Thursday 12 December 2013

SCOTTISH GOVERNMENT

Governance and Communities

Iain Gray (East Lothian) (Scottish Labour): To ask the Scottish Government what the Office for National Statistics national population projections used in its paper, Pensions in an Independent Scotland, suggest the difference will be between Scotland and the rest of the UK in relation to the number of dependents of pensionable age per 1,000 people from 2010 to 2035.

Holding answer issued: 15 November 2013 **(S4W-17845)**

Nicola Sturgeon: Updated 2012-based population projections have been produced by the Office of National Statistics and National Records of Scotland since the publication of *Pensions in an Independent Scotland*.

UK-wide dependency ratios are provided in the following table:

Dependency ratios per 100 working age population(2012)	UK	Scotland	England	N.Ireland	Wales
Overall	62	59	62	61	66
Pensioner	31	31	31	27	36
Children	30	27	31	34	30
Dependency ratios per 100 working age population (2037)	UK	Scotland	England	N.Ireland	Wales
Overall	66	66	66	68	70
Pensioner	36	38	36	37	41
Children	29	28	30	31	29

Notes:

1. Source: ONS/NRS 2012-based population projections. They show what happens under certain assumptions about future fertility, mortality and migration. The assumptions are based largely on past trends and although they will reflect past policy and economic impacts, they do not take account of future changes that may occur as a result of policy initiatives.
2. A useful summary measure of the age structure of a population is the dependency ratio, the ratio of people aged under 16 and those over pensionable age, to those of working age. Dependency ratios can be defined in different ways, but here are defined as the number of children aged under 16 and the number of people of state pension age per 100 people of working age. These ratios should be interpreted with care. For example, a simple interpretation is the number of older people or children who are “dependent” on people aged 15 to 64, the assumption being that most older people and children are not economically active. The reality is of course much more complex, since, to give just a few reasons, many people of typically working age are unemployed or economically inactive (e.g. at school or university), the age at which people retire varies greatly and many retired people are financially independent. However, these “dependency” ratios provide a useful way to examine the relative age structure of the population.
3. The figures for working age and pensionable age take into account the increases in the state pension age as set out in the 2011 Pensions Act. Between 2012 and 2018, the state pension age will rise from 60 to 65 for women. Then between 2019 and 2020, it will rise from 65 years to 66 years for both men and women. A further rise in state pension age is legislated to take place in two stages between 2034 and 2046 to bring the state pension age from 66 to 68. The data presented here do not reflect proposed further changes to the state pension age published by the UK government. The UK Government has introduced legislation to bring forward the increase to State Pension age 67, to be phased in between 2026 and 2028, and the 2013 Autumn Statement introduced the principle that people should expect to spend up to one third of their adult life in retirement. This implies further increases to 68 to occur in the mid 2030s and 69 in the late 2040s. These proposed changes are not yet law and still require the approval of the UK Parliament. Further information regarding these changes can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263942/35062_Autumn_Statement_2013.pdf

Jamie Hepburn (Cumbernauld and Kilsyth) (Scottish National Party): To ask the Scottish Government what it is doing to assist the Church of Scotland and other faith bodies to develop and promote a better use of credit unions.

(S4W-18842)

John Swinney: The Scottish Government recognises the valuable role played by credit unions in providing ethical and affordable financial services and products to a wide range of customers. We are committed to doing all that we can to support and promote credit unions, and to encourage more people in Scotland to become members.

As part of this commitment, we are working in partnership with the Church of Scotland and other faith bodies to help promote credit unions within their local communities. The Scottish Government has seconded a Senior Policy Advisor to the Church of Scotland to provide additional support for financially disadvantaged individuals and families in Scotland by assisting with the further development of credit unions.

Health and Social Care

Jim Hume (South Scotland) (Scottish Liberal Democrats): To ask the Scottish Government, further to the answer to question S4W-18385 by Alex Neil on 28 November 2013, whether it will provide the information that was requested and confirm with which countries it has had discussions; when they took place; who was involved, and what items were discussed, and whether it will confirm which of the discussions were on a formal basis and the countries that shared evidence-based information.

(S4W-18591)

Alex Neil: Further to the information provided in the answer to S4W-18385, the Scottish Government has had detailed discussions with the UK, Republic of Ireland, Northern Ireland and Estonia on minimum unit pricing of alcohol policy. Discussions with the UK, Republic of Ireland and Northern Ireland have been ongoing over the last few years and taken place at both ministerial and official level.

The Cabinet Secretary for Health and Wellbeing spoke about minimum unit pricing at an alcohol conference in Estonia in October this year, and had discussions with Ministers and officials. The Cabinet Secretary for Health and Wellbeing also spoke at an alcohol conference in Brussels in April this year which was attended by representatives of several countries within the European Economic Area.

At this conference, Professor Tim Stockwell presented his empirical findings on minimum pricing in Canada. The most recent results show a 10% increase in minimum prices significantly reduced consumption by 8.43% for all beverages combined; and a 10% increase in the average minimum price for all alcoholic beverages was associated with a 32% reduction in wholly alcohol attributable deaths.

Jim Hume (South Scotland) (Scottish Liberal Democrats): To ask the Scottish Government, further to the answer to question S4W-18444 by Alex Neil on 28 November 2013, in what areas the statistically significant results were located; for what reasons ISD Scotland carried out each initial investigation; how the number of incidences compared with the expected figure; whether further investigations took place and, if so, what the outcome was.

(S4W-18592)

Alex Neil: Table 1 shows a summary of the statistically significant results that were included in the response to question S4W-18444. All of these statistical analyses were carried out in response to requests from members of the public, as part of ISD's information request service. The information requests were send to ISD either directly by the member of the public or indirectly through their Health Board or the Scottish Government.

Table 1**.** Summary of statistically significant results produced by investigations into suspected cancer clusters; 2004-2013.

Year of Request	Type of Cancer	Gender	Observed Registrations (O)	Expected Registrations (E)	O/E	95% Confidence Intervals

						Lower	Upper
1) Cowie (Stirling) (1990-2004)							
2007	All cancers	Female	88	70.2	1.25	1.02	1.54
2) Moray Council Area (1991-2005)							
2008	Colorectal cancer	Males	547	471.6	1.16	1.07	1.26
	Colorectal cancer	Females	463	405.8	1.14	1.04	1.25
3) Various sites (2002-2011)							
i) Area around Torness							
2013	Prostate cancer	Males	58	35.8	1.62	1.23	2.10
ii) Area around Glasgow Royal Infirmary							
	All cancers	Males	95	74.6	1.27	1.03	1.56
	Lung cancer	Males	28	13.0	2.15	1.43	3.10
iii) Area around Glasgow Western Infirmary							
	Lung cancer	Males	30	18.2	1.65	1.11	2.35
iv) Area around Raigmore Hospital							
	Colorectal cancer	Females	19	9.1	2.08	1.25	3.25
4) Grangemouth (2002-2011)							
2013	All cancers	Males	570	520.9	1.09	1.01	1.19

Source: Scottish Cancer Registry, ISD.
Data Extracted: (1) November 2007; (2) June 2008; (3) May 2013; (4) June 2013.
Notes:
1. Cancer registration is a dynamic process: the data presented here may differ from other published data relating to the same time period.
2. 95% confidence intervals define a range between which there is a 95% probability that the value of the O/E ratio lies. By convention, if the range between the lower and upper 95% confidence intervals does not include the value 1.00, it is interpreted as a statistically significant difference in risk between the population being studied and the larger reference area.

Table 1 shows how the observed numbers of cancer registrations compare with the expected figures. The expected numbers of cancer registrations are calculated by applying the incidence rates for Scotland to the area in question. The observed/expected (O/E) ratio is the ratio of the actual number of cancer registrations to the number that would be expected if incidence rates were the same as in the whole of Scotland. The observed numbers of cancer registrations are subject to random variation, particularly when numbers are small. The confidence intervals around the O/E ratio give a measure of the extent of this variation.

In addition to these four analyses, an analysis was also carried out for the Committee on Medical Aspects of Radiation in the Environment (COMARE) in 2012 on the area around Dalgety Bay. This was part of a much larger investigation and is not included in Table 1. The results of that investigation will be published by COMARE in 2014. All of the other results were sent to the customer and to the appropriate health board. No further investigation was carried out by ISD.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it will provide a list of the country's (a) current and (b) planned major trauma centres.

(S4W-18597)

Alex Neil: Major trauma centre is not currently a designation used by NHS Scotland.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether any major trauma centres do not have support staff on duty on the premises 24-hours, seven days a week for (a) heart attacks, (b) strokes and (c) major orthopaedic operations.

(S4W-18598)

Alex Neil: Major trauma centre is not currently a designation used by NHS Scotland.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what undertakings the Scottish Ambulance Service has made regarding its sickness absence rates.

(S4W-18601)

Alex Neil: The Scottish Government has sought and received assurance from the Scottish Ambulance Service (SAS) that it continues to address sickness absence levels.

A key action point arising from the 2013 Annual Review was that SAS would make sustained progress towards the national HEAT sickness absence standard of 4%, in partnership with staff and their representatives.

From discussions on this matter at its mid-year review in November 2013, we are aware that the board has a number of initiatives underway, such as new occupational health arrangements to support staff and improve performance in this area.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it will carry out a review of how data are collated on nursing and midwifery staff to allow a retrospective review of the workforce following the integration of health and social care.

(S4W-18603)

Alex Neil: This is subject to on-going consideration associated with the Public Bodies (Joint Working) (Scotland) Bill in the Scottish Parliament.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it considers that the number of health visitors in work and in training will meet any increased demand and the switch into family nurse partnerships.

(S4W-18606)

Alex Neil: While it remains for individual NHS boards to plan and deliver services according to the needs of their population, the Scottish Government is working closely with NHS boards to monitor and manage the potential impact of expanding the Family Nurse Partnership programme. In doing so, it is taking account of the year on year increase in the number of health visitors since 2009.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it considers that there are sufficient post-registration midwives to meet demand.

(S4W-18607)

Alex Neil: With NHS Scotland and stakeholders we have been developing a suite of workload measurement and workforce planning tools in recent years to support evidence based decisions about the midwifery establishment in clinical areas. The Royal College of Midwives (RCM) endorses the use of these tools and NHS boards are must apply them in planning their workforce. Midwifery numbers have increased by 242.7 whole term equivalent (wte), or 8.8%, under this Government.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it considers that a 40% reduction in midwifery student intake and the closure of three out of seven university midwifery undergraduate schools is sustainable.

(S4W-18608)

Alex Neil: The Scottish Government works closely with stakeholders, including NHS boards, Higher Education Institutions, Scottish Funding Council and Partnership bodies, to ensure an appropriate supply of registered midwives to meet future workforce requirements and to ensure a sustainable model of pre-registration and post-registration midwifery education provision.

The recommended intake to pre-registration midwifery programmes in 2013-14 academic year was increased by 40% to 140 places. We are working closely with stakeholders, including higher education institutions and Royal College of Midwives Scotland, to inform recommendations regarding intakes to pre-registration midwifery programmes in 2014-15 academic year.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether it will publish the principles on which it considers GP contracts should be based.

(S4W-18611)

Alex Neil: The Scottish Government is committed to working with the profession, and stakeholders, to create a contract that focuses on delivering improved patient outcomes, is person centred, providing value for money and seeks to reduce unnecessary workload and bureaucracy, and emphasises patient and staff satisfaction, a contract truly delivering high trust and low bureaucracy.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what its position is on the recommendation in The Future of General Practice in Scotland: a Vision that it should establish a consultative service to support facilitated quality improvement visits.

(S4W-18612)

Alex Neil: The Scottish Government is committed to the use of continuous quality improvement in the delivery of healthcare in general practice. Scotland is the first country in the world to implement a national patient safety programme across the whole healthcare system and The Scottish Patient Safety Programme in Primary Care (SPSP-PC) was launched 14 March 2013.

To help deliver a person-centred programme of care for patients the Scottish Government is exploring, and supporting, a range of options to ensure the people of Scotland are provided with NHS services which meet their needs and maintains high standards of care.

Patients are at the heart of our NHS and everyone in Scotland has the right to expect the highest quality of care when they need it. This commitment is embedded in our Quality Strategy for the NHS.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what steps it is taking to ensure that all patients have access to online GP services, and what it considers these services should include.

(S4W-18613)

Alex Neil: Work in this area is being progressed under the eHealth Strategy, one of the aims of which is to support people to communicate with the NHS in Scotland and manage their own health and wellbeing. Both GP IT systems used in Scotland now offer online appointment booking and ordering of repeat prescriptions. In addition, GP practice websites offer a range of services, such as online registration, downloading of key practice documents, feedback and complaints, and an array of health related information. Work in the next year will look to increase the uptake of current online services, and broaden the range of services offered, based on people's needs.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what protected learning time is made available to GPs who work only, or for the most part, in out-of-hours services.

(S4W-18614)

Alex Neil: Protected Learning Time is generally co-ordinated by community health partnerships to meet locally identified training and development needs within general practice, and is facilitated by NHS boards. The information requested is not

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what its workforce plans are for (a) GPs and (b) health visitors in the next five years.

(S4W-18615)

Alex Neil: Although GPs are independent contractors, they are still given consideration when planning the NHS Scotland workforce. At present the structure and training of all doctors in the UK, including GPs, is under review. The Scottish Government is actively involved in these discussions to ensure that specific service needs in Scotland are addressed.

With regard to health visitors, it is for each NHS board to decide how best to plan and deliver services, including to meet the needs of its population.

We are leading the UK in developing a series of ground breaking Nursing and Midwifery Workload and Workforce Planning Tools that support evidence based decisions in relation to Nursing and Midwifery establishments. These tools are used to determine the number of nurses, including health visitors, or midwives needed for particular clinical areas through measurement of actual workload, as part of a broader approach that incorporates nurses' professional judgment and quality measures. The Workload and Workforce Planning tools have been mandated since April 2013 and we expect all NHS boards to use them to inform local nursing and midwifery workforce planning.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government whether there has been a recent rise in the number of sessional GPs and, if so, what its position is on this.

(S4W-18616)

Alex Neil: The Primary Care Workforce Survey 2013, a survey of Scottish general practices and GP Out of Hours Services was published on 24 September 2013 and provides a “snapshot” of locums. The report is available on the Information Services Division (ISD) of National Services Scotland website at:

http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-09-24/2013-09-24-PCWS-Report.pdf.

Overall, 89% of responding practices had used GP locums and/or sessional GPs in the year ending 31 January 2013. The estimated whole time equivalent (WTE) amount of time input by locum/sessional GPs to all general practices over this one year period was 290. This estimate is based on an assumption of eight sessions being equal to one full time working week and 44 weeks comprising a working year (allowing for six weeks annual leave and two weeks study leave). The estimated WTE input by locum/sessional GPs over the year appears to be a little higher than the equivalent estimate of 255 WTE from the 2009 Primary Care Workforce Planning Survey (for the year ending 30 January 2009).

However, as these two estimates are both based on incomplete data, they are broadly rather than directly comparable.

The role of the Scottish Government is to provide policies, frameworks and resources to NHS boards in order that they can deliver the healthcare services that meet the needs of their local population. Within this context, the actual provision of services and patient care is the statutory responsibility of health boards and healthcare professionals locally. GP practices are mostly all independent contractors who are free to decide (within the context of the services they must provide under contract with boards) exactly how they set up their operations in terms of employing staff whilst how NHS boards organise the provision of GP services is an operational matter for the board to determine, based on an assessment of local needs.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what steps it is taking to increase trainee GPs' awareness of their public health role.

(S4W-18617)

Alex Neil: It is the Royal College of General Practitioners (RCGP) which develops and maintains the general practitioner (GP) curriculum, and this has the public health role of the GP as a key element.

All three elements of public health, health improvement, promoting health and health care services, can be learnt in the practice setting and the GP trainees spend eighteen months of their training in practice. In this environment the GP trainee will be involved in health promotion, prevention and screening activities. They also have the opportunity to work with other health care professionals such as nurses and health visitors.

GP trainees can also use their protected educational half day to spend time with Public Health Specialists if this is an identified educational need.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what steps it is taking to increase GPs' public health role.

(S4W-18618)

Alex Neil: GP practices already have a significant role in health protection, prevention of ill health or deterioration in the condition, health promotion and health improvement issues, delivered through the The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, or The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004.

GP Practices play an important role in public health management of single cases and outbreaks of infectious disease. They are the liaison between Public Health and the patient e.g. they help taking samples for laboratory analysis and communicating results, they may help in recruitment of patients for studies (as happened in Edinburgh for legionella studies), they manage public concern and potential cases in an outbreak, they assess, treat and vaccinate patients in a flu outbreak in nursing homes.

In particular this year there has been increased involvement of GPs as two entirely new immunisation programmes have been introduced, rotavirus for infants and shingles for 70 year olds and both of these are being given in primary care. Furthermore this year saw the first phase of childhood flu vaccination being rolled out with all two and three year olds being offered flu vaccination in primary care.

The Scottish Government is also undertaking a review of the Public Health Domain within the GMS Contract, in conjunction with Scottish General Practitioners Committee, to ensure it fits with NHS Scotland's public health priorities.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government how many GP practices (a) have and (b) have not established a patient participation group.

(S4W-18619)

Alex Neil: As indicated in my answer to S4W-10514 on 7 November 2012, this is an important area for development and for the past 18 months the Scottish Health Council has been promoting and supporting the value of involving people and patients in primary care and in particular general practices. Its March 2013 report, *Promoting, Supporting and Developing Public Involvement in Primary Care* (available on its website at www.scottishhealthcouncil.org) estimates that at that point in time, 151 of Scotland's 1,032 General practices had established Patient Participation Groups. Through its local office network, the Scottish Health Council continues to offer support to general practices using tools it has produced to improve or widen their involvement practice.

All answers to written parliamentary questions are available on the Parliament's website, the search facility for which can be found at:
http://www.scottish.parliament.uk/parliamentarybusiness/28877.aspx.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government which of the local health care cooperatives that were in place in 2005 are still operating.

(S4W-18620)

Alex Neil: Community Health Partnerships were established across Scotland between 2004 and 2006 and replaced local health care cooperatives.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government what steps it is taking to support the development of so-called networked GP practices.

(S4W-18621)

Alex Neil: The Scottish Government's "Route Map" to the 2020 Vision for Health and Social Care in Scotland sets out a new and accelerated focus on a number of priority areas for action around Primary Care, a key aspect of this is our "Primary Care Modernisation Programme".

In November 2013 the Scottish Government announced £1 million towards this programme and an integral part its work will be to trial and test at scale a range of new models of care.

The learning from this work will inform future planning and spread of well-developed and tested new ways of working and models of care as standard across Scotland before 2020.

Richard Simpson (Mid Scotland and Fife) (Scottish Labour): To ask the Scottish Government which NHS boards use the Multi Disciplinary Information System.

(S4W-18624)

Alex Neil: The NHS boards currently using the multi disciplinary information system are: NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Highland, NHS Lanarkshire and NHS Tayside.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government, in relation to the IT failure at NHS Greater Glasgow and Clyde, whether (a) domain name system requests had been failing from 26 September 2013 and (b) new web filter software had been brought online on the day of the failure and, if so, for what reason this is not mentioned in the report, Technical Assurance Review: NHS Greater Glasgow and Clyde: Critical Incident - 1 October 2013.

(S4W-18638)

Alex Neil: (a) Domain Name requests had not been failing previous to the incident.

(b) Web filtering software was not brought online on the day of the incident and is not relevant to the incident of 1 October 2013.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government on what basis the report, Technical Assurance Review: NHS Greater Glasgow and Clyde: Critical Incident - 1 October 2013, concluded that "the design and implementation of the XGGC Microsoft Active Directory with associated services is a fit for purpose and resilient implementation" given that it found that the error was "associated with the Active Directory software environment".

(S4W-18639)

Alex Neil: A system can be designed and implemented in a manner deemed fit for purpose and resilient, and yet still suffer from an unforeseen incident.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government, in relation to the IT failure at NHS Greater Glasgow and Clyde on 1 October 2013, whether the built-in Windows back-up service was in use at the time of the incident.

(S4W-18640)

Alex Neil: Native Windows Server Backup was not being used prior to the incident. Symantec Backup Exec was used to backup the domain controllers. It was Symantec Backup Exec which was used to recover Active Directory.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government, in relation to the IT failure at NHS Greater Glasgow and Clyde on 1 October 2013, whether active directory auditing was switched off and, if so, for what reason.

(S4W-18641)

Alex Neil: Reduced auditing was in place due to the impact that such services have on systems performance. We are however reviewing this in light of the recent incident and will introduce appropriate and proportionate auditing in due course.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government whether NHS Greater Glasgow and Clyde has a disaster recovery site to switch to in the event of a failure of its main site and what the reasons are for its position on this matter.

(S4W-18642)

Alex Neil: NHS Greater Glasgow and Clyde runs dual active data centres, separated by 14 km and the River Clyde. These are linked by multiple super-high speed data connections, making the concept of a passive disaster recovery site redundant. This design is accepted best practice for modern data centres.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government whether, prior to the IT failure on 1 October 2013, NHS Greater Glasgow and Clyde had checked whether it could restore its active directory service from backups and what the reasons are for its position on this matter.

(S4W-18643)

Alex Neil: A full Active Directory recovery was not performed due to not having an environment where this could be done safely. This is now being re-assessed. However, the backups have been used previously to perform granular recovery of Active Directory objects in the live active directory.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government whether NHS Greater Glasgow and Clyde will publish its information security management system documentation.

(S4W-18644)

Alex Neil: NHS Greater Glasgow and Clyde regards its IT Information Systems as critical health infrastructure. Accordingly it would not be appropriate to put detailed systems documentation (especially Information Security) into the public domain.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government how many (a) planned and (b) unplanned service outages there have been on NHS Greater Glasgow and Clyde's IT systems since 1 October 2013.

(S4W-18645)

Alex Neil: NHS Greater Glasgow and Clyde's statistics for "Outage" include incidents where systems remain fully available to users, but elements are undergoing maintenance or remedial activities. In the period 2 October to 3 December there have been 10 planned outages (all restricted to either individual applications or sites. All occurred either out of hours when no users dependent on the services, or by pre-arrangement such that no risk to services occurred). There have been four periods of unplanned partial/total individual server outages during the period under review. These ranged between five and 60 minutes and on none of these occasions were patient services disrupted. This must be placed within the context of an IT estate with over 400 applications, supporting 11 major hospitals, over 250 GP and Health Centres and 40,000 staff.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government how many NHS Greater Glasgow and Clyde patients were attended by medical staff when the clinical notes were unavailable during the IT failure of 1 October 2013.

(S4W-18646)

Alex Neil: More than 10,000 patients were attended by medical staff during the IT failure of 1 October 2013. As there was variable access to both electronic and paper clinical notes throughout the incident it is not possible to quantify for how many patients clinical notes were not available in each case.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government how many rapid alerts were caused by the IT failure at NHS Greater Glasgow and Clyde of 1 October 2013.

(S4W-18647)

Alex Neil: Maternity and emergency services were maintained throughout the period disrupted by the IT incident.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government whether all the information actualisation/processing caused by the IT failure at NHS Greater Glasgow and Clyde of 1 October 2013 has been completed.

(S4W-18648)

Alex Neil: Information processing has been completed. All national returns have been provided and all patient transactions processed. No business or patient data was lost.

Rhoda Grant (Highlands and Islands) (Scottish Labour): To ask the Scottish Government what its position is on NHS Greater Glasgow and Clyde becoming “paper-light” over the next 12 months in light of the IT failure of 1 October 2013 and what guidance the Scottish Government will give to clinicians on treating patients when no patient information is available.

(S4W-18649)

Alex Neil: The position of Scottish Government and NHS Greater Glasgow and Clyde remains unchanged. The eHealth Strategy makes clear the commitment for all health boards to become ‘paper-light’ in a controlled and incremental fashion because of the considerable benefits that this brings (including better service continuity and information availability compared to paper). Paper workarounds do have their place in certain circumstances, but increasingly health boards are deploying more resilient ICT which means that information can still be available from alternative digital sources. Each board has business continuity plans, and associated guidance in this area.

Jackie Baillie (Dumbarton) (Scottish Labour): To ask the Scottish Government what the waiting times are for talking therapies in each NHS board.

(S4W-18662)

Alex Neil: The waiting times for psychological therapies in each NHS Board are published quarterly by ISD Scotland in Psychological Therapies Waiting Times in Scotland: http://www.isdscotland.org/Publications/index.asp. The latest publication took place on 26 November 2013 and covers the quarter ending 30 September 2013. Data collection systems are still being developed, and the publication contains information on data quality and completeness by NHS board.

Average adjusted waiting times for each NHS board area can be found in Table 2, and average unadjusted times are in Table 3.

Jackie Baillie (Dumbarton) (Scottish Labour): To ask the Scottish Government how many people are waiting to access talking therapies and what the (a) average and (b) longest wait is in each NHS board.

(S4W-18663)

Alex Neil: Information on how many people were waiting to access psychological therapies in each NHS board area is published by ISD Scotland in Psychological Therapies Waiting Times in Scotland: http://www.isdscotland.org/Publications/index.asp. The latest publication took place on 26 November 2013 and covers the quarter ending 30 September 2013. Data collection systems are still being developed, and the publication contains information on data quality and completeness by NHS board.

The number of people waiting to start treatment at 30 September 2013 by NHS board can be found in Table 5.

Average adjusted waiting times for each NHS board area can be found in Table 2, and average unadjusted times are in Table 3.

The publication does not include the longest waits, but the data tables include median and 90th percentile waits for each NHS board.

Jackie Baillie (Dumbarton) (Scottish Labour): To ask the Scottish Government how many people are accessing talking therapies in each NHS board.

(S4W-18664)

Alex Neil: Information on how many people have accessed psychological therapies in each NHS board area is published by ISD Scotland in Psychological Therapies Waiting Times in Scotland http://www.isdscotland.org/Publications/index.asp. The latest publication took place on 26 November 2013 and covers the quarter ending 30 September 2013. Data collection systems are still being developed, and the publication contains information on data quality and completeness by NHS board.

The number of people who started treatment in July to September 2013 by NHS board can be found in Table 2.

Jackie Baillie (Dumbarton) (Scottish Labour): To ask the Scottish Government what talking therapy services each NHS board provides.

(S4W-18665)

Alex Neil: This information is not held centrally.

While the Scottish Government sets the policy direction for the delivery of and access to psychological therapies, it is for Health Boards to determine the level and nature of the demand in their local areas.

The Scottish Government, with partners, have ensured that support is in place to help NHS boards plan their psychological therapy service provision, including publication of The Matrix: a Guide to Delivering Evidence Based Psychological Therapies in Scotland: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix.aspx.

Jackson Carlaw (West Scotland) (Scottish Conservative and Unionist Party): To ask the Scottish Government what procedures exist in the NHS for fast-tracking hospital appointments for people with serious ongoing conditions.

(S4W-18692)

Alex Neil: The timing of appointments should always be based on the patient's clinical need so those patients requiring to be seen urgently get early appointments either a serious ongoing or a new condition. It is important that GPs identify the need for an urgent appointment in their referral letter. To speed the referral process, the vast majority of GPs now email referral letters directly into hospital. This ensures no delay in the hospital receiving the referral letter.

Aileen McLeod (South Scotland) (Scottish National Party): To ask the Scottish Government how many (a) consultants specialising in emergency care, (b) emergency services technicians and (c) paramedics the NHS employed in September (i) 2006, (ii) 2007, (iii) 2008, (iv) 2009, (v) 2010, (vi) 2011, (vii) 2012 and (viii) 2013 and what the percentage change was over the period.

(S4W-18693)

Alex Neil: Information detailing how many(a) consultants specialising in emergency care, (b) emergency services technicians and (c) paramedics in the NHS, employed in September (i) 2006, (ii) 2007, (iii) 2008, (iv) 2009, (v) 2010. (vi) 2011, (vii) 2012 and (viii) 2013, and what percentage change was over the period can be found in the following tables.

Table 1 shows the headcount of (a) consultants specialising in emergency care, (b) emergency services technicians and (c) paramedics the NHS employed over the period 2006 to 2013.

Headcount	Consultants specialising in emergency care	Emergency service technicians	Paramedics
September 2006	76	x	x
September 2007	82	1,010	1,247
September 2008	113	989	1,269
September 2009	101	1,051	1,323
September 2010	136	1,009	1,391
September 2011	141	1,001	1,382
September 2012	151	1,023	1,393
September 2013	162	1,098	1,393
Overall change	113.16%	8.71%	11.71%

Overall change for consultants specialising in emergency care is from 2006 to 2013.

Overall change for emergency service technicians and paramedics is from 2007 to 2013.

Table 2 shows the whole time equivalent of (a) consultants specialising in emergency care, (b) emergency services technicians and (c) paramedics the NHS employed over the period 2006 to 2013.

Whole Time Equivalent	Consultants specialising in emergency care	Emergency service technicians	Paramedics
September 2006	75.8	x	x
September 2007	81.0	999.7	1,233.9
September 2008	107.2	980.1	1,255.0
September 2009	94.8	1,041.9	1,309.2
September 2010	128.4	997.4	1,376.3
September 2011	133.8	986.4	1,367.4
September 2012	144.4	1,010.4	1,376.7
September 2013	154.5	1,084.5	1,369.9
Overall change	103.83%	8.48%	11.02%

Notes:
(a) (i) Information on headcount and whole time equivalent of consultants specialising in emergency care for 2013 can be found on the workforce statistics web site at:
https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2013-11-26/Consultant_Staff_In_Post_S2013.xls?17378742.

(ii) Information on headcount and whole time equivalent of consultants specialising in emergency care for 2006 to 2012 can be found on the workforce statistics web site at:
http://www.isdscotland.org/Health-Topics/Workforce/Publications/2012-11-27/Consultant_Staff_In_Post_S2012.xls?66090757.
(b) (i) Information on headcount and whole time equivalent of emergency services technicians for 2013 can be found on the workforce statistics web site at:
https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2013-11-26/All_Other_Staff_S2013.xls?17378742.
(ii) Information on headcount and whole time equivalent of emergency services technicians for 2007 to 2012 can be found on the workforce statistics web site at:
http://www.isdscotland.org/Health-Topics/Workforce/Publications/2012-11-27/All_Other_Staff_S2012.xls?66090757.
(c) (i) Information on headcount and whole time equivalent of paramedics for 2013 can be found on the workforce statistics web site at:
https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/publications/2013-11-26/AHP_Staff_S2013.xls?17378742.
(ii) Information on headcount and whole time equivalent of paramedics for 2007 to 2012 can be found on the workforce statistics web site at:
http://www.isdscotland.org/Health-Topics/Workforce/Publications/2012-11-27/All_Other_Staff_S2012.xls?66090757.
During the release of national statistics in 2006, Scottish Ambulance Service and NHS 24 identified a discrepancy with the 2006 data, therefore 2006 figures for paramedics are not included.

Nanette Milne (North East Scotland) (Scottish Conservative and Unionist Party): To ask the Scottish Government what the capital infrastructure budget has been for each NHS board in each year since 1999.

(S4W-18740)

Alex Neil: Allocations to health boards over the period 2004-05 to 2013-14 are given in the following table:

Health Board	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08	2006-07	2005-06	2004-05
Argyll and Clyde									15.6	14.4
Ayrshire and Arran	11.4	12.0	21.6	18.5	21.8	21.5	21.2	17.6	14.7	13.4
Borders	3.4	4.3	5.5	5.2	6.1	6.0	6.0	5.0	4.2	3.7
Dumfries and Galloway	6.5	6.0	5.0	7.8	9.2	9.0	9.1	7.6	6.3	5.7
Fife	21.1	12.5	22.2	15.7	18.5	18.2	17.4	14.5	12.1	10.9
Forth Valley	6.4	5.0	11.4	12.5	14.8	14.5	14.4	12.0	10.0	9.0
Grampian	34.3	49.1	64.6	25.3	29.8	29.3	27.8	23.2	19.3	17.6
Greater Glasgow									55.6	51.0
Greater Glasgow and	293.6	336.4	215.1	83.9	98.9	97.4	97.6	81.3		

Health Board	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08	2006-07	2005-06	2004-05
Clyde										
Highland	15.5	8.3	13.6	16.0	18.9	18.6	18.5	15.4	9.3	8.4
Lanarkshire	14.8	19.2	18.5	25.4	30.0	29.5	28.4	23.6	19.7	17.6
Lothian	57.6	50.9	65.3	44.3	52.3	51.5	48.6	40.5	33.8	30.7
Orkney	1.4	1.0	0.9	0.8	0.9	0.9	0.8	0.6	0.5	0.5
Shetland	3.1	3.1	0.2	0.9	1.0	1.0	0.9	0.7	0.6	0.5
Tayside	15.0	15.6	18.3	21.2	25.0	24.7	24.3	20.3	16.9	15.4
Western Isles	1.3	1.7	0.4	1.6	1.9	1.9	2.0	1.6	1.4	1.2
Total Territorial Boards	485.4	525.1	462.6	279.0	329.0	324.0	317.0	264.0	220.0	200.0
Special Health Boards										
Healthcare Improvement Scotland	0.2	0.2	0.2	0.3	1.7	1.8	-	-	-	-
National Services Scotland	3.8	3.8	3.4	6.3	6.0	5.8	5.3	5.3	5.0	4.8
National Waiting Times Centre	4.8	3.0	1.8	7.1	6.6	9.7	3.3	3.5	13.5	2.5
NHS 24	0.3	0.3	0.2	1.3	1.6	1.6	2.0	2.0	2.7	2.5
NHS Health Scotland	0.7	0.5	0.2	0.3	-	-	-	-	-	-
Scottish Ambulance Service	13.5	14.3	10.9	19.3	13.2	15.2	11.7	11.4	10.4	3.0
The State Hospital	0.3	1.6	12.2	39.2	26.6	20.3	6.1	5.6	4.8	4.4
Total Special Boards	23.6	23.7	28.9	73.7	55.7	54.3	28.4	27.8	36.4	17.1

NHS Trusts were abolished on 1 April 2004. Allocations to health boards prior to 2004-05 did not cover Trusts' acute care facilities. Allocations to Trusts were made for specific projects, rather than by formula. Capital allocations from prior to 2004-05 are therefore not comparable to subsequent allocations.

Transport Scotland

John Pentland (Motherwell and Wishaw) (Scottish Labour): To ask the Scottish Government how many complaints were received in 2012 and have been received in 2013 regarding overstaging of concessionary fare journeys, in which bus companies inaccurately record the distance travelled by passengers; what it estimates to be the total cost of this, and what action it has taken against any companies involved.

(S4W-18756)

Keith Brown: In 2012, Transport Scotland received 258 complaints relating to overstaging. These complaints identified 621 separate instances where the cardholder claimed the recorded stages were inaccurate. Of these 621 instances, 384 were proven to have an element of overstaging.

So far in 2013, Transport Scotland has received 155 complaints relating to overstaging. These complaints identified 560 separate instances where the cardholder claimed the recorded stages were inaccurate. Of these 560 instances, 383 were proven to have an element of overstaging.

As a result of these instances of overstaging £502.17 in 2012 and £167.80 so far in 2013 was over claimed by bus operators.

Where it is confirmed that overstaging has occurred Transport Scotland has the facility to recover the value of the difference for each proven instance from the operators reimbursement claim.

If evidence of deliberate wide spread abuse of the scheme emerges Transport Scotland responds in accordance with its fraud strategy and policy, including taking legal action.