The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Thursday 19 March 2015

Session 4

Thursday 19 March 2015

CONTENTS

Scottish Parliament

Thursday 19 March 2015

[The Presiding Officer opened the meeting at 11:40]

General Question Time

Scottish Medicines Consortium (Drug Appraisal Process)

1. Jayne Baxter (Mid Scotland and Fife) (Lab): To ask the Scottish Government what its assessment is of the effectiveness of the reformed Scottish Medicines Consortium drug appraisal process and whether it considers that further reform is required. (S4O-04144)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Positive progress has been made by the Scottish Medicines Consortium. The Scottish Government has been monitoring the changes very closely, and we have said that we will now review how the changes are working and are open to considering any further steps that can be taken.

Jayne Baxter: Last month, the SMC rejected the use of abiraterone before chemotherapy in NHS Scotland. That was despite emphatic support from clinicians, who described the treatment as "a paradigm shift", and from patients, who told Prostate Cancer UK that they would feel "cheated", "dismayed", "marginalised" and "abandoned" in the event of SMC rejection of the drug. Now that the SMC has rejected the drug, can the cabinet secretary confirm her understanding of why the drug was rejected and what steps are being taken to revisit a decision that Prostate Cancer UK has called

"an intolerable blow to hundreds of men with incurable prostate cancer"?

Shona Robison: The first decisions under the new arrangements were made between October last year and March this year. Of the decisions on the 15 medicines that were considered under the new processes, 10 were positive and five were negative.

The Scottish Government absolutely recognises that patients and their representatives will be very disappointed by the decision on abiraterone. There is a clear demand for the drug, and around 100 patients in Scotland are already on this treatment through the reformed individual patient treatment request system. We have encouraged the Scottish Medicines Consortium and the manufacturer to find a resolution as soon as possible. We will keep the member informed on that.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): The cabinet secretary will be aware that the IPTR system was supposed to end in May 2014 and PACS—the peer approved clinical system—was to come into force then. I have an email regarding a constituent's case from NHS Lothian that says, "Thank you for your IPTR." I thought that the use of IPTR had ended. Can the cabinet secretary clarify the status of PACS?

Shona Robison: We have decided to carefully pilot the introduction of PACS. That is to ensure that there are no unintended consequences of reducing the increased access to medicines that is being seen at the moment. The current approach has seen hundreds more patients in Scotland accessing treatments as a result of the changes that were made last year.

Guidance is due to be issued this month to begin piloting from April. We are going to carefully monitor the situation together with the decisions being made by the Scottish Medicines Consortium under its new approach. In the longer term, as more and more decisions are made by the Scottish Medicines Consortium, the reliance on individual requests will be reduced.

Physical Activity (Teenage Girls)

2. Rhoda Grant (Highlands and Islands) (Lab): To ask the Scottish Government what it is doing to encourage teenage girls to become and remain more active. (S4O-04145)

The Minister for Sport, Health Improvement and Mental Health (Jamie Hepburn): Increasing the number of girls meeting recommended levels of physical activity is a priority for the Scottish Government. That is why we invest £500,000 annually through sportscotland in the active girls programme to increase girls' and young women's participation in physical education, sport and physical activity.

In addition, between 2007 and 2019, Scotland will have invested some £130 million in the active schools network, which increases the number of good-quality opportunities for children and young people to get active. The healthy living survey results from 2014 confirm that, with the help of investment from sportscotland and Education Scotland, 96 per cent of schools were meeting the target level of PE provision, which is up from below 10 per cent in 2004-05.

Rhoda Grant: The minister will be aware that a lot of young women drop out of physical activity. Does he agree that schools need to offer physical activity that attracts young women? We also need to develop role models to encourage them to take part. However, women in sport tend to be stereotyped when they are being interviewed and

talked about in the media. The focus falls on their looks and their relationships rather than their contribution to physical activity. What is the Scottish Government doing to influence schools to ensure that they offer physical activity in a way that is attractive to young women, and to address the sexist coverage of women in sport?

Jamie Hepburn: I recognise the points that Rhoda Grant makes. We understand that there is an issue with the levels of physical activity of teenage girls as opposed to teenage boys. I agree with her that we must offer physical activity opportunities that young girls will engage with. I have seen first hand that that happens in many locations across the country, and we should see that rolled out elsewhere.

I also agree with Rhoda Grant's point about the public perception of women in sport. We know that sports media coverage heavily favours men. For every 53 articles written about male sporting stars, there is just one penned about women. We need to ensure that we see better and more equitable coverage, although there is obviously a limit to what the Government can do in that regard. Part of the work of the women in sport working group, which reported last year, concerned women in the media, and sportscotland is taking forward the work of that group through its equalities group, which reports to the sportscotland board.

South Glasgow University Hospital (Dermatology)

3. Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): To ask the Scottish Government how many dermatology in-patient beds will be available at the new south Glasgow university hospital. (S4O-04146)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Six in-patient dermatology beds are currently planned for the south Glasgow university hospital. However, after operating at that revised level for two months, the service will undertake a review to consider the impact on service provision and waiting times for planned admissions. Once that review has been completed, a final decision will be taken on the bed numbers.

Patricia Ferguson: I am surprised to hear that a review will take place after a cut in the number of dermatology beds, because Greater Glasgow and Clyde NHS Board has told me that the dermatology in-patient beds currently have an 81 per cent occupancy rate, which means that the new south Glasgow university hospital will see a cut of 57 per cent in the number of beds available, from 14 to six, as the cabinet secretary said. Can she reassure my constituents whose treatment plans require them to be treated as in-patients that that will continue, in spite of the large reduction in the number of beds in that specialty?

Shona Robison: Medical advances, more effective treatments and the increased use of out-patient treatments have dramatically reduced the need for in-patient beds in dermatology. As a result, we have seen across Scotland a dramatic decrease in the number of dermatology beds required. Importantly, the dermatology service in Glasgow has received additional funding for four additional nurse specialist posts to support an increased day-patient and out-patient service, and the development of the day-patient and out-patient service will mean that there is less reliance on in-patient beds. The ward has a dedicated day treatment area, which will allow many patients to attend for treatment and return to their homes rather than being admitted, but I appreciate that in-patient care and treatment will still be required for a number of patients. The board will make its final decision on the number of appropriate beds after the two-month review and, if six is not adequate, more beds will be provided.

"Beef 2020 Report"

4. Alex Fergusson (Galloway and West Dumfries) (Con): To ask the Scottish Government when it will implement the recommendations of the "Beef 2020 Report". (S4O-04147)

The Cabinet Secretary for Rural Affairs, Food and Environment (Richard Lochhead): We plan to publish our response to the recommendations of the "Beef 2020 Report" next Friday.

Alex Fergusson: It is amazing how a well-timed parliamentary question can bring about a response like that.

I am sure that the cabinet secretary does not need me to tell him that the beef sector faces a particularly uncertain future under the common agricultural policy reforms and that it is not being done any favours by the continuing lack of detail from his department on many aspects of the reforms or on the apparent inability of the new information technology system to cope with the demands that are being made of it.

The recommendations of the "Beef 2020 Report", which the cabinet secretary commissioned and warmly welcomed when it was published last August, could give a much-needed boost to the sector's confidence. One of the principal recommendations was that a full electronic identification system for cattle be implemented by 2016. If that is to be done, it surely needs to be put under way now. Has it been done? If not, why not? If it has not been started, what is stopping him?

Richard Lochhead: I like the idea that I timetabled the announcement for next Friday

because of the parliamentary question from Alex Fergusson, but I am afraid that that is not true.

Alex Fergusson raises a number of issues. The "Beef 2020 Report" is very important to the future of the beef sector in Scotland. As he is aware, some of the recommendations for the Scottish Government—not all of them are for the Government, as some of them are for the red meat sector itself—require discussion with the European Commission. As he is also aware, those discussions are sometimes tricky and take time. However, we are now confident that we can make a number of announcements next week, as I have indicated.

On the IT system, Alex Fergusson will know that we have a particularly complex common agricultural policy to implement this year. All Administrations are facing similar challenges to those that are faced by the Scottish Government. The good news is that our IT system for filling in the single application forms opened this week. There may well be teething problems during these first few days of the system, but they will be sorted as quickly as possible. There are many advantages to the online system that did not exist before.

Along with many other members of the Parliament and representatives of the wider industry, Alex Fergusson asked for many of the additional complexities that are characteristic of the new common agricultural policy, to ensure that it was suited to Scottish circumstances. We have a complex policy to implement, but we are going to implement it and it will make a positive difference to Scottish agriculture.

Aberdeen City Region Deal Bid

5. Richard Baker (North East Scotland) (Lab): To ask the Scottish Government what discussions it has had with Aberdeen City and Aberdeenshire councils on the Aberdeen city region deal bid and what assistance it will provide to support the bid. (S4O-04148)

The Cabinet Secretary for Infrastructure, Investment and Cities (Keith Brown): I refer the member to the answer that I gave to Lewis Macdonald's question S4O-04104 during portfolio question time on Wednesday 11 March, in which I highlighted:

"We are working with Aberdeen City Council and Aberdeenshire Council to establish the detail of what a city deal for their region is intended to deliver."—[*Official Report*, 11 March 2015; c 10.]

Richard Baker: Given the announcement by the United Kingdom Government yesterday that it will start negotiations now on an Aberdeen city region deal, does the cabinet secretary recognise that a clear statement from the Scottish Government that it supports the deal in principle will be vital to its success? Will he give that clear indication today?

Does the cabinet secretary agree that the Scottish Government must stand ready to provide financial support for the deal, along with the UK Government and the local authorities?

Keith Brown: I have made that support clear to Aberdeen City Council by writing directly to its leader, who had written to us previously. I also met the leader of Aberdeen City Council yesterday at the Scottish cities alliance. We have made it clear that we are more than happy to work with Aberdeen City and Aberdeenshire councils.

This all comes on the back of substantial investment in the north-east: the £187 million investment in transport infrastructure; the construction that has started on the Aberdeen western peripheral route, with £745 million-worth of investment; the £3 billion of investment in the A96 Aberdeen to Inverness road; and the £407 million of health infrastructure investment since 2007. We have a track record of providing infrastructure in the area, and we are more than happy to work with our colleagues in Aberdeen City Council and Aberdeenshire Council to see what more we can do in terms of a city region deal.

Alison McInnes (North East Scotland) (LD): I am sure that the cabinet secretary agrees with me that a city region deal could help the region to remain competitive. To drive that forward and to ensure that momentum is not lost, will he ensure that, following the announcement yesterday, his civil servants and Government agencies put themselves at the disposal of the team that is developing the detail of the bid?

Keith Brown: I can confirm that civil servants have already been engaging with Aberdeen City Council. That will continue as we work our way through the bid. We received the bid itself around 10 days ago. There is quite a lot in it, but that continual support from Scottish Government civil servants and other Government-related bodies will be assured as we go forward.

Homelessness (Benefit Sanctions)

6. Nigel Don (Angus North and Mearns) (SNP): To ask the Scottish Government what its response is to the Crisis report "Benefit sanctions and homelessness: a scoping report". (S4O-04149)

The Minister for Housing and Welfare (Margaret Burgess): The report contains yet more evidence that the current sanctions regime is not working and emerging evidence that sanctions may increase the risk of homelessness, potentially undermining the substantial progress that we have

made in tackling homelessness in Scotland in recent years. We have long made our concerns clear that sanctions are unfair, punitive and do nothing to help people who are already struggling to cope.

The Scottish Government is doing what it can with the resources and powers that it has to help those who are affected. That includes investing about £296 million from 2013-14 to 2015-16 to limit the damage caused by the United Kingdom Government's reforms. We cannot fully mitigate all the effects of the welfare changes, but we will continue to make the argument for a fairer welfare system.

Nigel Don: Does the minister share my concerns not only that the welfare reforms are very damaging to folk in Scotland but that the level of sanctions appears to be higher in different areas, including, in particular, areas of Aberdeenshire in my constituency?

Margaret Burgess: I share the member's concerns. The Crisis report indicates that there are discrepancies across the country in how sanctions are being applied, and it illustrates that their application is not determined by the economic geography of the area, the strength of its labour market or even whether it is urban or rural. That suggests that the Department for Work and Pensions is not consistent in applying sanctions and further confirms that the system is unfair and unjust.

As we have made clear, sanctions are causing hardship to many people in Scotland who are in difficult circumstances and who often have to turn to food banks for help. The sanctions system should be changed and replaced with a system that is fairer and which helps people, rather than punishing them.

Oil and Gas Analytical Bulletin

7. Annabel Goldie (West Scotland) (Con): To ask the Scottish Government what plans it has to publish an oil and gas analytical bulletin. (S4O-04150)

The Deputy First Minister and Cabinet Secretary for Finance, Constitution and Economy (John Swinney): The Scottish Government will publish an oil and gas bulletin once we have completed our analysis of the changes made in the United Kingdom budget and assessed their implications for investment and production.

Annabel Goldie: Some perspective helps here. The Scottish Government's white paper estimated oil and gas revenues over the next four years at £27.5 billion. In May last year, the Scottish Government boosted that to more than £28 billion. Meanwhile, it mocked the Office for Budget Responsibility's initial estimate for the four years of £14 billion, which yesterday was further revised down to £5 billion.

Surely now is the time for the Scottish Government to show some contrition and humility, given the plunge in oil prices, and to bring forward a new, more realistic assessment of oil and gas revenues—or is that too embarrassing?

John Swinney: I say to Ms Goldie—I thought that I had covered it in my original answer—that the Government will consider the changes made in the UK budget yesterday, which will have an effect on the revenues that can be realised because of their significance. Of course, they reverse decisions that the chancellor put in place in the first place, in 2011, which have contributed to the difficulties that the sector faces.

The Government will consider all those issues. We will ensure that the analysis is undertaken effectively and we will assess the implications of the changes for investment and production and publish a bulletin accordingly.

Cancer Treatment Referral Waiting Times (NHS Fife)

8. Cara Hilton (Dunfermline) (Lab): To ask the Scottish Government what action it is taking to reduce cancer treatment referral waiting times for NHS Fife patients. (S4O-04151)

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Our cancer delivery team is working with NHS Fife to support performance recovery. A performance recovery action plan has been developed and progress against actions is regularly monitored and updated. The plan includes the allocation of more than £103,000 through cancer modernisation funds and more than £400,000 through the detect cancer early programme in 2014-15 to support diagnostic capacity and cancer services in NHS Fife.

Cara Hilton: I was recently contacted by a constituent who has been diagnosed with lung cancer. She was referred to the Western general hospital for radiotherapy and chemotherapy, and was told that she would get an appointment within two weeks, yet after six weeks she had heard nothing. She contacted her general practitioner, who discovered that the consultant she had been referred to was on long-term sick leave, so no action had been taken to schedule her appointment.

Will the cabinet secretary take action to improve the referral process for cancer treatment in the NHS to avoid such situations? Right now, it not only seems that NHS patients in Fife have the second-longest waiting times in Scotland for treatment, but it looks like lives are being put at

risk due to inadequate administrative arrangements.

Shona Robison: I will look into the specific case that Cara Hilton raises and write to her.

On the 31-day target, NHS Fife has performed at 96.1 per cent. Although improvements have to be made, we should recognise that level of performance. There are issues in colorectal, lung and neurological cancer types, which are causing concerns within NHS Fife. There are various reasons for the situation, including some staffing issues. Support has been provided, with senior management going out and visiting clinicians to understand the local challenges and, importantly, identify solutions to them. The most recent example of that took place on 12 February.

We will continue to support NHS Fife to make those improvements, but I will write to Cara Hilton about the case that she highlighted.

First Minister's Question Time

11:59

Engagements

1. Kezia Dugdale (Lothian) (Lab): To ask the First Minister what engagements she has planned for the rest of the day. (S4F-02674)

The First Minister (Nicola Sturgeon): Engagements to take forward the Government's programme for Scotland.

Kezia Dugdale: Official figures published yesterday confirmed that the Scottish National Party Government's most recent oil revenue estimates for next year are more than 10 times greater than those of the Office for Budget Responsibility. Will the First Minister commit to publishing a revised oil and gas bulletin?

The First Minister: Yes. As John Swinney said a few moments ago in general questions, we will take the time to analyse the fiscal changes that the Chancellor of the Exchequer announced in the budget yesterday. When we have done that we will publish an updated oil and gas bulletin, as soon as is feasible.

It is worth pointing out that, when the Scottish Government was projecting an oil price of $110 a barrel, the OBR was projecting an oil price of $100 a barrel and the United Kingdom Government's Department of Energy and Climate Change was projecting an oil price of upwards of $120 a barrel, so it is fair to say that everybody's projections about oil were wrong. [*Interruption*.]

The Presiding Officer (Tricia Marwick): Order.

The First Minister: The most revealing thing about Labour is how it gleefully pounces on anything that it can describe as bad news and how it steadfastly ignores anything that is good news about Scotland's economic prospects. The fact is that the projected decline in oil revenues over the next few years is dwarfed in every one of those years by the projected growth in our onshore non-oil revenues. In other words, our country's revenues are increasing and our public finances are improving. I know that that does not suit Labour's narrative, but it happens to be a fact.

Kezia Dugdale: I am pleased that the First Minister has finally run out of excuses and will publish a new oil and gas bulletin. It is not some dry statistical exercise; it is about the SNP's key general election demand for full fiscal autonomy within the UK: a plan that would scrap the stability of higher public spending through the Barnett formula and replace it with the austerity max of relying on oil revenues, which are projected in the SNP's current oil and gas bulletin.

The new OBR figures show something quite extraordinary. They show that, even in the SNP's most pessimistic scenario, oil and gas revenues are £10 billion more than they are in the OBR's latest forecast. In the SNP's preferred scenario, the difference is almost £30 billion—nearly the whole Scottish Government budget.

When the SNP Government published its March 2013 oil and gas bulletin, it did so just five days after the publication of the "Government Expenditure and Revenue Scotland" figures for that year, so it should not take too long this time. Will the First Minister confirm that the new oil and gas projections will be published before we meet again here next week?

The First Minister: I have just confirmed, as John Swinney confirmed, that we will publish the updated oil and gas bulletin as soon as possible.

James Kelly (Rutherglen) (Lab): When? When?

The Presiding Officer: Order, Mr Kelly.

The First Minister: Kezia Dugdale takes great glee in declining oil revenues. If we look to the year 2019-20, yes we will see that oil revenues are projected to decrease by £3 billion compared with the revenues in 2013-14, but in that same year our onshore non-oil revenues will increase by £15 billion. Our revenues are growing and our public finances are improving; that does not suit Labour but it is good news for Scotland.

On the wider question, here we have, yet again, the two faces of Labour. In England today, Labour is telling people that Westminster cuts are extreme and will take us back to 1930s levels of public spending. In Scotland, Labour is trying to tell people that Westminster is the saviour of our public spending. Is it any wonder that nobody believes a word that Labour says anymore?

The only cuts on the horizon are cuts proposed by the Tories and voted for by Labour. The only alternative to austerity in Scotland is the SNP.

Kezia Dugdale: The First Minister talks about two faces, but this week she was in England, telling people to vote Green, a party that wants to shut down the oil and gas industry. I also point out that I take no glee in these figures, because we are talking about thousands of jobs. I find that comment utterly disrespectful.

The SNP's plans for full fiscal autonomy rest on an oil price of $110 a barrel, but the OBR has revised down its oil price figures and now projects an oil price next year of more than $40 a barrel lower than the SNP's figures. That makes the case for having a Scottish office for budget responsibility even stronger than it was. To be frank, I think that the Scottish Government's figures simply cannot be trusted. Will the First Minister support Scottish Labour's call for an impartial and independent Scottish financial watchdog?

The First Minister: As Labour knows, we already have one, and this Government is taking steps to put it on a statutory footing. I would have thought that Labour would have welcomed that, but yet again Kezia Dugdale steadfastly refuses—[*Interruption*.]

The Presiding Officer: Order, James Kelly.

The First Minister: —to acknowledge the estimated growth in our onshore revenues, and that is before we have the additional economic and fiscal powers that would allow us to grow our economy even faster. That is the whole point of not letting Westminster continue to control our finances and taking more control ourselves.

As for how people in England should vote, is it any wonder that people are disillusioned with Labour? Just this morning, Ed Balls, the shadow chancellor, said that there was nothing from George Osborne's budget yesterday that he would reverse if he became chancellor. There is nothing in the budget of a right-wing Tory chancellor that a new Labour chancellor would choose to reverse. Really? Let me tell you—there is plenty that I would choose to reverse, starting with the austerity cuts that are going to be deeper than anything that we have seen before. I think that Ed Balls has just made our case for us: the only alternative to austerity in Scotland is the SNP.

Kezia Dugdale: Last week, the First Minister had to correct the *Official Report* when she did not tell the truth about how the SNP voted on a key austerity vote in the Commons. I am happy to correct the record, too. Last week, I said that scrapping Barnett would cost Scotland £6.5 billion in spending cuts. I was wrong; the OBR's oil projections confirm that the cost would, in fact, be £7.6 billion. That is a Barnett bombshell that would mean billions of pounds-worth of cuts—[*Interruption*.]

The Presiding Officer: Order. Let us hear Ms Dugdale.

Kezia Dugdale: Presiding Officer, SNP members are laughing about cuts to our schools and our national health service. They are laughing about cuts to thousands of jobs in Scotland.

Scots appreciate straight talking; what we cannot stand is when our Government tries to cover up the truth about the impact of its policies. When will the First Minister do the decent thing and admit that the SNP's plans to scrap Barnett would be devastating for Scotland?

The First Minister: Let me tell Kezia Dugdale what will come as a bombshell to people across Scotland today: it is the news that Labour will not

reverse any of the Tory cuts that were announced in the budget yesterday.

It might also have come as a bombshell to people in Scotland to hear yesterday Rachel Reeves, one of the Labour Party's shadow Cabinet, saying that Labour no longer stands for people out of work. These are the things that will come as bombshells to people across Scotland.

For the purposes of the record, let me confirm that the SNP did not vote for the Labour cuts put forward in the motion just over a week ago. The only cuts on the horizon for Scotland are the £30 billion of cuts that Labour voted for a few weeks ago—cuts that were proposed by the Tories and which we know as of this morning will not be reversed by Labour. The only alternative to Tory-Labour austerity cuts in Scotland is the SNP.

Secretary of State for Scotland (Meetings)

2. Ruth Davidson (Glasgow) (Con): To ask the First Minister when she will next meet the Secretary of State for Scotland. (S4F-02676)

The First Minister (Nicola Sturgeon): No plans in the near future.

Ruth Davidson: Yesterday, the Chancellor of the Exchequer delivered a £1.3 billion tax cut for the North Sea. The plan was widely welcomed across the oil industry. It was welcomed by Sir Ian Wood and by all Scotland's leading business associations. However, there was at least one voice of dissent. According to that source, what stood out in yesterday's budget was

"the huge tax breaks for the fossil fuel dinosaurs, which will drag us back from the cusp of a green energy revolution."

What does the First Minister make of such an analysis?

The First Minister: As the Deputy First Minister said yesterday—I will say it again today—we welcome the moves that the chancellor took in the budget yesterday to support the North Sea oil and gas sector. They are precisely the moves that this Government has for some time been calling for.

However, before Ruth Davidson gets too carried away, she would do well to remember that, on the supplementary charge, all that the chancellor is doing is reversing the tax hike that he imposed on the sector in 2011—in other words, undoing his own damage. However, we welcome those moves and wish that they had been taken a lot sooner.

Ruth Davidson: I asked the First Minister specifically about so-called fossil fuel dinosaurs. I asked because the criticism of the chancellor's oil industry boost came from the Green Party in England—the very same Green Party in England that Nicola Sturgeon wants people to vote for. In fact, on Monday she said:

"If I was living in England, I'd be probably looking at voting Green."

About four minutes ago, the First Minister talked about the two faces of Labour. Let us see whether we can get her story straight. When she is in Scotland, she calls on London—as she has just said—to deliver tax breaks to keep the drilling going, but when she is in London, she urges people to vote for a party that says that we should stop the drilling altogether and give hundreds of thousands of North Sea oil workers the sack. What kind of politics is that? What kind of judgment is that? [*Interruption*.]

The Presiding Officer: Order.

Ruth Davidson: Why is a First Minister of Scotland telling people in England to vote for a party that would kill Scotland's oil industry?

The First Minister: Dearie, dearie me. Just for the benefit of Ruth Davidson, and anyone else in the chamber, I say that I am Nicola Sturgeon, I live in Scotland, I am voting for the Scottish National Party and I encourage everybody else to vote SNP as well. I hope, for the benefit of everybody in Scotland, that nobody in England votes Tory, because the Tories are imposing austerity cuts in Scotland and the sooner we get rid of them, the better.

United Kingdom Budget (Implications for Scotland)

3. Kenneth Gibson (Cunninghame North) (SNP): To ask the First Minister what the implications for Scotland are of the UK budget. (S4F-02673)

The First Minister (Nicola Sturgeon): Although Scotland has paid more than the rest of the UK in taxes per person in every year for the past 34 years, our annual discretionary spending power has been cut by nearly £2.8 billion in real terms since the start of the spending review period. When we contrast the £30 million of consequentials announced yesterday with that cut, with the £12 billion cumulative cut in day-to-day spending that is expected over the next four years in comparison with 2014-15, and with the disproportionate impact that that will have on those on the lowest incomes, we can begin to fully understand the UK budget's implications for Scotland.

Kenneth Gibson: Can the First Minister tell us in more detail how those cuts—imposed by the Tories and now backed by Labour—will impact on the delivery of public services, public sector employment and the Scottish Government's ability to invest in infrastructure and support for the most vulnerable in our society? Only last week, the Institute for Fiscal Studies indicated that the cuts

could mean the loss of up to 900,000 public sector jobs across the UK over the next four years.

The First Minister: Kenny Gibson is absolutely right to flag up the impact of the cuts, which come on top of the billions of pounds-worth of cuts taken from our budget. It is interesting to note that Labour members were laughing as Kenny Gibson was talking about the impact of the cuts on public services and individuals.

One of the worst things that we see when looking at the analysis of yesterday's budget is the disproportionate impact of the Tory cuts on the poorest in our society. The combined impact of Tory tax, welfare and public spending changes will reduce the average household's income by 1.5 per cent, but the changes will reduce the income of the poorest 20 per cent by 2.2 per cent. The disproportionate impact is on the poor. That says all that needs to be said about the Tories' priorities.

Lewis Macdonald (North East Scotland) (Lab): We have heard very different views about the importance of the oil and gas industry going forward, as we did during last week's debate on the subject. Does the First Minister welcome the plans announced in the budget for the Oil and Gas Authority to fund seismic surveys in marginal fields to sustain production and jobs? Does she agree that public investment in oil and gas is critical to sustaining a key economic sector? Would she welcome further public investment in support of the oil and gas industry in Scotland and across the United Kingdom?

The First Minister: Yes. This Government has repeatedly called for a reduction in the supplementary charge, an investment allowance and support for exploration. For those reasons, I support the measures announced in the budget. I want continued public and Government support for our North Sea oil and gas sector.

Jim Hume (South Scotland) (LD): The UK Government announced in the budget £1.25 billion of extra spending on mental health services as part of its commitment to parity of esteem between physical and mental health. Will the First Minister commit to spending on mental health services the £125 million of consequential funding that the Scottish Government receives?

The First Minister: Of the £30 million total figure announced yesterday, £26 million comes from changes in health spending and, in England in particular, in mental health spending. I certainly want that money in Scotland to be directed to our health service. The Scottish Government will look carefully at what the priorities should be. Mental health is and always will be a priority for the Government. We will make a more detailed announcement in due course.

Alex Johnstone (North East Scotland) (Con): Yesterday, the Chancellor of the Exchequer committed to city deals for Aberdeen and Inverness. Will the First Minister commit the Scottish Government to working hand in hand with the UK Government to ensure that the deals are a success and that they bring economic growth to areas that are depressed as a result of low oil prices?

The First Minister: Yes—I give that commitment. I have made it clear that the Scottish Government will work with Aberdeen and Inverness. I want city deals to be progressed elsewhere in due course. Of course, the Government has committed £500 million to the Glasgow city deal, to help make it a success.

Racial Discrimination

4. Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): To ask the First Minister what action the Scottish Government is taking to tackle racial discrimination. (S4F-02671)

The First Minister (Nicola Sturgeon): There is absolutely no place for racism or, indeed, any discrimination in a civilised society. The Scottish Government is strongly committed to equality, including race equality, which is reflected in our key strategies and in our continued support for organisations that promote race equality, tackle racial discrimination and challenge racism. More than £8 million from the equality budget from 2012 to 2015 has supported activity to promote race equality and to address racial discrimination through a range of projects at local and national levels.

As part of the work to shift attitudes and provide a strong message about the Scotland in which we want to live, we launched last November the latest phase of the one Scotland campaign, entitled "Scotland believes in equality". That includes a focus on race. In addition, along with our race equality partners and Scotland's minority ethnic communities, we are working towards producing a race equality framework by spring 2016.

Christina McKelvie: I thank the First Minister for all the work that has been done. I direct her to article 14 of the European convention on human rights, which provides that

"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

Given that that is the highest standard of anti-discrimination policy in the European Union, does the First Minister join me in condemning the disgusting and downright discriminatory words of

David Coburn MEP directed to the Minister for Europe and International Development, Humza Yousaf, and in reasserting that there is no place in Scotland or Europe for sexist, racist or homophobic discrimination?

The First Minister: I know that I speak on behalf of the entire Parliament when I condemn David Coburn's utterly reprehensible comments. Yesterday, the Scottish Parliament stood in solidarity with our friend and colleague Humza Yousaf and voted unanimously to censure Mr Coburn. My clear view is that he is not fit to represent the people of Scotland in the European Parliament or anywhere else.

I also take the opportunity to condemn unreservedly the vile homophobic abuse that was directed at Ruth Davidson on Twitter last night and this morning. The individual in question has been identified and, this morning, their membership of the Scottish National Party was suspended pending a full disciplinary process.

Fiscal Autonomy

5. Jackie Baillie (Dumbarton) (Lab): To ask the First Minister, in the light of the new analysis by Professor Brian Ashcroft regarding fiscal autonomy, whether the two Scottish Government reports entitled "Benefits of Improved Economic Performance" are based on the continuation of the Barnett formula. (S4F-02680)

The First Minister (Nicola Sturgeon): The modelling does not simulate continuation of the Barnett formula. The Scottish Government analysis illustrates how being able to retain the benefits of improved economic performance in Scotland would allow us to invest in Scotland's public services and, in turn, to improve further our country's economic potential.

Jackie Baillie: I respectfully point out to the First Minister that this is not a good week for the Scottish Government when it comes to forecasting oil or analysing the economy. Professor Ashcroft has described the analysis as

"fanciful and … lacking in economic rigour".

Her Government has been caught red-handed fiddling the figures to try to make her economic policy add up.

In both analytical reports on the economy, which were published within six days of each other, the Scottish National Party assumes continuation of the Barnett formula at the same time as it is demanding full fiscal autonomy. The First Minister knows that we just cannot have both. With the SNP—

The Presiding Officer: Can we get a question, Ms Baillie?

Jackie Baillie: We will see not only Tory austerity but a £7.6 billion deficit, so the SNP will deliver austerity max.

The Presiding Officer: Ms Baillie, I need a question.

Jackie Baillie: Will the First Minister update the analysis to correct her Deputy First Minister and Cabinet Secretary for Finance, Constitution and Economy's mistake so that we can all see the true state of the nation's finances?

The First Minister: Jackie Baillie thinking that something is the case does not make it the case, as we know from experience.

The Barnett formula was not part of the modelling framework; the modelling framework looks at how, if we were to pursue particular policies and if we benefited and boosted economic performance, we could grow the revenues of Scotland. That should be of interest to all parties.

In response to Kezia Dugdale I said that our onshore revenues over the next few years are estimated to grow; by the time we get to 2019-20, they will be £15 billion higher than they are now. That is without our having the powers to pursue policies that will grow our economy more quickly. Imagine how much better we could do if we did not allow Westminster to control all our finances and, instead, took greater control ourselves.

I say to Jackie Baillie, as I said to Kezia Dugdale, that the only cuts that face Scotland at the moment are those that are proposed by the Tories, which—as we know from what Ed Balls said this morning—Labour will not reverse. That is shameful and the people of Scotland will draw their own conclusions.

Kevin Stewart (Aberdeen Central) (SNP): Does the First Minister agree that the real threat to Scotland's economy is the austerity agenda of the Labour Party and the Tory party, whose only disagreement is not on whether to keep cutting our vital public services but on how deep they should go?

The First Minister: Kevin Stewart has put his finger on it. The only argument—the only difference between the glued-together Labour and Tory parties—is about how deep the cuts should be. Therefore, if a voter in Scotland wants a clear and principled alternative to austerity, the only one on offer is the one that is coming from the SNP. [*Interruption.*] That is the reality. I know that Labour members do not like it, but they will keep hearing it all the way to 7 May.

Alex Johnstone (North East Scotland) (Con): In the past 20 minutes, the First Minister has praised the effect of a growing private sector on the Scottish economy and, at another point, demanded vast increases in the public sector. Will

she explain which economic theory she believes in?

The First Minister: I believe in investing in our public sector to protect the public services that people across Scotland rely on. I also believe—Labour used to agree—that if we use public funding for investment in infrastructure, innovation and skills, we will grow the economy faster. That basic premise is at the heart of my argument. Alex Johnstone is looking confused—perhaps that is why he is a member of a party that has missed its borrowing projections by £150 billion over the current United Kingdom Parliament.

National Health Service Staff (Confidentiality Clauses)

6. Annabel Goldie (West Scotland) (Con): To ask the First Minister what the Scottish Government's position is on confidentiality clauses for staff leaving NHS jobs. (S4F-02687)

The First Minister (Nicola Sturgeon): The Scottish Government has made it clear that we expect there to be a presumption against the use of confidentiality clauses. They should be used only if there are clear and transparent reasons for using them. That is why, last year, national health service boards were instructed to remove confidentiality clauses altogether from standard settlement agreements.

Furthermore, we have increased transparency. Every NHS board is now required to notify the Scottish Government of any settlement agreement to resolve a dispute if it is intended that that agreement will contain a confidentiality clause.

Annabel Goldie: Since February last year, eight health boards have used such restraints. Greater Glasgow and Clyde NHS Board alone has imposed them on 36 departing staff members. NHS gagging orders are less to do with keeping sensitive information private and much more to do with stopping embarrassing information becoming public. They are unfair to the employee who is leaving and they fail the public interest test. Such gagging orders are charters—they are charters for the inept, the incompetent and the bully. Does the First Minister agree that the practice is in serious need of urgent review?

The First Minister: The Scottish Government reviewed the practice and took action, which is why there is now a presumption against the use of confidentiality clauses. They used to be included in standard settlement agreements, but are no longer included.

As the Royal College of Nursing and the British Medical Association have previously recognised, there will be circumstances in which there are reasonable grounds for using such clauses, but we have insisted that when such circumstances exist boards notify the Scottish Government of them. We have taken action that I think is appropriate.

There is another extremely important point to make. Even with a confidentiality clause, it is not possible to gag people who have concerns about patient safety or malpractice within a health board. The fact that any agreement that sought to prevent staff from expressing concerns about patient safety or malpractice would be illegal under the Public Interest Disclosure Act 1998 makes such an agreement unenforceable.

I appreciate where Annabel Goldie is coming from, but I think that she should acknowledge the very clear action that the Scottish Government has taken.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Although it was announced last year that there would be no more gagging clauses, the fact that there have been 40 in the past year must be a matter of public concern. In order to be certain that gagging clauses are not being misused to cover up harassment, bullying or any issues that might impinge on patient safety directly or indirectly, and to ensure that the contacts that are made through the whistleblowers helpline—the national confidential alert line, as it is properly known—which our Government set up some two years after such a helpline had been set up in England, are being followed up fully, will the First Minister consider setting up an all-party parliamentary oversight committee to give the public absolute confidence that such clauses are being used only in appropriate circumstances?

The First Minister: Richard Simpson and Annabel Goldie have raised important issues. I want to acknowledge that and respond to them appropriately.

I argue that a mechanism such as Richard Simpson suggests already exists. As I said to Annabel Goldie, the Scottish Government must now be notified of any use that is made of confidentiality clauses to allow those clauses to be better scrutinised. In May this year we will give the first full year of that information to the Public Audit Committee of this Parliament. That cross-party committee will be able to scrutinise the information and make comments or recommendations as it sees fit. I think that that is appropriate.

We have said very clearly, first, that there is a presumption against the use of gagging clauses; secondly, that when such a clause is used because a health board and the member of staff in question think that that is appropriate, we must be notified in order to allow scrutiny; and thirdly, that it would be illegal to use such a clause to gag a member of staff who had legitimate concerns about patient safety. Taking all that into account,

Parliament should be assured that appropriate action has been, and is being, taken.

European Conference for Cold Water Island Tourism

The Deputy Presiding Officer (Elaine Smith): The next item of business is a members' business debate on motion S4M-12520, in the name of Kenneth Gibson, on the European conference for cold water island tourism. The debate will be concluded without any question being put. I would be grateful if members who wish to speak in the debate would press their request-to-speak buttons as soon as possible. I would also be grateful if guests who are leaving the gallery do so quietly, please. The Parliament is still in session.

Motion debated,

That the Parliament notes that 17 to 19 March 2015 marks the first annual European Conference on cold water island tourism, hosted on the Isle of Arran; understands that the conference will serve to create a means for cold water islands to come together and collaborate toward achieving a more sustainable tourism industry; celebrates the three overarching themes of the conference, which include opportunities from life, culture and heritage, access and business excellence, and congratulates the programme on highlighting and promoting what it considers the indispensable efforts of Scotland's cold water island industries to deliver sustainable employment and prosperity.

12:31

Kenneth Gibson (Cunninghame North) (SNP): I am pleased to open this debate on cold water island tourism. I hope to reveal in due course the significant impact that Scottish island tourism can and does have on the Scottish economy.

I thank all those who signed my motion and the delegates who are attending and supporting Scotland's first cold water island tourism conference, which is currently being held in Arran in my constituency. In particular, I thank Alastair Dobson of Taste of Arran, who has worked hard to bring the event to fruition and make it a success.

More than 100 representatives from northern Europe have gathered to share their insights and experience of the successes and struggles that face the cold water island tourism sector. The conference will benefit Arran directly by giving a fantastic introduction to one of the many alluring islands on the Scottish coast. It is a great way to promote the natural beauty of our cold water islands. Experience of Arran and its hospitality is a great way of stimulating international interest in Scotland's islands.

Just before I came down to First Minister's question time, I was contacted by Alastair Dobson, who said that some of the key themes that are coming out of the conference are: that islands go a long way towards defining a nation; that the

identity of each island is key to its success; that business-led joint and collaborative investment is important; and that islands are fragile, but are usually dynamic and innovative, as I am sure many of us already know.

In the past year, Scotland has played host to many prestigious events that have brought us to the international stage and amplified interest in Scotland as a global tourism destination. The 2014 Commonwealth games, the Ryder cup and even the independence referendum all contributed and built on earlier events—for example, the success of media productions such as the 2012 Disney Pixar film "Brave"—and renewed international visitors' interest in Scotland. That helped to propagate an idea of our country as one of beautiful landscapes, castles and coasts, with good food and great people.

Scotland's waters, our islands and, indeed, our mainland coastal communities offer tourists a unique opportunity to experience Scotland on a more intimate scale. We boast the longest coastline in Europe, with varied wildlife and unparalleled scenery. Each island is unique; each has a proud identity of its own and offers its own rich heritage. With 88 per cent of island tourism generated through small businesses, our islands allow tourists to experience a different and very Scottish experience.

The increased interest in Scotland in combination with devolved powers that could result in the Parliament being in charge of an increasing number of key levers that determine the success of our tourism sector creates a significant opportunity for the Scottish Government. Tourism represents 5 per cent of total Scottish gross domestic product, generates £10 billion of economic activity annually, and employs 200,000 people, which is 8.5 per cent of overall employment in Scotland.

Supporting Scottish tourism affirms our commitment to developing and sustaining fragile communities that depend on the tourism industry. Our islands are of particular concern, given that they are often relatively isolated from the main population centres on the mainland and the cost of doing business there is significantly higher, even when the road equivalent tariff and other initiatives are in place. Island communities have to work harder to earn their living in the modern world.

The Arran conference seeks to create a platform for communication between cold water islands in Europe, in an attempt to share their ideas, experience and economic development in the tourism sector. Sharing insights is fundamental to growth. The European conference for cold water tourism creates an arena for island communities to talk about what works for them and to discuss innovative strategies to build a sustainable future.

Of course, several strategies are already under way in Scotland to promote marine and sustainable island tourism. As we are talking about a European conference, it seems appropriate to touch upon the European Union's hugely ambitious blue growth strategy, which was developed by the EU in an attempt to promote sustainable growth in European island communities—along with mainland coastal communities—with the aim of creating 5.4 million jobs and producing €500 billion income per annum by 2020.

The strategy stresses the importance of renewable energy, aquaculture, sea bed mining, and blue biotechnology as the building blocks of sustainable development. The Scottish Government's target of producing 100 per cent of Scotland's gross annual electricity consumption and 11 per cent of Scotland's heat consumption by 2020 from renewables supports those initiatives and will generate jobs in the process. I am pleased that Johan Gille, special adviser to the European Commission's Directorate for Maritime Affairs and Fisheries attended the conference in Arran to talk about the blue growth strategy in more detail and to provide support for innovation and communication in cold water island tourism developments.

The Scottish Government supports sustainable development for Scotland's island tourism sector. Rather than provide details and steal the minister's thunder, I am happy to wait for him to touch on that himself.

In addition, the Scottish Tourism Alliance, working in tandem with the Minister for Business, Energy and Tourism, Fergus Ewing, recently launched the marine tourism strategy, which, as the name suggests, aims to bolster Scotland's marine tourism, which is a hugely important sector and one in which my colleague, Stuart McMillan, takes a particularly keen interest; I am sure that we will hear from him before too long.

The five-year plan aims to improve the tourism experience, to develop skills and facilities within the sector, and to promote events and activities that intend to bring more focus to Scotland's marine tourism. The STA hopes to achieve a 25 per cent increase in the total value of the sector by 2020, representing an increase in income of around £90 million per year.

Tourism gains from events and in many other ways, such as from cruising. The Scottish Government is working with Cruise Scotland and VisitScotland to continue to grow that market.

As we move forward, devolving responsibility for air passenger duty, if it happens, will give us the opportunity to end a burden that, since 2007, has resulted in £210 million less per annum being

spent on tourism and 1.2 million fewer visitors across Scotland—not just in our island communities, but tourists being further away from them when they arrive in the UK does not help.

I look forward to hearing how the Scottish Government will further promote island tourism and from other colleagues in the debate. The European conference on cold water island tourism represents an excellent example of the potential that can be heralded by collaboration across islands similar to those in Scotland. The success of the Arran conference will encourage countries to share their findings and promote sustainable prosperity for our islands for many years to come.

12:38

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I am well qualified to speak in this debate because it has been 44 years since I have been to a warm water island, but in the past seven years I have holidayed in Arran—I mention it first for obvious reasons and congratulate Kenneth Gibson on bringing the debate—Tiree, Skye, Orkney and Harris. I can testify to the coldness of the water because of a little bit of swimming on some of those islands.

Cold water islands, particularly those in the north Atlantic, face common tourism opportunities and challenges, and the conference was set up to consider strategies for economic growth and use of the islands' natural resources. Tourism is a mainstay of those communities and therefore plays an essential part in sustaining their livelihoods.

Alastair Dobson of Visit Arran said:

"Island tourism tends to focus on warm water locations, such as the Mediterranean, the Caribbean and the Pacific Ocean. Cold water island tourism is vitally important to the economy for the island communities but, importantly, cold water islands offer tourists a wonderful opportunity to get close to nature and to experience authentic island life and for northern European markets these experiences are much closer to home."

That is certainly true of Arran—and Kenny Gibson will be glad to know that this morning I was telling an American intern in the Parliament all about Arran, where she is going to spend the next couple of days.

One of the case studies at the conference, under the banner "food and drink" was the highly successful collaborative venture, a Taste of Arran. That initiative's joined-up approach to the development and marketing of local produce provides a template that other similar islands could replicate. It incorporates the development of the product as part of an experience on the island and serves as a fundamental component of the branding, positioning and marketing of Arran.

The success of the islands in both the high season and the low season is as dependent on their wider connectivity as on their ability to articulate a distinct brand. Connectivity is an integral part of developing innovative tourism strategies for islands, which I believe was reflected in the discussions this week.

One experience of island tourism that we will all be familiar with is the trip aboard CalMac Ferries ships, which have connected our communities for many years. CalMac has recently announced plans to turn the journey into an opportunity to promote Scottish culture and products while using digital connectivity to encourage travellers to visit key sites of interest. The company plans to introduce pop-up tastings, fashion shows and pop music to entertain visitors as they head to Scotland's islands. In a move designed to give tourists a flavour of what awaits them, CalMac will serve locally produced island food and drink, along with providing tourist information via free wi-fi. Details of places to visit on the island where the ferry is heading will be sent to passengers' mobile phones and via a smartphone app. That is in essence what maximising our island potential is all about: key sectors working in collaboration to make sure that the overall enjoyment of visiting the island supports the island economy and people buying into the ethos. The sense of destination package will be available on ferries to the Hebrides. Clyde routes such as Arran will also be included.

CalMac has also become adept in its use of social media to promote its various destinations. Its new blog site offers a glimpse of the various attractions that islands have to offer. For example, one family give their account of their time island hopping and visiting Barra—I do not think that I have time to share that account.

Our beautiful islands are there not to exist in isolation but to be experienced, lived in and connected to our mainland. They are to be appreciated for their vibrant and productive communities with their generosity and hospitality. Meeting other small islands, collaborating and sharing ideas and best practice are the best ways to ensure that whatever business opportunities are pursued are pursued with and for the communities themselves. I believe that that is what this week's conference was about and I congratulate Kenny Gibson on drawing it to our attention this week.

12:42

Stuart McMillan (West Scotland) (SNP): I, too, congratulate my colleague Kenneth Gibson on securing the debate. As he said, I chair the cross-party group on recreational boating and marine tourism, so I will struggle to limit my comments to four minutes.

Kenneth Gibson mentioned cruising. I believe that we are having a members' business debate on the cruise industry in Scotland next week, so I will not say too much about that today.

Today's debate illustrates once again the Scottish Parliament's commitment to and interest in cold water island and marine tourism in Scotland and its appreciation of the vast benefits drawn from that important sector in our economy.

Spending by tourists in Scotland generates some £10 billion in economic activity and contributes roughly 5 per cent of the country's GDP. The tourism sector accounts for more than 200,000 jobs. All those numbers continue to rise, thanks in part to the efforts of organisations such as VisitScotland and Visit Arran and conferences such as the one that we have discussed.

Scotland's islands have recently been recognised on the world stage for their breathtaking beauty and the unique opportunities that they afford to tourists. Lewis and Harris were named number 5 on tripadvisor's list of the top islands in the world, beating much of the tropical, warm-weathered competition. They were the highest ranked cold water islands and were surrounded on the list by islands in warmer climes to the south. Although cold water islands are not traditionally thought of as major tourist destinations, that accolade acknowledges the beauty of our islands and it will hopefully lead to more tourism in future years.

One of the issues that has come up in the cross-party group on recreational boating and marine tourism is just how important tourism is to the island communities across the country in terms of investment into infrastructure in the islands, particularly the infrastructure for marine tourism activities, whether that involves sailing, boating, canoeing, kayaking or whatever. Investment in those activities helps to stimulate and promote the economies of those island communities. As we know, these are cold water communities.

Cold water islands offer a unique destination for tourists that often includes marine-based activities, hand crafts, archaeology, lessons about the history of Scotland and of the islands' inhabitants, the spectacular natural beauty of Scotland and the food and drink aspects that we have already heard about. Visitors to the islands have the opportunity to get close to nature and the dramatic landscape, and to find insights into island life.

As we have heard, representatives from Scotland, Wales, the Netherlands and Denmark, among other places, are meeting in Arran this week to discuss strategies to increase cold water tourism. I look forward to finding out the outcomes of the conference.

Kenneth Gibson mentioned the recently published marine tourism strategy document, "Awakening the Giant". The strategy started in the cross-party group on recreational boating and marine tourism, after we held a symposium in March 2013. As a consequence of that activity, we have got to the point of having an actual marine tourism strategy for the country. On behalf of the cross-party group, I will take some credit for helping to fashion the first marine strategy that Scotland has ever had. I also wanted to put on record the work of not only that cross-party group but all cross-party groups in the Parliament and the things that they can bring to the table with regard to fashioning a policy agenda.

Once again, I thank Kenneth Gibson for bringing this debate to the chamber. I am sure that the conference will be a tremendous success.

12:47

Annabel Goldie (West Scotland) (Con): I also thank Kenneth Gibson for bringing this important motion to the Parliament. Loving Arran as I do, it is a great pleasure to take part in this debate.

I should mention that I am currently registering an interest that is relevant to the debate. On 8 March I was a guest at the annual dinner of the Arran Society of Glasgow, at which I spoke. I received hospitality and accommodation in connection with the event.

The first annual European conference on cold water island tourism, which is being held on the beautiful island of Arran, is a triumph of local resourcefulness and ingenuity. I join others in mentioning Alastair Dobson, and I pay tribute to him and to Visit Arran. As some have already said, behind the initiative is a vision of making small cold water islands destinations of choice, with the aim of helping to make them sustainable economically, socially and environmentally, while also making them attractive places in which to live and work.

The conference organisers could not have picked a better location for their conference. Arran is unique. It is close to the mainland, yet far from the bustle of the mainland. It is diverse in scenery and recreational opportunity, noted for geology and tourism and abundantly provided with quality accommodation and places to eat. No wonder it enchants all who visit.

The conference's mission is ambitious. It is to create

"a unique network of cold water small island destinations in order to benefit from having a representative voice of influence"

and to forge

"collaborative working and sharing practical solutions based upon successful actions and evidence."

That is a purposeful and relevant mission.

Indeed, the conference's prospectus describes the objectives as being, among other things, to

"Share knowledge of successful practical projects; Create networks of expertise and information; Discuss common issues and opportunities to grow the value of tourism; Identify innovative solutions to underpin sustainable growth; Celebrate and recognise best practice projects;"

and

"Develop a common agenda for support and development".

That reflects a very practical and sensible approach to the huge potential of cold water islands.

I could not help but notice that the conference prospectus has a stunning photograph of Machrie Bay, which was where I used to swim on my regular visits to Arran—and, yes, cold water island is a good description.

The islands of many cold water maritime countries make a valuable contribution to the tourism experience and to the economy. As Stuart McMillan said, there has been comparatively little research on value, market demand and economic impact to enhance our understanding of those issues. Any aim to redress that situation and recognise and identify cold water islands as viable tourist destinations is commendable. The whole initiative is tailor-made for Scotland and is relevant to all our island communities.

Island tourism can work hand in hand with island businesses, which tend to be microbusinesses. Arran is not short of successful local businesses that have forged themselves into providers of niche products that are sold well beyond Arran's shores. Not only are those businesses vital for the overall survival of island communities, but they enhance, and are enhanced by, expanding tourism.

I, too, am delighted that more than 100 delegates from across northern Europe have gathered in Arran to hear success stories, listen to experts involved in the economic development of islands and build networks and friendships. The first-ever conference examining cold water tourism is a unique event. It is a feather in Scotland's cap and a coup for the island of Arran. I congratulate all involved.

12:51

John Mason (Glasgow Shettleston) (SNP): I thank Kenneth Gibson for bringing the subject to the Parliament. I also congratulate him on wearing the same tie as me—for members who do not know, it is the tie of the charity Enable. There are at least three of us wearing the Enable tie today.

For me, the ideal place to go on holiday is an island. Being surrounded by water gives me the feeling of being away from it all and being able to wind down and relax. Today, I will be totally self-indulgent and talk about islands that I have visited. For example, last summer, just before the final few weeks of the referendum campaign, I spent nine days on Coll and Tiree and had an absolutely superb time.

I am not exactly sure where my attachment to islands first came from, but I remember as a youngster going on day trips to Millport on Cumbrae, and I had a teacher at school who took us on weekend trips to Arran, which is the island that I visited most recently, when the Finance Committee was there in December.

As a student, I remember a group of us going to Islay, which is due to be my next island destination when the Equal Opportunities Committee goes there after the Westminster election. If the weather is better, I hope to be camping when we go to Islay. That is my probably my ideal holiday: camping on a Scottish island.

It is not only Scotland that has great islands; other countries do too. A name that I have always known from the shipping forecast is Lundy, which is an island off the north coast of Devon, in England, and is well worth visiting.

Ireland, too, has a number of islands, some of which I have visited, including Aran—with one r—Rathlin, which is across from Kintyre, and Clare Island, which I found one of the most exciting and is in my favourite Irish county of Mayo. The Irish allow competition on their ferry routes and on a particularly windy day, with a choppy sea, we had two ferries racing each other across to the island. It was probably not safe, but it was good fun.

When we think of Wales, we might think of Anglesey, or Ynys Môn, as it is known. However, it has two bridges, so is it really an island? How do we define an island? I am a fan of Hamish Haswell-Smith's book on Scottish islands, and I agree with his definition that an island has to be surrounded by seawater at lowest tide and have

"no permanent means of dry access".

By that definition, Anglesey is not an island, and neither is Skye. In my opinion, the Uists and Benbecula form one island, not three.

The British isles contain more than just Scotland, England, Ireland and Wales. The Isle of Man was a traditional holiday destination from Glasgow. Its location is stunning, with all four surrounding nations in sight. Being there, we realise how central the island was in the past.

When the seas were the motorways of the time, the Vikings knew that Man was right at the centre.

If we are looking for history, Jersey and Guernsey take some beating. The whole story of the occupation during the second world war is fascinating. Many of the fortifications can still be seen—the islands were the most heavily fortified part of Hitler's Atlantic wall.

Continuing the war theme, I note that the Faroe islands were occupied by Britain in the second world war, and it was the British who encouraged them to have and use their own flag, rather than the flag of Denmark, which at the time was occupied by Germany. The closest country to the Faroes—where I stood a couple of years ago—is Scotland. However, it is disappointing—both to me and to the Faroese—that there is no regular transport link. I went by chartered plane. Perhaps the minister can look at transport links to the Faroes.

I hesitate to say that I have a favourite island in Scotland. However, the one place that I had long wanted to visit was St Kilda. When eventually I managed to, I found it absolutely superb. Sailing out from Lewis or Harris, I was almost out of sight of land, and then, out of the middle of the ocean—like in some spectacular film—came the cliffs, the amazing sea colour and thousands of birds.

The history and the evacuation in 1930 I find extremely moving, and there is a magic about the place. However, I reckon that it is somewhat spoiled by the military buildings. If I can finish with two suggestions for the minister, one would be to get rid of the military buildings, if he can do that. I also think that repopulating St Kilda would be a good project.

The Deputy Presiding Officer: Mr Mason, I ask you to draw to a close. Perhaps you would like to come back to Arran, if possible.

John Mason: I welcome the conference coming to Scotland. The islands are one of our great assets; let us do all that we can to encourage and support them.

The Deputy Presiding Officer: I invite Derek Mackay to respond to the debate.

12:56

The Minister for Transport and Islands (Derek Mackay): I am delighted to speak in today's debate on the cold water island tourism conference in Arran. I congratulate Kenny Gibson on securing the debate and North Ayrshire Council on its vision in supporting the conference's inaugural event.

Members might wonder why I am responding to the debate but of course I have ministerial responsibility for the islands—it is not just because tourism minister Fergus Ewing is not available. Malcolm Chisholm rather helpfully made a point about transport connections and how we can make cultural connections through transport. Given our capacity in that regard, there is a clear linkage.

I do not want anyone to draw any conclusions from the fact that I have been holidaying in Arran for the past 10 years or so. I am not permitted to have a favourite island, but members can draw their own conclusions from the fact that I am a regular visitor. Like Annabel Goldie, I may have visits to declare, although I think that they have all been at my own expense or, in a couple of cases, for Government events.

I am struck by the entrepreneurial spirit of Arran. How people there work together is certainly very impressive. The term "cold water conference" may conjure up an image that is not all that tourism partnerships would want, but, having swum off the coast of Arran, I can reveal a public health message: I have been sunburnt there, too. There is certainly warmth of hospitality in Arran, but the sun often shines as well.

The debate is about the conference, which is a fantastic event that brings together partners and stakeholders to release islands' potential. The involvement of Visit Arran and Taste of Arran is further evidence of close working and highly successful relationships across the whole island. I commend the branding therein.

The conference also has support from VisitScotland, through its conference bid fund. I hope that that sends the clear message that the conference bid fund can support businesses and conferences of 50 to 5,000 delegates across Scotland—it is for rural areas as well as cities. All conferences play a vital role in boosting the visitor economy in Scotland and acting as a showcase for all that Scotland has to offer as somewhere to live, study, learn from, invest in, buy from and visit again and again.

Arran has many attractions: stunning scenery; a range of activities for all tastes and levels of fitness; and delicious, locally produced food and drink, including that from the local distillery at Lochranza, the Arran Blonde series of beers and a range of delights from chocolate to cheese and from ice cream to rapeseed oil. They show that Arran is a microcosm of what Scotland has to offer. Arran Aromatics and many others also contribute to that sense of destination.

The year of food and drink in 2015 offers the industry so much to become involved in. It builds on the global exposure that Scotland had in 2014, which we should capitalise on.

The conference recognises that Scotland is doubly blessed. In addition to food and drink, we have a great network of coastal assets and inland waterways that facilitate a range of routes that marine tourists from the Nordic countries may take. As others have said, there is interest in the market potential there and in expanding that blue traffic throughout the seasons.

As the conference programme recognises, Arran is seizing the initiative and thinking about how to position all its attractions and enterprises not only during 2015 but during the other themed years from 2016 through to 2018.

There is European attention as well. Kenneth Gibson mentioned, and I am equally pleased, that Johan Gille of the consultancy firm Ecorys has been working closely with the European Commission's directorate-general for maritime affairs and fisheries, or DG MARE, on connectivity and innovative tourism strategies from an islands perspective.

Scotland stands to benefit from an EC focus on marine resources and we have been active in shaping European thinking in the sector. Stuart McMillan MSP, who is convener of the cross-party group on recreational boating and marine tourism, mentioned the potential of the sector, on which he has had good engagement with Commission officials. VisitScotland fielded a speaker at the EC conference on coastal and maritime tourism in Venice last year, and I know that DG MARE has been most impressed by its contacts to date with Scottish activity around coastal and marine tourism. It is vital that Scotland continues to provide positive input, such as the Arran conference, as the emerging pan-European approach to marine and coastal tourism is being actively developed.

The potential of marine tourism in opening up coastal areas has long been recognised, and it features as an approach in our work to date on the national marine plan and on the national planning framework, which I led.

VisitScotland's national tourism development framework shows an estimated £336 million of investment in tourism infrastructure, which will impact across Ayrshire and Arran over the next three years, further enhancing the quality of the visitor experience.

The industry-led Scottish marine tourism development group launched a strategic framework for Scotland's marine tourism sector on 5 March. It will put further energy into the right kind of infrastructure and the right decisions to support that work.

Crucially, as the conference recognises, this is not just about how to grow the marine sector, but about ensuring that sustainable economic growth carries across to coastal communities, inland waterways and wider tourism businesses to provide an authentic visitor experience.

A conference

"to promote, celebrate and help develop tourism on small cold water island destinations around the world"

is visionary and timeous. The Scottish Government for one would welcome receiving further detail on the conference outcomes once they become available. We will continue to work in partnership. The conference will clearly help us to understand not only how we can further increase all that Arran has to offer the visitor, but what more is possible for all our islands in Scotland, whether that involves transport, tourism, marketing or infrastructure. VisitScotland and its partners will all come together to learn the lessons from the conference.

The key to successful delivery of sustainable economic growth via the various sectors in our tourism industry is partnership working, which Arran has showcased. It has been an exemplar of how to develop an attractive model, particularly for tourism, to ensure that our islands in Scotland have a long, sustainable and successful future.

13:03

Meeting suspended.

14:30

On resuming—

Health and Social Care Integration

The Deputy Presiding Officer (John Scott): Good afternoon, everyone. The first item of business is a debate on motion S4M-12710, in the name of Shona Robison, on health and social care integration.

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): I am pleased to open today's debate on the integration of health and social care. It is very timely as we move towards the new world of integration from 1 April.

I was the Minister for Public Health in 2011 when we committed to introducing legislation to ensure that our system of health and social care focuses on the people who need it most. I also have experience of working in health and social care; before being elected, I was a home care organiser, so the subject is particularly important to me.

For people who have multiple complex needs, whether they be young or old, well joined-up health and social care support can be the key to living a full life, going to work, living in their own home and participating in their communities' lives. That people are living longer in Scotland is testament in large part to great improvements in our health and care services over many years, and that is a good thing. As people live longer, integration is about adding quality of life to their years of life, particularly for those who have long-term conditions.

We know that the numbers are going up. In 2013, more than 425,000 people aged over 75 were living with a long-term condition. By 2037, we expect the number to have risen by 83 per cent, to 779,000.

Integration is also about ensuring that we bring compassion and dignity to people and their families at the end of life. It is important that we plan ahead and ensure that our systems are in good shape to make Scotland an excellent place to live, whatever someone's age, circumstances or support needs.

I know that we all share those objectives for ourselves and our loved ones. I am grateful to Parliament for its support, across the floor, for the reform programme in the past few years. I am also grateful to colleagues in the Convention of Scottish Local Authorities, whose leadership on the agenda I greatly value.

This is a hugely ambitious national programme of reform. At its heart are people. I was reminded of that recently when I visited Clackmannanshire community healthcare centre, which provides a wide range of services to its community. The centre is home to two in-patient wards, three general practitioner practices, a day therapy unit and a local mental health resource centre. That is what integration is about—bringing together services and professionals to ensure an integrated and person-centred experience.

Nationally, we are moving into implementation. In a couple of weeks, the first of our new integrated partnerships for health and social care will go live. In one sense, years of hard work by colleagues in the national health service, local government, the third and independent sectors, the Government and Parliament are coming to fruition. In another sense, this is just one more—albeit large—stride along the path. That is why I will host a conference for leaders on integration later this month, to which I have invited some of the parliamentarians who are here today. I hope that they can attend.

The idea of integrating is not new. Community health partnerships set the baseline for today's reforms. Under the reshaping care for older people programme, we introduced the change fund, with the principle of pooling a proportion of the money that we commit to health and social care. We are building on that by bringing together budgets, planning and provision along the whole pathway of care, involving primary healthcare, social care and aspects of hospital care that provide the best opportunities for redesign in favour of prevention.

Progress is local, too. All around Scotland, chief officers are being appointed to lead the work of the new partnerships, and consultation is under way on their integration schemes—partnership agreements—which must be submitted for approval by 1 April. A lot of work goes into writing the integration scheme in each area. Each one is unique to the partnership's circumstances and each one depends on strong joint working between the health board and the council. It is great to see those core documents arriving now for sign-off. Just a few weeks ago, it gave me tremendous pleasure to approve the integration schemes for the three Ayrshire partnerships and lay the order in Parliament that will enable them to be established in April.

Of course, once the integration schemes are signed off, the local work to improve outcomes really begins, as partnerships get to work on their strategic plans for integrated services. Already we can see examples from around the country of local commitment to improvement through integration, such as Glasgow's ambitious programme to reduce delayed discharge and improve intermediate care.

It is not just Glasgow. Across the country, partnerships are starting to behave as if services were already integrated. Local information tells us that delayed discharges are starting to come down. Two thirds of partnerships look well placed to deliver the two-week target in April.

Such innovation will be crucial to success at improving outcomes, and what happens in communities within partnerships—in primary and social care settings—will be as important as what happens in hospitals. That is why we have legislated for localities within partnerships. Through localities, communities, clinicians and other professionals will directly influence how services are provided and resources are used. Localities' priorities must drive strategic planning in partnerships to enable a real shift towards supporting people in their own homes.

Of course, improving care is not a task only for the statutory partners; the third and independent sectors and the views of users and carers are important, too. Our legislative framework assures their role in strategic planning and localities.

As part of ensuring improvement in the quality of services, we are integrating and enhancing improvement support by bringing together Healthcare Improvement Scotland, the joint improvement team and the quality, efficiency and support team, and we are providing an additional £2.5 million to support improvement in the new integrated health and social care landscape.

I previously committed to refreshing our 2020 vision for health and social care. We will sharpen its focus even further on integration's foundation—the triple aim for raising performance of improving people's experience of care, improving the population's wellbeing and improving the use of resources.

Integration will bring together the significant resources that we commit to health and social care. We have provided flexibility for local systems to agree the integrated arrangements that are most appropriate to local circumstances. The legislation sets out the minimum that must be integrated, which amounts to at least £7.7 billion of health and social care resource being integrated across the country to maximise people's outcomes.

Nevertheless, we recognise that additional resource to support innovation is important. We are already providing £100 million in 2015-16 to support innovative integrated practice in partnerships under the integrated care fund. Earlier today, I announced the extension of that fund for a further two years—£100 million per year will be provided in 2016-17 and 2017-18. That £200 million is part of more than half a billion pounds of additional funding that we are providing over the next three years to support integration.

Jenny Marra (North East Scotland) (Lab): The cabinet secretary mentioned outcomes a moment ago, which we agree are particularly important. What is the Government's definition of outcomes from health and social care integration and how will they be measured?

Shona Robison: The outcomes have been published today and will be available to members. I was just about to say something about that. They will be measured through the information and data gathered through local partnerships. We are providing a lot of support to make sure that each partnership has a baseline. Each will have a baseline of information that they can measure progress against, so that they can show not just themselves but the wider population that they serve, and us, the progress that they are making across those outcomes. I will say a bit more about that in a minute.

The investment will support and drive innovation in local systems. The money will be used to build up preventative and anticipatory care, drive down delayed discharge, extend our use of telehealth and support primary care in its key role in leading integration.

How will we know whether integration is working? That is essentially the question that was just asked. Today, I have published indicators, which members can find in the Scottish Parliament information centre, that have been developed in partnership with the NHS, COSLA and the third and independent sectors.

The new partnerships will publish annual performance reports using those indicators, which replace the previous indicators for reshaping care for older people by drawing together measures that are appropriate for the whole system under integration. They reflect two important aspects of care: first, people's experience of care, such as the percentage of adults who can look after their own health well; and, secondly, key measures of the system's effectiveness, such as the rate of emergency admissions to hospital for adults and the percentage of people who are discharged from hospital within 72 hours of being ready.

Those indicators will help us to understand progress across Scotland towards our core priorities. The other ones will not be a surprise to people; they are exactly what members would expect us to measure in making progress.

We are investing in improving the data that is available to partnerships. Robust data that can be aggregated at different levels of granularity—for localities and partnerships—will be vital. Partnerships must use the data that is available to them to ensure that they focus their efforts on the

people for whom there are the greatest opportunities for improvement.

The new partnerships will manage the resources that are currently associated with 96 per cent of delayed discharges and 83 per cent of unplanned admissions for people aged over 75, for example. From our on-going work to improve the standard of the data that we collect, we now understand that, nationally, 2 per cent of the population accounts for 50 per cent of hospital and prescribing resource use. That represents a huge opportunity for partnerships to identify those people and, importantly, do something about supporting them better. We do not yet know whether that distribution is appropriate. We are gathering the community data that is necessary to understand the full picture, and we will help partnerships with that. Locally, such analysis will enable people, through strategic planning, to look closely at whether people are getting the right kinds of care to maximise their wellbeing.

By putting a human face on data, the new partnerships will be well placed to focus on priorities for improvement; on the people who need and use care most, to improve their wellbeing; and on improving the sustainability of services. In the future, that might mean providing more care in communities and making less use of expensive hospital care, when hospital care is not in the best interests of the person receiving care. We still have some way to go on shifting that balance.

Tackling delayed discharges and managing unscheduled care remain among my highest priorities. We allocated significant additional funding at the end of last year to reducing delayed discharge. The impact of our overall investments in delayed discharge will take some time to be felt, but I was pleased that the January census showed that 20 local authorities had only single figures for delays over two weeks and were well placed to deliver the zero target by April.

Our focus over the winter was on easing pressure on the acute sector, so it was pleasing that the most recent statistics indicated some improvement in delayed discharge across that period. However, we are not complacent, and we still have much to do. One patient delayed is one too many. I want to eradicate the problem. For people who are delayed, we provide the worst possible outcome at the highest possible cost. Clinical evidence shows that any delay of over 72 hours is detrimental to wellbeing. At the January census, 14 local authority areas recorded fewer than 10 delays of more than 72 hours, which shows that it can be done. Members will see that our indicators for integration include performance against a 72-hour discharge measure, which has been agreed and welcomed by COSLA.

Two priorities are key to the implementation of integration. The first, on which I have spoken at length, is improving outcomes for people who use services. The second, without which the first cannot succeed, is supporting the workforce into and through implementation.

The quality of health and social care in Scotland depends on its compassionate and motivated workforce. Ensuring that the workforce is organised appropriately to provide the right care in the right place at the right time will be central to success. People who work in multidisciplinary, multi-agency teams tell us that that approach is better for them and better for the people they care for.

Integrated working means that people are not working in silos. It avoids the situation where the left hand does not know what the right hand is doing. Most important, people find it satisfying to know that they are working in a team where the person who is being cared for is supported to achieve the outcomes that matter most to them.

Our ambitions for health and social care integration are clearly set out. Wherever someone lives and whatever their circumstances, we are committed to ensuring that this country is the best place to live a healthy, fulfilling and independent life.

In the spirit of consensus, I am happy to accept the amendments. I think that they add to our motion.

I move,

That the Parliament notes progress toward the implementation of the integration of health and social care, with new integration joint boards being established from 1 April 2015 in line with legislation; welcomes the substantial resources that are being invested to deliver integration; supports the agreement between COSLA and the Scottish Government on the core suite of indicators for integration; notes the commitment for NHS boards and local authorities to work together to deliver benefits for their patients and service users, and believes that integration is vital to realising the 2020 vision for health and social care, and providing the best caring environments for the people of Scotland.

14:45

Jenny Marra (North East Scotland) (Lab): I thank the cabinet secretary for the opportunity to debate the integration of health and social care services this afternoon. She and I agree that it is one of the biggest challenges for our health service; it is complex and difficult to get such things right, particularly at a local level.

The integration of health and social care is a reform that Scottish Labour has advocated for a long time. It is a firmly shared ambition of the Scottish Parliament. Against a backdrop of an increasingly ageing population and straitened

budgets, getting an efficient and smooth patient flow through our health system is essential if we are to end the shortfalls in care, which—let us be honest about it—exist in our communities today.

Integration should form part of a shift to a more preventative focus in the delivery of healthcare, dealing with smaller problems and identifying problems before they manifest themselves or become too big to manage in the home or in the community, and so end up as bigger, more expensive problems—in terms of their impact on both public budgets and people's lives—in our hospitals and acute system.

We recognise the hard work by local authorities and health boards across the country that is going into making the change happen. We recognise the willingness of people to create meaningful and effective working partnerships for the good of patients. We also acknowledge the difficulty in managing such a change, and we welcome the progress that has been made by the Scottish Government and local authorities across the country.

The establishment of the joint integration boards is a critical step in making a reality a reform that will, we hope, allow us to protect and care for people across our communities—predominantly the elderly but also others who are vulnerable—in their homes in a way in which we would want to care for our own loved ones.

I am struck by the many representations that I have had from stakeholders on the issues, because we know that there are complex and difficult challenges. Procedural issues have been raised with me, such as ensuring that our various local partners are consulted. There is also nervousness about budgets; as we speak, the two sides are coming together to thrash out budgets—how much the health boards put in and how much the local authorities put in. I have had many representations from councillors as to how local authorities will meet the expected budgets, given the constraints that they are under.

There is broad agreement on the principle of bringing together these two essential services and ensuring a joined-up and consistent approach. With such good will towards what is a difficult project, I am confident that everyone involved is doing their very best to make it a success. I am sure that we all agree that, although ensuring a more functional way of delivering health and social care is an important step, it can only be a starting point.

Today's briefing from the British Medical Association states that

"structural reform is not an end in itself and it is vital that these proposed new models for health and social care focus more on outcomes than management structures."

That is why I welcome the cabinet secretary's publication today of the core suite of indicators, which gives us a starting point as to what the outcomes look like so that we can measure progress against them.

The British Medical Association also cites investment in building capacity in community and social care services as a key issue that needs to be addressed. That is the essential point. When we have one budget struggling to deliver a service, and another budget that is also under constraints, pulling them together does not automatically deliver the results that we would want. I am sure that, like me, the cabinet secretary has received representations on that point.

Unless we properly resource our hard-working NHS staff and care workers with what they need, we will continue to see a logjam in the system and patient care will continue to be impacted. As I said, the boards' integration on 1 April is only a starting point. I think that a bigger step in the right direction would be a proper resourcing of care workers so that we can move to a point at which all care workers across the country are earning the living wage and where there are more of them to deliver the care that we need.

We also know—Labour has argued this point in the chamber before—that we need more nurses in our NHS to actually deliver the care that is required both in the acute setting in hospitals and in the community.

We would be remiss not to rehearse in this debate some of the challenges that people in our communities are facing, because it is quite a technical and complex matter to put together the joint integration boards. The human face of the current situation is never far from our surgeries as MSPs or from our communities. It is important to remember why the changes are necessary and why it is so very important that we get this right.

One reason is 15-minute care visits, which leave our elderly with insufficient care and more likely to end up in hospital as a result of not getting the care that they need.

There are unacceptable levels of delayed discharge. I take the cabinet secretary's point that she is making some progress, but I am sure that she would agree—as we had this debate in a public forum a couple of weeks ago—that the delayed discharge figures are still unacceptable. They mean that people are kept in hospital beds at the expense of their own health and at massive public cost.

Sandra White (Glasgow Kelvin) (SNP): Does the member agree that in some cases local authorities are simply not working with health boards, and vice versa, and that that causes delayed discharge?

Jenny Marra: What Sandra White says brings us to the whole point of today's debate. Local authorities and health boards are coming together to integrate care in order to prevent delayed discharge. I am trying to go through the impact in our communities, but what Sandra White says is indeed the whole point.

When Sandra White says that some local authorities are not working with health boards, I think that she touches on a good point. From what I have heard, some of the integration models across the country seem to be working more smoothly than others, and boards are coming together in a more holistic way in some parts of the country than in others. I ask the cabinet secretary whether she could address that when she sums up later: will the Scottish Government set standards for the country, so that we do not have a postcode lottery, for want of a better phrase, in which standards of integration are working better in some parts of the country than in others?

To go back to the human impact, we know that delayed discharge means that people are in hospital, at a cost to their own health but also at a great cost to the public purse, when they should be at home. We know that half a million bed days have been lost and that more than 400 patients have sadly lost their lives while waiting to be discharged after having been passed medically and clinically fit to go home.

We also know that the failure to meet accident and emergency targets across Scotland time and again, and especially this winter, is having an impact at the back door of the hospital, and that it is an integrated problem. We know that, every time we fail to get this right, a sick, vulnerable or elderly person is put through distress that should not happen in our modern health service. Despite the clear challenges that we face with our ageing population, and despite the budgets of both health boards and local authorities being under serious pressure, we can and must do better, and we must get this right.

We welcome the progress that has been outlined today, but we should also recognise that we are still a long way from realising our ambitions. I reiterate that integration on 1 April is the first step to getting it right.

It is our intention to support the Government's motion this afternoon, and I thank the cabinet secretary for supporting our amendment as well. In that spirit, I would be interested in hearing the Government set out its plan for exactly how delayed discharge will be ended. She pledged that it would be ended by the end of this year. Is that the end of this calendar year? If so, is there a plan on top of the integrated boards for how she will manage to do that? I share the cabinet secretary's determination and I look forward to her meeting her pledge on delayed discharge.

Today is a good opportunity to debate an important issue, and I look forward to hearing the contributions.

I move amendment S4M-12710.3, to insert at end

"; and welcomes the Cabinet Secretary for Health, Wellbeing and Sport's pledge to 'eradicate delayed discharge out of the system' over the course of this year".

14:56

Nanette Milne (North East Scotland) (Con): As the cabinet secretary said, the debate is timely, given that all health boards are required by law to submit their integration schemes for ministerial approval by 1 April, and given that the new health and social care partnerships across Scotland must be up and running by the same date next year.

Even before the legislative route was considered, there were a number of areas of good practice in which progress was being made towards the integration of health and social care—notably, from my point of view, the excellent collaborative work in West Lothian and Highland, which I saw at first hand as a member of the Health and Sport Committee. Unfortunately, such good practice is not uniform across the country—hence, the need for legislation. I am pleased to note that the first integration joint boards—for Ayrshire—have been approved this month, and I look forward to the forthcoming establishment of health and social care partnerships throughout Scotland.

From the unprecedented number of briefings that we have received ahead of today's debate, it is clear that there is complete agreement across all sectors that integration is vital if the 2020 vision for health and social care, which has cross-party support in Parliament, is to be achieved, and that that will require the ongoing commitment of NHS boards and local authorities to work together in pursuit of the outcomes that Scotland's patients and service users need and want, with services at local level being designed with and for the recipients of those services.

Without integration, it is hard to imagine how the complex needs of an ageing and increasingly frail elderly population can be met, and the aspiration achieved of people living good healthy lives in their communities for as long as possible, thereby reducing the need for unplanned hospital admissions, relieving pressures on our emergency services and helping patient flow through secondary care when that is needed, so that delayed discharge ceases to be the serious issue that it is currently.

However, it is clear—as other members have said—that there is still a considerable way to go to achieve the necessary integration between all the health and social care services that are required to cater for the increasing demands of demographic change. A number of organisations have this week expressed to us their current concerns on that.

The BMA stresses that health boards and local authorities must engage meaningfully with clinicians from primary and secondary care at strategic and locality level, and there is a clear message that GPs must have a leadership role locally, with the authority and influence to deliver effective integration. GPs, in my opinion, are pivotal in directing care for their patients, and their activities account for about 50 per cent of total spending on the NHS in Scotland, so their role in planning integrated services is clearly crucial. I was, I confess, a little bit dismayed at the Health and Sport Committee meeting this week, when we were discussing seven-day working, that although in our discussion around the table integration cropped up on several occasions, GPs were scarcely mentioned until I reminded witnesses of their key role—which, of course, they agreed with.

The Royal College of General Practitioners would like general practice to be recognised as the major hub in a network of community health provision, working with a team of health professionals including health visitors, district nurses, advanced nurse practitioners, associated health professionals, and social care and third sector providers, all of whom are key to the wellbeing of an ageing and increasingly dependent population.

Historically, those various professionals worked in silos—parallel to, rather than with, one another. It requires a significant change in culture and trust for people to set aside their professional differences and to come together as teams that are focused on the holistic needs of every person in their care.

The GP is the obvious person to lead such a team and to be fully engaged in planning local services. Having seen at first hand the success of the former local healthcare co-operatives, I read with interest the BMA's proposal for GP cluster groups within a geographical locality, working together and advising the health and social care partnership on provision and performance of services locally. The BMA suggests that that will give local control over service delivery, which will allow early resolution of problems, the development of best practice for patients and service users, and engagement of the GPs within the locality. Of course, we lost that engagement with the much larger CHPs, which had less responsibility.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I do not know whether Nanette Milne is aware of the King's Fund report, "Acute hospitals and integrated care: From hospitals to health systems", which was published very recently—in fact, it is dated 19 March. It reinforces exactly the point that she is making, which is that integration in England has been successful only where the challenge of integrating general practice and practitioners has been met.

Nanette Milne: I was not aware of that report, but I am glad to hear what Richard Simpson says. It is a fundamental point.

The third sector also has a key role in the successful integration of health and social care and could make a valuable contribution to service planning. Many good projects were developed using the change fund for reshaping care for older people, including the befriending service that was set up by Voluntary Action Orkney, and a collaborative transport project in my home region, which has been working to improve and co-ordinate health and social care transport, and to remove a barrier that prevents older people from getting to medical appointments or to local activities that are aimed at reducing social isolation. There is concern in the third sector that a loss of change funding could jeopardise the provision of such excellent preventative measures, which have been shown to improve the wellbeing of many people and have cut the number of GP and nursing consultations.

Marie Curie Cancer Care has stressed—I agree with it—that health and social care services are crucial to ensuring appropriate care for people who have terminal illnesses, whatever they are. The organisation is concerned about the lack of progress in some integration authorities' coming together, and it is worried that if the transition to integrated care is not done smoothly, there could be an adverse impact on third sector services that involve partnership with statutory bodies and which need decisions and funding to be agreed for service level agreements.

The Royal College of Nursing points out some issues that it feels need to be addressed in the year that remains before the deadline for integration if we are to be confident that the integration plans will, indeed, improve care. Those issues include the need for quality and safety to be written into commissions for providing services, whoever is delivering them. In order to ensure the robust governance of care, the RCN has developed a checklist of issues that it thinks local integration schemes should address. It also points out the need for integrated information technology systems across health and social care.

Nearly all the issues that are raised in the briefings that we have received indicate a need for

investment, and there is some concern, which was expressed in particular by the BMA, that the previously announced £100 million might not have been sufficient to build up the community and social care capacity that is needed to achieve genuinely integrated care. I have no doubt that the BMA will be encouraged by today's announcement of a further £200 million over the next two years.

There is widespread support for integration of health and social care but, as our amendment suggests, there are still enormous challenges to be overcome in order to achieve it.

We will support the other amendments at decision time.

I move amendment S4M-12710.2, to insert at end:

"; acknowledges the enormous challenge that integration represents, and calls on those involved at all levels to work to overcome obstacles, real or imagined, of previous practice or prejudice, to ensure the most successful outcome for both patients and staff".

15:03

Jim Hume (South Scotland) (LD): I start by welcoming today's announcement of £200 million for the integration fund, as well as the mention of telehealth and mental health services capacity.

The debate is timely, as we approach the deadline for local authorities to produce their integration schemes. That said, I note that Ayrshire has already had its schemes approved by the cabinet secretary. Clearly, the success of good integration will lie with detail from the very beginning.

However, there are challenges that we must address early in order to achieve the aims of the legislation, and I am sure that the Scottish Government will not be complacent at this stage. Health and social care integration comes at a moment when there is a chance to prevent a crisis from materialising.

As other members have done, I want to bring to the debate the views of the British Medical Association. The BMA has emphasised first the need to ensure that sufficient capacity building in community and social care services is accompanied by recurring and sustainable action for long-term planning. Secondly, the BMA said that there must be engagement among both primary and secondary care clinicians on the integration joint boards and monitoring committees, in order to allow co-ordinated and effective integration. Thirdly, it said that medical leadership must be allowed at local level, with GPs actively and strategically involved in planning of integration. Those three points are key to ensuring that patients and communities receive the necessary and appropriate capacity and support.

We know that the change will not happen overnight. Transition must occur in a highly facilitated manner while also addressing the main drivers for health and social care integration. Bedblocking is still a real threat to the maintenance of high-quality healthcare provision in hospitals. I welcome any progress that we are making, but the Royal College of Emergency Medicine warns that lack of hospital beds after emergency admissions is one of the main causes of higher patient mortality. To put it simply, crowding kills.

We have also heard that call from other experts. Patients are not being released from hospitals on time, which is causing bottlenecks in the system and reducing the capacity for caring for new patients. The numbers show that almost three quarters of total delayed discharge bed days relate to patients who are aged 75 or over, and it is estimated that the number will double in the next 10 years. We regret that the Scottish Government actually cut a third of geriatric beds after 2010, before integration was in place, because that has put additional pressure on the system, and we know the shocking figure that almost 170,000 bed days have been lost as a result.

An ageing population is a ticking time bomb unless it is addressed. More people are having to live with multiple complex and long-term conditions. Getting the right treatment at the right time and in the right place for those who need it is critical if we are to continue on track to make Scotland a leader in healthcare service provision.

We also need to think about how we can improve access to palliative care. We know from earlier research by Marie Curie Cancer Care, the University of Edinburgh and NHS Lothian that only 20 per cent of non-cancer patients in Scotland are receiving palliative care before passing away. Most patients in the study were identified for palliative care too late for them to benefit fully—on average, only eight weeks before dying. The resources that are put in place for integration should include resources for those who are at the end of life, who need support, empowerment and information to soften the transitions in their mental and physical health.

That is echoed by the British Heart Foundation, which is running a pilot programme of cardiac psychologists in NHS Ayrshire and Arran in which support is given after major incidents to patients with heart disease. Within two years of such incidents, 50 per cent of patients develop depression unless appropriate personal care is given. However, that is beyond the capacity of clinicians in hospitals. People should be assured of support when they return home after long hospital stays, and the only way to achieve that is by ensuring successful integration from the outset.

That is why I want to point out the last two points from the BMA. The involvement of GPs, who have an integral role to play through their expertise in public health, must be highly encouraged and facilitated. The Royal College of General Practitioners is calling for GPs to have the

"'network literacy' to ensure patients receive the care they deserve."

However, I remain concerned—the cabinet secretary will not be surprised that I raise this—that funding for general medical services has been cut to a record low.

I realise that the cabinet secretary will be at pains to talk about the £40 million of additional funding, but I am told by people in the profession that there is a lack of clarity about where that money is going, where it has been deployed and whether it has been allocated yet. Perhaps the cabinet secretary will mention that when she sums up.

Integration of health and social care is no small task, but it is welcome for the welfare of patients and for the dedicated health and social work staff who will be empowered to provide better care for their communities. It is a long-standing ambition of man—politicians and health professionals alike. For it to be successful, we need the Government to acknowledge the challenges and give the professionals the support that they need to allow them to give their patients the best care.

With nearly 170,000 bed days lost to boarding, the ticking time bomb cannot be allowed to continue. I look to the cabinet secretary for an assurance that she will support the Liberal Democrat amendment, which reflects the views of health professionals across Scotland. We will support all the amendments and the Government's motion.

I move amendment S4M-12710.1, to insert at end:

"; notes the view of the British Medical Association that successful integration of health and social care needs long-term planning of investment in building capacity in community and social care services, effective and meaningful engagement and involvement of primary and secondary care clinicians on integration joint boards and integration joint monitoring committees, and medical leadership and influence at the locality level, and calls on the Scottish Government to outline how it will achieve these key objectives".

The Deputy Presiding Officer: We move to the open debate. We have a bit of time in hand, so I can be generous with time.

15:10

Bob Doris (Glasgow) (SNP): I spent this morning with a gentleman called Tommy Taylor, who is 100 years old today and stays up in Parkhouse, in north Glasgow. He is a wonderful man and is still very sprightly. He lives independently in sheltered housing, but he has his own house. It was a privilege to meet and pass on my kind regards to him.

Tommy Taylor was not part of a "ticking time bomb"; he was part of the celebration of getting people to live into old age and be happy, healthy and content. I am not deliberately having a go at Jim Hume; it is just that the expression "ticking time bomb" does not sit easily with me. If we have an issue or a problem with people growing older, we have an issue with our value set. We should relish people growing older and value them in our society. I know that Jim Hume did not mean—

Jim Hume: That is not the impression that I wanted to give at all. I was suggesting that it is forecast that we will have more people who are over 75. The majority of beds that are blocked are for elderly people, so the problem is that we will get more and more pressure on beds.

Bob Doris: I promise that I was not trying to be unhelpful; I was just making the general point that we want more healthy, active ageing—that is all that I was trying to do.

The debate is an opportunity for the entire Parliament to come together and unite on the clear benefits that should flow from health and social care integration. Integration will begin in April 2015 and should be fully implemented by April 2016, so it is important that local integration partnerships are both supported and resourced. The Scottish Government has clearly invested and continues to invest much resource.

I will run through some of that investment. The integrated care fund, which we have heard about, will provide £100 million in 2015-16 for partnerships to improve outcomes and support service redesign in favour of prevention. Such financial support will build on the investment of the reshaping care for older people change fund, which provided £300 million over four years, ending this year. If we feed into the mix the £73.5 million retained centrally for national initiatives and the additional £100 million specifically for delayed discharge, we get a self-evident picture of huge investment in this area.

I have listed the undoubted resources that have been put in, but the point that I want to make is that the amount of cash invested is not necessarily a measure of the quality of service provided to patients. How the money is spent and invested in a strategic and co-ordinated way is what makes the real difference. The lived outcomes of older people are what matters.

We have the £100 million integrated care fund. Health and Social Care Alliance Scotland has brought our attention to the fact that a lot of what it

sees as successful pilots funded by the reshaping care for older people moneys have not been mainstreamed. The challenge for the integration fund over this year and the coming two years—I am delighted about the extra £200 million—is to mainstream some of that practice, and not just to have recurring pilots. I wanted to put that on the record.

On Tuesday at the Health and Sport Committee, my Labour colleague Dr Richard Simpson spoke about consultant vacancies in the NHS and concerns over the number of nurses who are being trained. I said that 1,200 additional consultants existed in the system and that there had been 2,300 additional nurses under the current Government. I was trying to put Dr Simpson's comments in context, but I also stressed that what is important is having the right professional, with the right skills, in the right place, at the right time, to help out. That professional will not always be a consultant or a nurse.

I get the feeling that on all sides of the chamber, including this side, we sometimes bean count and focus on the headcount in areas that get the headlines, be it consultants or nurses. Some of the evidence received by the Health and Sport Committee has shown that we need well-resourced, well-planned, multidisciplinary teams. Maybe we do not always need 1,000 more nurses. Maybe we need five or six nurses in a certain place, with a physiotherapist, another occupational therapist and a social worker available at weekends. Maybe we need that kind of thing.

Perhaps, when we take forward our integrated workforce planning, we should be less simplistic. Of course we need national workforce recruitment plans, national training plans for nurses and consultants and so on, but we also need better fleshed out workforce planning at a very localised level. I know that it is not impressive for politicians to say, "Can we have four more nurses and one physiotherapist?"; it makes more sense for us to grab the headlines by saying, "Give us 1,000 of this and 500 of that." However, this is about real quality local planning and multidisciplinary teams—and, surely to goodness, that must be what health and social care integration is about.

I have so many things that I want to say about this issue. I should, of course, mention Glasgow—and I hope that I can keep the consensus going by giving Glasgow City Council criticism and praise in equal measure. I think that there has been a bit of active gatekeeping in relation to vulnerable elderly people in Glasgow who are seeking residential home placements; indeed, I have constituency cases that would flesh out the significant concerns that I have about this matter.

In the same breath, however, I should say that David Williams, the head of social work in Glasgow, is also the head of the shadow integration board, and he and the health board have fast-tracked 120 new intermediate beds that I hope will tackle the very problem that I have highlighted. As I said, I wanted to give criticism and praise in equal measure. Perhaps we are starting to see some of the fruits of health and social care integration, because, as all the briefing papers that we received for today's debate point out, this is all about cultural shifts rather than structural change.

I want to say something about carers. For me, the health and social care multidisciplinary team must include care staff in a residential home. We have to get a bit more clever at identifying care worker churn—

The Deputy Presiding Officer: Could you draw to a close, please?

Bob Doris: —because we need stable committed care home staff to provide quality service in care homes. We also need better at-home care to ensure that people are able to live at home, happier and healthier, before they move to a care home. That should all be part of active positive local planning in a local area.

In conclusion, I appeal for fewer headline-grabbing claims about 1,000 more of this or 2,000 more of that and for good-quality local planning that does not grab the headlines but delivers for our constituents.

15:17

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): As Jenny Marra, quoting the BMA, reminded us, structural reform is not an end in itself. Although much of the guidance and many of the regulations over the past few months have related to structures, the truth is that structures are a necessary but not sufficient condition for successful integration. During the passage of the Public Bodies (Joint Working) (Scotland) Bill, various experts kept emphasising that the key issues were culture change, leadership, bringing teams together on the ground and locality arrangements, which are meant to be the engine room of integration.

I suppose that my first concern is that there is as yet no clarity about locality arrangements. At stage 3, I lodged an amendment that would have put something about such arrangements in the bill, but the cabinet secretary at the time, Alex Neil, said that it was unnecessary because there would be statutory guidance. However, that guidance has not yet turned up, and a general issue is that some of the guidance has been a bit delayed. For example, the City of Edinburgh Council told me that, although it had finalised its scheme with NHS Lothian at the beginning of November, a guide to

reviewing an integrated scheme suddenly appeared on 14 November and they had to make major changes. However, that is water under the bridge, and the scheme has now been finalised.

With regard to locality arrangements, the Scottish Government needs to establish clear frameworks and responsibilities, because we need to know what localities can decide, their role in delivering outcomes, who will be involved and whether budgets will be devolved to them. In particular, it is very important that all health professionals are part of the process. After all, we do not want the problems that we had with CHPs as a result of GPs not being involved enough; equally, however, we do not want the problems that we had with local healthcare co-operatives, with which other health professionals apart from GPs were not sufficiently involved. Nurses and all health professionals need to be involved in this.

Given the hope that integration will deal with problems such as unplanned admissions, I welcome the fact that all the specialities that are commonly associated with the emergency care pathway will be the responsibility of the integrated joint board. I will talk about that model, given that all areas apart from Highland are following it.

For more than a decade, the avoidance of any unnecessary emergency admissions, and the associated problem of eliminating delayed discharge, has been a kind of holy grail. It is therefore very welcome that the cabinet secretary has said that the indicators for those two issues will be central to the evaluation of the success of integration.

Jenny Marra rightly said that investment in social care services is crucial. I know, from a recent example in my constituency, the problems in social care. We all know about the 15-minute visits. The example that I have heard about over several weeks is that of a man in his 90s who needs to have two people visit him four times a day. However, that is not happening regularly. Sometimes there are missed visits and sometimes one person comes instead of two, which is no good, since my constituent requires to be lifted. The provider is private, and says that it cannot deliver his requirements because staff are leaving and it cannot get more. Furthermore, the council cannot take over my constituent's care. His situation encapsulates the current problems in social care.

I welcome the fact that we have the specialities commonly associated with the emergency care pathway in the integrated joint board, but there is a potential downside to that, which has been highlighted by the Neurological Alliance of Scotland—it has had a stand in the members' lobby all this week. Its point is that neurological care will be part of the non-integrated services, because there are not a massive number of emergency admissions and it is the number of emergency admissions that dictates whether the speciality will be in the integrated board. Neurology will not be there, and the Neurological Alliance is worried that those who are left with the non-integrated services will see little change in their care. The Neurological Alliance points out that specialist nurses for neurological conditions and other NHS professionals must have good links to colleagues in the community.

I talked to one man at the Neurological Alliance reception last night about the problems that he had had with getting care at home. Care workers were not relating to the health service and were not allowed to touch his medicines. That encapsulates the hard divide between local authorities and the health service, which we are trying to get beyond. I note the concerns of neurological organisations, because they will not be formally part of the integrated process.

When I talked to some of those organisations last night, it reminded me—I am sure that we do not really need reminding—of the crucial role of the third sector in services in the community. A few weeks ago, Jim Eadie hosted a reception for a report from "A stitch in time?", which was about older people with degenerative neurological conditions in Lothian and how the work of the various third sector neurological organisations did not just prevent avoidable hospital admissions, but optimised people's independence and wellbeing. That leads to the general point that the third sector must be centrally involved in the new integration arrangements, in terms of providing services, co-ordinating care and contributing to strategic planning.

The people who use support and services must be full partners in the design, delivery and improvement of health and social care. It is unfortunate that I am referring to them at the end, because they are more important than anybody else.

It is a good start for integration to bring together five health board executives and five councillors, but it is only a start if integration is to realise its full potential.

15:23

Sandra White (Glasgow Kelvin) (SNP): I welcome the debate and the progress that has been made towards the integration of health and social care, which the cabinet secretary mentioned. I look forward to the implementation of the new integration joint boards. However, I stress that health and social care integration must be patient centred. Patients, and older people in particular, must be part of the design and

treatment. Malcolm Chisholm has mentioned that issue. It should start from the bottom up. I am the convener of the cross-party group on ageing. I must say to Jim Hume that we look upon older people and getting older as something to celebrate. When we see how active lots of older people are today, they could put a lot of younger people to shame. We need to involve older people at the beginning to ensure that the legislation benefits all who need it.

I note that Nanette Milne's amendment highlights the challenges that integration presents, particularly between health boards and local authorities, as has been mentioned. I would perhaps go a little bit further. Like Bob Doris, I would suggest that culture change is probably the best way forward. Indeed, that is required to ensure that all agencies work together and that the legislation benefits everyone who it is supposed to.

Malcolm Chisholm spoke about the third sector. It is important that it is included. It does a fantastic job in our communities and beyond.

I will raise a couple of points that have not been mentioned but which are within the integration opportunities that are outlined in the Public Bodies (Joint Working) (Scotland) Bill's policy memorandum. A key outcome of seeking to integrate health and social care should be

"the utilisation of the talents, capacities and potential of all of Scotland's people and communities in designing and delivering health and social services."

The integration agenda should also be about the power balance. That important issue for health boards and local authorities has been mentioned. People must have greater control over the policies and services that impact on their lives. The Government acknowledges that in its 2020 vision which, building on Christie's recommendations, outlines the need to shift the balance of power to and build on the assets of individuals and communities, to support the self-management of long-term conditions and personal action, and to support partnership working, which includes a clear role for the third sector, community planning partnerships and new health and social care partnerships.

Dr Simpson: Does the member agree that neighbourhood care schemes, which are more significant in England and involve significant numbers of volunteers supporting vulnerable individuals before or after hospital care or, indeed, at the end of their lives in their communities, is a model that we should be supporting?

Sandra White: I thank the member for raising that point, but I do not think that there would be any use in pitting one agency against another. On Monday, the Equal Opportunities Committee visited Easterhouse, where I saw some fantastic agencies, such as the Food Train, which visits older people. Perhaps one size does not fit all. I take on board the member's point, but we have agencies here that deliver fantastic services for older people and others within their community.

I have another issue to mention. The growing older population has been mentioned on numerous occasions. As that population increases, we must look at the housing providers. That has not been mentioned. We must ensure that, whether it is Hanover Housing Association or others, they are fully utilised in the partnerships. I am sure that every MSP here has visited housing providers in their constituencies. They deliver a fantastic service, including enabling people to live independently or with help. It also helps people to have a community hub in their area.

We have perhaps slightly overlooked housing providers' role in the integration. I certainly think that they should be utilised more because they not only deliver local services but adapt housing for people who need it and they can create community hubs. They offer various levels of support, whether it be for care, specialised care or independent living. We should fully involve housing providers in health and social care integration, along with the other agencies that have been mentioned. People want to live independently. That is what the legislation is for. If we look at the housing associations along with the other community agencies, we will be able to give people a choice. That is what it should be about—not treating people like pegs to be fitted into holes but giving them a choice about how they want to live.

I appreciate and welcome Jenny Marra's amendment, as well as her recognition that, although some local authorities and health boards are not working well together, others are. I take on board and welcome her suggestion that we have a benchmark for care in the community. However, I do not know whether it would be possible to make one size fit all. Would a large local authority and a large health board working together work in the same way as smaller organisations would? We would need to look at that. It is a good suggestion, and I look forward to the minister coming back on the issue.

I also look forward to the annual reports that the cabinet secretary mentioned. It is vital that we look at whether integration is working. It is important that we see the results because, without them, we cannot implement the legislation fully.

I look forward to the legislation's implementation, so that people can live and be looked after with dignity.

15:30

John Pentland (Motherwell and Wishaw) (Lab): Like others, I look forward to better health and social care integration and improved partnership working to achieve that.

Of course, certain things will be necessary to ensure that partnerships work as efficiently and effectively as possible. For example, the IT systems that the NHS and local authorities use need to be compatible and the systems that are put in place need to do what they are supposed to. Unfortunately, from what I hear, that will not be a straightforward task. Perhaps that should not come as a surprise, considering that IT projects have a history of being overdue and over budget over and over again. I sincerely hope that lessons have been learned and that we do not find ourselves debating the negative side of integration in a year's time.

Obviously, the NHS and councils are the big hitters in the new arrangements. They have the budgets and responsibility to get the systems working smoothly in the new set-up. However, I want to ensure—and, indeed, they need to ensure—that that does not exclude, or obscure the importance of, other players in the partnership. The third sector's input is crucial to making sure that the systems work for the benefit of the patients and families whom they are supposed to serve. It has a really important role to play as part of the partnership that delivers the integration of health and social care services.

Certain basic principles of partnership working are essential to the success of the new arrangements from the viewpoint of patients, staff and third sector stakeholders. I recently spoke to mental health stakeholder group Lanarkshire Links about the importance of ensuring that it and other organisations can influence decision making and are not forgotten or pushed to one side when it suits those who hold the purse strings or have a different agenda.

It is very important that the structure and processes of partnerships recognise the importance of all stakeholders, including voluntary sector organisations, and facilitate their participation. In a true partnership, decision making is an inclusive process and consultation involves more than just decision makers giving information to those who are affected by their decisions. Consultation should not just be lip service; it should mean a genuine opportunity for people to have their responses taken on board and a genuine chance for them to influence outcomes.

It is also important that, when stakeholders are asked to sign up for plans, all the options are on the table. That should include options that require support from, or action by, others, such as the Scottish Government, other public bodies or a group of professionals.

Sometimes it is necessary to do the best that we can within available means, but we should not ignore alternatives or pretend that they do not exist, especially when they are preferable and would be feasible if only the Government or another body signed up for them. Transparency is pivotal so, if a plan is adopted because a better plan has been blocked, that should be made clear so that those who have blocked better options are held responsible.

When plans go out to wider public consultation, the public, as stakeholders, should also be made aware and get a right to comment on all possible options. Consultation documents should not conveniently ignore options, particularly when stakeholders have specifically stated that certain options should be included in public consultations.

After stakeholders and professionals have come together, devoted a lot of time and effort and given careful consideration to the issues before reaching agreement on the best way forward, Big Brother should not ride roughshod over their views when a plan is agreed. I know that when that happens, particularly if working relationships, careers and funding might be adversely affected, it is very tempting to suffer in silence, so hats off to those who are prepared to put their heads above the parapet and be counted.

The integration of health and social care will undoubtedly face teething problems and obstacles that will have to be overcome, but I am sure that those people who are tasked with delivering the changes will do so regardless of those challenges, provided—as the cabinet secretary said—that they leave their silo helmets at the door.

15:35

Kenny MacAskill (Edinburgh Eastern) (SNP): I join in with the spirit of consensus and agree with a great many of the points that John Pentland made. I put on record that integrating health and social care is the right thing to do. Arguably, it is long overdue. That is why we have such consensus. It is long overdue because it is a process that involves great difficulties and great complexities.

The biggest driver for the integration of health and social care is the fact that we have an ageing population, which puts stresses and strains not just on our ageing bones but on the services that require to be provided for those ageing people, whether in the national health service or at home by local authorities and social care. That in itself is a good thing. I recall getting a briefing—not in this chamber, but in a previous chamber—from Adair

Turner, who was doing research on the national pension age. I remember him mentioning that, in the space of a year, the average life expectancy had increased by considerably more than that.

That is a good thing because, in my parents' generation, when someone received their gold watch, they might be lucky if they had a sunset of six months to a year before they departed from this earth. In many ways, that was shameful. People should be able to enjoy their retirement and the benefits that they have accrued over a lifetime. However, the increase in life expectancy brings challenges, especially for those who have to deal with people who are more vulnerable or who have some of the difficulties that come with ageing or that they have acquired through ill health or other misfortune. It causes bedblocking and results in wasted resources. As MSPs, we all know about the humiliation that an old vulnerable person who wants to go home can suffer and the frustration that can be caused for families who are desperate to get their loved ones out, who must find resources in order to be able to care for them or to provide a home for them to go to, to avoid their being stuck in a hospital bed.

Such situations do not come about because anyone has a desire to see that happen, nor do they come about because people in local authorities or the health service do not care. They come about because of institutional difficulties. That is why we have to overcome the problems with bureaucracy. John Pentland made a point about people in silos in tin hats. Those matters have to be put beyond us. All constituency MSPs will be familiar with a to-ing and fro-ing that does not reflect well on the NHS or local authorities when it comes to people who want to get out of hospital and for whom places need to be found. Thankfully, such cases are few and far between and in the overwhelming majority of circumstances people come together to make sure that we end that.

However, it is not an easy process. The integration of health and social care will be extremely complex because, as John Pentland correctly said, we have multiple agencies. It is not simply personalities but bureaucracies that have to be overcome. All of us, regardless of the political party that we belong to and of whether we are representing a particular agency, local or national Government or the health service, are obliged to pursue the integration of health and social care, because it is the right thing to do. It is necessary, but it will not be easy.

I turn to the law of unintended consequences, which we need to guard against. That is less a matter for the cabinet secretary and the Government agencies and more one for local authorities. In particular, we must guard against unintended consequences for criminal justice social work. We need to take account of the fact that although there is sometimes a public perception that mental health is less important when it comes to the allocation of resources, criminal justice social work is a smaller section of the wider social work family.

There could be a great difficulty in that, as health and social care integrate, what is already marginalised in social work could be further jeopardised or endangered. I do not think that that would come about through any deliberate attempt by anybody, but the pressures that will be brought to bear on social work may impact on criminal justice social work.

We have some history of that in Edinburgh. I am old enough to recall the difficulties that we had with Caleb Ness. Changes took place in Edinburgh as a consequence of the tragedy that befell that child. Social work was brought within the ambit of education in the City of Edinburgh Council. That was probably prescient and the right thing to do. In a world of challenged resources, we had to limit the number of departments and ensure that we limited the bureaucracy, but there were implications for social work. As a consequence of the implications for social work, there were certainly implications for criminal justice social work.

That is but a microcosm of what we will see as we integrate health and social care. It is therefore incumbent on those who deal with social work and allocate resources to it to ensure that all the challenges that it faces, which are significant, are considered. Those challenges include the mental health issues that we face, which John Pentland commented on, issues that we face with child exploitation and historical sexual abuse, and all the issues that cause great public concern and put great pressures on social workers. If we do not take into account the requirements for the basic job of criminal justice social work, there is a danger that it may fall off the edge. As I have said, there is a requirement to monitor the law of unintended consequences.

Health and social care integration is the right thing to do. It is not just criminal justice social work that will be affected; there will be other aspects of social work in which clear pressure will be on health and social care integration. That is where the driver and the spotlight will be and where many of the indices that are sought by local and national Government will be focused. We have to ensure that, as a consequence of that, we do not see a debilitation of resources, morale or whatever else.

As I have said, that integration has to come about. Our people expect no less, our society requires it and the circumstances and the limited

budget mean that it is necessary. It is the right thing to do. However, sometimes when we do the right thing, we can take our eye off the ball.

That is why my plea to the cabinet secretary is to urge those who deal with the challenges that there will be in social work not to forget their co-responsibilities, because there will always have to be a social worker in court for a social inquiry report, and to ensure that the wider aspects of criminal justice social work are dealt with. We want to keep it local and at the point of interface. That is why the Cabinet Secretary for Justice will not go down the road of a single agency. However, we have to ensure that there is protection for the necessity of criminal justice social work and that we do not throw it out with the bath water as we see the integration rightly coming together.

15:43

Gil Paterson (Clydebank and Milngavie) (SNP): I am pleased to make a contribution in this debate as a non-member of the Health and Sport Committee. I was a member of that committee at the time of the evidence taking on the Public Bodies (Joint Working) (Scotland) Bill, which covered the integration of health and social care. I listened intently to the evidence and came to a conclusion fairly early. From the outset—I am speaking as an individual, not on behalf of that committee—it was clear to me that we were dealing with two massive beasts with vested interests not only in delivery of and responsibility for the services but in the size of their individual budgets.

From personal experience, I know that it is very difficult for a person to spend their budget in areas that they are not directly responsible for when they want to do their very best with what they have in order to live up to what is expected of them in respect of their own delivery. Therefore, it was almost inevitable that there was reluctance in some quarters to move outside their direct sphere of influence. It could be said that that is a natural state of mind.

The circumstances are challenging for Governments and I acknowledge that past Governments put a lot of time and energy into attempting to bring about the integration of health and social care. They should be congratulated on having the political will to do so.

When it comes to the present situation, and the fact that there is now a statutory obligation for the integration to take place, I am confident that the majority of members are committed to and supportive of ensuring that such a vital process is a success. Although the Scottish Government had to legislate to place a legal obligation on the two big beasts, nothing more than a simple cultural shift was needed, but it did not materialise. Hopefully, the legislation will encourage that meaningful shift to take place. A number of people, from service providers to service users, are relying on us to ensure that integration is a success, and we cannot fail them.

It should be acknowledged that there have been some very successful examples of integration without the need for legislation. For instance, in West Dunbartonshire, part of which I represent, an exemplary joint-working model is functioning at a high level, and that occurred without any legislation. The agencies, if I can describe them in that way, could see the benefits of integration to the public, particularly those who are in need of critical support, and to health and local government as well. Before people forget, we should put on the record our thanks to places such as West Dunbartonshire, which overcame the cultural barriers that still exist in many parts of Scotland, to deliver integration of services.

Another benefit of the consensus that exists in West Dunbartonshire between health and social care agencies is at a political level within the local authority. Although there was a political shift and change in the colour of the Administration, all parties were still signed up to what was best for the local people. The council is planning a very ambitious programme to provide new state-of-the-art care homes in different parts of the council district.

That has all happened through political consensus and a decision that will have a number of positives, including the opportunity to prevent bedblocking, which will have a positive impact on the health service at a national level while doing a great deal for the local people at the same time. For integration to be a success, there must be consensus and that is exactly what the West Dunbartonshire model shows.

I see consensus locally in the commitment to delivering an efficient, fair and high level of service to those who are in need of care and support. I also see consensus nationally in the Scottish Government, Parliament, local authorities and the health boards working together to ensure that integration is a success. I hope that the country and the people reap the rewards that will flow.

We can all take heart from and some credit for any success as the work on integration was started by previous Administrations and continued and delivered by the present Administration. If what we are proposing is a success and all the services work seamlessly together, the end product will be a general public who are satisfied and receive the highest level of care and support just when they need it. It sends a strong message to those that we seek to represent—the people of Scotland—that when our Parliament works

together, it is they who benefit most. I believe that the measure is of the utmost importance and I thank all of those members and colleagues in former Administrations who have worked through the years to deliver it.

I am sure that, because we are doing it by statute this time, things will happen fairly fast. I commend the motion and amendments; let us hope for a successful outcome.

15:50

Paul Martin (Glasgow Provan) (Lab): It does not get reported that often, but there are many occasions in this chamber when all the political parties represented here agree with each other. We agree with each other on the principles that have been brought forward in this case because all our constituents suffer because integration has not taken place. Kenny MacAskill made the valid point that it should have happened before now. The fact that it has been interrogated through the various levels of scrutiny in Parliament, and that we are going to implement it, is extremely important.

We have all heard in our constituency caseload the familiar tales of constituents who suffer as a result of the paperwork, the bureaucracy and the buck passing that have gone on for many years. Whatever level of government we are talking about, and regardless of the political parties represented at those levels of government, we have faced that challenge for many years. I hope that we can enforce the principles that the cabinet secretary has set out.

On many occasions we have heard kind words in the exchanges in this chamber, but it is extremely important that we ensure that the principles that have been set out today are enforced and that leadership is shown by whatever Government is in place. That will be extremely important in ensuring that the legislation is effective. In the past, we have passed legislation that integrated levels of government but it has not been enforced as effectively as it should be.

I take issue with the point that Bob Doris raised about the demographic time bomb. We have to face up to it. I will illustrate it in another way. Two days ago I turned 48. I was born on 17 March 1967. I know that I do not look 48—I do not expect any consensual comments in that respect. I hope to be 70 in the year 2037. By that year, it is projected that there will be 1.4 million pensioners. There is a ticking time bomb in respect of the fact that we have not prepared ourselves for the challenges that we will face in that year.

Sandra White made a valid point in referring to the housing challenges that we will face at that point. The cabinet secretary has laid out many of the challenges that we face, which I face as a constituency MSP almost on a weekly basis. Occupational therapy assessments have to be carried out to ensure that someone is able to be released back to their home, for example, and many other housing challenges have to be faced. Are we absolutely satisfied that our housing associations across Scotland are preparing themselves for the decades that face us? I cannot say with any degree of confidence that that is absolutely the case.

Bob Doris: That is a really helpful point. In my speech I tried to make the point that sometimes having an OT assessment take place on a Saturday morning might be more important than having an extra nurse on a Friday afternoon. I know that it is not a case of either/or, but does Paul Martin agree that workforce planning and management have to get a bit more sophisticated at local level?

Paul Martin: Bob Doris again highlights the practical realities. It is all very well for us to have passed legislation—it looks good on paper and it looks good in a document that is presented to the integration board. I am sure that there will be a number of acronyms to describe what these boards are meant to do. However, the proof of whether the legislation has been enforced effectively will be the experience of our constituents in the various constituencies and regions throughout Scotland.

I want to highlight the briefing that we received from Marie Curie in Scotland. I take this opportunity to commend Marie Curie for its excellent work. Few members—if any—will not have been touched by the good work of Marie Curie. I do not think that we recognise as often as we should its good work and how effective that is in ensuring that people can be discharged from hospital and that the end-of-life experience is handled as effectively as it should be.

The briefing makes a number of helpful points. First, it makes the point that 60 per cent of those with a terminal illness would prefer to die at home. I think that the figure could be higher than that and that the reason why there are people who do not say that they want to find themselves in that position is that they do not think that the proper support will be in place. I think that the challenge for us is ensuring that that point and the others that Marie Curie raised are faced up to. We must challenge that figure to ensure that those who want to die at home are able to access an effective package of end-of-life provision at that point.

Again, this has been a constructive debate. I have spoken in many constructive debates in this chamber. However, I stress that the proposal can be effective only if enforcement is in place, and we

must ensure that we monitor the legislation and come back to it—at an early stage, I suggest—to ensure that the integration boards are doing what they set out to do.

The Deputy Presiding Officer (Elaine Smith): We still have some time in hand for interventions, should members care to take them.

15:56

Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): I want to start by agreeing with Paul Martin's eloquent words about how we can all work together. The mechanics and the tools that will deliver the new integration boards, and the people who will use those tools, are crucial to the success of the approach that we are discussing.

The Scottish Government is well aware that proper financial resources need to be available. Everyone has made that case today, and I am sure that the Scottish Government is taking care of that. However, of course, it is not all about the money. As well as the undoubted commitment that is already in place through COSLA, the health boards and local authorities working for the benefit of the people of Scotland, we need to ensure that we extend those improvements beyond the immediate core aims of integrating adult health and social care, community health and some acute services.

With any substantial initiative that changes management structures, we need to be careful to avoid the traditional risks, such as financial wastage and inadequate or poorly positioned staffing arrangements—being on the Unison side of many an integration and change to an establishment, I know that having the staff in the right place at the right time is always beneficial. We also need to avoid the danger of neglecting stakeholder groups. I do not think that there is much danger of stakeholder groups being neglected; the number of briefings that we have all had sent to us shows that there is excellent engagement on their part.

I fully respect that a change such as the integration that we are talking about is not going to happen as a nice neat overnight package. We would love it if it did but, as my mammy used to say, nothing worth doing is ever easy. Different joint integration boards will probably introduce the system in slightly different ways, but it will be important to ensure consistency in the delivery of the services.

I want to concentrate on the theme of stakeholder engagement. As colleagues will already be aware, I have been involved in representing the interests of motor neurone disease sufferers for many years. The Neurological Alliance of Scotland has a stall just outside the chamber this week and has been testing all of our neurons. I am pleased to say that I got 9.5 out of 10—I got less than full marks because I did not know that smoking was good for someone with Parkinson's disease, but there you go.

Jackson Carlaw: There were actually 12 questions.

Christina McKelvie: They told me that I got 9.5 out of 10. I obviously missed the questions over the page. That has pushed me right down the list, and here I was, thinking that I was second from the top. I will go back and do it again.

Anyway, the Neurological Alliance of Scotland is the umbrella body of organisations and groups representing people affected by a neurological condition such as motor neurone disease. NAS points out that

"Living with a neurological condition can be a huge challenge for individuals and their families and friends. Neurological conditions are often complex, highly individual and impact on several aspects of a person's life. It's important that everyone involved is able to access the NHS, care and community support that is right for them throughout their life"

with any condition that they face. The authors add that integration has to be about people rather than structures. That seems so obvious that it shouldn't need saying, yet it is an omnipresent danger when bringing organisational change to a big entity—or two big beasts, as Gil Paterson described them.

We must never lose sight of the fact that it is at the "end users" that the services are directed. The end users are real, individual people with their individual needs and we must never, ever forget that.

Person-centred care is exactly what integration is designed to deliver. I am concerned a bit less about what it currently takes in and more about what it leaves out. Neurology services will not be integrated within the compulsory requirements demanded by the legislation. I know that it is a work in progress, but I think that that is a missed opportunity. As NAS puts it:

"This means that most people with long term or degenerative neurological conditions will receive their ongoing neurological care—including outpatient care—solely from the NHS. Meanwhile, social, community and primary care will be delivered via the local integrated health and social care partnership."

I fear it is an example of what we need to avoid, where structures become more important than patients. Unplanned admissions to neurology wards account for 54 per cent of all admissions, which is short of the 85 per cent threshold required. However, the percentage is misleading. Most people with neurological conditions will not

be admitted to a specific neurology ward from accident and emergency; they are much more likely to be on a general medical ward because of issues like falls and infections.

The driver behind integration of health and social care needs to be the breaking down of barriers to help people to access more person-centred care. NAS fears that

"unless the spirit of integration prevails across all services—and not just those that are subject to formal integration—people whose care is delivered in non-integrated services will see little change in their care."

I would hope that we can prove NAS wrong on that. In other words, to make this work, partnerships need to be made between the NHS, community, social care, third sector and, most importantly, the people who are receiving care services.

In a society where people increasingly suffer from a multiplicity of different conditions and where each person's home situation has a real impact—sometimes for good, but sometimes for bad—upon their physical health, we need to grasp this opportunity. Let us not use the legislation as an end result; rather, let us use it as a framework upon which to build stronger, better and more patient-focused services than the current structures allow.

From my 19-year career in social care, a few years into which I first met the cabinet secretary—we did not meet through politics, but met through our profession—I know, as does she, that for a big change to win buy-in and support from those who work in it and use the services we need to show that the outcomes are going to work.

With the imaginative and co-operative approach that we are taking in the Parliament today, and which the organisations are all taking, we have the tools, the people, and, most important, the will to make change happen for those who need it—the end users, who are the people who need these services.

The Deputy Presiding Officer: I reminded members that there is some time in hand for interventions, but I also remind members who make interventions to address them through the Presiding Officer. If members turn away from their microphones I cannot hear them, and worse than that, it is more difficult for the official report to pick up the points that are being made.

16:04

Joan McAlpine (South Scotland) (SNP): It has been said on a number of occasions today, and my colleague Christina McKelvie concluded on this point, that the debate should be about people, rather than structures. However, much of the material produced on the subject, by a range of organisations, is heavy on jargon and light on the human touch.

We need to get the management and operational structures correct, of course, and there is no getting away from the fact that health and social care integration is a very complex process involving a wide variety of organisations and professionals with different cultures and management styles. However, at the end of the day we are doing it for people—often vulnerable people—and everyone involved in the process, including us as politicians, must focus on their care, their needs and their individual wishes.

That is why I welcome the specific focus on individuals and their wellbeing in the core suite of indicators that the Scottish Government published this week. I welcome the fact that the indicators are person-centred outcomes and are based on feedback from those whose lives the change is meant to improve. I also welcome the scale of the indicators' ambition. The Government has set a high bar, which could be described as courageous, particularly given the financial pressures that we face in delivering public services—something that was underlined in the UK budget yesterday, which confirmed that £30 billion of deeper cuts are to come.

It is in that context that we view the outcomes published by the Scottish Government. They tell us what success looks like. Success will be judged on, for example, the percentage of adults who are able to look after their health very well or quite well; the percentage of those supported at home who agree that they are supported to live as independently as possible; and the percentage of people who agree that their health and care services are well co-ordinated and can be described as excellent or good. The Scottish Government has published 10 indicators that are based on feedback.

The Scottish Government has also published a further 13 indicators that are based on administrative data. They are no less ambitious or, indeed, person centred, because, of course, behind every statistic there is a human being. The statistical indicators judge success by, for example, reductions in premature mortality, emergency hospital admissions and readmissions after discharge. They also measure the number of falls, the percentage of adults with intensive needs receiving care at home, the quality of care in care homes and the amount of expenditure on end-of-life care.

It is vital that we keep a close eye on every single one of those 23 outcomes. I therefore welcome the establishment by the Scottish Government of the person-centred health and social care collaborative, which brings health and

social care together to help roll out best practice across Scotland. That is particularly important given that the changes will take place at a local level and, ideally, at a community level. Of course we expect national standards of care, but different communities will take different approaches.

For example, in Dumfries and Galloway, in the south of Scotland, the local authority and health board boundaries are identical. The council and the health board have therefore chosen, some would say, a more radical and ambitious plan for integration—perhaps the most ambitious in Scotland. I have to say that it has still to be approved by the full council and health board later this month.

In addition to the services that the Public Bodies (Joint Working) (Scotland) Act (2014) requires to be delegated to the integration joint board, the shared ambition of the NHS board and the council in Dumfries and Galloway is to include the entirety of acute hospital services, including facilities management and women's health services, as well as services for people under the age of 18. It is hoped that the full delegation of those services will alleviate any concerns, such as those expressed by the Neurological Alliance of Scotland, that some services will not be part of the compulsory integration of health and social care.

The proposal in Dumfries and Galloway is intended to ensure flexibility and full accountability for the effective deployment of resources, in order to enable the integrated system to focus on the whole health and social care pathway and the ability to redesign across the system. I very much hope that it will be a success and will offer a model of best practice to other parts of Scotland.

I was pleased to hear a number of members talk about the third sector. In preparing for the debate, I spoke to David Coulter, chief officer of the third sector interface in Dumfries and Galloway. The interface has an excellent relationship with its community planning partners and is fully committed to and engaged in the integration agenda locally.

The interface recently got agreement from the integration programme board to fund posts that will enable it to have staff who are dedicated to the integration policy agenda. The money will come from the integrated care fund that the Scottish Government announced in July last year. That is, of course, welcome. It demonstrates a real desire among public sector partners to work with the third sector. However, the funding is for one year only, so it is difficult to make plans beyond March next year. Third sector organisations often face such challenges at the local level. Perhaps Scottish ministers could give some guidance and direction to the joint boards in relation to the resources that the third sector will require if it is to fulfil its role effectively.

In that context, I take this opportunity to commend the briefing from Marie Curie Cancer Care and its comments on effective partnership working. The third sector is extremely wide and varied, with different organisations able to offer different levels of support and services. Marie Curie makes the point that it has been widely recognised for its expertise in designing and delivering palliative and end-of-life care. It should be involved in the co-design of services, even if it does not actually sit on the joint boards. The consultation with the third sector has to be deeper and wider than simply having the interface sitting on the board, and organisations with specific expertise, such as Marie Curie, should be consulted directly.

16:10

Elaine Murray (Dumfriesshire) (Lab): In taking part in the debate, I was concerned not only that I would have extra time of up to seven minutes or so, thanks to your generous timing, Presiding Officer, but that somebody would speak about one of the things that I wanted to speak about—the radical proposals from the Dumfries and Galloway area. Joan McAlpine has already partly described the scheme, so that has already taken a little bit out of my speech. It is important, as she said, to realise that the scheme has not been approved yet and that agreement still has to be got from the council and the health board, and ultimately from the Scottish Government. However, it is an interesting proposal and is to be commended.

It is, of course, easier for such a solution to be developed in Dumfries and Galloway because of the coterminosity of the council and the health board. It is obviously easier for two organisations to deal with each other rather than for one council to deal with several health boards or one health board to deal with several councils.

One of the exciting things is that, if the proposal goes through, the health board and the council will transfer some £300 million of resource budget, which is fairly significant. They will do so because the health and social care partnership board believes that that sort of major transfer offers the best chance of achieving real change and the devolution of decision making to localities, which is important in a large rural area such as Dumfries and Galloway. Such devolution means that locality management would occur in the four area committee regions of Dumfries and Galloway. Although the assets would remain with the health board, decisions over implementation of the capital programme would rest with the locality board. There would also be democratic

accountability through the area committees. The model could extend further if it is successful.

Kenny MacAskill made an important point about the potential threat to criminal justice social work services. This is an opportunity to look at how well those services work together. In criminal justice social work, there is a need for agencies and the third sector to work together to tackle reoffending, for example, and to consider how to prevent the involvement in the criminal justice system of young people who are at risk of becoming involved in it by providing services for them. As we take this work forward, there is a lot of opportunity for other service providers to learn from the experience of integrated care.

The model that is being developed could be of particular benefit in communities. I know that in Langholm, in my constituency, the health board and the council have already been working together with private sector providers to tackle local issues. There is strong support for the Thomas Hope hospital, but it is not really a modern hospital. It is an old-fashioned community hospital and it is not really up to what is required now. The only privately owned care home closed down because it refused to take on board the recommendations of the Care Inspectorate over a long period of time. There is also a shortage of suitable housing for what is an ageing population.

Discussions about those issues have been going on for a long time, but it looks as if a solution is there, and the implementation of the integrated joint board will help to bring that solution forward. The approach means that local solutions can be developed to meet the needs of local communities. Social work services, GP services and community hospitals should be managed locally so that they have the flexibility to respond to local need. The combined budget should mean that problems such as delayed discharge can be tackled across services.

Having said that, in my area, delayed discharge is not just about people not wanting to pay for care home places—it is not quite as simple as that. In parts of Annandale, Eskdale, Nithsdale and Upper Nithsdale, delayed discharge is often caused by an acute shortage of care providers, not because people are unwilling to take on the provision of services but because the care services are simply not there. In some towns and villages, the majority of people who come to me with delayed discharge problems say that they do not have the services in their area.

There are issues to be addressed around the payment of care workers, respect for care workers and promoting care work as a career.

The £3.4 million that was announced in January for the Dumfries and Galloway IJB is very welcome, but the money will not solve the problems immediately. There is other work to be done, and there will be challenges that the IJB will obviously have to face in trying to solve some of the issues.

I am excited about this. It is only five years since the closure of most of the community hospitals in my constituency, including those at Langholm, Lochmaben, Moffat and Thornhill, and since the health board was proposing the centralisation of services in Annan and Dumfries. Jim Hume will remember that: he led a members' business debate five years ago on that issue. A consultant paid both Jim Hume and me a visit and more or less told us that politicians should keep their noses out, because they did not understand the issues. Of course, we said that we were representing our constituents.

There has been a tremendous amount of progress from the position five years ago, when community facilities were being closed. We will have local management of those community facilities, although that does not mean that it will be easy or that there will not be difficult decisions to make. The Annandale and Eskdale area will have four community hospitals, and there will be difficulties over what should be prioritised for which communities and what should take precedence. Integration will not solve everything. The important thing is, I hope, that nobody will say, "It's just people in Dumfries making decisions for my community." There should be proper community engagement involving service users and their families.

This is exciting, and I really look forward to seeing how things work in practice. It will be possible to learn a lot from how we work across services. I very much welcome the approach.

The debate is obviously consensual, which is gratifying in itself. However, as the IJBs become established over the next year and start taking over the work, we will learn a lot of interesting things, which we will be able to apply across services and into other areas of service provision.

The Deputy Presiding Officer: Before I call Richard Lyle for the final speech in the open part of the debate, I note that there are members missing from the chamber who have participated in the debate. I encourage them to return to the chamber for the closing speeches.

Mr Lyle, I can give you seven minutes or so.

16:18

Richard Lyle (Central Scotland) (SNP): Thank you, Presiding Officer. It is unusual for me to be last and to get the full seven minutes. Generally, it

is cut down to four, three, two—or even none at all, which happened to me a couple of weeks ago.

The Deputy Presiding Officer: On this happy occasion, Mr Lyle, I can give you extra time.

Richard Lyle: I am more than pleased to take the extra time.

I begin by saying how pleased I am to speak in this important debate on health and social care integration. I am particularly delighted to speak as a member of the Parliament's Health and Sport Committee. I thank all the organisations concerned for their briefings.

The Public Bodies (Joint Working) (Scotland) Act 2014—the bill was passed in February 2014—finally put in place the framework for integrating health and social care and received cross-party support in the Parliament. I am very happy to hear this afternoon that that support remains.

The 2014 act allows health boards and local authorities to integrate health and social care services in two ways, which continues the Government's efforts to devolve decision making further by allowing health boards and local authorities to agree on which approach is best for local needs.

The first option that is available to local authorities is delegation to an integration joint board of responsibility for planning and resourcing service provision for adult health and social care services. The board will include health and social care professionals, the third sector, users, carers and other key stakeholders. The minimum that the health boards and local authorities must delegate, broadly speaking, is adult social care services, adult community health services and a proportion of adult acute services. As I am sure members know, it will be at the discretion of local partners to decide whether to integrate children's services now or in the future.

In order to achieve the best possible results, health boards and local authorities must involve and engage their key stakeholders in the development of a draft integration scheme and take into account the views and opinions that are expressed during that process.

The second integration model option that is available to local authorities involves either the health board or the local authority taking lead responsibility for planning, resourcing and delivering integrated adult health and social care services in their area. As with option 1, the lead agency can decide to include children's services in the integration programme now or at a future date. The chief executive of the lead agency will be responsible for developing the strategic plan for the integrated services and will be required to set up a strategic planning group.

We have the advantage of strategic plans for older people's services already being in place in every partnership area in Scotland, which will provide a good starting point for the work. Plans should be as fit for purpose as possible, regardless of which integration option a local authority adopts.

Integration is an ambitious programme of reform to improve services for people who use health and social care services. It will ensure that health and social care provision across Scotland is joined up and is seamless, especially for people with long-term conditions and disabilities, many of whom are older people. To that end, the Scottish Government announced that an additional resource of £100 million will be made available to health and social care partnerships in 2015-16. That money is being provided to support delivery, to improve outcomes from health and social care integration, to help to drive the shift towards prevention and to further strengthen the Government's approach to tackling inequalities.

Bob Doris: Richard Lyle mentioned the £100 million that will be available in 2015-16. Does he believe that the additional £200 over the subsequent two years that has been announced today—[*Interruption*.] I say to members that there is £100 million for 2015-16 and £200 million for the following two years. Does the member agree that that consistent funding over a long period gives local boards opportunities to take a long-term strategic approach rather than to think for the short term?

Richard Lyle: I certainly agree with Mr Doris. It is £200 million, and not £200, as he said.

The £100 million that is being provided will build on the reshaping care for older people change fund, which has been a powerful lever to support the third sector, the NHS and local authorities, among others, to work together more effectively and to share ownership of the local change plans and delivery.

The new integrated care fund will be accessible to local partnerships to support investment in integrated services for all adults. The funding will support partnerships to focus on prevention, early intervention, and care and support for older people with multiple complex conditions.

It is important that, as a country, we continue with integration of health and social care, because the people of Scotland are living longer and healthier lives. That is great news, but it means that the needs of our society are changing; the nature and form of our public services must change along with them. Overall life expectancy in Scotland has increased over the past 10 years, and our older population is likely to increase by about two thirds in the next 20 years, as most

members have said this afternoon. We need to change how we deliver health and social care now in order to prepare for the future.

It is hoped that by improving the quality and consistency of care for older people, we can stop the cost shunting between councils and the NHS that results in older people languishing in hospitals when they are fit enough to be sent home. I for one will welcome that.

It is important that this SNP Government remains absolutely committed to free personal care, which delivers better quality of life for vulnerable older people in Scotland. I firmly believe that it is only right that older people feel fully supported to live at home, or in as homely a setting as possible, within their own community, for as long as possible. The independence and dignity of older people should be celebrated.

The Deputy Presiding Officer: We turn to the closing speeches. There is still time in hand for interventions.

16:24

Jim Hume: We have had a quite consensual debate. The extra £200 million, on top of the current £100 million to help with integration, has been welcomed by all sides. However, there has been some acknowledgement that there is work to be done. Of course, there will always be work to be done.

A lot has been said about the importance of incorporating all relevant stakeholders into the integration of health and social care. Providing enough support to communities, doctors and—very importantly—carers to achieve proper integration is a considerable task that from the very beginning must be planned down to the last detail. A key part of my Liberal Democrat amendment recognises that. We are happy also to support the Conservative amendment, which also reflects the need for stakeholder involvement.

I want to emphasize the importance of the integration of health and social care and its impact on our NHS, which members have acknowledged. As I said earlier, we know that there are concerns about the increasing pressures that the NHS is facing; the Royal College of Emergency Medicine expressed its grave concerns to me recently that the NHS is close to bending under the pressure of an increasing number of patients to care for, with resources not being in the right place at the right time. I want to make it clear to Sandra White and Bob Doris that I absolutely celebrate the fact that more and more older people are living active lives, but Paul Martin helped to clarify matters by saying that there is still pressure as a result of the ageing population. For the record, in 23 years I will be one of the 75-plussers.

Let us be clear. In the quarter from October to December 2014, nearly 170,000 bed days were lost due to delayed discharge patients. The majority of the beds—more than 100,000 bed days—were occupied by patients who were aged 75 and over. We know, however, that since 2010 geriatric beds have been cut by a third. There is an imbalance there: bedblocking and lack of beds are causing jams in our systems.

Too many people who are ready to go home are still in hospitals as we speak. In January this year, 3,000 patients were waiting to be discharged. The waits extend to more than six weeks, which is no good for patients or—very important—for staff morale.

Bob Doris: I put on the record that in 23 years Jim Hume will be a time bomb.

On the serious point that he is making on delayed discharge, there are significant challenges for a number of allied health professionals including physiotherapists and occupational therapists, and for clinicians including pharmacists who face significant challenges regarding changes to their working patterns. I believe that they are all up for it, but does Jim Hume agree that significant changes to working patterns are required to assuage the pressures of delayed discharge?

Jim Hume: Absolutely—we must look at how everybody works. I know that the Government is considering that. We must look at how GPs work as well. It might not be popular with many, but perhaps we need to consider changes to GP surgery opening times.

Hundreds of people wait for more than 12 hours in A and E units because of shortages and we know that A and E admissions for older people are at an all-time high. With that in mind, the Liberal Democrats are happy to support the Labour amendment, and we look to the cabinet secretary for assurances that she will be true to her word on the commitment to end bedblocking. I am sure that she will.

For patients with terminal diseases, heart conditions, neurological illnesses—which Christina McKelvie mentioned—other physical conditions and mental illnesses, experts have been arguing that the smooth transition from care establishment to care in a community environment is the holistic approach that can exponentially improve their health. That is why we want to see meaningful engagement with specialists in the community. We want to see real support for GPs, carers and nurses, and also for the family members who take care of their loved ones. As members including Joan McAlpine have said, the solution must be person centred, which is why it is fundamental that we involve primary and secondary care clinicians,

and that we have all-round input on the right direction of community care.

As for carers, who have been mentioned this afternoon, it is vital that we look after them, because they will be delivering a lot of the work. Indeed, we should consider putting in place career structures that would allow them to progress their careers in the NHS and in local authorities. That would be an interesting approach.

The successful integration of health and social care is a major task for stakeholders, and we welcome the Government's announcement of an extra £200 million funding over the years. After all, we cannot afford to leave such a major project underfunded when we know that our population is ageing and that more people are living with multiple complex and long-term conditions. The integration of health and social care is not a static process and, like Paul Martin, I support Marie Curie's calls for regular reporting, particularly on palliative and end-of-life care services.

We must look at preventative measures, especially for our older population in their homes, so I wonder whether the cabinet secretary can confirm whether part of the budget will be allocated for housing adaptations and aids to allow people to live independently.

I note that in her announcement today the cabinet secretary mentioned telehealth and building up mental healthcare capacity, both of which I welcome. Service provision for children, adult and older people's mental health services is severely lacking, and I do not have to remind the cabinet secretary that treatment times in mental health are being missed. The Liberal Democrats believe that, to that end, the cabinet secretary and her ministers should take the bold step that I have already mentioned of enshrining in law parity between mental health and physical health, which would send a clear signal that the Scottish Government is taking mental health seriously. I know that the cabinet secretary will not be surprised that I am mentioning the issue.

It is vital that we focus our attention on alleviating the pressures that we know exist in the NHS and that we allow staff to do their jobs and patients to get the care they need. Integration will be key to achieving that by ensuring that the NHS and the local partner authorities work together. Elaine Murray mentioned Dumfries and Galloway community hospital, on which, as she correctly pointed out, I had a members' business debate. Within a day or two of that debate, NHS Dumfries and Galloway had withdrawn its consultation. Elaine Murray was also quite right about the clinician; he came into my office and said, "Hell mend you if this doesn't go through." Obviously hell will have to mend me.

As we approach 1 April, the role of the new joint bodies should be to develop care strategies by listening to the constituent authorities and various stakeholders and responding to their needs. Similarly, the minister's role must not be to dictate Government positions, but to assist in delivering optimum outcomes. As members have recognised, there is still much work to be done, and I hope that the cabinet secretary will respond to the issues that have been raised in today's debate.

As I have said, we will support the motion and all the amendments at decision time.

The Deputy Presiding Officer: Many thanks. I call Jackson Carlaw. Mr Carlaw, you have seven minutes or so.

16:32

Jackson Carlaw (West Scotland) (Con): I agree. [*Laughter*.] I realise that, if I were to leave my closing speech at that, it might not be entirely helpful to the Presiding Officer. However, the fact is that there has been a great deal of consensus this afternoon, and it is clear that members across the chamber have drawn on the unprecedented number of representations that we received to inform the debate. I therefore want to make a number of specific points as well as some general ones.

First of all, though, what has been itching my conscience this afternoon is Bob Doris's comment that the highlight for poor Mr Tommy Taylor on his 100th birthday was a visit from him. I simply seek an assurance from the member that there were greater treats in store for Mr Taylor as the day wore on.

Bob Doris: I should tell Mr Carlaw that Tommy Taylor was very pleased. He was having a celebratory lunch this afternoon and a surprise party tonight, so shush—don't tell anyone. I gave him a bottle of malt whisky that had been signed by the First Minister, and I am sure that when it is Mr Carlaw's 100th birthday the First Minister Nicola Sturgeon will do the same.

Jackson Carlaw: I think that that is quite marvellous, and I am quite sure that knowing that the duty on that bottle has been cut will have been a great boost to Mr Taylor. However, I put on record that if I am fortunate enough to live to that venerable age I do not wish to be visited by my local MSP. [*Laughter*.]

Otherwise, Mr Doris's speech was quite saintly in his quiet admonition of those of us who feel that another 1,000 nurses for the health service, funded by one means or another, might be useful. I only hope that, if the Government comes forward with a similar proposal next year, Mr Doris will be

equally circumspect and wonder whether that is nothing more than a headline that is being advanced. I will wait and see.

What brought Bob Doris to his feet was Mr Hume's comment about a "ticking time bomb". I do not look at Drs Milne and Simpson and think, "There's a ticking time bomb," although our ageing population certainly represents a challenge. However, I understand Mr Hume and sympathise with him. A ticking time bomb is obviously very much on the minds of Liberal Democrats as we move towards the general election. On the other hand, I was a little concerned to hear Mr Martin also publicly acknowledge the ticking time bomb metaphor. I wondered whether that, too, presaged something.

Integrated health and social care is hugely important. It has had support throughout the chamber and in the Health and Sport Committee at all the stages at which it has been discussed. However, the great challenge is that it is being discussed in relation to an NHS that is built on shifting sands. There is not just this one enormous challenge and all the complexities that are associated with it. There is a growing recognition that something substantial and significant needs to change in primary, secondary and preventative care, in mental health and in palliative care. The challenge of integrating health and social care therefore sits not in isolation but alongside all the competing challenges that face the health service.

Last week, I visited an A and E department and the staff told me that social care is great if the patient presents Monday to Thursday, from 9 till 4. However, if the patient presents after that, we have a problem, because we do not seem to have the apparatus beyond the A and E department, in hospitals or out there with social work, to put together the kind of package that is necessary. That is one of the big challenges.

Another example is my mother—she will not thank me for mentioning it. She was in hospital repeatedly recently and her GP knew nothing about it. When she came out, we tried to get her an appointment with her GP, whose secretary said, "If she's been discharged from hospital she can't need to see the doctor." The earliest appointment was five days hence, during which time she was at home in what I felt was a completely unsuitable condition. When she finally saw the doctor, something was done. However, when she was in hospital, no one gave me a leaflet. I wondered how we were going to organise any kind of support. No one discussed it. I eventually had to rake through all the drawers, open up the "Yellow Pages" and find something. I have the wits to do that, but—despite everything that we say about the excellent experience that many people have—there must be lots of people who do not have the wits and who find themselves floundering in a situation that is completely avoidable and totally unacceptable. That is another of the challenges.

Dr Simpson: Mr Carlaw may be interested to know that we are just completing a freedom of information inquiry that is aimed at determining how many social workers are sited in the acute hospitals. It is quite surprising how many of our acute units have no social workers based in them. Mr Carlaw's point is well made.

Jackson Carlaw: I thank Paul Martin and Sandra White for raising the issue of housing; I have raised that issue in debates before. We are not just talking about social housing and housing associations. In planning, we now need a recognition that we have a population who will enjoy living to a far greater age but who will want to stay within their community and be independent within their community. Someone said to me, "I don't want to go somewhere where the only conversation the following morning is who survived the night." I understand how they feel; I quite often feel that way on Thursday afternoons. We need to ensure that people have the option of housing within the community. As we plan new housing, we should plan that option, too, because that is where people will be safe. Many of the problems that arise happen because people have lived too long in accommodation that used to be appropriate, but which, as they have aged, has become less so.

There were lots of good contributions to the debate, for example from John Pentland, Kenny MacAskill and Gil Paterson. I very much agree with Christina McKelvie's point about the Neurological Alliance. Although it is not included in integration, I think that we want to see the same culture shift in that area—we do not want people to feel that they are excluded. Joan McAlpine made pertinent points, as did Paul Martin, about palliative care and the challenge that that presents. As a nation, we have relied very much on the generosity of many people out there to sustain the present palliative care option. We must recognise that, as a country, a nation, a Government and a state, we will need to contribute far more directly to that as we go forward.

Presiding Officer, I know that your colleague, John Scott, is delighted that North Ayrshire, Arran and the three councils there are ready to progress the plans from April.

As I said, the NHS is built on shifting sands. That is not a criticism; rather, it is the reality of all the challenges that it faces. We have tremendous hopes. We hope that those will overcome our fears, some of which were fuelled by the community health partnership experience, where

some of the good will implicit at the start of the process was eroded. We must ensure that that does not happen here. However, it would be naive not to have some fear for our hopes. The process will not be smooth and, despite all the good will and the expectation, there will be challenges. We have a cross-party alliance in Parliament on this issue, so we will have to step up and face and meet those challenges as we go forward.

16:40

Rhoda Grant (Highlands and Islands) (Lab): The Scottish Labour Party supports the integration of health and community care. We, too, believe that health must be delivered in the community.

The Scottish Government's 2020 vision states that care should be delivered

"at home, or in a homely setting."

It is clear that the whole chamber is united around that aim. However, Gil Paterson and Paul Martin pointed out that it will take much more than legislation to make it happen. A culture change in the organisations that we are asking to integrate is needed, along with an end to the buck passing that happens just now. People will need to work together with the aim of providing the best service to their patients and clients.

We need more skilled nurses and GPs in the community, so I disagree with Bob Doris in that regard. However, I agree with him that we need more allied health professionals—OTs, physiotherapists, speech therapists and the like—working in the community, supporting people at home and providing anticipatory care that keeps people well and independent in their homes.

Bob Doris: I am sure that the member does not want to misrepresent my point. I was saying that to focus on one discipline, such as nursing, rather than on how that staff group links in with multidisciplinary teams, might not be the visionary idea that we would want for health and social care integration. We should not be simplistic. We are not saying whether there should be more or fewer nurses; we are saying that we must get the right number of nurses as part of a multidisciplinary team and that the workforce needs must all be planned. Surely the member would welcome that.

Rhoda Grant: Indeed I would. I was making the point that we need all the health professionals working in the community to provide support. However, we must go further. We need to get consultants and specialists out of the hospitals and into the communities. That is not always easy, but we can use, for example, telehealth, to link hospital consultants and experts in their field with community medical and care staff. That would make a big difference.

We must also empower the staff working in the integrated service. They must be able to intervene quickly and make decisions about care, so that they prevent people from going into hospital in the first place. That is hugely important. It has worked well where staff on the ground have been empowered to do that.

We welcome the cabinet secretary's commitment to end bedblocking by the end of the year. However, as Jenny Marra said, it would be good to see a plan of how that will happen. We must also keep monitoring the situation. That is important because, at the moment, community care is not suitable. As Elaine Murray said, it is often a lack of suitable care, especially in rural areas, that leads to people remaining in hospital and not getting out.

We also need step-up and step-down care that not only prevents people from going into hospital in the first place but speeds up their discharge, so that they can return home, where they would have more specialised care until they became more able.

Jenny Marra and Kenny MacAskill talked about the effect on a person's health of being inappropriately stuck in hospital. It can deskill, disenable and weaken them. They are trapped there, without their families around them. They suffer the consequences; they are disempowered.

We must invest in our home-care staff. We need to have a career pathway; we must professionalise the service. It is important that we recognise the skills of the workforce. We also need to make sure that they are trained for the job that they do and that they understand the conditions of the people that they are looking after.

I was at a conference in Inverness recently where there were two home-care workers. One had worked in a nursing home and the other in people's homes for a number of years, but it was only when they moved to work with Highland Home Carers that they received any specialist training in the field in which they worked. They said that that made a huge difference, especially for those who deal with people with Alzheimer's. It is very important to have carers who are trained to look after such people properly at home and who are able to use some of the technology that exists to help to do that, such as pressure pads and help calls.

A number of speakers talked about neurology, including Christina McKelvie and Malcolm Chisholm. It is disappointing that it has been left out, as people with neurological conditions would benefit a huge amount from having integrated care, because a lot of their care will have to be provided at home and in the community to allow them to live their lives properly.

We need to ensure that care workers are paid properly. It is important that they are paid a living wage and that we look at how we compensate them for their skills and training. We need to end the 15-minute care visit, which is difficult for everybody involved—the carers and the care providers—and have proper, paid breaks for home-care workers. Indeed, they should also have paid travelling time between clients because, especially in rural areas, travel is difficult.

Most of all, we need to make sure that the care that people receive is what they require. It must be decided by the client, their family and their own carers, to ensure that it is person centred. We need to bear that in mind throughout the debate. Integration must empower people who live at home.

A number of members talked about the role of the third sector as service providers and patient representatives. Those roles are very different and how they feed into the process is different, but they are crucial.

Elaine Murray and Malcolm Chisholm talked about locality planning. It is particularly important for small third sector organisations to be involved in that because they can bring a huge amount to the table that is, perhaps, not available uniformly throughout the area but which they provide in their localities. I refer to organisations such as the Badenoch & Strathspey Community Transport Company, which does an awful lot more than just provide transport in its area, because it can keep people enabled in their communities. It is important that such organisations are involved in planning.

A number of speakers talked about palliative care. I join them in paying tribute to the contribution of Marie Curie Cancer Care. It provided us with a briefing for the debate, as it has on many occasions. As Jim Hume pointed out, it mentioned that only 20 per cent of non-cancer patients get palliative care, which means that 80 per cent of non-cancer patients received no palliative care at all.

As Paul Martin said, 60 per cent of people want to die at home but do not. When we look at this, it is important that we consider palliative care. The change fund was used to fund palliative care where it had not been funded before. That is part of the integration funding and we need to emphasise to the integrated bodies that they need to think about how they provide palliative care in the community. Jenny Marra said that 400 people died in hospital while waiting to go home. I am sure that most of them were waiting for palliative care, specialist help and equipment to allow them to go home. It is wrong that people who want to die at home are not given that opportunity to die at home with their families around them.

A number of people talked about the role of GPs. We need more GPs. People feel that they are not able to access their GPs, which drives them into hospital. We need to consider the role that GPs play in the integration process.

A number of speakers mentioned older people. I do not want to use the term time bomb. People are living longer, which is good, but they are also living healthier lives and making a contribution. We need to celebrate that.

The debate is hugely important. We are willing to work together with the Government, but the people who receive the care must be at the centre of the debate.

16:49

Shona Robison: It has been a very good, constructive and positive debate, so I want to spend the time that I have responding to as many points as I can.

Jenny Marra asked about the plan for tackling delayed discharge. Work on that began over the winter period with engagement with partnerships in the areas where the problem was most acute. As far as future work is concerned, there are two aspects to it. The plan for tackling delayed discharge in Glasgow will be different from the plan for tackling it in the Western Isles or Aberdeen, because different challenges are faced in different areas. Some areas have more developed intermediate care facilities, some have a greater shortage of care homes and some face more challenges in recruiting care staff, so it is extremely important that each plan is tailored to meet local needs. The Government can help by assisting partnerships to identify what works and share best practice, and by supporting them in development of their local plans. That is what we are doing and will continue to do.

Healthcare Improvement Scotland will also work to support improvements in localities and to help the local partnerships. Common issues will include the focus on admissions and readmissions and ensuring that the local plans are robust and will work. The £100 million that is being provided over the next three years represents a significant investment in tackling delayed discharge, and it will help integrated joint boards to progress the local plans.

Jenny Marra: I appreciate that the local plans will be specific and tailored to each area. How will the cabinet secretary ensure that she will eradicate delayed discharge by the end of the year, as she pledged?

Shona Robison: I think that I have just explained that. The local partnerships will come up with plans for how to spend the £100 million—a

significant amount of money—that has been put into the system to tackle delayed discharge over the next three years. The Scottish Government and its agencies have the expertise to support them in doing that, but of course it will be deployment of that resource locally to develop and deliver services that will get people out of hospital and help to avoid their being readmitted. The local plans will deliver the change; our job is to oversee that and to ensure that the plans are robust and do what they need to do.

Nanette Milne talked about engagement with GPs. Of course that is important, but engagement with other health professionals, the third sector and others is important, too.

Jim Hume mentioned the primary care development fund. I assure him that discussions are taking place with, for example, the Royal College of General Practitioners, which I met just the other day. It has a number of ideas about how the resource should be spent. What is important is that that resource and any other resources face in the same direction—towards integration. We want the fund to underpin and support all the other measures that need to be taken to make sure that we deliver the new world of integration.

Bob Doris talked about pilots that have been developed through the initial fund. It is important that continuation of the funding provides the opportunity for longer-term plans to be put in place. That will mean that services can be changed and staff can be recruited over a longer period than is possible with a one-year fund. That is why today's announcement was very important.

Bob Doris also quite rightly paid tribute to the provision of additional intermediate care beds. The number of intermediate care beds has doubled, but there is more to be done. That is a good model that we want to be developed in other areas.

Malcolm Chisholm mentioned locality arrangements and statutory guidance. The draft guidance will be shared with stakeholders very shortly—it is on the cusp of being made available. Over the past six months, we have kept in touch with partnerships on the content of the scheme. Regulations on that were passed only in November, so guidance will come very shortly.

Malcolm Chisholm also made a point about the need for more involvement in integration by people other than statutory representatives. That is important, of course. The legislation and the regulations assure a seat on the integrated joint boards for clinical and professional advisers, and their inclusion in the strategic planning group, which must also include the third and independent sectors and people who represent patients, service users and carers. That is also important.

Sandra White made a very important point about housing; she was absolutely right. I have been in discussion with the Cabinet Secretary for Social Justice, Communities and Pensioners' Rights, Alex Neil, on developing a joint approach on housing to support integration. We will make an announcement about that shortly.

Kenny MacAskill made an important point about criminal justice social workers. They are on the "may be integrated" list, so they are not excluded. We are working closely with the officials who are working on the forthcoming criminal justice social work bill to ensure that there is alignment. I will ensure that the points that Kenny MacAskill made are fed in and captured, because they are important.

Christina McKelvie and other members spoke about the Neurological Alliance and the points and concerns that it has raised. On the basis of what has been said, I would be happy to look at the issue again, given the close links to other groups. I think that we can do that in short order and ensure that the concerns that members' and the Neurological Alliance's concerns are taken on board and addressed.

Paul Martin made a similar point to the one that Sandra White made about the practicalities of getting someone home. Sometimes that is about an OT assessment. The integrated care resources could, of course, be used to ensure that there are more of those assessments. The resources are there to address local issues. If there is a shortage in respect of getting the assessments done, that should clearly be a priority for the local partnership.

Jim Hume made a similar point about adaptations. Again, there is nothing to stop resources being used for adaptations. It will depend on priorities.

Joan McAlpine made a point about ambitious plans that are being developed in Dumfries and Galloway. I acknowledge that work. Some very exciting plans are emerging, which should be welcomed.

There is, as I have said, a requirement for involvement of the third sector. We will, of course, monitor that to ensure that that involvement is seen through on the ground.

Elaine Murray asked about further integration opportunities; I have mentioned the Neurological Alliance's views and the members who have raised that issue. A third of the boards will immediately include children's services, for example, and a third plan to do so. The other third do not plan to do so at the moment. In the light of experience, we might move towards further integration on the basis that, if it makes sense to include those services, it should happen. We will

work with the remaining third to look at how they can move forward.

A number of members talked about palliative care, which is very important because integration of health and social care can without doubt provide much more coherent services in end-of-life care. It is absolutely clear that many people want to spend their last few days and hours in their own home and do not want to be in a hospital environment. There is a duty on all of us to ensure that the integrated teams focus on enabling that, and it should be an early priority for them.

On Jackson Carlaw's point about finding care out of hours, that is one of the things that the Lewis Ritchie review of primary care is looking at, but it cannot be looked at in isolation. Of course he is looking at other issues, including availability of care services, because we need that cohesion. As we know, care is not just needed during office hours; it can be needed through the night and at the weekend. Integration will provide an opportunity to deal with that.

I thank members for a constructive debate and for the key action points that have emerged from it.

Decision Time

17:00

The Presiding Officer (Tricia Marwick): There are four questions to be put as a result of today's business. The first question is, that amendment S4M-12710.3, in the name of Jenny Marra, which seeks to amend motion S4M-12710, in the name of Shona Robison, on health and social care integration, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that amendment S4M-12710.2, in the name of Nanette Milne, which seeks to amend motion S4M-12710, in the name of Shona Robison, on health and social care integration, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that amendment S4M-12710.1, in the name of Jim Hume, which seeks to amend motion S4M-12710, in the name of Shona Robison, on health and social care integration, be agreed to.

Amendment agreed to.

The Presiding Officer: The next question is, that motion S4M-12710, as amended, in the name of Shona Robison, on health and social care integration, be agreed to.

Motion, as amended, agreed to.

That the Parliament notes progress toward the implementation of the integration of health and social care, with new integration joint boards being established from 1 April 2015 in line with legislation; welcomes the substantial resources that are being invested to deliver integration; supports the agreement between COSLA and the Scottish Government on the core suite of indicators for integration; notes the commitment for NHS boards and local authorities to work together to deliver benefits for their patients and service users; believes that integration is vital to realising the 2020 vision for health and social care, and providing the best caring environments for the people of Scotland; welcomes the Cabinet Secretary for Health, Wellbeing and Sport's pledge to 'eradicate delayed discharge out of the system' over the course of this year; acknowledges the enormous challenge that integration represents; calls on those involved at all levels to work to overcome obstacles, real or imagined, of previous practice or prejudice, to ensure the most successful outcome for both patients and staff; notes the view of the British Medical Association that successful integration of health and social care needs long-term planning of investment in building capacity in community and social care services, effective and meaningful engagement and involvement of primary and secondary care clinicians on integration joint boards and integration joint monitoring committees, and medical leadership and influence at the locality level, and calls on the Scottish Government to outline how it will achieve these key objectives.

Meeting closed at 17:01.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78568-190-5

Revised e-format available
ISBN 978-1-78568-206-3

Printed in Scotland by APS Group Scotland