement, efficiency and governance, access and treatment—HEAT—target for health boards on mainstreaming telecare; that is part of my amendment. Wardview can help to deliver that, as it ticks the boxes perfectly in relation to the three domains of the route map: quality of care, health of the population and value and financial sustainability.

I am sure that Wardview is not the only tool that we can use; the cabinet secretary mentioned a few. Telecare from doctors on the other side of the world could be of use in the middle of the night. As

we all know, getting doctors to cover out-of-hours services in Scotland is proving difficult, so why not use a doctor in New Zealand, for example, in the middle of the day there? Delivering that will depend on good, fast broadband, so the focus on spreading faster broadband throughout Scotland must continue, although that is a debate for another day. However, we can make progress now—we do not have to wait for faster broadband.

I hope that we can realise our 2020 vision long before 2020. The technology is here, so let us get it out there. I welcome the Government's motion, but it can be strengthened by my amendment, which recognises how beneficial the likes of Wardview already are for our health service and the technology's potential to develop into an even more powerful tool. Setting targets—I have on purpose not stated what the targets should be, as that is for the experts—will focus health boards on mainstreaming the use of telehealth. We hope that Scotland leads the way with innovative solutions that will undoubtedly lead to better healthcare for our patients.

I move amendment S4M-09222.1, to insert at end:

"; welcomes innovations such as Wardview, which can help to reduce the length of patient stays, improve patient safety and make more efficient use of clinicians' time; believes that technology will play an important role in meeting the challenges of the future, especially from the growing population of older people and the extra healthcare that they will need; further believes that Scotland should establish national-scale telehealth services, and would welcome the establishment of a specific HEAT target for NHS boards to mainstream the use of telehealth in the delivery of patient care".

15:12

Nanette Milne (North East Scotland) (Con): My party welcomes this debate to bring us up to speed with the growing contribution that technology makes to the delivery of the Scottish Government's 2020 vision for NHS Scotland. We will support the motion at decision time.

I cut my medical teeth at the University of Aberdeen on the pioneering work of Professor Nelson Norman, who was at that time a senior lecturer in surgery, in developing remote healthcare, which would soon be used for the benefit of people who were employed in the growing oil and gas industry in the North Sea. It is particularly appropriate that the first director of the recently established digital health institute, Professor George Crooks, is also a graduate of that university and an experienced former practitioner at the coalface of primary care in the city of Aberdeen.

The institute has been set up with the remit to promote innovation through the use of technology in supporting people to live longer and healthier lives at home or in a homely setting and, as a result, to generate economic benefit for Scotland as a leader in the growing global digital healthcare market. The DHI's collaborative work will position it well to assist the delivery by health boards, local authorities and the third sector of the outcomes that are envisaged in the 2020 vision for NHS Scotland. That work is open to anyone with an interest in digital health and improving technologies in Scotland and beyond, and there is significant interest among the business community—particularly among the small digital health business community.

The briefing that the institute sent us refers to exciting new developments that are in the pipeline, one of which is the assessment of new technologies to allow for easier identification and earlier treatment of patients with atrial fibrillation, which is a common cause of heart failure and stroke in the elderly. Recording on a smartphone an electrocardiogram that can then be interpreted remotely has enormous potential for reducing unnecessary hospital admissions and allowing patients to self-monitor their condition, which would be reassuring for patients and would allow GPs to better tailor their care to patients' needs.

Such developments will have a major impact on patient healthcare journeys, especially for those who live in the more remote and rural parts of the country, by allowing earlier diagnosis and triage well outwith the acute healthcare setting and enabling those who do not need admission to be cared for in the community, while those who need it will have speedy access to the specialist facilities that their condition requires.

There are many exciting possibilities, and I look forward to hearing a lot more about the innovative healthcare that results from the DHI's collaborative work.

I welcome the cabinet secretary's announcement today of financial support for health boards to expand home health monitoring programmes. I also welcome his proposal on the universal availability of personalised electronic patient records by 2020 at the latest. I could have done with such a record recently. I turned up for a rescheduled appointment for pre-op assessment, but I had not been told that the venue had changed, so my notes were at a different hospital. That meant that my appointment had to be rescheduled again, even though the nurse was free to see me because another patient had not turned up. Of course, the nurse could not see me without having my notes. An electronic record would have been useful.

As we have heard, there are a number of successful uses of technology in healthcare. It can be used in the monitoring and management of

long-term conditions such as chronic heart failure and COPD. Skin lesions can be diagnosed remotely by a dermatologist, and an endoscopy can be assessed by a consultant via videoconferencing equipment. Many traumatic injuries can be assessed remotely by the same means. That all saves unnecessary journeys to hospital for patients and is an efficient use of specialists' time, cutting back on the time that they spend travelling to remote and island communities. Patients are happy, and, by and large, staff are happy.

I must mention the excellent work that many optometrists in Scotland are doing. Digital retinal screening is picking up many health problems early, when they can be managed effectively. I urge everyone, particularly people in the older age groups, to have the regular free eye checks that are available to them. That could save them a great deal of grief in future and help them to live safely and independently in their homes and communities well into old age.

It is taking a long time for telehealth and telecare to catch on in some board areas, especially when we consider that some of the technology that we have been talking about was available in the 1960s. Given the enormous and increasing demands on the NHS, further innovation through technology will be vital if the 2020 vision for health and social care is to be achieved and if the integration of health and social care is to achieve the best outcomes for patients, with everyone who is involved in care planning, including patients and carers, having meaningful input in the patient journey.

We have a long way to go. Delayed discharge is on the way up again—in my area, that is due to the difficulty in recruiting home carers, given the lure of the oil and gas industry. There is severe pressure on acute hospital beds, and patients are complaining that they must wait an unreasonable time to see a GP. In my 10 years as an MSP, I can honestly say that I have never had so many disgruntled patients get in touch with me as I have had in the past two or three months.

The Royal College of Nursing Scotland summed up the situation well in its briefing. It said:

"While the 2020 vision for our NHS is a very positive plan for patient care, the pressures on our NHS have become more intense since its launch in 2011. New policy directions, such as the integration of health and social care, 7 day working and unscheduled care, to name but a few, on top of day-to-day activity to meet targets and standards, mean that decision makers in our health boards are being pulled in too many directions. So now is a good time for politicians, the NHS and local authorities to have a renewed focus on the 2020 vision, to ensure it becomes a reality."

Technology is clearly a key factor in achieving that reality, but only in conjunction with our dealing with the existing pressures that are working against it. I support the Scottish Government in its pursuit of innovation to achieve high-quality patient-centred care, but I urge it not to lose sight of the growing pressures on the NHS, which are threatening the achievement of those aims.

I am not convinced that Labour's demand for an independent review of the service is necessary, which is why we will not support Richard Simpson's amendment, but it is right to draw attention to the problems that face the NHS in Scotland. We will support Jim Hume's amendment.

I look forward to further updates on the 2020 vision in the months ahead.

15:19

Aileen McLeod (South Scotland) (SNP): I welcome the cabinet secretary's announcements about additional funding for NHS boards to support the expansion of home health monitoring solutions and the goal of a personalised electronic patient record for every Scottish citizen by 2020.

Digital health technologies provide us with the opportunity radically to change how healthcare is delivered and accessed. The quality of healthcare for our elderly and vulnerable has already been improved significantly by the adoption of person-centred delivery systems, and the potential for future development is virtually unlimited. The importance of digital health technologies in enabling patients to be more in control of their own care should not be underestimated. They pave the way not only for better healthcare but for a more financially sustainable model of healthcare.

Harnessing the potential of digital health will give us a key enabling tool in delivering the 2020 vision for health and social care, with everyone able to live longer, healthier lives at home or in a homely setting. For example, NHS Dumfries and Galloway is piloting a number of telehealth projects, including the use of regular diabetes telemedicine clinics at the Galloway community hospital in Stranraer. Those clinics are linked to specialist diabetes services that are 70 miles away at the Dumfries and Galloway royal infirmary in Dumfries.

While those pilots are very good, they tend to be small in scale, and if we are seriously to address the societal challenges that our health and care systems face, we need to upscale our current efforts through the deployment of safe, effective and evidence-based solutions that meet the needs of all our citizens.

Achieving the aims of the Public Bodies (Joint Working) (Scotland) Bill, which the Parliament passed last week, will require local health and social care partnerships to deliver digital

healthcare at a scale that is larger than a single site or single service. Financial investment will be required to assist the development of new capacities and ensure that Scotland remains at the forefront of European and global research and development in digital health.

Last October's launch of the DHI and its use of experience labs, which allow companies and academics to work quickly with practitioners on the ground to test new solutions and develop commercial exploitation, are significant steps in the right direction. Scotland is in pole position to export its world-leading digi-health technology. We are already recognised as a world leader in developments in the area. By exploiting our expertise in digital health, we will deliver significant benefits to those who rely on health and social care; we will address the twin challenges of demographic change and public spending constraints; and we will create a significant economic opportunity. Scotland is therefore ideally placed to make a significant contribution to one of the major challenges facing European society today.

The European Commission has identified healthy and active ageing and digital health solutions as key priorities in its Europe 2020 growth agenda. That is highlighted in a number of initiatives, such as the new EU health programme 2014 to 2020; the e-health action plan; the European innovation partnership on active and healthy ageing, which already has significant Scottish participation; the forthcoming m-health green paper on mobile devices; and the horizon 2020 research and innovation funding programme. Within the EU, there is very clear recognition of the digital health sector's potential as a key driver for economic growth and job creation. That all links particularly well with achievement of the Scottish Government's 2020 vision.

Scotland has a massive opportunity to take its world-leading digital health technology to the next level through the international consortium bid, led by the University of Edinburgh, to establish a European Institute of Innovation and Technology knowledge and innovation community—KIC—in the area of healthy living and active ageing. If successful, it will be financed by the new EU horizon 2020 funding programme. LifeKIC, as the Scottish-led KIC is called, will focus on developing new digital health technology through telehealth and telecare initiatives that, when implemented, will allow EU citizens to lead healthy, active and independent lives as they age, as well as through new models of health and social care integration. It will also build on excellence in research and innovation.

The call for new KIC proposals was published on 14 February. Professor Mark Parsons and Professor Stuart Anderson of the University of Edinburgh have been working tirelessly—supported by the DHI and others such as Scotland Europa, Scottish Enterprise, the Scottish Government and Professor George Crooks, who is the medical director of NHS 24—to build a team Scotland approach and to bring in other partners in Denmark, Spain, Italy and Germany and the city of Amsterdam to act as co-location nodes within LifeKIC.

If successful, the Scottish and UK part of LifeKIC will be hosted in Edinburgh, and the overall KIC will be headquartered in Edinburgh. That will enable the university to participate as an innovation hub—that is, as a centre of excellence that integrates higher education and research and business activities.

Given that Scotland really is on the cusp of the development of world-leading technology in the area, it is important for the Parliament to give its full support to the LifeKIC bid. I would very much welcome the cabinet secretary's support, and I ask that everything that can be done is done to ensure that there is also support from the UK Government in the bid being taken forward in Brussels.

Digital health has the potential to improve both performance in health and the patient experience in Scotland and to do so cost effectively. It is an economic prize that is worth pursuing, and I am delighted that the Scottish Government is approaching that challenge with such commitment.

15:25

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I have never been very knowledgeable about e-health but I have been aware of its importance for a long time, which is why I chaired the e-health strategy board when I was a minister. I was pleased that the David Kerr report made its recommendations on IT fairly central. For example, it recommended a common IT system for NHS Scotland, a telehealth technology resource centre and an electronic health record for all. Like other members, I was pleased to hear the cabinet secretary announce the goal of personalised electronic patient records by 2020. I wonder, however, whether the record will be owned by the patient; that was an interesting recommendation from the great English GP, Sir John Oldham, who produced an important report for the Labour Party in England yesterday. Perhaps the cabinet secretary could look at that—I am always asking the cabinet secretary to look at health in England, although he knows that I do not support its health system.

I could, as others have, spend my speech giving examples of progress since the 2005 Kerr report, but I will touch on that only briefly, always

remembering what Richard Simpson said: that this is not a substitute for all the other things that have to be done.

Videoconferencing has developed. I remember seeing it in accident and emergency in Aberdeen 10 years ago, but it has become more extensive. For example, some people get speech and language therapy by videoconference.

Aileen McLeod referred to the monitoring of diabetes. That applies to other conditions, too, such as cardiac problems. Telecare services are available at home. Again, even 10 years ago, I saw that in houses in West Lothian, where the movements of older residents were being monitored remotely.

Jim Hume mentioned electronic whiteboards, although Richard Simpson reminded us that they are not seen everywhere. In relation to rehabilitation, there is, for example, remote pulmonary rehabilitation at several sites in Scotland.

The cabinet secretary referred to stroke thrombolysis, although it is in only 11 out of 14 health boards, so Richard Simpson's point about making that apply everywhere stands. However, it means that it is possible to have immediate access to a stroke specialist wherever in Scotland someone happens to have a stroke.

There are lots of great examples, many of them based on smartphones and other hand-held devices, often involving apps. Aileen McLeod, who is the expert in the chamber and further afield on matters European, reminded us of all the European developments, including a European consultation being launched this month on health apps. That is really interesting because there are many good examples of those, one of which was developed by Leslie Holdsworth, one of the great clinicians who was a member of the group that produced the Kerr report. She and others developed an app for musculoskeletal problems. If members want to find out more about the European consultation on health apps, they should look at Leslie Holdsworth's Twitter feed, where yesterday she posted a wonderful video by the Commission vice-president Neelie Kroes, who explains what the consultation is about. The Commission is interested in ensuring that such apps are accessible to people across Europe, wherever they travel, and in the quality and safety of such developments. That is interesting.

Apps came up at the eating disorder conference last week and an interesting issue emerged. There are 231 million people in the world who have health and fitness apps, but we must think about the potential negatives. Some of those who attended the conference on Friday, including the outstanding clinician Dr Jane Morris from Aberdeen, expressed some reservations because conditions such as anorexia nervosa could be made worse by a health and fitness app unless it was programmed sensitively to cover the obsessive nature of that and similar conditions. That is just a cautionary note. Such apps are positive but they are potentially negative, too.

Of course, there are sceptics out there. I was pleased to hear Richard Simpson—I always listen to his medical advice—say that the benefits of telehealth are well evidenced, but I noticed in the material for debates an article in the *British Medical Journal* that concluded that there was not a lot of evidence of its effectiveness in the regions that the researchers examined. I think that that view is being overturned by the positive examples that are emerging. I suppose, however, that we have to convince the sceptics in this regard.

Clinical trials are important. An excellent example of that concerns another outstanding clinician who was a member of the Kerr group, Nora Kearney. Last week, she launched the advanced symptom management system, which allows patients to report the side-effects of their chemotherapy via a mobile phone. The information is immediately sent securely to a computer that assesses their symptoms and triggers alerts to doctors or nurses within minutes if they require specialist intervention. She is the chief investigator of a pan-European study on the system, which will feature randomised controlled trials at 17 sites across Europe. Unfortunately, she has recently migrated to the University of Surrey, but we should pay tribute to the enormous contribution that she has made to health in Scotland in the past 30 years.

Clinical trials are important, but the reason why I mention that system is that I believe—and, crucially, Nora Kearney, who knows a lot more about the issue than me or anyone in this chamber, believes—that it will lead to great improvements in terms of personalised cancer care, the area that she is concerned with, and person-centred care more generally. The technology has a great deal of potential. We should be absolutely positive about it. We should welcome the announcements that are made today, but we should also bear in mind the caveats made by Richard Simpson.

15:31

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): I started my employment in computers in the 1960s, and have spent an awful lot of money on technology over the years, but I come to this debate not as an evangelist but as an iconoclast, and I will disagree with a vast amount of what has been said—I hope in a constructive way.

I will start with something on which I suspect members will agree. Let us imagine a person called Shona, who lives in a remote, rural location. She is well stricken in years and a bit overweight; she has a sedentary lifestyle and she has had a heart attack. If Shona were near a hospital, she might get treatment in one way, but she is not. If we can create helpful connections between her and her medical advisers, that is great.

The telephone was first demonstrated in 1876 and, today, we can use that same piece of copper wire that might have been in Shona's house for 100 years to do much more, using the internet and technologies such as Skype that cost her nothing and build on existing infrastructure, to connect her to people who can help her. That is great. If a specialist somewhere in Scotland or elsewhere—New Zealand was suggested, but I think that that is a little extreme—is able to talk to her about her experience, that is likely to be helpful to her and cost-effective for the health service. However, that specialist needs access to her medication records, her previous medical history and information about her positive and negative reactions to various drugs if they are to give good advice.

I am just a simple soul. I would get the Lloyd George envelope out of the cabinet and just scan the files in. I would not interpret them or convert them; I would just get an image. Once that has been done, it would not matter where the information was and, if someone went to the wrong hospital, it could still be read. I would do simple things like that, and forget all this complicated techy stuff.

Shona needs a little bit of technology. That is probably something that she can manage. If she has some way of recording what she is eating and the exercise that she is taking, and she is getting advice based on that that can help her to move to a healthier lifestyle, that will be good. That is the kind of technology that is worth investing in.

Of course, Shona might live in a remote, rural location without broadband. Plenty of places in Scotland do not have broadband, but 999 houses out of 1,000 can get satellite broadband for £35 a month. It costs £70 to put someone on a treadmill to test their cardiac response and their breathing so, from the health service's point of view, it could be well worth putting in that satellite connection. Talk to the Minister for Energy, Enterprise and Tourism, get some money out of that budget and just do it.

Of course, many treatments are cheap, but even to send a GP to Shona's door for a single visit is probably the cost of a couple of months of broadband connection. We should just do it and be very simple. If Shona gets good advice, she will eat better, take more exercise and get fitter, but she will also feel involved in the management of her condition. At the end of the day, that is the most important thing.

At the health service end, we need some of the big technology and infrastructure that makes it work. We have heard reference to the disaster of the NHS communications network down south; 20 years ago, there was a huge disaster in the London Ambulance Service when an attempt was made to put radio location in and it made things worse, not better. The bottom line is that, if we contract a company to deliver technology, we should not be surprised if it delivers technology. We need to contract companies to deliver health benefits and pay them only if they do.

If we are going to have a project, it must be a multiphase project because, as a project develops, the specification changes. If it does not change, the people who are using it are disengaged from the project because, as we engage in our project, we learn more and change our view of what we need. Therefore, we always have to have a phase 2 in which we put all the change. We accept no change in phase 1, unless we displace something from phase 1 to phase 2.

The one thing that we must do in projects is manage the relationship between the time, the effort and what is delivered. If we fix the time, everything else will work in. If that means taking function out to fix the time as we go along, we should do so and put it into the second part of the project.

Innovation and failure are necessary bedfellows because, when we innovate, we are doing something that we have not done before and we cannot be certain of outcomes. Let us stop being afraid of failure and let us not go for the uniform solution at the outset. If we are innovating, let us innovate small scale so that we can detect failure, fix it and limit the damage. We will get to the point of deploying it big scale later.

Let us also avoid ISO standards like the plague. They reflect yesterday's needs and constrain future innovation. Do not do it. They are about processes, not outcomes.

Shona wants us to have IT project managers who get a modest wage for turning up and get paid only when the health benefits are delivered. We must let Shona decide whether they have been.

15:37

Hugh Henry (Renfrewshire South) (Lab): The health service is one of the few broader public policy areas in which most us in the Parliament agree on the fundamentals. Irrespective of party colours, everyone in the chamber is committed to

a public health service that delivers for all our constituents and all Scotland.

Having such commitment across the political spectrum gives us an opportunity to consider things totally differently. Yes, come election time, we will all have our disagreements about what policies might be better and what voters might want to hear but, in between the elections, it is surely not beyond us to take a step back and consider what can be done to improve matters.

Stewart Stevenson's speech was first class because he not only reflected on some of the issues about how we deliver but gave some warnings about what might or might not be achievable and the consequences of not preparing and not delivering properly. The key thing that he said was about innovation and failure going together. That brings me back to the politics, particularly when we consider the use of technology to try to improve patient care.

If we get obsessed with the politics—if we get obsessed with everything that we have to say between now and September being predicated on the referendum and, thereafter, everything being predicated on who wins in 2016—we will never move forward. If Stewart Stevenson's words are to have any effect, we must be prepared to take risks and try things out, not haphazardly or cavalierly but in a considered and thoughtful fashion in order to ensure that, when we decide to move forward, we do so for the best of reasons.

I believe that there is political consensus, and on such an issue it cannot be beyond our collective wit to put aside our differences and consider what is best for the public and for patients throughout Scotland.

That is why the call in Richard Simpson's amendment for a review is important. It is not about Labour trying to score points against the Scottish National Party or win the argument with voters in order to win elections. If we take the issue out of the political framework, we can sign up to a considered, thoughtful and objective approach. We can all put our differences aside and ask what is and what might not be possible, and people can by all means put their own political slant on at the end.

I have pondered a couple of points that have been raised in the debate. I welcome the positive contributions that the cabinet secretary mentioned, such as extra money for various services. Of course, that gets politicians good headlines and press releases and goes down well when they are talking to the public, but the key to whether the innovations and improvements in telecare and other areas make a difference is the need to reflect on what they mean for the individual patient.

I have a personal slant on the Renfrewshire technology project for people with dementia that the cabinet secretary referred to, as my wife and I are supporting elderly relatives who have dementia and who live in that area. We have not seen any evidence of that project, but daily and weekly we see the difficulties that the home care services experience in coping with the demands of not just our relatives, but other people too. If that welcome innovation is to have any effect and impact locally, we must ask what it means in terms of quality of life for people with dementia such as those I know, and how it helps us as a family to cope with their demands.

The cabinet secretary mentioned the extra £10 million for home help monitoring solutions. However, we are seeing—this is not a criticism of the council but a fact, given the pressures that it is under—home helps who are run ragged and who come in, do their job and get out quickly. People with dementia, in particular, need more than what is on offer.

The cabinet secretary can by all means shout to the rafters about the extra money and the innovations, but unless he heeds Stewart Stevenson's warning about being prepared to fail in trying out something new, and unless we are prepared to put our political differences aside and look at what is best for the NHS in Scotland, we will continue to try to score political points off each other all the way through from election to election and we will not move forward in the way that is possible.

Although there have been improvements in the health service, everything that has been mentioned today suggests that we could do better. At some point we can surely put aside all that political point scoring, have a review and look at it independently, and sign up to do what is best for our patients and our constituents and for the health service in Scotland.

15:44

Chic Brodie (South Scotland) (SNP): I am delighted to speak in the debate, as I believe that the NHS in Scotland is on a positive and exciting journey. I support the approach that Hugh Henry outlined and the comments from Stewart Stevenson.

At least some of us will recall that, not all that long ago, patient and medical details were required to be held in folders, files and documents. I remember authorisations that required multiple signatories, and patient data being created with time gaps and completed on different media types. That had to be reviewed and then passed along to the next person in the medical cycle, whether that was a porter, nurse, doctor or consultant, each of

whom had a different frame of reference on the patient's activity, health, safety or welfare. A lot of that militated against meaningful patient benefit.

Today, we have moved on and have embraced new technologies in many areas, such as radiology, which Richard Simpson mentioned, and in the use of new data analysis and collection techniques and communications. Scotland has always had a reputation for pioneering medical research and, as members have said, innovation. That reputation was and still is international. However, it would be wrong to be complacent. The reputation has to be enhanced and we should be in the van on that. We should recognise that that must be one of the foundation stones as we build on the constancy of change that our society and health provision and service demand.

We have the innovation; the research capability in our universities and hospitals; the provision and results of educational research; and a robust life sciences industry. Above all, we have a skilled and professional health service team. Throughout the coming period of significant change, we will need to harness all those aspects and increase the connectivity between them if we are to create the world-leading health service for the 21st century that I believe we can produce, and which I believe could be an exportable health service.

President Obama is talking of spending $12 billion on an electronic medical records programme, which would be an important step for the USA, but Scotland has made an average investment of £110 million a year—which is nearly £800 million over the past seven years—and has already taken some major steps. However, we still face many challenges if we are to see and grasp our vision for 2020. We face the challenges of demography and finance, but we are in a good place to start that process.

We have made recent progress on improving quality. Of course, things are not perfect yet and there are still many challenges, but we should all embrace the fact that successive Scottish Governments have shared an inherent compassion and capacity to succour the sick and elderly—all those Governments should be applauded for that. I say to all members that the healthcare community is a cord that I hope binds us all. I do not believe that there is one member of the Parliament—although there might be—who is not committed to the values of a publicly provided national health service, and nor is there one who does not wish to see patients, customers, clients, family, friends and neighbours at the heart of the service. As I said, we still face challenges. We face a radical future change in healthcare provision as well as financial and demographic challenges.

With your indulgence Presiding Officer, I will focus on two specific situations. East Ayrshire Council, which to my mind is a progressive council, has as part of its tripartite transformation strategy what we call the Dalmellington project, which aligns with the strategic imperative to consider how best to support older people to live more independently in the community. There are many key actions in the strategic priorities report. The project involves working with the third sector, which is important, to allow older people to participate in and contribute to the community. There is also a determination to implement support for older people to live not just in the community but in their own home.

That dovetails with NHS Ayrshire and Arran's plan, which has been recognised by the Scottish centre for telehealth and telecare and the Scottish Government, to lead on projects that allow communication directly into the homes of the elderly to allow monitoring of their health. The aim is to secure their wellbeing through a range of connected technologies, all of which are remotely connected to a response centre.

No matter how good the digital interconnectivity network is, ultimately it depends on people: professionals in the health service. Patient safety, efficiency and care—both integrated and direct—all depend on teamwork, openness, transparency and participation without fear or favour of performance appraisal at all levels. That means change built on continuous improvement, founded on outcomes rather than targets, constructed on a programme of continuous training and education, so that we have the right skills in the right place, married to a single source of correct data that is provided at the right time and in the right place. It also means that we need strong leadership to drive that change in the NHS, which will see a professional, technology-driven, unified and interconnected health service that puts the patient's wellbeing, health and safety at the heart of its purpose.

The Deputy Presiding Officer (Elaine Smith): Thank you very much. I ask members to stick to their six minutes, please.

15:50

Mark McDonald (Aberdeen Donside) (SNP): The 2020 vision was an acceptance of the evolution of healthcare and the need to make use of available technology to facilitate a greater sense of personal independence for the patient. The principles that lie behind the 2020 vision include those around the integration agenda, which I will come back to, and a focus on ensuring that people get back to their home or community environment as soon as is appropriate, with minimal risk of readmission. A key part of that is ensuring that

appropriate care packages are put in place for when people return home.

Nanette Milne highlighted the difficulties that exist in Aberdeen, which we both represent. My casework contains many examples of individuals who have been delayed either in hospital or in a care home because of the local authority's inability to put in place a care package that would have allowed them to return home. More than one politician has called for a care summit to be held, to bring together local authority and third sector providers to look at how the problems could be overcome. The local authority in Aberdeen has been resisting those calls; I hope that it might reconsider. As we move forward with the 2020 vision it is vital that everybody work together towards the common goal of a person-centred approach that gives the individual the best possible care.

That is why the advances in digital health and e-health are important. They can ease some of the pressures and assist in dealing with challenges that public bodies face. Provided that all authorities sign up to the available technologies, there is no reason why some of the difficulties that arise cannot be overcome. I recognise that such technologies will not necessarily put carers into houses, but their use can overcome some of the current difficulties.

Better working is required across traditional silos, which is why the passage of the Public Bodies (Joint Working) (Scotland) Bill is so important. When I was on the Health and Sport Committee we heard evidence from some parts of the country about fantastic working between healthcare and social care services, but we heard evidence from other areas—we could all cite anecdotal evidence—of gaps where that joint working does not always happen. We need to ensure closer working together so that patients receive better outcomes and do not fall into the gaps.

Often the idea is held that technology is used to replace things in the health service. The key thing to say about use of technology is that we are looking to augment and support the health service's work. We want not necessarily to replace that work, but to make it more efficient and to ensure that the NHS spends its time more efficiently, so that people are not in a healthcare setting for longer than they need to be.

I note the work that NHS Research Scotland is doing in contributing to the life sciences sector. Life sciences have a strong foothold in Aberdeen; I have met a number of life sciences companies in my constituency and seen first-hand some of the great work that is being done. The work and strategic direction of NRS will help the sector. I recognise that challenges exist with regard to attracting talent and ensuring that companies that could locate in Scotland are able to do so. I know that a lot of good work is being done to get more companies to come and view Scotland as an opportunity. I note NRS's recent announcement that four health boards will become Pfizer INSPIRE—investigator networks, site partnerships and infrastructure for research excellence—sites, which will see them being included among the company's preferred international sites for future research studies. That is a positive development that I hope can be built on.

I also note that the innovations in the Grampian area include looking at whether provision of iPads and tablets to community midwives might assist in their work and improve the patient experience.

I was intrigued by the digital health institute's project on future use of ambulances. The shift in service demand for ambulance services from emergency to a more primary, community, and social care service function has seen those who are involved examine how ambulance services should be developed. I would be very interested to see the outcome of that work, particularly given that it could be transferable. Indeed, a key element of a lot of the technologies is that they are transferable not only in the healthcare setting but to other sectors.

Hugh Henry's call to leave party politics to the side was a good one. We must be very cautious to ensure that, as healthcare evolves, the same evolution applies to how healthcare is structured and delivered. We must avoid the knee-jerk reaction that sometimes comes from saying that a change is bad, just because something happened in a particular area, without our looking at where that change has impacted, what has taken place elsewhere and how that change is improving the service. If we can agree to leave party politics to the side, we can develop the 2020 vision much more collaboratively.

15:57

Duncan McNeil (Greenock and Inverclyde) (Lab): As Richard Simpson and others have done, I welcome the cabinet secretary's speech and his vision of creating a digital transformation of the health service. We wish him well in that work. We also welcome some restoration of the IT budget and the moneys that he announced.

Although we can all get excited about technology, the focus on digital leads to some of the other fundamental issues. We should keep in mind how the introduction of technology impacts positively on patients—members have mentioned the positive impact on diabetes and other conditions. However, we should—as has been alluded to—also look at technology in a different

way. For example, we should consider how a mobile phone impacts on care workers; it makes it even more possible for them to do 10-minute or 15-minute visits, which increases the pressure on that person to get in and out as quickly as possible. Technology is exciting—it makes innovation and change possible, but patient outcomes are all-important.

I am pleased to take part in the debate. We accept and broadly support—across all parties—the 2020 vision and the need to make progress. However, as was said by no less a person than Nelson Mandela

"vision without action is merely day dreaming"

and

"Action without vision is only passing time".

That applies to not only to the digital issues, but to all other issues on the route map. We cannot just have a debate about digital innovation, and today's debate allows us to explore the issues without too much political knockabout. However, we could have discussed safe care, patient-centred care, unscheduled or emergency care and all the other much more difficult issues that present us with problems.

Stewart Stevenson—who has left the chamber—said that with change comes risk. That applies not only to digital change and innovation, but to service change. We know that vision, when it is accompanied by action, can change the NHS in Scotland. Action that was taken in the early years of the Parliament on the three big killers in Scotland has significantly reduced mortality. We know that getting together to make that change worked. People in my constituency and across the country are alive today as a result of that action, which was a priority in the Parliament's early days. We know that the great public health measure of banning smoking in public places has significantly changed not only the lives of individuals, but wider society in Scotland.

The question now, given the challenges that we face, is whether we can achieve comparable change in the health service. I do not want to dwell on this, because the point has been made time and again, but we have had amber warnings from Audit Scotland, we have been told by the British Medical Association, the RCN and many others, and we know from our own experience about the reputational damage that has been done by the way in which we look after our elderly people in the community and in hospitals. Time after time, inspection reports have confirmed repeated mistakes.

We need to step up to the challenge, and there is no doubt that there are many distractions. The Government is often forced to react to a situation instead of trying to prevent it from arising. As we know from what happened on accident and emergency waits, the campaigns on rare diseases and the prescribing of end-of-life medicines, money flows in after a crisis. We must address concerns that exist, but we must guard against chasing issues in that way if we are determined to change the health service for the better. Hugh Henry asked whether we could do that by coming together in a non-political way.

Chic Brodie mentioned that we focus on inputs rather than outputs. We are too focused on the clinical workforce and not focused enough on the community workforce of the future. Those are difficult issues. I remember that there were campaigns in Parliament for more dentists in Aberdeen, where people's inability to get a dentist caused a riot. Now, we cannot get people to look after the elderly, because we do not value care workers as highly as we value the clinical workforce.

I support Richard Simpson's and Labour's call for an independent review. In many ways, a review would give politicians space; the NHS is too important to be left to political debate. We need to let in some air, refocus and develop a vision of change whereby we could in 2016 have joint manifestos that were based on everything that we agree on. Instead of the issue being a dividing line, we could have a shared vision of a new national health service in Scotland.

16:03

Bob Doris (Glasgow) (SNP): As Aileen McLeod said, we recently passed the Public Bodies (Joint Working) (Scotland) Bill, which will integrate health and social care services for adults. It takes a permissive view of further integration and, as far as our 2020 vision is concerned, I suggest that housing is of particular importance when it comes to use of telehealth and new technologies more generally. Indeed, social landlords are a key part of the solution in supporting adults—as the motion says—

"at home or in a homely setting",

and in reducing the number of hospital readmissions, which is another aspiration of the Scottish Government on the 2020 vision that is mentioned in the motion.

I want to talk about the work of a social landlord in communities that I represent. North Glasgow Housing Association is already actively involved in keeping the wider community healthier. It has appointed a sports co-ordinator, who is part funded by the Winning Scotland Foundation. The co-ordinator's role is to focus on helping the local community to be and to stay active.

The north Glasgow sports legacy project has promoted many activities including football, athletics, table tennis, rugby, cycling, cricket and basketball, and hundreds of young people have already benefited from it. Tackling physical inactivity and promoting physical literacy are vital to ensuring that the next generation is as healthy and as active as it can be; indeed, we all hope that it will be far better placed to be fit, healthy and happy at home for longer. Of course, that highlights the preventative aspect of the issue that we are discussing this afternoon. We should not wait until people get old and then sustain them at home; instead, we should ensure that they have a certain quality of life.

What about the current generation of older people? Like other organisations across the country, the housing association that I mentioned offers a range of activities to keep older people healthy and active. However, it is also very keen to explore use of new technologies to support tenants. Suggestions that I have heard include putting smart televisions in the home of every older person and developing bespoke apps for them. I certainly see a clear connection with telehealth in that respect. Perhaps in the future older residents will use an app to connect to their housing officers or the janitorial staff from their home. Indeed, the same televisions and apps might also be used to promote contact with healthcare workers or allied health professionals from people's homes.

We heard earlier about 10 or 15-minute care visits by home helps, but such technological approaches might help older people to build up a relationship with the individuals who make face-to-face visits with them. I stress, however, that none of it should be a replacement for face-to-face visits; instead, it should complement them and support people in feeling happy and content in their homes.

I mentioned the social rented sector but, of course, we also have to consider the many people in old age who use the private rented sector or who still own the accommodation in which they live. When we think about the technologies that might be used in people's homes, be they in the social rented sector, the private rented sector or the owner-occupied sector, we should ensure that they are developed and brought into houses in a co-ordinated way. There is no point in an initiative in one part of the country using one form of technology that does not complement what another good initiative in another part of the country is using. We must ensure that the systems speak to each other and that all this is undertaken in a co-ordinated way.

Of course, we should not use technology for technology's sake. When we think about how smart TVs and apps might be used, we should also think about what they will be used for in people's homes. Who is better placed to decide that sort of thing than much of the third sector, which, in any event, should be involved in the co-production of services at a very local level? In putting the technology in place, we must also think about the tasks that it is being asked to carry out. I ask that, when we develop technologies to support people in their tenancies or homes, we ensure that they actually want the service or product in question. The third sector certainly has a very important role to play in that respect.

In the time that I have left, I want to say a little bit about using e-health to provide peer support to people who are housebound or similar and cannot get to conventional support groups. With regard to people with orphan and ultra-orphan conditions—an issue with which I know the cabinet secretary has been involved—if only seven or eight people in Scotland or 20 or 30 in the whole UK have a condition, how on earth are they supposed to be able to meet with and talk to each other? E-health might have a role to play in that.

My final point is not really about e-health but about another issue that I have been working on: how we support people to stay at home but promote activity to get them out of their houses and ensure that they have productive and active lives. I have been doing a lot of work with continence nurse specialists in Glasgow on the services that they are seeking to promote—

The Deputy Presiding Officer: You should be drawing to a close, Mr Doris.

Bob Doris: When a person is housebound, it can impact on their mental health. It can affect their balance, resulting in gait syndrome, and could have a variety of other impacts. I want to put on the record that that is something that I am involved in that not only supports people in being happy and active in their homes—

The Deputy Presiding Officer: Please finish.

Bob Doris: —but ensures that they can get out into the wider community.

The Deputy Presiding Officer: Richard Lyle has up to six minutes, please.

16:09

Richard Lyle (Central Scotland) (SNP): I will try to stay within the six minutes.

It is very nice to see Dr Richard Simpson back leading for Labour in the debate.

The Scottish Government's 2020 vision has already been outlined. I feel confident that, because of that vision, everyone in Scotland will be able to live longer and healthier lives at home,

or to live in a homely setting in which they feel comfortable, and that we will have a healthcare system that is second to none, with integrated health and social care.

There is, rightly, a focus on prevention, anticipation and supported self-management. Where hospital treatment cannot be avoided, day-case treatment will be the norm. Despite all the changes and technical advances, and no matter what the setting is, care will be delivered to the highest standards, and patients should always be at the centre of all decisions about meeting their individual needs and requirements. I am confident that that is achievable because Scotland is already one of the front-runners in e-health. Indeed, Scotland was recently referred to as the European leader in taking forward e-health programmes.

SmartCare, which is one such programme, is being piloted in my region in North Lanarkshire and other areas of Scotland and in other countries, including Italy, Denmark and Spain. SmartCare began in March 2013 and is jointly funded by the European Commission. I know that the Scottish Government aims to use technology to support delivery of integrated services across health and social care, and Scotland in particular is looking at best practice pathways in order to prevent falls and to manage our responses to falls management and prevention. It is projected that, if that pilot is rolled out, it will impact on many thousands of patients across Scotland, including patients in Lanarkshire in my region.

Some £770 million has been invested in the e-health strategy to date. Due to that investment, Scotland has electronic patient records in both primary and secondary care throughout the country, e-prescribing is widely used and patient ordering of repeat prescriptions is available in many, if not all, practices.

Increasing the use of e-health technology will help with delivery of the 2020 vision in a number of ways, including in electronic access to services—for example, booking and cancelling appointments online, electronic patient access to their own health information and electronic access to information about local services and specialist health information. The introduction of e-health has delivered the core infrastructure to support the reduction of paperwork and the move to electronic records management across the NHS.

Scotland again showed its innovation by launching the digital health institute in 2013. That partnership between healthcare providers, industry and academia will create the next generation of technology. The institute will help to drive growth and innovation in Scotland, and the potential market opportunity for Scotland will be up to £1 billion per annum.

Our strong reputation in digital health has attracted major international companies to engage with NHS Scotland. In turn, that has increased the opportunities for Scotland to influence and get early benefits from new technologies and applications.

On 7 February 2013, it was announced that a Lanarkshire-based life sciences company and University of Dundee researchers had won a major Europe-wide drug discovery contract. That is the biggest investment of its kind in Scotland from the European innovative medicines initiative. Industry experts at BioCity Scotland in Newhouse in my region are working with University of Dundee scientists on a £100 million international project, researching new drug treatments. That facility puts not just Scotland, but Lanarkshire, at the heart of international drug discovery.

The SNP vision for the NHS, as has been stated before, is that the Scottish NHS should remain a publicly delivered service that should not blindly follow the privatisation agenda of the Con-Dem parties in Westminster. I am sorry for that pop, but I could not go on without saying it. In order to facilitate that, the SNP Government has met its commitment to protect the NHS budget. The health resource budget will be a record £11.8 billion by 2015-16, which reflects a real-terms increase of over £161 million. That is in line with our belief that the NHS in Scotland should not be privatised.

I compliment the cabinet secretary, Alex Neil, on his drive and commitment to Scotland's NHS, and I welcome the £10 million project that was announced today. I will support the motion at decision time.

16:15

David Stewart (Highlands and Islands) (Lab): I welcome the opportunity to debate the 2020 vision for health in Scotland, particularly the emphasis on innovation through technology and digital health and care. As I am co-chair with Nanette Milne of the cross-party group on diabetes, it is no surprise that my focus will be on diabetes, specifically insulin pumps and research into the use of an artificial pancreas. I will also provide evidence for why I believe the Scottish Government should provide an immediate and independent review of the NHS.

I was going to ask the cabinet secretary to say something about this in his wind-up speech but, unfortunately, he is not in the chamber. Nevertheless, I make the general point that links between business and education are vital to develop innovation; for example, there is the link between LifeScan Scotland in Inverness and the

University of the Highlands and Islands that has funded a professor of diabetic care.

A few short months ago, I strolled in the Melbourne summer sun from my hotel to the Victoria state Parliament house. I was due to speak at a very unusual conference of nearly 100 champions for diabetes from as far afield as Russia, Ukraine, Nigeria and Canada; South Africa even sent its first lady. All those people were elected members and advocates on diabetes, and each represented their own country. The conference concluded with the signing of the Melbourne declaration—I have spoken about it in Parliament previously—which committed Parliaments across the globe to ensuring that diabetes is high on their own political agendas. The declaration is very important for the present debate, because it calls on nations to place a higher emphasis on preventative work, early diagnosis, management and access to adequate care; and to ensure that treatment and medicines, including digital health initiatives, are available for all those living with diabetes.

I was proud to talk to the conference delegates about Scotland and about issues of international significance for diabetes. I am still proud to come from a nation with a strong track record in innovation and discovery. We all know that we have Scots in our history such as Alexander Fleming, who discovered penicillin; James Watt, who invented the steam engine; and Alexander Graham Bell, who invented the telephone. However, international collaboration is where real strides can be made. In 1922, Professor John MacLeod from Aberdeen, working with two other outstanding scientists, Dr Banting and Charles Best, discovered insulin. MacLeod and Banting won the Nobel prize for medicine in 1923 and shared the money with Charles Best. That discovery in the 1920s was a step change. Its equivalent today is the digital health revolution that we are having.

The most recent parliamentary question that I asked of the health minister gave me the response that around 250,000 people are diabetic in Scotland; a staggering further 620,000 are at high risk of developing type 2; and that 49,000 people have the condition but are undiagnosed. That means that approximately 1 million people in Scotland are directly affected by diabetes through having it or being at high risk of developing it.

I concede that there have been some strong, positive steps in care for people with diabetes. Digital information is vital, but the provision of insulin pumps to under-18s is very Important indeed. The number of people with the condition is rising, which will have a serious effect on Scotland's immediate future. Given that the Melbourne declaration on diabetes focused on prevention of diabetes, the Scottish Government must have a focus on the condition that properly reflects the size of the problem in Scotland.

An example of technological innovation is shown in Diabetes UK's funding of two groundbreaking research projects to develop and test an artificial pancreas for adults with type 1 diabetes. The artificial pancreas is a system that measures blood glucose levels on a minute-to-minute basis using a continuous glucose monitor and then transmits that information to an insulin pump that calculates and releases the required amount of insulin into the body.

That device is one example of the way in which we can transform lives, particularly those of people who find it difficult to maintain good blood glucose control. I will give an example. Mark Wareham from Cambridge, who has had type 1 diabetes for 27 years, usually uses an insulin pump to control his condition, but he took part in the trial earlier this year. He said:

"I am so glad I took part in this trial as I don't think I would have believed what a positive outcome the artificial pancreas would have. I believe that people with type 1 diabetes should use this fantastic facility. I felt fantastic and my energy levels were through the roof."

In the final section of my speech, I will focus on why I believe that an independent review of the NHS would help those who are at risk of diabetes and how the Scottish Government's 2020 vision can deliver for people with diabetes. I have a couple of points to make to the cabinet secretary. First, we need to focus on finding the undiagnosed through screening for type 2 diabetes. We need to target those who are overweight, those who are over 45 and those with a family history of the condition.

Secondly, we need to review the Scottish diabetes action plan and develop a proactive agenda for the future. We need to raise awareness among parents, carers and healthcare professionals of the signs and symptoms of type 1 diabetes through Diabetes UK's four Ts, to ensure that in future children are diagnosed before an emergency.

The key point is that diabetes raises huge issues for the health of individuals in Scotland. It is the main cause of blindness in people of working age and the main contributor to kidney failure, amputations and cardiovascular disease. We have a great opportunity to raise the bar in healthcare through innovation in technology. Scotland has one of the highest incidences of type 2 diabetes in the world, and it is time that we tackled the ticking time bomb. Not only will that be cost effective but, on an individual scale, it will tackle a condition that blinds, maims and kills.

16:21

George Adam (Paisley) (SNP): I welcome the debate and the Scottish Government's vision for delivery by 2020. I also welcome the tone of this debate, because it is important that we get that correct. Presiding Officer, you are going to hear something that has probably not been heard in the 20 years for which Hugh Henry and I have known each other. He was correct when he said that we have to get beyond the politics on such issues and get down to how we can deliver and make the difference.

The cabinet secretary is right. Technology is an enabler. It is something to help. It is not something that we have instead of the solution; it is something that is part of the solution. It is part of the basket of measures that can help people who are dealing with issues in their lives and dealing with the NHS, because it makes interaction with the NHS a lot easier.

I welcome the £10 million that the cabinet secretary announced today to support the expansion of health technology, and I particularly welcome his personalised patient record because, as he said, that empowers people. The use of technology to access health professionals helps people who are living with long-term conditions.

Like Dave Stewart, I am the convener of a cross-party group: the cross-party group on multiple sclerosis. As my wife has MS, I am aware of the situation and the difficulties that people can have with managing their condition. One of the issues that we discussed at our first meeting was access to information and people's ability to go to health professionals and get further information. The opportunities that arise from healthcare technology will make things a lot better for people who are dealing with long-term conditions such as MS. One thing that was mentioned constantly at that meeting was people's desire for those opportunities.

Instead of having to phone up and see the doctor every two or three weeks, as my wife currently does, there is a good chance that she will be able to access information and find out things that could help to make a difference. There is a cost benefit because such contact will probably be cheaper but, more important, the access to information through the computer system, which I assume will be 24/7, will make a massive difference to people with such conditions. Constant interaction with health professionals can make a difference to them.

The route map describes 12 priority areas for action, and the vision for high-quality, sustainable health and social care services in Scotland has the three domains of quality of care, health of population, and value and financial sustainability. I think that the information in one of the reports that I just picked up at the back of the chamber answers some of the questions that the Opposition has asked about value and financial stability, as it states that every resource has to be effective and that one of the main aims is the quality of outcomes. That answers a lot of the questions that Opposition members have rightly asked.

One part of the quality of care is independent living. Bob Doris made the important point that we are talking about the quality of life and ensuring that everyone knows that it is a case of not just getting a service at home but providing a quality service that gives patients a quality of life.

Like some of my colleagues, I welcome the creation of the digital health institute. As with Mark McDonald, the future ambulance service project caught my eye. The aim is to look at how new technology can be used in the ambulance service in the future and at how we can use plug-and-play technology in other blue-light services, such as the police and the fire service. I remember from my time as a councillor that all those services have different systems. It is important that the digital health institute pushes us in the right direction to ensure that everyone can use the technology in the future and to sort everything out. I find that positive.

Telehealth and telecare have been mentioned. A lot of programmes have been referred to, but I will say that technology is already being delivered to patients in Renfrewshire. Mr Henry said that he was unaware of that happening in Renfrewshire but, when I was a councillor there, we started to go down that route with patients who have dementia. That was not just a case of delivering services more cheaply; the concern was about the quality of services and ensuring that the technology worked.

Perhaps Mr Henry is correct to say that there should be a way to change some things, but the self-reported outcomes from Renfrewshire community health partnership gave estimated net savings attributable to the 325 clients with dementia of more than £2.8 million over a five-year period, which is equivalent to £8,650 per client with dementia who received telecare. That delivered for families and made lives better. The most important issue is making lives better for families who are dealing with conditions such as dementia and ensuring that we get all the technology to work and make a difference in their lives.

I welcome much that members have said in the debate. Some things in the route map answer a lot of the questions that Opposition members have raised. We need to continue down the road that we are on to ensure that we can deliver all that we can in the NHS in 2020 for people in Scotland.

16:28

Jim Hume: We have had a more or less consensual debate about many health service issues. I welcome the commitment to have personal electronic records for patients, the £10 million for the home health monitoring scheme and the cabinet secretary's commitment in relation to the part of my amendment on Wardview and the like.

In its amendment, Labour again looks for a full and

"independent review of the NHS to identify pressure points".

I do not disagree that there are pressure points—we have a postcode lottery for access to psychologists; the number of bed days for delayed-discharge patients increased to 135,000 in the last quarter of last year; 774 A and E staff were attacked while trying to go about their work in the past two years; patients have waited more than 20 hours in A and E before being admitted; and an unacceptable disparity exists across the country in the treatment of some cancer types—so it is incumbent on boards to devise strategies to overcome the difficulties.

When health boards are struggling, it is the cabinet secretary's responsibility to step in and resolve the situation effectively. Situations such as that when NHS Grampian needed oncologists, which had knock-on effects on patients in Orkney and Shetland, cannot be allowed to happen, but we know all that and more. We do not need the NHS to go on hold while a full review is undertaken. We need the cabinet secretary to act now. Because of that, we will not support the Labour amendment at decision time. However, we will, as always, press the Government to act urgently on the pressure points that we know exist.

In my opening speech and in my amendment, I mentioned the innovative control system that NHS Borders is pioneering. The system is an impressive tool and has huge potential. When I visited it, the staff's enthusiasm for the programme was clear. It aids all the clinical staff and will even help with catering and with transport to and from hospital—it has the potential to help health visitors, too.

The staff's enthusiasm is important. No change of system will work without buy-in from staff, and we get buy-in when we make a system user friendly and appropriate to the complicated and multifaceted tasks that our NHS staff take on very well.

Any digital innovation must be person centred. The number of bed days in which beds were occupied by delayed-discharge patients increased to 135,000 during the last quarter of last year. Patients who are ready to go home cannot do so, because they cannot get a place in a care home or simply find a way to be transported home. That causes patients huge distress, it is a drain on NHS resources and it blocks beds for people who need to be admitted.

There is a change in our demographics. We are all part of an ageing population, and 73 per cent of total bed days relate to occupation by patients who are over 75. The proportion is forecast to increase as people live longer—which is good—and live longer with ailments.

I am not suggesting that the problem can be fixed overnight, but there are low-hanging fruit to pick. Wardview has been proven to help patient flow management and prevent bedblocking. It is flexible and portable, so it has the potential to be used in all corners of Scotland, which would help to address points that Richard Simpson and Nanette Milne made well about patients who move from one health board area to another. Wardview's real-time information and updated estimated date of discharge enable information to transfer seamlessly with the patient. The system is known to assist in reducing the length of stay.

The use of Wardview is a low-hanging fruit and it must be encouraged, along with more use of Skype, which Stewart Stevenson mentioned—I do not know whether we should be advertising companies, so I will refer to voice over internet protocol, which is the correct way to talk about the technology.

Stewart Stevenson said that new systems should be introduced in two phases. I take that slightly further. When I visited the NHS I heard about the PDSA approach—plan, do, study, act, and then plan, do, study and act again, so that people continually learn, rather than saying, "Oh we tried that but it didn't work, so let's go back to the old chalk boards." Plan, do, study, act—I am sure that that is implanted in the cabinet secretary's mind.

Texting appointments and reminders is another innovation in the NHS, and some patients can text to book or cancel appointments. We all have that technology in our pockets; it is quite old technology and it is available to most people.

I welcome the minister's remarks. The Government needs to prioritise the roll-out of telehealth on a national scale, and if it is to do that, it needs to establish a HEAT target for health boards, as my amendment says, so that they put patients first by mainstreaming telecare throughout Scotland. That is a challenge for the cabinet secretary, but it is also a chance for him to prove that he has the mettle quickly to deliver much-needed improvement in how our health service works.

16:34

Jackson Carlaw (West Scotland) (Con): Presiding Officer, I will start with a question for you—don't panic, it is a rhetorical question and you do not have to answer it. Can you remember the actress Janet Webb?

The Deputy Presiding Officer: No.

Jackson Carlaw: Members of a certain age will know who Janet Webb was. She was the woman who used to burst on at the end of "The Morecambe and Wise Show" and say, "Thank you all for watching me and my little show here tonight. If you've enjoyed it, then it's all been worth while. Good night, and I love you all."

That was very much the cabinet secretary's modus operandi during his speech. What a difference a fortnight makes in the conduct of a debate on the future of Scotland's health service. That might very well be in part because of the measured and thoughtful contribution from Dr Simpson; the Labour bull in a china shop was not with us this afternoon. I welcomed hearing Dr Simpson's contribution, which, while being totally supportive of the general thrust of the Government's motion, nonetheless reminded us that we are talking about a very complicated jigsaw in which all the various parts have to work.

I welcomed the cabinet secretary's Janet Webb modus operandi this afternoon. Outside of the chamber, he has been a little bit florid in his rhetoric recently. Apparently it was Mrs Thatcher who introduced alcohol to Scotland, which was news to a great many people. Apparently there are thousands of civil servants down south who are teeming with rage and trying to undermine the Scottish health service and rob us of all the consequentials.

On that, I would just like to say to Mr Lyle, who was going on about the increase in health spending, that, according to a response to a written question from the cabinet secretary, every penny of additional money in Scotland's health service between 2011 and 2016 is accounted for by consequentials coming from the Westminster Government. I would have thought that he would be grateful for that support and that he would not fall back on his traditional rhetoric.

There were two contributions this afternoon that I want to mention. I was intrigued by what Malcolm Chisholm said, and also Hugh Henry, who amplified a point that I tried to make during the previous debate that we had on this topic. I will make the point again, because Mr Brodie was another who referred to the issue. Scottish Conservatives are totally committed to a publicly funded and publicly owned health service in Scotland. There is no longer a ball to kick across the park here. The question is not whether we believe in that but how we can collectively work to make Scotland's health service the best that it can be.

On today's subject of new technology, we MSPs form a collection of atrophying old fogeys when it comes to the subject. Any one of us with children, irrespective of their age, will recognise that the generation behind us does not even think about these things now. They are totally embedded in the use of technology and they appreciate how rapidly it changes. When we look back in a decade, we will realise that we have gone through the biggest clinical, pharmaceutical, and technological changes of any point in the health service's history, and that change is breathtaking.

I have questioned this before. I wonder whether our current model of 14 health boards and 14 different area drug and therapeutics committees, all of which are prescribing, and 14 different organisations that have to make all this technology work, will be appropriate as we go forward.

I focused on what Malcolm Chisholm had to say because, with the benefit of hindsight, I accept—and I hope that he will accept the corollary—that we did not all embrace Kerr in the way that we should have done at the time. I wonder whether a sufficient consensus was built behind Kerr so that we could embrace it. When the cabinet secretary says that he is going to invite all the political parties in for a giant pow-wow and chinwag to see whether we can find common ground and build on Mr Henry's appeal, the important thing to note is that, if there is no ball to kick across the park, we will have to come up with a structure that we can all sign up to and collectively seek to make work.

I also wonder whether 2020 is relevant. We have a lot to do by 2020. It is almost a decade since Greater Glasgow NHS Board absorbed Clyde, yet only now is that health board beginning to think of some of the strategic changes that need to take place to complement the plan that it had for Glasgow with a plan for the Clyde area. I think that we will have to evolve a 2025 and a 2030 vision that will be quite distinct from the pressure that we all understand and the day-to-day politics that Mr Henry talked about. Clearly there will be occasions on which we fall short of immediate expectation.

Aileen McLeod made a very non-partisan speech this afternoon. I was dazzled by all the acronyms and organisations in Europe to which she referred. It emphasised the point that we are talking about not just a Scottish appreciation of how healthcare is changing. It is an appreciation across a much wider world. Whether they come from England or anywhere else, we have lessons to learn and we should be perfectly prepared to embrace them to ensure that we achieve the outcome that we all want.

The spirit of this afternoon's debate might have lacked sparkle but, in its substance, there was far greater cohesion, understanding, and appreciation of what is necessary. We, for one, will welcome the opportunity to participate with the cabinet secretary in the discussions in which he has suggested he would like to involve us.

The Deputy Presiding Officer: Dazzling. Thank you.

16:40

Rhoda Grant (Highlands and Islands) (Lab): There has been a great deal of consensus in today's debate. Hugh Henry was right when he pointed out that we are all committed to an NHS that delivers. There is political consensus throughout the chamber. The only slight discord was about whether Margaret Thatcher introduced us to alcohol or, as I suspect, drove most of us to drink. However, we will leave that for another day.

Jackson Carlaw: If we look at the graph, it is intriguing to see that the deterioration in Scotland's alcohol consumption began almost the day Margaret Thatcher left office. Was that because Scotland was dancing in the streets, or was it because people were bereft at her loss? I leave that to the member to decide.

Rhoda Grant: We will all reach our own opinions on that. Perhaps I should not take up too much time on it because we could debate it all day.

It was clear from this afternoon's debate that, as Duncan McNeil said, we need a vision and we need action. It was also clear that there is a joint vision for the NHS and what we want it to deliver. Indeed, in that vein, the cabinet secretary invited us to a presentation on the 2020 vision. I am glad that he has done that. That will be important, so I hope that he listens to what we have to say. As Duncan McNeil said, it would be helpful if we could build a consensus around a joint vision so that we all go into the next election with a shared vision of the NHS, and so that it is no longer a political issue but something that we can unite around.

Labour believes that we need a comprehensive review of the NHS in order to identify where the pressure points are and to have a vision and deliver it for the 21st century. It is not just Labour that is saying that. The RCN, the BMA, the Scotland Patients Association, the Chartered Society of Physiotherapy and many others want to see that vision developed in a sustainable way. It will not stop progress but it will provide the action. We already share the vision—I think that we can agree on that—but we need the action and we need to know where the pressure points are so that we can unite and deal with those as we go forward.

The cabinet secretary described how IT should be used within the NHS. Sometimes he was talking about things that should have been mainstreamed but have not been mainstreamed. That, too, came out in the debate, when members talked about the good IT and e-healthcare that is out there, while others were clear that that was not happening in their communities. We have a fragmented IT system, which we need to pull together so that all the systems speak to each other. Bob Doris talked about how that should happen in patients' homes. When we introduce IT into a patient's home, we should ensure that it works with other technologies and services going into that home.

We need that approach throughout the healthcare system. Even in hospitals, we have systems that do not speak to each other and we have to depend on paper records. Nanette Milne referred to an appointment when she could not be seen because her records were elsewhere.

We have talked about the money that has been spent on developing systems—some of them very good—that have not been taken up because there is not the culture or the drive to use some new technologies. I will return to that issue shortly.

It would be wrong not to highlight the existing problems, such as the IT failures in Glasgow. The report has not identified what happened. We need to find out what happened and build resilience into the system, and other NHS boards need to learn from that.

We also need to deal with confidentiality issues relating to patients' records. While I very much welcome the cabinet secretary's announcement on personalised patient records, I think that it is extremely important that confidentiality is built into that process. There is also the issue of ownership. Who owns the records? Is it the patient? Will patients be able to see who is viewing their record? If so, it would address the confidentiality issue because patients would know whether that access was appropriate. We need to look at all of those issues.

Many members talked about good examples. I will take the opportunity of mentioning Professor Grant Cumming of Dr Gray's hospital, who is a world leader with regard to using technology to give people information in a way that they can access it, when they need to access it. That makes a big difference to patients' lives.

Aileen McLeod talked about IT systems being in place but not always being used. I think that the only health board that I know of that regularly uses videoconferencing as part of its day-to-day work is NHS Shetland. That basic technology could be used much more widely.

Stewart Stevenson talked about access to broadband and mobile connectivity. They are the very basic requirements if we are going to use the systems that we are talking about in people's houses. It is people in rural and remote communities who could benefit most—if they can access health services locally, it will save them travelling—but they are the very people who are least likely to have access to broadband and mobile technology.

Some of the solutions can be really simple, if the technology is being used simply to pass on information. Nanette Milne mentioned a couple of good examples, including one relating to atrial fibrillation—I struggle with that word, so I am glad that I got it out correctly; I sympathised with the cabinet secretary earlier, when he started using medical terms. I had an ECG taken on a smartphone during a meeting in the Parliament. It was quite strange to see my heart being monitored on someone's phone, but what a difference it could make if people were diagnosed in that way.

With regard to optometry—another word that I can struggle with—developments in sending records to specialists have really helped the patient pathway. Some patients have not had to visit a specialist at all, because their records were seen and the diagnosis was delivered remotely, while others have had quick access to the help that they needed.

David Stewart, the Scottish diabetes champion, talked about the technological work on insulin. He has worked hard to have insulin pumps introduced more widely, but the real prize would be an artificial pancreas. What a difference that would make to people's lives. I hope that the studies that are being carried out by Diabetes UK will bring that about, because it will be absolutely life changing.

Malcolm Chisholm and Chic Brodie talked about monitoring movements at home. The technology exists, but Hugh Henry pointed out that it is not always available to those who need it, so we need to think about how we roll out that technology to others.

Jim Hume used a great deal of his speech to talk about Wardview. It seems like an excellent project. Why is it not being rolled out?

The cabinet secretary mentioned self-management. I have spoken about the transitions of young people with heart disease. In Glasgow, those who are treated in Yorkhill self-manage and are able to give themselves anticoagulants according to the tests that they administer themselves. However, when they move into the adult service, they are told that that is no longer available to them, and they have to attend regular appointments and clinics. That is wrong: it is not self-management and it is not a patient-centred approach. We need to think about how we deal with that issue. There are cheaper and better options available, but they are not being used properly.

I notice that I am running out of time. In conclusion, I say that we cannot ignore the challenges that face the health service now with regard to bed blocking, falling numbers of nurses and A and E pressures—I could go on, and many members mentioned other issues.

We can use e-health and e-care to build sustainability into the health service, but we need to heed calls for a review so that we can build a health service that we can all be proud of and that we can unite around in the way in which we have done today.

16:48

Alex Neil: I agree with Jackson Carlaw that this has been a good debate, and perhaps a more mature debate than we have had in the past. I think that we owe it to everyone in Scotland to have this debate in that way, because everybody is either a potential or a current patient of the NHS.

I think that people want to see us working together to address the challenges in the national health service and the social care sector, rather than always trying to make political capital out of issues such as 0.03 per cent of the people who attend A and E having been on a trolley for more than 12 hours. Such situations should not happen but, nevertheless, we must get things in perspective.

I absolutely agree with Hugh Henry about the need for us to concentrate on what we agree on rather than focus on what we disagree on because, to be frank, we all agree—I include the Scottish Conservative Party—on more than 95 per cent of the points that are relevant to the future of the national health service and the social care sector in Scotland.

That is why I said that I would, and have confirmed again today that I will, invite representatives from all the parties in the Parliament to have a discussion with us as the beginning of a process on the route map to the 2020 vision. Invitations will go out, if not this week, early next week. I want a detailed plan to be developed for 2020.

I take Jackson Carlaw's point that it is not only 2020 but 2020 and beyond, because we are clearly not dealing with a situation that terminates in 2020. In health, it can take a number of years before we get the structures in place—particularly when we are dealing with the application of

technology—to make something universal throughout the system.

I repeat the invitation. It will go out to representatives of all the parties in the Parliament. The objective is to maximise co-operation on the vision and plan for 2020 and beyond.

The Government will accept the Liberal Democrat amendment, although I qualify our acceptance. We recognise the importance of HEAT targets and will give serious consideration to the call in the amendment to establish a HEAT target on telehealth. However, as I am sure Jim Hume will accept, we do not make such decisions unilaterally but consult widely, as we will do when we set HEAT targets over the coming months.

We will give serious consideration to the point, but I cannot give a categorical commitment that we will include such a target because, at the end of the day, it depends on wide-ranging stakeholder consultation. However, we will agree to the Liberal Democrat amendment.

I say with genuine regret that we will not vote for the Labour amendment for exactly the same reasons as the Conservatives and Liberals have given for why they will not support it, which relate to the call for a review.

The review remit would be "to identify pressure points". I say in a positive and friendly tone that we know the pressure points. There is no new discovery to be made about the pressure points in the national health service in Scotland. I could stand here and make a speech about the pressure points in health and social care in Scotland.

We should move on from that and put an action plan in place to deal with the pressure points, among other things, rather than spend time trying to identify what we already know. Indeed, in the chamber, Richard Simpson in particular has been articulate in highlighting a number of the pressure points in the health and social care sector in Scotland. That is why we do not need a review but, together, need to put in place an action plan that deals with the pressure points.

Rhoda Grant: I appreciate what the cabinet secretary says, but the staff working in the health service believe that a review would be helpful. We see the outcomes of the pressure points because they appear in the statistics for accident and emergency waiting times and other problems. Do we know what causes them? We may need a review to go into that. Sometimes, the reason might be some distance away. That is why the staff are keen that a review should be held.

Alex Neil: We have as much analysis of the pressure points as we could ever get. The staff I speak to want a plan to face up to the challenges of the pressure points. Therefore, although I agree with everything else that is in the Labour amendment, unfortunately, because of the call for a review, I cannot recommend that we vote for it. However, I reiterate that we invite all of the parties into the discussions to put a plan in place to deal with the pressure points and to ensure as far as we possibly can that there are none in the future.

I acknowledge in particular the points that members have raised with regard to social care, which was highlighted by Hugh Henry. There are pressure points in the social care system that need to be addressed—a number of them sooner rather than later—and we are working on that with our friends in the Convention of Scottish Local Authorities, the Society of Local Authority Chief Executives and Senior Managers and elsewhere.

We recognise, particularly with regard to care home provision in Scotland, that we need an approach that is different from the present system. However, social care is not just about care home provision. One current pressure point concerns the fact that the Care Inspectorate has imposed a moratorium on new admissions to 57 care homes throughout Scotland because of the poor or insufficiently good quality of care. That has taken nearly 800 beds out of the system, which is a contributing factor—although not the only one—in the recent increases in delayed discharges.

We are working through those issues. I can tell Mark McDonald that there is a meeting in Aberdeen this week between the health board and the local authority in the city, as the figures for Grampian show that the pressure is not in the rural areas, but very much in Aberdeen city.

Richard Simpson raised a number of issues—there was quite a long list—relating specifically to telehealth and e-health. I will write to him on all those points, because he is perhaps not as up to date as he could be on some of them. I am happy to place a copy of the letter in the Scottish Parliament information centre so that all members are up to date on those issues.

I hear what members are saying on the issue of fragmentation, and the time has come to concentrate not only on conducting pilots but on rolling out the successful pilots across the country. I have announced £10 million to roll out projects such as the Girvan and Dalmellington initiatives and the hospital at home scheme, which incorporates a large e-health element, because the pilots have proven to be successful in nearly every single case and have reduced rates of hospitalisation by up to 70 per cent.

My number 1 priority overall in the health and social care sector in Scotland is the need to reduce the levels of avoidable hospitalisation. The NHS Lanarkshire report that was published just before Christmas indicated that up to 30 per cent

of the people in hospital in Lanarkshire did not need to be there. That figure does not take into account the impact of programmes such as the Dalmellington and Girvan telehealth projects, but those people have been admitted to hospital for various reasons when, in today's world, they should not be there.

The common theme running through the 2020 vision is that hospitals should be a last and not a first resort in providing modern healthcare in Scotland. I think that we would all sign up to that because it is the right way to go.

I accept that there is still too much fragmentation, and perhaps too many pilots and not enough national roll-out at pace and at scale. That is precisely one of the agenda items that we discussed at the e-health summit yesterday, and we will produce an action plan to address those issues.

I will deal with the points that were raised by David Stewart, who is a well-known champion of diabetes issues.

The Presiding Officer (Tricia Marwick): I ask you to respond briefly, cabinet secretary, as your time is nearly up.

Alex Neil: We recognise the points that he raises, and we will take action on them. Unfortunately I do not have time to explain in detail all the action that we will be taking, but I will write to David Stewart on the initiatives that we will progress.

We have had a very good and mature debate, and I think that there is broad consensus on the way forward. I look forward to hosting representatives of all the other parties in the chamber when we present our plans for the 2020 vision, and to receiving and considering seriously their ideas and input so that when we produce a detailed action plan for 2020 it will—I hope—enjoy the total support of the Parliament.

Business Motion

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of business motion S4M-09226, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Tuesday 11 March 2014

2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Topical Questions (if selected)
followed by	Stage 3 Proceedings: Tribunals (Scotland) Bill
followed by	Scottish Government Debate: Year of Natural Scotland
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 12 March 2014

2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions Health and Wellbeing
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 13 March 2014

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 Debate: Local Government Finance (Scotland) Amendment Order 2014 [draft]
followed by	Welfare Reform Committee Debate: The Impact of Welfare Reform
followed by	Legislative Consent Motion: High Speed Rail (London – West Midlands) Bill 2013– UK Legislation
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time

Tuesday 18 March 2014	
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 19 March 2014	
2.00 pm	Parliamentary Bureau Motions
2.00 pm	Portfolio Questions Culture and External Affairs; Infrastructure, Investment and Cities
followed by	Scottish Government Business
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 20 March 2014	
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	Stage 3 Proceedings: Bankruptcy and Debt Advice (Scotland) Bill
followed by	Business Motions
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time—[*Joe FitzPatrick*.]

Motion agreed to.

Parliamentary Bureau Motion

17:00

The Presiding Officer (Tricia Marwick): The next item of business is consideration of a Parliamentary Bureau motion. I ask Joe FitzPatrick to move motion S4M-09227, on the referral of the draft Local Government Finance (Scotland) Amendment Order 2014 to the Parliament.

Motion moved,

That the Parliament agrees that the Local Government Finance (Scotland) Amendment Order 2014 [draft] be considered by the Parliament.

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

Decision Time

17:00

The Presiding Officer (Tricia Marwick): There are four questions to be put as a result of today's business.

The first question is, that amendment S4M-09222.2, in the name of Richard Simpson, which seeks to amend motion S4M-09222, in the name of Alex Neil, on an update on delivering the 2020 vision in NHS Scotland, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Beamish, Claudia (South Scotland) (Lab)
Bibby, Neil (West Scotland) (Lab)
Boyack, Sarah (Lothian) (Lab)
Chisholm, Malcolm (Edinburgh Northern and Leith) (Lab)
Dugdale, Kezia (Lothian) (Lab)
Fee, Mary (West Scotland) (Lab)
Ferguson, Patricia (Glasgow Maryhill and Springburn) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Griffin, Mark (Central Scotland) (Lab)
Henry, Hugh (Renfrewshire South) (Lab)
Hilton, Cara (Dunfermline) (Lab)
Kelly, James (Rutherglen) (Lab)
Macdonald, Lewis (North East Scotland) (Lab)
Marra, Jenny (North East Scotland) (Lab)
Martin, Paul (Glasgow Provan) (Lab)
McCulloch, Margaret (Central Scotland) (Lab)
McDougall, Margaret (West Scotland) (Lab)
McMahon, Michael (Uddingston and Bellshill) (Lab)
McMahon, Siobhan (Central Scotland) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McTaggart, Anne (Glasgow) (Lab)
Murray, Elaine (Dumfriesshire) (Lab)
Pearson, Graeme (South Scotland) (Lab)
Pentland, John (Motherwell and Wishaw) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Stewart, David (Highlands and Islands) (Lab)

Against

Adam, 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)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Dey, Graeme (Angus South) (SNP)
Don, Nigel (Angus North and Mearns) (SNP)
Doris, Bob (Glasgow) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Eadie, Jim (Edinburgh Southern) (SNP)
Ewing, Annabelle (Mid Scotland and Fife) (SNP)
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)
Hyslop, Fiona (Linlithgow) (SNP)
Ingram, Adam (Carrick, Cumnock and Doon Valley) (SNP)
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)
McArthur, Liam (Orkney Islands) (LD)
McDonald, Mark (Aberdeen Donside) (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)
Russell, Michael (Argyll and Bute) (SNP)
Scott, Tavish (Shetland Islands) (LD)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Sturgeon, Nicola (Glasgow Southside) (SNP)
Thompson, Dave (Skye, Lochaber and Badenoch) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Urquhart, Jean (Highlands and Islands) (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

Brown, Gavin (Lothian) (Con)
Buchanan, Cameron (Lothian) (Con)
Carlaw, Jackson (West Scotland) (Con)
Davidson, Ruth (Glasgow) (Con)
Fergusson, Alex (Galloway and West Dumfries) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lamont, John (Ettrick, Roxburgh and Berwickshire) (Con)
McGrigor, Jamie (Highlands and Islands) (Con)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)

Scott, John (Ayr) (Con)
Smith, Liz (Mid Scotland and Fife) (Con)

The Presiding Officer: The result of the division is: For 32, Against 70, Abstentions 14.

Amendment disagreed to.

The Presiding Officer: The next question is, that amendment S4M-09222.1, in the name of Jim Hume, which seeks to amend motion S4M-09222, in the name of Alex Neil, on an update on delivering the 2020 vision in NHS Scotland, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that motion S4M-09222, in the name of Alex Neil, on an update on delivering the 2020 vision in NHS Scotland, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament recognises that innovation through technology is vital in delivering Scotland's 2020 Vision for health and social care, whereby everyone is able to live longer, healthier lives at home or in a homely setting; considers that enhanced home-based monitoring services are instrumental in reducing levels of hospital readmission; acknowledges that digital healthcare should be a catalyst for people interacting with services and information online, building on examples such as the Key Information Summary and the internationally acclaimed Emergency Care Summary, and recognises that Scotland has a clear opportunity to be a leader in the growing global digital healthcare market, following the establishment of organisations such as the Digital Health Institute, welcomes innovations such as Wardview, which can help to reduce the length of patient stays, improve patient safety and make more efficient use of clinicians' time; believes that technology will play an important role in meeting the challenges of the future, especially from the growing population of older people and the extra healthcare that they will need; further believes that Scotland should establish national-scale telehealth services, and would welcome the establishment of a specific HEAT target for NHS boards to mainstream the use of telehealth in the delivery of patient care.

The Presiding Officer: The next question is, that motion S4M-09227, in the name of Joe FitzPatrick, on the referral of the draft Local Government Finance (Scotland) Amendment Order 2014, be agreed to.

Motion agreed to,

That the Parliament agrees that the Local Government Finance (Scotland) Amendment Order 2014 [draft] be considered by the Parliament.

Marie Curie Cancer Care

The Deputy Presiding Officer (Elaine Smith): The final item of business is a members' business debate on motion S4M-08894, in the name of Linda Fabiani, on Marie Curie Cancer Care's 2014 great daffodil appeal. The debate will be concluded without any question being put.

Motion debated,

That the Parliament welcomes Marie Curie Cancer Care's Great Daffodil Appeal 2014, which will run throughout March; applauds what it understands is the over £4 million raised every year in Scotland by the appeal, which supports the charity in delivering services across the country; believes that Marie Curie Cancer Care supports people with terminal illness by providing free care at home with the help of its nurses or in the community at its Glasgow or Edinburgh hospices; recognises what it sees as the vital role that its volunteers, such as the East Kilbride Fundraising Group for Marie Curie Cancer Care, play in supporting the work of the charity by collecting and raising funds, helping patients, acting as patrons and advisors, supporting services and hospices or working as assistants in its shops; understands that, in 2013, over 4,000 volunteers helped Marie Curie Cancer Care in some way, and acknowledges what it sees as the vital role that they play in communities throughout Scotland.

17:04

Linda Fabiani (East Kilbride) (SNP): I am delighted to have the honour of holding this debate on behalf of Marie Curie Cancer Care. It is nice to see how many members have supported the motion and how many have remained in the chamber, because I know that everyone is very busy. I say to any of my colleagues who does not have a daffodil that one will be provided later—I am sure that we will all wear them throughout the month of March. It is fantastic to see so many people in the public gallery all wearing their daffodils.

Of course, March is the month in which we campaign on behalf of Marie Curie and do the annual great daffodil appeal. More than £4 million is raised in Scotland every year by the appeal: a lot of money. It supports the Marie Curie charity in delivering services across the country.

The way that we have to word motions in the Parliament is interesting. The motion says:

"The Parliament believes that Marie Curie Cancer Care supports people with terminal illness by providing free care at home"

and that we believe that fundraising groups work hard. We do not just believe that; we know it, and everyone knows it. The Marie Curie charity is one that absolutely everyone in the country knows about and supports. It is a truism, but every one of us has had someone we love who has suffered from cancer or another disease that brings life to an end and who has been supported by Marie

Curie in some form, whether that be through research or the vital care that it gives.

Underpinning the work of the Marie Curie nurses, staff, researchers, scientists and all the people who work for it are the volunteers, whom we should celebrate tonight. The volunteers work hard in all different ways for Marie Curie. We have people here tonight from all over the country and I am quite fascinated when I look at the list. We have people from the East Kilbride fundraising group, of course. Although it is fairly new, Ann Openshaw and her team of volunteers have been working really hard and doing some fabulous fundraising.

Maureen Watt (Aberdeen South and North Kincardine) (SNP): Will the member take an intervention?

Linda Fabiani: It is a shame that Maureen Watt intervened. I was going to say what fun some of the fundraising events are and I know that Maureen Watt donned a funny hat at the weekend and did some fundraising in Aberdeen.

Maureen Watt: Yes; it was good fun.

Does Linda Fabiani believe that volunteers face an uphill struggle because some places, such as shopping malls and garden centres, now charge for volunteers to collect? Like me, does she believe that that is a nonsense and that those organisations should look to their corporate social responsibility?

Linda Fabiani: I am pleased that Maureen Watt raised that, because I did not know that and I am absolutely shocked to learn it. I hope that we will hear more from some of the volunteers tonight about where that is happening. If charging volunteers for collecting is happening in our areas, I hope that after the debate and tonight's event we will get on to our keyboards—I was going to say get the pen and paper out, but we are all a bit beyond that now—and make sure that we protest in the strongest way about that. That is outrageous; it is absolutely ridiculous. I hope that it is not happening in East Kilbride, but if it is I will certainly get on to it.

I was talking about where other people have come from to get here today. Volunteers are here from across the country: from Stranraer to Thurso and from Glasgow—the biggest conurbation in our land—to Garioch, in the north-east. I am very grateful to my colleague, Mark McDonald, for telling me how to pronounce Garioch. Welcome, one and all.

Marie Curie is a big, very professional organisation that employs around 740 people in Scotland. In 2013, more than 3,000 people in Scotland gave their time to help Marie Curie collect for the great daffodil appeal. Work is being done in all our local authority areas by the volunteers and by the professionals, who provide a great service.

There is absolutely not the time for me to go into all the work that Marie Curie does, but one very important service is helping people in their last hours to die at home, if that is what they want.

A few years ago—probably more years ago than I care to remember—a Marie Curie-led campaign mentioned that it was at the forefront of providing palliative care in people's own homes. That is so important—it is about what people need.

Very often, we tend to think about those services being provided for the elderly. However, I learned recently that Marie Curie supports young adults to make the transition from children's hospice services to adult nursing care at home. That service is extremely important, too. Cancer affects everyone from all walks of life, no matter their age. The service that is provided by Marie Curie is so important because it is all inclusive.

In the last few seconds of my speaking time, I thank every one of Marie Curie's volunteers, no matter what role they play. I thank them very much for all that they do and for being here.

17:11

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): It is a great pleasure to follow Linda Fabiani. I congratulate her on introducing the debate but, even more important, I thank all the Marie Curie volunteers and staff who have come to Parliament tonight, as well as those all across Scotland. I am told that 740 staff and 400 nurses support more than 4,000 patients, and that there are also 4,000 volunteers. I am pleased that Linda Fabiani's motion places special emphasis on volunteers, because without them the work of Marie Curie would not be possible.

I am told that there are 67 community fundraising groups. There are also shops—I think that there are six in Edinburgh, one of which is in Goldenacre in my constituency. The debate's main purpose is to record our appreciation for all those people's work and to thank them for it. I express my apologies because I will not be at tonight's event, which is certainly not due to a lack of respect for Marie Curie and everyone who is involved in it. I usually attend the Marie Curie event, but I must go to another event here at which two constituency groups will deliver presentations, before I go to a meeting in my constituency.

More generally, Marie Curie is helping to achieve what we might call an end-of-life revolution. Sixty per cent of people in Scotland die in hospital, but most of them do not want to die

there. There must be a choice about that. Many people identify palliative care with hospices; Marie Curie makes a great contribution through its hospices in Edinburgh and elsewhere. However, giving people choice and developing a community-based model of end-of-life care to make that choice a reality is what is important.

I note from Marie Curie's briefing that its patients are twice as likely to die at home as the population who do not have access to its services. Its patients also have fewer emergency hospital admissions. In fact, Marie Curie is helping to redesign palliative care services in Edinburgh. It was also recently involved in writing a report with NHS Lothian and the University of Edinburgh. That report was important in developing the new end-of-life care model. I think that Nanette Milne sponsored a debate on that issue a few months ago.

I will highlight two important points from the report. First, although 75 per cent of cancer patients get palliative care, only 20 per cent of non-cancer patients do. A great deal of work must be done to address that issue. Secondly, the report emphasised the importance of a gradual long-term approach to phasing in support and palliative care. In other words, patients should be identified earlier. In order for that to happen, we need to break down the stigma that is associated with talk about dying. A lot must be done with regard to the end-of-life and palliative care revolution, and Marie Curie is absolutely key to that work.

In my last minute, I will mention two other bits of work that involve Marie Curie that I have learned about from the stand that I was pleased to visit, which is in the members' lobby all week. First, Marie Curie is involved in research that is important for all aspects of healthcare. To use another Edinburgh example, it has been involved in research about anticipating prescribing at the end of life in south Edinburgh care homes. The availability of key medicines to manage symptoms that are likely to occur when a person is dying is very important.

Last—but certainly not least—Marie Curie is working with the Children's Hospice Association Scotland on the rest assured service, for when children leave a hospice to die at home. It is tragic that children are important in this context but, numerically, older people are more important.

My final point, which is again from the Marie Curie briefing, is that the number of over-75s in Scotland will increase from the current 420,000 to 780,000 in 2037, which is an 86 per cent increase. That is marvellous news, but it will mean more older people with terminal illnesses and multiple conditions, so it will be even more important that we develop the right models of palliative care.

I thank Marie Curie for all that it does, and I thank especially its volunteers.

17:15

Stewart Maxwell (West Scotland) (SNP): I congratulate Linda Fabiani on securing the debate.

As members are aware, an important part of our parliamentary work is to give a voice to people who undertake important work in our communities. That is particularly relevant when we are speaking about the work of Marie Curie Cancer Care, which delivers vital assistance to people who are suffering from cancer and—as Linda Fabiani mentioned—other terminal illnesses.

Marie Curie has published some interesting figures on the work that it has recently undertaken. Some of the numbers in its briefing are quite mind-blowing. In 2012-13, it assisted more than 38,000 people across the United Kingdom and almost 4,500 people in Scotland, and spent more than 1.3 million hours caring for terminally ill patients and their families. That was, of course, made possible through the vital contribution of thousands of volunteers. Last year's daffodil appeal generated £6.6 million in funding, and 98 per cent of people who used Marie Curie's service rated it as good or excellent, which clearly demonstrates that it has a commitment to professionalism and high-quality care.

However, there are aspects of the organisation's contribution that are not quantifiable and which are not reflected in the statistics; it is not possible to express in figures the gratitude of families and carers who are given advice and support in their time of need, nor is it possible to quantify the feelings of companionship and comfort that patients experience as a result of the care that Marie Curie offers in one of the most difficult periods of a person's life.

Marie Curie's services are always free to patients and their families, but that requires fundraising of some £10,000 per hour every day in order to enable it to continue to provide that level of service. Funding for nursing services and hospices is allocated on a 50:50 basis in partnership with the national health service, but much of the £93 million that Marie Curie spends every year on care and research and development comes from the generous donations of the public, so it is entirely appropriate that Linda Fabiani's motion recognises that and the important contribution of volunteers to making all those things possible.

I am pleased that many of the unsung fundraising heroes are in my region of West Scotland. For example, funding groups in Renfrewshire, Inverclyde and East Dunbartonshire

work alongside Marie Curie shops in Port Glasgow, Largs, Alexandria, Bearsden and Saltcoats.

George Adam (Paisley) (SNP): Stewart Maxwell mentions fundraising in West Scotland. I do not know whether he is aware that, only a couple of weeks ago, I had a Saturday night out that involved me walking over fire for Marie Curie. I have done many things over the years. Some of Marie Curie's members from Paisley are here today, including Jane Evans, who is a good friend of mine. She was one of the people who asked me to do that. I think that they are here to pick up the money, so I ask everyone to remember to sign my sponsor sheet when they go to tonight's event.

Stewart Maxwell: I thank George Adam for that intervention—or rather, that advert for his fire-walking experience. I am sure that many members will contribute; I am certainly happy to do so. Indeed, I am sure that many of us would spend even more money to see him walk over fire again.

Individual participation in Marie Curie events such as the 10km walk at Pollok country park also assists in delivering the £6.5 million of funding that allows Marie Curie to finance its hospice and nursing care services in Scotland.

I would like to welcome some of the on-going work that Marie Curie is undertaking. In particular, I highlight the move to enable more people to be in the comfort of their own home when they pass away. Studies that have been highlighted by Marie Curie show that a majority of people would prefer that option, so I welcome measures that help to fulfil patients' wishes in that respect and I note that significant progress has already been made, with seven out of 10 people who are cared for by Marie Curie nurses passing away in their own homes. Moreover, an independent study of the experiences of 30,000 people in Marie Curie's care provided strong evidence that patients who receive such care are more likely to be able to die in their own homes and are less likely to have to go to hospital.

I also welcome some of the other work that Marie Curie is pursuing, including moves to widen access for minority groups—for example, those who, as Linda Fabiani mentioned, are moving from children's to adult services—the expansion of services related to terminal illnesses other than cancer, and the expansion of the Marie Curie helper service. All are worthwhile measures that will continue to improve Marie Curie's already excellent standards of care.

Finally, I reiterate my thanks to Marie Curie's volunteers for all their dedication and commitment to the organisation and the patients for whom it cares.

17:20

Nanette Milne (North East Scotland) (Con): I, too, thank Linda Fabiani for lodging the motion, which once again recognises Marie Curie Cancer Care's great daffodil appeal, and I should say that the debate follows a debate that I sponsored last September on Marie Curie Cancer Care's signpost to palliative care.

It is now getting on for 30 years since the great daffodil appeal was launched and I am sure that in two years' time we will have a great celebration to mark that anniversary. As we have heard, the appeal has raised more than £70 million across the UK, with £4 million a year raised in Scotland alone.

Each March, many of us wear the distinctive daffodil that is the symbol of Marie Curie Cancer Care. I do not mean to be disparaging when I say that, apart from the poppy that I wear in November, I do not tend to wear any other badge that signifies a charity. That does not mean that I do not support other organisations or charities, but I have a particular affinity with the tremendous work that Marie Curie nurses perform.

At the core of Marie Curie Cancer Care is an emphasis on helping people to remain in their own homes for as long as possible or on providing the right environment in which palliative care meets the needs of individual patients. We are fortunate in Scotland to have two excellent Marie Curie hospices, one in Edinburgh and one in Glasgow, that cater for a range of people who are facing the end of life because of cancer or other terminal illnesses.

I am aware of the huge work that Marie Curie undertakes in my North East Scotland region and was fascinated by some of the statistics that Richard Meade, the head of policy and public affairs for Marie Curie in Scotland, gave me. A remarkable 88 per cent of patients looked after by Marie Curie Cancer Care who live within the NHS Grampian area and a further 91 per cent of people in NHS Tayside were able to die in their preferred place of death, whether that was at home, in hospital or in a hospice.

The 24/7 provision of planned Marie Curie nursing care and the rapid response team that covers Aberdeenshire are a testament to the dedication of its staff, and it is also worth noting that, last year, the 1,700 Marie Curie patients in the north-east received 9,559 visits from Marie Curie nurses, who provided more than 25,000 hours of support and care to patients in the Grampian region.

Of course, we cannot forget the community fundraising groups right across Scotland and particularly, for me, in the north-east that raise so much money for Marie Curie Cancer Care. In my

region, those groups stretch from Ellon and the Garioch in rural Aberdeenshire to the heart of the Mearns in Angus—and I should say that I see two friends of mine from upper Deeside sitting in the gallery.

In the debate that I led on Marie Curie Cancer Care's work, my motion specifically focused on what I described as a difficulty in discussing death and dying. I reiterate what I said at the time: we should not be afraid to talk about death and particularly about cancer-related illnesses and the consequences of the devastating news that a condition is terminal.

I will finish by mentioning my friend and former colleague, David McLetchie, who as we know succumbed to cancer last year. His bravery in dealing with his illness is well known and the fact that he attended the Parliament almost until the end of his life has been acknowledged by many members across the chamber. The care and dedication given to cancer sufferers at St Columba's hospice in Edinburgh, where David spent his last days, is recognised throughout Scotland, and we are very grateful for its work.

Like many charities, Marie Curie Cancer Care plays a very important role in dealing with the effects of cancer and other terminal illnesses. However, despite the many families that have had to deal with this kind of devastating diagnosis, we are still inclined to avoid talking about its consequences.

I am grateful to Linda Fabiani for bringing this debate to the chamber, to Marie Curie for its tremendous work in supporting the patients and families who have to cope with the multiple problems of terminal illness and to the loyal fundraisers who raise so much money for the organisation.

17:24

Jim Hume (South Scotland) (LD): I join other members in congratulating Linda Fabiani on securing this members' business debate on a great issue. I also, of course, congratulate Marie Curie Cancer Care on its daffodil campaign, which, as members have already noted, raises £4 million in Scotland every year. I hope that the 2014 appeal is just as successful as previous appeals. However, we should not forget that staff and volunteers continue that work throughout the year in Marie Curie charity shops and through local fundraising events. None of what the Marie Curie nurses do on the ground with patients could be achieved without that team effort.

Marie Curie nurses are the very definition of care. At a time when people face losing a loved one, their kindness of spirit and nursing expertise in what should be seen as a specialist area of healthcare are immensely comforting to families and patients in their last days, weeks and months of life.

The fantastic team effort meant that, in 2012-13 in South Scotland, which I represent, Marie Curie Cancer Care saw 663 patients and made 4,333 visits. Through the care and support of Marie Curie nurses, 95 per cent of their patients in NHS Ayrshire and Arran were able to pass away in their preferred place of death. In Lanarkshire, the figure was 92 per cent; in the Borders, it was 94 per cent; in the Lothians, it was 96 per cent; and in Dumfries and Galloway, it was 79 per cent. Those patients were able to choose how they wanted to die, thanks to Marie Curie Cancer Care and the fundraising groups in Ayrshire, Stranraer, the Machars, Kirkcudbright, Melrose, Kelso, Galashiels, Berwickshire, Gretna, Hawick, Peeblesshire, Dumfriesshire, the DG5 area, Moffat, Castle Douglas, Selkirk and North Berwick.

I recently had the pleasure of attending a panel discussion on palliative and end-of-life care that was organised by the Marie Curie team. It was clear from that discussion that palliative care is one of the areas of healthcare that people—patients, relatives and family members alike—find it difficult to talk about. That is not an easy problem to solve, because in essence it involves challenging our society's fear of death and dying. It also raises the question of our own mortality. However, what came out of that discussion for me was that it is possible to have a peaceful and—dare I say—good death, in which the patient feels in control and is medicated appropriately, and in which their dignity is maintained.

For that to happen, it is clear that earlier identification and intervention are needed in considering patients as candidates for palliative care. We all know the shocking figure that only one in five non-cancer patients is referred on for palliative care and that, sadly, in many cases that intervention is made too late for some patients to truly benefit from the care. That is especially concerning as we face the challenges of an ageing population. We know that general practitioners and other healthcare staff find it hard to discuss death and dying with patients, so let us ensure that they are properly supported to do so.

With the integration of health and social care, we have an opportunity to tackle head on the issues of patient choice and improving patient access to palliative care. Indeed, much was said last week in the Public Bodies (Joint Working) (Scotland) Bill debate about engaging with the third sector that I fully support. In that context, I wonder whether we now have a chance to tie that in with further progress on the Scottish Government's living and dying well action plan and the subsequent 2012 update report, both of which

underline the key issues for continued focus in addressing the issue of palliative and end-of-life care. I look forward to the minister perhaps addressing that.

I wish Marie Curie Cancer Care good luck in its daffodil appeal and hope that it breaks all fundraising records this year. I thank it for the vital work that I know that it does.

17:28

David Torrance (Kirkcaldy) (SNP): I thank Linda Fabiani for bringing the motion to Parliament and welcome the opportunity to talk about Marie Curie Cancer Care's great daffodil appeal 2014.

As one of the UK's largest charities, Marie Curie Cancer Care has endeavoured to raise money every year since 1986 to support those who suffer from terminal illness. I believe that everyone who is unfortunate enough to be faced with that diagnosis has a right to high-quality, patient-friendly and emotionally supportive palliative care. Marie Curie Cancer Care undoubtedly fulfils those criteria by delivering high-quality services while prioritising patients' wishes. In providing free end-of-life care, it plays a significant role for patients in allowing them to choose the kind of end-of-life care they would prefer. That choice provides care that puts patients and their families first and allows patients to die in their homes surrounded by their loved ones if that is what they want.

Despite that exemplary work, every five minutes in the UK someone dies without getting the care that they deserve. According to research that was commissioned by Marie Curie, 65 per cent of the people concerned would choose to die at home. However, the reality is that only 25 per cent receive the opportunity to do so. Providing more palliative care at home would ease the burden on the healthcare system. Statistical data from 2013 estimates that if community services were put in place for 30,000 more patients, the potential saving to the NHS would be as high as £34 million.

The great daffodil appeal is of such great importance because it not only raises money to provide nursing for those affected by terminal illnesses but helps to develop strategies to tackle successfully the challenges facing an ageing society. As with most areas in Scotland, my constituency of Kirkcaldy is confronted with finding solutions for sustaining an effective healthcare system for the increasing number of citizens who are aged over 75. At the moment, Marie Curie Cancer Care is in partnership with NHS Fife to deliver suitable services for around 3,000 people requiring palliative care. However, a majority of them still die in hospital, which shows the potential for further increasing home nursing in the future.

Cognisant of those statistics, Marie Curie Cancer Care and NHS Scotland, with the help of Michael Matheson, the Minister for Public Health, recently launched a new initiative in Kirkcaldy called the helper programme, which is due to begin in Fife on 1 April. The aim of the programme is to further improve palliative services by training volunteers who will provide companionship and emotional support for at least three hours each week to at least 240 patients a year. After a pilot trial in Fife, the initiative will be expanded to the rest of the country, thus strengthening the partnership between the volunteer community and the NHS.

Volunteers are also integral to the success of the great daffodil appeal. Their efforts in raising awareness of the importance of palliative care and helping to foster support for the terminally ill and the Marie Curie organisation itself by encouraging people to wear a daffodil pin are of paramount importance in the collection of the £4 million that is raised every year in Scotland. Last year, I was fortunate enough to be able to join the volunteers at the Marie Curie Cancer Care stand in the Mercat shopping centre in Kirkcaldy. I was heartened and pleased by the generosity of shoppers. At the end of the day, the collection tins were filled with donations. I will be helping again with this year's appeal.

I wish Marie Curie Cancer Care and all volunteers who are involved across Scotland the best of luck in the great daffodil appeal 2014. Their efforts truly deserve our full gratitude and support. I offer my family's gratitude to Marie Curie's staff and volunteers because, for the second time in a short space of time, we will be calling on their services.

17:32

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): I begin in the traditional way by congratulating Linda Fabiani on securing this important debate to celebrate the great daffodil appeal 2014.

I have the privilege to represent the constituency where the Glasgow Marie Curie hospice is based. It is fair to say that the Marie Curie hospice at Stobhill is an important part of the communities of north Glasgow and very highly regarded throughout Glasgow and beyond.

Most of us will know someone who has benefited from the services that Marie Curie offers people in their own home or in one of its hospices. Many of us think of cancer when we think of Marie Curie, but of course the organisation provides care and support to people suffering from terminal illness no matter what it might be. Figures supplied to us by Marie Curie suggest that as many as

eight out of 10 non-cancer patients with a terminal illness are not accessing palliative care and that many who manage to get palliative care do so only in the latter stages of their illness. I can only agree with Marie Curie when it says:

"We need to do much more to end the inequality of access."

As Malcolm Chisholm said earlier, given Scotland's ageing population, the number of people who are going to be living longer with terminal conditions is bound to rise. Marie Curie is right to suggest that we must keep under review the framework that is in place to support the care for them.

I have had the opportunity to meet the staff and some patients of my local hospice and to speak to some people who are living at home with their illness but who visit the hospice for group discussion, exercise and complementary therapies. I must say that I personally very much look forward to the home baking that is always on offer when I visit the hospice. I am sure that that is true also for anyone who knows the Glasgow hospice.

Programmes of care are drawn up for patients after discussion between them and a specialist nurse or doctor and are individual to the patient. To me, it is that individualisation that makes the kind of care that Marie Curie offers so important. When we speak to someone who uses Marie Curie, the overwhelming feeling that they describe is one of care and support, but it also seems to me that the care gives the patient confidence to continue to live a good life, because they know that Marie Curie is there for them and their families when it is needed.

The diagnosis of a terminal condition is always hard for family members, and many struggle to come to terms with it. Sometimes, the family of the terminally ill person do not recognise that they, too, need help. They might need support or advice or even just a safe place to blow off some steam. Marie Curie is there for them too, but we as legislators must remember that group of people when we discuss policies that affect carers.

All that excellent work takes money, much of which comes from fundraising, as we have heard, and the annual daffodil appeal is an important element of that effort. More than £70 million has been raised across the UK as a result of the annual appeal, and the efforts of the army of fundraisers, volunteers and professionals must be recognised. Marie Curie shops are well known—there is one in the Springburn shopping centre in my constituency, not too far from the Marie Curie hospice. However, I want to talk about volunteers in an individual way, too.

In the past few months, one of my constituents, Bobby Hetherington, retired as a volunteer fundraiser. I will not give away his age; let us just say that he reached pensionable age quite some time ago. For more than 25 years, he organised annual dances, sold raffle tickets and did everything that he could to support his local Marie Curie hospice, raising tens of thousands of pounds in the process.

Mr Hetherington would hate me to single him out—in fact, he will probably have words with me when he next sees me—but I do so because he happens to be the voluntary fundraiser I know best and he is typical of so many others who work away quietly in their communities to make sure that support and care are there when we need them. We owe all of them and the staff of Marie Curie a debt of gratitude.

The Deputy Presiding Officer: Finally, I call Jamie McGrigor.

17:37

Jamie McGrigor (Highlands and Islands) (Con): Thank you, Presiding Officer, for allowing me to make a last-minute contribution, albeit a short one.

I congratulate Linda Fabiani, and I declare an interest as I am a patron of Marie Curie Cancer Care, which I consider a great honour. Some members might remember the book of MSPs' recipes that I compiled and published a few years ago, which raised some £17,000 for Marie Curie. I hope that it did not give too many people indigestion. There were some priceless cartoons by Brian Adcock in the book that have a timeless quality. Perhaps we should do a rerun of it to try to raise some more money.

Marie Curie and her husband were incredibly brave people who were pioneers in the world of radiation. They literally gave their lives to ensure that future generations could benefit from their efforts on X-rays. They must have known that they were killing themselves, but their desire to bring people relief and to invent cures kept the Marie Curie flame burning. That flame is now represented by the daffodil emblem, and it has never been extinguished.

We must all be grateful to Marie Curie and her husband, and now to the wonderful nurses and volunteers who maintain this fabulous charity that does nothing but inspire good in people.

The Deputy Presiding Officer: I now invite Michael Matheson to respond to the debate.

17:38

The Minister for Public Health (Michael Matheson): Like others, I congratulate Linda Fabiani on securing time for this important debate that recognises the important work that Marie Curie Cancer Care undertakes across our communities in Scotland.

Particularly in sharing their experiences, members have illustrated very well the way in which Marie Curie works effectively with individuals and families during what are often the final stages of an individual's life. It does so in a way that is very much focused on being person centred and providing the individual with safe and effective care at that difficult time in their life. On the Scottish Government's behalf, I thank all the staff and volunteers who undertake a tremendous amount of work over the year to provide such excellent care.

I recognise that, for Marie Curie and many other voluntary organisations, campaigns such as the daffodil appeal are key in helping them to obtain the necessary funding to provide the care that families across the country need when they go through difficult times. I recognise the invaluable role that some 4,000 volunteers play each year in helping Marie Curie to realise its ambition of providing first-class care and support to individuals and families.

The Government's aim is that, by 2020, everyone will be able to live longer and healthier lives at home or in a homely setting. Marie Curie Cancer Care, working closely with our NHS in Scotland and with other voluntary organisations, has a fundamental role in helping us to realise that aim.

The key to achieving the aim is to work effectively and to work in partnership with individuals on what they feel best suits their needs, rather than tell them what to do. We want the development of services in Scotland that are founded on joint agreement with the communities and individuals whom they are there to support, and we want everyone to understand where we are going and why that is the best approach.

The need for a clear vision on the future of palliative and end-of-life care is widely recognised by the Scottish Government, NHS boards and colleagues across a range of organisations, including those in the third sector. The national action plan "Living and Dying Well", to which some members have referred, has proven successful in raising awareness of the need for high-quality palliative and end-of-life care and has brought together a range of stakeholders and groups to agree on the requirements for change.

One of the best approaches that we can take to sustain further improvements is to support the development of a strategic framework for action that is linked to our 2020 vision for health and social care, which will help to ensure that our commitment to high-quality palliative and end-of-life care for all is clear to everyone who is involved in such care. There is general agreement that the development of the strategic framework for action will provide the clear and strong message that is required to support the future focus for such care.

The Government is committed to supporting a wide range of organisations and clinical and care staff to spread reliably and sustainably the good practice that is necessary to achieve the aims. The Government is working with the living and dying well national advisory group to support key stakeholders by setting out how they can apply "The 3-Step Improvement Framework for Scotland's Public Services" to the changes that they identify in supporting the strategic framework.

In the past couple of weeks, we have passed legislation to integrate health and social care. That legislation will set in place a framework for how services must better organise themselves to work in partnership, and it will be central to realising better palliative and end-of-life care provision. Close working between our acute sector, our community sector, social work services and third sector organisations will ensure that we get the balance right, particularly at key points in the provision of palliative and end-of-life care.

I am conscious that a key part of the discussion about how we improve palliative and end-of-life care is tackling public attitudes to such care. We need to address effectively the taboo that exists—here in Scotland and in other parts of the world—about discussing issues that are to do with death and dying.

The Government supports the good work that the Scottish Partnership for Palliative Care is taking forward on the good life, good death, good grief initiative, with its vision of a Scottish society in which people are able to talk about death and deal constructively with related issues. If we are to achieve that vision, we must ensure that that dialogue goes on. It can help to prevent unnecessary suffering and the financial and practical complications that can be associated with death.

The absence of effective advance care planning can result in inappropriate admissions to hospital, as we heard, futile and distressing medical interventions and, at times, the isolation of the very ill and bereaved, when families and individuals are uncomfortable about talking about the issues.

That is why it is extremely important that we get much better at anticipatory care. Anticipatory care planning is now central to health and care in

Scotland, and the approach is growing as a result of its inclusion in new quality indicators in the GP contract.

We must get it right for patients who have cancer. It is also important that we improve palliative care provision for people who have other conditions. As Nanette Milne said, a debate on the issue in September highlighted that point.

My view, and the view of the Scottish Government, is that by working together we can make more progress in the provision of palliative care. We cannot afford to be complacent; much more needs to be done. The Government remains committed to delivering high-quality palliative and end-of-life care.

I hope that this year's daffodil appeal is a tremendous success and that Marie Curie Cancer Care is able to continue the invaluable work that it does in communities throughout Scotland, day in and day out.

Meeting closed at 17:47.

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