The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Tuesday 5 November 2013

Session 4

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Scottish Parliament

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

Time for Reflection

The Deputy Presiding Officer (Elaine Smith): Good afternoon. The first item of business this afternoon is time for reflection. Our time for reflection leader today is Mrs Manjit Kaur Jheeta.

Mrs Manjit Kaur Jheeta (Gurdwara Guru Granth Sahib, Glasgow): I thank the Presiding Officer for giving me this opportunity to say a few words to the Parliament and its members.

Today, I am representing the Scottish Sikh community in my capacity as a representative of Scotland's first purpose-built gurdwara—the Glasgow gurdwara. On behalf of Scottish Sikhs, I bless this chamber with the highest Sikh greeting of peace and prosperity Waheguru Ji Ka Khalsa, Waheguru Ji Ki Fateh.

The gurdwara, or Sikh centre, is named after the universal Sikh scriptures, Guru Granth Sahib, which provide eternal guidance and solace to millions of people all round the world. The values of these scriptures—equality, justice and humanity—have been sparked amongst the Scottish Sikh community through the opening of the £4 million purpose-built facility.

Every pound devoted towards the building came from members of the faith and those of no faith, making the building truly equal and accessible.

This community-led project has prioritised the needs of people and education has been firmly placed at the core of the gurdwara's purpose—serving young people and adults with free education.

My own role is the head of biology at Hutchesons' grammar school in Glasgow, where I have witnessed first hand the value of education, and it is that enlightenment through education that helps society move forward.

As a Sikh, I am taught that, as human beings, we should set a high moral and ethical standard to inspire and motivate all those who come into contact with us. Our lives revolve around this service to the community and it is this aspiration that has been embraced by Scotland's young Sikh leaders. Young individuals who once had little opportunity have been given a platform to shape their society and enable others to reach their potential.

Since opening in April 2013, we have recorded over 30,000 visitors and, in true Scottish Sikh spirit, we welcome you all. We want to motivate all people in Scotland with our aspirations and shared values, so that together we can create a society that moves forward together.

Topical Question Time

14:02

Bedroom Tax

1. Linda Fabiani (East Kilbride) (SNP): To ask the Scottish Government what its response is to reports that local authorities are owed more than £3 million in rent as a result of the so-called bedroom tax. (S4T-00501)

The Minister for Housing and Welfare (Margaret Burgess): The Scottish Government is doing all that it can to help the people who are hit by the bedroom tax, with £20 million of funding available this year and up to a further £20 million available next year. That money has been given to local authorities, which can provide discretionary housing payments to tenants who are in financial difficulties. I urge those tenants to contact their local authority so that they may access the money provided by the Scottish Government and pay their rent in full. Mitigating the full impact of welfare reform will not be possible. The only way we can end the bedroom tax and protect Scottish families is if we have full control of the welfare system in an independent Scotland.

Linda Fabiani: Of course, the discretionary housing payment is meant to mitigate some of the effects for some and to enable people to stay in their homes. Will the minister give me her view on the level of discretionary housing payment funding that comes from the Department for Work and Pensions and the way that the Scottish Government is able to top it up? Is the combined sum adequate to keep people in their homes?

Margaret Burgess: The level of DHP funding from the United Kingdom Government is totally inadequate. Scotland receives only 8.9 per cent of the total DHP budget, despite having 12 per cent of those affected. The DWP estimates that Scotland and London have the same numbers affected by the bedroom tax, yet in 2013-14 Scotland received £15.3 million compared with £58.2 million for London. The funding provided by the Scottish Government will take seven out of 10 people out of the bedroom tax altogether, which should go most of the way towards alleviating the position for those who are unable to pay the tax.

Linda Fabiani: Although that funding helps some, others feel very much threatened by the potential loss of their home. Does the minister share my concern about the recent report that the Tory and Labour-run South Ayrshire Council is sending out threatening letters to families who are finding themselves in arrears as a result of the bedroom tax?

Margaret Burgess: I share the member's concern about what we read in the press about the Tory-Labour administration in South Ayrshire, particularly the reference to children's services in the letter that it issued, and I accept that that caused a lot of concern for many tenants. I wrote to the council leader on 3 November expressing my concern and urging the council to ensure that tenants in financial difficulty can access the funding, whether through discretionary housing payments or through the Scottish welfare fund. On 2 October, I wrote to South Ayrshire Council informing it of Scottish Government funding of more than £389,000, giving it a total of £651,419 to help tenants who are affected by the bedroom tax. The council is also aware that that funding will be provided in the next financial year, too.

Iain Gray (East Lothian) (Lab): Surely the message of the figures is that more than 80,000 Scottish families are struggling to pay their rent due to the effect of this iniquitous tax and that the half measures of mitigation, both from the DWP and from the Scottish Government, are not doing enough to relieve them. The Scottish Government is not doing all that it can to mitigate the effects of the bedroom tax. It could find the full £50 million that is needed to banish the effects altogether, so that all families would know that that support was available to them. That is exactly what the Northern Ireland Executive has done, with the agreement of the Treasury and the DWP. Will the minister reconsider the position and banish the bedroom tax from Scotland?

Margaret Burgess: We have made it very clear that how we will banish the bedroom tax in Scotland is by having a yes vote in next year's referendum.

The member is well aware that social security policy is devolved in Northern Ireland, which means that it is able to take that action. In all the meetings that I and the Scottish Government have had with United Kingdom ministers, we have made the very point that we should be able to do likewise. We are clear that benefits, including housing benefit, should be controlled in Scotland.

The member should also be well aware that we are doing everything within our legal powers to top up discretionary housing payments. The only way that the Scottish Government is able to give grants to individuals is by paying the money to the local authorities so that they can top up those payments to the maximum level.

Sandra White (Glasgow Kelvin) (SNP): Does the minister share my concern that the work of successive Scottish Administrations to reduce homelessness will be undermined by the bedroom tax, which is a pernicious policy that we did not choose, from a Government that we did not elect?

Margaret Burgess: I absolutely agree that this is a pernicious policy from a Government that we did not elect. The Scottish Government is leading the way on homelessness throughout Europe. Homelessness is a devolved matter, a fact that the Scottish Parliament has taken on board not only with this Government but since the Parliament came into being. It is appalling that we have a UK Government whose policies are undermining our approach. Our priority for homelessness remains that we should take preventative measures, and we will do everything that we can to ensure that our homelessness policy is not affected by UK Government measures.

Neil Findlay (Lothian) (Lab): Appalling though the bedroom tax is, its impact on councils and housing associations is nothing compared with what will happen when the payment of universal credit moves from landlords on to tenants. The Northern Ireland Executive successfully lobbied to prevent that from happening there. Has the minister approached the UK Government to ask it not to pay universal credit direct to tenants?

Margaret Burgess: As I said to Iain Gray, I have asked that very question and have asked that the money in Scotland be paid direct to landlords and not to tenants, because that is what the landlords want and, more important, it is what the tenants want. I made that point very strongly to the UK ministers when I last met them.

Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): The minister will be aware that I have written to the Prime Minister twice about the impact of the bedroom tax on people who suffer from motor neurone disease. Can the minister give any comfort to MND sufferers—many of whom will have only 14 months to live—who have been told by the Labour-appointed Lord Freud to work longer hours and take in a lodger?

Margaret Burgess: That is part of the reason why we are lobbying on the matter. I agree absolutely with the member that the suggestions about taking in a lodger and working and all the other suggestions that have come from the UK Government are entirely inappropriate. They are inappropriate for most people, but they are particularly inappropriate for people who have a disability—particularly one as severe as MND. We have continually lobbied for disabled people to be exempt altogether from the bedroom tax, and that is something that we will continue to lobby on.

I hope that people in the situation outlined by the member will be able to take up the discretionary payment, as they should not be left with the worry that they currently have about the bedroom tax.

Person-centred Healthcare

The Deputy Presiding Officer (Elaine Smith): The next item of business is a debate on motion S4M-08155, in the name of Alex Neil, on person-centred healthcare.

14:12

The Cabinet Secretary for Health and Wellbeing (Alex Neil): I thought that it would be useful for us to have a fairly wide-ranging debate on health and social care in Scotland, given where we are—particularly as we are approaching the time of year when the pressures on the national health service are always at their greatest.

I will begin by summarising what I see as the three big strategic challenges facing the health service not only in Scotland but in other developed countries. The first and most obvious one is the financial challenge, not only as a result of the reductions in public spending overall that we have had inflicted on us but because costs in the NHS, particularly for new technology and new treatments, are continuing to rise.

Secondly, as the Auditor General for Scotland outlined some months ago, despite all the excellent efforts of successive Governments over the past 30 or 40 years we still have a problem of inequality of access to health in Scotland.

That is an issue that we must address. I do not think that the health service can address it by itself, but we have a part to play.

The third challenge is the ageing of the population. We know that over the next 20 years or so the number of people over 75 living in Scotland will nearly double. Indeed, statisticians reckon that a fifth of all children born in Scotland today will live until they are about 100 years old. The people who will prepare telegrams for King William or King George to send will not be out of a job for some time.

The key issue is how we respond to those challenges. I could probably spend three or four hours telling members about everything that we are doing in health and social care in Scotland. Members will be well aware of some aspects of what we are doing, such as the integration agenda, and there are other things that we are doing to innovate and take forward new ideas and ways of working.

Our vision for the national health and social care system in Scotland is that by 2020 everyone should be able to live longer, healthier lives at home or in a homely setting.

Moreover, our quality strategy delivers a high standard of healthcare through safe, effective and person-centred care.

Person-centred care looks different in every setting but, fundamentally, it is about asking a person not, "What's the matter with you?" but "What matters to you?" Later this month, my colleague Michael Matheson, the Minister for Public Health, will address the third national learning event of the person-centred health and care collaborative, at which more than 500 delegates will come together to learn from each other, service users and world experts in person-centred care, in which Scotland is a leading nation.

The person-centred approach benefits our dedicated staff as well as the people for whom they care; after all, they came into healthcare to help people, not "the case in bed 7". Over the past five years, we have invested almost £10 million directly in community-based projects across Scotland through the self-management fund. For example, Mr Matheson and I have on different occasions visited the Thistle Foundation in Craigmillar and both of us have met Brian Brown, an inspirational former soldier whose life had been wrecked by post-traumatic stress disorder but was turned around with the sort of person-centred care that we want to become the norm. On my recent visit, Mr Brown, who now supports others at the Thistle, told me:

"I've learned that what I needed was to be listened to, to be treated as a person not as a diagnosis, and to be supported to find my own way forward and deal with my own demons."

Listening carefully to people and changing how we support them is not only right but necessary, as no nation can afford to continue with the healthcare model that we have pursued to date. It is right that we look at a person in totality rather than at a particular ailment that is giving them trouble at a particular time. We must transform our approach and the main focus of that transformation will be a shift towards primary care.

Last month in Musselburgh, I met a group of local general practitioners who were concerned about their workload, bureaucracy and, more important, the length of time that they get to spend—or, to be more accurate, do not get to spend—with their patients. Like, I am sure, fellow members, I get complaints in my constituency mailbag about problems with getting a GP appointment. However, there are not two sides to this story. Patients and GPs want the same thing: a proper relationship with each other that is based on trust, local knowledge and clear communication. That is the view not only of patients but of doctors, and I am determined to make it the norm.

Our 2020 vision sets out the urgent need for an expanded role for primary care and general practice in particular. We want to keep people healthy in the community for as long as possible, reducing health inequalities and unscheduled care; we will do everything possible to support our excellent primary care workers to deliver care, freed from avoidable bureaucratic paperwork; and we must further develop primary care teams, allowing them to work in partnership with patients and carers to deliver much more person-centred, safe and effective care. As a result, we intend to modernise the GP contract and transform our approach to primary care, and I want to talk about each of those aims in turn.

With regard to modernising the GP contract, I have already said that GPs and the people of Scotland want the same thing—more quality time with each other. We know that getting appointments can be an issue and that the 48-hour access target can cause problems, albeit well-intentioned ones. We have a great opportunity at this time to make things better for Scotland. Late last year, we negotiated for the first time ever—and not for constitutional but for health reasons—a more Scottish contract with the British Medical Association in Scotland, allowing us to reach a negotiated agreement that differs from that imposed on GPs by Westminster and which has paved the way for a new approach. We are currently carefully considering with the BMA in Scotland what next year's contract should look like.

As part of that, I am today asking my officials to work with the BMA in undertaking a review of access across all GP practices in Scotland and to develop an action plan to address any issues that arise from that review. That is just the first stage. We need to move to a new contract for GPs to match our 2020 vision and to recognise that the direction of travel of the health service north of the border is entirely different from the direction of travel south of the border, particularly in primary care and how it is organised. That will take time, but my clear ambition is for a new Scottish GP contract that will ensure that GPs get the time to do what they need and want to do, which is to work with individuals to ensure that their medical care is right for them, for their family and carers and for the local environment.

GPs are, of course, only part of primary care, and we must develop a full approach to safe, effective and person-centred primary care.

Neil Findlay: Before the cabinet secretary moves off the subject of GPs, will he address the system of GP appointments? In some practices, people have to take a ticket as though they are buying sausages at the butcher's, and they must sit there all day holding their ticket until they are

called. We should have moved on from that in this day and age. Will the cabinet secretary look into that?

Alex Neil: We are already looking into it, and a number of pilot schemes have been carried out in Midlothian. In one GP surgery, the patients preferred not to have an appointments system at all but to go back to days gone by, when they could just turn up and take the risk of having to wait half an hour or even an hour. My view is that we should look at what works best but leave it more up to local decision making and not have it centrally imposed through targets or otherwise by the Cabinet Secretary for Health and Wellbeing.

In primary care modernisation, throughout our health and social care system there are many great examples of innovation and improvement that are delivering for their local area. I have heard of examples from inner city Glasgow to rural Aberdeenshire and from the Isle of Arran to suburban Edinburgh, all of which suggest new ways of working and new models of care. For instance, the deep-end practices, ably led by Professor Graham Watt, are 100 practices that work in Scotland's poorest communities and take a genuinely bottom-up approach. They demonstrate some of the very real health inequality challenges that are faced by our most deprived populations and suggest how we must begin to address them.

I have also heard about an initiative in Buckhaven that is based on the Alaskan nuka model of care, which puts the needs of the community at the heart of the healthcare system and assists both in finding solutions to seemingly intractable healthcare challenges. A number of initiatives like the Alaskan model, such as patient access, productive general practice and managing patient flow, show that the solution lies in primary and social care teams focusing on the needs of the people whom they support. That is challenging for us, but it is at the heart of our moves towards the integration of health and social care and the legislation that we are introducing to make that happen.

To make that a reality, we must understand what works, why it works and how it works. We must invest in developing new models of care and ensure that we spread the learning from the approach far and wide. That is why I am today announcing a modernisation programme to support innovation and best practice in primary care. I am also delighted to announce that, in year 1, there will be pump priming of £1 million to pilot the new developments and move the agenda forward, along with the massive resources that we already have in primary care.

The first stage of that modernisation will be in commissioning strategic assessments of primary care from each of our health boards as part of their normal planning process. It will be a modernisation programme that truly delivers change. The transformation of primary care needs to be delivered in partnership across health and social care, and the mutual NHS model that we have in Scotland is the right one for delivering safe, effective and person-centred care.

There is a sharp contrast between our approach, which is based on the founding principle of services being free at the point of care, and that in England, where privatisation is growing ever more pronounced and damaging. Although we have abolished prescription charges, in England they remain, with the result that some people on low incomes are forced to choose which of their prescribed medicines they can afford. We have legislated to ensure that there is no privatisation of GP services in Scotland, and we have banned the privatisation of cleaning contracts, which we have supported by providing more than £23 million of additional resources since 2009 to pay for the hundreds of additional cleaning staff who keep our hospitals safe. Free personal and nursing care, to which patients in England are not entitled, currently improves the lives of more than 77,000 older vulnerable people in Scotland. Those are achievements that not just the Government but the Parliament can be proud of.

I have set out our ambitious approach to person-centred, safe and effective care and have announced a clear direction for the transformation of primary care to match our 2020 vision. Given the increasing divergence between what happens north of the border and what happens south of it, I hope that every member will agree that ours is the right way forward. I began by outlining the serious strategic challenges that health and social care services in Scotland face. We need to create a health and social care system that is fit for purpose in the 21st century. That is why we are taking forward our 2020 vision. My ambition is not just to have the safest health service in the world—which, according to the world's leading expert on the issue, we already have; it is that the Scottish people will have the best health service in the world by 2020.

I move,

That the Parliament recognises the importance of person-centred healthcare in delivering the best health outcomes possible; supports measures to ensure that individuals are supported to be active partners in their own care; agrees that all parts of the healthcare system should be focused on the patient, and that should include both community and hospital care, and further supports Scotland's modernisation programme to test measures to make GP services more accessible for patients, while reducing bureaucracy for GPs and freeing their time to focus on patients.

14:26

Neil Findlay (Lothian) (Lab): I begin by declaring an interest, in that my wife and daughter work in the NHS.

I say at the outset that Scottish Labour shares and supports the good intentions of the Government motion. Person-centred healthcare, as it says on the tin, puts the patient at the heart of their healthcare. Patients should, of course, be centrally involved in all key decisions that affect their journey along the treatment pathway, so the text of the Government motion, which stresses those points, has our support.

It is not just in that area that we agree with the Government. In its 2020 vision, the Scottish Government states that it is committed to the values of the NHS—the NHS that was created by that great post-war Labour Government—which are timeless values of solidarity and co-operation, and the collective sharing and pooling of resources in a system that is based on need and not the ability to pay. I am absolutely delighted that the Scottish Government shares those Labour values. I am glad, too, that the Scottish Government opposes the marketisation of the NHS and expresses its support for continued investment in the public rather than the private sector.

I welcome the cabinet secretary's rejection of the disastrous so-called reforms that are being introduced by the coalition in England. Thankfully, what is happening in Scotland's NHS is different from what is going on in England, but the cabinet secretary should not use Tory ideology and an attack on the NHS there as a diversionary tactic to cover up what is happening here and now on his watch.

Patients should always be at the centre of health policy, funding decisions and clinical priorities. I am sure that all members of the Parliament agree that all decisions should be considered on the basis of how they will impact on the patient, but there are many areas of current policy in which that approach is very much an afterthought or is missing completely.

For months now, policy makers, professional bodies and trade unions have been raising the issue of how prepared the NHS is for winter. Such preparation is key to delivering person-centred care, particularly at the most testing time of the year. Last year, accident and emergency units were full to bursting and patients were stuck on trolleys for hours on end because bed and staff numbers had been cut. Since 2007, the system has lost 1,000 beds and there are 1,200 fewer nursing and midwifery posts than there were in 2009.

How would the patients affected by those cuts view our warm words about person-centred healthcare? Doctors and nurses complain about having to look after increasing numbers of patients without the support that they need. How would the patient who has not seen a doctor all day because of the pressures that the doctors are under view the warm words about person-centred healthcare?

Further, what about the repeated boarding out of patients during their stay in hospital because of pressures? Staff tell me about patients being moved time and again from ward to ward to free up space. Who could forget the appalling story last winter, exposed by the *Daily Record*, of John McGarrity, a frail 84-year-old who was left for eight hours on a hospital trolley without even a pillow after being rushed to hospital with chest pains? John was not the only patient to be left on a trolley, but his son described the scene to me as

"like a scene from a third world country, not something you would expect to see in Scotland."

How would John and his family view their experience of person-centred healthcare?

Mark McDonald (Aberdeen Donside) (SNP): I take on board what the member is saying, but as he will know there have always been and will always be individual examples of people whose care does not meet the high standards that we expect. Does the member accept that, in the 2012 in-patient experience survey, 93 per cent of patients responded that they were treated with care and 92 per cent responded that they were treated with respect?

Neil Findlay: That might be the case from a survey, but I tend rather to speak to people on a daily basis who come to my surgery, email me and talk to me. I am sure that members across the Parliament, irrespective of which party they are in, have the same experience as me.

Of course, we also have A and E waiting times, with targets that were missed for four years and then changed to try and help the Government to meet them, which mean that the goalposts were moved in the middle of the match. How does that sleight of hand fit with person-centred healthcare? The cabinet secretary mentioned GP practices, but there are some practices in which patients cannot get an appointment, staffing is stretched and GPs want to spend more time with patients with complex needs but are unable to do so.

It is those areas and the general state of the nation in Scotland's NHS that should be debated. I suspect that the people of Scotland, the patients and their families, and the staff working heroically under enormous and growing pressure would prefer us to consider the nuts and bolts and day-to-day realities of the world as they face it rather

than the woolly but worthy motion presented today.

In such a debate we could hear from the Government on basic questions. Do we have enough staff? Are they in the right places? How many patients should doctors be expected to look after? Is the level of financing right? How do we develop a long-term approach? What level of care do we as a nation want to see? Those fundamental questions have been highlighted very ably by *The Herald* in its NHS campaign, which reflects the concerns raised by people in our communities and in our mailbags day in, day out. One consultant I spoke to recently summed it up when she said:

"If I can appeal to you to raise one thing with the government it is the need to end crisis management in the NHS—at present we just lurch from one crisis to another, we cannot go on like this."

How does person-centred healthcare sit with that view from a person in a front-line post in the NHS?

We as a society owe the vast majority of staff working in the NHS and other care services a huge debt of thanks for their tireless and unstinting efforts to ensure that our NHS continues to function and look after us. However, the reality is that they are being asked to do that while the Government makes decisions that make their lives much more difficult. Not only are they being asked to do more with less, but the very people expected to deliver the person-centred care to which we all aspire have seen their incomes cut as wages stagnate. What kind of message did it send out to them when the cabinet secretary awarded a miserly 1 per cent pay increase to the lowest-paid staff while giving a 4 per cent rise to senior managers? Is that redistribution Alex Neil style?

How will the healthcare system support people this winter? Will the cabinet secretary give us a sign of his confidence in winter planning by guaranteeing that the waiting times will be met? Will he guarantee that? I am happy to give way to the cabinet secretary if he wants to intervene. I see that he is not taking that opportunity, which is maybe telling.

The Government itself states in its 2020 vision that there are economic challenges ahead, but those challenges are undoubtedly having an impact on healthcare across the board. Scotland's Auditor General expressed concerns about that, putting the NHS on a financial amber warning last year. The Auditor General raised similar concerns about long-term financial planning this year.

Audit Scotland noted that pressures increased in 2012-13 and that the focus is all too often on short-term measures. A senior nurse, speaking to the media, remembered the worst years of the Thatcher Government, when hospitals were desperately underfunded, and said:

"We are definitely getting back to that now."

What about the critical role of social care in person-centred healthcare? As a society, not just as a Parliament, we have to address the morality of a system that has been driven down to the lowest common denominator by cuts to local government. At the moment, we have a system in which care providers compete for contracts that are ever more squeezed and care staff are often paid at the lowest level. Contracts are cut to the bone, followed by wages that are at or sometimes below the minimum wage, 15-minute care slots even if people need more than that, and elderly people being put to bed at 6 o'clock because that is when their care slot is. Where is the person-centred approach in that?

What is happening in social care in the community is being repeated in the care home sector. What is going on in social care is grossly unfair to the councils and the good providers who are doing their best with reducing budgets, immoral for the staff who are involved, and inhumane for the elderly and vulnerable people who need the person-centred care that we all aspire to.

We support the principle of person-centred care—healthcare has to be built around the individual. However, I fear that this winter will be one of the most difficult yet for the NHS in Scotland, and unfortunately it will be staff and, most important, the patients who will suffer.

The Deputy Presiding Officer: I ask you to move your amendment, Mr Findlay.

Neil Findlay: I move amendment S4M-08155.1, to insert at end:

"; commends the hard work and dedication of those working in Scotland's health and care services, and calls on the Scottish Government to guarantee that the health service is ready for winter and that all waiting time targets will be met over the winter period."

14:36

Jim Hume (South Scotland) (LD): I, too, welcome the opportunity to participate in this afternoon's wide-ranging debate.

In 2010, when the Deputy First Minister introduced the Patient Rights (Scotland) Bill to the Parliament, she stated:

"patients should be at the heart of everything the health service does."

I do not think that anybody in the chamber would disagree with that statement. I welcome today's debate and the Scottish Government's confirmation that it retains that central tenet in its

delivery of healthcare in Scotland. Indeed, it is one of the key principles in the 2020 vision for Scotland's NHS, which states:

"Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions".

The Royal College of Nursing has highlighted that it can be difficult to sustain such a model of healthcare when demands on the NHS are increasing and pressures on certain services, such as accident and emergency services, continue to grow. Given that situation, coupled with the overstretched workforce, the Royal College of Nursing can be forgiven for stating:

"All of these factors can contribute to inconsistent care that is focused on the delivery of care itself, rather than the individual needs of the patient."

The evidence certainly backs up the RCN, and even the cabinet secretary admits that we still have some way to go. The most recent NHS workforce statistics from ISD Scotland show that, in June, there were 221.9 whole-time equivalent consultant vacancies, which is double the number two years ago and is the highest level of vacancies that has been reached under the Scottish Government.

Alex Neil: I explain to the member that one reason why there are so many more vacancies is that there are many more jobs because we have doubled the number of consultants since we came to power.

Jim Hume: I am grateful for that, but the situation is worse with nurses and midwives. In June, there were 1,672.9 whole-time equivalent vacancies. The number of vacancies has more than doubled in 18 months and it increased by about 650 in just a year.

While I am on the subject of consultant vacancies, I add that we cannot forget last winter, when the crisis in Scotland's accident and emergency departments left hundreds waiting more than 12 hours for treatment. I presume that delivering person-centred healthcare was not at the forefront of the minds of the hard-working staff who had to catch up and deal with that situation last December and January.

Members will recall that, in response to that experience, various action plans were produced and additional front-line staff were promised in February. That crystallised into the promise in June of the immediate recruitment of 18 consultants. However, when I questioned the cabinet secretary last month on whether those consultants were in post, he was able to inform me of only three at that stage, who had been recruited by NHS Greater Glasgow and Clyde.

Following press inquiries, the Government pressed the cabinet secretary to declare hastily that there were actually 13 consultants now in post. I am not sure why he had been unable to give me an accurate answer a few hours earlier, given that he had had eight days' advance warning. That is a little unclear, but I am glad that the possibility of negative headlines managed to concentrate the minds of those in Government. Perhaps the cabinet secretary will be able to clarify later whether we now have the promised 18 consultants.

Staffing is not the only critical component in delivering the infrastructure—resources are needed too. Throughout the country, however, there are regional discrepancies in treatment times for various conditions. One board may perform well in providing timely access to clinical psychologists but may be found wanting in scheduling appointments for cardiologists.

Nothing demonstrates that better than the variance in the boards' ability to meet the 62-day treatment time guarantees across all 10 cancer types. The 95 per cent national standard is achieved for only four out of 10 cancer types, but the differences in timely treatment between boards are alarming.

The most recent data highlight the fact that only 66 per cent of colorectal cancer patients are treated on time in Grampian, whereas the figure is 72.7 per cent in the Borders. In Tayside, only 71.4 per cent of melanoma patients are treated on time, with the figure reaching 75 per cent in Fife and Grampian. For cervical cancer, the figure is 75 per cent in Lanarkshire, 80 per cent in Fife and 83.3 per cent in Lothian. Only 60 per cent of patients with ovarian cancer in NHS Highland were treated on time.

The reality is that, as well-intentioned and desirable a model as person-centred healthcare is, the raw materials must be in place for an individual's treatment pathways to be tailored to their requirements and values. What use is a person-centred model of healthcare if the resources are not in place to cater for it and the staff—either because of workforce issues or because they have too many demands on their time—are not in a position to deliver it?

I will go into deeper detail with regard to the mental health aspect of my amendment in my later speech today, and I hope that other members will pick up on its importance. Suffice it to say that mental health is the basis of good health in Scotland. There are still stigmas attached to mental health and illnesses, and although we have come a long way there is still some way to go in Scotland in providing access to psychological therapies, art therapies and the like. We still have to make further progress on that.

We will support the Government's motion and the Labour amendment.

I move amendment S4M-08155.2, to insert at end:

"; believes that all people in Scotland should be supported to live a longer, healthier life; acknowledges that this support can only be delivered in a person-centred manner with a well-resourced and motivated workforce; considers mental wellbeing to be a foundation for good health and good healthcare, and believes that further work is needed to break down barriers and tackle the stigma that continues to exist around mental ill-health."

14:43

Nanette Milne (North East Scotland) (Con): Despite certain parts of the previous two speeches, I think—and hope—that the debate is likely to be another fairly consensual one on health. None of us can deny the importance of person-centred healthcare in achieving the best possible health outcomes for people who are using the NHS.

I hope that the days are long gone when patients were told what was best for them and when hospital consultants stood at their beds and discussed their condition with a retinue of staff and medical students—as I am sure my colleague Richard Simpson will remember; it is very good to see him back in the chamber—with scant reference to the patients themselves and in language that was almost impossible for a lay person to understand.

In the days of yore, when I was a practising anaesthetist, I used to see my patients after the ward round, and I usually had to explain to them in simple language what lay ahead because they had completely failed to pick that up from the preceding discussion around their bed. There was little—if any—patient participation in discussing possible treatment options, and patients just assumed that the doctors knew best and that they were passive recipients of their care.

It is obviously right that those days are behind us and that patients themselves are involved in making decisions about their health. However, that means that they must become active partners in their own care by, for example, self-managing their long-term conditions and adjusting their lifestyle to avoid the complications of obesity, high blood pressure and other common features of the modern Western world.

To achieve that, and to maintain a good quality of life for as long as possible—nowadays, often into extreme old age—people require support from a health and social care system that is focused on their needs rather than on those of the care providers, whether they are in the community or in hospital. That requires a well-trained, well-resourced workforce at all levels and in all parts of Scotland, which is difficult to achieve when the needs of an ageing population are growing year by year and enormous pressure is being put on restricted financial budgets.

Much has been done and is being done to improve the patient experience and to put people at the heart of healthcare planning. There is a plethora of patient-centred programmes in the NHS: Scotland's patient experience programme, better together; living and dying well; the Long Term Conditions Alliance Scotland; the supporting self-management practice toolkit; and several others. The Social Care (Self-directed Support) (Scotland) Act 2013 and the Public Bodies (Joint Working) (Scotland) Bill that is going through Parliament have a clear focus on patient wellbeing, and aim to improve person-centred care and to remove the barriers to accessing services by better integration of health and social care.

The thrust of all those policies is indisputably right, but there is still a long way to go to achieve their aims, principally in changing attitudes and cultures. Only last weekend, I encountered two anecdotal instances of unhappiness with the way in which older people are being dealt with. A 90-year-old man's care at home fell short of expectation because his carers were very young and inexperienced and because they were working against pressures of time. The other case is of an elderly lady whose family had to be very assertive with staff to prevent her from being moved from ward to ward during a short hospital stay, and then being discharged before proper home care was in place. They were even told that she could not have a Zimmer frame at home until she had been formally assessed by social work.

Such anecdotal stories abound in the NHS and, although overall our NHS staff do a fantastic job, pressures on the system and inadequate staff numbers can result in a failure to achieve the best outcomes for the people who are on the receiving end of care.

For those who are at the end of their lives, I support the efforts of Marie Curie Cancer Care to have NHS Scotland carry out a national survey of the bereaved, as has been done in England, to examine all aspects of end-of-life care, including the quality of care, place of death, respect and dignity, and personal preferences. If that was done and the results were acted on, it would help to ensure that care focuses on what people really want, which is truly person-centred end-of-life care.

I am very pleased to hear that the cabinet secretary is taking primary care and the accessibility of GP services very seriously and that he is looking at what can be done to improve accessibility by working with the profession to see

how bureaucracy can be reduced for GPs, giving them more time to focus on their patients.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Is the member aware of the fact that the guidance that was issued on the quality outcomes framework in May this year, one month after it came in, ran to 224 pages?

Nanette Milne: I confess that I was not aware of that, but it is interesting information—I thank Dr Simpson.

When my husband did GP locums after retiring from full-time practice, the joy for him was that he could do what he was trained for and concentrate on patients, untrammelled by the form filling and administrative issues that had beset him as a senior partner in his practice. I was happy to support the new GP contract when it was introduced in 2004 as it removed the responsibility for out-of-hours care from GPs because it was becoming difficult to recruit new entrants into primary care because they were not prepared to do the on-call work that had been done by their predecessors without extra payment. Now, of course, we are all used to going through NHS 24 to access out-of-hours medical care.

That is all very well after 6 o'clock in the evening and at weekends, but I am concerned—this is a personal concern—that many practices now close down at lunch time on Wednesdays, so that they can concentrate on staff training, and for several days at a time over public holidays such as Christmas and new year. Previously, training was done out of hours and staff shared holiday duties on a rota. Although I think that by and large NHS 24 covers those periods well, the new system has certainly not improved patients' access to the GP.

I applaud the cabinet secretary for encouraging general practices to improve access, for instance by extending opening hours by offering early morning and evening appointments and by working with GPs and health boards to ensure that practices across the country will have an on-line repeat prescription facility. Personally, I would also like to see more specialist nurses being deployed in primary care because they can do so much to help patients to keep well within the community, thereby preventing repeated hospital admissions and freeing up GPs to give more of their time to patients who need the expertise.

I look forward to the outcome of the cabinet secretary's negotiations on a new Scottish GP contract and to the roll-out of best practice across the country as a result of his modernisation agenda.

As I said before, much good work is being done to improve the patient experience by putting patients at the heart of healthcare planning, but we are still at the early stages of achieving the desired outcome. The Conservatives will support both amendments at decision time.

The Deputy Presiding Officer: Before we move to the open debate, I remind members that those who participate in the debate must be in the chamber for closing speeches at the end of the debate.

I also remind members that business timings on a Tuesday are fluid. The debate start times are dependent on the number of topical questions that are lodged, the number that are chosen by the Presiding Officer, and the supplementary requests that are received on the day. Members should therefore be in the chamber for the start of business, since those who are late run the risk of not being called to speak in oversubscribed debates. This afternoon, however, we have time in hand, so speeches in the open debate can be up to seven minutes long.

14:51

Bob Doris (Glasgow) (SNP): I am delighted to speak in today's debate on person-centred care. As deputy convener of the Health and Sport Committee, I often meet stakeholder groups in health and social care—be they doctors groups, nurses groups, allied health professionals, pharmaceutical companies, pharmacists, social workers, addiction workers or occupational therapists. I could go on and on, but do not worry, Presiding Officer, I will not.

I mentioned that list of groups because I am sure that for all those stakeholders, the user—the patient—is their primary concern. However, every group also has a specific interest and a specific point of view that sometimes contrasts with and is different from the interests and views of other stakeholders. Person-centred healthcare and social care should see the interests of such stakeholders—vested interests, if you like; I mean that kindly, not negatively—as being secondary to the needs of the constituents; the people we represent, who are the service users.

Progress has been made: for instance, GP surgeries are now open for longer and their hours are more flexible. I have listened to some of the concerns that have been raised, but it is now easier, in many cases, to see a GP than it was previously. That is a positive change.

I am pleased that the HEAT—health improvement, efficiency and governance, access and treatment—target that was introduced in 2007 to ensure that all patients see an appropriate member of the GP practice team within 48 hours has been met in almost every health board; Fife just missed out. That target's having been met means that more than 90 per cent of patients see an appropriate person within 48 hours.

There should, however, be no complacency about that; targets tell only part of the story, which is why I am delighted that the Cabinet Secretary for Health and Wellbeing has looked for unintended consequences from that 48-hour target and is considering more imaginatively how we can use the GP contract better to meet the needs of our constituents. On that last point, I also took part in the keys to life debate on learning disabilities, and I know that the Scottish Government is actively considering the possibility of having a quality and outcomes framework in relation to people with learning disabilities and the special attention and support that they need from GPs.

I welcome that possibility, but this is not just about GPs. Perhaps health centres more generally should consider services beyond 9 to 5 and 5 days a week. Why should we single out GPs? Associated support services also have to be in the health centre; if a person has to see a community nurse after they see their doctor, does not it make sense to have community nurses in the health centre on Saturday morning if GPs are working on Saturday morning? We have to think more imaginatively about how we can use the overall resource. I am delighted to know that there are on-going discussions on how we might do that.

I am also encouraged that the Scottish Government has established a person-centred health and social care collaborative; its third meeting will be held shortly. I am sure that the 500 stakeholders will consider how services can be developed in the long term. I looked at the remit of the collaborative and was delighted to see that one aspect of the remit is to focus on what we can do now, because sometimes when such things are set up, it is "Mañana"; it is about what can be done in two years, three years or four years. However, the collaborative is actively looking at what can be done in the short term—in the months and the years ahead—and not just in the long term, important though long-term planning is.

I also welcome the fact that the Scottish Government is giving £4 million to five health boards, including NHS Greater Glasgow and Clyde in my area, to look at innovative ways of delivering a seven-day health service and of enhancing round-the-clock care. Let me give two examples of that—although I should perhaps first, like Mr Findlay, declare a slight interest, in that my wife is a nurse in a high dependency unit in Glasgow, and has worked in a variety of capacities in surgical nursing.

If a patient is ready for discharge, but staff cannot get hold of the pharmacist because the pharmacy is closed, that can lead to a delayed discharge. If, before going home, a patient needs to be declared fit and capable, or able to use appropriately and safely any support equipment that he or she has been given, the patient cannot go home if the physiotherapist is not around. Therefore, we need to look more imaginatively at when various health professionals are on ward, on call, in the hospital or in the health centre. I hope that that £4 million will help us to think of good ideas for how to do that.

I am also pleased that the Scottish Government is looking to make both health and social care more person centred. That is welcome, given how liberating self-directed support can be for individuals. Self-directed support has had some negative press, because a number of local authorities have introduced it as a cost-cutting exercise rather than because they adhere to its principles. It is therefore only reasonable that I mention how my local authority has treated people with learning disabilities in the context of its day-centre reforms and closures.

In its briefing for today's debate, the Health and Social Care Alliance says that there should be shared decision making when changes happen, but there was no shared decision making between Glasgow City Council and learning disabled individuals and their families, who were just told that their centres would close. That approach goes completely against the principles both of person-centred care and of self-directed support. As the Learning Disability Alliance Scotland has said, in designing services we should apply the principle, "Nothing about us without us", but that was simply not the case in Glasgow.

I thank the cabinet secretary for offering Glasgow City Council the chance to think again about the proposals to close three day centres, and for offering to work in partnership with the council, but I am disappointed that the council seems to have snubbed that offer. However, we live to fight another day on that one.

To come back to the positive aspects of person-centred care, I should mention some good work that already takes place. Revive MS in Glasgow already offers person-centred care not just to people who have multiple sclerosis, but to families who support MS patients. However, person-centred care is always work in progress. For example, my constituent Mr James Jamieson has contacted me about the need to support people who are living with hidradenitis, which is a brutal skin condition, and how we can improve care for such patients. I am in correspondence with the cabinet secretary to seek to improve that, but there are a lot of good things already happening.

Let me finish off by saying that, with £300 million already spent through the reshaping care for older people change fund moneys, and with a £100 million fund on the table to help with health and social care integration, I am really excited

about the opportunities that lie ahead, but I also have it in mind that we need to scrutinise the changes that we make in order to ensure that they deliver what we said they would deliver. What we want is truly 24/7 health and social care that meets the needs of my constituents and constituents across the country.

14:58

Siobhan McMahon (Central Scotland) (Lab): Last week, I and a number of colleagues from Lanarkshire met Healthcare Improvement Scotland's review team. During what I thought was a productive meeting, the topic of patient-centred healthcare was a recurring theme. Many of the difficulties and concerns that members raised with the team were solely about putting the patient first. I raised my concerns about the issue; I feel that we are letting down patients and staff because we are not giving them the resources to deliver the vision that we all want. I am talking not only about financial resources; sometimes what is required is a clear vision from Government for those who are delivering on the promises. Far too often, that link is missing, which leads to one part blaming the other part, with the patient left in the middle.

I understand that staff in our health service are under extreme pressure at present, which I would like to see being addressed in any forthcoming bill. Rather than add more to the workload of staff, we should try to reduce the burden that is placed on them.

As a result of pressures, the little things are sometimes missed, such as GPs actually listening to what a patient says rather than hearing what they think the patient is saying. Currently, I am helping a gentleman who went to his GP in June with what he thought was a urinary infection. The GP prescribed a seven-day dose of medicine, despite the fact that my constituent informed the GP that he was prone to such infections and that a seven-day dose had never worked for him. Obviously, the GP dismissed those concerns and sent the man on his way. When he completed the course of medicine, the infection returned and he appeared back at his GP for more medication. Had the GP actually listened to his patient and his experiences, that might not have happened, and what was to follow might not have happened.

My constituent was referred to a urologist at Hairmyres hospital in October. His appointment date was delayed, during which time he had to go back to his GP for yet more medication, as the infection persisted. He attended the clinic on 7 October and had various tests done, but was referred for further tests and told that an appointment would be forthcoming. When his appointment arrived, it was not for Hairmyres, as he was expecting, but for the Golden Jubilee hospital. He attended that appointment and had further tests done. My constituent still has the symptoms that he presented with to his GP in June and, five months on, has yet to receive a diagnosis. Will the Government's vision for patient-centred healthcare actually make a difference to people in such situations, or will it be something that politicians speak of as an ideal rather than a reality?

Recently, the Equal Opportunities Committee heard evidence from a number of disability organisations on the Scottish Government's proposed budget. During that evidence, there was discussion of self-directed support, which Bob Doris touched on. It was clear that everyone supports the idea of SDS, but there is a great deal of concern and confusion about how it will work in practice. Pam Duncan of Independent Living in Scotland said about her experience of SDS:

> "I consider myself to be a particularly resilient person, but I went through the personalisation process very recently and I can honestly say that it just about broke me. It was the most demoralising, inhumane and degrading experience that I have ever had.
>
> However, I have come out of that at the other end still believing that self-directed support is absolutely the way to deliver social care. Self-directed support delivers choice, control, freedom and dignity in a way that the disability movement has campaigned for for many years, but it does that only at the end point when you get the budget rather than at the point when you get your assessment or become eligible for support."

On the same issue, a representative of the Glasgow Centre for Inclusive Living said:

> "there is no doubt that self-directed support is a good thing for disabled people. Where it works well, self-directed support is fantastically empowering, but that can be totally overridden by the lack of availability of funds. I think that the situation has become so serious that we need to take a long hard look at how we fund social care".—[*Official Report*, *Equal Opportunities Committee*, 10 October 2013; c 1631-2.]

As I said, SDS is about giving individuals the choice of a care package that is suitable for their needs; that vision is shared by the majority of members in Parliament. I know that it is early days in the process, but we are already hearing about the difficulties that people are experiencing when trying to access the service. If a patient-centred healthcare system is to work, we have to learn the lessons from other similar policy initiatives. I ask the Government to look closely at the ways in which SDS is being implemented across the country and to learn from that.

I thank the organisations that sent briefings for the debate; in particular, Inclusion Scotland's briefing caught my attention. That body welcomes the move towards person-centred care, but it is concerned that the approach remains focused on management of conditions and not on the wider needs of the person, including access issues, how

they are treated by others and support for independent living. Further, Inclusion Scotland states that disabled people have a real concern that, as worded, the Public Bodies (Joint Working) (Scotland) Bill might facilitate a move back towards the medical model of care rather than to development of a human rights based social model of care. It is essential that in any policy that is developed to obtain person-centred healthcare, we do more than simply adopt a social model of disability, and that the model is implemented at every stage of the healthcare system. If we go back to the medical model of disability, we will undermine the proposed approach at the very beginning.

The cabinet secretary mentioned that primary care services should be tailored to the area. He will be aware that one size does not fit all people; for example, the Douglas Street practice in Hamilton has not fitted everyone. I listened to the cabinet secretary's remarks and I welcome the additional money for the fund that he announced, but I ask him specifically to consider what patients tell us in their areas. It is not enough to say that the system in Lanarkshire works because—as, I am sure, he is aware—there are different aspects in Lanarkshire. If we are serious about person-centred healthcare, we need to review things that are not working for patients and individuals. At present, the system is not working for the people of Hamilton.

I welcome the principle of the Government's motion, but as I said at the beginning of my speech, if the vision is to be realised, the Government will need to provide all the resources that are required—financial, educational, training and leadership resources—for the policy to be achieved and for it to be a success for each person whom we represent. The policy should be about everyone, regardless of their needs. I hope that that can be delivered.

15:05

Aileen McLeod (South Scotland) (SNP): I welcome the opportunity to speak in this debate on a fundamental principle in the delivery of safe, effective and world-class care for the people of Scotland, which is that health and social care services should be firmly integrated around the needs of individuals, their carers and families, and that we place people at the centre and ensure that they have the support to direct their own care.

I thank the Health and Social Care Alliance Scotland, the RCN, Marie Curie Cancer Care, Macmillan Cancer Support and Inclusion Scotland for the helpful briefings that they provided in advance of the debate.

As the cabinet secretary outlined, the principle of person-centred care is one of the three quality ambitions in the 2010 healthcare quality strategy, which reflects the priorities of the 2020 vision of Scotland as a country in which people live longer and healthier lives at home or in a homely setting.

Last week, I attended an event in Parliament with allied health professionals, at which I met a young disabled woman called Emma who lives independently but relies on care. She called good-quality, person-centred care her "passport to life". That says in a nutshell what we are trying to achieve and why.

A key consideration in making NHS services truly person centred is how we provide them in ways that suit the needs of individual patients—what matters to them. As the cabinet secretary has said previously, that does not mean routine operations taking place at midnight, but it certainly should mean that a patient who is ready to be discharged from hospital on a Saturday morning does not wait until Monday because the right mix of integrated services is not available over the weekend.

That is why, like my colleague Bob Doris, I welcome the £4 million that the Scottish Government is investing across five health boards—NHS Borders, NHS Lanarkshire, NHS Forth Valley, NHS Tayside and NHS Greater Glasgow and Clyde—for trialling innovative approaches in acute care to ensure that Scotland's NHS is a genuinely seven-day service.

That, in turn, will require a transformative shift in approach within primary and community health care to ensure that our GPs have the necessary time, capacity and support to deliver person-centred, safe and effective care locally, and to enable greater access to GPs and other practice services. Partnership working with patients, their families and carers, the third sector, allied health professionals, community nurses, pharmacists and social care providers will be key. That is central to the health and social care integration agenda.

A number of innovative projects that focus on new models of care delivery and new forms of partnership with GPs are worth highlighting. For example, the Health and Social Care Alliance, in partnership with the Royal College of General Practitioners, undertook an 18-month pilot project called improving links in primary care. It was funded by the Scottish Government and used four pilot sites to explore how the providers of support in the statutory and third sectors can be integrated for mutual benefit, and to explore what the benefits are of strengthening connections between general practice and local communities, for example through signposting people to local services.

It also tested the feasibility of embedding in general practices the access to local information to support self-management—ALISS—system. That, in essence, is a bottom-up approach that connects existing online resources and makes it possible for people and local organisations who know best to access and share local information. That shows what can be done.

Another example is how the deep-end general practices tackle the serious challenges that face many GPs who work in areas of multiple deprivation and health inequalities, and deal with the increasing number of patients who require more complex long-term health care. Of course, all those problems have been exacerbated by the welfare reform changes. Through the assistance of Professor Graham Watt, I recently met a number of members of the deep-end group of GPs, who work in some of the most deprived communities in Scotland. They want to tackle head on what they call the "dark synergy" of factors that generate health inequalities. They argue that the population-based distribution of GPs does not match the demands and needs of the most deprived communities and the challenges of lower life expectancy, higher incidences of serious long-term conditions and comorbidities. Their vision affords GPs at the deep end the time and resources to start to tackle the effects of deep-seated societal issues on patient health, and to turn GP surgeries into integrated healthcare hubs for provision of a variety of interdisciplinary care and support services, with social workers attached to general practice and the link-worker role connecting practices and patients to community resources for health.

It is with those examples in mind that I welcome the cabinet secretary's announcement today of an initial £1 million development fund as part of a modernisation programme to support innovation and best practice in primary care, and that a first step in that modernisation will be the commissioning of strategic assessments of primary care from each health board, as part and parcel of their planning process.

I wish briefly to highlight one final aspect of integrated, person-centred health and social care, which is in relation to ensuring that patients have access to appropriate end-of-life care. In Dumfries and Galloway—part of the region that I represent—there is an out-of-hours multipatient service, which is a partnership between Marie Curie Cancer Care, NHS Dumfries and Galloway and the Alexandra unit, which specialises in in-patient palliative care. The service is designed to provide care and support for people who have life-limiting illnesses and who are very ill, outside normal working hours in their homes, thereby avoiding the risk of their immediate admission to—and perhaps their dying in—hospital. In 2011-12, when a place of death was recorded, 54 per cent were at home against only 5 per cent in hospital.

What has been announced today by the health secretary is an ambitious approach to person-centred, safe and effective care. Through the support of everyone working together with our primary, acute and social care teams, who do a fantastic and tireless job, I believe that it is the right way forward in enabling our constituents to have a health and social care system that is fit for 2020.

I support the motion in the cabinet secretary's name.

15:12

George Adam (Paisley) (SNP): The Scottish Government's ambitious plans for person-centred healthcare are to be welcomed. The Scottish Government introduced its healthcare quality strategy in 2010 under the three key points of its being safe, person centred and effective. Today's debate is more about the person-centred part of the scenario, which includes mutually beneficial partnerships between patients, their families and those who deliver healthcare services. That is what Nanette Milne was talking about earlier, with regard to the days gone by when health professionals talked with, rather than to, people about their care. It is an issue that people have had complaints about in the past, and this is a good way to ensure that we address that. Person-centred healthcare sounds like new-age language but, as Mr Findlay said, it does what it says on the tin. That is the most important thing.

Bob Doris said that a good example is self-directed support. I agree. Self-directed support gives individuals the independent living for which they strive.

In years gone by, when I was a councillor, I was the council's representative on the Renfrewshire access panel. Many times, the debate was not about access or mobility issues but about health and social care issues. That is why I decided that it might be a good idea to have a Renfrewshire disability forum that covered all forms of disability, so that people had access to health and social care professionals and workers at senior level, who could make a difference in their area. It seems that that has worked, because at the last meeting that I attended, I heard that people are doing the jobs that they are meant to do and that health and social care issues are being left to the disability forum. That is about empowerment, making care person centred and ensuring that people get the opportunity to say what their problems are.

Neil Findlay: Maybe I could mention the other side of self-directed support. People come to us

from third sector organisations that provide person-centred support and they tell us that when their organisation bids for a contract but cannot win it at the cost at which it won it the previous time they tendered, they put in a lower price. They win the tender, but what happens? The day after they win the tender they are told that for the sixth year in a row, their wages are frozen and they will be working two more hours a week. What does that mean for the quality of care that is being provided?

George Adam: If I was Mr Findlay, I would make sure that I was speaking in the right debate when I said things. What he raises is more a procurement issue than an issue about the person-centred approach that we are debating today. This debate is about the individual and about making sure that we can deliver the approach that they want. I suggest that he brings his issue up at a later date when we talk about procurement.

In talking about person-centred healthcare, members will not be surprised if I mention multiple sclerosis, because everyone will be aware that my wife Stacey has MS. In Scotland, the incidence of MS per head of population is greater than it is anywhere else in the world. This year the Multiple Sclerosis Society published the report, "A lottery of treatment and care—MS services across the UK", which we discussed in the chamber during MS awareness week. The report showed that there are things in Scotland that we are particularly good at, but also things that we still need to work on.

The positive thing is that after the debate, the Multiple Sclerosis Society wanted to work with us to create a cross-party group on MS for the first time in Parliament's history, so that it could work with the Parliament, the Government and everyone else to see what we could do to make things better. We do not want to come along with a list of complaints every MS awareness week, but instead to work with the Cabinet Secretary for Health and Wellbeing and people in the medical profession to make a difference, so that we are not just shouting from the sidelines but are taking an active approach. MS is a condition that is specific to the individual. Every patient is individual. A person-centred policy is perfect for someone who suffers with MS, because, as the minister said, it means that we are dealing with the person, rather than the condition. We have to make sure that we listen to the individual and not just look at their diagnosis or condition.

Regardless of the conditions, there are so many things that we can do. Keeping people healthy within their communities is really quite important. Earlier in the year, my mother was diagnosed with cancer and eventually died. During that period we considered giving her the opportunity to be at home—at one stage it was to be for a year or two years. Her plan was to make sure that she was with her family and within the community in order to make things better. Things did not work out for us, because her health got worse during that period. That is where the person-centred approach comes in. Of course, in that situation we have to consider the family and make sure that patients are with their families and in their communities at those difficult times. It is not just financially prudent; it is the right thing for us to do.

As a number of people have said, we face challenges with regard to our ageing population. The integration of health and social care for adults will help with that. Siobhan McMahon mentioned situations where there was not joined-up communication when an elderly person was coming out of hospital to return home, which meant that care was not available. The integration of health and social care will give us the opportunity to make sure that we can provide a complete rounded service for people and their families. There have been times in the past when we as politicians have had to intervene. That should never happen. Things should never get to that stage; it should always be part of the service.

The Scottish Government has protected health budgets. I was listening to some of the things that Mr Findlay said, and what he described is not the NHS that I recognise; it is not the NHS that is out there. The way he talked about some workers in the NHS in Scotland was negative. My wife has MS—a long-term condition. Other people who are genuinely engaged with the NHS on a regular basis do not recognise Mr Findlay's belief about what the NHS is. The Scottish Government is to be commended for making investment in the NHS a priority. The increase in the resource budget to a record £11.8 billion in 2015-16 just tells us exactly how important the NHS is to the Scottish Government.

On the NHS, how we care for our people defines who we are. The Scottish Government has shown a commitment to the NHS. The person-centred approach is very welcome. If we do not support the people we serve, how are we relevant to them in the long term? I support the initiative and applaud the Scottish Government for its continued support for our national health service.

15:19

Margaret McCulloch (Central Scotland) (Lab): The Royal College of Nursing tells us that person-centred care is one of its eight principles of nursing practice. It is a holistic approach based on mutual understanding and a relationship between patients and those who are responsible for their healthcare. I am sure that we can all endorse that approach today. However, the nursing profession

also tells us that there are challenges to delivering that holistic approach to care. I want to highlight some of those issues, particularly in relation to my region.

First, we must all recognise the context in which we are having this debate. From 2010-11, when the coalition Government came into office, until 2015-16, when I hope it will leave, the Scottish budget will undergo a real-terms reduction of 11 per cent. That is a difficult context for public services, despite the level of protection that both the coalition and the Scottish Government appear to have afforded health spending. However, we should not allow a headline commitment offering notional protection for health spending to prevent us from following the money and examining in detail where it is being spent and how that affects healthcare.

Our ambitions for the health service should be to shift the balance of care; to prevent ill health through early intervention; to promote healthier lifestyles; and to support self-management of the chronic illnesses and long-term conditions that are far too prevalent in Scotland due to our health inequalities and ageing population. Our ambition should be to diagnose and treat people in the community wherever possible in a primary care setting and to create pathways for patients that better support a preventative, as well as a person-centred, approach.

By getting the balance of care right, we can reduce emergency admissions, prevent avoidable and expensive surgical interventions and create economies of scale in the NHS without undermining front-line services. By getting the balance of care right, we can ease the pressures on hospitals, especially in Lanarkshire where we have had long-standing issues with recruiting the right number of consultants for our three acute sites, and we can address those constantly recurring long waits in our A and E units and bed shortages in our hospitals.

I am concerned that we are too often treating the case for prevention and shifting the balance of care as a novel idea or recent development. However, it has been almost 10 years since Malcolm Chisholm, as the then health minister, commissioned the Kerr report, and six years since "Better Health, Better Care." In Lanarkshire, we have not seen the new primary care infrastructure that supports the vision and ambition that we had for a health service at that time or which we have for it now.

NHS Lanarkshire's response to the Kerr report, "A Picture of Health," sets out plans for new minor injuries units and health centres across Lanarkshire that would support a holistic approach to health. We were told that the Scottish National Party supported those plans; we were told that all that it opposed in Lanarkshire was the decision to downgrade the Monklands A and E unit. Yet here we are, all these years later, and the three new health centres for Wishaw, Kilsyth and East Kilbride had their outline business cases approved only last month. Those units were supposed to be commenced or completed within five years of the publication of "A Picture for Health," but that was published in December 2005.

Alex Neil: Our capital budget has been cut by 26 per cent this year alone. That cut originated from Alistair Darling. It is impossible to meet all the original commitments that we made all those years ago when our capital budget has been sliced to ribbons, first by Alistair Darling and then by the coalition Government.

Margaret McCulloch: We support the protection of front-line services; that is not happening under the SNP's watch.

Meanwhile, plans for minor injuries units in places such as Cumbernauld have been scrapped entirely.

All those delays and abandoned projects and all that underinvestment in primary care happened under this Government—a Government that once promised to keep healthcare local. The result is not just seasonal pressure in hospitals and in A and E, which the Labour amendment covers, but recurring, all-year-round challenges in Lanarkshire.

Weekly figures compiled by NHS Lanarkshire show that it failed to meet the 95 per cent target for patients to be seen at A and E within four hours—never mind the 98 per cent target—in September and October of this year. However, it is not just patients' experience of waiting in emergency rooms that worries me; it is what that reveals about our health service. Pressures that were anticipated years ago are manifest in our NHS across the country and in Lanarkshire in particular.

I support calls from the Labour front bench for an inquiry into the pressure points in our NHS; I support investment in primary care of the kind that people in my region were promised years ago; and I support all the health workers at the coalface whose job it will be to maintain a person-centred service this winter and beyond. We can all endorse the person-centred approach, but I stress to the Parliament that we have to do much more to support the people who are responsible for delivering it.

15:25

Fiona McLeod (Strathkelvin and Bearsden) (SNP): The ambition to have person-centred healthcare is not new, as I know from my many

years as a health service librarian. More than 20 years ago, I worked in palliative care, and more than 14 years ago the centre for integrative care was opened in Glasgow on the Gartnavel hospital site. I warn members now that my speech is very much that of a health librarian—with evidence and references. That is where I want to start.

It is fantastic that that ambition now has a great body of evidence behind it to show that person-centred healthcare is the way forward for treating our patients, and I am also pleased that there is such great Government support for patient-centred healthcare. The cabinet secretary said that it would take him three hours to list all that the SNP Government is doing to support person-centred healthcare; I have half a page of examples in my notes, but I refer members to the list that Nanette Milne read out and the examples that Bob Doris and Aileen McLeod gave of the work that the SNP Government is doing around the person-centred initiative.

For me, the core of person-centred healthcare is health literacy. I always used to quote a phrase from Confucius:

"I hear and I forget. I see and I remember. I do and I understand."

That is the core of person-centred healthcare, whereby the patient does healthcare for themselves and therefore understands what they are doing.

There are two aspects to person-centred healthcare that we must consider. The first aspect is the therapeutic relationship, in which the patient is a partner in their healthcare. Nanette Milne referred to the dark days of the 1950s and 1960s, when patients were talked at rather than talked to and with. The other aspect is therapies. When we talk about patient-centred healthcare, we need to consider the therapies that are used and the therapeutic environment in which patients are treated. We need to look at the whole person and their holistic care, rather than just the treatment of the illness with which they have been diagnosed.

On the therapeutic relationship, we often talk in terms of the expert versus the passive recipient, that is, the doctor versus the patient. Many people would say that the patient is the expert in their illness—George Adam talked about that in the context of multiple sclerosis—but that does not mean that the patient does not have such a relationship with their clinician, because the patient is the expert in their illness and not in the medicine that is needed to treat it.

If patients are to be partners in their healthcare, access to high-quality information is fundamentally important. The clinician and the patient must both have access to the evidence base for the treatment that will be followed. Many years ago, in 2003, I left the Scottish Parliament after losing my seat and went back into health librarianship. I discovered that in the four short years in which I had been a member of the Parliament—hey presto!—the e-library had been developed. The e-library was the most amazing resource. Every health professional in the NHS in Scotland could access it via a computer and find the peer-reviewed evidence base for everything that they did in their work.

The e-library is now called the knowledge network and it continues to grow. I would love it if not just every clinician but every patient could get access to it. However, there would have to be health literacy, so that people could not just access but assess the information and work out how it applied to them.

We have to look at holistic therapies when we look at patient-centred healthcare. I would like to read out a few quotes that relate to the fact that we are talking not just about medicines and operations, but about holistic, integrative healthcare. It has been said:

"There is a growing body of evidence for integrative interventions such as Mindfulness-based therapies, self-efficacy and self-management strategies, and wellness enhancement"—

that is a lovely expression—

"which all build self-awareness and inner resource development skills"

for patients, and that

"The ethos of this approach is to enable a person to rediscover or rebuild their own inner resilience, strength, and creativity, in order to engage with effective self-care and self-management. It is an inherently individualised, person-centred, and whole-person approach. Evidence from interpersonal neurobiology empirical research into compassion and empathy forms much of the bedrock of this approach.

Current research indicates that the activation of a person's self-care abilities can trigger lifestyle changes e.g. healthy nutritional and exercise choices, as well as attitudinal shifts supportive of successful long term outcomes and the ability to 'cope'."

When we talk about person-centred healthcare, it is incredibly important to talk about the whole person.

I want to move forward from the whole person or patient and talk about carers and their family, as well, because if we are doing person-centred healthcare, the person will come with their carer and family. To quote again:

"there is empirical evidence that the involvement of carers in a patient self-management initiative significantly improves therapeutic adherence, with resulting improved outcomes".

That is what person-centred healthcare is about, and that is what I as a professional 20-odd years

ago was working towards. I am delighted that we now have a fantastic evidence base to prove that person-centred healthcare is the way forward.

George Adam talked about not recognising the health service that Neil Findlay referred to. I agree with him. Neil Findlay and Nanette Milne talked about the casework that has come to them about people with problems in the health service. That casework is reflected in mine, but I remind members of Mark McDonald's intervention. The casework that we get is from the approximately 10 per cent of patients who have had an unsatisfactory experience in the health service. I refer to my experience as the carer for my mother, with her multiple morbidities and possible five healthcare emergency admissions a year. She and I are among the 93 per cent who are satisfied with the care that they get from the NHS in Scotland.

Patient-centred healthcare is about patients as partners. That ultimately leads to fewer patients, and it also leads to effective and engaged practitioners. Is not that the way that Scotland would want to see its NHS?

15:33

Mark McDonald (Aberdeen Donside) (SNP): We have heard much about what person-centred healthcare and support are. A 2011 Joseph Rowntree Foundation report entitled "Transforming social care: sustaining person-centred support" has been highlighted to me. It took a bit of time to discuss with participants how they would define "person-centred support". The terms that were put forward as key components of that included:

"putting the person at the centre, rather than fitting them into services ... treating service users as individuals ... ensuring choice and control for service users ... setting goals with them for support ... emphasising the importance of the relationship between service users and practitioners ... listening to service users and acting on what they say ... providing up to date, accessible information about appropriate services ... flexibility; and ... a positive approach, which highlights what service users might be able to do, not what they cannot do."

I think we would all accept that most of those things are important in developing a person-centred approach.

It was interesting to read the quotation at the start of the report from one of the practitioners involved. They said:

"It's not another job, it's *the* job. Person-centred support is not another thing that you have got to do, it is *what* you have got to do."

I am sure that that message is getting across from the direction that is being given from the Government and in the work that health professionals are doing to ensure that person-centred support is paramount.

Another report that was highlighted to me is from the University of Stirling and is entitled "Person Centred Care: what is it and how can it be improved?". It looks at two guiding principles of person centred care:

"each individual feels they have been recognised and responded to as:

a. a unique human being with intrinsic value, and a personal identity, life story and life plans that matter but that may be vulnerable in health care contexts; and

b. an individual with a capability for developing and exercising autonomy that matters but that is vulnerable in social contexts, including healthcare."

It is about recognising the individual at the heart of the process and ensuring that things are worked with the individual, rather than the individual being worked with the process.

I take on board the points that Mr Findlay raised, but he must accept that we have made progress on accident and emergency waiting times, although perhaps not to the extent that we would want. When we came into government, 87.5 per cent of patients were waiting for less than four hours and there has been a significant improvement in the number of waits of less than four hours since then. I am sure that Mr Findlay will at least be gracious enough to acknowledge that.

Neil Findlay: I am sure that the member will be gracious enough to acknowledge that, because the Government could not meet the targets, the cabinet secretary had to change the targets.

Mark McDonald: It is good to see that Mr Findlay does not accept the progress that the Government has been making on accident and emergency waiting times.

During Mr Findlay's speech, when I quoted from the national in-patient experience survey—I will quote some figures from it again—in support of a point that I was making to him, which he seemed to be amused by when Fiona McLeod reiterated it, Mr Findlay said that it is all well and good to quote surveys but he wants to quote the people who come to see him at his surgery. I get people coming to see me at my surgery—as, I am sure, every MSP does—to tell me about their individual experiences of the health service. The problem is that people come to us if they have an issue that needs to be resolved, so the people who have had a fantastic experience in the health service generally do not turn up at our surgeries to tell us that.

However, that is not in any way to denigrate or undermine those people who have had an unsatisfactory experience in the health service. It is important that we do all that we can to ensure that everybody has a fantastic experience in the health service, but we must accept that that will

never be possible for every person who goes through the health service. It is a human organisation and all human organisations are fallible. There will be occasions on which an individual does not have the experience that they would want or that we would want them to have, and it is important that lessons are learned from those experiences and applied to ensure that the experiences are not repeated in the future. That is what we must do in dealing with such issues with the health service.

Dr Simpson: We passed an excellent Patient Rights (Scotland) Act 2011 with a new complaints system that includes the four Cs: compliments, comments, concerns and complaints. Why are we not getting reports, both to health boards and from health boards to the cabinet secretary, that are a composite of all those things? Without that, we cannot get a balanced view such as Mr McDonald seeks.

Mark McDonald: Dr Simpson makes an interesting point that I am sure the cabinet secretary and the minister will take on board. I cannot make a commitment on their behalf—well, I could but I do not think that they would thank me for it. It is good to see Dr Simpson back in the chamber. [*Applause*.] I have missed his contributions at the Health and Sport Committee, and I welcome him back.

I quoted the national survey figures for "I was treated with care" and "I was treated with respect", which were 93 and 92 per cent respectively. In addition, 95 per cent of people responded positively on "I had privacy when being examined and treated", and "The main ward or room I stayed in was clean" received a 93 per cent positive response. The general consensus out there is that there is a positive response from patients regarding their experience with the health service. However, that is not to say that we should not always strive to improve, and that is what we do.

The motion talks about making GP services "more accessible for patients". I will talk about a local example in my constituency—the Danestone patient participation group. I met the group at the Danestone gala in the summer, where it was involved with the Danestone medical practice stall.

Essentially, the group is a sounding board and a forum for patient involvement in the GP practice. Members of the group discuss improvements that would help to make patients' experience of the practice better. In addition, the group can be asked for its thoughts on the coming into operation of new legislation that would concern patients. It has recently hosted evening meetings on topics such as asthma, men's health and diabetes, for which it has brought in affected patients from the practice. Recently, it held a seminar that was entitled, "Thinking ahead: preparing for winter", for which it brought in elderly members of the community and talked to them about how they could make appropriate preparations, for example by reducing the risk of slips or falls on their paths. The local police and doctors from the practice were also brought in to participate in the discussion.

The approach that is being taken in Danestone is interesting, and I am aware that it is being taken by other GP practices across Scotland. The cabinet secretary might want to consider applying the approach more widely and introducing such groups in other areas to ensure that the GP practice is not just the place where people turn up when they are sick, but a place where people feel that they have an involvement in developments and in helping the practice to improve in a way that patients would want to see. I leave that on the table for the cabinet secretary to consider. I would be happy to discuss it with him and the minister after the debate if they would like to find out more.

The Deputy Presiding Officer (John Scott): At the moment, there is plenty of time for members to take interventions and for the encouragement of lively debate.

15:41

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): Person-centred care is defined as

"providing care that is respectful of and responsive to individual patient preferences, needs and values".

The words in the Scottish Government's quality strategy directly echo a description of person-centred care by the Institute of Medicine in its seminal work, "Bridging the Quality Chasm".

In more detail, I would say that person-centred care is about recognising and responding to patients as unique individuals, supporting patients' personal autonomy and ability to make choices about their care and treatment, being flexible in responding to each patient as a person and emphasising—as the briefing from Macmillan Cancer Support does—the relational aspects of care, especially the principles of dignity and respect. That collection of phrases gives us a good starting point for describing person-centred care.

Another way of looking at person-centred care is as the opposite of the kind of paternalistic and often aloof approach to the care of patients that was so common in the past. The reality is that that approach is not unknown now. Unfortunately, as MSPs, we sometimes still hear examples of that unacceptable attitude, which used to be so common. However, as the cabinet secretary has concentrated on primary care and GPs in particular, I should say that my GP is a model for person-centred care in action. I am sure that we

can all think of many clinicians to whom that statement would apply.

That is not always the case in primary care or in hospitals. I understand why the cabinet secretary wanted to turn the debate into a debate about primary care, but the reality is that many of the concerns about the absence of person-centred care relate to what happens in hospital. Neil Findlay was absolutely right to relate the debate to pressures on the system. There are time pressures in primary care, but there are even more acute pressures in our hospitals, and that makes the achievement of person-centred care much more difficult. We should certainly acknowledge that.

Person-centred care would not flourish automatically if the pressures in the system eased, so specific actions must be taken to make the service more person centred. Some actions are being taken, to which I will refer shortly, but we should remember that some developments towards personalised care will happen because of scientific advances. In the cancer debate three or four weeks ago, we talked about developments in drugs that will mean that medicines will be more targeted to a specific individual. That will happen independently of the other actions that we must take to address the relationship between clinicians and patients.

One of several examples mentioned in the debate is the health and care collaborative. I wish that the cabinet secretary had said more about that because it seems to be a critical initiative in improving and advancing person-centred care. We have heard over many years about the involvement of patients in service redesign, which is another important way of helping to create more person-centred care. Many examples could be given. The Minister for Public Health spoke at the spina bifida reception in the Parliament last week about the Neurological Alliance and the good work that it does. One of its projects is called neurological voices, which is to do with training and involving people who have suffered from neurological conditions in developing and redesigning services.

We will all know of positive examples of person-centred care in the NHS. I remember debates on that in the chamber, particularly the MS debate and the Parkinson's debate a few months ago, when clinical nurse specialists were praised as models for person-centred care. Of course, we heard earlier in today's debate from Mark McDonald and Nanette Milne about the patient experience surveys, which are another important feature of person-centred care. Of course, we must ask the right questions in those surveys and act on what we find, because person-centred care is about not just better care for an individual, but improving the quality of care for all. I started by talking about the Government's quality strategy, and the whole issue of person-centred care must be put right bang in the middle of the quality agenda.

I hope that members will forgive me for quoting two sentences only from a speech that I gave more than 10 years ago on 18 June 2003. When I was thinking about this debate, I remembered what I had said in that speech, which was:

> "The starting point for improving quality must be the experience of every single patient who passes through the health care system ... We might be missing important aspects of patients' experiences because we are not asking them properly or not asking them at all."—[*Official Report*, 18 June 2003; c 803.]

That is why I thought that it was important to fund research into patient experience, and patient surveys are obviously a feature of that. However, we must ask the right questions and act on the findings. I think that there has been some progress on that, which is absolutely key to improving quality, but there is still quite a long way to go. If we learn from patients' experiences, that in itself will ensure much better-quality person-centred care.

I agree with the cabinet secretary's criticisms of the English health system, but I have two points to make about that. We should not be too complacent about how much better we are. Our system is better, but we should still look to England, because many of the issues there are the same as those here and many of the actions being taken in England are about trying to improve person-centred care. I have been very struck by the work of Jocelyn Cornwall—I follow her on Twitter, and members can do so—who is director of the point of care programme. The work that it is doing to improve the delivery of compassionate patient-centred care focuses to an extent on work that is no doubt similar to that of the health and care collaborative in working with clinicians to develop that kind of care. We need to be a little bit careful in criticising the English health system so that we do not cut ourselves off from the many examples of good practice and good developments in England that we could learn from.

I think that we are all moving in the same direction on patient-centred care, but we must remember the points that Neil Findlay made, because all of this becomes very difficult in a system that is under pressure.

15:48

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): I admire Malcolm Chisholm's ability to remember what he said 10 years ago. I struggle to remember what I said in a debate last week—I wish that I was joking about that.

I welcome this debate. I think that the quality of healthcare is a key concern for all the people we represent. People will not have to interact with every agency, but everyone will have to interact with the NHS at some stage in their lives, be it when attending their GP, having planned care in hospital or presenting at accident and emergency. Indeed, I cannot help but reflect on the fact that in 2012 there were 68,483 attendances at Monklands hospital's A and E, which serves my constituency and that of the cabinet secretary.

Clearly, how the NHS deals with individuals is important. Frankly, a person-centred form of healthcare must be viewed as the only type of healthcare worth having. By and large, that is the system that we have.

The NHS is staffed by thousands of dedicated individuals who are motivated by patient care. We should reflect on the words of the health practitioner whom Mark McDonald quoted, which really got to the essence of what motivates the people who work in the NHS.

A number of members, including Malcolm Chisholm in the previous speech, have made the point that there are circumstances in which the NHS lets people down and does not meet the standards that it should meet. We have all had experience of constituents bringing to our attention cases of that happening. Our task is to deal with them individually, take them forward and try to resolve the problem for those people, but the health service has to learn the lessons of such experiences, where appropriate, to try to ensure that the concept of person-centred healthcare remains the driver for the national health service.

We should reflect on the fact that, as has been commented on, satisfaction with our national health service is high. The Scottish household survey in 2012 found that 87 per cent of people were satisfied with local health services. The figure has gone up by some 7 per cent in the lifetime of the current Scottish Government. We should all welcome that. It suggests to me that people's experience of the health service is a good one.

However, we should not run the risk of being complacent. We should be willing to respond continually to calls for further improvement, placing the person at the centre of healthcare. We have seen the Scottish Government doing that in recent years. I was pleased to see the Cabinet Secretary for Health and Wellbeing responding to patient feedback and piloting extended visiting times in five health board areas. That came on the back of his four visits to hospitals across Scotland. Jean Turner, who is known in this place and is now chief executive of the Scotland Patients Association, welcomed that move. It is a small change, but it responds to the concerns of patients and their families and it can make a big difference to the individual. It would be helpful if the minister, in closing, could tell us what the early lessons from the pilots have been.

Bob Doris and Aileen McLeod mentioned the investment of some £4 million to trial innovative approaches, to ensure that the NHS is genuinely a seven-day service and that pharmacists, physiotherapists, porters and all the other staff that we need for patients to move through and be discharged from hospital are available every day of the week. Again, it would be useful to know what the early lessons from the pilots have been. Of course it is important that the relevant staff are on hand to ensure that no one is in hospital for longer than they need to be, because of the costs that are involved, but it is also important that no one is in hospital for longer than they want to be. No one wants to be in hospital for longer than is absolutely necessary. We need to ensure that people are discharged when they are ready for that, rather than their having to wait for the relevant health professional to be available. Bob Doris made that point. With those approaches, we are seeing a more effective and efficient health service with reduced costs, but also a more patient-centred health service.

The change fund for older people can also play a role in improving person-centred health care. The change funds are an important part of the preventative spend agenda and they ensure that there is better use of public funds. As a member of the Finance Committee, I know how vital that is at a time of straitened finances. However, more important even than that is to improve outcomes for individuals through use of the change funds. If we can ensure that people are more active and that their care is delivered differently, that can reduce the requirement for hospital admissions. Again, that is better for both the NHS and the individual.

Recently, I was happy to meet Cumbernauld Action on Care of the Elderly—an organisation that I know the cabinet secretary knows well—and it was able to tell me about the work that it is undertaking with NHS Lanarkshire, North Lanarkshire Council and the change fund locally to deliver some really imaginative local projects that put people at the very centre.

It will be critical to ensure that the change funds are working effectively. I raised that point at the Finance Committee yesterday, and it will be important for the Parliament to look at whether the investment is making a difference on the ground.

I want to raise what might be thought of as a difficult issue, which Nanette Milne and George Adam also mentioned: the importance of person-centred healthcare at the end of life. We all had a briefing from Marie Curie Cancer Care, which

emphasised the importance of ensuring that people have greater choice as they come to the end of their life.

We rightly think that person-centred healthcare is about working to get people better or to support them in dealing with and managing whatever condition they have. However, as we all know, medicine has its limits, and the way in which we care for people at the end of their life and ensure dignity is important. Marie Curie has made a number of recommendations—I am sure that the Government is aware of those, and it would be interesting to hear about how it might respond.

I believe that the Scottish Government is doing what it can to ensure that we have a person-centred healthcare system. There have been a range of actions in recent years, such as the healthcare quality strategy in 2010; the 2020 vision for healthcare in Scotland; the setting up of four quality ambition delivery routes, including a person-centred delivery route; and the person-centred health and social care collaborative. There has been real action to ensure that we have an NHS that can serve all the people of Scotland in the 21st century, moving into the years ahead.

15:56

Richard Lyle (Central Scotland) (SNP): Person-centred planning is about learning through shared action; finding creative solutions rather than fitting people into boxes; and problem solving and working together over time to create change in a person's life. In order to have a truly patient-centred healthcare system, it must be built on solid principles. The first is respect: both patients and carers should have the fundamental right to healthcare that respects their unique needs, preferences and values as well as their independence.

The second is choice: all patients should have the right to participate in decision-making processes regarding their care, as long as they are comfortable in making those decisions. In order to achieve that, Scotland needs a responsive health service—as I believe it has—that provides suitable choices in treatment and management options that fit patients' needs.

Thirdly, patients should be involved. They deserve to share the responsibility for healthcare policy through meaningful engagement at all levels of the decision-making process. Such involvement should not be restricted to healthcare policy; it should extend to social policy that will have an impact on patients' lives.

Fourthly, all patients should have access to the healthcare services that their condition requires, including treatments, preventative care and health promotion activities. Provision must be made to ensure that all patients, regardless of their condition or location, have access to the necessary services. It is not enough just to treat the illness; a person-centred healthcare system must consider non-health factors such as education, employment and family issues that impact on a patient's approach to healthcare choices and management.

Lastly, accurate, relevant and comprehensive information is essential in order to ensure that patients and carers make informed decisions about their healthcare treatment and living with their condition. The information that is provided to the patient must be presented in a format that takes into account their condition, language, age, understanding, abilities and culture.

We have one of the best health services in these islands. It already supplies excellent round-the-clock care, and patients throughout Scotland can access the service day or night. I had a good opportunity some years ago, before I came to this place, driving for the out-of-hours doctor's service for two and a half years. I worked in Wishaw, Monklands, Hairmyres and Lanark, and the out-of-hours and A and E services in those hospitals were second to none.

The NHS is truly a seven-day service. Those working in all aspects of it, including pharmacists, physiotherapists and porters, must be on hand to help patients and to give them the support that they need to return home when it is best for them, any day of the week. To improve the service that patients receive within the NHS, I note that the Scottish Government is investing £4 million across five major health boards to examine innovative approaches to healthcare and how to deliver them across the NHS.

I am pleased to note that the cabinet secretary, Alex Neil, has committed to implementing the recommendations of the Royal College of Physicians' recent report in order to achieve the needs of patients and involve them in the decision-making process on their care. Those recommendations include: extending the role of hospital physicians into the community; having a consultant presence on wards over seven days; ensuring that care for patients focuses on their recovery; enabling patients to leave hospital as soon as their clinical needs allow; and ensuring that patients can get appropriate care in the community if required.

The Social Care (Self-directed Support) (Scotland) Act 2013 is designed to give those who require community care more choice and control over the social care that they receive, and it will integrate the language of self-directed support into legislation. The act also extends all four self-directed support options to children who receive care services, which will ensure that children who

have disabilities have access to the same support as their non-disabled peers. In keeping with patient-centred healthcare, the act also places a duty on councils to provide advice and information to support people and to ensure that they can make informed decisions about the support that they want.

It is widely considered that patient-centred healthcare is the best way of providing care for patients by allowing them access to the decisions that are made on their behalf. The best way to continue with patient-centred healthcare is to have a Scottish NHS that remains publicly funded, publicly delivered, and that does not follow the disastrous Westminster privatisation agenda that the present Con-Lib Government is following in England. The Westminster Government has reneged on a pay rise for health workers in England while the SNP Government has said that it will pay the rise as promised for health workers in Scotland. I have total confidence in the work that the cabinet secretary and the minister are doing, and I hope that members will support them and their work on behalf of the people of Scotland. I also support the motion.

16:02

Duncan McNeil (Greenock and Inverclyde) (Lab): I will begin in the same way as many other members have begun by quoting some definitions of person-centred care. The NHS Scotland quality improvement hub defines person-centred care as:

"providing care that is responsive to individual personal preferences, needs and values and assuring that patients guide all clinical decisions."

Inclusion Scotland welcomes the move towards person-centred care, but says:

"we are concerned that this approach remains focused on the management of conditions and not on the wider needs of the person, such as access issues, how they are treated by others, and support for independent living".

It is important to say that, because we have heard many different definitions of personalised care; I am sure that someone will count them all up but everyone seems to have their own. It would make a nice start if those who receive the services, those who provide them and the Government, which develops the policy and legislation, could all agree on a clear definition of the purpose that we are chasing.

What is not in dispute is the action that all parties are taking on developing policy that will move in the direction of the personalisation of care, although that concept might still be ill-defined. We could also agree that progress on the journey has been slow and frustrating.

Some speakers here believe that we are bounding ahead and that there are no problems at all. That borders on complacency. I believe that the Social Care (Self-directed Support) (Scotland) Act 2013, which we supported and welcomed, and the Public Bodies (Joint Working) (Scotland) Bill, which we are working on now, are both evidence of that shared frustration about how we move this agenda on.

We have come up against many barriers, which we describe generally as the need for a culture shift, the lack of leadership or whatever, but there is no accusation against this Government or indeed others that they have not tried to tackle the issue. As a group of politicians supporting the Government, we are looking for more sustained action and outcomes.

The Health and Sport Committee inquiry into elderly care some 18 months ago highlighted many of the issues raised in the debate. Although the inquiry brought about a U-turn in the inspection of care homes, which we welcome, we also made recommendations on the impact of procurement and commissioning—something that was described by one of the members today as having nothing to do with the debate. There have been two committees in the Parliament that I have convened—one was the Local Government and Communities Committee. When we were confronted with a Panorama programme about e-procurement and its disastrous impact on the care of the elderly, we had an inquiry and e-procurement did not survive a week—it did not survive the session.

Unfortunately, in the world in which we live, procurement and commissioning have consistently impacted on the day-to-day care that is provided. Our ambition is to deliver more and more health services at home, which people clearly want. Whether there are pots of money or whether the budgets are shrinking, that is the right thing to do, irrespective of budgets. How do we sustain that move when we have commissioning and procurement policies that bring about the 10-minute visit—something that is bringing great reputational risk and damage to care in our communities?

There is a complete absence of continuity of care, which is a recognised principle right across the provision of care. People might get six, seven, eight, 10 or 28 carers coming into their home over a month and they do not know who is coming to visit—that issue needs to be dealt with.

The Health and Sport Committee also called for a review of the national care standards in that elderly care inquiry. As I said, that inquiry was 18 months ago. The national care standards are now 12 years old. The cabinet secretary may want to respond to the points about procurement and the review of care standards. When the minister winds up, he may want to say something about that.

The lack of progress and the lack of impact on policy, standards, guidelines or legislation are not dry matters; they are very personal indeed. One of the other outcomes of the inquiry into elderly care was the announcement by the previous cabinet secretary of the inspection of elderly care services in our hospitals. The inspections produced by Healthcare Improvement Scotland have emphasised the lack of personalised healthcare plans that meet the needs of patients in the acute hospital setting.

Indeed, the most recent inspection report, for St John's hospital in NHS Lothian—it was an unannounced inspection that came a full two years after the test inspections that showed the same things and highlighted the very same issues—states in relation to the care that is provided to dementia patients:

"Care plans were generic, pre-printed documents which were not specific to the needs of individual patients. This does not provide a clear record of the care required and given to a patient and does not demonstrate evaluation of that patient's care."

Two years on, despite report after report and the push or direction from the Government that was announced by the cabinet secretary on the ground, there is still an issue there with delivery.

Yesterday, I met David Robertson of the learning disabilities advocacy group, which is doing a really good job of working with health boards, with the Government's support, to ensure that publications are fit for use by people with learning disabilities. Those campaigners are still campaigning for a voice with GPs. We know that people are entitled to an annual health check, but people with learning disabilities still have problems when calling or visiting the GP. For example, they complain about GP staff such as GP receptionists—I reminded him that many of us have had cause to complain about GP receptionists—who lack the training to engage with people with disabilities. Although the Government's policy and drive is to create change there, their experience tells a different story.

Obviously, we also need to recognise the challenges that we face. As others have said, this is a journey and we all hope to arrive successfully, but there is a dramatic increase in demand and less public money. Governments past and present have made efforts, with cross-party agreement, to introduce change funds to provide changes in direction for budgets.

However, one thing that is missing is that the people who are in receipt of services are not at the table. The people who are debating person-centred care are the politicians and the budget holders. It is time that people power came to the table, so that we can ensure that we get a change of culture within organisations. People must have positive rights to ensure that there is the change that they deserve.

The Deputy Presiding Officer: I call Gil Paterson, after whom we will move to closing speeches. Mr Paterson, I can give you a generous six minutes.

16:12

Gil Paterson (Clydebank and Milngavie) (SNP): I am pleased to participate in the debate, as I am a member of the Health and Sport Committee. From listening to members and reading the motion and amendments, it is plain to see that, across the chamber, everyone supports the principle of person-centred healthcare. Malcolm Chisholm summed up matters extremely well when he described us as all travelling in the same direction. A positive aspect to the debate is that we are all striving to achieve an approach that will bring health and treatment benefits for the people of our country.

The NHS is something that we all hold dear. At one point or another, we, or certainly a family member, will need to use it. Every one of us has a stake in the NHS, and it is paramount that we are all involved in making it work. The staff across the NHS should be commended for the work that they put into looking after others. That is especially so at this time of the year, when the cold weather puts extra strain on the system, as the Government has recognised. At times such as now, we truly appreciate the hard-working staff of the NHS, as I will come on to say later.

For the NHS to continue to deliver top-quality care, it is imperative that patients and families are at the heart of delivery, but we must also acknowledge that treatment can take all sorts of forms, from within hospital to within the community. Therefore, there must be a dialogue with patients to ensure that the best possible care is provided that takes into consideration the individual's needs.

That is why I was pleased to speak in favour of the Social Care (Self-directed Support) (Scotland) Act 2013, which was passed by the Parliament last year. The main aim of that act is to ensure that those who require community care have the independence to make their own decisions about the care that is provided to them.

That was an important move, as it gave people who are genuinely removed from society because of their illness or condition the opportunity to become actively involved and to respond to their own caring needs. Giving patients that independence is an important aspect of person-centred healthcare. I argue that the motion builds on the measures that are contained in the 2013 act.

When we focus on delivering the best health outcomes, it is important not only that we involve individuals but that we speak to and engage with local communities as a whole. Recently, in my constituency, I carried out a survey on accident and emergency provision, which attracted a high return rate. That is not really a surprise—I will say more about that later. Although many of the responses focused on accident and emergency provision, which was the basis of the questionnaire, a number of respondents expressed their general feelings about other aspects of the NHS, including access to GPs and some of the other services that are provided, of which there is a wide range.

It is therefore welcome that the number of GPs working in Scotland has risen by 262 since September 2006, which is a 5.7 per cent increase. In many cases, GPs are on the front line of healthcare, as most people first seek access through them rather than through any other part of the NHS. That is why I am pleased that the HEAT target that the Scottish Government introduced to ensure access within 48 hours to an appropriate member of the GP practice team has been met by nearly all health boards in Scotland.

There is still work to be done, but that progress is a sign that the Scottish Government is not resting on its laurels. When dealing with illness, it must be acknowledged that illness does not take a break. We must have measures in place to ensure that patients and families have access to the NHS at all times. That is why I am pleased that the Scottish Government is investing £4 million to trial innovative ways to ensure that we have a genuine seven-day service in the NHS. Convenient access times were another priority item that a number of people highlighted in the returns to my survey.

Yet another issue that constituents raised in my survey was the rigid nature of hospital visiting hours. People argued that those hours do not take individual needs, family pressures or financial constraints into consideration. In my constituency, the Golden Jubilee hospital will take part in a pilot user-friendly scheme that will involve extended visiting hours. I am sure that many members will have intimate knowledge of the impact on patients' mental health of being in a hospital all day with very little contact with family members or friends. Therefore, that scheme is most welcome. I hope that, if successful, it will be rolled out across the country to the benefit of all patients in Scotland.

To go back to my survey, it is surprising how many people in my constituency engaged at that one moment. In some regards, it is although I asked specific questions on a particular subject, it is gratifying that people took the opportunity to sit down and write fairly long letters to explain their recent experiences. Some of those letters are very personal ones in which people express gratitude for the things that were provided in the health service. To be frank, all members across the chamber should be proud of that.

The motion represents progress, not as a means to an end but as a means of building on the important work that is carried out in the NHS. We never stop trying to perfect a system of healthcare that continues to deliver for our patients, families and staff. The next time, when I write out a survey, we will get even more nice letters back complimenting the way that not only the Government but the Parliament deals with health service matters.

I commend the motion to the Parliament.

16:20

Jim Hume: We have had a wide-ranging debate, as the cabinet secretary predicted.

The Government motion that we have debated is sound. I fully support the principles of person-centred healthcare. Duncan McNeil was correct to say that we have to define person-centred healthcare and ensure that power goes to the people who use healthcare services. Neil Findlay was right to say that the motion has to do what it says on the tin.

We have heard stats from various sides about satisfaction levels, missed targets and postcode differences—different areas having different access, particularly to cancer services. Neil Findlay mentioned a gentleman who had to stay 12 hours, I think, on a trolley. Nanette Milne mentioned the cases of a 90-year-old man and of an elderly lady who was moved from ward to ward and was discharged when her home was not ready and she was unable to use a Zimmer. Although there are high levels of satisfaction, there is work to do. If one or two people are still not getting complete satisfaction, we must try to address that.

I was interested in the cabinet secretary's remarks about examining access to GP appointments. That is good work and I am glad that the BMA will be working with the Government. As Duncan McNeil said, it is important that we keep people involved in that process.

I would be interested to hear the minister's views on some of the anomalies that we get with appointments. For instance, when someone who is ill rings up on a Thursday afternoon, it is possible that, because it is not an emergency, the practice will say, "We have no appointments we can give you tomorrow but, if you ring back at 8.30 in the morning, we will try and fit you in then." To users, that is really quite bizarre. I know that that system has been on the go for some time.

I was also interested in Bob Doris's bringing pharmacists into the debate. For some time, pharmacists have been interested in gaining better access to patients' records so that they can do some of the work that GPs do, especially on repeat prescriptions. I would be interested to hear the minister's views on that.

I said in my opening speech that I would say more about mental health, which is mentioned in my amendment. In a debate on a crucial approach to the delivery of healthcare in Scotland, it is vital to introduce mental wellbeing into the discussion.

The publication of the mental health strategy was a welcome move, as was the opportunity to debate it earlier this year, but the challenges remain stark. One Scot in four will experience mental ill health at some point in their lives. The resulting socioeconomic and personal cost that is associated with mental health problems is estimated to be in the region of £10.7 billion a year. As it is the dominant health problem among people of working age, it is estimated that the cost to employers is in excess of £2 billion a year.

Bob Doris: Jim Hume has mentioned mental health issues and mental ill health. Does he agree that our mental health needs nurtured consistently along with our physical health? Does he also agree that, if more consideration was given to that in health and social care, we could take preventative measures to prevent mental ill health—that is an unfortunate term—from ever happening in the first place?

Jim Hume: I could not agree more. The earlier that we can detect any form of illness or health problem, the better the chances of a good outcome.

I stated earlier that person-centred healthcare is defined as being responsive to individual preferences and needs. More often than not, what those suffering from mental ill health desire and need is someone to talk to. That is why there are such incredible demands on the time of clinical and other applied psychologists throughout the country. With just 13 months until the HEAT target for accessing psychological therapies is to be met, just 81 per cent of patients are being seen by a psychologist within 18 weeks—that was more or less Bob Doris's point. In itself, 18 weeks is quite a long time to wait for someone who is suffering the trauma of mental ill health and will likely have done so for some time before visiting a GP to seek a referral. Early access is therefore important.

Unfortunately, there are regional variations. Only around 60 per cent of patients in NHS Forth Valley and NHS Lothian are seen within 18 weeks. The figures in Shetland and the Highlands are also significantly under the national average. However, we have 13 months to go, so I hope that we will get there.

When we analyse the distribution of psychologists throughout health boards, the same picture emerges. There are 15.7 psychologists per 100,000 population in NHS Greater Glasgow and Clyde, but just 8.6 in neighbouring NHS Highland. There are 15.2 per 100,000 in NHS Fife, but less than half that next door in NHS Forth Valley. I have mentioned that previously in the chamber.

I have heard anecdotal evidence of some GPs refusing to refer patients because of the length of waiting lists in certain areas. That is not acceptable. To be fair to the Scottish Government, there has been an increase in the number of psychologists in recent years—we almost certainly have the impending HEAT target to thank for that. However, it is clear that many people still struggle to access psychological therapies.

I return to my earlier point. Patients can enjoy the patient-centred healthcare experience only if the resources and staff are in place to deliver it. Good work has been done to improve Scots' mental wellbeing but there is still much to do, not least in widening access to talking therapies. If we are truly to offer person-centred healthcare, I would have to agree with the cabinet secretary that the NHS must genuinely become a seven-day service.

I welcomed the cabinet secretary's recent announcement that more had to be done to move away from variations in care at the weekend, and I will take a keen interest in the efforts of the task force that he has established to oversee those changes. However, the implementation of such a cultural change will regularly require substantially more than the £4 million investment that the cabinet secretary announced last month. His press release spoke of ensuring that pharmacists, physiotherapists and porters are on hand every day of the week. However, I gently remind him that consultants and registrars will also be vital cogs in a truly seven-day service. I am sure that he is pretty well aware of that.

The minister—the cabinet secretary I should say; I do not want to demote him—mentioned in his intervention during my earlier speech that there are more consultant positions now than there were previously. However, there is a large increase in the number of vacancies, so will the minister, in his summing up, inform me whether we are struggling to fill those vacancies?

The Lib Dems will support the Government's motion and we see value in supporting the Labour amendment, too. I hope that the rest of the Parliament supports my amendment—it is a constructive amendment that is aimed at emphasising the importance of person-centred

care, a motivated and appreciated workforce and the work that still needs to be done on mental health and its stigma. As Bob Doris says, mental health is the basis of good healthcare.

16:29

Jackson Carlaw (West Scotland) (Con): This afternoon's debate has been stuffed full of health debate season ticket holders. They are all welcome, but it has been particularly nice to see one of our debenture ticket holders, Richard Simpson, back in the chamber. It is good to have him back.

When we started the debate, I feared that we would get involved in the ritualistic and tribal attacks on the health service in England and the coalition policies there. I have said previously in debates that we carry no torch for what goes on in the health service in England. This is a devolved Parliament and we have a devolved health service. We are quite happy to seek to make the health service in Scotland the best that it can be and we understand and accept that that is on the basis of the health service that exists just now. It would be churlish not to acknowledge that in England the coalition Government has ring fenced health service spending, which has produced the consequentials that have been available to the Scottish Government to spend as it sees fit on its health priorities in Scotland.

I was grateful for Malcolm Chisholm's observation—because I have often thought this—that even where this Parliament does not want to follow the model of the health service in England, it would be churlish simply to say that every operational practice elsewhere must be inferior and that there is nothing that can be learned from it. That is the wrong approach. It is important that, wherever good practice is to be found, we are prepared to acknowledge and accept it.

I want to talk about the contributions of various speakers and then make a few points of my own at the end—I hope that some will be new, but others will, of course, fall back on tried and tested views from this side of the chamber.

I particularly want to comment on Nanette Milne's contribution, because I think that she made several well-informed, important points, particularly on the subject of access to GP practices, such as her comment about the sustained lack of availability over holiday periods and, as a result of training, some mid-week periods. She also talked about the way that patients are dealt with in hospital. I say to Fiona McLeod that I do not think that Nanette Milne referred to the 1950s; that would mean that Dr Milne was in her mid-80s. It would be ungallant to suggest that—indeed, it is impossible that it could be so.

Malcolm Chisholm also made the point that patients have to be talked to as persons, not things, when they are in hospital. GPs manage that interaction better. Many of us who have been in hospital have found ourselves being spoken to rather loudly and as if we are in some way incapable of understanding the normal English that is spoken to us.

I do not know whether Bob Doris is going to like this at all, but I found his contribution this afternoon one of the least blindly tribal that I have heard him make in all my years in Parliament, and I thoroughly enjoyed it. That might do for his future career.

I thought that Siobhan McMahon made a very pertinent point, which was simply stated: is person-centred healthcare to become a politicians' slogan rather than a patients' reality? That is always the fear with any initiative and one that we should keep in mind.

There were characteristically loyal speeches from Aileen McLeod, Richard Lyle and Jamie Hepburn, in which some effective points were made.

I very much enjoyed hearing from George Adam, who told us about Mrs Adam and multiple sclerosis. I sat as a substitute on the committee that approved the establishment of a cross-party group on MS. All members are concerned about the proliferation of such groups, but it was George Adam's personal commitment to the issue—which I think is well understood in the chamber—that persuaded members of the committee that day that such a group would be a worthwhile addition to the Parliament firmament. I thought he was a little unfair on Mr Findlay by suggesting that Mr Findlay had been criticising health service staff. Let me say of Mr Findlay—I hope he takes this as a compliment, because it is meant to be—that he has always struck me as very much of the Eric Heffer tendency in the Labour Party: solid, robust, socialist, uncharacteristically wrong about everything, but with a bonhomie and an enthusiasm that are to be welcomed.

Neil Findlay: Will the member take an intervention?

Jackson Carlaw: I fear I must.

Neil Findlay: Being accused of being wrong about everything by the member is surely a badge of honour.

Jackson Carlaw: I am happy that Mr Findlay should think so.

We also heard from Mark McDonald, who is the celebrity among us—I note with interest that he

has been nominated as the one to watch by *The Herald*. I have to tell him that I was nominated for that once and then lost to Shirley-Anne Somerville, who then lost her seat. I leave it to him to establish what the moral of that example is.

I turn to the issue of GP access. We underestimate the public response to the way that we have talked about accident and emergency departments being centres of excellence. We have all understood that the greater the range of specialisms that exist within an A and E department, the more successful treatment of patients is likely to be.

However, we have underestimated the success of that approach, which a lot of members of the public have registered by cutting out the middle man and going straight to A and E. We must ensure that people understand that GPs are there for a very particular purpose, and that is why I welcome what the cabinet secretary said about making GPs more accessible.

We have talked about the provision of walk-in centres in some of Scotland's cities as a way forward, and I hope that that happens. They already have walk-in centres in England. It is interesting that, when patients were asked where they would have gone if not to the walk-in centre, 40 per cent said that they would have gone straight to accident and emergency, with only 20 per cent saying that they would have gone to their GP. We must ensure that there are online repeat prescriptions and that appointments are made available. Perhaps our GPs would benefit from spending some contractual time in accident and emergency departments in order to persuade patients that, in going to their GP, they are going to a local centre of excellence, just as an accident and emergency department is a centre of excellence. That idea, which has been suggested by some down south, is worth exploring.

We should also look at the growing number of people who do not attend the appointments that are made for them. Effective communication must underpin the appointments system. My most recent visit to hospital as an in-patient was a couple of years ago, after which I had follow-up appointments. I invariably received notice of my appointment on the day that it was taking place. As it happened, I was not doing anything else, so I was able to attend, but that was not ideal. Indeed, some people will miss their appointment because some sort of slow mail process is used to advise them of when their appointment is. It is also not helpful that people are unable to get appointments in our hospitals and GP surgeries because the appointments are booked by those who then find themselves well but are not disposed to let anybody know that they no longer need their appointment, thereby freeing up the service for others.

I have talked before about the Conservative view of a national universal health visiting service. I still believe that that would be of fundamental value to much of what we are discussing, because it relates to preventative care, which, in the long run, is how we reduce the burden on GPs and hospitals.

We will support the rather cheeky amendment that the Labour Party slipped in. Maintaining waiting time targets will be a challenge this winter, and all the health boards would do well to follow NHS Lothian's example and be candid about exactly where they think that the pressure points will be. It is better to know those now than to find out in a distressed situation. We will also support Jim Hume's amendment and the Government's motion.

16:37

Rhoda Grant (Highlands and Islands) (Lab): I, too, welcome Richard Simpson back to the chamber. For those of us on his email list he has not really been away—he barely paused in his work. I remember opening an email quite late one night—I think it was sent from intensive care—which began "They have given back my iPhone". The emails have continued ever since, making points about policy and what we should be doing, which I appreciated.

I welcome the opportunity to debate person-centred care. We can all unite around the issue because it is crucial, although many members made the point that we cannot have it in place without resources and time. Malcolm Chisholm amplified our amendment, which commends those who deliver health and community care in what are often difficult conditions. If we are to deliver person-centred care, we must have the proper tools, such as beds, blankets and pillows.

Neil Findlay mentioned last winter and the striking case of John McGarrity. Around the same time, a senior staff nurse—I am not sure whether it was a woman or a man—said:

"It is completely normal, and a common occurrence, to have old and very ill people lined up in corridors on trolleys because there are not enough beds.

"In some cases, they are the lucky ones. Others don't make it out of the waiting room because there are no trolleys or staff to put people on them."

Such situations occurring are a real concern when we have 1,000 fewer beds and 1,200 fewer nurses than we had in place in September 2009.

We have listened to the concerns that people have brought to us and their fears that the system will fail again this winter, so the Labour

amendment asks the Scottish Government to guarantee that waiting time targets will be met during the winter months. By doing so, the Government would reassure people that it has learned the lessons from what happened last year, assessed the pressure points and taken steps to ensure that the same thing will not happen again. If it is clear from the minister's closing speech or from how SNP members vote that the Government cannot give that guarantee, that will demonstrate that the concerns that are being expressed to us are real. If that is the case, the Government needs to act now to ensure that we do not end up in the same place as we did last year.

Members mentioned the RCN's briefing, which described the particular pressures of the winter and said:

"In addition, staff are overstretched as vacancy rates increase and use of bank staff continues to go up."

I think that Jim Hume quoted the same sentence.

As Nanette Milne said, people need to be involved in conversations about their care so that they can be involved in making decisions. However, if we do not have enough staff and rely on a transient workforce of bank nurses, how can we listen to people? Indeed, how can we recruit nurses if we cannot offer the right pay and conditions? It is sad that senior managers in NHS boards are getting a 4 per cent pay increase, while the nurses who deliver the service are getting only 1 per cent.

Alex Neil: The member and Mr Findlay are totally misinformed about the increase. I will be happy to send them the details, because they keep repeating something that is just not true.

Rhoda Grant: I am disappointed that the cabinet secretary did not take the opportunity to put on record what the truth is. That is the truth as we understand it. It would be nice if all health service workers were treated the same and if we showed our appreciation of their work by ensuring that their standard of living does not fall.

Many members talked about self-directed support as part of a person-centred approach. Siobhan McMahon talked about Pam Duncan. Those of us who have met Pam realise just how tough she is, and if she has experienced difficulty in applying for self-directed support, surely everyone else will be put off by the process. I ask the cabinet secretary to look again at the process, to ensure that people are not being put off.

I recently attended a conference of the Scottish Personal Assistant Employers Network. SPAEN helps service users and carers to take control of their budgets, employ carers and take their experience into their own hands. I was impressed by what the organisation is doing; I was also quite shocked by some of the things that I heard during the conference. Tommy Whitelaw gave a presentation. Anyone who meets Tommy or hears him speak cannot help but be moved by his experience. He is doing a number of sessions, entitled "Tommy on Tour", and I suggest to members that if he comes to their area they should go and listen to him. He talks about looking after his mother, who had dementia, and how difficult that was as she became a non-person to a lot of people who provided services. He became very isolated at a time when he should have been supported. We need to listen to the experience of people who use care services, and we must ensure that they lead change in how we deal with the issues.

Bob Doris talked about council cuts. This is a time of concern for people who depend on services. Health service budgets have been ring fenced, but councils have faced cuts in their budgets. There is an unfunded council tax freeze, for which the Scottish Government is responsible. SNP members cannot complain about councils making cuts if their Government is not giving councils the resources that they need if they are to provide services. Councils are at the front line of preventative healthcare, so we must ensure that they have the resources that they need, or more costs will fall on the health service as it picks up the fallout from the cuts.

Bob Doris: I will not get into a political debate about cuts to local authorities, but given that I mentioned Glasgow City Council, I say to the member that there are no cuts in the social work budget in Glasgow in relation to adults with learning difficulties. A political choice has been made not to support self-directed support in Glasgow; that is not to do with cuts. I wanted to put that on the record.

Rhoda Grant: Duncan McNeil is shouting behind me that all cuts are a political choice. It is a political choice of the Government not to fund the council tax freeze, and that is leading to very difficult decisions being made not only in Glasgow but in councils all over. I listen to councillors who say that this is not what they got into politics for. They deliver very difficult decisions.

Duncan McNeil talked about personalised care. That is a step further and we should pursue it. The person is not centred to the care; rather, the care package starts with the person at the core.

We also need to look at the financial pressures. We have been told that health budgets are ring fenced, but the Auditor General for Scotland has put health boards on amber warning. I think that that is because of some of the pressures that are coming from other areas, such as local government. People are going into A and E as unplanned admissions, and there is no way of

taking them back out of hospital, because the resources are not there in the community.

A number of members have spoken about procurement, which is vital, because if we do not get the services in the community right, how can we put people at the centre? How can a 15-minute visit achieve anything at all? I do not know whether anyone watched a programme—I cannot tell members what it was called, but it caught my attention—in which an elderly lady and her husband both got a 15-minute care visit. The carer said that she could not deliver the care that they required and that she sometimes thought that those clients were afraid to ask her to take them to the toilet because time was so short. Those things are the very basics of care. We need to have such support in place, and we cannot do that by paying the minimum wage and having 15-minute care visits and untrained people working in those services. We need to value all those who deliver those services.

Things will only get worse, because a demographic time bomb is coming. We need to ensure that there is funding and that it is fair. For instance, is it fair that people who suffer from Alzheimer's have to pay for their own care, whereas people who have cancer get their care funded? Those are the things in our system that we need to look at.

We also need to ensure that people have access to palliative care. We listened to Marie Curie Cancer Care talking about those with cancer having access to palliative care, but people with other conditions not having the same level of access. Those are all things that are coming that we need to talk about. Indeed, Marie Curie Cancer Care brought to our attention a number of issues, including the bereavement survey—it would be helpful to learn from that—and the out-of-hours multipatient service in NHS Dumfries and Galloway. That seems to me to be an excellent initiative to keep people out of hospital and give them the care that they require at home.

You would not believe it, Presiding Officer, but there are many other things that I could say, despite using the additional time that you allotted to me. I will finish by saying that person-centred care is really important. I think that we all agree that it is essential and we want it to work for all, not 90 or 96 per cent. We need to value the staff who deliver it and give them the tools to do so. They need time, resources and planning. We need the Scottish Government to ensure that those tools are in place so that it can provide more than warm words.

16:48

The Minister for Public Health (Michael Matheson): I have listened with real interest to many of the contributions in this debate. Duncan McNeil invited us to make a good start to debating these issues by agreeing on the definition of person-centred care. Obviously, we have set out in our strategy what we believe the definition is.

We have explored issues around person-centred care. If there is anything on which we can agree, it is that there is more on the agenda about how we should progress person-centred care that we agree on than divides us.

All members also recognise that the status quo is not an option. The environment in which we have to make the change makes it more challenging, but we all recognise that, even if we were in the land of milk and honey, there would have to be changes in the way in which we deliver services.

As the cabinet secretary set out in his opening speech, the change must take place against the backdrop of the three big challenges that we face in our health and social care system. The first is the financial challenge that has been forced on us by the current situation, meaning that changes must be managed within the available financial envelope.

The second challenge is the inequality that continues to exist in society—and Scotland's health inequalities are marked. Historically, we have tried to identify a health service solution to address health inequalities, but the reality is that health inequalities are symptoms of wider inequalities in society—inequalities in income, social opportunity, education and attainment. If we are to tackle health inequalities, we must address their root causes much more effectively and we need a system that is able to do that in a combined way and systematically over a period of time.

The third challenge that the cabinet secretary set out is the demographic shift that is taking place in our country and in most others throughout the world. Given the challenges that are being created by people living longer with different health conditions, we must ensure that our health and social care system is configured so that we can meet people's care needs in a person-centred way and support individuals to live long, healthy lives in their own homes or in a homely setting.

Health debates often focus largely on the acute secondary care setting, and the brickbat goes between what should happen in different departments in the acute sector. We brought this debate on primary care to the chamber specifically in order to focus on the sector in a way that we often do not in debates on our healthcare system.

The primary care system is an important part of the overall system, sitting between secondary care and the social care system, and we must integrate it in the most effective way in order to provide person-centred care to individual patients. We all recognise—as Duncan McNeil did in his speech—that patients increasingly expect to receive their care in that way.

Like everybody else, I recognise that the delivery of person-centred care will not happen at the drop of a hat and on the back of a single strategy that says that that is what we want to do. There are challenges in taking it forward because of the way in which the system is configured. There are also interprofessional challenges and cultural shifts that must take place if we are to do it, although I do not think that any of those is insurmountable. We must be committed and recognise not only the vision that we have set for our health and social care system, but the measures that we must take to achieve that vision.

Several members, including Neil Findlay, have referred to individual cases. Like other members, I get constituents at my surgeries who are dissatisfied with the way in which the NHS has performed. I have witnessed the NHS not getting it right, but I know that our NHS gets it right more than it gets it wrong, and we should always keep that in mind when we discuss such issues. We should not use individual examples to suggest that the whole system is, in some way, falling apart or not working effectively. That does a disservice to the thousands of staff in our NHS who are dedicated to their jobs and work day in, day out to deliver the best possible care for patients—for which we, as a country, are grateful.

Neil Findlay: We should also not have a debate that skates over the real issues that people bring to us on a daily basis.

Michael Matheson: That was an extremely helpful comment. Mr Findlay gives the impression that the cabinet secretary and I live in an ivory tower and think that everything is perfect. We have brought forward a debate on how we can improve the system, because we know that it is not good enough. No one is trying to skate over the fact that there are problems in the system, or to kid on that there are not, but we must be realistic about how we go about dealing with those challenges, instead of just making throwaway comments that do not contribute to the debate about how we can improve the system overall.

In addressing such issues, it is key that we learn from the mistakes that are made in the system when we get things wrong. When the NHS does not work as well as it could, we must learn from that. As Malcolm Chisholm and Jamie Hepburn said, we need to ensure that we listen to the patient experience and that we build on that by ensuring that we do not make those errors again in the future.

Rhoda Grant: Will the minister give way?

Michael Matheson: I would like to make progress on my point.

Despite the fact that patient satisfaction levels in Scotland have improved and continue to be at a very high level, we are in no way complacent. I want our health service to get it 100 per cent right every time for every patient but, like Mark McDonald, I recognise that sometimes that will not happen. We need to ensure that we learn from the experience of things going wrong and that we use it to ensure that it does not happen again.

Rhoda Grant: I am grateful that the minister is keen to learn from experience. Has the Government learned from the experience of last winter, when many people were not able to get access to beds in hospitals? Can he guarantee that that will not happen again this year?

Michael Matheson: I will come on to the issue of accident and emergency departments, given that it was raised in the course of the debate. As soon as the winter period is over, our NHS boards begin to plan for the following winter. In doing so, they learn from previous years' experience.

It is good to see Richard Simpson back in the chamber, because he always makes a substantial contribution to health debates and is duly respected for that. He made a point about learning from the complaints process and the patient experience process that are taking place as a result of the Patient Rights (Scotland) Act 2011. I can announce that I have asked the Scottish health council to do an analysis of the first round of reports from all our NHS boards, which were produced in September of this year as part of the feedback and complaints process, and for that analysis to be completed by the spring of next year so that we can see the areas of good practice, where there is learning that can be built on. That will enable us to use that information much more effectively across all our boards. I have no doubt that Richard Simpson will look forward to the Scottish health council publishing that report in the spring.

I turn to the issue of accident and emergency departments. The pressures that A and E departments in Scotland faced last winter were no different from those that were faced across the rest of the UK. There are a variety of reasons for that. As Jackson Carlaw highlighted, rather than make use of primary care services, some individuals have a tendency to go straight to the A and E department. The weather and flu can affect demand, which can have an impact on the system.

Rhoda Grant asked whether we had learned from last year's experience. One of the things that we have done since last winter is provide £50 million for an unscheduled care programme. All our boards have been commissioned to develop a localised unscheduled care plan programme to look at what they need in the way of staffing and other resources to assist them in ensuring that they can meet the demands that they will undoubtedly face this winter. In doing that, they have made significant progress.

Jim Hume raised questions about the recruitment of staff. So far, 18 A and E consultants and 39 nurses have been recruited. The extra recruitment for this year alone must be considered in the context of what has happened over recent years. Since 2006, the number of A and E consultants in our health service has increased by more than 100 per cent—we have doubled their number. Through the additional 18 consultants that we are paying for this year, we will take the increase since 2006 up to almost 110 per cent. That demonstrates the level of resource that we are putting in to support our A and E departments to meet the demands that they will face this winter much more effectively.

When Margaret McCulloch talked about the challenges that our A and E departments face, including in Lanarkshire, she seemed to forget that it was not the Scottish National Party Government that proposed closing the Monklands A and E department but the last Labour-Liberal Democrat Administration. She might be interested to know that up until June this year, the Monklands A and E department had dealt with 67,000 attendees. Members can imagine the state that we would be in if we had listened to the last Labour-Lib Dem Administration and closed that department, because the pressure would be even greater on A and E departments across the country.

That is an example of the type of practical measure that we have taken to try to address issues. The Government is very much committed to ensuring that we build on the good progress that we have made over the past six years in our NHS. We are happy to accept the two amendments to the motion that have been lodged. I give members a clear guarantee that we will protect the NHS and do all that we can to support our NHS boards and our partners over the winter to ensure that they meet patients' needs in Scotland during the winter months.

Decision Time

17:01

The Deputy Presiding Officer (John Scott): There are three questions to be put as a result of today's business. The first question is, that amendment S4M-08155.1, in the name of Neil Findlay, which seeks to amend motion S4M-08155, in the name of Alex Neil, on person-centred healthcare, be agreed to.

Amendment agreed to.

The Deputy Presiding Officer: The next question is, that amendment S4M-08155.2, in the name of Jim Hume, which seeks to amend motion S4M-08155, in the name of Alex Neil, on person-centred healthcare, be agreed to.

Amendment agreed to.

The Deputy Presiding Officer: The next question is, that motion S4M-08155, in the name of Alex Neil, on person-centred healthcare, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament recognises the importance of person-centred healthcare in delivering the best health outcomes possible; supports measures to ensure that individuals are supported to be active partners in their own care; agrees that all parts of the healthcare system should be focused on the patient, and that should include both community and hospital care; further supports Scotland's modernisation programme to test measures to make GP services more accessible for patients, while reducing bureaucracy for GPs and freeing their time to focus on patients; commends the hard work and dedication of those working in Scotland's health and care services; calls on the Scottish Government to guarantee that the health service is ready for winter and that all waiting time targets will be met over the winter period; believes that all people in Scotland should be supported to live a longer, healthier life; acknowledges that this support can only be delivered in a person-centred manner with a well-resourced and motivated workforce; considers mental wellbeing to be a foundation for good health and good healthcare, and believes that further work is needed to break down barriers and tackle the stigma that continues to exist around mental ill-health.

Glasgow Women's Aid

The Deputy Presiding Officer (Elaine Smith): The final item of business is a members' business debate on motion S4M-07773, in the name of Sandra White, on Glasgow Women's Aid's 40th anniversary celebration. The debate will be concluded without any question being put.

Motion debated,

That the Parliament congratulates Glasgow Women's Aid, which will celebrate its 40th anniversary on 1 November 2013; commends this organisation, which provides information, support and refuge for women, children and young people who experience the many forms of domestic abuse; understands that this help can take the form of signposting to other support organisations, providing information about legal, housing and financial rights, supplying interpreting services and providing access to safe refuge accommodation; notes that it also provides a service that allows people to talk to its staff members confidentially; considers that its work with women and children, through group work and support, is hugely important in the recovery process from domestic abuse, and hopes that it, and its staff, enjoy every success in providing meaningful and lasting support to women and children across Glasgow who face some of the most challenging times in their lives.

17:03

Sandra White (Glasgow Kelvin) (SNP): It was a great privilege to secure this debate and it was also a privilege to attend Glasgow Women's Aid's 40th anniversary celebrations on Friday in St Andrew's in the Square in Glasgow, which was attended by 160 people. I say 160 people because there were two men there, so 158 women and two men attended that fantastic event.

The event had lots of things in it, including outreach and breakout participation, and music from SheBoom, which was proud and energising, and from Karine Polwart, with enduring melodies that had a powerful message. There was a wild women writing event, which had spellbinding poetry that was wonderful, inspiring and very moving. There was also a choir at the end of the event. I think that we all went home in great spirits, feeling very positive. I apologise to those whom I unfortunately do not have time to mention, but I thank everyone for their participation in a great day.

It is amazing to think how far Glasgow Women's Aid has come since its humble beginnings back in 1973, when the first refuge—a second-floor flat in the Gorbals—was handed over to Maura Butterly, a founding member of Glasgow Women's Aid. From there, weekly meetings took place with the volunteers and the women and children who were staying in the refuge. The next year, the flat next door was added, doubling the capacity, and then in 1975 a house with seven bedrooms was secured. In the same year, a parliamentary inquiry into violence in the family was launched, and that is when the issue of domestic violence became much more mainstream, with recognition that it existed and discussion about how best to tackle it.

In 1979, in response to a growing demand for information, Glasgow Women's Aid opened its first office, in the aptly named Hope Street. Now, it runs seven refuges and offers a wide range of other services. It provides information and support, supports children and young people, helps other support organisations, points people in the right direction, provides information on legal, financial and housing rights, and supplies interpreting services. It does fantastic work.

Last October, Glasgow Women's Aid and advocacy, support, safety, information services together—or ASSIST—launched the children experiencing domestic abuse recovery—or CEDAR—programme, which is a therapeutic group work programme that aims to help both women and children to come to terms with the domestic abuse they have experienced or witnessed. That highly innovative approach is, to my mind, a huge success, and I understand that funding has been secured to expand it over the next two years.

I hope that the Scottish Government will look to and learn from the CEDAR model in its approach to other forms of intervention. As has rightly been said, it is clear that using a multi-agency approach and sharing information and resources is a successful way of working and that better outcomes can be achieved for everyone.

All that cannot be achieved without the hard work and dedication of the staff. I welcome in particular Angela and Marie from Glasgow Women's Aid, who are in the public gallery tonight. I extend our heartfelt thanks for all the work that Glasgow Women's Aid and others do. As Angela has said, their innovative, creative, multi-agency approach helps them to form lasting partnerships.

Glasgow Women's Aid relies on donations to provide its services. As little as £5 helps to provide the materials for a child to take part in a children's group activity, which helps them to regain confidence and involvement with others, and £10 provides an emergency pack for women who are fleeing domestic abuse. That seems a small amount to us, but it goes a long way. Donations help Glasgow Women's Aid to provide services for the 5,000 women and children who contact it each year.

Funding is important for refuge places and outreach work with schools and young children. It is important that young children learn from an early age what domestic abuse is. Prevention is one of the most important things, and I hope that, if we have people in schools talking to young

children about domestic abuse, we can prevent it from carrying on from generation to generation. I ask the Minister for Commonwealth Games and Sport to update us, if she can, on work that is on-going in that important area, which has been raised with me and Glasgow Women's Aid on numerous occasions.

There are issues in the justice system, which I have told Glasgow Women's Aid I am happy to raise with the Cabinet Secretary for Justice. I do not expect the minister who is here tonight to address this, but there are important questions about, for example, access to children and sheriffs' interpretations of the justice system. We have to talk about those things. Perhaps I will raise them in the near future while we are looking at the Victims and Witnesses (Scotland) Bill. I give the cabinet secretary a heads-up on that.

We are all aware of the issue of domestic abuse, but we sometimes underestimate its extent. One woman in four will experience domestic abuse at some point in her life, and on average two women per week are killed by a male partner or ex-partner in the United Kingdom. In Scotland, we have, unfortunately, seen a rise in the number of reported cases of domestic abuse. That could be due in part to victims being more willing to come forward. People have said that women feel more confident about coming forward, and I hope that that is why more cases are being reported. I am sure that the support that Glasgow Women's Aid and others offer is invaluable in ensuring that those who are suffering from abuse feel that they can come forward and report it and that they will be supported.

More work needs to be done to ensure that, where there is evidence of domestic abuse, the perpetrators are brought to justice. Recently, there has been much discussion in the Parliament about the requirement for corroboration and the need for it to be reformed, with one of the chief reasons being cases of abuse. There are arguments on both sides and the issue is contentious. However, if we are to send out a clear message to those who suffer from domestic abuse and those who perpetrate it, we have to have in place appropriate, accessible mechanisms to secure convictions and reassure victims that they will be protected.

Glasgow Women's Aid and others—I note that Edinburgh Women's Aid celebrates its 40th anniversary some time this year—all do a fantastic job, for which I commend them. I look forward to the day when domestic violence and abuse are no longer tolerated in any society.

17:10

Jackie Baillie (Dumbarton) (Lab): I congratulate Sandra White on securing this debating time and on the subject of her motion. I also congratulate Glasgow Women's Aid on its 40th anniversary. Sandra was right about Edinburgh Women's Aid: one of her colleagues lodged a motion today that congratulates it on its 40th anniversary, too.

We have come a long way since those early days, but it is a matter of considerable regret that domestic abuse is very much still with us. Like many colleagues in this chamber, I have participated in many debates in which we hear people assume that domestic abuse is somehow caused by drink, drugs or stress. I am in no doubt that those factors can contribute, but let us be clear about the root cause. It is not exclusively a problem for women from poorer backgrounds; domestic abuse is not a respecter of class or income. At its root it is an abuse of power, and while men still hold more power than women in our society, unfortunately the problem will continue, as that disparity means that women are somehow viewed as having fewer rights than men. It is essential that our approach is about both challenging society's view and that imbalance of power, as well as practically helping women and their children leave abusive partners.

I remember volunteering for Strathkelvin Women's Aid a very long time ago indeed. At that point there was limited refuge accommodation, little dedicated support for the children and little follow-on support for the women themselves. The services were patchy right across Scotland. That experience has now been transformed. In Glasgow, for example, there is now practical support with benefits advice, access to lawyers, and support plans that consider emotional needs as well as practical and financial needs. There is also follow-on support to help women in new communities, so that the transition from the refuge to a new home is as smooth as possible.

Accommodation has also been transformed. Glasgow Women's Aid now offers self-contained flats, shared accommodation and satellite flats. That is a long way from its starting point, which Sandra White outlined. I well remember our £10 million capital fund to increase refuge accommodation so that wherever in Scotland someone lived, they would have access to a refuge place. I credit all successive Governments, whether Labour or the Scottish National Party, because funding has increased year on year.

We need to continue to provide that level of support, because the incidence of reported domestic abuse is increasing. I hope that that is because more women feel able to come forward and that the numbers are not increasing overall,

but we need to keep a close eye on things. Labour established domestic abuse courts in Glasgow in 2005 and there was a second pilot in Edinburgh and clusters elsewhere, but we need to be vigilant. The courts are becoming overloaded, particularly in Glasgow, and they must be afforded the capacity to deal with the volume of cases presented.

In 2012-13 there were 60,000 reported cases, which is up from 53,000 in 2008-09. Importantly, the number of cases then reported on to the Procurator Fiscal Service has risen from 51 per cent in 2003-04 to 78 per cent last year, so we see the pressure. Many of those cases—as much as 61 per cent of cases last year—involved repeat offenders, and that is the challenge.

Despite the hard-hitting advertising campaign and the success of women's aid, the need for what it does remains to this day. When we look at the figures for repeat offenders, it is evident that we need to do much more to challenge the imbalance of power, and to challenge those in the next generation who think that it is okay in certain circumstances to hit a woman. Changing attitudes and culture is of critical importance to this agenda and we absolutely need to bring renewed focus to our work, particularly with young people, to bring about that shift in a generation's attitudes. Sandra White was right to say that prevention is key.

Finally, I congratulate Glasgow Women's Aid and all the women's aid groups across Scotland. What they do is critically important but we need to look at what we can do to support them in their endeavours, and we need to increase the amount of support that we give them. Sandra White is absolutely right to say that we need to increase our focus on prevention.

17:15

James Dornan (Glasgow Cathcart) (SNP): I also start by welcoming Angela and Marie to the chamber, and I thank Sandra White for bringing the motion for debate, because it gives us the opportunity to debate and celebrate the great work that Glasgow Women's Aid has done during the past 40 years, as well as, unfortunately to look forward to its necessary and continuing role in the coming years.

As we have heard, the first refuge in Glasgow was opened in 1973 and was underpinned by an ethos that had come from the Canadian Interval House model, which is based in Toronto. Glasgow Women's Aid was set up mainly as a way of putting feminist theory into practice, and of positively affecting lives in a real and useful way.

As many of us will remember, the culture around domestic violence back then was totally different to what it is today. Domestic abuse was a behind-closed-doors issue and the police and wider society seemed to be willing to turn their heads away from it. Things were changing even then, but the pace was still glacial. It is my view that the change of attitudes that was brought about by Glasgow Women's Aid and the wider Scottish Women's Aid movement was its most effective work. Without the pioneering work of women's aid groups, I doubt very much that Scottish society would have progressed as far as it has in terms of seeing abuse of all kinds as being simply unacceptable.

I was astounded to learn that the Glasgow and Edinburgh centres were open for almost a decade before spousal rape was made illegal in Scotland, and that it would be a further 10 years before it was made illegal in England. Against the backdrop of spousal rape then still being legal, it is no great surprise that when Glasgow Women's Aid started, it was assumed by many—mostly males, I suspect—that the women who were involved just hated men and wanted to break up families, to ruin men's lives, and to turn women against them. Although there was some support from the social work department, there was also unease among some social workers who, in the words of one of the contributors to the documentary that was made by Scottish Women's Aid about its history, saw it all as "a bit odd".

Of course, we now know that the work that Glasgow Women's Aid has done is not "odd"; rather, it has been integral to our understanding of what domestic abuse actually is and how we can deal with it. As well as the fantastic assistance that women's aid groups give to individual women and the families who come to them, Glasgow Women's Aid has become the model that other organisations across Glasgow and, I am sure in the wider country, work to. It is clear that although the refuge part of the work that Glasgow Woman's Aid does is important, the support network that it offers is just as crucial.

I was delighted to hear Sandra White mention CEDAR. I have met CEDAR a couple of times and have a member's business debate scheduled for later this year or early next year on its behalf, in order to congratulate it on the good work that is doing and its good practice.

Testimony from the countless women and children who have been helped over the years by Glasgow Women's Aid shows that its support has been integral to their recovery. It is clear that domestic violence can happen to any woman, at any time, in any part of Glasgow, at any age, and in any social class. The common thread that runs through all the women who have been helped by Glasgow Women's Aid is their shared experience. Being able to talk things through in a supportive and understanding environment, and getting help

to get a new job or a new home has allowed them to move forward with their lives.

The Glasgow Women's Aid model is now used across Glasgow, with Women Against Violence, and the domestic abuse project that is based in Castlemilk in my constituency, which offers help and support to women and children who have fled domestic abuse. The Jeely Piece Club offers a play strategy to assist children who have difficult, chaotic and stressful home lives. The local housing associations also try to act sensitively when issues of domestic abuse are raised, and they do what they can to ensure that women and children are housed appropriately. Although all those organisations are crucial, on my visit to Glasgow Woman's Aid I was delighted to hear about its aim to expand its work in the south of Glasgow. As I made clear at the time, I am keen to help where I can to ensure that that expansion comes to fruition.

Unfortunately, although the work of Glasgow Women's Aid has helped countless women and children, we are not yet free of the scourge of domestic abuse. Attitudes are changing, but we still have a way to go with the message that the person who is being abused is never to blame for the abuse, regardless of whether they are drunk or have consented before. There is still a role for Women's Aid educational outreach programs to ensure that the "The abused is not to blame" mantra is reinforced to young adults, because recent research shows that some young people continue to find certain forms of abusive behaviour acceptable within relationships. That attitude clearly needs to be challenged through education; curriculum for excellence offers an avenue for that to be explored.

Once again, I thank Glasgow Women's Aid for all the work that it has done. I look forward to seeing it expand its services into the south-east of Glasgow and I will help in whatever way I can.

The Deputy Presiding Officer: Thank you. I would be grateful if members could stick to their four minutes—that will allow me to take everyone. I call Alex Johnstone.

17:20

Alex Johnstone (North East Scotland) (Con): Having heard from the opening speech that only two men turned up at the commemorative event to celebrate the 40th anniversary of Glasgow Women's Aid, I am keen that as many men as possible participate in the debate, and am glad that I am able to be one of them.

I am not a signatory to the motion—it is part of my party's practice to ensure that we have someone come forward to speak in every members' debate and I was delegated to do so, but it is a pleasure to do so and it is a pleasure to be able to congratulate Glasgow Women's Aid on its 40th anniversary. If only it were not necessary—but it is such a vital service. I remember hearing about Glasgow Women's Aid when it was first established in the 1970s and I am delighted to have learned more about it during the course of the debate.

One of the things that impresses me most about it is the fact that it is essentially a self-help approach to a particular domestic abuse problem, so I am delighted that it is an example of organisation that has allowed women to take control of their own lives and which has allowed them to build their self-confidence and security after such desperately disastrous domestic situations as domestic abuse have been allowed to take place.

I also want to talk about the rise in reported domestic abuse that we appear to be experiencing, which has been mentioned already. Like other members, I hope that it is a result of an increase in the willingness of individuals to report crime. I believe that we have seen a substantial change as regards the willingness of police and the justice system to be involved in domestic abuse issues. I hope that there is, as a consequence, more faith in the law and greater willingness among victims to come forward.

However, I believe that the key is the fact that the Women's Aid approach is a self-help approach. Although there is much that we can do to encourage the justice system to work with victims of domestic violence and to ensure that justice is achieved, it is also important to encourage that self-help element.

I believe that although we have the opportunity to support such organisations in a number of ways, it is essential that they retain their autonomous status, because only by allowing individuals who have become victims of domestic violence to build their confidence and to regain their independence can we ever hope to ensure that we return them to a stable and predictable form of existence.

I believe that Glasgow Women's Aid has set an example, which was copied very quickly in Edinburgh and has continued to be copied around the country. It is sad that we continue to require the support of organisations such as Glasgow Women's Aid for women who have become victims of domestic abuse, so I hope that we can, with the aid of all the parties in the chamber, continue to progress towards a situation where we can give more confidence to women and children who have become the victims of abuse, and that we may avoid that in the future.

17:23

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I, too, congratulate Sandra White on bringing this important motion to the chamber, and I join her in paying tribute to all the superb and—sadly—much-needed work that Glasgow Women's Aid has been doing for the past 40 years.

I was struck by a statement on Glasgow Women's Aid's website:

"Abuse is a violation of your human rights. You are entitled to live your life free from abuse. It is not your fault."

That is a clear and straightforward statement that is beyond dispute, as I am sure we all agree, but it was not so long ago when that would not have been a statement that was widely accepted by society. I think that there was a turning point 40 years ago. As it happens, Edinburgh Women's Aid was started at more or less the same time. I think that there is a bit of a dispute about which one started first; in fact, Edinburgh Women's Aid claims that prize, but I will not get involved in that debate this afternoon. It was an important turning point and, of course, it was not an accident that both groups were established at the same time because both grew out of the strong and growing feminist movement of the time.

Obviously, it is important that men have joined the campaign and are now an important part of it but—let us be realistic—it was women who brought the issue out of the shadows and, crucially, placed it within the context of unequal gender relations within society.

Our understanding of domestic violence has changed, but, as Sandra White reminded us, Glasgow Women's Aid still receives, sadly, 5,000 contacts each year. That reminds us that domestic abuse is still a massive problem, which is why the prevention work that Glasgow Women's Aid is doing in schools is important. However, the centre is most noted for the various kinds of support that it provides, including its refuge accommodation. We should certainly pay tribute to that superb work as well as to its multi-agency approach, which has already been mentioned.

I do not know all the detail of what happens on the ground in Glasgow, although I was pleased to visit some of the projects and initiatives a few years ago, but I remember that in the debate that I held on zero tolerance earlier this year, Anne McTaggart talked about a women's aid centre in Drumchapel that is open 24/7. I vividly remember her description of that. Clearly, there are a broad range of important domestic abuse services in Glasgow, with Glasgow Women's Aid very much heading them up.

I should not really talk about Edinburgh Women's Aid—I am pleased that Marco Biagi has lodged a motion on it, so perhaps it will be up for debate soon—but, among other things, Edinburgh Women's Aid provides the support service for the Edinburgh domestic abuse court. As Jackie Baillie mentioned, there have been problems in the Glasgow domestic abuse court, which was a great initiative that I remember well from when it started some time ago. If, in winding up the debate, the minister could say something about that and offer further support for the ASSIST service, that would be welcome.

In my remaining minute, I want to talk about Glasgow Women's Aid's services for children, which have been supported by the current Scottish Government as well as by previous Administrations. It is important to recognise that children and young people are also in need of support and refuge. I was struck by the animated video on the website that explains, through the eyes of a child, both what the real, lived experience of domestic abuse is and how young people can seek help. The ultimate goal, of course, is to ensure that young people have the necessary information and are given the tools to seek support whenever they feel capable.

As my time is up, I will mention that I agree with the motion that the Parliament wishes Glasgow Women's Aid every success for the future, but I am sure that all members will join me in sincerely hoping that Scotland's women and children will need such services less in the future. Once again, I congratulate Sandra White on lodging the motion, which I whole-heartedly support, and I say thanks from all of us to Glasgow Women's Aid.

17:28

Stewart Maxwell (West Scotland) (SNP): Like others, I begin by congratulating Sandra White on securing this important debate.

Domestic abuse can happen to anyone at any time—young or old, male or female, rich or poor, gay or straight. Some victims may not even realise that it is happening to them, because they are trapped in a controlling and abusive relationship, in which they live in fear and intimidation with no real idea of how to break free. At this point, I will say that I agree very much with Jackie Baillie that domestic abuse is, at its heart, an abuse of power. That is why organisations such as Glasgow Women's Aid are so important, and that is why it is worth celebrating the invaluable advice and support that it has offered to women, children and young people over the past 40 years.

I was delighted to be invited along to the 40th anniversary celebration at St Andrews in the Square in Glasgow last Friday, so it was with much regret that I was unable to attend. I should explain that I was unwell, but I would have been the third man there if I could have managed it. I

apologise for my absence—I had thought that it would have gone unnoticed, but there were only two men there, so perhaps it was noticed. I am grateful to have the opportunity to speak in this evening's debate and to pay tribute to the fantastic work that is carried out by Glasgow Women's Aid.

During the summer, I had the chance to visit the Glasgow Women's Aid offices in Bell Street. I met the chair of the GWA board, Jennifer Cairns, and the manager, Angela Devine, to discuss the support and refuge services that the service offers to victims of domestic abuse in Glasgow and West Scotland.

I was particularly impressed with GWA's children and young people service and its ambitions to improve links in the community through an outreach service in local schools. That is a reminder that not only adults are affected by domestic abuse. Such projects help to change the attitudes of young people and raise awareness that support and advice is available.

Back in 2008, as the then Minister for Communities and Sport, I helped to launch the national domestic abuse delivery plan, which was an approach to tackling domestic abuse that was informed by the experiences of children and young people who had witnessed, or who had been part of, abusive relationships. Since then, the Scottish Government has continued to make tackling violence against women a national priority and has committed to supporting the work of organisations such as Glasgow Women's Aid.

Since 2007, the Scottish Government funding that is allocated to combat violence against women has increased by 62 per cent, with £34.5 million of investment committed between 2012 and 2015. It is a credit to the Parliament that the issue has cross-party support and that the political make-up of Governments has been of no relevance whatever; the attempts to tackle domestic abuse have been supported by all parties.

The Forced Marriage etc (Protection and Jurisdiction) (Scotland) Act 2011 and the Domestic Abuse (Scotland) Act 2011 are two important pieces of legislation that have helped to improve outcomes for victims of domestic abuse. However, domestic violence and abuse continue to blight the lives of too many women, families, children and communities in Scotland. There is no place in Scotland for violence against women, and I am confident that the Scottish Government's new national violence against women strategy will help to move us another step closer to protecting women and children from all forms of violence.

The Cabinet Secretary for Justice has continued to highlight the need to modernise Scotland's criminal justice system to ensure that it better serves victims of rape and domestic violence. I accept that ending the absolute requirement for corroboration in criminal cases is controversial, as Sandra White mentioned, but I tend to share the view of Scottish Women's Aid and Victim Support Scotland that, on balance, it is the right step. We must do all that we can to give victims the confidence to come forward and engage with the criminal justice system. In the past, too many have suffered in silence, behind closed doors.

The appointment of Anne Marie Hicks as specialist procurator fiscal for domestic abuse is also welcome. She brings a wealth of experience to the role, having led the Crown Office's domestic abuse unit in Glasgow after spending a number of years working as a prosecutor in the west of Scotland. Anne Marie is committed to ensuring a robust prosecution policy that supports victims and brings perpetrators to justice.

I conclude by paying tribute to the many staff, volunteers, supporters and fundraisers who have contributed over the past 40 years to making Glasgow Women's Aid the organisation that it is today. As it advocates a multi-agency approach to tackling domestic violence, it would be remiss of me not to mention the partner organisations. Rape Crisis Scotland, Children 1st, White Ribbon Scotland, Barnardo's Scotland, Zero Tolerance, the Scottish Refugee Council and many more support organisations work tirelessly to help to address domestic violence. I am grateful to Glasgow Women's Aid for all its work over the past 40 years. I look forward to seeing it continue to go from strength to strength in the years ahead—while, unfortunately, it is still needed.

17:32

Claudia Beamish (South Scotland) (Lab): I, too, am glad to speak in the debate and to congratulate Glasgow Women's Aid on its 40th anniversary. I thank Sandra White for holding the debate. As we have heard, Glasgow Women's Aid has done groundbreaking work over the past 40 years in tackling an extremely sensitive issue with great care and diligence. I was especially interested to hear about the early history from Sandra White.

Although a great deal of work has been done in recent years to address domestic abuse, unfortunately, there is still a long way to go, as we have heard. It is simply unacceptable in this day and age for people, especially women and children, to be subjected to such disgraceful treatment in their homes. It is a human rights issue and an abuse of power, usually by males. It is vital that organisations such as Glasgow Women's Aid exist to support women through their ordeals.

It is crucial that we continue to raise awareness of zero tolerance of domestic abuse in Scotland. For many years, the issue was not even talked about and, frankly, in some cases, it was accepted as part of life for women. Given that, I am encouraged that Glasgow Women's Aid has taken a number of initiatives to raise awareness.

Domestic violence is not confined to our cities—it is also a rural issue. As Jackie Baillie stressed, it is an abuse of power by men, and I emphasise that it is a gender issue. It knows no boundaries. I worry about the isolation that victims in rural Scotland might feel, so I was heartened when I was recently asked by Police Scotland to open an awareness-raising event in my local town of Lanark. The event was an interagency morning that took the form of stalls from a wide range of relevant support agencies and was held on a wide walkway between the entrance, cafe and changing rooms of the South Lanarkshire Lifestyles Lanark leisure centre. Many people came through—men, women and children—just in that morning. The message was clear: nobody needs to suffer in silence.

Having looked at Glasgow Women's Aid's excellent website and through recent contact with its staff, I am clear that awareness raising is an integral part of its work. It uses avenues such as social media and preventative work in schools, about which we have heard from other members. Internet and phone access is important in rural Scotland, including in the South Scotland region, which I represent.

Through its child exploitation and online protection team, Glasgow Women's Aid has been able to hold support sessions. Its children's outreach team has been doing fantastic work teaching primaries 5, 6 and 7—the stage at which domestic abuse should be talked about.

Stewart Maxwell stressed the importance of education. In an ideal world, Glasgow Women's Aid would like to expand its work to include the training of teachers but, unfortunately, it has not received adequate funding from the Scottish Government to support that. Might the minister comment on that at the end of the debate?

Concerns have been raised at the cross-party group on men's violence against women and children—of which I am a deputy convener—about teenage perceptions of domestic abuse. Studies such as the recent one by the University of Manchester suggest that young girls can often have a skewed view of what is acceptable behaviour with regard to domestic abuse and that it is not treated with the seriousness that it demands. White Ribbon Scotland highlights the point that one teenage girl in three who is in a relationship suffers an unwanted sexual act. There is also evidence to show that some girls think that a slap does not matter, but it jolly well does.

At the CPG, we heard from young people who were working with Police Scotland's violence reduction unit on peer mentoring in Portobello high school—apologies to Glasgow—and the wider community. I was most impressed by hearing from the young people themselves about peer group work that they are doing to help other young people to analyse and come to terms with their behaviour themselves and agree on what is, and is not, acceptable. I hope that similar mentoring initiatives, which are also happening in Glasgow, can be introduced throughout Scotland, including rural Scotland.

Let us be sure that we provide Scottish Women's Aid and groups throughout Scotland with enough funding to support the work with the next generation so that we really can remove domestic abuse from our shores.

The Deputy Presiding Officer: Finally, a brief contribution from Drew Smith.

17:37

Drew Smith (Glasgow) (Lab): More often than the external impression might be, we have consensual debates in the chamber, but it is still rare for us to have a debate in which it is possible to say that we have agreed with every single word that every other member said. That will allow me to be brief, Presiding Officer, and not repeat too many of the points that have already been made.

I thank Stewart Maxwell for his confession about not being able to attend the 40th anniversary celebration event. I was in a similar boat myself and was hugely disappointed not to go. I am hugely embarrassed to have to confess that in front of three Labour colleagues who do an awful lot of work on the issue.

I agree with what Sandra White said about Glasgow Women's Aid because, like Stewart Maxwell, I had the opportunity to visit its premises earlier in the year and discuss more of the day-to-day work that it does. I congratulate her on securing the debate and ensuring that the Parliament has the opportunity to congratulate everyone involved with Glasgow Women's Aid.

I do not want to repeat the points that others have made, but simply to agree with, and reinforce, what Jackie Baillie said about the issue representing a power abuse. It is an issue of gender relationships, gender roles and, ultimately, gender violence.

The debate offers us an opportunity to reflect on how far we have come since the establishment of women's refuges throughout the country. We have made huge progress. We no longer regard an

incident as being "a domestic" and, therefore, something that does not concern the rest of us.

As Sandra White said, 5,000 women and children still in contact with the service is a huge number, so we should not pat ourselves on the back too much that the work is finished.

However, there is a positive here that we can aim for, because there is another side to the issue. Stewart Maxwell and others touched on that aspect in relation to other crimes, particularly of sexual violence, where it remains a big job for us to challenge and change attitudes. I am talking about what young people—and others—say about non-domestic relationships between men and women, and the view that when a sexual crime is committed against a woman, it is possible that the victim is to blame for it. Jackie Baillie mentioned a few of the contributory factors, which include things as simple as the perception that the way in which someone is dressed gives people—predominantly men—the right to make judgments about them and therefore to commit behaviours that in any other circumstance would be beyond them. There is a story in what we have achieved through Scottish Women's Aid, which should influence how we deal with that wider issue in society.

I congratulate Glasgow Women's Aid on everything that it has achieved and look forward to the minister saying a bit more about the wider policy work that is going on. We sometimes get debates in which we celebrate the anniversaries of great things that are going on, and I hope that we get further such opportunities during this session of Parliament. Given the minister's appointment, I am sure that she will be keen to debate these policy issues, and any associated issues, for other women's organisations.

17:41

The Minister for Commonwealth Games and Sport (Shona Robison): First, I congratulate Sandra White on securing this hugely important debate and welcome Angela and Marie from Glasgow Women's Aid to the public gallery. It is absolutely right that Parliament should join in celebrating the 40th anniversary of Glasgow Women's Aid and the huge contribution that it has made over the past four decades in supporting women, children and young people who are experiencing domestic abuse. I am in no doubt that its tenacity and support have given strength to many women who have been victims of domestic abuse.

On Friday, I had the pleasure of speaking at Glasgow Women's Aid's 40th anniversary event, which Sandra White also attended. I do not say that to make Drew Smith and Stewart Maxwell feel any worse. It was a fantastic event, and whether or not they were there, the support in this place, and among many men, for the work of Women's Aid is well appreciated and understood.

I had the pleasure of speaking to Maura Butterly who, in 1973, was one of the pioneers in the establishment of Glasgow Women's Aid. She is such a modest woman that she did not want to be in the limelight at all. Maybe that is the mark of the woman. She did all that work, having come back from America with the concept of refuge. As Sandra White laid out, she got on to Glasgow Corporation, which was initially loth to accede to her demands. However, she is a tenacious lady and eventually she got the support to develop the first refuge, which was a fairly small and basic flat. From small acorns, many important things have emerged.

In my address last Friday, I read out a quote from a friend of a woman who had been helped by Glasgow Women's Aid. It said:

> "I want to thank Women's Aid for helping my friend today, you have helped to save her life, thank you so much, your organisation is amazing".

That really sums up how important Glasgow Women's Aid is—it literally saves lives.

From those small acorns, it has grown to provide a huge number of family spaces in the seven refuge bases throughout Glasgow. It employs 35 workers, who work with children and do outreach work, and family resource workers. It provides a huge amount of support.

As Sandra White laid out, the number of women who seek Women's Aid's support is huge. Its services are unfortunately very much in demand. I suppose that the flip-side of that is that, as members have said, part of the reason for the rise in demand for services is that women are feeling more confident about coming forward. That is welcome, but it is a sad reflection on our society that we still have huge challenges in dealing with this issue. I am very grateful to Glasgow Women's Aid for being there for those women and children at one of the most difficult times of their lives.

As a nation we have made a journey since the early 1970s. It is undeniable that in the field of women's rights a great deal of progress has been made. In 1975, the Sex Discrimination Act made it illegal to discriminate against women at work, although there are still many issues for women at work. Statutory maternity provision was introduced and it was made illegal to sack a woman because she was pregnant. Reference has been made to the law of no defence in respect of rape in marriage. At all those points in history, important things have been won by women. We should remember that women were at the vanguard of all those battles—many of them were battles indeed.

We have a lot of work still to do. Violence against women continues to be perpetrated. Girls and women around the globe face it on a daily and unrelenting basis. In Scotland, women, children and young people are still suffering domestic abuse.

The way in which violence is being perpetrated has changed and is changing. Earlier this week I spoke at an event organised by the Women's Support Project and Rape Crisis Scotland about the sexualisation of culture and its impact on the relationships that our children and young people form. We know about issues such as sexting, sexual exploitation and online bullying, all of which underpin the power base and values within our society.

One of the things that we are taking forward with the Convention of Scottish Local Authorities and others is the development of a strategy for Scotland to tackle violence against women. That will include domestic abuse but will capture many of those other important issues as well. The strategy will be the first such document in Scotland and will shape the way in which we tackle violence against women in the years ahead. We will consult on it in early 2014, which might be the opportunity that Drew Smith talked about to have a wider debate.

We will also continue to recognise the need and demand for intervention services that provide support for women, children and young people who are experiencing domestic abuse and other forms of violence. We will continue to work with men who use violence through, for example, the Caledonian project to change behaviours and challenge violent men, which is important.

Our strategy will reinforce the links between all forms of violence against women, from domestic abuse, rape and sexual assault to honour-based violence and commercial sexual exploitation. It will emphasise the need for an increased focus on prevention and early intervention.

I reassure Sandra White and Jackie Baillie that Police Scotland has made domestic violence one of its top three priorities and there will be a real focus on repeat offenders, which is important.

I say to Malcolm Chisholm that ASSIST has been a really important partnership because of the intelligence sharing about where these men are and what they are doing. That is hugely important. We are funding a roll-out of the ASSIST programme.

It has been said, quite rightly, that we know that violence against women is rooted in gender inequality and the imbalance of power between men and women in our society. This afternoon I spoke at the women on board conference, which looked at the barriers to women's representation on Scotland's public boards. Why does that matter? It matters because it is about reducing and eventually eradicating the inequality in our society. It is that inequality and power imbalance that provide the breeding ground for attitudes towards women that can lead to violence against women. We must look at that in the round.

Let me leave members in no doubt that the Government is absolutely committed not only to ensuring that domestic abuse and violence against women are consigned to the past, but to achieving equality between men and women in our society.

Meeting closed at 17:50.

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