The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

Tuesday 19 May 2015

Session 4

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Scottish Parliament

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

Time for Reflection

The Presiding Officer (Tricia Marwick): Good afternoon. First of all, we have time for reflection. Our time for reflection leader today is the Rev Dr Daniel Frank, minister of the Wallacewell community fellowship of the Church of Scotland.

The Rev Dr Daniel Frank (Wallacewell Community Fellowship, Church of Scotland): Presiding Officer and members of the Scottish Parliament, thank you for this invitation.

"What we know matters but who we are matters more."

That is the quote that is written on the learning centre wall of the oasis project at the Wallacewell community fellowship. Brené Brown, its author, captures the essence of what people want more than anything else from their leaders.

Great men and women down through history were men and women of character. All of them had flaws, and many of them were far from perfect, but who they were and how they lived their lives in caring for, supporting and loving the people they led meant that history remembers, respects and honours their contributions to society—Gandhi, Mother Teresa, Martin Luther King, Winston Churchill, David Livingstone and women such as Jane Mathison Haining, a Scottish farmer's daughter, a missionary and matron of the Jewish mission girls home in Budapest during world war two.

When war broke out she was on leave in Scotland, but she put herself in great danger by travelling back to Hungary to care for the children. When Germany invaded Hungary, she remained to defend the children in her charge, was arrested by the Gestapo and was sent to Auschwitz concentration camp. She died as a result of her immense compassion and courage.

Today, as the face of the United Kingdom is changing, its leaders will be called upon to give insight and to lead the people with wisdom and grace into the 21st century, where the impact that we have can make a difference for all of society.

Leadership is based on who we are, our character and ethics. Those will be what are remembered over time and what will make the greatest impact for Scotland and the world. It is not what we know that matters; who we are matters more.

Ultimately, that is what Jesus Christ modelled. He is, for Christians, the single greatest leader, who demonstrated the kingdom of heaven on this earth. He lived a moral and ethical lifestyle in which, historically, no one has ever been able to find fault.

The reality is that people did not follow Jesus for what he said or even for what he knew; they followed and follow him for who he is. He attracts the poor and the lost, the lonely and the addicted, and it is because he lived the fruit of the spirit—love, joy, peace, patience, kindness, goodness, gentleness, faithfulness and self-control—that fault cannot be found.

What we know matters, but who we are matters more.

Topical Question Time

14:03

Road Traffic Statistics

1. David Stewart (Highlands and Islands) (Lab): To ask the Scottish Government what assessment it has made of the recently published road traffic statistics. (S4T-01018)

The Minister for Transport and Islands (Derek Mackay): Transport Scotland will publish the official road safety statistics for 2014 in our document "Key Reported Road Casualties" on 17 June 2015. We will base our assessment on those official statistics. The road safety framework to 2020 sets ambitious and challenging targets and sets out a range of education, engineering and enforcement measures, which all play a key role in our comprehensive approach. The road safety strategic partnership board is conducting a strategic mid-term review during 2015 of the progress that has been made under the framework.

David Stewart: The minister will be well aware that the number of road deaths increased by seven from 2013 to 2014. Although fewer people in cars and on bikes died, there has been an increase in the number of pedestrians and motorcyclists killed. Stuart Hay from Living Streets Scotland has said:

"the pedestrian safety battle is far from won".

Will the minister clarify the Scottish Government's plans to make our streets safer for all road users, particularly pedestrians and motorcyclists, in light of the figures?

Derek Mackay: As I have said, we will be publishing our statistics and our response to them. Of course, any casualty, injury or fatality is to be regretted. I take road safety very seriously and have worked closely with partners on it since my appointment. I know that David Stewart, too, cares very deeply about road safety. We have been able to undertake a range of actions in education in particular and will continue to do that.

On wider road safety issues, I think that it was right to lower Scotland's drink-drive limit. That was the right approach, which may well be copied elsewhere if media reports are to be believed. We have had high-profile publicity campaigns such as the road safety campaign and the recently launched live fast, die old campaign, which urges motorcyclists to stay safe, particularly on bends and during the biking season. We have had a country roads campaign featuring David Coulthard and we work closely with roads officials and roads authorities.

We also published new guidance on 20mph zones to encourage their deployment across the country, and the City of Edinburgh Council is very much leading the way on that. We have also had careful and considered use of average speed cameras on the A9. However, education will be central to our efforts and I will continue to work with a number of partners to ensure that our roads are safer for all.

The Presiding Officer (Tricia Marwick): Minister—sorry, Mr Stewart.

David Stewart: Maybe in the future, Presiding Officer. [*Laughter*.]

Young motorists, particularly men under 25, are a high-risk group for death and injury on our roads. Does the minister agree with my campaign for a graduated driving licence scheme, which Dr Sarah Jones of Cardiff University said would save 22 young lives in Scotland and more than £80 million? Will the minister seek an urgent meeting with Patrick McLoughlin, the Secretary of State for Transport, to support my bid for Scotland to pilot the graduated scheme within the UK?

The Presiding Officer: Minister.

Derek Mackay: While not necessarily agreeing with Mr Stewart's ministerial promotion any time soon—if he will forgive me—I would be happy to continue our efforts with the UK Government to promote the graduated scheme and I would be happy to pilot it in Scotland. As the member is well aware, we have made approaches to the UK Government on the issue in the past, and I will continue to do that. If the Labour Party and others want to assist us in that, I will happily take a cross-party approach and try to progress the issue once again.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): The minister will be aware of the particular dangers on rural roads such as those in my constituency from—if I may call them this—our fair-weather motorcyclists who see the apparently quiet road as a speedway, forgetting the slow-moving tractor round the corner or the livestock crossing their path. What particular steps can the Government take to educate those leather-clad motorcyclists, who are quite often middle-aged, to take care and not underestimate the dangers that may lie ahead?

Derek Mackay: As it happens, our campaign for motorcyclists is age targeted, because that is an issue. In terms of geography, there is an issue with rural roads, which is why we had the country roads campaign. As well as taking general road safety measures in education and engineering, we have very focused campaigns for those who will be most receptive to them. Rather than being just a blunt Government message, the campaigns have been market tested. I hope that all of that, as

well as the measures that I described in my earlier answer, will assist.

With the use of social media, the campaigns do not necessarily have to be expensive. Intelligent, well-focused, targeted campaigns will help us to address the issue. As I said, any casualty or fatality on the roads is to be regretted. Some of the circumstances might be very specific and individual, but anything that the Government can do to make our roads safer, we will do.

Alex Johnstone (North East Scotland) (Con): Is the minister's consideration of engineering measures likely at any time to include further consideration of a grade-separated junction at the junction of the A90 with the A937 at Laurencekirk?

Derek Mackay: As with all capital investment, it is a matter of specific local engineering solutions. I am aware of the concerns about that junction. We are progressing more works at the moment specifically on that junction to move towards a funding proposition and so on. Where specific engineering solutions can be put in place to make roads safer, we are doing that, and the A9 dualling is an ideal example. Discussion is under way as to how we progress work at Laurencekirk.

Jenny Marra (North East Scotland) (Lab): I speak as a member who experienced a road death accident in an urban area just last week. The minister will know as well as I do that the speed limit in urban areas in Scotland is 30mph. It is also my understanding that the limit for prosecution, if a driver goes over 30mph, is far in excess of that and is actually nearer 40mph under Crown Office guidance. How many miles per hour over 30mph does the minister think is acceptable for non-prosecution?

Derek Mackay: The answer that I would like to give is that people must keep to the speed limits per se. What my justice colleagues pursue will be a matter for them. I am happy to write to the member about the issue, and it might be better for me to do that rather than to broadcast something here and now—not that the public at large will be watching, but I do not think that it would be a helpful message to suggest that anyone should flout the speed limits. People should stick to the speed limit that is appropriate to the road.

I am happy to engage in more private communication with the member on the wider justice issues. I am also happy to take the matter up with the road safety partnership and Police Scotland, because I believe that there may well be an issue with the enforceability of our speed limits.

Allied Health Professionals

The Presiding Officer (Tricia Marwick): The next item of business is a debate on motion S4M-13196, in the name of Maureen Watt, on allied health professionals—enabling active and independent living. I say to members at the outset that we have a generous time allocation for the debate, so the Presiding Officers will be sympathetic to anybody who wishes to make interventions, and we will ensure that members get time for any interventions that they take.

14:12

The Minister for Public Health (Maureen Watt): I am delighted to open this debate on the vital role that is played by allied health professionals, or AHPs as they are known, and their contribution to the health service. They enable active and independent living and they contribute to the overall improved health and social wellbeing of the people of Scotland.

AHPs are a diverse group of professionals. They can be arts therapists, diagnostic and therapeutic radiographers, dieticians, occupational therapists, orthoptists, paramedics, physiotherapists, podiatrists, prosthetists, orthotists or speech and language therapists. As the motion states, it is key that the Parliament recognises the importance of prevention, early intervention and enablement in supporting the health and social wellbeing of the population throughout their lives; the key role that AHP rehabilitation and enablement services play in supporting individuals to live productive and meaningful lives; and the centrality of that approach in underpinning and strengthening the integration of health and social care services.

I start by emphasising just how key the AHP approach to enabling is to the Government's ambition to improve the health and wellbeing of the population of Scotland, and my belief that rehabilitation and enablement will be instrumental in achieving many of the key national outcomes that are agreed jointly by NHS Scotland and local authorities across Scotland.

As we all know, Scotland has a growing elderly population, which is a testament to the many successes in our public health, social care and national health service systems. Although the fact that most people are living longer is to be celebrated, the way in which we now go about supporting people to maintain their health, their abilities and their social support networks will be vital not only in supporting individuals to live full, active and meaningful lives, but in sustaining our health and social care services for the future. That is critical, given the demographic and financial

pressures that are already being experienced across the western world.

I remind members of some of the challenges. The number of over-65s is predicted to increase by 39 per cent by 2031. By the age of 65, two thirds of people have a long-standing illness, and the figure rises to three out of four people who are aged 75 or over. People with a long-term condition are twice as likely as those without such a condition to be admitted to hospital, and they stay in hospital disproportionately longer.

Of more concern to our health and social care providers is the predicted 86 per cent rise in the number of over-85s by 2031. Too many older and vulnerable people end up in hospital when they should not, and too many stay there for much longer than is needed. Up to 90 per cent of people who fall are taken to hospital, whether they need to be or not, as that has been the accepted pathway. To change that will require a not insignificant shift from traditional models of care, which have tended to focus on deficits and problems that need to be named and fixed, to a model that is asset based and which sees the patient's experience and knowledge of their condition as a resource that can be built on to support resilience and self-management. It will also be essential that we enable our AHPs and support staff to meet the growing demand for their expertise and interventions.

Rehabilitation is not a new concept. In fact, it was established around the time of the first world war to support soldiers to recuperate and adapt to life after service injury. It is fundamentally a partnership between patient and therapist as well as family and carers. It is not a passive process and is heavily reliant on the motivation and participation of individuals to recover and adjust, to achieve their full potential and, where possible, to live full, productive and active lives, whatever their age.

Improving community-based rehabilitation and enablement services needs to be integral to the prevention of dependency on healthcare and support services through the promotion of independent living. That includes the provision of equipment and adaptations, which are highly effective at keeping people independent and active in their homes. They are also cost effective. In fact, every £1 that is spent on adaptation gives savings of up to £6 that would otherwise have been required for more expensive services.

The national falls improvement programme has succeeded in driving improvement through co-production involving the health, social care and ambulance services and local communities. For example, in Argyll, there has been a 50 per cent reduction in hospital admissions after a fall.

Without the further devolution of strategies on matters such as rehabilitation and enablement, the costs of health and social care for all ages are expected to rise by about £2.5 billion over the next 20 years. The Christie report, which was published in 2011, estimated that

"as much as 40 per cent of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach."

Sandra White (Glasgow Kelvin) (SNP): Does the minister recognise the role of housing associations such as Bield Housing Association and Trust Housing Association in working in communities to keep older people in particular living more independent lives?

Maureen Watt: Yes. Sandra White is absolutely correct. I have read the contribution to the debate from Bield Housing Association and Hanover (Scotland) Housing Association. Clearly, that role is absolutely key, for example, in relation to adaptations of social housing.

The integration legislation that we have put in place and the preliminary work of the integration joint boards have put us in a strong position to accelerate the pace of improvement and shift our focus to prevention, early intervention and enablement, which will achieve the outcomes of integration and support for people to live independently for as long as possible in their homes and communities.

Jenny Marra (North East Scotland) (Lab): I am sure that the minister, like me, will have noticed from the briefing papers that not every new joint board for health and social care integration has an AHP representative. Given AHPs' key role in letting people stay in their homes and reducing delayed discharge as well as their role in the integration agenda, does she agree that all boards should move to that level of representation?

Maureen Watt: I very much take on board Jenny Marra's point, but we want to keep integrated joint boards as focused as possible. They could become great big bodies that might not be as focused on the work ahead. However, I know that they all recognise the key importance of AHPs in ensuring that integrated services work and that they very much recognise AHPs' contribution. I am sure that they will communicate with AHPs in different ways, although AHPs might not have a seat on the board.

I acknowledge the commitment, energy and enthusiasm that AHPs bring to improving care and delivering outcomes across health and social care. They are driving improvement across a range of priorities that are embedded in our public service reform pillars.

AHPs build strong partnerships with other agencies. For example, they work with the fire service to reduce fire-related deaths among vulnerable groups across Scotland, and they are driving improvement in prevention through falls prevention partnerships, helping to reduce falls in care homes across Scotland by up to 50 per cent.

People are being enabled to live life to the full through the AHP physical activity pledge. In case members do not know what that is, it involves ensuring that all AHPs intervene with the people whom they come across to ensure that they take as much exercise as possible and are signposted to places where they can take part in physical activity. In addition, children are supported to get the best possible start in life, participate in the curriculum and achieve their full potential. Further, up to 66 per cent of people with enduring mental health problems are being enabled, through vocational rehabilitation, to gain paid employment, sometimes for the first time, and people with dementia are remaining a part of, rather than becoming apart from, their communities through the dementia-friendly community initiative, which is supported by AHP consultants in dementia. Jim Hume's amendment strengthens the motion in that regard, and we will accept it.

AHPs' contribution to better performance has been notable through the evolution of new models of care, such as self-referral to musculoskeletal therapists, which includes physiotherapy. That has helped to redesign orthopaedic services; reduce waiting times by up to 25 per cent and the number of magnetic resonance imaging scans by up to 30 per cent; improve patient experience; and ensure that those who need surgery get it sooner.

Such transformations will ensure that patients and people who use services get rapid access to the right health professional at the right time. They will also support self-management and help to reduce the overall costs of service provision as well as manage rising demand for services in a more person-centred way.

People are able to self-refer to AHPs for a whole range of conditions in addition to musculoskeletal problems, including communication difficulties and support with independent living, foot health and mobility problems. Patients—and their families—consistently tell us that those services make a huge difference to their health and wellbeing and, most important, their quality of life. The health economic data tell us that that work supports our preventative spend agenda and is associated with both cost avoidance and positive cost consequence for public health as well as health and care services.

AHPs now recognise the importance of building on their co-production work with local communities to strengthen their preventative approach and place it on a more sustainable footing. That is evident in the partnerships with leisure services that run exercise classes for older people, for people with dementia and for individuals having post-cardiac or specialist rehabilitation. Those enable people to rebuild confidence and remain socially connected as well as physically active.

AHP leadership will remain key to the rehabilitation and enablement agenda. I am heartened to see that AHPs' leadership role has been recognised and strengthened since the publication of the AHP national delivery plan.

I want to see AHP leadership better represented on integrated joint boards, to make better use of that talented group and the solutions that AHPs bring in shifting our paradigm of health and social care towards greater emphasis on prevention, early intervention and enablement.

It is more than two years since the launch of the national delivery plan. Although significant progress has been made, considerable work remains to be done in the remaining 10 months of the delivery plan's life. We have a solid platform of achievement on which to build. During that period, we will continue to work with and support integrated joint boards and partners across health and social care to deliver on the actions, demonstrate impact and, importantly, spread, embed and sustain improvements that are being made across services.

I propose to refresh the national delivery plan, with a focus on improvements in population health, in the experiences of and quality of care for people who use services, and in better outcomes for lower cost across health and social care. Rehabilitation and enablement should be a strong theme, as should the continuation of the work to support prevention and intervention that underpins the new models of care that are required for sustainable and affordable healthcare.

I am pleased to announce to Parliament a new £3 million fund to enable active and independent living for people who are recovering from illness or injury. The fund will help AHPs deliver the active and independent living programme over the next three years. It will aim to help people with illness, disability or injury to find new and innovative ways to lead lives that are as healthy as possible and stay in their own homes for as long as possible.

For all our differences, we have a shared objective in ensuring that the financial and demographic challenges that our health and social care services face are met. I look forward to hearing members' speeches. I will make sure that suggestions from across the chamber are used to inform work to ensure the continued improvement of the services provided by our AHPs to enable active, independent and productive living for all.

I move,

That the Parliament recognises that allied health professionals (AHPs) possess a diverse range of unique skills and expertise in rehabilitation and enablement that are key to supporting self-management and enabling active, independent and productive living; recognises and congratulates the increasing number of AHPs in Scotland on the important role that they play in prevention, early intervention and enablement in supporting the health and wellbeing of the people of Scotland throughout their lives, and believes that this approach can be further strengthened through the ongoing integration of health and social care services.

14:27

Jenny Marra (North East Scotland) (Lab): I thank the minister for bringing the debate to the chamber and for the opportunity to take part in it.

I commend the minister for her announcement of a £3 million active and independent living fund. She knows as well as I do the incredible work that allied health professionals do in our communities, especially with our older and vulnerable people. I am sure that that funding will make an enhancement and allow AHPs to do more of that work.

The minister read out a long list of allied health professionals. I will add to that, and probably repeat some: physiotherapists, occupational therapists, community pharmacists, radiographers, chiropodists, speech therapists and all the rest. Those skilled professionals are critical to delivering the independent living that we want for all our communities. In the Parliament, the public gallery and across Scotland I think that everyone sees members of their own families trying to live independently in their ageing years, but perhaps struggling and being assisted by AHPs, who show immense patience, courage and skill in providing that support.

AHPs are the front line of our national health service. They go into people's homes daily. They provide early diagnosis and treatment and ensure that people get quick and appropriate support. Through such interventions, they are lifting the burden on our doctors, consultants and nurses, as well as reducing costs at a time when our NHS budgets are under pressure.

As we have agreed, AHPs are a varied and multidiscipline group. I think that it is fair to say that the 12,000 workers across Scotland who are classed as allied health professionals perhaps do not feel that they have the status of some of their colleagues in the health service; nonetheless, they are absolutely critical to that service.

We must recognise the central role that AHPs will play in realising our shared ambitions in this Parliament for the 2020 vision and our ambitions for a truly integrated health and social care service that allows people to remain in their homes. These professionals' experience, flexibility and expertise will be vital in linking the different parts of our health and social care system and enabling them to do their job effectively. In that way, we can ensure that patients do not get caught in a clogged-up system as we have seen too often in the past.

In 2012, the Scottish Government described the allied health professionals as "agents of change". That was no understatement, and I am glad that the minister has renewed that role for them with the refresh of the strategy today. The national delivery plan, which was launched in 2012, was a welcome framework for the targets and ambitions that have been set for the past three years, and we recognise and credit the progress that has been made. It was widely welcomed by those in the professions as giving them a proper role within the community-based NHS that we all agree is the right way forward.

Now that we have reached the end of that three-year span, there is a natural break in which we can take stock of that progress, understand whether we are getting it right and set out what we still have to do. Given the importance of the allied health professionals in the on-going integration of health and social care, it is important that we remain vigilant about the effectiveness of our support for those workers. I welcome the Scottish Government's progress report, which sets out the milestones that we have already reached. A 52 per cent national completion rate by the end of last year is a significant achievement, but it leaves us with much still to do.

We have set a welcome and agreed direction of travel, but it is important that we mark out the distance and how we will make good progress on this journey. Today, those on the Labour benches support the calls of many allied health professionals for a national audit to assess how far we have come and what challenges need to be addressed. That audit would allow us to set robust measurements, smart objectives and a plan to deliver going forward. In her closing remarks, the minister might say whether she can put that audit into her strategy.

I spent yesterday sitting in a multidisciplinary team meeting in a local practice in the north-east of Scotland, and I suggest that any members of the Health and Sport Committee, any Scottish ministers or any parliamentarians who are interested should ask to go along to such a meeting to get a flavour of the incredible work that those professionals are doing. A multidisciplinary team meeting is a model of excellence in how to deliver health and social care. The general practitioners, physiotherapists, occupational therapists, district nurses, social workers and

hospital consultants all sit around the table and discuss a list of patients. They talk about where they are, and different people around the table have different information about those patients in their homes and how they can help each other to prevent their being admitted to hospital, or to get them into hospital if that is needed. They also talk about how they can monitor those patients' medication, and the community pharmacist is involved. It is a real model of people working together efficiently, communicating with each other and managing the process properly.

I was struck yesterday—as I was struck at the previous MDT meeting that I attended just a few weeks ago—by the enthusiasm and dedication of every one of those people around the table, no matter which job they were doing in our national health service, in caring for the patients as individuals and ensuring that they are leading quality lives at home. From the occupational therapist chipping in to ask whether the person needs a walking frame or a different type of commode, to the district nurses monitoring their medication and someone keeping a record so that the GP knows the next time that the person comes in, the system that I saw yesterday was excellent and is a testament to the contribution that allied health professionals can make to care, especially the care of older and vulnerable people. That is why I am delighted that we are having the debate and that the Scottish Government has set out its strategy to mark the role that AHPs play in the system.

I turn to physiotherapists and some concerns that have been raised about workforce statistics. We can see from the latest statistics that the number of senior physiotherapists has fallen considerably. The minister will correct me if I am wrong, but I think that that is a cost-saving measure. For example, the number of physiotherapists in band 7 decreased from 731 to 652 whole-time equivalents between September 2010 and the end of last year. That sharp reduction in physiotherapist clinicians with specialist skills in various fields will mean that we are less likely to make the early assessment and provide the treatment that can improve outcomes and prevent re-referrals. The loss of that specialist expertise is likely to cost the NHS more in the long run, and it will only have a negative impact on care.

In the short time for which I have held the health brief, I have been struck by the innovations that physiotherapists can make in our national health service. A few months ago, I was at a meeting in the Parliament at which a nurse from the Western Isles spoke about how a programme of a few weeks of physio can prevent incontinence, especially in women, and can avoid their considering the use of mesh implants. The Parliament has debated the issue of mesh implants and we know about the dangers and the potential litigation associated with their use; indeed, patients who have been severely affected and disabled by mesh implants have been to the Parliament. We also know that such devices cost £15,000 per implant. The provision by physiotherapists of a preventative course involving exercise seems a much more holistic way of working, and I ask the minister to reflect on the role that physios play in innovating and preventing the drive to acute treatment and surgery when she assesses the cut in the number of band 7 physios from 731 to 652.

We know that by investing in allied health professionals we can reduce the burden and the cost in other parts of the NHS—I have just highlighted an example of that—while improving patient care and reducing inconvenience. That was recognised in the delivery plan of 2012, which put the role of AHPs on a sounder footing, and we welcome the refresh. However, the representations that we have received from various groups lead us to believe that an audit is necessary to back up the Government's new strategy. I hope that the minister will consider including in her strategy the audit that Labour's amendment calls for, thereby supporting AHPs in our community.

I move amendment S4M-13196.2, to insert at end:

"; further believes that the valued role of AHPs would be best supported by understanding the areas that are most in need and therefore calls for an audit of the *National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015* with a specific focus on performance of self-referral as a primary route for access and musculoskeletal AHP waiting times; notes that the Chartered Society for Physiotherapy has concerns regarding declining numbers of band 7 physiotherapist clinicians, and calls on the Scottish Government to bring forward a long-term plan to reverse this trend".

14:38

Jim Hume (South Scotland) (LD): I thank the minister for bringing the debate to the chamber, and I welcome the fund that she has announced. I look forward to hearing details on accessing the fund. Perhaps the minister will mention that in her summing up.

This is a welcome debate because it gives us a chance to shed light on healthcare issues that have not been given enough attention. Just as one would not live in a house that had foundations but whose roof and walls were missing, we cannot have a successful debate on the state and future of our healthcare system without discussing allied health professionals. At a time when we are on the brink of enormous changes in how healthcare and social care are administered through integration of

the two, it is vital that we ensure that proper attention and support be given to everyone who is involved in the process. From the outset—as I have said in previous debates—the devil lies in the detail.

Allied health professionals are a vital and core group in the plan. Their input on what type of support and what kind of efficiency are most effective should therefore be listened to; their expertise on what works on the ground must inform policy making. What the more than 11,000 allied health professionals do to support acute and primary care services is irreplaceable and should be given more attention and support.

In its briefing on the Scottish Government's 2015-16 budget, the Allied Health Professions Federation Scotland raised numerous points that should be alarming in terms of the general direction of Government prioritisation. It said that money is not shifting in line with policy—although we have had a small announcement today. That means that although there are increased expectations of allied health professionals, there has not been a sustainable matching of investment in AHP provision.

We have learned that on top of increasing demand, although there has been a real-terms increase in funding for the NHS front-line AHP services face cuts of well over the 3 per cent target for efficiency savings that the Scottish Government set in its draft budget. A striking example is the 8.8 per cent budget cut between 2010 and 2014 for speech and language therapists, with cuts across 10 of the 11 health boards and in local authorities, with some cuts being as high as 21 per cent.

We also know that GPs are not referring people who suffer mental ill health to therapies because the therapies are not there. I take this chance to repeat the call for mental ill health to be given parity with physical ill health in the statute books.

If healthcare is to be made more efficient and accessible, there has to be a focus on sustained and effective workforce planning. Allied health professionals note with concern that workforce planning is still not integrated and that it has to occur systematically, rather than through short-term and piecemeal solutions. That includes taking into account the environments in which allied health professionals have to work—in hospitals and other healthcare environments, as well as in the private homes of many patients who receive their care. The importance of a healthy, steady and safe house environment in which care is provided should be stressed as an urgent priority. We now know that almost 1,000 elderly people were left this past winter on waiting lists for home-care packages, with health boards being unable to provide them with the basic help that they need for washing, cooking and transportation.

However, that problem will not be solved simply by throwing money at it. Prevention and planning have to start at the earliest possible stage. Audit Scotland said that 90 per cent of clinically able patients over 65, and up to 50 per cent of patients over 85, are unable to leave hospital because of lack of arrangements for their care, support or accommodation. Such arrangements are critical to relieving the many pressures on and overstretched resources of hospitals.

Patients' having safe and reliable housing to return to after hospitalisation is extremely important. Bield Housing Association, Hanover (Scotland) Housing Association and Trust Housing Association, which are the three largest Scottish providers of housing, care and support services, tell us that the growing elderly population is in urgent need of caring environments that can meet their needs.

In addition to the housing issue, we know that some conditions are exacerbated by the health inequalities that some communities face. I echo the concerns of organisations in the allied health professions that call for solutions that can cross boundaries between social care environments including education, justice, and local government. By empowering local governance we will be able to empower a lot of people who are essential in providing health services.

The Allied Health Professions Federation Scotland has said that

"AHPs working across these boundaries are in a position to deliver optimum productivity gains."

That would translate into potential savings and flexibility to allocate resources in a more efficient way across the entire NHS. Put simply, it is spend to save.

The care that is provided by the allied health professions goes way beyond the care for clinically able people to return home. It is an issue that must be tackled through prevention and early access to necessary services, including mental health services from physiotherapy to dementia care. The allied health professions are part of a framework that is indispensable for keeping an ageing Scottish population healthy. However, instead of seeing support for the long-term and sustainable development of AHPs, we are seeing a decrease in the number of staff in some of the professions, which Jenny Marra's amendment mentions in relation to physiotherapists. There has been a 10 per cent decrease in senior physiotherapy posts since 2010, as well as a steady vacancy rate in all allied health professions of more than 400 whole-time equivalent posts throughout Scotland.

It is no wonder that GPs are not referring people who are suffering mental ill health for some therapies; therapists are not there to be referred to. That trend is worryingly mismatched with the needs that arise from an ageing population who have complex and increasing needs. The fact that one in four of us will at some stage suffer from mental ill health means that that is an important issue.

We are happy to support the Labour amendment. We will also support the motion in the name of Maureen Watt and I am glad that she will support my amendment. I look forward to support for it coming from across the chamber.

I move amendment S4M-13196.1, to insert after "living":

"; believes that AHPs are crucial in the treatment and prevention not only of physical ill health but also of mental ill health; recognises the added value that AHPs can have in terms of preventative, upstream approaches; acknowledges that AHP interventions can significantly reduce unnecessary hospital admission and can help to reduce dependency on care services, resulting in savings to health and social care".

14:46

Nanette Milne (North East Scotland) (Con): I welcome the opportunity to discuss the valuable and, indeed, essential contribution that AHPs make to the health and wellbeing of people throughout Scotland at every stage of life by helping them to manage their long-term health conditions and to live their lives to the limits of their capabilities.

All members who are present recognise that our health and social care services are facing unprecedented demand—predominantly from the large and increasing number of people who live into advanced old age with a complexity of manageable long-term conditions, but also from young people who can now often live productive lives with conditions that previously would have resulted in death during childhood, including some forms of muscular dystrophy and cystic fibrosis. That demand, which is already with us, is set to grow as the population ages and we face the impacts of dementia, cancer and the many other degenerative conditions that can accompany advancing years.

Acute services already feel the pressure. The number of people aged over 65 who attended accident and emergency departments rose by 12.6 per cent between 2009 and 2013, and 60 per cent of them were likely to be admitted to hospital, compared with 23 per cent of patients under 65. We all know how difficult it can be to get care packages for people once they have been admitted. That leads to delayed discharge, which is not good for patients whose stay in hospital is prolonged, often for many weeks, and it is to the detriment of other patients who require hospital treatment but cannot get beds.

There is widespread agreement that the status quo is not an option and that—as the Allied Health Professions Federation Scotland states in its briefing on the 2015-16 health budget—the NHS in Scotland needs sustainable reform in order to shift the focus of investment and services away from acute-care driven and disaggregated provision towards prevention, early intervention and self-management in the context of community-based integrated services. The Scottish Government acknowledged that in its 2020 vision for the NHS in Scotland, which has already been extended beyond 2020, as is desirable and appropriate. It envisages a healthcare system in which healthcare and social care are integrated and in which there is a focus on prevention, anticipatory services and supported self-management, as well as on ensuring that people get back home or into a community setting as soon as is appropriate and with minimal risk of readmission to hospital.

AHPs have a key role to play in shifting that balance of care into the community. Nearly 11,200 whole-time-equivalent registered AHPs work in Scotland's NHS and social care services, and others are employed in local authorities and the third sector. They make up more than 8 per cent of the NHS workforce—almost the same as medical and dental staff—and have the diverse skills and expertise that are key to supporting self-management and to enabling active, independent and productive living at all ages.

Many areas of Government policy have significant impacts on demand for AHPs including—to name but a few—the early years framework, early detection of cancer, the national falls programme, the dementia strategy, and improvement of services for heart disease, stroke, diabetes and other long-term conditions.

Access to clinical interventions for people with long-term conditions can be inefficient. However, the self-referral system has proved to be very effective for physiotherapy and could be used to equal effect in other services, including women's health and continence services, respiratory services and stroke and falls prevention.

Physiotherapy has a very important role to play, especially in supporting older people and their families and carers through care pathways: from living at home to hospital admission, to supported return to living at home, through to a decision to enter residential or nursing-home care. It also has a major role in management of dementia, of stroke and of chronic obstructive pulmonary disease by supporting people to continue living at home and in residential care in order to help them to maximise their independence, function and quality

of life. The £3 million fund that the minister has announced this afternoon will, I am sure, be very welcome to the physiotherapists, occupational therapists and all the other AHPs who work so hard to maximise their patients' mobility and independence.

Overall—as the motion notes—the AHP workforce has gone up recently, but the increase has been very modest. In speech and language therapy, for example, there was between 2010 and 2014 an 8.8 per cent reduction in funding, with a significant cut recorded in a number of health boards and councils. We are told that front-line AHP services continue to experience real-terms budget cuts above the 3 per cent efficiency savings that are required of NHS boards.

Although we all acknowledge the essential contribution that AHPs make in many disciplines, and their cost-effectiveness to the NHS in enabling people to live in the community for as long as possible, and although we all want successful integration of healthcare and social care, we need to pay heed to Audit Scotland's warning that the Government is facing significant challenges in making the changes that are required in order to achieve its 2020 vision within the financial resources that are available. As Audit Scotland points out, those changes need to happen while the NHS continues to provide services to meet the current needs of patients.

I also note the recommendation in the Audit Scotland report that the Scottish Government should review current financial and performance targets for the NHS, and the planned indicators for integration of joint boards, in order to ensure that they fit in with implementation of the 2020 vision, and I note the recommendation that milestones be introduced to measure the progress of health boards towards more preventative and community-based care.

I note—alongside the comment from the Royal College of Speech and Language Therapists about the fact that the Government currently has no strategic AHP workforce planning group—the Allied Health Professions Federation's concerns regarding the current unidisciplinary nature of workforce and workload planning. I also note the AHPF's desire for workforce planning policy to address the capacity of all the professional groups that work throughout the integrated care pathways. I am gratified that the minister appears to agree with that ambition; I look forward to progress in that.

Maureen Watt: Nanette Milne made an important point about speech and language therapists. That workforce has increased by 3.1 per cent during the period, and we are developing a transformational AHP plan for children and young people, which is one of the deliverables from the national delivery plan. It will be published later this year, and I hope that Nanette Milne will look forward to seeing it.

Nanette Milne: Thank you. I find that information very encouraging.

We have in Scotland a highly skilled AHP workforce with a wide range of skills and the ability to support people to maintain their health and wellbeing throughout life. If we are to use those professionals for optimum benefit to the communities that they serve, they must be an integral part of planning for the future and should have an important leadership role in developing integrated services. I am glad to hear that the minister is of the same mind, in that.

We will support the Government motion and the amendments, but I hope that the minister will pay heed to the concerns that I have raised as she oversees the development of integrated healthcare and social care in the months ahead.

The Deputy Presiding Officer (John Scott): We move to the open debate. There is quite a bit of time in hand this afternoon.

14:53

Sandra White (Glasgow Kelvin) (SNP): I welcome the minister's announcement of the £3 million fund, which is welcome. I am sure that every member in the chamber welcomes it on behalf of not only the health service but their constituents.

The number of allied health professionals in NHS Scotland has increased by 26.2 per cent, which is very welcome. The implementation of the AHP national delivery plan for 2012 to 2015 is demonstrating a significant impact across Scotland.

I believe that AHPs' expertise in rehabilitation and enablement will be the key to supporting our vision for health and social care integration, as has been mentioned by the previous speakers. AHPs play a central role in helping individuals and families—particularly older people and those with dementia or complex needs—to live self-determined and independent lives, wherever possible in their homes, thereby avoiding unnecessary admissions to hospital or to care settings.

AHPs can make an immediate impact on the lives of older people with long-term conditions such as dementia, and they can ensure that resources are used to the best effect by preventing unnecessary admissions to hospital.

As convener of the cross-party group on older people, age and ageing, I intend to base my speech on the issues of older people. People in

Scotland are living longer, which is good news. We want to ensure not only that people are living healthier, longer lives but that more older people are supported to stay in their own homes and within their local communities. AHPs can play a key role in that.

Nanette Milne set out very well the welcome work AHPs do in the communities. Over the past 10 years, overall life expectancy in Scotland has increased. According to National Records of Scotland statistics from 2014, male life expectancy increased in all areas of Scotland from the period 2001 to 2003 to the period 2011 to 2013 and female life expectancy increased in most areas of Scotland over the same time.

Our older population is likely to increase by around two thirds in the next 20 years; because of that, we need to change how we deliver care. That is why it is important that we have integrated care and that we have this debate.

In Scotland, 90,000 people have dementia and that number is expected to double over the next 20 years. In 2011, Scotland's first dementia care standards stated that everyone has a human right to safe, effective care that protects and promotes dignity in all care settings—anything that falls short of that is totally unacceptable.

Scotland's national dementia strategy points to the role of AHPs in the delivery of the strategy and notes the growing evidence base supporting the active non-pharmacological interventions delivered by AHPs.

AHPs are working to ensure that self-management and choice are at the forefront of the delivery of services to people with dementia. They are doing that through the development of dementia-friendly communities, partnership work, sharing their experience online through social media and online communities, and supporting the training of a skilled and informed workforce.

Action point 2.4 of the national delivery plan calls for AHP directors to

"work with directors of social work to support older people and those with disability and complex needs to live independently in their own home/homely setting".

I note from the February 2015 progress report on the NDP that there are still a number of challenges for full implementation, although it is worth noting that the progress report states that such actions are only now being realised as a result of the need for the enablement and integration agenda to be achieved first. Perhaps the minister could comment in her summing-up speech on how that next step could be achieved and promoted.

The Labour amendment lodged by Jenny Marra calls for an audit of the NDP. I have some concerns about the amount of time, work and money that would be needed for an audit. The progress report was produced in February and there are on-going updates on the delivery of the plan. In my mind—not perhaps in everyone's mind—it seems a bit premature to have an audit before the plan has been given time to run its course. There are continual progress reports, so I wonder whether an audit is needed. That is just my opinion on that particular point.

The progress report also states that

"only a few Boards have embedded the work of the NDP in their Local Development Plans and local performance management arrangements".

That makes it a bit difficult to get a clear picture of the delivery of the NDP. Perhaps the minister could address that point in her summing-up speech as well.

Housing associations point out that they complement the idea of independent living that the NDP seeks to achieve. Their point is that, while there is focus on AHPs and the delivery plan, without their infrastructure the aims might be quite hard to achieve.

Jim Hume also mentioned housing associations. They are important in that they provide not only housing but care and support services. Bield, Trust and Hanover housing associations have been mentioned. Housing associations contribute greatly to the needs of a diverse and growing older population, and I hope that they are fully consulted as the delivery plan goes forward. I am not asking that they should sit on a board or anything—they have enough work to do. Nonetheless, the work that they do to house older people and help them to live an independent life is something that we should all look to be achieved.

15:50

Jayne Baxter (Mid Scotland and Fife) (Lab): Too often, when we talk about health, we focus on services provided by doctors and nurses in traditional health settings such as GP surgeries and hospitals. In fact, most healthcare takes place outside hospitals, but the work of allied health professionals is hugely underappreciated in our society. From arts therapists to therapeutic radiographers, those health workers make an invaluable contribution throughout Scotland to the wellbeing of people suffering from illnesses and disease.

Each branch of allied health professionals possesses core specialist knowledge and skills. Allied health professionals together share many common attributes, such as a patient-centric approach to healthcare and unique abilities to assist in rehabilitation. Although virtually all allied health professionals offer direct and specific interventions to patients, they also work closely

with other allied health professionals and other medical professionals. What the chief health professions officer has described in the past as the allied health professional "family" represents, as she has noted,

"a diverse group of professions who, as members of multidisciplinary, multiagency teams, provide a wide range of interventions and contributions to promote good mental health and recovery from illness."

I want to discuss further the need for the work of allied health professionals to be part of an integrated programme of healthcare. The delivery of care should not be a tug-of-war between health boards and local authorities. Integration goes beyond co-operation and co-ordination of autonomous bodies. True integration is about softening boundaries and the emergence of a new work unit. That is possible only when we recognise how tensions arise and boundaries become lines of defence.

People need accountable, clear and truly integrated health services. They need responsive services in which the professionals who support them work together to build local networks, knowledge and continuity of care. It is critical that, through integration, the emphasis is on health and wellbeing, not sickness. The time of compartmentalised service provision must end. For integration to work, general practitioners, third sector organisations, allied health professionals, front-line staff, patients and service users must be part of the decision making, and decision making must be clear and coherent. Beyond ensuring that we get the structural aspects of integration right, the difficulty of merging cultures lingers. That will take strong leadership and a secure framework that provides the right environment to engender a new work culture.

Active and independent living is of the utmost importance to people of all ages and circumstances. A sense of independence and control over one's life is something that many people take for granted. However, someone suffering from, for example, a chronic or mental illness cannot take independence and control for granted. It is imperative that we ensure that people suffering from such illnesses are supported into active and independent living. The work of allied health professionals is invaluable in achieving that. Doctors and nurses are often unable to provide the sort of time and commitment to people with such illnesses that they would like. In Scotland, a GP has on average a little over five minutes with each patient. That is clearly not enough to provide more than a cursory evaluation of someone's difficulties, let alone the in-depth assessment required for many people.

It is in those circumstances that allied health professionals step in. They provide help and assistance that is of equal value to that of a GP but, crucially, they can give the time needed more than a GP can. That is not to say that allied health professionals are not extremely busy—of course they are—but it is intrinsic to what they do that they provide a patient-centric experience. That is the true value of many allied health professionals.

Maureen Watt: I congratulate Jayne Baxter on her really good contribution, but does she agree that that is why it is so important that the allied health professionals have been really proactive in moving into communities? Eighty per cent of AHP activity is now in the community—exactly where she says that it should be.

Jayne Baxter: I absolutely agree. About five years ago, I had cancer. The health services gave me great treatment, made me better and fixed my health, but it was the voluntary sector and the services that I was able to access locally that taught me how to be well and change my approach to my life.

We must recognise that our increasing older population in Scotland, with their well-established wider care needs, means that there is an ever greater need for appropriate health and social care assistance. We have all received a briefing from the Bield, Hanover and Trust housing associations, which says:

"Bed blocking and 'boarding' is placing pressure on the current health and social care system for older people affecting patient safety, patient care, and patient dignity; and despite recent legislation, the potential opportunity for housing associations to help deliver independent active living, through the delivery of health and social care solutions remains undervalued and underused."

That goes to the heart of my next point. The work of enabling active and independent living is not completed purely by allied health professionals. It is only in partnership with housing associations, local authorities and other bodies that an active and independent life can be sustained for many people, particularly older people. As I have already noted, that integration must be at the heart of everything that is done in this area. We should look at ways to enable close ties to develop between those organisations and allied health professionals.

I think that there is broad agreement across this Parliament that patient-centred health policies are the way forward. There are clear economic benefits to helping people back into their homes, rather than keeping them in hospitals or other facilities where space and staffing resources are at a premium, but there is also an inherent social value in helping people who can lead an active and independent life to do so. No one would prefer staying in hospital to being at home. Allied health professionals do incredible work in supporting

people. We must recognise the value of their work and create systems that help them do it.

In summary, I think that it is important that we adopt a holistic approach to ensuring that people live active and independent lives, and allied health professionals are undoubtedly a central part of that. In this Parliament and in our communities, we must work to ensure that the Scottish Government follows through on its promises to create an atmosphere that is conducive to allowing allied health professionals to support everyone who needs help in living an active and independent life. I think that we can all agree that a collaborative and consensual approach, using the skills of a diverse range of health professionals from a broad range of bodies, is the best way to foster that atmosphere.

15:07

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): Before I get into the centrality of what I want to say, I will address one or two things that have been said in the debate so far.

I might be wrong, but Jenny Marra seemed to imply that each type of AHP should be represented on local boards. [*Interruption*.] I am glad to see her indicating that she did not intend to say that, because the smaller that a board is, the more effective it is. Simple arithmetic tells us why that should be so: if there are three people on a board, there are three links between them; if there are six people, there are 15 links; if there are nine, there are 42 links; and if there are a dozen, there are 74 links. That is why, as boards get larger, they slow down and impede delivery.

Jenny Marra: For clarity, it was not my intention to suggest that every allied health professional should be represented on every board. As Maureen Watt and I made clear, there are many allied health professionals. However, it would perhaps be useful to have some representation of them as a group.

Stewart Stevenson: I understand where Jenny Marra is coming from. That is a helpful clarification, but I do not think that boards are about the representation of anybody; I think that they are about getting the right mix of skills, knowledge and experience. That is likely to lead to AHPs being on them, but I do not think that they should have a right to be on them simply because they are AHPs.

I now turn to the subject itself and will not get too bogged down in managementspeak, which we might otherwise do.

I think that the casework that we do as constituency and regional members gives us a pretty good insight into the issues that we are discussing. People—particularly older people—rarely come to us with an issue that fits simply into the Scottish Parliament's responsibilities. The issues that older people, in particular, have touch on the responsibilities of Westminster, the Scottish Parliament and the council, and our job is to tease out the issues and find out who can help. The whole debate around breaking down barriers therefore gets to the essence of what is required. A member's role in dealing with constituency casework is to do that; that is also the role of allied health professionals and everyone involved in social care and the health service.

Jim Hume talked about psychiatric help, and I absolutely agree with him. I was particularly pleased that the child and adolescent mental health services workforce has risen by 24 per cent in the past five and a half years or so, providing important extra help for young people with mental health problems.

It is also important to look at what AHPs do. When my father became a general practitioner in the 1940s, and during most of his working life in the 1950s, 1960s and 1970s, there were not many formally recognised AHPs around. My father was probably slightly unusual in that he used to send those for whom he felt he could not do very much to people such as chiropractors, which was somewhat frowned upon by his professional colleagues, but it worked for a proportion of the people whom he sent. Of course, things are much better now, because there are formal qualifications, training and protocols for educating those in that discipline, and in many others, in the range of support that we can provide. The whole point about how we work together now is that it is based on evidence-based models of practice, and is focused on rehabilitation after illness or difficulties of one sort or another.

Integrating social care and healthcare is important. We have the benefit of a progress report from February, which tells us some interesting things. First of all, it tells us about the local delivery plans. We have planning down at the grass roots, but planning is the easy bit; it is delivering on the content of the plan that is difficult. I have spent much of my life managing large projects, and my guru was Professor Fred P Brooks, who wrote the wonderful book, "The Mythical Man-Month". His advice to anybody who is involved in a project of any kind is, "Just do it, and cut the size of your team if you want to do it fast."

Some of the interesting things in the progress report have come up in Parliament before. For example, there has been substantial progress on foot care guidelines. That sounds like a simple, little thing—I know that Mary Scanlon has spoken about it on a number of occasions over the past

decade—but if we keep people moving, their health improves, they can go to the shops and their social interactions are better. Sometimes quite straightforward interventions can make a difference, so it is good to see that we are making progress on that. As we get older, the risk of falls grows, and we see progress on that, but there are also opportunities for further progress.

The Labour Party's amendment to the motion refers to an audit, but what we might get from an audit is already being delivered. If we have a formal audit and send in the auditors, all that they will do is slow people down and divert effort away from their work, so I think that the choice of word may be wrong. I suggest that, instead of conducting an audit, we should consider doing something that is not currently on the agenda. I encourage the Labour Party and all members to think about perhaps having an improvement service, such as local authorities now have, to ensure that good practice—of which there is plenty within the range of professionals that we are talking about—is picked up, refined and presented to those who will benefit from knowing about the good practice of others. If we are to spend more money on oversight, I suggest that that is more like the kind of thing that we should do.

Like Jayne Baxter, I will draw on my personal experience. About 30 years ago, I had a tingling sensation, starting in the back of my neck. Over a period of months, it eventually reached the outside of my thumb and the outside of a finger. At that point, I decided that it was perhaps time to consult a professional, and I did so.

The moment I described the symptoms, he knew exactly what it was. He offered me three options. He said that I could be sent for an operation to cut a little bit off my spine—I had a trapped nerve and a bit could be cut off; I could have acupuncture; or he could do manipulation. He paused and said, "And I can do the manipulation now."

I said that we should try manipulation. He sat me on the couch, put his knees on my shoulders, pulled my head up about half an inch, turned it through 90° and folded it forward. There was a great crack. He said, "You'll be okay, but you'll be sore for a few days."

That one intervention, which lasted approximately three minutes, has stood me in good stead for 30 years. That was an allied health professional really doing his job, and I am immensely grateful. I hope that they are all as successful for everybody else.

The Deputy Presiding Officer: I am very glad you survived.

15:15

Anne McTaggart (Glasgow) (Lab): Someone has just said, "Follow that," but members will be glad to hear that I will not be discussing many of my ailments today.

I am grateful to be given the opportunity to speak in today's debate. All of us in the chamber recognise the role and celebrate the valued contribution of allied health professionals in health and social care. They play a vital role in our communities, leading the way to enable people to lead independent lives outside hospital and residential settings.

AHPs are a fundamental part of our health service. They work across the three areas of health, social care and education, while having particular expertise in enabling approaches that make them that essential component of our health service. AHPs are a key NHS staff grouping in the development of rehabilitation services, which include physiotherapists and occupational therapists. I am sure that everyone in the chamber will agree that AHPs develop innovative and creative solutions to health challenges and are an asset to our NHS.

The term "allied health professional" is merely an umbrella term that covers anything from dieticians to therapeutic radiographers. They make up a sector of our health force that is 8.2 per cent of the total, which is almost equal to the percentage of dental and medical staff.

Since the publication of the AHP national delivery plan in 2012, AHPs have been able to bring about a much more desired effect through facilitated groupings and through working together to provide significant service transformation and improved outcomes for people and communities across Scotland. The delivery plan is a significant document, offering important recognition of both the role and the contribution of AHPs in health and social care. It also recognises the potential of those professions to deliver improved services across health and social care.

It remains essential that the allied health professions are valued for their specific and unique contribution to service provision and to fulfilling the wider aims of health policy in Scotland. However, an audit of the AHP national delivery plan is essential in order to support AHPs by understanding the areas that are most in need, focusing on the performance of self-referral as a primary access route. That is important because, to meet our population's complex needs, we need multidisciplinary teams. We also need to use our knowledge of populations and the risk stratification tools that are available to us to direct patients more effectively and efficiently to the treatment pathway that is right for them.

Services need to be accessible to the growing number of patients in all communities who have long-term conditions. People with a long-term condition often have the best insight into their condition and know when they need a clinical intervention. For them, one of the biggest frustrations of the current system is that they have to start from the beginning each time. That is the most inefficient way to provide health care.

Self-referral to physiotherapy and to specialist services in particular is already tried and tested, having been advanced in Scotland. However, there are many other services—for example, women's health and incontinence services, respiratory services and stroke and falls prevention—where self-referral would deliver considerable benefits for patient care.

Although there was a substantial increase in the AHP workforce in NHS Scotland between 2000 and 2010, I am extremely concerned about the loss of senior clinicians. The Chartered Society of Physiotherapy has stated that the reduction in the number of senior grade roles means that the experience and knowledge of those clinicians will be lost to patients. NHS Scotland workforce statistics reveal there has been a 10 per cent reduction in senior posts since 2010. Those posts are vital, as specialist clinicians deliver the leadership and expertise that are necessary for improving patient care, and they have a very positive impact on quality of life for many patients. It is therefore important to establish a long-term plan to reverse the trend.

It is vital that we continue to pay tribute to all AHPs for the changes that they are making in delivering new models of care; supporting self-management, innovation and improved outcomes; and enabling independent living. All of those are essential in securing sustainable and affordable health and social care services for the future.

I believe that an audit of the 2012 national delivery plan for AHPs is required if we are to identify good practice and provide greater support for all our allied health professionals in Scotland.

The Deputy Presiding Officer: I call Christine Grahame, to be followed by Bob Doris—you have a generous six minutes and time for interventions, Ms Grahame.

15:22

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): Thank you very much, Presiding Officer.

I commend allied health professionals for the services that they deliver across my constituency, including in the Hay Lodge community hospital in Peebles and the Eastfield and Penicuik medical practices, which are the link to allied health professionals for many people.

I begin with that metaphorical cradle-to-grave journey. First, I reference from the national delivery plan this particular sentence:

> "Many young people who encounter the justice system as a result of offending behaviour have existing speech, language and communication difficulties; it is clear that there can be a connection between such difficulties in early years and the social and behavioural impact in later life."

That was evidenced to the Justice Committee when we asked why children who are alienated from school progress from disruptive offending behaviour to criminal activities.

We took evidence from speech therapists that was riveting and has stayed with me to this day. Examples were given that members may very well recognise, such as that of the young mum who gets on the bus with her baby in a buggy. The baby is fed, watered and clean but has a dummy-tit in its mouth; the mum is texting all the way or is on her mobile and does not communicate with the child at all. She gets off the bus, still not communicating with the child.

Let me compare that example with the example of the mum who gets on the bus with a child who looks at her—a mum who makes faces for and interacts with the child, who looks across the bus at other people who also interact with them. That is early communication—a child learning their place in society and learning to read expressions and understand sounds, whether encouraging or otherwise. It is very basic, but the speech therapists made it plain that if it goes wrong then, it can stay going wrong right through the early years into nursery and primary school, where the child might become detached, quiet and inhibited—or they might become the bully and start causing trouble because, frankly, they just do not know how to get along with people, which might finally lead them to graduate into a life of crime.

That evidence really brought home to me something that I had never thought about: how important speech therapy, language and communication are right at that early stage, even without words.

I move on to the grave part, or one foot in it, perhaps. We have an increasing elderly population, and 70 is the new 60—I certainly hope so. However, with age comes wear and tear, both physical and—sometimes—mental. The role of and access to physiotherapists and occupational therapists become more important, and the sooner people see them, the better. Access to them is more important than access to a mechanic for a much-loved but vintage vehicle.

I say to Stewart Stevenson that my late father always said, "You must take care of your feet because they keep you upright." I am on the podiatrists' side. That is not a lighthearted comment, because elderly people do not always have access to podiatrists. Once someone cannot move about, they cannot move about, and it is literally downhill from there.

For some—I say to Mr Stevenson that I am not looking at anybody in particular—the body soldiers on with occasional first aid, but sometimes that is not the case for the mind. The role of art and music therapists is crucial here as they stimulate the recesses of the mind where memories of self and past may be just waiting to be unearthed, even if only temporarily.

I am thinking of a service at the National Mining Museum Scotland at Newtongrange. The lady there—Alison Shepherd—is actually an education officer rather than a drama and arts therapist, but she has lots of wee memory boxes for different decades, and each relates to a different mining community. They stimulate memories and bring things back to mind for people who have perhaps just been sitting vegetating in care and residential homes. They cheer up and their eyes brighten as they remember things from the past.

Each one of us recognises the perfumes of the past, which bring moments in time, perhaps from childhood, back to life. Sometimes, a tune brings memories, good or bad, flooding back, even taking us unawares. The smell of wild flowers and I am back guddling for taddies in the Union canal, with my mother standing on the bridge screaming at me to get back from the dirty water. Melodic whistling and I can see my dad stravaiging back from his work. We are all cut from the same memory cloth, and for some it is the only route to retrieve, for a time, the individual who once was.

We have talked about allied health professionals as a broad group, but I wanted to focus on drama and arts therapists, just in case nobody else does so. Sometimes, they and they alone can bring back people who were lost.

15:27

Bob Doris (Glasgow) (SNP): It seems a fair while since the minister opened the debate by reeling off a huge long list of allied health professionals, finishing off—last but not least—with speech and language therapists. It is always a risk when we seek to thank a long list of people, or in this case professions, in case we miss out someone or some profession. I am sure that the minister would not have made such an error in opening this debate. I think that 13 allied health professions were mentioned, representing more than 11,000 professionals. Later in my speech, I will come back to that and comment on adding to that, but perhaps not with health professionals.

The value of allied health professionals, which has been recognised in the debate, was recognised in "AHPs as agents of change in health and social care: The National Delivery Plan for the Allied Health Professions in Scotland, 2012-2015", which other members have mentioned. That plan was seen as a key driver towards reducing unnecessary hospital admissions, reducing the length of hospital stays and helping people to be happier and healthier and remain in their homes for longer.

There has been much discussion of the numbers of allied health professionals. Colleagues have put it on the record that, in a seven-year period since 2007, there has been a 26.2 per cent increase in allied health professionals. I do not quote that figure as something to give the Government comfort. There is a separate reason for quoting it. For occupational therapists, the increase was 3.5 per cent, for physiotherapists it was 9.8 per cent and for radiographers it was 21.2 per cent. Why is the figure 3.5 per cent for OTs, for example? Why is it not 2 per cent or 7 per cent? For radiography, why is the figure 21.2 per cent? Why not 10 per cent? There has to be a meaning underpinning the numbers of AHPs in the system and an explanation of why we got to them. That is my reason for reading out the numbers, although I should say that it is of course a good thing that we have more of them. I will return to that point in a moment.

I want to speak about some general issues that have been raised and which have affected me personally and my family. Are strokes and TIAs—transient ischaemic attacks—always detected when they happen? If they happen and are not detected, or if they are detected and treated as relatively minor, are we aware of the muscle wastage that might happen? It might be minimal to begin with but, if there is no quality physiotherapy follow-up, there could be significant muscle wastage over a number of years. That can be compounded if people become frail anyway and then cannot use a walking stick or zimmer frame because of the frailty of their limbs. Allied health professionals have a key role in dealing with that issue.

Jenny Marra mentioned continence issues. I have been working with some fantastic continence nurse specialists in NHS Greater Glasgow and Clyde. Incontinence is an issue, particularly but not exclusively for women, but it is not an inevitable aspect of growing older and it can be reversed and mitigated. Continence issues also relate to gait syndrome, which increases the likelihood of slips, trips and falls at home for older people. Incontinence can lead to older people

rushing to the bathroom through the night, which leads to a heightened risk of falls. Also, there is the isolation and stigma that come with that issue. It is not just allied health professionals who work on that—nurse specialists have a key role to play. Whether or not physiotherapists are the most appropriate intervention at that point, which Miss Marra talked about, nurse specialists have a key role in developing the service.

On delayed discharge, the Scottish Government has said that it wants to give 200,000 bed days back to individuals and families by 2017 and £100 million is to be invested in that. Much of that money will not necessarily be spent in traditional ways. Some will be spent in non-traditional ways, such as on ensuring that older peoples' houses are fit for purpose and are slip, trip and fall proof, so that when they get out of hospital they are less likely to be readmitted. There is some real prevention stuff there. OTs may have a role in that regard. Specialist housing officers could have a key role in that with the housing association movement, or it could be dealt with in the care sector.

I said that I would return to the issue of how we get to the increases in the numbers of allied health professionals. I do not know what the percentages should be. We have a series of health and social care integration boards getting off the ground, and each local area will have its own strategy for dealing with many of the aspects that I have raised. When the boards have that strategy, they should have a workforce planning model around that, and that could be different for Glasgow and Grampian, because they may set different priorities and pathways. Therefore, although we need a national framework that underpins the figures, there are issues about how we do national planning on that, particularly in relation to empowering local health and social care integration boards.

Perhaps the term should be "allied health and social care professionals", because we have to build up the status of the care sector. On the much-demonised 15-minute home care visits that we have heard so much about, of course I would rather have 30-minute or 40-minute visits but, for older people who are isolated at home, that point of contact nurtures their mental health. That cup of tea and a blether for those 15, 20 or 25 minutes are essential. Surely that is part of workforce planning and building up the status of allied health and social care professionals. The picture that I am trying to paint is that, although we should use the debate to recognise allied health professionals, everything is interlinked at local level and in local development planning.

I finish with a final appeal, which goes back to the status of the care sector. Many young people want to become nurses, but they may not yet have the qualifications to access the course. If people have two, three or four years in the residential care sector with a clear career progression and support pathway to become a nurse, that may be one way to build up the status of the profession. The wonderful job that those people do on pretty low pay right across the country is absolutely exceptional. They are not allied health professionals, but they are allied health and social care professionals, and they must also count at a local level when we do our planning.

I hope that the minister will take that on board.

15:35

Cara Hilton (Dunfermline) (Lab): I am grateful for the opportunity to take part in this important debate on the allied health professions and their vital role in enabling active and independent living.

Like other colleagues, I commend the hard work and dedication of all those who work in the allied health sector. My oldest son has benefited greatly from the support of both the occupational therapy service and the speech and language therapy service. I commend the contribution that is being made not just in our health and social care services, but in our education services.

There is absolutely no doubt that the allied health professions have huge potential to deliver even further improvements across health, social care and education. That was rightly recognised in the allied health professionals delivery plan, which was published in 2012, but the changes that Scotland and our health service face mean that the sector needs a lot more than recognition; it really needs to be at the centre of Scotland's health and wellbeing policy. We probably agree that across the chamber.

The minister has outlined the scale and impact of the demographic time bomb that Scotland faces. Obviously, that must not be underestimated. By 2033, the number of people over the age of 60 in Scotland will have gone up by 50 per cent, and the number of people aged 85 and over will have gone up by 144 per cent. Although it is great news that people are living longer, our economic prospects obviously depend on our paying a lot more attention to keeping our ageing population fit for work and ensuring quality of life for them in retirement.

In that respect, early access to services such as physiotherapy and rehabilitation in the community can make a huge difference to outcomes and people's wellbeing. That often reverses much of the impact of disease and disability, reduces the need for hospital admission and social care, and helps people to stay in the workplace.

In our approach to health and social care policy, it is crucial not only that we recognise the vital contribution that allied health professionals make, but that we give them the value and status that they deserve in our national health service. Currently, that does not always happen.

I want to highlight Unison Scotland's report, "Under pressure: Scotland's occupational therapists speak out", which surveyed Unison members on the state of the service and its future prospects. The Unison survey found a dedicated but frustrated workforce that finds it increasingly difficult to deliver its service. Some 57 per cent were concerned about the impact of cuts on the service; 60 per cent said that they had to cope with fewer staff; and 82 per cent reported increased workloads. Many said that pressures on budgets meant that their professional assessments were overruled and their recommendations were overturned. Where they were approved, people faced longer waits to get the equipment and adaptations that they needed. Obviously, that is having a huge negative impact on people's quality of life.

Unison's OT survey said that changes in the way in which services are delivered mean that more time is being spent on assessments and form filling and less time is being spent focusing on patient care, and that changes elsewhere in the care system and the NHS often have a knock-on effect on occupational therapists, who sometimes feel that they are not fully or appropriately utilised in the planning process, particularly for patient discharge. As other members have highlighted, the result all too often is that patients end up being readmitted to hospital and caught in a revolving door due to the gaps in support, which can make independent living very difficult.

One Unison survey respondent said:

"Despite evidence showing an increase in OT can actually reduce the length of hospital stay, improve patient experience and increase or maintain independent living, there is still a requirement to do more with less—this is leading to budget cuts, staff ... issues, poor morale and poor patient experience."

We all have constituents who are paying the price of the pressures that are faced in the OT service and the gaps that continue to exist between health and social care. I want to highlight the example of one of my constituents in Dunfermline, who is 87 years old and has prostate cancer. My constituent needs a walk-in shower as he simply does not have the movement to get in and out of his bath. He has been told that he is not a priority, and that he should wash himself at the sink, despite the fact that he can barely bend, which makes washing himself that way very difficult to do. He is on a long waiting list for an OT assessment, and has been told that nothing can be done before that happens. Therefore, he has had no option but to pay for a private carer to come and bathe him twice a week. He can barely walk—he is virtually housebound.

My constituent has been told that the funding is simply not available right now for anyone who is deemed to be in low or moderate need and that, in all likelihood, he would qualify for a care package and adaptations only if his need becomes critical.

Another constituent, who suffers from dementia, recently had a bad fall down her stairs. Her social worker has confirmed that adaptations are needed, but that nothing can happen until there has been an OT assessment to authorise them. Four months on, she is still waiting for the assessment to happen.

Those are just two examples of how the pressures and gaps in the service are having an everyday impact on people's wellbeing and quality of life.

Occupational therapists, like other allied health professionals, contribute greatly to people's welfare and wellbeing—indeed, they can transform their quality of life. Too many of them feel undervalued, overlooked and under pressure. That must change. It is vital that the central role of allied health professionals is fully recognised, valued and reflected in how our health and social care services are designed and delivered. Scottish Labour's amendment calls for an audit of the AHP delivery plan to ensure that that happens.

We need to see Scottish Government action to address some of the shortfalls in, for example, physiotherapist numbers. Recent NHS Scotland statistics show that, since 2010, there has been a 10 per cent drop in senior physiotherapist posts. That is a loss to patients and to the NHS at a time when we should be shifting more towards preventative spend and care. Indeed, investment in services such as physiotherapy would not only dramatically improve people's wellbeing and quality of life but generate substantial savings for our national health service, as the minister acknowledged.

Scottish Government figures on emergency admissions to hospital show that 86 per cent of over-75s are admitted as a result of unintentional injuries, which are mainly falls. In its briefing for the debate, the Chartered Society of Physiotherapy highlights the falls prevention economic model that it has developed to support health boards in identifying how they can best protect people from falls. It estimates that, each year, 19,000 falls could be prevented through improved access to physiotherapy-led prevention services. That would save many lives, as well as saving the NHS £27.1 million a year. Indeed, for every £1 spent on physiotherapy, the NHS would get back £1.49 in savings.

The debate is welcome. It is great to hear the work of our allied health professionals being celebrated across the chamber. The delivery plan is a welcome step, but more must be done to ensure that health professionals receive the recognition and the support that they deserve. Much more must be done to ensure that people can have early access to the occupational therapy and physiotherapy services that they need without beginning each time from scratch and fighting every step of the way.

15:43

Colin Keir (Edinburgh Western) (SNP): First, I welcome the new £3 million fund that the minister announced. I am sure that the fund will become invaluable in the coming months as we take forward the services that we have talked about.

For a number of years, it has been clear that the way in which our health system works requires to be changed. We are living longer and it is vital to reflect future demographics. I think that we all agree that the decision to work towards a system of prevention instead of reaction is the correct path to take.

With the integration of health and social care, it is clear that the connection between the old ways of doing things has been broken. I firmly believe that the new integrated boards should and will value and take cognisance of the allied health professionals and their work. That is absolutely vital. Stewart Stevenson mentioned the size of the boards and how they will react faster and provide better outcomes. I am sure that that will happen. The change is definitely required; I am sure that it will happen successfully.

I am delighted that the motion highlights and recognises the work that is done by allied health professionals. In some cases, they are seen to take second billing behind doctors and senior medical professionals when, in fact, they hold our health service together. The skills that have been brought into not just health but social care are vital in changing the services that we provide for the people of our country, bringing our health service well into the 21st century.

I am delighted that there has been a rise in the number of allied health professionals, with well over 11,000 individuals now involved. Although, as Bob Doris said, that could be seen as just an arbitrary number, I believe that the Scottish Government is seeing how valued allied health professionals are, and the AHP national delivery plan gives a clear direction of travel that we must take to address future needs.

As the minister pointed out, some extremely good results have come out of the NDP progress report of February this year. In my constituency, I have heard numerous stories relating to the help that allied health professionals have given. One of my favourites relates to podiatry, and I am sure that Mary Scanlon, Christine Grahame and Stewart Stevenson will appreciate it. A lady to whom I spoke just the other day, who is in her late 70s, has struggled for some time with problems with her feet but can still get around. The podiatrist who has dealt with that lady has been successful in ensuring that she is still mobile. However, she remembers the same problem being faced some years ago by her mother, who unfortunately did not receive the same level of care and had to endure much more discomfort, especially in her final years. Whatever we say, it is all about quality of life, and my constituent fully understands why we have podiatrists in our health service, such has been the effect on her life.

We all want to see more people spend more time in their homes and communities, and the work that the allied health professionals do in trying to ensure that people of all ages spend less time in hospital care is invaluable. I have seen examples of that on numerous occasions in my constituency. If it was not for the work of the AHPs, many of my older constituents would be in full-time care. Enablement programmes are superb examples of why we require allied health professionals. Particularly for the elderly, enablement allows independence in the community, but it is workable only with allied health professionals.

Like Jenny Marra, I have sat through multidisciplinary team meetings at health centres over the years, and the one thing that I have been unable to help noticing is the real professionalism that is shown at such meetings. Even more important, those people really do care—it is not just an action or a job to them. Working with doctors, allied health professionals are extremely impressive.

Our constituents want to live their lives normally for as long as they can within their communities.

AHPs deal not just with adults with physical difficulties; as Nanette Milne and others have pointed out, virtually every strand of society requires the help of AHPs. They help kids to get the best start in life, they help those with mental health issues and they help people with extreme complex needs. Physiotherapists provide an example that is very close to home for me. My father was terminally ill with Huntingdon's disease and required one-to-one care towards the end of his life because of the involuntary movements and the other difficulties that he had. The work of the physiotherapists was absolutely phenomenal and made life much easier for him in the long term while he was in care.

Bob Doris talked about not just people who work in the national health service, but those who work in the care system—in care homes and the like. They have been undervalued and really do need respect and authority, and the training to bring everything to the same standard; they need to be seen in that way by the public. Social care is not a second-rate system, and we should help it as far as we can.

Until fairly recently, I had not really thought about the work that drama and arts therapists do, which Christine Grahame brought up. The work that they do on sensory perceptions and bringing out colours, sounds and smells is fantastic for people who require that kind of help. By evoking memories, they give people a better quality of life.

Bob Doris was right to bring up workforce planning. I believe that, given the way in which we are moving forward, the proposed audit is not necessary, but I might be proved wrong. I tend to agree with what Stewart Stevenson said.

The people whom we call allied health professionals are not just people on the periphery of the NHS; they are absolutely vital to it.

15:50

Richard Lyle (Central Scotland) (SNP): It is a great privilege for me to speak in a debate on allied health professionals, not only because I am a member of the Parliament's Health and Sport Committee, but because it gives me an opportunity to recognise the invaluable role that AHPs play, as the motion says,

"in prevention, early intervention and enablement in supporting the health and wellbeing of the people of Scotland throughout their lives".

As many other members have done, I welcome the extra funding that the minister has announced.

I am sure that the Scottish National Party Government recognises the importance of the contribution that AHPs make to the lives of the people of Scotland. I am sure that it also recognises the wide range of allied health professions that there are in Scotland, which shows the depth and the breadth of the skills that lie within the sector.

In total, there are 13 allied health professions in Scotland, with more than 11,000 individual professionals working as arts therapists, paramedics, physiotherapists and much more. They are extremely important, because they are the only professionals who are expert in rehabilitation and enablement at the point of registration. Their expertise in rehabilitation and enablement will be crucial in supporting the introduction of the 20:20 vision for our NHS, which we have discussed on many occasions, which will help the people of Scotland to live longer, healthier lives at home and will deliver on key NHS quality outcomes.

It is clear that the work of AHPs is vital. None of the work that they do is more important than the work that they do for individuals and families, particularly older people and those with dementia or complex needs. AHPs play a central role in helping them to live self-determined and independent lives. Patients and carers consistently report that the services that AHPs provide make a significant difference to their health and wellbeing and, importantly, their quality of life.

I know that the SNP Government recognises that, and I am pleased that, under it, the number of AHPs in NHS Scotland increased by 26.2 per cent between 2007 and 2014. The largest percentage increase between 30 September 2007 and 31 December 2014 was in prosthetics. The number of AHPs working in that area increased by 249.5 per cent, and there were notable percentage increases in the number of multiskilled AHPs and AHPs working in orthotics, which increased by 130 per cent and 90.6 per cent respectively.

The implementation of the national delivery plan for AHPs is extremely important. The plan is already having a significant impact across Scotland. The plan, which was launched in 2012 and developed in line with the 20:20 vision, calls for AHPs to be more visible, accountable and impact orientated. The implementation of the actions that are set out in the national delivery plan for AHPs is having a significant impact across Scotland as AHPs contribute to reductions in the number of unnecessary admissions to hospital and in the length of stay for those who are acutely ill and for whom admission to hospital is the most appropriate option.

As ever, there is always more that we can do. The Government is always striving to improve and to get better. That is why in the remaining months of the delivery plan there should be continued work done with the boards and support given to them to deliver on the actions, demonstrate impact and, importantly, spread, sustain and embed the improvements made across services to truly make them work for the people of Scotland.

Allied health professionals are a vital element of the delivery of primary care, providing professional skills that add value to the services that a practice can provide. Acting as the first-point-of-contact practitioners, AHPs make a vital contribution to faster diagnostics and earlier interventions in primary care. They work closely with general practitioners and community teams to provide alternative pathways to secondary care referral and to prevent admissions in areas such as falls prevention and musculoskeletal services.

AHPs have a significant impact on the lives of older people with long-term conditions and dementia and they ensure that resources are used to best effect by preventing unnecessary admissions to hospital or care. They also work towards this SNP Government's vision for children and young people in creating a Scotland that will be the best place in the world to grow up. AHPs have a vital role to play in the delivery of the early years framework agenda in areas such as early intervention, anticipatory care, prevention and health promotion. In particular, the provision of speech and language therapy can support children with communication difficulties to access the curriculum and to achieve their full potential.

It is clear that AHPs play a truly invaluable role in delivering essential services for the people of Scotland and ensuring that they live, long, happy and healthy lives. We should all be proud of all of those who work in the allied health professions, and indeed all who work in healthcare here in Scotland. They truly are changing people's lives here in Scotland and we should salute them all.

15:57

Hanzala Malik (Glasgow) (Lab): I hope that the minister will accept the Labour Party amendment in Jenny Marra's name.

It is a pleasure to speak about the importance of allied health professionals and the vital role that they play in our health service. Allied health professionals—or AHPs for short—work with people of all ages and groups across a range of communities and hospitals. They contribute to health provision, health improvement, recovery from illness and injury, support a return to work and enhance quality of life, which I am sure that we all agree is so important.

The 2012 delivery plan recognises both the role and the contribution of AHPs to health and their potential to deliver improved services across the health and social care sector. It has provided an excellent opportunity for AHPs across health, social care and the third sector to work together in delivering the services that our communities today need.

Evidence shows that early access to physiotherapy and rehabilitation in the community can result in improved diagnosis and care. Disability in individuals can be identified far sooner and rectified, reducing the number of frail elderly people being readmitted to hospital and dependency on social care.

So far, we have cross-party agreement on the important role that allied health professionals play and the wider concept of the integration of the health and social care functions.

Now, I get to the outcomes. The progress report on the AHP national delivery plan is an odd document to say the very least. It gives percentages for completion rates of NDP actions. If members do not know what that means, that is okay, because frankly it means very little.

In reality, because of the percentage system, the progress report has no analysis of whether the targets are right, action has been good or the AHPs or the people whom they serve have benefited.

Evidence from my constituents indicates that self-referral does not work quite as smoothly as it ought to. A constituent tried to phone for an appointment for a relative and had to wait more than a week after eventually leaving a message on an answering machine. Then it took another three weeks to get an appointment.

Clearly, improvements can be made. I accept that no system is perfect, but self-referral to physiotherapists is already an established fact in Scotland and, therefore, one expects it to run reasonably smoothly, particularly in cities such as Glasgow. The Chartered Society of Physiotherapy highlighted that many other services could benefit from delivery by self-referral but, if people face difficulties already, that will only compound the situation.

The ultimate aim in Scotland is to change the culture and the way that we deliver health services. That takes a long time and we need a proper audit to find out whether real progress is being made. We need to examine what works and what can be done to better the service. Without such audits and statistics, it is not possible to measure whether the work that is being done is reaching its conclusion.

Bob Doris mentioned that young people who aspire to be nurses could work with allied health professionals. I would guard against such an intervention because it might mean that the allied health professionals come to depend on them, which is a dangerous slope to go down because the job that they do is professional and important. People need the appropriate qualifications to be in the service in the first instance.

I have made several inquiries because, as a former councillor, I know that a number of constituents used AHP services. They felt that they waited far too long for appointments, that the service was very slow and that it could be improved. I appreciate that there is always room for improvement and, as long as there is, we should strive to improve.

The work that AHPs do is valuable. I once needed services for an injured knee and the service that I received was excellent. I was given very good advice that helped my recovery

tremendously. I do not think that my doctor was in a position to provide the service that the AHPs did.

I thank all the allied health professionals. My heart and soul goes out to support their objectives. If, for example, they are looking for additional services—which they seem to suggest they are—there needs to be a clear vision of what they want to do, what direction they want to travel in and how they intend to audit them.

Auditing is essential. The report that we have in front of us is wasteful. It could have been better and is a lost opportunity. We need to be clearer about what is happening not only in Glasgow, Aberdeen and Dundee, but nationally. We need two sets of figures—one that shows us what is happening in local areas and another that shows us what is happening nationally—so that we have a clear picture of what is happening and what services we are receiving.

I am interested to hear what the minister's feelings are about the future of the service. We strongly support its improvement. I am happy for the AHP service to be extended further if that can help the health service to build on its current success rate.

The Deputy Presiding Officer (Elaine Smith): We still have a little bit of time left, if members wish to take interventions.

16:04

Mike MacKenzie (Highlands and Islands) (SNP): It is an unfortunate irony that, in healthcare and in many other areas of social policy, we are becoming a victim of our own success due to the simple fact that we are, increasingly, living much longer than previous generations. The ageing demographic is perhaps the biggest challenge that we in Scotland, along with other western democracies, are facing.

That is especially true in the Highlands and Islands region, where lifespans tend to be longer than the average. The situation is exacerbated by the fact that for generations we have exported our younger people. More recently, in addition, we have begun to import older people. Retirement migration has become a characteristic of almost all parts of the Highlands and Islands, especially in our more rural areas, which throws up particular challenges for rural healthcare delivery.

The ageing demographic, along with a number of other factors, means that we cannot depend on traditional methods of delivering healthcare. It is important that our rural healthcare system evolves to meet that challenge in the 21st century. One aspect of that involves spreading the work that was traditionally carried out largely by GPs, often in single-handed practices without much assistance at all, among a much wider group of health professionals.

Hanzala Malik: I thank Mike MacKenzie for taking an intervention. He is almost mirroring my earlier suggestion that we should have statistics and figures not only for certain areas but nationally. That would, I hope, pick up information on areas in which—as he mentioned—there is a shortage of professionals. We want to ensure that the communities in those areas do not suffer as a result of that shortage. We should try to find a solution so that it does not happen and we have good service right across the country.

Mike MacKenzie: I thank Hanzala Malik for his intervention; I am very pleased to say that I agree with what he suggests, and I am glad that we are of one mind on the need to address that challenge.

As a group, allied health professionals include art therapists, chiropodists, diagnostic radiographers, dieticians, drama therapists, music therapists, occupational therapists, physiotherapists, prosthetists, speech and language therapists and many more. All those allied health professionals can help to share the work of delivering healthcare and they have a very important role in doing so.

Much of the focus of their work is about allowing and facilitating people with health problems to continue living in their own homes rather than being admitted to hospital. There is a preventative aspect to their work as well as a role in assisting people who have been discharged from hospital.

In my previous career as a builder, I sometimes worked in collaboration with occupational therapists who recommended alterations to homes that would allow people with medical conditions or disabilities to continue living at home. The opportunities for facilitating that through imaginative and not always expensive alterations go far beyond the scope of building standards in dealing with disability access. There is a genuine opportunity for better thought and creativity in design that can pay large dividends in allowing people to continue living high-quality lives in their own homes despite health problems and disabilities. Perhaps some of our architects ought to take up that challenge, because there is real scope for improving the design of homes and not just meeting the minimum requirements of building standards.

I want to single out and pay tribute to one such occupational therapist with whom I worked: Elaine Robertson. I am sure that Michael Russell will also know Elaine Robertson. In her previous role as an occupational therapist, she brought care and creativity to her work; since her retirement, she

has continued to serve her community as a councillor in Argyll and Bute Council.

Long before integrated health and social care was properly brought into being, Elaine Robertson was putting those principles into practice by informally networking across a whole range of people in different professions, all of whom knew and respected her. That is perhaps an aspect of rural community life, where people tend to know each other, that is helpful in facilitating such good practice.

I am pleased that that sense of community and humanity is still prevalent in many of our rural communities, where people relate to each other in a way that goes beyond their professional job titles or their job descriptions. That is one of the most uplifting aspects of rural life.

It is in that sometimes informal space that the work of our allied health professionals takes place, which makes their work so valuable. It is the type of work that is often difficult to quantify and to put a value on. That is precisely why we categorise such work as invaluable.

16:11

Michael Russell (Argyll and Bute) (SNP): This is indeed a vitally important subject for every area of Scotland and for every citizen. All of us will require and get services from AHPs at each stage of our lives.

Mike MacKenzie mentioned the particular challenges in rural Scotland and in extremely rural constituencies such as Argyll and Bute, where there is a large set of challenges for all healthcare professionals, whether they be AHPs, GPs or people working in hospitals. There are problems to with distance and travel, professional support and recruitment. There are such problems for rural GPs and for health delivery right across Argyll and Bute. Mike MacKenzie was right to mention the work of at least one of those people, who has moved from being a health professional into Argyll and Bute Council. There are many other people to whom we should pay tribute working right across the area, from Campbeltown to Dunoon, and from Tobermory to Inveraray.

There are not only challenges, however; there are opportunities. The minister mentioned the progress that has been made in the reduction in falls, which has led to a reduction in admissions. Christine McArthur is the NHS Highland co-ordinator for prevention of falls. She gained a PhD from the University of the Highlands and Islands while working on the island of Bute, and she studied community involvement in healthcare in research on Islay. She was able to build and deliver an enormous and important range of skills by living in an island community and working with island communities.

As the minister said, the number of allied health professionals has grown in Scotland—even in rural areas that have recruitment problems. That is good news. However, one area of concern is the decline in the number of art and music therapists. Art and music are not an add-on to life. Creativity liberates individuals, focuses us on our common humanity, helps us to make connections, adds to our sense of wellbeing, lifts us from depression and gives us purpose. In short, it makes us better and it can make us—and keep us—well.

I was lucky to see an example of that recently in Glasgow, where I visited an art therapy class. Greater Glasgow and Clyde NHS Board is very clear about the effects of art therapy: its website states that from the art therapy that it invests in, it expects to see:

> "Reduced amount of drug consumption
>
> Shortened length of stay in hospital
>
> Improved mental, emotional and spiritual wellbeing
>
> Enhanced quality of service
>
> Reduction in workplace violence
>
> Increased job satisfaction of staff".

That is an enormous range of achievements for a single therapy.

There are a number of art therapy charities and organisations working in the field, but they need the help of the NHS to allow them to access the widest range of people whom they can assist, and they need positive support from the Government.

Some of those charities have exhibited in Parliament, as has Nordoff Robbins, the music therapy charity. Its approach to music therapy is well documented and researched. It undertakes a range of inspirational activities—the one that strikes home most is the work that it does in children's hospices. Nordoff Robbins lists conditions for which music therapy is particularly useful, including autistic spectrum disorders, learning disabilities, mental health problems, dementia, profound and multiple learning disabilities, and what it calls life-limiting illnesses. The charity goes further, however, and suggests that there is not really any health issue that cannot be touched or soothed by the application of music therapy.

I hope that, as investment continues to grow in allied health services, and given the increasing focus on mental health, attempts will be made to reverse the decline in art and music therapists and to find new ways of allowing as much access as possible to those therapies.

Maureen Watt: I accept that there has been a reduction in the number of art therapists who are directly employed by the health service, but Mike Russell himself said that many are now employed by charitable organisations and arts and drama groups. Much of the work that art therapists do is still being done but is being delivered by different mechanisms.

Michael Russell: I accept that: the minister makes a good point. However, it is important that the national health service and the Scottish Government continue to support art and music therapy, even if they are delivered outside the health service. It would be too easy for that work to be contracted out, essentially, and thereby to diminish in importance.

I want to talk about a new therapy—one that is not much used yet in Scotland but which could be used. It is called reminiscence therapy, which might also describe a speech by Stewart Stevenson. It aims to use prompts including photos, music and familiar items to encourage patients to talk about their memories. It seeks to help people who have mood or memory problems and those who have mental health problems that are associated with the difficulties of ageing. It is a fascinating therapy and has an interesting basis. The idea that reminiscing could be therapeutic was first proposed in the 1960s by Robert Butler, who was a prominent American psychiatrist who specialised in geriatric medicine. He coined the term "life review". He proposed what many people now take as a given: when they are approaching death, people find it helpful to put their lives in perspective. In earlier decades, talking about distant memories was thought of as "living in the past" and was therefore discouraged.

The idea behind reminiscence therapy is consistent with the theories of adult psychological development. Erik Erikson, for example, thought that for the greater part of adulthood, we are challenged to find creative and meaningful ways to avoid feeling stuck or alienated. In the final phase of life, we may try to review where we have been and what we have accomplished in the hope that we can feel good about it.

Research has shown that elderly people who have symptoms of depression and who participate in reminiscence therapy develop their self-esteem and are more positive about their social relations than people who do not receive the therapy. They also tend to have a more favourable view of the past and are more optimistic about the future.

The results for patients with dementia are not quite as encouraging or clear, although mental abilities and behaviour do seem to improve. There is quite a dramatic improvement in terms of reduced stress among the people who care for such patients; they get more knowledge of the patients and are able to relax more with them.

As times change, as longevity increases and as health budgets come under more pressure, there will be a need to help individuals to stay well physically and mentally. There will be new therapies that allow us to do so. All the existing therapies and those new therapies have a role to play in that task, and I hope that they will continue to have what has been significant and meaningful support from this Government.

16:19

Jim Hume: We would all agree that this has been an important debate on allied health professions; Hanzala Malik was correct to say that there has been cross-party agreement on the issue. Many members have related their personal experience of allied health professionals; I have used AHPs successfully to tackle a trapped nerve in my neck.

It was interesting, therefore, to hear Stewart Stevenson reminiscing about his experience of having his neck manipulated, which included having his head twisted through 90° in a sharp movement. I assume that that allied health professional was trying to help Stewart Stevenson, even if it was kill or cure. I am glad that it worked and that there is no pain in the neck for him any more.

In many respects, AHPs have been enablers for people to lead more independent and dignified lives. That is why I want to stress the importance of hearing their views and of allowing their input to educate, inform and shape policy, especially during the current integration of healthcare and social care. I also want to point out that that input will not do much in the way of getting things right if the right amount of information and data are not collected from the Government when they should be. Information gathering and sharing must go both ways—to and from the allied health professions and all relevant Government departments.

Integration of healthcare and social care, which was mentioned by Colin Keir, Stewart Stevenson and others, is a way for people who have dementia and other mental illnesses to adapt as easily as possible to life with those conditions. It is to a large extent the role of the people within the allied health profession groups that will enable them to do so. Naturally, I do not discount the role of nurses and GPs, as well as hospital staff, who provide their time and care to the fullest extent for those people. However, we know from experience that when community support for the care of discharged patients is lacking, patients and their carers can suffer. Professionals including speech

and language therapists, paramedics, physiotherapists, dieticians and many more who provide vital services must be part of the plans, whether they are represented on a board or not. Stewart Stevenson's point in that regard was fair. They will be the ones who are able and ready to provide support to someone who has just been discharged, perhaps following a stroke, and who needs the services of a speech therapist, a physiotherapist and many more experts. However, we see that the workforce numbers are unable to keep pace with the rising numbers of people who have multiple and complex conditions.

What is more important than providing support to the people who have played, and are playing, a crucial role in delivering the Scottish national dementia strategy? There are 90,000 people with dementia in Scotland, and that number will double in 25 years—that represents 180,000 people with dementia in what will, we hope, be our lifetimes. Through the national dementia strategy, those people have the right to one year of post-diagnostic support, as was set in the health improvement, efficiency and governance, access and treatment—HEAT—targets, and that support is being delivered through a number of AHPs.

Although I welcome the development of academic programs for AHP training at undergraduate and MSc levels at Queen Margaret University, the Government will need to put its entire weight behind making sure that people with dementia will be able to receive the care that they have a right to receive. The same thing applies to parity of treatment for people who suffer mental ill health and those who suffer physical ill health. We do not want a situation in which GPs cannot refer people with mental health issues to therapies because the therapies are not there.

Enabling people with conditions such as dementia to live more independently will have multiple far-reaching benefits. It will allow doctors and nurses in acute care to devote more time to other patients and it will reduce the burden of the hundreds of thousands of bed days that we know are taken up by people who are clinically able to go home. Furthermore, it will ease the tension on overstretched NHS resources. Support in the community is not only right—it is reasonable. That is why we acknowledge the service of the allied health professions today, but also call on the Government to make its policies, and especially its funding, more flexible and responsive to the real needs and concerns of AHPs in the long term.

There are three things that we need to take away from the discussion: leadership, funding and workforce. Of the three years that the Government had to ensure that its AHP national delivery plan for Scotland was implemented, there are seven months to go until the end of the year, and just slightly over half of the plan has been delivered. There is clearly a misalignment between what the Government promises and what it delivers, and the representation of allied health professions needs to be met with actions, not just with words of encouragement. That becomes obvious when we see the lack of allied health professions' representatives on boards and the 10 per cent reduction in AHP consultants in the past three months.

There is also the issue of the workforce, which is not increasing at the rate that is needed to replace retirements from the professions. Finally, there is what many organisations in the allied health professions call the disparity between policy and funding. To put it in their words, the money is not shifting. We welcome the £3 million, but there are longer-term funding needs.

The Government must realise that, just as one cannot drive on the motorway while looking only in the rear-view mirror, one cannot set goals while the practice for achieving them is not changing fast enough. That is why we have been pressing the Government to listen to the needs of the experts and to adapt to the realities on the ground.

I conclude by pointing out the importance of developing better policies in the context of AHPs' work environments. They are multidisciplinary, with a variety of treatments and experts, with some treatments taking months or even years to take full effect. We cannot afford to have short-term or piecemeal solutions to the growing demands of our healthcare establishment. I look forward to hearing the Government's response from the minister, and to changes in its approach to the allied health professions in the long term.

As I said, the Liberal Democrats will support Labour's amendment and the Government motion. I am grateful that the Government is supporting my amendment.

16:26

Jackson Carlaw (West Scotland) (Con): We have had quite a long and thorough opportunity to discuss the allied health professions this afternoon. The Conservative group will support the Labour amendment and, in the spirit of fraternal sympathy with our former colleagues in another place—described there as an "elite cadre", although I do not know quite how they are known here—we will also support the Liberal Democrat amendment.

I particularly enjoyed two or three speeches. I enjoyed Mike Russell's sobriquet describing Mr Stevenson's speeches as "reminiscence therapy". I do not know whether Mr Stevenson was here to hear that tribute but, like Jim Hume, I did enjoy hearing about his "tingling sensation" of 30 years

ago. To think that the world was in abeyance for those three minutes—we all held our breath waiting to hear what happened next, and were accordingly either disappointed or relieved.

I very much enjoyed the splendid and confident contribution from Anne McTaggart, which belied the cruel and unkind traducing of her talents by anonymous Labour colleagues in the weekend press. We in this chamber know her to be among the cream of the Holyrood Labour crop, full of charm, and we wish her well. On the strength of this afternoon's debate, she will be able to recommend various occupational therapists to her former Westminster colleagues as they try to adjust to life in the community.

The new Southern general hospital in Glasgow is already known affectionately, if incongruously and rather unfortunately, as "the Death Star" by the medical community and the local population—not, one hopes, because of the seeming prognosis of those who enter it, but because of its shape and size. Even as it opens, however, the whole purpose of our health policy is to stop people going to it and to keep them out of hospital.

The minister began by telling us that we have in prospect a 39 per cent increase in over-65-year-olds, with two-thirds of those over 65 and three-quarters of those over 75 potentially having long-term conditions. It might have been Cara Hilton who said that there is also in prospect a 140 per cent increase in people over the age of 85, which gave me great hope. I have previously had to admit that Carlaw men do not live long, so I shall take comfort from that.

As Sandra White said, there is a real determination that more and more people should be able to live in their homes and communities. I digress for a minute to return to a point that I have made before. Those homes and communities are very much a part of the equation, too. If we are to ensure that older people can live within communities, we have to think now about the type of accommodation that is provided within those communities that will be suitable to help to prevent the falls that Mike Russell mentioned. If people live in the large family home to which they have been accustomed, and if they have the sort of attitude where—like my mother—they think that they will leave in a box, the chances are that they may well do so, because that home will not be suitable accommodation for them if they are to live to a great old age.

Stewart Stevenson: Jackson Carlaw makes a valid point, but we may equally wish to consider that, as we get older, it is more difficult to make new friends, and we tend to lose our old friends. Therefore, there is a mental health downside to leaving very familiar surroundings, which has to be put in balance. I do not come to any particular conclusion, but I think that the issue is very complex.

Jackson Carlaw: That is why I have said that we need to think now about how to provide suitable accommodation within the community. For some people, their retirement living or residential accommodation is appropriate, but many older people tell me that they do not want simply to have conversations about who survived the night, and that they want to be in a broader community in which births and all such action and activity are parts of their lives, too. Housing has a part to play in all this.

Our debate is about allied health professions, of course. We have heard lists of various health professions being read out, a bit like for one of the questions on the quiz programme "Pointless": can we make a list of allied health professionals that nobody knows about? The two that nobody seemed to want to get their dentures around through the course of the debate were orthoptics and orthotics. I note that they regularly did not get mentioned by colleagues when they gave their lists.

Jayne Baxter and Colin Keir both made the point that allied health professionals are often unsung heroes who are not fully appreciated for the work that they do. The challenge for them is similar to that in the general discussion on health that we have here regularly. How, within an integrated healthcare profile, with general practices that have increasing lists and an ageing profile of GPs, do we evolve a model for the future within timescales that will allow people access to allied health professionals—many of whom sometimes complain that the facilities that they are asked to operate from seem to be like the old changing rooms in abandoned baths, where the electricity might work some days but not others.

We need a model in which allied health professionals can operate as part of an integrated healthcare programme within the community, but within reach of people and in facilities that make access to them and the services that they can provide desirable.

I will mention Christine Grahame's speech, which was poetic and lyrical, I thought. She talked about speech and language therapists and the vital contribution that they make in the early years. I simply wish to point out that that is why thattish Conservatives believe in the need for a universal health visiting service. We have to identify who needs access to those services as much as we need to provide them. I know from having hosted events for speech and language therapists that we might as well not sugarcoat the candy. Many allied health professionals feel that they are not numerous enough and that the availability of the services that they offer is variable across health

boards. Speech and language therapists are very much at the heart of that issue.

Christine Grahame: This may be heretical, but I have done it before: I very much support the Conservatives in their call for more health visitors. Those who are selective with their health visitors miss the point.

Jackson Carlaw: Thank you.

I return to a point that Nanette Milne made. As we evolve the integrated healthcare model, I suggest that the pace of change and the shape of what there will be in the future is probably way beyond any of the imagining that we currently have, given the shifting demographic pattern of our population and the way in which healthcare services will need to reflect that. It is important that allied health professionals have a leadership role in determining the evolution of that model and of the services that they provide, and that they are not simply thought of as something that will also be done—they should be central.

I do not make this point in a party-political way, because I recognise that there are members in other parts of the chamber who are sceptical. If the Westminster Government fulfils the promise that it has made about significant extra funding for health, the consequentials that will come to this Parliament could, by the end of the process, be several hundred million pounds a year. It is terribly important that we do not allow that money to be used just to keep things as they are and the ship of state as it is. The model that we need to see evolve has to make use of the opportunity that it is given to allow real development in all the services. I know that the minister will be keen to see that that is so, thatI think that it will be a challenge that we will have to ensure we rise to as we go forward.

16:35

Rhoda Grant (Highlands and Islands) (Lab): The debate has been positive and I think that there is consensus across the chamber on the importance of AHPs' role. AHPs are not unused to hearing that and have heard it often, but they also expect a bit more from us to enable them to play their roles fully and provide the benefits from that.

I welcome the additional £3 million of funding that the minister announced today, which will go part of the way towards redressing some of the cuts that we have heard about. The additional funding is welcome, but possibly more needs to be done. It would be helpful and useful if the minister told us in summing up whether that funding has come out of the integration budget.

I will not list all the AHPs and the services that they provide. Some members tried to do that but got their tongues in a twist, so I will not even go there. As has become clear from the debate, there are so many AHPs that, if we start trying to list them, the chances are that we will miss out a number, and they all have an important role to play. An especially important role is cutting the number of unscheduled admissions to hospital and keeping people out of hospital, as well as getting them out of hospital once they are in there. The AHP service is not an add-on service but one that forms a crucial and required part of the healthcare team.

Our amendment calls for an audit of the national delivery plan, which AHPs have called for, too. That is because, although there are only 10 months left to run until the plan is completed, the Scottish Government has barely reached the halfway mark with the plan, which it acknowledges in its progress report. We need to see how the outcomes—particularly those that are the greatest challenge—will be met in the future. That is especially important because the outcomes that are really lagging behind have the most to offer in tackling unscheduled admissions and delayed discharge. The four most significant areas that are falling behind are support for independent living, reconfiguration of enablement services, the shift to community-based activities and self-referral. If we are at only 52 per cent achievement, we need to make progress in the plan's final months.

A number of speakers have said that self-referral gets people back on their feet much faster and cuts down double-handling, which saves time for GPs. Previously, people went to GPs to be referred to, for example, a physiotherapist, but that was a waste of GPs' time. People can self-refer and it is extremely important that that happens, not only for achieving the plan but because it means that people are back on their feet much more quickly. Hanzala Malik said that self-referral gives better outcomes and faster recovery times, but he also said that the system has to be improved if we are looking to build in that speed, because waiting for maybe three weeks to have a call back from a referral service means that somebody might be off their work or that their condition worsens.

A lot of people have talked about the challenges that we face that make the AHPs' role even more crucial and have given the example that people are living longer. I agree with Mike MacKenzie that living longer is a success that we should celebrate and be proud of and something that we all hope to attain. However, we need to ensure that the additional years that people get are quality years. Older people need to be active and independent, as Jayne Baxter said. Living longer is an aspiration that, with the help of AHPs, I think that we can fulfil.

Mike MacKenzie: Does the member agree that, although rural healthcare presents particular challenges, they can be at least partly addressed through the use of allied health professionals? If so, I will be extremely pleased, because it will mean that we agree on two issues this afternoon.

Rhoda Grant: I have to admit that that is a rare occurrence. I agree with Mike MacKenzie. Not only do AHPs have a huge amount to offer in rural areas, but the way in which we deliver AHP services by using things such as e-health—I will discuss that if I have time—is important.

A number of speakers talked about falls prevention. The use of exercise to strengthen frail elderly people prevents falls. One of the briefings that we received for the debate states that falls cause 86 per cent of unintentional injuries among people aged over 75 that lead to hospital admissions. Hip fractures are a great cause of mortality, so we need to deal with that.

Stewart Stevenson: I apologise if this has already come up—I had an important meeting to go to, so I was away from the debate for about half an hour—but one of the professions that I have not heard mentioned is that of the dietician. Good eating preserves the quality of the bones in older people and reduces the incidence of breaks and the effect of falls. Would the member care to agree that dieticians are an important part of the landscape as well?

Rhoda Grant: Indeed, and my colleague Jenny Marra just whispered in my ear that the role and nutritional impact of meals on wheels is important. However, we should consider not only dieticians but speech therapists and their role, working with dieticians, in relation to swallowing and making food easier for older people to consume. That needs to be included, and again it shows us the variety of services that AHPs provide.

A number of speakers talked about dementia. Sandra White talked about dementia-friendly communities and non-pharmacological services. That is the only one of the difficult-to-pronounce professions that I will mention. As Christine Grahame said, art and music therapy triggers memories in people with dementia. It is important that we have people who understand past art, music and the like that people can relate to according to where their memories fall and who understand the customs and practices of the societies that people lived in, because that reassures them. Michael Russell talked about the drop in the number of AHPs who work in those areas. As we have more dementia in our communities, those roles are becoming increasingly important, because such work makes people who are experiencing that condition feel reassured.

I have talked about the enabling and rehabilitation services that AHPs provide. It is important that they are provided early, including in hospitals when people are being prepared for discharge, because we know that hospitals are disabling. If older people cannot walk around and be independent, they can quickly lose the ability to look after themselves, so OTs should be available in hospitals and early after discharge. The service may need to be intense in the initial stages of somebody's discharge in order to get them back on their feet.

Jenny Marra talked about AHP representation on integration boards, and she was clear that she was talking about representation of AHPs as a collective and not as individuals. That is important because, if we are really to shift the balance of care, the boards that make the decisions need to know what is available. Boards have medical and nursing representatives on them, but we need to ensure that they also have AHP reps, because AHPs need to be at the centre of decision making. As members have said, it is only when we start speaking to AHPs that we learn about the impact that they can make.

Colin Keir: Does the member agree with me and Stewart Stevenson, who made the point earlier, that large boards could inflict a degree of damage because of the slow speed of decision making, and that there is no requirement for everyone to be on the board?

Rhoda Grant: I think that the member misunderstands our point. We are talking about having one person on the board. A number of boards have already appointed an AHP representative, so we are talking about only the boards that have ignored the role and have not included an AHP rep. We are talking about having one representative of the AHPs collectively rather than a representative of each profession. That could make a big difference to the understanding and make-up of the boards.

I see that I have to finish soon, Presiding Officer.

The Presiding Officer (Tricia Marwick): You can continue for a wee bit yet.

Rhoda Grant: Okay—just tell me when you need me to sit down. I can continue, because I have not yet touched on a couple of important issues.

Hanzala Malik: I highlight the point that was made about people who treat others through art and drama. Local volunteer groups and other local organisations, rather than the NHS, are taking up that responsibility. If that happens, is there a danger that we will suffer a drain of expertise from the NHS? Relying on local organisations could mean that, in the long term, we will lose

mainstream employees and we will not have the uniform service that we currently enjoy. [*Interruption*.]

The Presiding Officer: Could whoever has their telephone on switch it off immediately?

Ms Grant, I would be grateful if you responded to Mr Malik's point and made your final points.

Rhoda Grant: My response is that we need both. We need people in the community. I recently visited the Highland Football Academy Trust and saw ex-football players meeting people with dementia and talking to them about their experience of playing the game when they were young and as supporters. It is important that we have both NHS staff and community groups involved.

We need to tackle the drop in the number of physiotherapists, which several members talked about, and in the number of senior clinicians. We need to address that to ensure that they are there to give expert advice. Members talked about incontinence and stroke, and Cara Hilton talked about education. We need to ensure that there are enough senior clinicians to make an impact.

Other members talked about housing associations and adaptations. It is clear that housing associations have a role, but such housing needs to be available in our communities so that people are at the centre of their communities. Too often, they are tucked away in a backwater. The Howard Doris centre, which my mother stays in, provides sheltered housing, but it also has a library and it runs art exhibitions. It is the pulse of the community and it is almost a community centre as well as a centre for sheltered housing. We can learn a lot from that.

As I said, AHPs are used to getting warm words from politicians. We are all quick to point out the value of their contribution to healthcare and prevention, but they have to be valued as part of the healthcare team and held in equal esteem. More than anything, that would allow them to fully bring to bear their skills in prevention and cure.

The Presiding Officer: I call the minister to wind up the debate.

16:48

Maureen Watt: At the outset of the debate, I acknowledged the importance of rehabilitation and enablement in supporting the health and social wellbeing of Scotland's population. Members from across the Parliament have supported that and have recognised the achievements made and the challenges that remain.

Jayne Baxter said that the work of allied health professionals is undervalued. She made an excellent speech, but I do not think that the work is undervalued by people who know about what AHPs do or by people in communities. However, I would say that their work is very much underpublicised in the media. I hope that the debate has gone some way towards changing that and that, through it, we can communicate with AHPs directly. Perhaps the debate will be reported in their professional magazines, and perhaps we can all use the columns in our local press to publicise the work that we believe AHPs really do in our communities and how valuable it is to the overall health of our population.

As members have heard, the implementation of the AHP delivery plan is demonstrating a significant impact—for example in our national musculoskeletal programme and our national falls prevention programme. AHPs are working in co-operation with a range of partners in building community assets, supporting public health, reducing inequalities and enabling people to live full, active and productive lives. Through our unscheduled care improvement programme, they also contribute to the reduction of unnecessary admissions to hospitals, facilitate early discharge, support people to stay at home, and reduce the length of stay for those who are acutely ill or those for whom admission is the most appropriate option.

AHPs have shown themselves to be senior clinical decision makers alongside their medical colleagues, and they are working across Scotland as first-point-of-contact practitioners to support prevention, early intervention and enablement.

Jenny Marra mentioned a multidisciplinary team. We must remember that, if the patient is not in a meeting, they are always at the heart of it and that their needs must be taken into account and discussed with them.

AHPs play a central role in helping individuals and families—particularly older people and those with dementia or complex needs—to live active and self-determined lives and in avoiding unnecessary admissions to health or care settings.

Jenny Marra: Given that we agree on the efficacy and effectiveness of the multidisciplinary teams, what plans does the minister's Government have to ensure that it rolls those out across Scotland? They are a model of best practice, but they do not exist everywhere. What is the Government doing to encourage that approach across all GP practices?

Maureen Watt: I will come to that.

In many areas, AHPs have taken the lead in ensuring that rehabilitation pathways are integrated across health and social care and, in doing so, they have developed strong links with the voluntary and independent sectors.

We have heard many excellent examples in which significant achievements have been delivered across Scotland, in which preventative spending is already being achieved, and in which outcomes are being improved for service users and their families. I was particularly interested in reminiscence therapy, which Mike Russell mentioned. That is now widely used with people with dementia. The AHP consultant in the Care Inspectorate has supported the focus on activity in care homes with "Make Every Moment Count". Christine Grahame mentioned that approach, too.

Many members have mentioned the importance of physiotherapy rather than the horror of mesh implants.

Christine Grahame: Notwithstanding the minister's response to Mike Russell on the drop in the number of arts therapists—I see that the number is down 27 per cent, from 32 therapists to 23—will the minister look at that drop and, given Mike Russell's contribution and, in a minor way, my own, reconsider increasing the number of those therapists across the spectrum of needs?

Maureen Watt: I am not sure whether Christine Grahame was in the chamber when I replied to that particular point by Mike Russell.

Christine Grahame: Yes.

Maureen Watt: As I pointed out, many other organisations are doing that work. However, we will certainly take that point away and look at it. [*Interruption*.]

The Presiding Officer: Ms Grahame, stop heckling.

Maureen Watt: I want to highlight again the leading work that AHPs are undertaking on the roll-out across Scotland of a centralised musculoskeletal referral management system, which offers self-referral, triage by telephone, promotion of self-management and web-based resources, and specialist advice or intervention from a physiotherapist or podiatrist when clinically indicated.

NHS boards using the MSK telephone service demonstrate on average that 13 per cent of patients transferred from AHP to self-management and sustainable AHP-led pathways show evidence of an up to 25 per cent reduction in orthopaedic referrals combined with increased conversion to surgery rates, and up to 30 per cent fewer low-back MRIs by use of consistent protocol.

The chamber has heard how practical assistance in the form of advice, equipment and adaptations can enhance independent living. In North Lanarkshire, a fast-track assessment approach using the smartcare programme was piloted by local authority occupational therapists in one area. In three months, the waiting times for assessment by an occupational therapist were reduced.

Cara Hilton mentioned how NHS Fife and the council were not dealing properly with delayed discharge. They could take a leaf out of the book of the OTs in North Lanarkshire, who have introduced a portal for web-based self-assessment, which has freed up OTs to undertake further assessment for those most in need. Waiting times there have gone down from nine months to eight weeks. That is exactly the type of example that Jenny Marra was calling for to be rolled out across the country.

Hospital-at-home services are central to the delivery of the outcomes for integration and the 20:20 route map and there are examples of such services. Assessment, diagnosis and management of the acute episode are undertaken within one hour and 86 per cent of patients assessed are able to be treated at home. The average length of stay on the team is 4.4 days, which is less than 50 per cent of that for those patients admitted to hospital, and the service cost is between two thirds and 50 per cent that of a hospital stay. Patients have told us that the quality of care is as good, if not better than hospital care. One said:

"This is the way healthcare should be."

Another said:

"It was like the Cavalry coming over the hill."

Although we see a role for AHPs to move out into the community, they also work in accident and emergency departments, where they prevent significant numbers of unnecessary admissions.

I am proud of what has been achieved. AHPs in Scotland are being recognised across the UK and internationally for the leading edge and innovative work that they are doing to improve care, redesign services and enable active, independent and productive living. For example, discussions are under way with Australia and New Zealand about testing our musculoskeletal service model in their health services.

I said in my opening remarks that, although significant progress has been made in service delivery, still more needs to be done. We will strengthen our enabling approach to service delivery through the actions in our national delivery plan and its refresh as we discussed today. That will provide the opportunity to focus even more on rehabilitation and enablement and on other aspects of efficiency and productivity. It will also ensure that NHS Scotland is best placed to realise the 2020 vision by providing safe, effective, person-centred care, which supports people to live at home or in a homely setting for as long as possible.

I reassure Rhoda Grant that the extra £3 million, which will help to drive that forward, has not come from the integration fund; rather, it has come from the chief health professions officer's budget and from the primary care capacity building programme. I hope that she will be pleased to hear that.

Members from across the chamber have identified areas where they would seek further improvement. We will bear those in mind as we reflect on our delivery plan refresh. As I said in my opening statement, I agree with the Liberal Democrat amendment. Much of what Jenny Marra asks for in the Labour amendment is being delivered.

There is regular benchmarking with NHS boards to identify all the deliverables and we have published a national report on the programme to date. We will seek to co-produce a refresh of the AHP national delivery plan to reflect the areas that require additional support. It is up to the Public Audit Committee to decide whether it wants to have an audit of the programme and Audit Scotland might do that, but we are looking at it all the way along to see what is working and what is not working.

Self-referral is already happening in some areas and is being rolled out as the plan develops.

The Presiding Officer: Please bring your remarks to a close.

Maureen Watt: I think that Jenny Marra would agree that the number of physiotherapists is a board decision. When I first came to the Parliament, too many physiotherapists were not getting jobs. They are now getting jobs and are in the system.

In the spirit of being consensual in the debate and sending a clear message to AHPs that they are doing a great job, I will accept Jenny Marra's amendment.

Decision Time

17:01

The Presiding Officer (Tricia Marwick): There are three questions to be put as a result of today's business. The first question is, that amendment S4M-13196.2, in the name of Jenny Marra, be agreed to.

Amendment agreed to.

The Presiding Officer: The second question is, that amendment S4M-13196.1, in the name of Jim Hume, be agreed to.

Amendment agreed to.

The Presiding Officer: The third question is, that motion S4M-13196, in the name of Maureen Watt, on allied health professionals, as amended, be agreed to.

Motion, as amended, agreed to,

That the Parliament recognises that allied health professionals (AHPs) possess a diverse range of unique skills and expertise in rehabilitation and enablement that are key to supporting self-management and enabling active, independent and productive living; believes that AHPs are crucial in the treatment and prevention not only of physical ill health but also of mental ill health; recognises the added value that AHPs can have in terms of preventative, upstream approaches; acknowledges that AHP interventions can significantly reduce unnecessary hospital admission and can help to reduce dependency on care services, resulting in savings to health and social care; recognises and congratulates the increasing number of AHPs in Scotland on the important role that they play in prevention, early intervention and enablement in supporting the health and wellbeing of the people of Scotland throughout their lives; believes that this approach can be further strengthened through the ongoing integration of health and social care services; further believes that the valued role of AHPs would be best supported by understanding the areas that are most in need and therefore calls for an audit of the National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015 with a specific focus on performance of self-referral as a primary route for access and musculoskeletal AHP waiting times; notes that the Chartered Society for Physiotherapy has concerns regarding declining numbers of band 7 physiotherapist clinicians, and calls on the Scottish Government to bring forward a long-term plan to reverse this trend.

World Whisky Day 2015

The Deputy Presiding Officer (Elaine Smith): The final item of business today is a members' business debate on motion S4M-12302, in the name of Kevin Stewart, on world whisky day 2015. The debate will be concluded without any question being put.

Motion debated,

That the Parliament notes that the 4th World Whisky Day will take place on 16 May 2015; understands that this global celebration of whisky last year saw 250,000 people attend whisky-themed events in over 40 countries; notes that the event is now managed by the Edinburgh-based Hot Rum Cow Publishing, supported by the founder of World Whisky Day, Blair Bowman; considers that World Whisky Day provides an amazing opportunity to highlight and promote Scotland's national drink, and raises a dram to the event's continued success.

17:03

Kevin Stewart (Aberdeen Central) (SNP): World whisky day took place on Saturday, with events going on across the globe. I first lodged a motion on world whisky day in 2012, when Aberdeen-based student Blair Bowman founded world whisky day. World whisky day is now being managed by Hot Rum Cow, and last year 40 countries participated with whisky-themed events involving 250,000 people.

This year, over 178 events have been organised in 48 countries around the world. For the first time ever, there was an event on every continent—a world whisky day first. There were events at sea and in distilleries, bars and homes from Bali to Colombia and from South Korea to Nigeria. The most isolated event was in the sub-Antarctic Tasmanian territory of Macquarie Island, which is 1,000 miles south-west of Tasmania and 2,300 miles north of Antarctica. The winter population of the island is only 13, but they celebrated in style at their Macca Mash Tun event.

In Scotland, around 300 hardy whisky fans sought to enjoy a tasting 2,000 feet up on Aonach Mòr, and Haig Club ambassador David Beckham took to US television's "Jimmy Kimmel Live!" to answer three ridiculous questions for world whisky day; I understand that his ugly selfie went viral. The #worldwhiskyday hashtag was used almost 8,000 times on the day, which resulted in it having an estimated reach of 11,305,843 hits, and it trended in New Orleans for 13 hours.

Many folk in the Parliament took to Twitter and Facebook to promote world whisky day. The Cabinet Secretary for Rural Affairs, Food and Environment, Richard Lochhead, took to Twitter to advertise Speyside and the quality whiskies that it produces, as did his Westminster parliamentary colleague Angus Robertson.

Charities also got in on the act, and they were sometimes a bit cheeky. The testicular cancer awareness charity Cahonas Scotland tweeted:

"Enjoy the whisky, but don't forget the 'rocks'!

#TesticularCancerAwareness #TartanChecks".

Other organisations used world whisky day to promote their whisky heritage. The provost of Aberdeenshire launched foreign language translations of the brochure "Secret Malts of Aberdeenshire".

This year is Scotland's year of food and drink, which is a Scottish Government initiative led by EventScotland and VisitScotland, and May is, of course, whisky month. Malcolm Roughead, VisitScotland's chief executive, said:

"Whisky is one of Scotland's most valuable commodities, with visitors from across the globe coming to our shores to experience an authentic Scottish dram. World Whisky Day is a fantastic initiative and a chance for novices and enthusiasts everywhere to raise a glass to Scotland's national drink.

Widening the appeal of whisky is important if we want to encourage more visitors to come to Scotland, particularly during the Year of Food and Drink 2015. Events are a key part of that and I hope this year's Whisky Month celebrations, of which World Whisky Day is a key part, inspire Scots and visitors to Scotland to come and discover more about one of our most famous exports."

Kathryn Mutch of Scotland Food & Drink said:

"Scotland Food & Drink is delighted to have supported World Whisky Day since its inception and it is fantastic that it is continuing to grow year on year. Scotland is blessed with a world-class natural larder and World Whisky Day provides the perfect platform to showcase our Land of Food and Drink throughout the world. With 2015 being Scotland's Year of Food and Drink and May being Whisky Month, what better way to celebrate than with a dram!"

Members will notice that a theme is developing here.

The founder of world whisky day, Blair Bowman, said:

"World Whisky Day just keeps getting bigger and better. To see it grow from a simple idea to something which has spread across all seven continents and is bringing together thousands of people to celebrate whisky is such a thrill ... We're going to have to work hard to top this next year—now space is the final frontier for World Whisky Day!"

In terms of space drama, the advocacy of whisky by Scotty from "Star Trek" could be said to have already gone where no dram has gone before.

The First Minister also took to Twitter. She said:

"Great to see an iconic Scottish product bringing so many people around the world together!"

It seems that world whisky day brightened up the lives of many, and let me cheer up those who may be feeling a little bit down after all the amazing events by reminding them of the old proverb, "Today's rain is tomorrow's whisky."

Slàinte mhath, Presiding Officer.

17:09

David Torrance (Kirkcaldy) (SNP): I start by apologising that I will not be able to stay for the whole debate, because I have another engagement.

I thank Kevin Stewart for bringing this motion to Parliament, and I extend my congratulations to all those who have contributed to making world whisky day 2015 a success.

I welcome the opportunity to speak about whisky. Not only is it our national drink; it is a significant driver of Scotland's economy. With regard to both aspects, world whisky day represents a great opportunity. It allows Scotland, as well as whisky lovers all over the world, to celebrate whisky by promoting the product on a global scale.

This year more than 170 events in celebration of world whisky day were registered in many different countries. That shows that, rather than being exclusive, whisky is a drink to be shared among friends. In that spirit, I believe that whisky reflects the welcoming nature and hospitality for which we Scots are renowned.

Without any doubt, whisky is one of the country's most iconic industries. Distilling has a long history in our country, which also favoured the development of many regional characteristics. I dare say that, back in the day, whisky was also a sign of Scotland's sometimes rebellious character.

What characterises our whisky industry today is the fact that much of the tradition has been preserved. It is of course true that many distilleries are owned by bigger companies. Nonetheless, Scotch whisky is renowned for its diversity, taste and flavour, due to the fact that ingredients are sourced from different locations.

World whisky day allows us to celebrate all types of whisky, whether a Highland, Lowland, Speyside, Campbeltown or Islay whisky—not to forget the blended and blended malt whiskies. The art of blended whisky is still very much a traditional practice that is carefully passed on from one generation to another. One of my constituents in Kirkcaldy, Ian Norval, has followed the family tradition and continues to blend his own whisky, "Norval's Sensible."

Another issue that I want to mention today, which I am particularly delighted about, is the way that our whisky industry combines its historic roots with the newest technologies. That not only leads to high quality but contributes to a more sustainable product.

In 2009, the Scotch Whisky Association published its first environmental strategy, which sets out the specific targets to increase the use of non-fossil fuels and reduce greenhouse gas emissions. Overall, the aim is to make the industry more energy efficient. The Scotch Whisky Association will publish a performance report later this year. I look forward to hearing about the achievements, and I believe that other industries can learn from the whisky industry's lessons in moving towards environmentally friendly practices.

I have already mentioned the economic weight of the whisky industry. Ninety per cent of whisky is exported to more than 200 countries; thus, whisky exports contribute £3.95 billion to our economy. The past decade has seen a surge in exports, accounting for an increase of 74 per cent. Despite exports declining in 2014, the whisky export market is still expanding. With emerging markets gaining greater interest, the industry is challenged to evolve constantly, while maintaining its good reputation. However, I am confident that companies are well equipped to face these hurdles and that sales will continue to grow.

Today many distilleries welcome visitors to observe and learn more about how whisky is produced. Whisky tourism is an additional economic benefit that strengthens Scotland's tourism sector as a whole. It also allows producers to display their rich histories and offer tasting sessions by attracting new customers.

While talking about whisky, we should not forget that the industry also supports over 40,000 jobs in the United Kingdom. Those people's hard work, dedication and determination to achieve high quality has been integral to the success story of whisky. Thus, I take the opportunity to thank all involved as well as to wish them all the best for future endeavours.

This year's world whisky day has met all expectations in celebrating our national drink. It offered many distilleries the chance to promote their products abroad, while reminding us to cherish whisky's long-standing tradition and economic importance.

I am positive that Scotch whisky will continue to thrive here in Scotland and around the world. We might call it the water of life; however, I remind each and every one of us to enjoy whisky responsibly.

17:14

Sarah Boyack (Lothian) (Lab): This is a really appropriate debate and I thank Kevin Stewart for bringing it to the chamber, because it enables us to celebrate one of Scotland's greatest products and to focus on our economy, our tourism industry and, crucially, our culture.

I first heard at first hand about the debate on Facebook. I have repeatedly been invited to world whisky day events over the past couple of years. That is a really good example of the point that Kevin Stewart made about the huge impact that world whisky day has had on Facebook and in social media generally. I wonder whether that is because Blair Bowman started the initiative while he was studying at university—access to the media for students today is totally different from what it was for those of us who studied some time ago.

The number of people who now celebrate the initiative is fantastic. The global reach of more than 50 million people on social media is just incredible for the industry and is absolutely worth celebrating. It is about making whisky inclusive and enjoyable, and trying to move away from whisky being something that only a few people drink—something that is seen as a bit more exclusive or niche.

Although I did not attend the event, I understand that the Angels Share in Edinburgh had a fantastic celebration on Saturday—I see at least one of my colleagues nodding. Whisky is hugely important to us in Edinburgh as part of our economy and tourism offer. The North British Distillery Company, which is based in Gorgie in Edinburgh, was founded 130 years ago. When it was founded in Wheatfield, it was on the edge of the city—it was a pig farm at the time—and it is an indication of how Edinburgh has grown that it is now part of the inner city.

The site was perfectly suited to the business: it was beside the Union canal, so there was access to water; it was close to the railway for distribution; and it was close to the then main sewer of the city for the disposal of effluent. Neighbouring dairy farmers provided a ready outlet for the disposal of draff and dreg residue. Those of us who were in the chamber last week know that that is a perfect early example of the circular economy in Scotland.

The North British Distillery Company is a hugely important business in the area. It has changed over time and has been developed. It is striking that, in its first 108 years, it was a co-operative arrangement: the distillery was financed by the trade so that distillers could get spirit that was of a consistently high quality at a price that they could control to use in the whisky industry.

The company is still one of the largest Scotch grain whisky producers in Scotland, and although it does not market its own brand, the whisky spirit that it produces is used in a number of popular, well-known brands, such as the Famous Grouse, Johnnie Walker Black Label and Cutty Sark.

It is great for us in Edinburgh to be able to celebrate whisky, because it is still being produced in the city. However, in this year of Scottish food and drink, it is important that we celebrate its role in our tourism industry as well. Although we do not have a branded whisky in Edinburgh, we benefit from the cultural associations with our national drink. The city is home not only to two of the Scotch Malt Whisky Society's three members rooms—there is one in Leith, one in the city and one in London—but to the Scotch Whisky Experience tour, which takes visitors through a replica distillery to learn how Scotland's national drink is made.

Personally, I will always remember world whisky day. It will always be memorable to me because of my birthday, so I will always celebrate it.

I am glad that Kevin Stewart asked us to widen whisky's appeal. It is also appropriate that it was suggested that we should drink whisky not only in moderation but sensibly. I will add my suggestion for how we can widen its appeal.

I do not drink whisky straight. My personal preference is to add it to cranachan, which is one of my favourite puddings. Members who are pudding aficionados will know that whisky can be added to many Scottish puddings. That is one of the ways in which we can expand its attraction and appeal. In the year of Scottish food and drink, we should think laterally about how we can promote all the different brands of whisky that we have in Scotland and about how can we drink it differently.

I add my congratulations to those who initiated world whisky day. I celebrate the fact that so many jobs in Scotland are associated with whisky and that it is worth £5 billion to our economy every year—£3.3 billion directly and £1.8 billion invested across our domestic supply chain. It is hugely important and, on its own, accounts for—it is a staggering figure—a quarter of the United Kingdom's food and drink exports.

We should celebrate whisky. It is part of our culture, our tourism offer and our economy. It is part of who we are. Let us make sure that we celebrate it responsibly and enjoy it.

17:19

Mary Scanlon (Highlands and Islands) (Con): I have had whisky poured over a haggis at a Burns supper, but I have never tried it in a pudding. There we go.

I congratulate Kevin Stewart. We do not often agree, but I whole-heartedly agree with him today, and I commend him for securing this debate to acknowledge the fourth world whisky day, which allows people around the globe to raise a glass to this incredible Scottish product.

I acknowledge the points that David Torrance made, particularly on the whisky industry's

environmental credentials. The industry may be an old one, but it is very modern in addressing environmental issues. I also note Sarah Boyack's comments about exports and about the visitor experience, which in the Highlands is highly professional and second to none.

I am the co-convener, with Gordon MacDonald, of the Parliament's cross-party group on Scotch whisky. As an MSP for the Highlands and Islands, whisky is never far from my radar. For example, Moray is—as the cabinet secretary will know—the constituency with the most distilleries in Scotland, and hosts the famous malt whisky trail. As for the islands, I am particularly fond of Islay, which produces whiskies such as Laphroaig, Lagavulin, Bruichladdich and Bunnahabhain, and of Orkney, which produces Highland Park. The rest of the region hosts countless maltings and distilleries, as well as the farms that supply some of the finest grain to provide that special Scotch flavour.

All whiskies in Scotland are similar, yet they are all totally different. Every time we visit a distillery, we find that the stills are a different shape. There are different techniques in every distillery, and I give all credit to them for what they do.

The whisky industry is a success not just for the Highlands but for Scotland. The Scotch Whisky Association certainly welcomed the 2 per cent reduction in duty that George Osborne announced earlier this year.

I will focus on some of the new distilleries that have opened or are being planned. Many of them are small craft distilleries that—at least initially—will not produce a massive volume of whisky but will provide a different style of whisky for a niche market. At its next meeting, the cross-party group is holding a tasting of whiskies from the new craft distilleries, and I hope that some of my colleagues in the chamber today will come along.

The growth in new distilleries is phenomenal. The £2 billion of investment spent last year and proposed for this year represents the biggest growth in the industry since the 1970s. The new developments include the Saxa Vord distillery on the isle of Unst in Shetland; the Islands of Uist Whisky Company in Benbecula; a new distillery in Tarbert on Harris; and the Adelphi distillery in Ardnamurchan. We may sit here in Edinburgh and say, "Well, there are only 15 people working there," but 15 people working in a remote and rural area means 15 families with security of employment and income for a long time. There is also a new distillery at Ballindalloch. Along with Highland colleagues—and Mr Lochhead too, I presume—I will be attending the opening of Dalmunach distillery at Carron near Aberlour next month, so there is yet another new one.

In all those examples, and many more that are venturing into the craft distillery side, companies have seen potential in their products. They have also been able to overcome what could be a daunting challenge. A large amount of capital is required to build a new distillery and, as it takes a minimum of three years for the product to mature, it can sometimes take years after the initial outlay to get a return on the investment. That is why support from the Scottish Government and Highlands and Islands Enterprise is so important.

We have a great deal to be proud of. I am looking at the time, but I want to raise just one more point. The Scotch Whisky Association often reminds us at meetings of the cross-party group that what protects Scotch whisky that is made in Scotland is an act of Parliament that was passed at Westminster. The act means that Scotch cannot be produced in Japan, Australia, America or anywhere else. It was the equivalent of a member's bill here, and the person who introduced it—to whom we should all be grateful, given the huge increase in the volume of whisky exports and whisky consumption—was the Tories' own Bill Walker.

17:24

Liam McArthur (Orkney Islands) (LD): I join other members in congratulating Kevin Stewart on bringing the debate to the chamber. I mean no disrespect to him or to our internationally renowned whisky industry but, at present, following momentous events in Orkney last Saturday, 16 May stands out for me as the day that Sanday finally defeated reigning champions St Ola in the Orkney parish cup.

That victory, like any good single malt, has taken time to achieve, but it was well worth the wait. I am reliably informed that members of the Sanday squad who are hardier than me marked the happy coincidence of our victory being on world whisky day with the odd dram or two.

I am delighted to take part in the debate, which is timely and welcome, as Sarah Boyack said. As everybody has acknowledged, this is a genuinely world-class industry with a global reach that is almost unsurpassed by any other sector of the Scottish—or indeed the UK—economy.

As Sarah Boyack indicated, the numbers are staggering. The industry makes a £5 billion contribution to the UK economy overall, with £4.3 billion in net exports, and directly and indirectly supports well over 40,000 jobs.

Like other members, I see the impact locally in my constituency. Perhaps Highland Park is the more familiar distillery, and demand for Highland Park whisky has certainly grown significantly domestically and internationally over recent years.

It has been particularly intriguing to see the impact on the wider tourism sector. There are tourists who come solely or mainly because of the presence of Highland Park and the other distilleries or because they see it as part of an attractive tourism offering. Edrington and Highland Park are to be commended for their investment in the visitor centre and their support for that tourism traffic.

I certainly do not want to overlook Scapa's contribution. It is a very different and much smaller distillery that produces craft artisanal whisky. I had the privilege of getting a tour of the distillery a few years back and I am delighted that, with the support of Chivas, Scapa distillery is now opening its doors to the wider public after about 130 years. Commenting on that other momentous event in the Orkney calendar, Brian MacAulay, the distilling manager at Scapa, said:

"I have personally taken pleasure in removing our 'No Visitors' sign and I know I speak on behalf of the team here in saying that we can't wait to see the Scapa Distillery form an interesting, educative and welcoming part of the Orkney community."

That illustrates how Highland Park and Scapa are a key component—and see themselves as such—of the overall tourism offering in Orkney, as well as an integral part of the high-quality, world-class food and drink sector. In many respects, Orkney is therefore a microcosm of what is happening more generally in Scotland.

As well as acknowledging the individual companies in the sector, I think that a special mention is due to the Scotch Whisky Association for its work. It promotes the industry exceptionally well at home and abroad and takes up a wide range of interests on the industry's behalf.

David Torrance and Mary Scanlon were right to draw attention to the sector's environmental record. David Torrance was also right to highlight the responsible drinking message that is reinforced time and again—I say that as the honorary patron of the Orkney Alcohol Counselling & Advice Service.

The promotional work is not done just by the SWA. I also acknowledge the voluntary commitment of global Scots around the world such as Eric Huang, chair of the Scotch Malt Whisky Society in Taiwan, whom I met at the end of last year. He can take some personal credit for the remarkable growth in whisky exports to that market.

It is absolutely right that we have the debate. We can look forward with a degree of optimism. I congratulate Kevin Stewart and Blair Bowman and I wish Highland Park, Scapa and all those working in and alongside the sector well in the years ahead.

The Deputy Presiding Officer: Last in the open debate—although I am sure not least—is Stewart Stevenson.

17:29

Stewart Stevenson (Banffshire and Buchan Coast) (SNP): Thank you very much, Presiding Officer; I will try not to let you down.

I am pleased in particular that world whisky day is now anchored in the calendar for years ahead as the third Saturday in May. That will be a huge disappointment for Sarah Boyack, because it will not be on her birthday until 2020. The rest of us, however, will celebrate the day every year—on 21 May next year, then on 20 May and so on and so forth.

The day will come two Saturdays after the next Scottish parliamentary election, when there will be those of us who are celebrating a release from this place and those of us who are celebrating our reappointment to this place. Some might be celebrating their departure with less than a glad spirit, but we will all have an excuse to taste one of Scotland's finest materials.

Mary Scanlon talked about Bill Walker's act of Parliament. That is trivial by comparison with the Immature Spirits (Restriction) Act 1915, which my father's cousin James Stevenson took through the Westminster Parliament. That act is responsible for whisky under three years old not being permitted to be sold, which has created the quality that we depend on in the industry today.

Like others, I congratulate Kevin Stewart on securing the debate. It is timely, appropriate and interesting, and I will go away having learned something.

Mary Scanlon spoke about the distilleries on Islay. I am a private pilot and one of the things about flying to Islay is that all the distilleries have their names painted in huge letters on their roofs. Air traffic control at the airport on Islay navigates aircraft to the airport by reference to the distilleries' names, on the basis that pilots can look out of the window and see that they are at the right one. That helps many people who have to be stone cold sober in what they do.

Kevin Stewart mentioned Antarctica but did not tell us the whole story. There were two events on Antarctica. One was at Davis station, which is one of the few places in the world without a postcode. On 16 May, between 7 o'clock and 10 o'clock, the expedition team celebrated world whisky day by hosting a whisky appreciation evening, when it sampled a variety of whiskies from the personal collections of the wintering expedition team. At Mawson station, between 6 o'clock and 8 o'clock,

there was a whisky tasting between each course of dinner.

Around the world, people have been celebrating, including people in Nairobi, Kenya, and people in Cambodia, in the warehouse in Siem Reap's old market area. In Kiev—troubled as Ukraine currently is—people were able to make time in Sofiivs'ka Street for whisky tasting. In a traditional gentleman's bar in my niece's home town of Townsville in Queensland, there was a whisky menu from which one could select a wide range of whiskies.

I am surprised that an event in this city has not been mentioned. At the Coach House at Newliston, under the aegis of the Edinburgh School of Food & Wine, there was a gourmet cookery school for men—that particularly attracted my attention—where a one-day cookery course was followed by a tutored whisky tasting. I am sure that that would have been an excellent event. However, I particularly favoured a Glasgow event called "Spirit of Independence Tasting". To be fair, that was not a political reference; it was about the independent distilleries that are not owned by the big boys. People there seem to have had a terrific time, if the adverts are anything to go by.

I am jealous of Mary Scanlon and even more jealous of my colleague to the west of me, Richard Lochhead, who will respond to the debate. I celebrated world whisky day on Saturday with a refreshing draught of anCnoc from the distillery at Knock. I welcome the constituency boundary changes in 2011 that gave me that distillery to add to the couple that I already had, but I am looking forward to making a takeover bid for Moray at the next election, because I want more of them. You cannae get enough.

17:34

The Cabinet Secretary for Rural Affairs, Food and Environment (Richard Lochhead): As the self-styled minister for whisky in the Scottish Government, it gives me great delight to close this debate. I congratulate Kevin Stewart on securing it. It is appropriate that he has done so, as he is a champion of the Scotch whisky sector and represents Aberdeen, where world whisky day was founded.

I have listened closely to many of the contributions and will do my best to respond to the themes that were raised in the debate.

I noted what Mary Scanlon said about pouring a bottle of whisky over a haggis. I was once asked to pour a good-quality bottle of Glenfarclas into the River Spey to open the fishing season, which was a privilege but also quite painful. I know that, given the number of times that we are asked to donate Scotch whisky to raffles and auctions, we have all invested in the future of this magnificent sector.

Mary Scanlon: For the record, I poured a little glass of whisky over the haggis, not the bottle. I think it is quite important to state that, in the interests of my credibility.

Richard Lochhead: I am sure that it was still a fine-tasting haggis, with the added benefit of the whisky.

It is quite amazing that we are here discussing world whisky day in Parliament, given that it was only back in 2012 that Blair Bowman founded the event. That shows how the celebration has gone from strength to strength.

Scotch whisky is an important product. It is amazing that a product that is made from only three key ingredients—barley, water and yeast—can have such a profound impact on many lives in this country and on our economy. Not only that, but as we have heard today, it is enjoyed by millions of people across the planet.

The fourth magical ingredient of Scotch whisky is people, because much of its creation is a result of the passion, the craftsmanship and the devotion of our citizens who work in the industry. It is important to recognise the role that many people have played over the past couple of centuries in building up an enormous asset that is now celebrated around the world. As Kevin Stewart said, last Saturday, on world whisky day itself, for the first time ever, events were taking place on every continent.

As many members have said, the industry supports many jobs—some 40,000—directly and indirectly across these islands, with every job in the Scotch whisky industry supporting just under three more jobs in the broader economy.

The industry is going from strength to strength. In recent years, we have all been fascinated by how many new distilleries have opened in Scotland and by how many more are under construction or are planned for the future. It is an amazingly booming sector. Exports alone have increased more than 50 per cent since 2007.

In the past few weeks, I had the benefit of visiting Kingsbarns distillery in Fife, and Ballindalloch single-estate distillery, which was opened a couple of weeks ago in Speyside, in my constituency. We know that many more have opened in the past couple of years and that many more are due to open. Some of those have been supported by the food grant scheme that the Scottish Government runs, the new version of which is worth £70 million and was launched only this week. No doubt there will be a flurry of applications to that from new whisky distilleries

across the country. That is a sign of the rude health of the industry.

I should also add that there are other spectacular projects in the pipeline. The new Macallan distillery in Speyside will be a world-beating facility as well as a major tourist attraction. It will indeed be an iconic distillery.

That reminds us of the tourism value of Scotch whisky. Many of the most popular visitor attractions in the country are connected to the whisky industry, including various locations on the Royal Mile, as well as those in our rural communities. That is important from the point of view of the employment value of the industry, especially with regard to our rural communities.

We should also bear in mind that the industry underpins primary production in this country, particularly with regard to our agriculture sector. The barley that is grown by our farmers is a key ingredient of Scotch whisky, and we are looking at how to improve the excellence of barley growing in this country, through research and development, in order to ensure that our quality whisky product can go from strength to strength.

This Thursday, I will have the benefit of visiting the Scotch Whisky Research Institute. I look forward to meeting the people who work there and to learning about the work that is always going on to improve the excellence of Scotch whisky.

Scotch whisky also depends on Scotland's pristine environment, and the success of the sector reminds us that we have to look after our environment and ensure that our good-quality water and the natural environment that we enjoy always underpin our key economic sectors.

The success of the Scotch whisky industry is a magnificent story, and world whisky day is all about telling it. As we have heard, world whisky day falls in the middle of whisky month, which is part of the year of food and drink 2015.

Kevin Stewart: In telling the story, we have seen more than 11 million hits on Twitter. Can we use social media to the utmost, on world whisky day and every day of the year, to promote whisky, to promote Scotland and to ensure that we have a vibrant economy based on the back of that quality product?

Richard Lochhead: Social media give us a fantastic opportunity to promote Scotch whisky: Kevin Stewart makes a good point. We should certainly continue to investigate how we can make the most of that. If there are new ideas that can be used this year, the year of food and drink, we will certainly support them.

Another way in which we have helped to promote Scotch whisky is through the many events throughout the country that are sponsored by EventScotland and supported by VisitScotland as part of the year of food and drink. The spirit of Speyside whisky festival was supported by those bodies, and it in turn sponsored a further 400 events across Speyside. The Mhor festival at Balquhidder takes place this weekend. It is a family event celebrating local produce and Scotch whisky. The Islay festival of music and malt is a nine-day festival, now in its 31st year, and it sponsors many different events across that spectacular island. There is also create:eat:whisky, which marries food and whisky and is described as a "multi-sensory whisky adventure", and which is also sponsored. Some of those events are taking place this month, in whisky month, and others take place throughout the year. There are, of course, many events taking place in the Royal Mile here in Edinburgh.

A lot of those events have been celebrating the long-standing success of Scotch whisky in this country and many are taking advantage of the publicity that is generated by world whisky day. That is why we cannot do enough to praise both Blair Bowman, who founded world whisky day, and those who are now taking it forward. Blair Bowman is even having his own event in Aberdeen called whisky dinner and drams, which is taking place at the Tipping House on 27 May—so, there is a plug for his event, which I hope will be a great success. I hope that Blair Bowman is proud of the progress that world whisky day has made since 2012. He is still involved, as Kevin Stewart said, although the brand has now been taken over by Hot Rum Cow publishing, which continues to work with him.

I hope that we will have many more debates in this chamber to celebrate the success of Scotch whisky, its economic and cultural value, and the fun and enjoyment that it brings to our lives here in Scotland and around the world. I congratulate all members on their contributions, and Kevin Stewart on securing this evening's debate. I wish everyone a belated happy world whisky day, having done so on Twitter on Saturday. I think that it is now time to retire to the bar and allow Kevin Stewart to buy us all a dram to celebrate his motion.

Meeting closed at 17:43.

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