MEETING OF THE PARLIAMENT

Wednesday 26 March 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

CONTENTS

Wednesday 26 March 2008

Debates

Scottish Parliament

Wednesday 26 March 2008

[THE PRESIDING OFFICER *opened the meeting at 14:30*]

Time for Reflection

The Presiding Officer (Alex Fergusson): Good afternoon. The first item of business is time for reflection. Our time for reflection leader today is the Rev Scott Guy from Northfield parish church, Aberdeen.

The Rev Scott Guy (Northfield Parish Church, Aberdeen): It is a great privilege to be here today.

I am sure that everyone here is familiar with campaigns—perhaps too familiar. Just a couple of weeks ago, I took part in a campaign of a different sort in our local secondary school, Northfield academy, in Aberdeen. The theme of the week was "There is hope". As school chaplains, we were joined by a Christian rock group called the One Band, which went down a storm with the young people.

The aim of the week was to share with the young people and with everyone in the school that there is hope for each one of us, no matter how hopeless our individual or family situations might be. On our visits to the school over the years, we had come to see for ourselves just how little hope the young people in the academy had. They seemed to have no sense of value or self-worth and no confidence in themselves. As chaplains, we wanted to make each one of them feel that they were valued members of our society and that they had an important part to play in it. We wanted them to see that God loves them and values them as individuals and that he wants the best for every single one of them.

We each took different characters from the Easter story and tried to show that, when Jesus died, all their hopes died with him and they felt lost and alone, with no meaning or purpose in their lives, but that when Jesus rose from the dead and appeared to them and spoke with them, everything changed and their hopes and purposes were wonderfully restored. For example, Peter, who deserted Jesus and denied three times that he even knew him, was singled out by the risen Jesus and reassured by him. Peter went on to be a great ambassador for Christ and later wrote these words in his letter:

"Because Jesus is alive, everyone can now have hope. Everyone can have a real, living hope because Jesus is alive."

Where there is life, there is hope. That was the message of the first Easter and it is still the message for each one of us today. God values each one of us and sees us as important in his own eyes. He tells us that in the Bible when he says:

"You are precious and honoured to me and I love you."

Our hope as school chaplains is that all the young people in Northfield will come to realise that they are loved by God and that they will discover for themselves that there really is hope for each one of them, no matter what their different situations might be. Where there is life, there is hope. The Easter story shouts out that there is life, and so there is hope—a real, living hope for each one of us.

Business Motion

14:34

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-1632, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a revised business programme.

Motion moved,

That the Parliament agrees the following revision to the programme of business for Wednesday 26 March 2008—

after

Wednesday 26 March 2008

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions

insert

followed by	Ministerial Statement: Scottish Prison Service Report on Robert Foye—[*Bruce Crawford*.]

Motion agreed to.

Scottish Prison Service (Robert Foye Case)

The Presiding Officer (Alex Fergusson): The next item of business is a statement by Kenny MacAskill on the Scottish Prison Service report on Robert Foye. The cabinet secretary will take questions at the end of his statement, so there should be no interventions.

14:34

The Cabinet Secretary for Justice (Kenny MacAskill): I begin by talking about someone who is much more important than Robert Foye: his victim. I cannot begin to imagine the suffering that has been inflicted on her and her family. Her fortitude and resilience throughout the whole tragic process have been truly amazing, and I pay tribute to her determination in seeking to rebuild her life. I apologise unreservedly to her for the shortcomings in our prison system that have allowed that individual to put her through such pain. I will meet this brave young woman and her family soon to give her that apology in person and to pass on with it the admiration and good wishes of all members.

As members know, Robert Foye was arrested on 25 August 2007 in the Cumbernauld area, having absconded from Castle Huntly on 18 August. On 23 January this year, he pled guilty to the charge of rape while unlawfully at large. His final sentence for that matter is still pending. We must not lose sight of the full responsibility that he alone bears for that crime.

On 24 January this year, I announced to Parliament that the Scottish Prison Service would carry out an urgent internal review of the circumstances surrounding the Robert Foye case and that I would write to Henry McLeish, chair of the Scottish Prisons Commission, emphasising the importance to the Government of the commission's consideration of the use of the open estate as part of its wide-ranging work on the future of prisons in Scotland.

I have already made it clear that we have no plans to expand the current open estate, whether at Castle Huntly or Noranside. It is worth noting, too, that there is a welcome downward trend in the numbers of prisoner absconds. In 1996-97, there were 98 absconds from a much smaller prison population; in the past year, there have been 66. However, as the First Minister has said, every abscond is one too many.

As members will be aware, the SPS report was published last week. The work of the McLeish commission is on-going, and it is expected to report this summer. The SPS report contained

seven recommendations, and the SPS has established a group to ensure that they are all implemented. It is possible and, indeed, likely that the McLeish commission may make further recommendations. I anticipate that those, too, will be implemented as quickly as possible to ensure that the open estate works as effectively as it can and must.

I have asked for two steps to be taken to build public confidence in addition to the implementation of the seven immediate recommendations. First, I have instructed the SPS to establish individual governors at Castle Huntly and Noranside prisons in view of the substantially increased numbers of prisoners now held in those facilities. Secondly, and more important, there will be a clear presumption against returning a prisoner to the open estate if they have previously absconded. That will send the clear message to all those trusted with a place in the open estate that if they abscond from open conditions, they can assume that they will not return to open conditions again without a compelling reason.

It is widely accepted that to return a prisoner to society straight from a closed prison does not help to reduce reoffending. Long-term prisoners require a staged return to re-establish relationships with children and families, and to help them prepare for integration with society and improve their employment prospects. I understand the concern that can arise when a prisoner who has absconded previously is returned to open conditions. However, we have to retain the possibility of returning some such offenders to the open estate if we feel that public safety could be enhanced by so doing. Moreover, a blanket ban would be subject to legal challenge.

Public safety must always be paramount. That is why the presumption will be against return unless good reason is shown. As an additional safeguard, I have insisted that approval for the return to the open estate of a prisoner who has previously absconded will now be required to be given at SPS headquarters and at a senior level. I expect such approvals to be few and, most important, justifiable.

Action is being taken already on absconders, and further action will be taken, if required, in the light of the deliberations of the McLeish commission. The open estate will continue to remain a vital part of our penal system. That is accepted by all parties and is necessary to help break the cycle of reoffending that scars Scotland.

The systems in the open estate have been in place for several years and it is right to review them, as we are doing. As the First Minister said last week:

"I think all of us want to see the open estate working at its best."

We also want our communities to be kept safe from harm and from dangerous individuals.

Previous Labour, Conservative and coalition Administrations in Scotland have seen the open estate as an integral part of managing the prison population. The open estate also gives the Parole Board for Scotland more insight, making decisions on an individual's fitness to be released on licence much easier and more accurate. We would be remiss if we lost sight of that.

In his letter of 30 October 2007 to the governor of the SPS open estate, Bill Aitken said:

"I have been at pains to underline that I am not opposed to Open Prisons per se. I have stressed this and indeed a number of newspaper articles have represented this view."

In response to a parliamentary question from Alex Neil on the purpose of open prisons, my predecessor Cathy Jamieson—the former Minister for Justice—said:

"Society benefits first from these long-term prisoners being carefully prepared, in stages, for release."—[*Official Report*, *Written Answers*, 5 December 2005; S2W-21073.]

We are well served by our prison service. Prison staff are tasked with making difficult decisions and judgments about difficult and often dangerous individuals in the interests of wider society and public safety. Prison staff do not take lightly the responsibilities that we place on them to make those decisions. We must learn from mistakes and try as best we can to prevent such incidents from happening again. It is impossible to eliminate risk, but prison staff must make judgments every day about how prisoners will behave, and we need to remember that they do so well in the vast majority of circumstances.

As Her Majesty's chief inspector of prisons, Andrew McLellan, said when publishing his follow-up inspection of the SPS open estate in February 2007:

"The Open Estate has a crucial role to play in the preparation of prisoners for release. It should make it possible for prisoners to develop their sense of personal responsibility and be reintegrated into society when they have served their sentences. Thus public safety should be improved. That is why I am pleased to see evidence of real improvement across the Open Estate in Scotland."

Nobody underestimates the gravity of the situation, the seriousness of the offence that Robert Foye committed or the hurt and upset that that offence has caused many. We must do everything in our power to ensure that the processes that we use to assess people for transfer to open prisons and to manage them while they are there are as robust and accurate as possible.

The open estate's value has been recognised by previous Administrations of all political hues, by prison inspectors—as I mentioned—and by independent experts. We have taken action. We are implementing the recommendations that are in the SPS report and we have gone further: I have asked Henry McLeish to report separately on open prisons, and we are reviewing the entire penal policy.

The Government is committed to achieving the right balance between public safety and confidence and the need to assess prisoners properly and prepare them for release. I do not believe that any of us has the luxury of a simple choice between one option or the other—not if we are serious about delivering and sustaining a safer society for all of us and our communities.

The Presiding Officer: The cabinet secretary will take questions on the issues that his statement raised. I intend to allow about 20 minutes for questions, after which we will move to the next item of business.

Pauline McNeill (Glasgow Kelvin) (Lab): I welcome the Cabinet Secretary for Justice's statement and the provision of an advance copy of it. I also welcome the apology that he has issued; so far, the SPS has failed to issue an apology.

The events that led to the rape of that young girl are shocking and deeply concerning. They call into question the management of the open prison estate. It is the Scottish Government's job to put things right. Hard questions need to be asked about how Robert Foye became eligible to serve his sentence in a part of the estate that seems to have little or no supervision.

Given the mistakes that were made under the current SPS system, what checks will exist in the future to ensure that prisoners are properly categorised and accurately assessed? Will the cabinet secretary give an assurance that he will consider that matter?

I fully understand why prisoners come before the Parole Board for Scotland after they enter the prison estate, but will the cabinet secretary also consider whether there might be a further check on prisoners' suitability if they are moved to the open estate after they are at least halfway through their sentence? The board could then have the chance to look more closely at their record, conduct and suitability for the open estate.

Kenny MacAskill: I will deal with Ms McNeill's questions in reverse order. The point about the Parole Board for Scotland is worthy of consideration, and it appears to me that we can happily factor it into our consideration.

I think that Ms McNeill has already spoken to the McLeish commission. The issue that she has raised is important and should be reflected on, and I undertake to ensure that Henry McLeish and his fellow commissioners consider it when they review the use of the open estate. All parties recognise that the open estate is necessary—that recognition has been with us not only under one or two Administrations, but for several generations. Penal experts also accept that the open estate is necessary, but it is clear that matters require to be reviewed, and I give Ms McNeill the undertaking that they will be.

The checks that will be made in the future and the criteria that will be used are referred to in the seven recommendations that are contained in the SPS report. Many of the issues in question are procedural and bureaucratic. Action is being taken and proposals are being implemented. It has been made clear that there will be a presumption against returning to the open estate people who have absconded once, and that cases will have to be considered at SPS headquarters.

I reiterate that a belt-and-braces approach is being taken. The matter is being put to the McLeish commission, and the SPS's recommendations will be reviewed by that commission. If it believes that there are issues relating to the Parole Board for Scotland or the actions—or, indeed, the inaction—of the SPS, it will pick up on those issues and make recommendations, on which, I assure members, the Government will act.

Bill Aitken (Glasgow) (Con): The cabinet secretary was initially reluctant to make a statement on the SPS report. I am pleased that he has done so, and I thank him for the courtesy of providing advance copies of the statement. I also associate the Conservative party with his comments on Robert Foye's victim. None of us who read the story in this week's *Sunday Mail* could have been other than moved by it. We all hope that his victim will in time be able to put her nightmare behind her and move on from what must have been an awful experience.

Unanswered questions remain. There is a role for open prisons, but will the cabinet secretary say what he envisages that role to be? Are open prisons for those who represent no physical threat or for those who are reaching the end of high-tariff sentences? That is my conception of what open prisons are for. They should not be for someone who is three years into a 10-year sentence for attempted murder.

Will the cabinet secretary review the policy on those with a previous episode of absconding? I heard what he said, but surely the vast majority of the public—and, I suspect, the vast majority of members—take the view that there should be no second chances. Those who abscond once should not have the opportunity to do so again.

I refer Mr MacAskill to paragraph 2 in section 9 of the SPS report, which states, inter alia:

"the purpose of the open estate is to test offenders … and to inform future judgements on suitability for release."

Does he agree with me and the vast majority of the public that prisoners are in custody for the protection of the public and not to undergo some sort of experiment or test, which Mr Foye failed with such tragic consequences?

Finally, I agree that we can all have 20/20 vision in hindsight, but does the cabinet secretary agree with me—and the vast majority of the public—that those who were prepared to consider as a suitable candidate for the open prison estate a man barely into a 10-year sentence, with a previous record of drug abuse and dependency and considered likely to abscond, were lamentably lacking in judgment? Does he agree that, in a situation that is very urgent indeed, leaving the answers to be found by Henry McLeish is not addressing the problem with the degree of urgency for which we might wish? Indeed, if he is looking for answers from Henry McLeish—the Scottish National Party's new best friend—I suggest that he is perhaps asking the wrong questions.

Kenny MacAskill: Notwithstanding the barb against Mr McLeish, I will pass on to the victim those good wishes and the esteem in which she is held by all members of the Parliament.

The Scottish Prison Service is dealing with matters with alacrity. As Mr Aitken will be aware, the SPS implemented immediately four of the seven recommendations—recommendations 1, 5, 6 and 7. Other aspects of recommendations 1, 3, 4, 5, and 6 will be implemented within up to three months. One aspect of recommendation 2 involves external parties, so it remains rather more problematic. However, it is clear that the recommendations are being dealt with and that action is being taken.

The purpose of the McLeish commission is to review the role of the prison estate. As Mr Aitken recognises, there is a role for the open prison estate. In my view, that role is to seek to reintegrate into society those who have been incarcerated for some period of time. That current theory behind the open prison estate is accepted across a broad range of opinion. However, I will listen with an open mind to what Mr McLeish may pick up from others. We will listen to people on that issue and take action.

I give Mr Aitken the assurance that action is being taken to deal with matters speedily and that the role of the open estate will be reviewed. Clearly, Mr McLeish's remit is predicated on the fact that we have problems within our penal system, in that far too many people seem to be in prison for relatively trivial matters. To avoid clogging up the system, we need to ensure that prison is for those who have committed serious offences and who are a danger to our communities. Clearly, judgment calls require to be made at some stage about when those who have been convicted of serious offences or are considered a danger to our communities but are due to be released—a circumstance that we cannot change—should be considered appropriate for reintegration into society. Doubtless, some prisoners will never be considered eligible for the open estate; others will be considered eligible even though they have committed serious and heinous crimes. That is the nature of a society that recognises that people can be reintegrated. One of the roles of prison, as well as seeking to punish, is to rehabilitate.

However, I assure Mr Aitken, notwithstanding his disparagement of Mr McLeish, that we will look forward with interest to the commission's conclusions. Mr Aitken can rest assured that we will act upon those.

Mike Pringle (Edinburgh South) (LD): I thank the cabinet secretary for the advance copy of his statement and I associate the Liberal Democrats with his comments about Robert Foye's victim, who has the admiration and good wishes of all in the Parliament. It is a shame that we cannot dwell more on her courage, but we obviously have to dwell on Robert Foye.

Robert Foye had been given an abscond risk assessment. Will the cabinet secretary comment on how, as a result of what happened subsequently, such risk assessments can be further improved? I think that he has said a bit about that already.

As the cabinet secretary will be aware, the rules about who should be sent to the open estate changed a few years ago when the open estate was opened up to short-term prisoners. The population of Castle Huntly prison has doubled in the past three years. Is he content that the prisoners who are being sent to the open estate are those who are most suitable and most likely to respond to the open prison regime, and that they are not being sent there by other prisons simply to deal with the wider issue of overcrowding in the prison estate as a whole?

Kenny MacAskill: I assure Mike Pringle that the SPS is not seeking to use the open estate as a repository for prisoners because of the current overcrowding problems that we face, and that steps are being taken to ensure that the necessary judgment calls are made. Recommendations 1, 3, 4, 5, 6 and 7 relate to how the SPS will ensure that all judgments are made on the best available evidence. Evidence can never be foolproof and, tragically, would not have sufficed in the case of Robert Foye, with all the difficulties that resulted.

The tariff for serious offences takes into account the fact that all serious offenders have a propensity to reoffend, on the basis that if someone has crossed the proverbial Rubicon it is likely that they will be prepared to do so again. Although Mr Foye probably had a propensity for reoffending, his case was assessed on the basis that he had no previous history of sexual offending. Not all the evidence on sex offenders is scientific, but it is not normal for people to start committing such dreadful, heinous acts at the age of 28, or however old Mr Foye was when he committed his offence.

There is no getting away from the fact that the judgment was wrong. It is great to have the wisdom of hindsight, but the SPS has taken action to ensure that such judgment calls—which can only ever be judgment calls, whether they are made by the SPS, by the Parole Board for Scotland or by a judge or sheriff when imposing the sentence that is thought to be best in the circumstances—are based on the best available information. Politicians make judgment calls and sometimes get them wrong. Prison services make judgment calls and, tragically, sometimes get them wrong.

The Presiding Officer: We come to questions from back-bench members. We should manage to fit everyone in, if questions and answers are relatively succinct.

Jamie Hepburn (Central Scotland) (SNP): I echo the tribute that the cabinet secretary has paid to the victim in this case.

The cabinet secretary mentioned that in future there will be a presumption against returning to the open estate any prisoner who has previously absconded. What further action may be taken to build on the reduction in recent years in the number of prisoners absconding from the open estate and further to reduce absconding from all prisons? How does he expect that the McLeish commission will consider the matter?

Kenny MacAskill: It is for the McLeish commission to decide how best to consider the matter, but I assume that it will take evidence not just on what happens in the Scottish prison estate but on what happens in prison estates elsewhere. That is the direction that the commission has taken on penal policy to date, and I have faith in its ability to address the matter.

It is important that we should go back to basics and first principles to work out what we mean by the prison estate, who should be there and what the eligibility criteria should be. We should build on the current circumstances and change them if need be, enhancing and, in some instances, abandoning them, if appropriate. The Government is establishing a presumption against giving people who breach the considerable trust that has been placed in them a second opportunity to go to the open prison estate. Such prisoners have been convicted of committing offences and the decision to trust them has not been taken lightly. If that trust is breached, they should forfeit some of the rights that they accrued during their period of rehabilitation for good behaviour.

As well as establishing the presumption that I have described, we have indicated that the decision to transfer a prisoner to the open estate will now be made not by the governor of a secure prison, but at a senior level in the Scottish Prison Service. A variety of criteria will be taken into account, to ensure that there is uniformity and that all available information—not simply what is known to the prison governor—is viewed. It is not possible for us to go beyond that without getting into difficulties with the European convention on human rights or becoming involved in other court actions, but the presumption that prisoners who breach trust will not be returned to the open estate will stand. We will have the security of knowing that such prisoners will be trusted again only in the most extraordinary circumstances. After such prisoners have broken the trust that they have been given, they will have to show good reason why it is in the public interest that they should be given a second opportunity. Such instances might arise and, if appropriate, it seems to me that the opportunity should be offered, as a blanket refusal is not legally tenable.

This Government has introduced a presumption against return to the open estate, which is a change to how the prison estate has operated not simply under previous Governments since devolution, but under an 18-year Tory Government.

Paul Martin (Glasgow Springburn) (Lab): The cabinet secretary rightly set out the seriousness of the situation and the suffering that has been inflicted on a young woman and her family as a result of Robert Foye's actions. Lessons have to be learned, and some of them are set out in the internal review document that has been prepared by the Scottish Prison Service. I ask the cabinet secretary whether the Scottish Prison Service should be judge and jury in respect of those lessons. Would he support an external review of the Foye case that would allow for more objective scrutiny?

Kenny MacAskill: No, because we already have an external review in the form of the McLeish commission. Ms McNeill contributed to the commission's inquiries and I have no doubt that if Mr Martin has anything to contribute, Henry McLeish and his colleagues will be prepared to listen to him.

We have made a statement about the case today, we have made the report public and we will see what the McLeish commission finds. If Mr Martin wishes to draw to my attention particular issues, not only am I happy to ensure that Henry McLeish listens to him, but I am more than happy to meet him myself.

John Wilson (Central Scotland) (SNP): I welcome the cabinet secretary's statement, and my sympathies go to the individual who suffered the attack and her family.

Although I accept the recommendations in the report, does the cabinet secretary agree that there has to be more vigorous and robust scrutiny of the assessment of prisoners who are placed in the open prison estate? Does he also agree that adequate resources should be put in place to carry out home background assessments to determine a prisoner's suitability for early release?

I will follow up Mr Martin's question and ask the cabinet secretary to think carefully about and comment on whether it is adequate for the SPS to carry out its own investigations into the Foye case. Rather than referring the case to the McLeish commission, will he consider other ways that are external to the SPS in which investigations into incidents such as the Foye case can be carried out?

Kenny MacAskill: A variety of checks and balances exist in the prison system, including Her Majesty's chief inspector of prisons, who has reported on the open estate, as I mentioned. He has not been asked to report on the Foye case, but I have no doubt that he will make further comment on the open estate in due course. Although the inspections system was not instigated by this Government, it serves Scotland well and we support and welcome it.

Mr Wilson is right to say that we have to ensure that a robust assessment system is in place because it is a matter of fact that that dreadful incident happened, and we must learn lessons from it to minimise the likelihood of such an incident happening again. The McLeish commission offers independent scrutiny and analysis and the Government has undertaken to act on its findings.

Mr Wilson was also right to say that external factors have to be considered. Recommendation 2 deals with that point. It says that the SPS will have to interact with community-based justice and social work authorities to ensure that relevant information is available. Those external factors are as important as the behaviour of the individual in prison, and we have to ensure that there is joined-up working between the Scottish Prison Service and criminal justice and social work agencies outside the prison walls.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): I associate myself with the cabinet secretary's opening remarks about the victim and her family. However, I take no comfort from his statement, just as I took no comfort from the Scottish Prison Service report.

The cabinet secretary apologised to the victim and her family and stated that Robert Foye was responsible for the attack, but who will take responsibility for the total mismanagement of that offender? How can a prisoner who tested positive for drugs on 7 July be assessed on the very same day as being fit to be out on release?

I believe that a prisoner who absconds from the open estate should not be sent back there. The cabinet secretary said that decisions on such cases will be taken at a senior level. Does that mean that they will be taken by the cabinet secretary himself or by someone associated with the Scottish Prison Service?

Kenny MacAskill: Notwithstanding her comments, I presume that Cathie Craigie welcomes our decision to have a presumption against giving someone who has absconded a second opportunity to do so—[*Interruption.*] If Mrs Craigie will listen, she will learn that that is a significant change to the policy that we inherited and which was in situ when this tragic incident took place. We have sought to act on the matter.

Instead of having a witch-hunt, we need to find out what went wrong and to ensure that we learn lessons from it. The fact is that something went wrong, but we will better serve the interests not only of the victim but of public safety—which is of paramount consideration—if we act on the lessons that we can learn instead of throwing blame around and casting aspersions.

The decision whether someone who has absconded once from the open estate should be given a second opportunity will be made not by me but by the assistant director of prisons at the SPS, who, given his very significant position, will be able to examine a range of information. That is how the matter should be dealt with.

The Presiding Officer: As we are rapidly running out of time, I ask for very brief questions and answers.

John Lamont (Roxburgh and Berwickshire) (Con): Will the implementation of the SPS report's recommendations mean that certain prisoners could be reassessed and transferred back to a closed prison? How will that impact on the apparent rights of prisoners such as Robert Foye legally to challenge such a move?

Kenny MacAskill: I am not able to interact with people who might wish to raise actions under the ECHR—even when we as the Government are

gobsmacked by certain events and find ourselves having to pick up the tab because of the actions or inaction of previous Administrations.

The fact is that people go back and forth between the secure estate and the open estate. We inherited that situation and it will continue. I have no doubt that if, in implementing its recommendations, the SPS finds it inappropriate for a particular prisoner to be in the open estate, they will be transferred. Indeed, I would expect nothing less. Equally, if people breach other significant rules—not just those relating to absconds—in a way that constitutes a breach of trust, they, too, should be transferred.

From what the SPS and I have said, the member should feel assured that we are not going through the motions with these investigations. Instead, we want to ensure that our communities are as safe as possible. If it becomes clear that an error of judgment has been made about someone who is in the open estate—and if that error is notified—we expect that person to be transferred back to the secure estate in exactly the same way that they would be transferred were they, for example, found to be in possession of drugs, mobile phones or whatever else.

Andrew Welsh (Angus) (SNP): Does the cabinet secretary agree that, although this tragic and abhorrent crime has brought the open prison system into disrepute, we must maintain a sense of perspective and not, as a result of the foul acts perpetrated by the few, forget the good done by open prison staff in rehabilitating the vast majority of Castle Huntly prisoners? As the real problem lies in deciding which prisoners should be allowed into Castle Huntly's supervision, will he ensure that those who take the decision to send prisoners to Castle Huntly and to grant outside access always err on the side of caution?

Kenny MacAskill: Absolutely. The symbolism—indeed, the fact—of our introducing a presumption against returning to the open estate prisoners who have absconded once should send the message that we are going to err on the side of caution. That is certainly the approach taken in the review.

I thank Andrew Welsh for his well-made point that, despite the disrepute that it has been brought into because of this dreadful case, the open prison system remains important and vital and commands support from all parties in the chamber.

Health Care Associated Infection

The Presiding Officer (Alex Fergusson): The next item of business is a debate on motion S3M-1621, in the name of Nicola Sturgeon, on the health care associated infection task force.

15:10

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I am pleased to open the debate and to present our ambitious new plans for tackling health care associated infection in Scotland during the next three years and beyond.

It is important that we acknowledge that Scotland is a world leader in tackling HAI. During the past five years, our HAI task force has taken forward a high-quality programme of action to address infection and I take this opportunity to commend its work. On the amendment to our motion, I have no difficulty in recognising the previous Administration's contribution in setting up the task force and the Scottish National Party intends to support the amendment.

Although action that has been taken in recent years has stabilised rates of some infections and reduced rates of others, the overall rate of infection in our acute hospitals remains stubbornly high at 9.5 per cent, which is unacceptable. HAI takes a heavy financial toll—it costs the national health service nearly £200 million per year—and the threat of HAI erodes public confidence in the NHS. Many patients believe that, as a matter of course, they will catch an infection during their stay in hospital. We must work to recapture a sense of ownership and pride in our hospitals. NHS staff must embrace a culture in which keeping patients free from infection is not just their responsibility but everyone's responsibility.

In tackling HAI we must understand two important points. First, we will not eradicate all infection from our hospitals; what we can do is reduce infection and control it better. Robust and stringent infection control measures that are regularly applied in our health care environment will go a long way towards effectively tackling HAI.

Secondly, the NHS is not always to blame. Many infections are brought into hospitals from the community. That means that the public have a vital role to play, for example by washing their hands thoroughly, not sitting on beds and not touching drips and intravenous stands. However, it is essential that the NHS redoubles its efforts to drive down infection. A fresh and more targeted approach to HAI is needed if we are to ensure that the NHS delivers to the high standards that patients rightly expect.

Last November, I announced the largest ever investment in the fight against HAI in Scotland—£54 million over the next three years—to drive infection rates down from the rates that were published in July in the final report of the NHS Scotland national HAI prevalence survey. I also made it clear that the key elements of our patient safety and patient experience programmes will link with the HAI agenda to bring about a coherence of approach in the way the NHS in Scotland delivers its service.

It is also essential that we set NHS boards tough targets and hold them more firmly to account. A key example is the health improvement efficiency access and treatment target for all NHS boards to achieve a 30 per cent reduction in Staphylococcus aureus blood infections by 2010. We are at an early stage of monitoring progress, but the signs are good: seven mainland NHS boards already show signs of a downward trend. I am encouraged by that and I have asked the HAI task force to put in place stronger supporting mechanisms to assist boards in achieving the HEAT target.

Another core target is good hand hygiene compliance among NHS staff. Good hand hygiene is the single most effective way of cutting infection rates in hospitals and simply must become more embedded in everyday culture. The first Scottish national hand hygiene NHS campaign audit report, "Compliance with Hand Hygiene—Audit Report", which was published in December, showed that compliance had risen from 68 per cent in the first audit period, in February 2007, to 79 per cent in the second audit period, in September.

The increase in compliance is welcome, but there remains enormous scope for improvement. Patients rightly expect the highest standard of hand hygiene from staff, and a compliance rate of 79 per cent is not nearly good enough. I have set all NHS boards a target to achieve at least 90 per cent hand hygiene compliance by November. To help NHS boards to attain that target, Health Protection Scotland will step up its monitoring regime and publish quarterly audits from April this year. HPS will also take charge of a new look campaign that will be aimed primarily at NHS staff, patients and visitors.

Health Facilities Scotland has also been invited to raise the bar on hospital cleaning. It will overhaul the monitoring framework to ensure that it continues to set demanding and challenging standards for boards.

All those actions—and many more—are part of the new three-year HAI delivery plan that starts on 1 April. It aligns key action areas with the findings in the Scottish point prevalence survey and complements and co-ordinates the work being carried out on patient safety. The plan will be backed by £5 million of annual resources over the next three years.

I am making available £90,000 a year from the budget to allow the Scottish Commission for the Regulation of Care to recruit a nurse consultant for infection prevention and control. The nurse consultant's main target area will be to promote and increase higher standards of prevention and control of infection across the range of services that are regulated by the care commission, particularly those for the elderly. I know that that point is covered in the amendment to the motion.

I understand and stress how vital it is that we tackle all hospital infections, but the next matter that I want to touch on is our ambitious plan to tackle MRSA in our hospitals through the implementation of a national screening programme.

I have on previous occasions made clear my intention, subject to successful piloting, to roll out a national MRSA screening programme from April next year. That is in line with recommendations in the NHS Quality Improvement Scotland publication "The clinical and cost effectiveness of screening for meticillin-resistant *Staphylococcus aureus* (MRSA)", which was published in September 2007. To pave the way, and to ensure that we move ahead on the basis of robust evidence, we will invest £7 million this year in a screening pilot. NHS Ayrshire and Arran, NHS Grampian and NHS Western Isles will host the pilot as pathfinder boards from April this year. Those three boards together cover a population of almost a million people—a fifth of the Scottish population. They represent a diverse mix of urban, rural and island areas and include a range of hospitals from the very smallest to large teaching hospitals. The pilots will be an exhaustive test of the screening model and, crucially, will enable us to make informed decisions about the shape of the national programme that we intend to roll out from next year.

We should be under no illusion that MRSA screening is an ambitious undertaking, but I am proud that Scotland will lead the way with a planned, structured and deliverable national screening programme, which will help us to combat MRSA in our hospitals. I hope that the Parliament will give it enthusiastic support.

Closely linked to our work to tackle MRSA is our national initiative on improving the use of antibiotics. Earlier this month, I launched our new Scottish management of antimicrobial resistance action plan—ScotMARAP for short, which is perhaps not one of the NHS's better acronyms.

We have already invested £1.25 million in automated equipment to allow rapid standardised testing of antibiotic resistance in our laboratories.

A new national forum will oversee implantation of the plan and will collate and disseminate information to help us to up our game in a key plank of the fight against infection in our hospitals.

I hope that in the short time that I have had today I have managed to convey to Parliament and to the public the priority that I personally, and the Government as a whole, have accorded to the fight against infection in our hospitals and other care settings.

My announcements today mark a new era of HAI action in Scotland. A multimillion pound investment is being made in Scotland to reduce HAI and I am setting a raft of demanding targets for NHS boards.

Allied to that, we will deliver a linked agenda with that on patient safety and patient experience to ensure a coherent approach. We will drive up standards, deliver more effective measures to minimise the spread of infection, lessen the number of ward closures and bring down HAI rates. We intend to deliver an NHS that is safer, more reliable, more anticipatory and more integrated. The effect of that will be to ensure that all those who are involved in the provision of NHS care in Scotland have a renewed sense of purpose to improve the quality of care that they provide.

Our new approach to tackling HAI means that health boards will have to adopt more flexible practices, develop new roles and design new ways of working. I will expect better motivation and support from senior NHS staff, to help individual staff members to understand why it is essential that they adopt safer and better practices. I assure members that I will expect NHS boards to deliver in this important area. Progress will be monitored closely. I look forward to reporting back to the Scottish Parliament on the progress that is being made on reducing infections in our hospitals.

I move,

That the Parliament notes the Scottish Government's commitment to bring infection rates down by investing £54 million to support a far more intensive and targeted three-year programme of healthcare associated infection (HAI) work from 1 April 2008; believes that the Scottish Government is right to introduce a one-year pilot MRSA screening programme to shape a planned, structured and deliverable national screening programme from 2009-10; welcomes the links that will be established between the Patient Safety and Patient Experience programmes and the HAI agenda to bring about a coherency of approach in the way that NHSScotland delivers its service to patients; welcomes the Scottish Government's continuation of the multi-agency HAI Task Force, and agrees with the challenging target that the Scottish Government has set for all staff of NHS boards to achieve at least 90% hand hygiene compliance by November 2008.

15:21

Margaret Curran (Glasgow Baillieston) (Lab): I emphasise how much we in the Labour Party welcome the debate. We acknowledge that our amendment will be accepted. I associate myself with many of the points that the Cabinet Secretary for Health and Wellbeing made about tackling the issue, which is a challenging policy area.

It is important to begin by giving some context and by appreciating the scale of concern that exists more broadly in Scotland about the human impact of the lack of control of infections and its consequences. I will begin with a story that is from south of the border but which illustrates the human dimension to the issues that we are discussing. In October 2003, Emma Lynch gave birth to her daughter, Daisy, at Derriford hospital in Plymouth. Within two weeks, Daisy began developing a cyst on her chest. That one cyst spread and soon cysts covered her entire body. Daisy and her mother fought the infection for the next three years. It turned out that the child was sick because of an antibiotic-resistant form of the MRSA infection. She developed the infection at a hospital, a place where, one would assume, children are supposed to be taken care of, especially in the early years. In all likelihood, the little girl developed that horrific and life-threatening infection because someone did not wash their hands.

That story exemplifies how crucial the issue of health care associated infections is. As has been said, the number of such infections is on the rise. In the United Kingdom, the number of cases of infections that cause meningitis, pneumonia and toxic shock has increased by up to 100 per cent since 2002. The rate of MRSA infection has increased by 6 per cent and that for E coli infection has risen by 48 per cent. I acknowledge the cabinet secretary's focus on MRSA, but our amendment mentions the significance of tackling other infections.

As has been said, Scotland seems to have limited the spread of MRSA infection. According to a Scottish surveillance quarterly report, incidents of MRSA infections as well as the number of deaths resulting from them have remained largely stable since 2003. On the other hand, Clostridium difficile has been on the rise in certain areas in Scotland. In NHS Highland, the number of documented cases of C difficile rose to 120 in 2006, whereas there were only 50 in 2005. We have a problem with the spread of such infections in Scotland. We need to stay ahead of the rest of the UK on combating the spread of health care associated infections.

The fact that we have controlled infections such as MRSA is in large part a result of work by the previous Labour-led Executive. In England, emphasis has been put on investing in tackling

such infections. I hope that Scotland will maintain the progress that we made in the past. We produced the first health care associated infections action plan, in 2002, and established a ministerial task force in 2003 that had the explicit goal of tackling issues such as the decontamination of medical instruments and antibiotic prescribing. The task force has established numerous initiatives, such as the promotion of alcohol-based hand rubs, the national cleaning services specification for hand hygiene and the cleanliness champions programme, which is an education initiative.

The task force has recognised risk management methodologies and model infection-control policies, and it has promoted the innovative "NHSScotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection (HAI)". As I said earlier, it is important that Scotland continues to lead the way in fighting all health care associated infections. We will no doubt debate that again and again in the Parliament.

The Government's commitment to more funding to address the potential spread of infections is welcome—it is representative of our approach when we were in government. We welcome the investment as a necessary step in ensuring that Scotland remains at the forefront of medical advances in the field, and in ensuring that health care associated infections are addressed. As I have said, there are more cases of C difficile in the UK than cases of MRSA. I hope that the cabinet secretary will address that issue in the near future.

As the cabinet secretary said, it is important that we focus on—and provide funds for—tackling the issue of antibiotic resistance. That, too, will be a continuation of work that has gone on in the past. The 2005 prescribing policy established recommendations for proper practice in acute hospitals; increased NHS boards' accountability; promoted training and education in prescribing; and defined the minimum requirements for collecting information, auditing, and developing performance indicators. It is proper that the priority given to tackling the unnecessary prescribing of antibiotics is continued. It will undoubtedly be a crucial part of fighting the spread of health care associated infections.

One of the most important points that the cabinet secretary made was that we have to focus on the importance of promoting hand hygiene—a significant and effective way of stopping the spread of health care associated infections. I am persuaded that full hand hygiene compliance is essential in health care facilities if we are ever to control such infections. Health care workers must be trained in proper hand hygiene. It can be difficult to grasp that doctors, nurses and other members of staff need to be trained in hand hygiene. Knowledge of hand hygiene should be common to all, but the prevalence of health care associated infections shows that it is not. That must remain a priority.

Patients need to feel confident about speaking up if they think that a health care worker has not used proper hand hygiene measures when treating them or other patients. We need to let people know that they have the right to speak up. That will be imperative in addressing the problem of high rates of infection.

I note that the Government has set what seems to be an aggressive target of achieving 90 per cent hand hygiene compliance by November 2008. The quarterly statistics will help us to measure that. The Health Protection Scotland report shows us how and where the problem of a lack of hand hygiene compliance is most severe. I understand that some NHS boards, such as NHS Forth Valley and NHS Orkney, as well as the national waiting times centre, already have compliance rates of over 90 per cent. They should be congratulated on that. However, in some areas, compliance is below 70 per cent and, in others, it is below 60 per cent. It is vital that we continue to address the problem.

It is imperative that the Government focus on care homes, as we suggest in our amendment. The previous Executive made important strides in that area and we need to ensure that that work is continued.

In 2005, the care commission published "A Review of Cleanliness, Hygiene and Infection Control in Care Homes for Older People". I note what the minister has said today, but it is vital that older people in care homes can be promised a clean and secure environment. They have to be protected from infection.

It is vital that funding levels are maintained in order to match those in England. I hope that the minister will reassure us on that.

Nicola Sturgeon: I hope that I can reassure Margaret Curran that the investment that we have set aside for the next three years is 260 per cent higher than the investment over the past three years. I hope that Margaret Curran will take that as an assurance of our commitment to the right kind of investment in this issue.

Margaret Curran: I will take that—graciously, I hope—as an indication of the cabinet secretary's commitment. However, as I understand it, England has prioritised the issue, and we need to ensure that Scotland matches that.

We support the pilot screening programme. It is vital that it is introduced, but it will have to be assessed properly. The full conclusions of the pilot

will have to be brought to Parliament, because there is some debate over the effectiveness of the screening programme. However, it is clearly one prong in the attack on infections.

I hope that we can continue this debate and that we can assure the people of Scotland that we can master the challenge of tackling continuing infections.

I move amendment S3M-1621.1, to insert at end:

"commends the progress made by the previous Labour-led government in establishing the HAI Task Force and ensuring that Scotland was a model for tackling healthcare associated infections and should continue to be so; asks the Scottish Government to commit to tackling all healthcare associated infections, not just MRSA; notes the importance of combating infections in care homes, and calls for a specific plan of action to do so."

15:30

Mary Scanlon (Highlands and Islands) (Con): It is always good to follow the gracious Margaret Curran.

The Conservatives welcome the debate on health care associated infection. We also welcome the investment of £54 million in the targeted three-year programme of action on health care associated infection from April this year alongside the one-year MRSA screening pilot. However, we do not know whether £54 million is enough and I did not know until I came to the chamber exactly what outcomes we could expect from the programme and how they would be measured.

I also want to be gracious in welcoming the quarterly audits. It will be helpful to see not only what the outcomes are and where the money is invested, but how effective the investment is.

I acknowledge the target of 90 per cent hand hygiene compliance by November. My colleague Nanette Milne will say more on that. We note the previous Government's work on the issue. Although the measures that it took had a negligible effect on the number of infections, we can only assume that the situation would have been much worse had that action not been taken. We can all safely assume that the detection and recording of infections are also much better thanks to the measures that have been put in place.

However, while I was preparing for the debate, I came upon some interesting statistics and information. I ask the Minister for Public Health to consider responding to one or two of the points in her closing speech.

First, I notice that, in response to a written question from Margaret Mitchell in July last year, the cabinet secretary confirmed:

"Recording of MRSA infection on death certificates is based on the clinical judgement of each doctor."—[*Official Report*, *Written Answers*, 13 July 2007; S3W-1495.]

Given the £54 million investment, should we not insist on a standardised method of recording MRSA and other health care associated infections when they are significant contributory factors to death? Unless the information is recorded consistently, we will never know the true extent of the problem. Moreover, in 2002, hospital-acquired infections were not notifiable causes of death. Has that changed in the past six years? I trust that the minister will respond to that in her closing speech.

We need guidelines on the provision of proper changing facilities for staff to combat the possibilities of cross-infection. All members have probably had letters from constituents asking whether it is all right that their doctor walks round Tesco with his uniform on or that nurses walk their dogs with their uniforms on. I do not know the answer, but Brian Adam posed that question in 2006, and the British Medical Association confirmed that research has shown that pathogenic micro-organisms, including—I hope that I pronounce this right—S aureus and C difficile are frequently carried on clothes, which represents a potential source of infection in the clinical setting. Are there clear guidelines on wearing the same clothes in hospital and outside? Unless the basic facts about how health care associated infections spread are made known to staff, we are unlikely to be able to prevent them and treat them early.

Many hospital patients now fear a hospital-acquired infection more than surgery. The cost to the health service is significant: £186 million a year. Hospital-acquired infections also mean that patients take longer to recover and have longer hospital stays, which reduces bed nights for other patients and delays admissions and discharges. There is also the cost of closing wards to prevent the spread of infection.

I welcome what the health secretary said about the care commission recruiting a nurse consultant to address standards in care homes—the point about care homes is well made in the Labour amendment. The delivery plan states that care home surveillance will be explored in March 2009. I would like more information about that. I welcome the recruitment of the nurse consultant, but we must wait another year before there is proper care home surveillance.

There is another interesting set of figures relating to MRSA rates for large, medium, small and very small hospitals. I noted that the very small hospitals fared the best, whereas the large hospitals fared the worst by far. There could be many and various reasons for that, which I hope will be investigated during the period of the

delivery plan. However, it is concerning that the training package for infection control teams relating to ventilation and water systems has no stated target completion date in the delivery plan. Once again, I ask the minister to address that in her summing-up speech.

15:36

Ross Finnie (West of Scotland) (LD): I do not discern—and I suspect that, by the end of the debate, I will not discern—any disagreement with the proposition that, because health care associated infections continue to pose such a significant problem, as the cabinet secretary pointed out, it is vital for the Government, supported by all of us in the chamber, to continue to support the HAI programme and bear down on the problem. There is no great surprise about that.

It is therefore difficult, if not impossible, to disagree with the thrust of the motion—save only for one small point, which I hope is a typing error. I do not necessarily approve of the Americanisation of our language, therefore I find the noun "coherency" not to be preferable to the word "coherence". I hope that that proves that I read the motion, and I hope that there is not an undesirable trend in the language that is used in the chamber.

Nicola Sturgeon: I am pleased to intervene on that very serious point. I hope that the member will take some reassurance from my pronunciation of "coherence" during my speech. The word "coherency" in the motion is nothing more than a typing error. I know that the member will rest easy tonight, knowing that.

Ross Finnie: I am greatly comforted. We must maintain standards in the chamber.

Health care associated infection is a serious issue, and I welcome the debate. Margaret Curran is right to point out the previous Government's important role in recognising the problem and in establishing the HAI task force—although, without wishing to be picky again this afternoon, I notice the amendment's reference to "the previous Labour-led government". I comfort myself, however, with the knowledge that the radical thrust, and indeed the majority for everything that was passed, was provided by the Liberal Democrats.

The amendment refers to

"tackling all healthcare associated infections, not just MRSA",

with which I am sure we all agree. It was my understanding that the health targets for 2007-08 included reducing by 30 per cent the incidence of all Staphylococcus aureus—including MRSA—bacteraemia by 2010. Like Mary Scanlon, I have difficulty with the pronunciation. I would be grateful if the minister clarified that, as it is quite important in relation to the amendment. We obviously will support the amendment: it adds to the motion.

We welcome the Government's positive approach and its building on the work of the previous Government. Although the problem has not proved intractable, the figures remain extremely worrying. As the cabinet secretary suggested, we now have more evidence on the nature of HAI, and it is clear from the epidemiology that resources must be targeted at those people who are identified as being most susceptible to the infections that we are trying to address.

I mention targeting because it will be useful as we examine the issue in greater depth. The Dutch have developed much tighter controls on the use of antibiotics and have much higher standards of general hygiene in their hospitals, but they put their ability to control infection down to targeting, thus they restrict testing to all patients from high-risk groups. That is an extremely important point, to which I think the cabinet secretary alluded in her opening remarks. We welcome the establishment of further means to address those high-risk groups and we welcome the establishment of the screening pilot and the whole thrust of trying to tackle MRSA in particular.

We have an assurance that the situation will be monitored. Margaret Curran was right that an assessment will be brought to the Parliament. Although, on the face of it, the proposals appear to be a better way of ensuring that we get to the high-risk groups, we need evidence for that. The establishment of the MRSA screening pilot and of the C difficile reference library will go a long way to ensuring not just that we identify the disease but that we get results from testing to our hospitals much quicker than before.

I trust that the commendable resources that the Government is allocating will involve not just provision but capacity in hospitals, because there could be problems if we start to identify other difficulties.

I share some of Mary Scanlon's concerns. I hope that, in the next few weeks and months, the minister will help us to understand where we have got to with the action plan that was developed. The plan contained five clear headings under which we needed to develop where we were going—I accept that the previous Government did not complete the work. We need to get from the minister, at a fairly early stage, a statement that does not just reiterate the five broad areas—patient safety, education, surveillance, guidance and standards, and physical environment—but sets out the targets and where we are in meeting them. That is extremely important.

Finally, there is the issue of the public themselves. I welcome the emphasis on hand hygiene, but we must also deploy the work that the Food Standards Agency did in getting the general public to be much more aware of hand hygiene and engaging them in understanding and tackling the very difficult problem of HAI.

15:42

Ian McKee (Lothians) (SNP): We have heard a lot—and I am confident that we will hear a lot more as the debate progresses—about the virtues of cleanliness in preventing health care associated infections. That is right, because methicillin-resistant Staphylococcus aureus and, to an even greater extent, Clostridium difficile are easily spread as a result of poor hygiene—I yield to my Latin-usage adviser, Ross Finnie, as to the correct pronunciation of difficile.

Initiatives ranging from the deep cleaning of hospital wards to a simple insistence on regular hand washing to a wear-nothing-below-the-elbow policy all have their place in prevention, although I assure the chamber that the wear-nothing-below-the-elbow policy refers to the arms and not the rest of the body.

Moves that the cabinet secretary has announced, such as implementing a screening programme for MRSA in three pathfinder boards, are welcome. However, there is more to HAI than that. I want to break away from the cosy consensus that has pervaded the chamber and consider another factor in the genesis of HAI: the pressure on clinical staff to treat more and more patients under circumstances that are less than ideal. Part of the problem is that there are two measures of a hospital's efficiency. First, there is the financial or accountancy yardstick, in which bed occupancy is a measure of success. By that measure, the ideal outcome is 100 per cent bed occupancy 365 days a year. That is recognised in hospital private finance initiative contracts, where the number of beds is reduced to achieve that so-called efficiency. Here in Edinburgh, to achieve affordable unitary charge payments under the PFI contract for the new royal infirmary, there had to be a 24 per cent reduction in acute hospital bed numbers throughout Lothian.

Apologists for that sort of draconian reduction, which is not confined to Lothian, claim that a reduction in the number of acute beds is justified because more people are treated in the community, and even in their own homes. Although it is true that many people with medical problems such as asthma can now receive satisfactory treatment without involving a hospital, the same is not the case for surgical conditions. Several years ago, I happily excised cysts or removed toenails in my health centre treatment room, and one of my colleagues had a regular vasectomy list. However, all of that has now stopped. My old health centre, like the majority of general practitioner premises around the country, cannot be modified to suit the requirements of the Glennie report, which was aimed at preventing the transmission of new variant CJD, and such operations now have to take place in hospitals.

It can be argued, rightly, that minor operations rarely end up with admissions to a hospital bed, but they add to HAI risk, because they occupy hospital staff's time and expertise. Further, they introduce patients into an environment that is more likely to be populated by antibiotic-resistant pathogens.

What is the result of the policy of shrinking the number of available beds so that 100 per cent occupancy rates can be achieved? I mention in passing that, for many weeks over the past few months, GPs in Lothian have received a message informing them of the red status of Edinburgh royal infirmary, which states:

"Capacity on site is at present challenged. Any deferrals or alternatives to admission would be appreciated."

GPs are being asked not to send to hospital patients whom they feel unhappy about treating at home. That certainly involves a health risk, but not a cause of infection.

The real threat of infection comes from the so-called hot bedding that needs to take place so that treatment can continue. Patients lying on trolleys in accident and emergency wards have to be found a bed somewhere. In some hospitals, patients having operations such as hip joint replacements, in relation to which wound infection is a disaster, end up in inappropriate wards because they must go where a bed is available. Further, the shorter the time between one patient leaving a bed and another filling it, the greater the chance that the cleaning process will be inadequate.

I mentioned that there are two measures of a hospital's efficiency. The second is a clinical measure. It does not mind a proportion of empty beds; it requires a bed in an appropriate ward at an appropriate time. It requires staff who are not rushed off their feet. Perhaps we should examine the effect of some of our waiting list targets on that measure. It also requires an environment that is conducive to care, not speed. Unless and until we can return to those basic clinical principles—well known to Florence Nightingale—fighting HAI will be an uphill struggle.

15:48

Helen Eadie (Dunfermline East) (Lab): I agree with Ross Finnie's suggestion that there is likely to be near unanimity on this vital issue.

I welcome the cabinet secretary's announcements about the multimillion pound investments and wish her well. However, I am having some difficulty in keeping track of the various amounts of money that she is investing. Perhaps she will provide us with an overview of the investments when she winds up the debate.

I am sure that all politicians in the land will share the collective ambition that we express today.

In the time that I have been an MSP, my most harrowing and challenging case has involved one of my elderly constituents whose family has been decimated in four years. First, his wife died from MRSA, then his son died from the lack of appropriate mental health support and then his other son died of a heart condition. All of those deaths could have been avoided, but he has been left alone without anyone in the world. As if that were not bad enough, my constituent has had to cope with the withdrawal of all his advocacy support because of failures over the period in which he tried to complain and have his concerns addressed.

At a time when patients are vulnerable because they have just been diagnosed with a serious illness, the last thing that they should be doing is fretting. They need to have complete trust in the hospital where they are being treated and in the people who are delivering their care. However, one thing that causes patients great concern is the fear that their recovery will be hampered because their admission to hospital will lead them to contract a life-threatening superbug infection. Having had two major operations, I know that it is more than enough to have to cope with the worry of the surgery, without having to worry about further infection challenges. The Cabinet's commitment to screening is to be warmly welcomed.

NHS Quality Improvement Scotland raised many issues in the work that it undertook in 2003, the most important of which were about the inadequacy of monitoring, reviewing and evaluating policies on hospital-acquired infections. That thread applies throughout a number of health boards. Perhaps the cabinet secretary will discuss that issue further with NHS QIS and encourage it to revisit its 2003 investigations and update its work on this vital matter.

I was going to raise a number of other points, but I will not do so, because Ian McKee covered them adequately.

I share Ross Finnie's view. International experts paid tribute to the previous Labour and Liberal Democrat coalition when it produced its model for tackling hospital-acquired infections with a task force in 2003. At that time, an expert said:

"I am very impressed by the work of the HAI Task Force which is addressing this problem in a comprehensive manner … Reducing the levels of infection, including MRSA, is a major challenge for all countries. As Scotland points out, infection control is everybody's business, and the strategy followed by Scotland is an excellent model for others to look to."

That was said by Professor Didier Pittet. I say to Ross Finnie that I hope that I got the pronunciation right; I apologise if I did not. Professor Pittet is the World Health Organization's leading expert on MRSA, and those were his comments on the approach of Labour and the Liberal Democrats to controlling hospital-acquired infections.

I urge Nicola Sturgeon to take on board Ian McKee's points. Instead of repeating them, I will make some points that he might have missed. We can perhaps learn some lessons by looking south. In February 2008, a new antibiotics campaign was launched to remind the public, general practitioners and other doctors about the use of antibiotics. I do not remember whether the cabinet secretary mentioned that. If she did, I apologise, but it is important.

Nicola Sturgeon: I am always happy to consider lessons from elsewhere, and I appreciate Helen Eadie's point, but I remind her that I mentioned our policy, which I launched earlier this month, on dealing with antibiotic prescribing. Perhaps she would like to take this opportunity to congratulate the Scottish Government on making resources available for MRSA screening, which is something that the Government south of the border has not yet done.

Helen Eadie: I am sorry that the cabinet secretary feels aggrieved, but if she had been listening she would know that I congratulated the Government on its screening initiative and apologised if she had already mentioned antibiotics.

I urge the cabinet secretary to pick up on an important point that was made by Scotland's leading microbiologist, Professor Pennington, who believes that we need to consider death certification, because there is significant underreporting of MRSA and Clostridium difficile. He said:

"The whole process of death certification is basically flawed … I would not be surprised if we did a proper study of all deaths in a hospital that we would find the actual number involving MRSA was ten times higher."

Finally, we need to ensure that we support the calls from trade unions throughout Scotland and take hospital cleaning back in house where it is not already provided in house, because the matter is of serious concern.

15:54

Michael Matheson (Falkirk West) (SNP): I welcome the Cabinet Secretary for Health and Wellbeing's statement. In the spirit of consensus, I acknowledge the work that the previous Labour and Liberal Democrat Executive did to tackle HAI. However, despite the inception of the HAI task force in 2003, patients are still being exposed to avoidable infections. The overall rate in acute hospitals remains high: the cabinet secretary stated that it is in the region of 9.5 per cent. I was interested to note that hospital-acquired infections contributed to 422 deaths in Scotland last year, which represents a 5 per cent increase compared with 2005. Some 13 per cent of deaths are now associated with infections that are acquired after surgery. There is clearly a deep-running problem in our hospitals and health service if so many people suffer from hospital-acquired infections and, tragically, so many lives continue to be lost because of them.

I welcome the fact that, soon after she took up her portfolio, the cabinet secretary made it clear that tackling hospital-acquired infections was a priority not just for the Government but for her personally. In November last year, she announced £54 million to be invested in the coming three years to drive down hospital infections. Those resources underscore the Government's commitment to ensuring that preventing people from acquiring infections when they receive health care continues to be a priority in our health service.

A considerable part of the cabinet secretary's speech focused on MRSA. The problems associated with MRSA in the NHS are not new; they have been around for many years. I can remember in my previous career dealing with many patients who had MRSA, which extended their period in hospital and, sadly, for some resulted in their passing away.

I was interested to note that 51 deaths were attributed to MRSA in 2006, which was 38 up on the previous year. I suspect that the sudden jump is due to greater recording on death certificates. As we have already heard from Mary Scanlon and Helen Eadie, there is an issue about recording deaths caused by MRSA. Professor Hugh Pennington has stated that the real number of deaths linked to MRSA could be 10 times greater than the official statistics, which depend on recording the cause of death on the death certificate. If we are to tackle what the cabinet secretary correctly described as a stubborn problem with MRSA, we must ensure that we have the right data on which to base our judgments, which means that deaths must be properly recorded.

I welcome the delivery plan to deal with the problem more effectively, and the screening programme, which will be introduced in pilots. I am disappointed that my health board—Forth Valley NHS Board—was not selected as a pathfinder board, although I am reassured that, if the screening programme is successful and proves worth while, Forth Valley will be in a position to implement it in 2009-10. The additional funding for the pathfinder boards is welcome in trying to deal with infections.

The cabinet secretary accepted that hospitals will never be sanitised, infection-free places and that control in tackling the problem is the way forward. I agree. She also highlighted the importance of hand hygiene. All the moves proposed in the delivery plan, including more auditing and ensuring compliance, are to be welcomed, but a more consistent approach is needed throughout different hospitals. In the past six months, I have been in four different hospitals, all of which have a different approach to ensuring that staff and visitors clean their hands properly when entering wards, visiting bed units or leaving. There is a need to ensure greater consistency because, as Ross Finnie said, we must get people on board—the patients and the people who visit hospital. I hope that, as part of the delivery programme, there will be greater focus on ensuring more consistency in how hospitals get the message across to people about when they should clean their hands.

My final point is on the design of some of our hospitals, because it is clear that some designs contribute to the problem. For example, a patient in a single bed unit who has an intravenous drip and is being barrier nursed and who does not have a toilet in their unit must leave the unit to use the toilet outside the ward, which compromises infection control. In the long term, we will need to ensure that patients who are barrier nursed in single bed units in some of our older hospital estate buildings have integrated toilet facilities. In this day and age, it is unacceptable to expect people to use commodes when they could use toilets.

Patients, the public and staff must be united in tackling the problem. I hope that, through the additional resources, we will start to drive down the number of hospital-acquired infections rather than stabilise it, as at present. By reducing such infections, we will ensure that patients have more faith that, when they go into hospital, they will not contract an infection.

16:00

Irene Oldfather (Cunninghame South) (Lab): I welcome the commitment that the cabinet secretary has made and the opportunity that the

debate gives us to consider how we can reduce the risk of contracting hospital-acquired infection. It is clear that members across the parties are willing to debate the matter constructively.

I will talk about one of the most at-risk groups: the frail elderly. The key issue is that acquired infection is, in the main, preventable. Hand washing and good hygiene are obvious and cheap yet, for many years, we as a society did not do enough to promote them. Progress is now being made.

An important principle is the presumption against admission. For elderly people—and particularly those with dementia—hospital can be a risky place. I am sure that every member knows of an elderly person who was admitted to hospital for a minor ailment but who at best ended up as a delayed discharge or at worst acquired C diff or a fracture because their resistance was lower and their vulnerability to adverse incidents was higher.

To state the obvious, we need to ask whether the balance of risk for an elderly person is greater at home or in hospital. Ian McKee touched on that. Too many elderly people are admitted to hospital not for an operation or a blood transfusion—for something major or serious—but for diagnostic testing. Improving access to diagnostic testing could play a major role in decreasing the number of admissions and therefore the number of hospital-acquired infections. The Forth Valley project on care pathways for people with dementia has taken an innovative approach that ensures that accident and emergency staff are fully trained in dealing with dementia and encourages them to ask whether an admission is absolutely necessary and where the balance of risk lies.

In relation to admission to hospital, I will talk about closed wards. I found out only recently that patients are not allowed into or out of a closed ward but a visitor can visit freely without a gown, mask, gloves or even an information leaflet about why the ward is closed. Relatives need to be provided with information. If a ward is closed but visiting is allowed—that appears to be the case occasionally—relatives must be required to undertake basic barrier precautions. I emphasise that that is not a matter for clinical staff; a top-down management decision needs to be taken. I would welcome the minister clarifying in her summing-up whether some of the resources that have been announced could be allocated to addressing that issue.

That leads me to contaminated laundry. Mary Scanlon made the important point that viruses can be transmitted on clothing. I was surprised to learn that when a patient is in a closed ward—even when there is vomiting or diarrhoea—relatives are expected to take home contaminated personal laundry for washing. Given what Mary Scanlon said about bugs being transmitted on clothing, that issue is serious. I ask the minister to consider how we can ensure that, when wards are closed for good reason, in-house provision is made for laundering contaminated clothing.

I turn briefly to the care home sector. I was surprised to read in the Scottish Commission for the Regulation of Care's report on cleanliness, hygiene and infection control for older people that there have been a higher number of outbreaks of the norovirus—the winter vomiting bug—in care homes than in hospitals. The regulations relating to, and the monitoring of, acquired infection are much more rigorous in the acute sector than in care homes and there are more resources in that sector. I welcome the additional resources that the minister said will be available, but it is vital that those resources ensure that there is appropriate monitoring and surveillance—Mary Scanlon made that point—and that care home staff are adequately trained. Currently, too many staff in care homes go to work when they are unwell because they are low paid and do not receive sick pay. A culture change is needed, as there has been with hand washing. Staff who are ill must be encouraged not to go to work and so place frail elderly people at risk.

Having clearer procedures for closed wards where such procedures are necessary, dealing with contaminated laundry and—most important—raising standards in hospitals and care homes for the elderly could help to reduce acquired infections. It is no longer acceptable that some of the most frail and vulnerable people in our society, who have no voice, should be treated in such a way. Let us say that we are on their side, that we are their voice, and that we will work tirelessly in the Parliament to raise standards for them.

I support the amendment in Margaret Curran's name.

16:07

Nanette Milne (North East Scotland) (Con): This debate on dealing with health care associated infections is extremely important. However, I cannot help feeling sad that the reputation of a health service that has achieved so much for so many patients has been blighted by a problem that, to a large degree, is preventable. There have always been patients who have developed wound infections following surgery, and cross-infection has always been an issue. However, many people now live into frail and advanced old age; large numbers of patients are on treatments that impair their immunity; many more invasive procedures are routinely carried out in a variety of clinical settings; and many people expect to be given antibiotics for the most minor of ailments, whether or not there is a proven scientific need for them.

As a result, it is hardly surprising that HAIs have become a significant problem.

As infecting organisms increasingly develop resistance to antibiotics, it is important to try to prevent infections in the first place. Such attempts will be successful only if people work together and constantly bear in mind the need to avoid passing infections on from person to person. There must be awareness of how to prevent infections at all levels of health care and in all clinical settings.

Almost all health professionals of my vintage bemoan the informality and apparent lack of discipline in today's NHS compared with what happened when we started our careers. We all have tales of belligerent ward sisters whose eyes were everywhere and who would pick up the slightest infringement of the strict disciplinary code of the ward—a code of efficiency and cleanliness. In those days, no pieces of fluff were seen under beds or in corridors and bedpans and urine bottles were disposed of immediately. Any visitor or doctor who sat on a patient's bed could expect an explosion of wrath and visitors were strictly kept to their visiting hours. No more than two visitors were allowed around a bed unless the patient was close to death. White coats and uniforms were for wearing inside hospitals; we never saw nurses, physiotherapists, radiographers and suchlike in uniform in buses or shops. There was constant polishing and cleaning, and there was obsessive tidiness in general. Perhaps such an approach is old-fashioned, but it seemed to work. I will be honest: I do not recall huge emphasis being put on hand hygiene then, except, of course, when people were preparing for invasive procedures, when they were thorough and meticulous. However, MRSA was not endemic in the population then and few organisms were resistant to antibiotics.

As Ian McKee highlighted, life in the NHS was less pressurised in those days. Managers did not breathe down people's necks to push more and more patients more rapidly through the system, and the turnover of beds was slower. Time was taken to clean and fumigate all equipment thoroughly between patients' use of it. Things have now changed and it is even more important to run a tight ship, with rigid control of hygiene at institutional and personal level. Therefore, infection prevention and control activities must be everyday practice and applied consistently across the board, with all health care professionals sharing responsibility for them. The BMA's guidelines on health care associated infection must be heeded by all staff, including—perhaps especially—the more senior staff, who are role models for their juniors.

Antibiotic prescribing should be done responsibly to reduce the development of organism resistance. That can be difficult for a busy clinician, especially in primary care where patients demand treatment for minor ailments that would get better if left alone, although they might last a day or two longer. I must say that I am concerned about what will happen once prescription charges are dropped. Many patients nowadays think that they know it all—they browse the internet; they watch health programmes on television; they think that they know best—but they lack the years of training that go into making a competent health professional. Somehow, such patients must be educated to accept that a doctor who says that treatment is unnecessary is usually right, that viruses such as the common cold do not respond to antibiotic treatment and that, in normal people with normal immune systems, nature can often be an effective healer without the need for adjuvant drug therapy.

I think it sad that we need an HAI task force within the NHS, but I agree that, unfortunately, such a body is now needed if we are to be effective in combating such infections. I also think that the Government is right to pilot MRSA screening, and I very much welcome the cabinet secretary's announcement that three health boards will be involved. I will take a particularly keen interest in the pilot in the NHS Grampian area.

I accept that there must be a coherent approach to NHS service delivery, with links between patient safety and experience programmes and the HAI agenda. However, although I accept that a 90 per cent hand hygiene compliance target across Scotland may be reasonable and is right for this year, I think that we should nonetheless aim higher by seeking 100 per cent compliance as soon as possible thereafter. I am old-fashioned enough to recognise that that will be achieved only through stringent local enforcement by those who are responsible for the behaviour of staff, patients and their visitors—the old-fashioned ward sister, if you like—so that junior staff become so inured to good practice that it soon goes against their nature ever to breach the hygiene code and so that patients and visitors are constantly supervised to achieve the same result. I have seen that work effectively in a transplant unit, where infection control is, of course, vital. I see no reason why such enforcement should not work throughout the entire NHS.

I commend the cabinet secretary for her announcement this afternoon. I wish the Government every success in its endeavours to overcome HAIs and I hope that it will soon be able to report a very much reduced incidence of such infections in all health care settings.

16:13

James Kelly (Glasgow Rutherglen) (Lab): I welcome the opportunity to take part in this afternoon's debate on health care associated infections. I endorse the cabinet secretary's announcement and, obviously, I support the Labour amendment.

There is no doubt that HAIs are a serious issue. The human impact of such infections, which Margaret Curran mentioned, was driven home to me earlier this week when I read an obituary in *The Herald* for Drummond Hart, who was a hospital consultant. I did not know anything about Drummond Hart beforehand but he was clearly an active man who was successful professionally and had many interests in life. Sadly, in his last five years, he was wheelchair bound after he contracted MRSA while in hospital for an operation on his spine. That shows the indiscriminate nature of MRSA and how it can strike innocent people. People enter hospital looking to be cured of their illnesses; they do not expect to leave with an illness that they did not have when they went in. That shows the seriousness of the task that the Government faces.

The cabinet secretary spoke about the costs and strains that MRSA imposes on the health budget. This year's health budget of £10.25 billion is targeted mainly at heart disease, cancer and strokes. However, MRSA results in more people being admitted to hospitals, which imposes greater strain on the health service and its budget and diverts resources from the main health issues that the Government and the service are trying to tackle. Addressing health care associated infection is not only right but, hopefully, will lead in the long run to a healthier Scotland and more efficient use of the health budget.

I support the publication of the delivery plan and many of the measures that it contains, which build on the work of the previous Executive. Like other members, I welcome the publication of the MRSA screening programme. Much can be done to track the programme and lessons can be learned from it, to ensure that we have in place an effective plan to combat MRSA.

I reiterate the comments that many members have made about hand hygiene. It seems basic, but poor hand hygiene is one of the major causes of the spread of infection in hospitals. I agree with Michael Matheson that we need to put across a consistent message throughout the country, in all health boards, to ensure that people take hand hygiene seriously and that we meet the hand hygiene compliance target of 90 per cent that has been set. Audits can be an effective way of measuring progress towards the target and of learning positive lessons.

Local campaigns are also important. The NHS is a big organisation; even boards cover large areas. It is important that we get down to the grass roots of the NHS, through local campaigns to put across the key messages in tackling the spread of infection. Education is important in that regard. The necessary staff must be in place in boards and we must work closely with the trade unions and patient groups such as the Scottish patient safety alliance.

I reiterate my colleague Helen Eadie's comments on the importance of in-house cleaning services. We should work towards establishing a presumption in favour of such services.

The Labour amendment refers to care homes, about which Mary Scanlon and Irene Oldfather made good points. I pay tribute to both members for their excellent record of promoting investment in care homes. Patients in such homes are less able than patients in other parts of the NHS to look after themselves, so they are potentially more vulnerable to the spread of diseases such as MRSA. I welcome the positive announcements that the cabinet secretary has made on the issue.

This has been a good debate, although it has not evoked much interest in the press gallery, which is empty. Parliament has an important role to play on the issue. As Ross Finnie said, it is important that there should be accountability on both the delivery plan and the action plan. I look forward to the cabinet secretary giving us regular updates on those.

Health care associated infection is a serious problem that affects communities and families throughout Scotland. Today there has been much agreement on the issue across the chamber. I am sure that Scotland will watch closely as we seek to continue to make progress towards making our hospitals and care homes free from infection.

16:19

Sandra White (Glasgow) (SNP): The cabinet secretary is to be congratulated on this initiative. As the Labour amendment states, the previous Government is to be commended for the establishment of the HAI task force. The additional money that the cabinet secretary announced today and previously will be greatly significant in targeting not only MRSA but other virulent infections.

The incidence of MRSA has risen steadily over the years, as my colleague Michael Matheson and other members said. There are numerous reasons for that increase, but I will concentrate on just a few of them. A number of members spoke about the increase in drug-resistant infections, which has been brought about by the overprescribing of antibiotics. Nanette Milne targeted that point very

well in her contribution. I welcome the cabinet secretary's announcement on how we will monitor and tackle that problem. People have been used to going to the doctor and receiving antibiotics because of a perceived need. That has led to antibiotics no longer working and our being left with virulent infections.

Another area that gives cause for concern is the movement of patients between hospitals and wards. Not so long ago, it was much less common for patients to be moved from hospital to hospital or even between beds. Unfortunately, it is much more common now, which has something to do with the spread of infectious diseases.

Helen Eadie and Irene Oldfather mentioned the contracting out of hospital cleaning services, which has had a direct effect on the spread of infectious diseases. Staff are now paid less and less time is allocated to cleaning wards. It is certain that those circumstances have contributed to HAI. I hope that the cabinet secretary, or perhaps the task force, will look at that area. The one-year screening programme pilot will have positive results, but only as part of a coherent and integrated approach to overall hygiene in hospitals. That point was mentioned in the motion and recognised by the cabinet secretary.

I know that the cabinet secretary is aware of the different views about screening. I offer two examples. In Geneva, 3,000 patients were screened for MRSA and the conclusion was that there was no benefit in such a programme. However, three hospitals in America used screening for MRSA and the conclusion was that screening did work. That is why it is beneficial for us to run the screening pilot, which must be monitored and audited after a year, as was mentioned. The pilot scheme is most welcome.

The cabinet secretary spoke in her opening remarks about the appointment of nurse consultants. Could that role be enhanced to include targeted cleaning pilots? Ross Finnie raised that point, as did the HAI task force, which I think referred to the housekeeping monitoring group. Combined targeted cleaning, which would entail the cleaning of clinical equipment and the patient environment, including lockers and bedframes, would be extremely beneficial. If it is not possible to extend the role of the nurse consultant in that way, will the cabinet secretary consider a pilot of targeted hospital cleaning?

Nanette Milne and others spoke about the role of former matrons. We know that we cannot go back to those days, but it is important that hospitals are clean not only for patients and visitors, who are encouraged to wash their hands; the hospital environment must be considered too. Michael Matheson mentioned that services vary in hospitals. In a letter to *The Herald* yesterday, I think, a lady said that she went to visit her mother in hospital and was appalled to see blood on the handrails of her mother's bed. That is totally unacceptable. Although it is up to the hospital management to deal with the problem, a targeted cleaning pilot would tackle such situations and they would not be allowed to happen. Over time, it would become the norm for hospitals to reach that high standard of cleanliness.

Everyone here agrees that patients must come first. They must have faith in the health service. The MRSA screening programme and additional money that the cabinet secretary announced today will bring benefits not just to this generation but to many generations to come.

16:24

Rhoda Grant (Highlands and Islands) (Lab): Many members have talked about consensus, but consensus does not make the debate any less important—we should debate such issues.

The cabinet secretary mentioned the Western Isles hospital and I am pleased to have heard her announcement that it will form part of the screening pilot. The ethos at the Western Isles hospital is about infection control. When a person walks into the hospital, they hear a recorded message telling them to wash their hands if they have not already done so. They find hand-cleaning lotion for their use at the entrance to the ward and to the patient's room, and inside it at the foot of the bed, beside the patient notes, and by the wash-hand basin. The hospital strongly emphasises hand washing and informs patients, visitors and staff that they, too, should emphasise it. As I said, I am pleased that the Western Isles hospital is involved in the pilot. That demonstrates the effectiveness of the course of action that the hospital has taken. The pilot will also show any improvement that results from patients being screened before coming into hospital.

In many cases, it is too late to wait until someone has walked into a hospital to educate them on infection control. Patients are worried about their condition and what lies in store for them. Relatives, too, worry about what is happening to family members. That said, notices advising people to wash their hands are important. The Western Isles hospital displays them prominently. Other hospitals could learn from its example.

Hospitals have notices telling people not to sit on a patient's bed, but they do not tell people why they should not do that. We need a system that informs people about infection control long before they walk into a hospital, when they are feeling stressed because of what lies ahead for them, or their loved one.

Hand washing used to be taught in all schools. It then became part of community education, with notices posted in public places telling people to wash their hands. We need to return to those first principles on hand hygiene. We should mount a public information campaign to tell people why the rules have been put in place. People need to know about the importance of not sitting on a patient's bed, but on a chair, and of washing their hands before they visit the ward. Indeed, if someone is visiting more than one patient, they should be told about the importance of washing their hands between visits.

Advertising campaigns should be used to do that, given that they have been successful in the past. We also need to use the popular media. I am thinking of television programmes that highlight the health services, such as "Casualty" and Holby City" that have been used to put across good and important messages. We need to be told that it is everybody's responsibility to cut down on infection—staff, patients and visitors.

More public information is needed on the use of antibiotics, as many members have said. General practitioners are often pushed for time; they can come under a huge amount of pressure to prescribe antibiotics. Before patients go to their GP, it is important for them to be well informed about the ill effects of antibiotics on their health and that of others. We need to stop the over-prescribing of antibiotics, and responsibility for that lies not only with GPs but patients. Work also needs to be done on use of antibiotics in treating animals and, more generally, in farming. The impact of such use is not fully known, and it is an important source of antibiotic resistance.

We need also to counteract some of the scare stories that appear in the press on hospital-acquired infection. As other members have said, people can be reluctant to go into hospital because of the fear of catching an infection. It is also important that people understand the nature of the infections and where they arise. Hospital-acquired infections are obviously acquired in hospitals, but they do not always arise there; they can be brought into hospital.

We need to work with staff. I was interested to read the BMA briefing for the debate, which raised the importance of work clothing being designed with short sleeves and no ties. Perhaps it is time for us to look at the provision of uniforms for all staff. It is important for us to do so, given that the BMA has highlighted the issue. In the hospital pecking order, some staff wear uniforms and others do not.

Nicola Sturgeon: Rhoda Grant makes an important point. It may be of interest to her and other members to know that we are working with the trade unions on a national uniform specification. We will outline our plans in due course. I hope that that reassures her.

Rhoda Grant: Yes. I am grateful to the cabinet secretary for that information. The BMA position shows that doctors have the will and wish to see the proposal progressed.

We can use patients to reinforce the message about hand washing. It is important that we empower patients by giving them a role in telling people to wash their hands. Hand washing is part of nurse training, but what about the staff who qualified before it was included in the programme? Is hand washing included in training for other NHS staff? It is important that such matters be considered and that hand washing training becomes part of continuous professional development.

We must consider all other aspects of health care in the community. Members have mentioned nursing homes. Reducing infection is everyone's responsibility—staff, patients and visitors. We must all take our share of the fight against infection.

16:30

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): I agree with nearly everything that has been said in this worthwhile debate. The unanimity of the message will be encouraging to patients and health professionals.

Nicola Sturgeon pointed out that Scotland is a world leader in tackling health care associated infection. However, she also said that the infection rate in acute hospitals is 9.5 per cent and HAI costs us £200 million per annum. She was right to say that staff must have ownership of, and take pride in, hospitals. She made two important points. First, she said that eradicating infection is simply not possible—anyone who knows anything about science will realise that—but control of infection is possible and must be achieved. She mentioned funding of £54 million over the next three years. Members questioned whether that is enough money, but the proof of the pudding will be in the eating. Secondly, she talked about targeting health boards.

MRSA, which I think stands for methicillin-resistant Staphylococcus aureus—the cabinet secretary is nodding—is upon us. Indeed, a member of my family has suffered from MRSA. Luckily they made a complete recovery.

Margaret Curran welcomed the acceptance of the amendment and told us a harrowing tale, as did James Kelly, who referred to a recent obituary. Margaret Curran also made a good point about older people in care homes.

Mary Scanlon welcomed the quarterly audits and got into interesting territory about death certificates when she quoted from the response to a written question. That relates to Michael Matheson's point about whether the perceived rise in deaths from MRSA is related to recording methods. We are interested to know whether that is the case.

My colleague Ross Finnie emphasised that there is no disagreement in Parliament and made two important points. First, he said that resources must be targeted at the infections that we are trying to tackle. If we do not point the weapon at the right target we will be failing. He made play of the interesting and groundbreaking targeting work that the Dutch are doing, in particular in testing all patients in high-risk groups, so that audit can be as accurate as possible. Secondly, he was probably the first member to highlight the importance of the public. Many members subsequently made that point.

Reference was made to the pressure on clinical staff to have 100 per cent occupancy and to treat more and more patients—I think that the expression is "hot-bedding".

Helen Eadie and other members, including Rhoda Grant, Nanette Milne and Sandra White, talked about antibiotics, which is a big issue. I stand to be corrected on this by Dr Simpson or Dr McKee after the debate, but in my experience GPs and health professionals are now much less inclined to prescribe antibiotics and the regime is much stricter, which is a welcome step in the right direction. My mother, who is known to Mary Scanlon, Rob Gibson and other members, has a wee medicine cupboard, which is full of half-used antibiotic prescriptions, which seems to her to make eminent sense. How dangerous is that? I assure members that whenever I get the opportunity the antibiotics go straight into the bin.

Michael Matheson made an interesting reference to different approaches in hospitals and to hospital design. If I may turn, with the Deputy Presiding Officer's indulgence, to my constituency, the point has been made that big hospitals differ from little hospitals. That is not always accurate, but it is a general trend. Two small hospitals in my constituency are the Caithness general hospital and the Lawson Memorial hospital. Everything that the cabinet secretary and others have said is borne out by their experience: it is about environmental cleanliness and a hand-cleaning regime. The Lawson Memorial hospital asks visitors to maintain a hand-cleaning regime. As other members have said, there is no uniform approach—it varies from hospital to hospital. The regime that I have outlined is one of the factors that makes at least two hospitals in my constituency relatively successful.

I return to the points that were made by Ross Finnie. We must target resources. The minister and all members know—if we are honest about it—that resources are limited; we cannot throw endless money at the problem, so targeting is crucial. I flag up the Dutch example as one form of very good practice.

I conclude on the most positive aspect of the debate. As Ross Finnie and others said, the unanimity of contributions to the debate must surely give great encouragement to people who are potentially at risk of acquiring such infection, and to health professionals. It is an example of Parliament's being able to speak with one voice in a constructive way.

16:36

Jackson Carlaw (West of Scotland) (Con): We welcome all that Nicola Sturgeon has said today in her speech and her interventions, including the MRSA pilot that she announced, in what has been a useful debate on a matter on which there is often more fresh heat than fresh thought. This is one of those problems for which there is a commonsense remedy that is all too often absent, or the message is in danger of becoming overcomplicated in its delivery.

My experience of being a hospital patient is relatively recent, as an accident and emergency admission within the NHS with what turned out to be a fairly routinely diagnosed complaint of gall stones one year and kidney stones the next. After treatment had helped alleviate the immediate discomfort, I found it fascinating just to watch. So much is made of the experience of patients by politicians that—admittedly, this is almost a perverse logic—it was almost a privilege to be a politician who was also the patient.

It was fascinating to watch the endless stream of individuals who strolled through the men's general surgical ward. There were committed public servants going about their business and there were patients and their families. The newspaper trolley man was astonished and unable to oblige when I requested *The Herald*—he ensured that the ward was made aware of the special delivery for "the professor" the next day to my bed in a window corner. There was the self-evident suspicion of fellow patients at the various baskets and bowls of spring bulbs that were delivered to the same corner—it was seemingly further evidence of, at the very least, some extravagant erudition.

There was the delight of the man opposite me, whose colostomy bag burst frequently in the night, or of the Irishman in the bed next to me, who did a runner because, as he confided to me, "The Southern general makes a much better job of

drilling open a seized rear end." He was replaced by a young gentleman substantially the worse for wear after a Scotland match, whose excessively noisy comeuppance through the night was less than endearing. The hospital porters arrived, like buses, all at once—sometimes to ferry patients who had blocked a bed throughout the day and night for a routine X-ray, after which they could be discharged, but who as a result of lack of organisation lingered on, so other patients could not be admitted.

The staff—nurses, doctors, consultants, deliverers of meals and cleaning staff—were all doing their best, and the other patients were an on-going delight. There was the disembodied conversation heard over the partitions between an elderly man, who asked, "When did you get in, son?" and a recent arrival, who responded, "Just the day, big man, and no for long. And yersel?" "1952", came the reply. There was a daily procession of visitors, family and friends.

Not once, on either admission, did I hear anyone being challenged, or asked, to wash or sterilise their hands or not sit on the beds, nor was I ever savaged by a tie—the poor defenceless tie, around which now can be heard the clamour of indignant outrage as it is identified as the source of all infection. Ties, if worn, were tucked away within a coat or a jersey.

It seems to me that the most obvious action is the one that is least applied—washing or sterilising hands. In part, that seemed to me to be because there was no dragon enforcing the rule. I know that Conservatives have in the past called for matron, and I hope and believe that that has been for practical reasons and not just to fantasise about the swish of uniformed authority—I look over my shoulder, but no, she is not here. What is needed is a figure who has both the authority and confidence to bawl at anyone—patient, visitor, visiting politician, nurse, doctor or consultant—that they should wash or sterilise their hands and not sit on the beds. It appears that there are currently too many different chimney stacks of employee accountability and that in this grievance-rich age no one is able or prepared to take the risk of assuming overall command.

In saying all that, I accept that developments in medicine now keep us on the go until a greater age, often when hospitalised and with longer recovery times, and that our potential exposure in wards for longer and in a weakened state is a consequence of that. Therefore, when the BMA tells us that

"compliance with hand hygiene among professionals varies as a result of a lack of understanding of the associated risks and a lack of knowledge of the basic guidelines",

I cannot help but feel that there is considerable window dressing of a perfectly simple and straightforward concept: people should wash or sterilise their hands regularly and thoroughly. For hospital professionals, doing that and addressing the associated issues that Irene Oldfather raised should be as routine as is putting on a seatbelt for the driver of a car.

I have sympathy with the BMA's concern about inappropriate prescribing of antibiotics. I read its briefing on that subject and instantly recognised my mother, who—like Jamie Stone's mother—is a serial attendee of her local general practitioner, with an unshakeable belief that an antibiotic is the cure for all ills, from something genuinely serious to a blocked kitchen sink. There is a widespread belief that, even if an antibiotic is inappropriate, no harm can be done, yet those who prescribe them must know that harm is being done, as resistances are diminished. Again, public education is important, but the resolve of the medical profession in the face of what sometimes amounts to badgering is necessary, too.

In general, we believe the Government to be sincere in its objectives and we will support it today and will watch with interest the emerging outcomes. If the measures are successful, they will be a considerable achievement that will benefit the NHS hugely. I started by saying that common sense ought to be the rule but, as I have observed before, the problem with common sense is that it is not very common. The challenge for the Government is to make it so.

I hope that I have not made light of the subject. My sister-in-law—a mother of three in her 40s—is in the later stages of facing the cruel fate of the complications arising from untreatable breast cancer. Her journey has been made all the more stressful and grim by a hospital-acquired infection along the way. For that reason alone, I hope that the Government's announcements have a successful outcome.

16:42

Dr Richard Simpson (Mid Scotland and Fife) (Lab): As all other members who have spoken have said, the debate has been consensual, informed and of a high standard. As Jamie Stone said, that should give comfort to people out there. The problem is not new—it used to be called hospital-acquired infection. More than a century ago, Semmelweis solved some of the problems of puerperal deaths by getting people to wash between practising anatomy on cadavers and attending women in childbirth. That simple approach saved many lives. Jackson Carlaw is right that some of what we need to achieve is simple, or appears to be simple, yet it has been hard to achieve.

The first step in dealing with any such matter is to recognise the problem. I thank the cabinet secretary for her courtesy in accepting our amendment. I pay tribute to the 2002 action plan and the establishment of the ministerial task force, which, led by the chief medical officer and chief nursing officer, has been instrumental in setting up a model that has been praised as being excellent. However, despite that work, levels of MRSA have remained stubbornly high and consistent in the past few years.

Members mentioned some of the factors in that. Ian McKee referred to overoccupancy, although I must say that, despite the references that he made, the number of acute beds per capita in Scotland is still substantially greater than in England. However, it is true that overoccupancy rates of more than 90 per cent are associated with increased rates of infection. Delayed discharges were a major problem, because they increased the occupancy problem. The target that was set to eliminate delayed discharges by March 2008 has freed up more than 3,000 beds, which is a massive contribution to tackling the occupancy problem, as well as to tackling the problem of people who are kept in beds for a long time in hospital being more likely to contract a condition. Important changes have been made.

The rapid throughput of patients is another contributory factor, as has been said. Another factor that contributes to the problem is boarding out—rather than hot-bedding—which is the movement of patients between wards to allow more acute patients into the appropriate wards. Several members referred to those pressures.

Members have also referred to antibiotics—their type and their appropriate use. Such issues are of great importance, as Sandra White, Ross Finnie and others said. Not only must we have a public education programme on the appropriate use of antibiotics, but we must have antibiotic pharmacists in every trust, who can teach junior doctors and ensure that prescribing is appropriate, stating which antibiotic should be used, when and for how long. That will help to reduce rates of resistance. The national guidance that the cabinet secretary mentioned is indeed welcome.

Michael Matheson and other members referred to the physical environment. Redesign of some of the less appropriate elements will be important. Another important issue is decluttering—removing from wards items that do not need to be there. A more pristine environment can help.

Effective control of sterilisation of instruments is needed, and that issue has been tackled effectively. Irene Oldfather spoke about cleaning of soiled clothes, and that issue should be investigated. It would be useful if the task force could comment on whether the issue is important.

Helen Eadie, Ian McKee and others also spoke about clothing. Jackson Carlaw wittily but seriously discussed the clothing of all staff. It is important that people's clothing is right, so I welcome the cabinet secretary's announcement of a national clothing specification. The BMA would say, "Ditch the tie." In Ian McKee's early days and mine, if a doctor turned up without a tie, he was not allowed on the ward, but now he must turn up without a tie or he will not be allowed on the ward. That, I suppose, is progress.

Helen Eadie referred to cleaning of wards. I take issue with Nanette Milne about one issue among her reminiscences about the good old days. It was the Conservatives who, in effect, privatised cleaning services in hospitals; but it was the Labour Party, when it came to power with its Liberal colleagues in 1999, which said that there would be a presumption that the services would be taken back in-house. Cleaners are a very important part of the care system.

Nanette Milne: My point was that it does not matter who actually does the cleaning. What is important is the supervision of a high standard of cleaning.

Dr Simpson: I hate to say this, but I could tell Nanette Milne numerous stories of when contract cleaners have come in, done their bit and gone away, leaving the question of who would clean up the mess in the toilet when someone was sick. Senior nurses end up having to do that. That is fine—we all have to muck in and do the job—but because the cleaners are not part of the team, they are not there all the time. Taking the services back in-house is important.

Important too are the overall staff structures. When she responds to the debate, I would like the Minister for Public Health to address the December 2007 report "National Hand Hygiene NHS Campaign". Under the heading "Next Steps", the report says that funding to allow local health board co-ordinator posts should

"continue for at least two years".

Such work should be mainstreamed. I assume that that can be dealt with using the new funding. We need the whole team to be in place.

I welcome the cabinet secretary's announcement of a nurse consultant for the care commission, but I agree with Mary Scanlon that progress must be made on care homes. Irene Oldfather reminded us that inability to provide home care on a day-case basis can lead to unnecessary hospital admissions, which adds to the pressures.

I welcome the screening programme that has been announced and the funding for it, although I would correct one thing that the cabinet secretary

said. Alan Johnson has announced the introduction of screening for all elective patients by March 2009 and for emergency patients as soon as possible over the next three years. He has announced £130 million of funding to achieve that. He has praised the Dutch programme to which Ross Finnie and Jamie Stone referred. The Dutch call it the "search and destroy" system. That programme—Sandra White referred to two other research programmes—will have to be considered carefully. Before any pilots are established, I hope that the monitoring or evaluation group will have a chance to comment on how they are being run.

I have not covered hand hygiene to any great extent. The variation in compliance rates in the two audit periods is alarming. The range in compliance is 50 per cent to 94 per cent in the first audit period and increases to only 59 per cent to 94 per cent in the second audit period, so the 90 per cent target, which I welcome—it is also the World Health Organization's target—is entirely appropriate. It is a challenging target, and we will need a partnership between different groups to achieve it. As Margaret Curran and James Kelly indicated, it is important that patients be encouraged to say to doctors—who are the worst-performing group in the monitoring figures—that they must wash their hands when they move from one patient to another. The Scottish patient safety alliance should be asked to help in that regard.

The audit is obviously important. We are making good progress, but there needs to be a full partnership between health care staff, patients and visitors. We also need to share experience with our colleagues in England, who are introducing substantial programmes, so that we do not develop different methods. The funding in England is huge—£270 million annually by 2011—so I wonder whether we will have enough funding to tackle the issue in the way that the cabinet secretary clearly wants to.

16:51

The Minister for Public Health (Shona Robison): I have listened with interest to this constructive, stimulating and wide-ranging debate, which has served as a stark reminder that the Scottish Government and the NHS have a range of complex issues to tackle.

I will respond to as many of the issues that have been raised as I can. First, I want to underline some of the key points on our commitment to tackling HAI that the cabinet secretary outlined. The publication of the Scottish point prevalence survey came when we were new to government, but we reacted swiftly and made it clear that we simply would not tolerate a situation in which 9.5 per cent of patients in our acute hospitals suffer from some form of health care associated infection, with some of our elderly patients caught up in a seemingly endless cycle of infection and treatment.

Our investment of £54 million over three years is 260 per cent higher than the previous budget. It is a thorough and more robust HAI programme, which will bring about a number of benefits and make huge inroads into reducing the estimated £180 million that it costs the NHS in Scotland every year to treat patients with health care associated infections.

We have set a number of challenging targets for NHS boards to deliver on, not least the target to achieve a 30 per cent reduction in S aureus blood infections by 2010. The target of reaching at least 90 per cent hand hygiene compliance by November 2008 is another major challenge for boards, but we have made it clear that they will be given all the help that they need from infection control managers, local health board hand hygiene co-ordinators and Health Protection Scotland.

Our £7 million MRSA screening programme, which will be implemented by pathfinder boards next year, will take us a step further towards ensuring that each and every pre-admission patient is not unnecessarily exposed to an avoidable infection. We are convinced that, taken together, the measures in our coherent HAI delivery plan will make huge inroads into achieving our long-term goal of substantially reducing the rate of HAI in Scotland.

The debate has raised a number of interesting points, to which I have listened carefully. I will do my best to respond to them and I apologise if I do not cover them all. Margaret Curran and, I think, Rhoda Grant referred to the training of cleanliness champions. I remind members that all undergraduate nurses and doctors undergo cleanliness champion training. Nearly 4,500 have now completed that training programme.

Mary Scanlon, Michael Matheson and, I think, Helen Eadie mentioned MRSA being recorded on death certificates. Our quality control measure of MRSA instance is the national surveillance programme for blood infections. Those data give us a hard measure of the problem, whereas ascribing the cause of death can often be a subjective judgment. Having said that, I recognise the concerns that have been raised in the debate and we will consider the issue further.

Ross Finnie talked about the need to measure all HAIs, not just MRSA. We know from the point prevalence survey that MRSA and MSSA are a good proxy for HAI rates in general. It is not necessary to measure all types to know that we are winning the fight against infection.

Helen Eadie asked us to revisit the Quality Improvement Scotland review of NHS boards' HAI

policies. QIS has just published a revised set of HAI standards, against which boards will be assessed in 2009.

Michael Matheson spoke about the design of hospitals contributing to infections. We acknowledge that, and we have national guidance on hospital construction specifically for reducing infection risks. We are considering specifying single-room provision in hospitals, which, in future, will have many more en suite single rooms—up to 100 per cent where appropriate. The existing estate is more challenging, and we need to make progress on that.

Michael Matheson also talked about getting across the message about good hand hygiene to patients and visitors. A lot of work has gone into that. We had the six-week television and radio campaign at the beginning of the year, and a new campaign—aimed at members of the public who visit hospitals—is scheduled to begin later this year. That marks a shift in emphasis, which I am sure that many members, having raised the matter in the debate, will welcome.

Sandra White spoke about targeted hospital cleaning. As was indicated in the cabinet secretary's speech, the cleaning monitoring tool is being revised to ensure that improved, modern and rigorous standards apply in all NHS board areas.

Jackson Carlaw and Nanette Milne spoke about the nurse in charge—the matron, as I think Jackson Carlaw said. We are concluding a fundamental review of the role of the ward sister and charge nurse, which we will publish in the spring. That review makes it clear that the central responsibility of the ward sister lies in compliance with standards. I hope that that reassures those members.

Much of our new delivery plan will bring about quick results and improve patient care straight away. Care bundles will bring significant benefits to patients, who will receive consistent provision of care in many areas of hospital practice. However, there are other issues that we will not be able to solve so quickly. For example, it will take until 2010 for health boards to achieve our target of a 30 per cent reduction in S aureus blood infections, and it will be April 2009 before the national MRSA screening programme can be rolled out.

If we are to deliver our ultimate goal of a safer, cleaner and more efficient health service, I ask for members' patience. There are no quick or easy solutions, and we need everyone to play their part. We want to get it absolutely right, so that everyone in Scotland can once again be proud of our NHS and the service that it provides.

We have set out our stall today, and a huge amount of action will take place over the coming months and years to tackle HAI. We aim to bring about significant change in attitudes and behaviour across the NHS, and we will make a number of changes to the way in which services are delivered, so that patients can once again be confident that they will be safe and cared for while they are in hospital. We are instilling a sense of pride, progress and direction. However, as the cabinet secretary and I have both said, action on HAI must be taken over the longer term and across a wide range of fronts if we are to succeed.

It is clear from today's debate that HAI is an issue on which there is wide, cross-party support, as well as broad engagement from a wide variety of agencies, which are actively and enthusiastically tackling the problem. With the Parliament's support, the Scottish Government and the multi-agency HAI task force will do all that they can to reduce the rate of infections in our hospitals and other health care environments. I thank all members who contributed to this important debate.

Business Motions

16:59

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-1633, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 16 April 2008

2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Ministerial Statement: Scotland Week
followed by	Justice Committee Debate: 4th Report 2008 - Report on Inquiry into the Effective Use of Police Resources
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 17 April 2008

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Labour Party Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Finance and Sustainable Growth
2.55 pm	Stage 1 Debate: Public Health etc. (Scotland) Bill
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Wednesday 23 April 2008

2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Scottish Government Business
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business

Thursday 24 April 2008

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12 noon	First Minister's Question Time
2.15 pm	Themed Question Time Europe, External Affairs and Culture; Education and Lifelong Learning
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business—[*Bruce Crawford.*]

Motion agreed to.

The Presiding Officer: The next item of business is consideration of business motion S3M-1634, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a timetable for completion of stage 1 of the Creative Scotland Bill.

Motion moved,

That the Parliament agrees that consideration of the Creative Scotland Bill at Stage 1 be completed by 20 June 2008.—[*Bruce Crawford.*]

Motion agreed to.

Parliamentary Bureau Motions

17:00

The Presiding Officer (Alex Fergusson): The next item of business is consideration of Parliamentary Bureau motions S3M-1635 to S3M-1637 inclusive, in the name of Bruce Crawford, on the approval of Scottish statutory instruments.

Motions moved,

That the Parliament agrees that the draft Civil Legal Aid (Financial Conditions) (Scotland) Regulations 2008 be approved.

That the Parliament agrees that the draft Advice and Assistance (Financial Conditions) (Scotland) Regulations 2008 be approved.

That the Parliament agrees that the draft Protected Trust Deeds (Scotland) Regulations 2008 be approved.—[*Bruce Crawford.*]

Decision Time

17:01

The Presiding Officer: The first question is, that amendment S3M-1621.1, in the name of Margaret Curran, which seeks to amend motion S3M-1621, in the name of Nicola Sturgeon, on the health care associated infection task force, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR

Adam, Brian (Aberdeen North) (SNP)
Ahmad, Bashir (Glasgow) (SNP)
Allan, Alasdair (Western Isles) (SNP)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brown, Keith (Ochil) (SNP)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Campbell, Aileen (South of Scotland) (SNP)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Margaret (Glasgow Baillieston) (Lab)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
Gray, Iain (East Lothian) (Lab)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Hepburn, Jamie (Central Scotland) (SNP)
Hume, Jim (South of Scotland) (LD)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Kerr, Andy (East Kilbride) (Lab)
Kidd, Bill (Glasgow) (SNP)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Central Fife) (SNP)
Mather, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McArthur, Liam (Orkney) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)

McCabe, Tom (Hamilton South) (Lab)
McInnes, Alison (North East Scotland) (LD)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McMillan, Stuart (West of Scotland) (SNP)
McNeill, Pauline (Glasgow Kelvin) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Mulligan, Mary (Linlithgow) (Lab)
Murray, Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
O'Donnell, Hugh (Central Scotland) (LD)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Paterson, Gil (West of Scotland) (SNP)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scott, Tavish (Shetland) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Somerville, Shirley-Anne (Lothians) (SNP)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stewart, David (Highlands and Islands) (Lab)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Swinney, John (North Tayside) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Tolson, Jim (Dunfermline West) (LD)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)
Wilson, Bill (West of Scotland) (SNP)
Wilson, John (Central Scotland) (SNP)

ABSTENTIONS

Aitken, Bill (Glasgow) (Con)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brownlee, Derek (South of Scotland) (Con)
Carlaw, Jackson (West of Scotland) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lamont, John (Roxburgh and Berwickshire) (Con)
McGrigor, Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)

The Presiding Officer: The result of the division is: For 96, Against 0, Abstentions 16.

Amendment agreed to.

The Presiding Officer: The second question is, that motion S3M-1621, in the name of Nicola Sturgeon, on the health care associated infection task force, as amended, be agreed to.

Motion, as amended, agreed to.

Resolved,

That the Parliament notes the Scottish Government's commitment to bring infection rates down by investing £54 million to support a far more intensive and targeted three-year programme of healthcare associated infection (HAI) work from 1 April 2008; believes that the Scottish Government is right to introduce a one-year pilot MRSA screening programme to shape a planned, structured and deliverable national screening programme from 2009-10; welcomes the links that will be established between the Patient Safety and Patient Experience programmes and the HAI agenda to bring about a coherency of approach in the way that NHSScotland delivers its service to patients; welcomes the Scottish Government's continuation of the multi-agency HAI Task Force, and agrees with the challenging target that the Scottish Government has set for all staff of NHS boards to achieve at least 90% hand hygiene compliance by November 2008; commends the progress made by the previous Labour-led government in establishing the HAI Task Force and ensuring that Scotland was a model for tackling healthcare associated infections and should continue to be so; asks the Scottish Government to commit to tackling all healthcare associated infections, not just MRSA; notes the importance of combating infections in care homes, and calls for a specific plan of action to do so.

The Presiding Officer: I propose to put a single question on motions S3M-1635 to S3M-1637 inclusive, on the approval of Scottish statutory instruments. If any member objects to a single question being put, please say so now.

The question is, that motions S3M-1635 to S3M-1637, in the name of Bruce Crawford, on the approval of SSIs, be agreed to.

Motions agreed to.

That the Parliament agrees that the draft Civil Legal Aid (Financial Conditions) (Scotland) Regulations 2008 be approved.

That the Parliament agrees that the draft Advice and Assistance (Financial Conditions) (Scotland) Regulations 2008 be approved.

That the Parliament agrees that the draft Protected Trust Deeds (Scotland) Regulations 2008 be approved.

Terminal Illness (Patient Choice)

The Deputy Presiding Officer (Alasdair Morgan): The final item of business is a members' business debate on motion S3M-1452, in the name of Jeremy Purvis, on choices for people coming to the end of terminal illness. The debate will be concluded without any question being put.

Motion debated,

That the Parliament recognises and commends the committed work of all health professionals and carers who support patients with terminal illness; welcomes the advances in the palliative care movement over recent years that have benefited patients who are coming towards the end of terminal illness, specifically in the Borders; further welcomes national campaigns to allow patients to be aware of choices that they can make about their treatment and facilitate more patients to make the choice of dying at home, but believes, however, that there remain patients who wish to have greater control of their treatment and that it is right to debate allowing greater legal support for the choices that some patients may make to ask for assistance to die as they come towards the end of their terminal illnesses.

17:04

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): I am very supportive of the work of the palliative care movement in Scotland. I represent a constituency that has no hospice institution and relies heavily on the outstanding and caring work of the community palliative care staff under the consultant Dr David Jeffrey, for whom I have great regard. However, there are some people who are coming to the end of a terminal illness for whom the best palliative care available is not sufficient. They want greater control over the precise arrangements of their death. There is a choice gap in relation to allowing people to die at home for example. Marie Curie Cancer Care used that term in highlighting that, although 75 per cent of people say that if they had a terminal illness they would wish to die at home, only 25 per cent are likely to achieve their wish. A small number of those patients who wish to die at home would wish to have a greater say, when they are at the end of their life, over the precise circumstances of the timing of their death.

I wish to clarify my position. I do not propose euthanasia. I am not proposing a change in the law that will affect children. I am not proposing a change in the law that will affect all adults. My proposals concern not the elderly, the infirm or the depressed; they concern mentally competent adults with a terminal illness.

Although I acknowledge that the term is "physician-assisted suicide", the emphasis is not on a debate about suicide, in so far as that involves an individual choosing whether to live or die; rather, it is on situations in which an individual has been informed by two doctors that they have a terminal illness and the issue is how and when they die, rather than if.

I want to consider briefly the aftermath of the San Francisco earthquake in 1906. I will quote an eyewitness, the beer magnate Adolphus Busch. He said:

"The most terrible thing I saw was the futile struggle of a policeman and others to rescue a man who was pinned down in burning wreckage. The helpless man watched it in silence till the fire began burning his feet. Then he screamed and begged to be killed. The policeman took his name and address and shot him through the head."

I ask all those who will contribute to this debate, who are watching it or who are reading the *Official Report* whether they believe that the police officer in that incident should have been arrested for murder.

There will always be situations in which people can have their quality of life and their dignity robbed from them because of medical conditions, the disease that they suffer or the circumstances that they are in. People will address difficult times in different ways, seeking support from faith or medicine to assist them.

After a landmark case in 1996, the then Lord Advocate, Lord Mackay, issued a statement that he would not authorise the prosecution of a doctor if the doctor, acting in good faith and with the authority of the Court of Session, withdrew life-sustaining treatment from a patient with the result that the patient died. Commenting on the case, Professor Sheila McLean of Glasgow University's institute of law and ethics in medicine said:

"What our law does, therefore, is to endorse decisions which will result in the deaths of certain patients (most notably those who cannot express a preference) but not those who are competent to ask for aid in dying."

One person who is competent is a friend, whom I went to see on Saturday. He is in a palliative care bed in hospital. I have known him all my life. I have always respected him and he has been an inspiration to me, no more so than on Saturday. He has been and is a profoundly committed community and family man. Nothing is too much trouble for this former postmaster and councillor. He has been robbed of his physical, but not his mental ability by illness. He is a man of strong faith. He told me that he knows that he is leaving this world for a better one, and that his time to do that is now upon him. He has asked for treatment to be withdrawn and is now receiving only increasing amounts of palliative medicines. We do not know precisely the day that he will die, and that frustrates him. He told me that he is not afraid to die, and he has made the arrangements for his funeral. He has instructed that it will be forbidden for anyone to cry at his thanksgiving. His family is wonderfully supportive and loving, but I am not

sure that it will be possible to obey all his instructions.

He asked for assistance to die and was told by his doctor, "This is not Holland." We do not blame the doctors. I have not done so when I have previously debated this issue. However, there was underlying frustration that, now that his condition is terminal and he is with his family and friends and is ready to go, he is being told that he cannot be helped. I told him of this evening's debate, and he asked me to argue ever more strongly for a safeguarded way in which people in his situation can choose a dignified ending when they are ready to go.

The annual reports from the Oregon department of health allow us to consider an area where such a provision exists. The summary report on the Oregon Death with Dignity Act 1997 that was published in March this year shows figures from 1998 to 2006. In 2006, 65 prescriptions for lethal medications under the provisions of the Death with Dignity Act were written. Thirty-five patients took the medication, 19 died of the underlying disease and 11 were alive at the end of 2006. That corresponds to an estimated 19.7 DWDA deaths per 10,000 deaths, in a state of the United States of America whose population is not considerably different from Scotland's. Ninety three per cent of the patients died at home and 87 per cent had cancer. There is now 10 years' worth of evidence in Oregon, with clear published information about reports to the authorities. There has been no discernible abuse. When I visited Oregon, I met the medical examiner and spoke with doctors in the regulatory bodies.

The debate is not about statistics, but I quoted those statistics because I have heard time after time in recent years that the law would be abused by a mythical queue of doctors who are waiting to abuse a new law even though they have every means available to them to abuse the current law.

Towards the end of their lives, most people consider how, when and where they will die. That is perfectly natural. We now give patients much greater information on how they will die and they have the power to decide where they will die, but they cannot decide precisely when they will die. My proposal neither undermines the sanctity of life nor concentrates on death more than life.

On 4 October 2007, I asked the First Minister whether he agreed

"that there is no reason why a parliamentary committee could not debate fully, in detail and sensitively all these legal issues".

He replied:

"The right to die is an issue of conscience. The Parliament's Health and Sport Committee has every right to investigate these matters, which I hope it will do."—[*Official Report*, 4 October 2007; c 2474-5.]

Whether it is the Health and Sport Committee, the Justice Committee or the Equal Opportunities Committee that considers the matter, I hope that there is consensus that an inquiry is due.

I have not persuaded colleagues before now to make the change to the law that would help my friend. I feel a deep sense of regret about that. My friend has celebrated life all his life and has helped others. He is frustrated, as I am. However, he has asked us, if we remember his life when he is no longer with us, to ensure that other people's wishes can be respected as they approach the end of their lives, if his wishes cannot be respected this week or next week.

17:12

Roseanna Cunningham (Perth) (SNP): It is customary at members' business debates to congratulate the member concerned on obtaining the debate, but, although Jeremy Purvis's persistence can definitely be acknowledged, I wonder at what point he will recognise that there is simply no enthusiasm in the Parliament for what he wants to do. That is surely borne out by the fact that his motion gained only one signature.

As vice-convener of the cross-party group on palliative care—I see that the convener, Michael McMahon, is here as well—my interests lie in a diametrically opposed direction. I seek an expansion of palliative care and an extension of the hospice movement, not the introduction of something that would have the opposite effect. I hope that medical science will increasingly allow us to ease the last few days, weeks, months or years of our lives, whatever the reason for our final breath. Nor do I expect heroic efforts always to be undertaken by doctors. Sometimes it is right that people be allowed to refuse further and perhaps painful and pointless interventions that will be effective for only a little time, but standing back and letting nature take its course is not the same as intervening deliberately to help nature along.

I said that palliative care is diametrically opposed to what Jeremy Purvis proposes, but I go further. What he proposes would have a detrimental effect on palliative care. I do not accuse him of malign intent. I am certain that he acts from the best of intentions, but he is profoundly mistaken, because with the best will in the world, his idea, if implemented, would lead us down a dangerous road.

The experience in other countries has been by no means as positive as has been presented. In the Netherlands, the law has been used to demand an extension of euthanasia for those in extreme mental distress. Involuntary euthanasia has also been practised there. I think we used to call that murder, actually. The Dutch guidelines

have been almost unenforceable and constantly contravened. One Dutch study discovered that more than 50 per cent of Dutch doctors had actually suggested euthanasia to their patients and a staggering 25 per cent owned up to ending patients' lives without their consent. Brave new world, indeed.

Margo MacDonald (Lothians) (Ind): Does the member have information on the percentage or number of doctors in this country who have owned up to effective euthanasia?

Roseanna Cunningham: I do not know whether such figures exist. If they do, it would be interesting to have them.

When the law is changed, the position changes from being exceptional to being routine, and both palliative and hospice care begin to lag behind. Why bother, after all, if we are ending the lives of those who might benefit from that care? Oregon has fared little better—I acknowledge that Jeremy Purvis is trying to fix one of the deficiencies in the Oregon experience by confining his intentions to people who are coming to the very end of terminal illness, but palliative care has been compromised there and that is a consistent pattern. Members will all have received the British Medical Association's briefing for this debate—the BMA's position is implacable, and rightly so. However much sympathy we may have for those who are dying and wish to hasten their own end, they do not have the right to demand that other parties be implicated in that process.

Jeremy Purvis: The member will know that two years ago the BMA voted to be neutral on the issue, and it has now gone back to its former position; so opinion is finely balanced within the BMA. Given that I have visited and spoken to the palliative care movement in Oregon, will the member acknowledge that the movement has been supportive of the Death with Dignity Act rather than opposed to it?

Roseanna Cunningham: We can trade studies, and I have seen studies that suggest that the situation in Oregon is by no means as positive as the member suggests. The profoundly destructive nature of the change in the law for the relationship with all medical staff cannot be overstated. There have been a massive number of opt-outs for conscience reasons, followed by a decision that those with serious concerns should stay out of those branches of medicine in which it will become an issue.

There are practical reasons for not going down that road, but ultimately there is another, higher reason: it is plain wrong in itself, morally and ethically. For goodness' sake, let us concentrate on alleviating pain and suffering to ease death, not to bring about death as the member advocates.

17:16

Michael McMahon (Hamilton North and Bellshill) (Lab): I commend Jeremy Purvis for securing the debate. Although I profoundly disagree with the member on every aspect of his argument, it is admirable that in the face of continuing and overwhelming opposition from colleagues here, the medical professions, numerous voluntary sector carers groups and even his own political party—the members of which voted against his position at the Aberdeen party conference—he continues to plough his futile furrow.

In the short time that is available to me it is not possible to rehearse all the reasons for opposing the motion. With the overwhelming evidence and array of concerns about Mr Purvis's intentions, it would entail a difficult debate, and it is difficult to know where to start on his position on euthanasia. He can call it whatever he wants—it is euthanasia. I could use religious or ethical arguments, but I have neither the theological nor the ethical knowledge to expound on those in any great detail.

I appreciate, however, that in June 2006, when doctors voted overwhelmingly against legalising physician-assisted suicide and euthanasia, the BMA made it absolutely clear—as mentioned in the briefing that was sent out to members of the Parliament in anticipation of this debate—that properly resourced palliative care makes euthanasia unnecessary. Euthanasia is a desperate, negative and ultimately fruitless method of dealing with the issues that affect the terminally ill. It might be a cost-effective way to treat the terminally ill, but it will undoubtedly discourage the search for cures and treatments and it will undermine the motivation to provide good care and pain relief for the dying.

Margo MacDonald: Does the member contend that there is effective palliative care for every condition, or does he accept that there are some conditions for which there is no effective palliative care?

Michael McMahon: Those who participate in palliative care would argue that there is effective palliative care for every condition. Euthanasia is an inherently selfish concept that ignores the danger that vulnerable people will come under pressure to end their lives. Elderly and sick relatives will be coerced by selfish families, or face pressure to free up medical resources. Patients whose families believe that euthanasia is the only solution will be abandoned.

Palliative care can be enough to prevent a person from feeling any need to contemplate euthanasia. A sick person matters to the last moment of their life. Medical professionals can

help someone to die peacefully, but also to live until they die. They key to successful palliative care is to treat the patient as a person, not as a set of symptoms or a medical problem. As the World Health Organization states, palliative care

"affirms life and regards dying as a normal process; it intends neither to hasten or postpone death … it provides relief from pain"

and suffering, and it

"integrates the psychological and spiritual aspects"

of the patient. Good palliative care is the alternative to euthanasia. If it were available to every patient, it would certainly reduce the desire for death to be brought about sooner.

Mr Purvis used the example of Oregon, as do most people who support his position, but the reality is that comparing Oregon with Scotland is comparing apples with oranges. The hospice movement and palliative care in America are not the same as the hospice movement and the palliative care service in Scotland.

Ending a patient's life by injection is quicker, easier and cheaper than palliative care and many people fear that introducing euthanasia would reduce the availability of palliative care, because health systems would inexorably veer towards the most cost-effective ways of dealing with dying patients. Providing palliative care can be very hard work, physically and psychologically, and it is dearer than euthanasia. If we concentrated our efforts on ensuring that palliative care and the hospice movement were adequately resourced, positive and effective end-of-life care could become more widely available throughout Scotland.

Proper palliative care makes euthanasia unnecessary. I urge Jeremy Purvis to divert his efforts into fighting for the positive palliative route towards a person's death and away from his negative and destructive solution.

17:21

Mary Scanlon (Highlands and Islands) (Con): I thank Jeremy Purvis for giving us the opportunity to debate the motion. I agree with him that everyone has the right to a dignified end to life. My party has a free vote of individual conscience on the issue, so the views that I express are personal.

In March 2004, the House of Lords debated a bill, the purpose of which was

"to provide an option for terminal patients who are suffering unbearably to bring an end to their suffering".—[*Official Report*, *House of Lords*, 10 March 2004; Vol 658, c 1316.]

My starting point is that no one should suffer unbearably. I acknowledge the excellent work that Michael McMahon has done in the Scottish Parliament's three sessions to raise awareness of and bring about improvements and excellence in and better access to palliative care.

Gil Paterson and I run the cross-party group on chronic pain, which Dorothy-Grace Elder established in the first session and which Jean Turner and I ran in the second session. Jeremy Purvis is welcome to join that group. I am pleased to say that tremendous progress in dealing with chronic pain has been made through the McEwen report, the new NHS Quality Improvement Scotland report, a managed clinical network in Glasgow, the development of QIS clinical standards and meetings between pain consultants and the Scottish Medicines Consortium to ensure that drugs to alleviate pain are given due consideration to achieve better patient care.

No terminally ill person in Scotland should suffer unbearably if this Government—like the previous one—takes seriously palliative care and the treatment and management of chronic pain. I pay tribute to all the staff who work in the national health service, in hospices, in primary care and in the voluntary sector—particularly in Marie Curie Cancer Care, which Jeremy Purvis mentioned—to support patients who suffer from persistent and chronic pain. Please let us not make people afraid that they will suffer unbearably when they are dying. Palliative care services and pain management are improving by the day, although there is still a long way to go to achieve equal access, as Jeremy Purvis said.

For several reasons, I do not support Jeremy Purvis's motion. I do not want any person to be frightened of pain when they are dying. I do not want anyone to feel that they are being a burden by taking up an NHS or hospice bed. I do not want anyone to think that their life is worth less than another's or that they have outlived their usefulness. No person should feel obliged to choose to die sooner than nature dictates because, for example, they are worried about being a burden or about the financial implications for other family members of a long-term illness.

Another issue is trust between a doctor and a patient and the honouring of the Hippocratic oath and the duty of care by all doctors. It can be difficult to interpret the wishes of a terminally ill patient if they are delirious, confused or—as in many cases—depressed. How can a clinician be absolutely confident that a request for a life to be ended sooner does not arise from a person's state of mind, whether or not that state of mind is treatable?

Finally, the BMA's briefing for the debate is excellent. I would have thought that no politician should force doctors who voted by an overwhelming majority against legalising physician-assisted suicide and euthanasia to change their minds.

17:25

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): There is no question in my mind about the importance of this debate. I, too, congratulate my friend and colleague Jeremy Purvis on securing it. I am sure that he has again been made well aware of the feelings of members throughout the chamber on the issue. Like other members, I welcome the opportunity to contribute. I agree that it is entirely appropriate that there should be such debates in the Scottish Parliament and in wider Scottish society.

Many people and organisations outside the Parliament attempt to portray moral issues in easy, dogmatic, black-and-white terms. As a Christian—I make no apology for saying that—I believe in the sanctity of human life, but as a liberal I fervently believe that I cannot impose my moral beliefs on other people. I follow John Stuart Mill's philosophy that people should be free to take their own actions—and be responsible for those actions—as long as they do not cause serious harm to others. In that context, I have real difficulty with the motion and assisted dying for the terminally ill.

I believe that if the law were changed to make suicide legal in certain circumstances, as Jeremy Purvis wants it to be, immense pressure would be brought to bear on the most vulnerable people in our society—those who know or fear that they are near the end of their time here. I do not think that people in such circumstances would really have a free choice. What messages would we be sending them? Would we be saying that they have outlived their usefulness and that they are a burden on society? That does not have to be done in clear ways; it can be done in unclear ways.

The issue of free choice is central to the debate. Everyone in our civilised society has a right to life. We are talking about the possibility of changing Scots law to allow people to ask for assistance to die as they come towards the end of a terminal illness. I do not believe that any proposals could deal with the indirect coercion that could—and I am sure would—occur in such circumstances.

Jeremy Purvis: If a vulnerable patient is surviving only because they are receiving life-sustaining treatment or nutrition and water, what protections currently exist against subtle pressure being brought to bear by the type of people whom the member has mentioned that could result in that patient making a request for that life-sustaining treatment to be withdrawn?

Mike Rumbles: As I said, we are not talking about easy, black-and-white issues. There is quite a difference between withdrawing somebody's life support and assisting in their death.

There is no doubt in my mind that the change to Scots law that Jeremy Purvis is championing has been proposed for the best of reasons. He wants to change the law to help people in the direst circumstances, but I cannot support what has been proposed. As a liberal, I understand Jeremy Purvis's arguments, but I firmly believe that we would break John Stuart Mill's fundamental principle of freedom if we changed the law. We should not change the law to allow people to ask for assistance to die because that would precipitate real and devastating harm to the most vulnerable people in society. I urge members not to support such a change to Scots law in the event that the proposal comes before us in the future.

17:29

Ian McKee (Lothians) (SNP): I congratulate Jeremy Purvis on securing the debate and hope that everyone accepts that there is good faith on both sides. As Mike Rumbles said, the issues are not black and white. There is no desire to end people's lives casually or to prolong people's agony unnecessarily.

As a general practitioner for most of my professional lifetime, I have devoted many years to caring for patients. I have shared the good times as well as the bad times with people whom I now consider to be more friends than clients or customers. There can be nothing more precious than helping someone whom one has known for years to end their life in dignity and in circumstances that they have chosen when the time comes.

The care of people with a terminal illness has improved immensely. It is strange to look back at a time when hospices did not exist in Edinburgh. In those times, people with terminal cancer were sent to hospital to end their days in a most inappropriate setting or—perhaps worse still—left languishing at home with scant support for themselves or their relatives. Today, we have not only hospices but teams of devoted and experienced professionals who help such people to stay at home, help them to manage intractable pain and remove much of the fear that inevitably surrounds people when they are at the end of their days. How often I have heard laughter restored to a home that previously knew only fear.

The motion is right to draw attention to the great advances in palliative care and the committed work of all who administer it and otherwise care for the terminally ill—yet, sometimes, even that is not enough. There are people who, for reasons that are right for them, do not wish to live life to the bitter end. They may have the same condition as a parent had and know exactly what is in store for them. Whatever the reason, it is right that we at least consider whether there are any circumstances in which society should consent to help them to achieve their desired end.

The motion deliberately does not go into specifics, which should be the subject of prolonged and intensive debate. For example, it is vital that patients do not have the perception that the doctor who is looking after them might be part of a team that ends life. We need to learn lessons from countries where such a right already exists and see how it works in practice. The nature of the consent and the method by which someone's wish to die is assisted are just two more issues that require extensive debate before any legislation can be introduced, but it is a debate that we should have.

I have every sympathy with those who find even consideration of the topic repellent. I can think of only one or two patients in my time as a GP who I thought genuinely wanted to end their lives at a time chosen by them, but I regard it as a failing in our system of care that that course was not open to them. In my experience, and despite what has been said today, palliative care is not always effective. When it is, the need for other measures will probably fade away. Let us take the first step in the debate by continuing to discuss the issues that are so important to us all.

17:32

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Dr McKee has demonstrated the difficulty that the medical profession faces in this debate. We want to do our best for patients by supporting them and supporting their wishes, but being involved in ending life when one's whole creed is based on sustaining life presents an enormous difficulty. I met the group to which Jeremy Purvis referred. After discussing the topic, I was still left wrestling with it, rather as Dr McKee is.

I began my work in the field back in the early 1970s, as part of a team that comprised a surgeon, a psychiatrist and a nurse who were supported by the Scottish Health Education Council to go round Scotland to raise the issue of palliative care. The first hospice in Edinburgh was founded at that time and St Joseph's hospice in London had just been founded. After that, I was associated with the group that founded Strathcarron hospice. I served on the hospice's board of management and eventually served as its chair over a period of some 12 years. In a sense, a lot of my professional life has been associated with the end of life as well as with supporting sick people in other ways.

Occasionally, despite all the best efforts being made, palliative care is insufficient to prevent death being difficult, troubled and disturbing for the individual and the relatives. It is not perfect, but I believe that we have made progress. It was, frankly, a disgrace throughout the United Kingdom. The journey is not yet complete by any means, but there have been enormous advances.

It is vital that we focus on palliative care at home, because the purpose of the hospice movement is to provide symptom relief and restoration of the best possible function, and to allow people to return to where the overwhelming majority wish to end their lives—at home. At the moment, that does not happen because there is inadequate symptom control, because palliative care teams are not strong enough, because there are not adequate resources to maintain primary care teams or because individuals feel that they will become an overwhelming burden on their relatives.

People fear death. We cannot remove that fear totally from patients, but in the overwhelming majority of cases we can take away fear of the symptoms that are associated with death. In my experience, the vast majority of people accept psychologically the process of death and dying as natural for them and as a transition that does not require assistance.

At this stage, we should not amend the law. We should continue the debate and discussion that is under way, promote palliative care at home, ensure good symptom control and ensure that living wills and advance directives, which we have debated in the chamber, are sustained and improved. The burden on individuals and professionals of introducing euthanasia is too great. Thank God we are not in the same situation as America, where 40 per cent of bankruptcies are caused by health problems. Patients here are not subject to the same stimulus to desire death to lift a burden on themselves. The time is not yet right for Jeremy Purvis's motion, but I thank him for giving us an opportunity to debate the issue.

17:37

Nanette Milne (North East Scotland) (Con): I am sorry that Jeremy Purvis has chosen to raise this issue again, scarcely three years after his previous members' business debate on dying with dignity and the Parliament's detailed consideration of his attempts to have the concept of assisted dying for terminal patients embedded in Scots law.

Much of the motion is completely uncontroversial. Of course we recognise and commend

"the committed work of all health professionals and carers who support patients with terminal illness"

and welcome

"the advances in the palliative care movement over recent years"

that have been of immense benefit to people facing end-of-life problems and to their families. We also support campaigns such as that led by Marie Curie Cancer Care to raise awareness of

treatment options and to help to realise the wishes of those who want to die at home, in familiar surroundings, with their loved ones, pets and treasured belongings close by.

We cannot and should not prevent discussion of what Mr Purvis describes as

"allowing greater legal support for the choices that some patients may make to ask for assistance to die as they come towards the end of their terminal illnesses."

However, as I said during the 2004 debate,

"For me, a former health professional who is bound by the Hippocratic oath and trained to improve and prolong life where possible, the idea of actively and deliberately ending a human life is disturbing."—[*Official Report*, 11 November 2004; c 11883.]

Although I understand Jeremy Purvis's concerns, based on the tragic examples that he has cited this evening, I think that his proposal would risk undermining patient trust in doctors and medical advice. Although I regard as acceptable the withdrawal or withholding of life-prolonging treatment from a terminally ill patient who no longer wishes to have it, that is a long way from actively assisting a terminally ill patient to die. I accept that pain relief, to be effective in dealing with a terminal illness, may on occasion have to be given at levels that exceed the limits of tolerance, but that is different from deliberate physician-assisted suicide, which would be a dangerous concept to enshrine in law.

As Jeremy Purvis's motion states, in recent years there have been significant improvements in palliative care. The spreading implementation of the gold standards framework of palliative care, together with on-going work by Marie Curie Cancer Care and others, should make it possible before long for the vast majority of patients to experience a dignified and comfortable death when that inevitability arrives.

End-of-life care is as vital a part of health care as any that a patient receives throughout life. It is my sincere belief that good palliative care that takes the fear and pain out of dying is far better than exploring the route to euthanasia and legally assisted suicide. I know of very few people in the health care professions who believe that we should be heading down that route. I very much agree with the BMA's opposition to assisted dying, backed by a large majority of its members. I also agree strongly with the BMA that good, effective palliative care must be made more widely available throughout Scotland and that that is the goal towards which we should all be working.

The Deputy Presiding Officer: Because a couple of members are still waiting to speak, I am minded to accept a motion without notice to extend the debate by up to 10 minutes.

Motion moved,

That, under Rule 8.14.3, the debate be extended until 5.55 pm.—[*Jeremy Purvis*.]

Motion agreed to.

17:41

Michael Matheson (Falkirk West) (SNP): Although I recognise Jeremy Purvis's commitment to this cause, I am somewhat disappointed that we are revisiting the debate after just over three years. I had thought that he would recognise that there is no political, public or professional support for the introduction of euthanasia in Scotland.

Jeremy Purvis: So far, no member has explained why the result of the previous BMA vote was clearly in favour of neutrality, although the result has since changed due to the balance of opinion in the profession. Is the member saying that there is no public support for euthanasia? It is clear from opinion poll after opinion poll that people think that there should at least be a debate on the subject, whereas some members are saying that there should not even be a debate in the Parliament.

Michael Matheson: There is a big difference between the public wanting to have a debate and their supporting euthanasia.

The BMA's briefing is clear, so I will quote from it for Jeremy Purvis's sake. It says:

"In 2005, the BMA considered the merits of allowing Parliament and society at large to decide this controversial matter and took a neutral stance. In 2006, however, BMA members voting at the annual meeting made clear that the majority oppose"

the idea of introducing physician-assisted suicide. The BMA's position is clear. It has gone from a position of neutrality to one of opposing euthanasia. I believe that the direction of travel in the debate is to oppose euthanasia. The BMA has taken a firmer stance on the matter since the time of Jeremy Purvis's previous debate.

The birth of life is a natural process and death should also be natural. Those who actively promote euthanasia state that it is their human right to decide when they should actively end their life. Under the European convention on human rights and considerable case law on the subject, there is no such right to die.

I turn to the impact that euthanasia could have on the doctor-patient dynamic. To provide a doctor with a licence to kill or to assist in euthanasia would give that doctor a role that does not sit comfortably with their role as a healer and carer. Such a role would fly in the face of the Hippocratic oath and would undoubtedly impair the doctor-patient relationship, which is founded on trust. The doctor-patient relationship would be seriously

compromised if patients could not express their distress lest it led to the possibility of euthanasia.

Doctors and nurses should not be put under any pressure to consider the possibility of assisted suicide, nor should patients have to feel under pressure to consider the same possibility should they be in a state in which they might be considered for assisted suicide. The BMA also highlighted that issue as one of the potential downsides of any change to legislation.

Euthanasia is not simply about deciding whether to switch off the life-support machine; it is about deciding whether a person should die. It is a form of suicide that cuts short a person's life. The case law to which Jeremy Purvis referred has more to do with switching off life support than it has with actively promoting a person's death.

I turn to the bigger picture. As a society, we could consider going down the route of allowing people to make this type of decision, with all the implications that that entails. However, if we did that, too many people would be put into the position of having to consider the value of their life. I do not believe that that is a healthy place for society to be.

17:45

Margo MacDonald (Lothians) (Ind): It is very healthy for all of us to consider the value of our life. In fact, it should be mandatory for the human condition. We should all concern ourselves with the contribution that we make to society in general throughout our life, right up to the moment of death.

As the chamber knows, I have a degenerative condition. I would like to have the right to determine by how much my capacity to fulfil my social, familial and personal functions will be truncated. I would like the ability to take that decision. I do not want to burden any doctor, friend or family member; I want to find a way in which I can take the decision to end my life in the event that I am unlucky enough to have the worst form of Parkinson's near the end of my life. From the responses to interventions, we can see that the medical practitioners among us have admitted that palliative care is not as effective in all cases as everyone wants it to be. I am mindful of that. I may be one of the unlucky ones. I apologise for the personal nature of my contribution, but this is not theory for me.

I fully appreciate why Michael Matheson wanted to invoke the law. However, in this case, yet again the law may be an ass. To say that it is illegal for anyone to force themselves to die is to deny the bravery of countless soldiers over the ages. People have taken that decision for one reason or another. It is just that we are now accepting that it is possible for someone to take that decision when they are in sound mind and they can do so in a measured capacity.

I am mindful of what the doctors say and how difficult it is for them. However, I have read the personal testimony of doctors and have seen doctors who have admitted in court to assisting a suicide. They are no less doctors in my estimation for having done that.

I congratulate Jeremy Purvis on bringing the debate to the chamber as quickly as he could. Many people have a lot less time than I have.

17:47

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I join Margo MacDonald in thanking Jeremy Purvis for bringing the motion to the chamber. I thank all members who contributed to the debate.

I believe strongly that the chamber should be a forum for debating difficult and sensitive issues—issues on which we take different views. The quality of this evening's debate has done the Parliament great credit.

At the end of my remarks, I will turn to the issue of whether people should have the right to seek assistance to die. Before I do so, I take the opportunity—very deliberately—to set out our plans for palliative and end-of-life care. In my view, it is impossible to overstate the importance of good-quality palliative care that is based on the wishes and needs of patients. I agree very, very strongly with Roseanna Cunningham, Michael McMahon and other members that our clear focus must be on improving palliative and end-of-life care services. As Ian McKee and other members said, much still needs to be done to ensure that we provide the quality and range of services that people have the right to expect.

I place on record my great admiration and support for the work that professionals, volunteers and carers do to support people who are in the final stages of terminal illness. Over the past few months, I have had many opportunities to see that work for myself during visits to hospices and when I launched the new dedicated palliative care ambulance in Tayside last year, which is a commendable example of partnership working between the NHS and the voluntary sector.

The presence of so many members in the chamber undoubtedly reflects the sensitivity of the issue and the deep-rooted feelings that we all have about the importance of ensuring that people who have been diagnosed as suffering from a life-ending illness receive the most appropriate care. People who are terminally ill and are nearing the

end of life must receive the best palliative and end-of-life care available. I take seriously the Government's obligation to ensure that such care is delivered, which is why in our "Better Health, Better Care" action plan we made a clear commitment to strengthening palliative care services throughout Scotland.

We are committed to ensuring that the NHS takes full account of the recommendations of the Scottish partnership for palliative care report, "Palliative and end of life care in Scotland: the case for a cohesive approach", which supports a single approach—for the first time—to palliative and end-of-life care provision throughout the country.

Our aim is and must be to ensure that palliative and end-of-life care will be provided to anyone who requires such care, regardless of diagnosis, to ensure quality of life for patients and their carers and families. As Mary Scanlon and other members said, we must ensure that people do not suffer unbearably during the final stages of life.

Mary Scanlon urged the Government to maintain the momentum of the previous Government on improving palliative care services and I assure her and other members that we will do so. Our palliative and end-of-life care action plan will be published later this year. The action plan will focus carefully on the recommendations of the Scottish partnership for palliative care report and it will incorporate developments that have been made since the report's publication. We will write to NHS boards and key stakeholders by the end of the month to set out our plans. To support and drive that work, a national clinical lead for palliative care has been appointed, and every NHS board has an executive-level lead.

I agree strongly with Jeremy Purvis that people must have greater choice about where to die. I praise the Marie Curie Cancer Care supporting choice campaign, which has highlighted a desire among patients who are suffering from an end-of-life illness to be treated and to end their life at home if possible. That choice should not be questioned and we should encourage the development of services to support it. Community health partnerships and managed clinical networks play a crucial role in enabling patients to remain at home during the terminal stages of their illness, by allowing for the integration of specialist palliative care and primary health care teams. Such an approach is vital if people are to have the right to choose to die at home, as many people want to do, if that is at all possible.

On the final point in the motion, many members mentioned the parliamentary debate on the issue that was held in November 2004. The position has not changed since then. Although suicide is not illegal in Scotland, actively assisting someone to end their life is illegal. If the issue comes before the Parliament again it will be a matter of conscience that will require careful consideration. However, although I appreciate that there are many strongly held views, I detect no consensus that there should be a change in the law. Indeed, although I respect the views of Jeremy Purvis, Margo MacDonald and other members, I share the concern that members expressed about the consequences of a change in the law; about the difficulty of ensuring adequate safeguards; and about the danger of making terminally ill people, particularly elderly people, feel under pressure to end their lives. It is extremely important to acknowledge, as members have done, the fundamental difference between refusing life-prolonging treatment and seeking active assistance to die.

Our view remains that patients' wishes should be respected as far as is practicable and possible, but that the provision of care and treatment must be within the confines of the law. At this stage, we have no plans to change the law, although I repeat the First Minister's comment that it is open to any parliamentary committee to examine the issue in more detail if it wishes to do so. I hope that our plans for palliative and end-of-life care demonstrate our deep commitment to improving the quality of life of people with terminal illness and their families and carers. That is where our efforts should be focused.

I hope that what I have said assures members and the public that patient choice is uppermost in our minds when we deal with end-of-life issues. We will continue to seek to ensure that suitable choices are available and that the wishes of individuals and their families are respected.

Meeting closed at 17:55.

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

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Wednesday 2 April 2008

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley